Analysis of the Maryland Executive Budget

For the Fiscal Year Ending June 30, 2017

Volume III: J00J00 – N00I0006

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Volume III

Analysis of the Maryland Executive Budget – Fiscal 2017

J00J00
Maryland Transportation Authority
Maryland Department of Transportation

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
Nonbudgeted Fund	$382,861	$403,384	$423,275	$19,891	4.9%
Adjusted Nonbudgeted Fund	**$382,861**	**$403,384**	**$423,275**	**$19,891**	**4.9%**
Adjusted Grand Total	**$382,861**	**$403,384**	**$423,275**	**$19,891**	**4.9%**

- The fiscal 2017 budget increases by $19.9 million, or 4.9%, with the largest change, an $11.5 million increase in debt service costs.

- Other changes include a $3.7 million increase in personnel costs and a $6.0 million increase for the establishment of a facilities renewal fund.

PAYGO Capital Budget Data

($ in Thousands)

	Fiscal 2015	Fiscal 2016		Fiscal 2017
	Actual	Legislative	Working	Allowance
Nonbudgeted	$325,882	$293,513	$279,454	$363,520
Total	**$325,882**	**$293,513**	**$279,454**	**$363,520**

- The fiscal 2016 working appropriation is $14.1 million lower than the legislative appropriation. A decline of $44.1 million on system preservation minor projects is offset by a $30.0 million increase in spending on the InterCounty Connector (ICC) project due to cash flow changes.

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

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- The fiscal 2017 budget grows by $84.1 million, or 30.1%, compared to the current year working appropriation, with the change largely driven by system preservation minor projects and major rehabilitation projects at the Fort McHenry Tunnel and the Baltimore Harbor Tunnel.

Operating and PAYGO Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Operating Budget Positions	1,779.50	1,761.00	1,749.00	-12.00
Regular PAYGO Budget Positions	0.00	0.00	0.00	0.00
Total Regular Positions	**1,779.50**	**1,761.00**	**1,749.00**	**-12.00**
Operating Budget FTEs	0.00	0.00	0.00	0.00
PAYGO Budget FTEs	0.00	0.00	0.00	0.00
Total FTEs	**0.00**	**0.00**	**0.00**	**0.00**
Total Personnel	**1,779.50**	**1,761.00**	**1,749.00**	**-12.00**
Vacancy Data: Regular Positions				
Turnover and Necessary Vacancies, Excluding New Positions		83.95	4.80%	
Positions and Percentage Vacant as of 12/31/15		159.00	9.09%	

- Personnel decreases by 12.0 regular positions compared to the fiscal 2016 working appropriation. The reduction is accomplished by eliminating vacant positions.

- The budgeted turnover rate is 4.80%, requiring 83.95 vacant positions. As of December 31, 2015, the Maryland Transportation Authority (MDTA) had 159.00 vacant positions, for a vacancy rate of 9.09%.

Analysis in Brief

Major Trends

Tolled Traffic Grows, Toll Revenue Sees One-year Decline: In fiscal 2015, traffic totaled 115.7 million vehicles, an increase of 2.8%. In fiscal 2015, toll revenue totaled $631.9 million, a 10.1% increase from fiscal 2014. In fiscal 2016, revenues are estimated to total $586.9 million, a decrease of $45.0 million, or 7.1%, due to the reduction of toll rates.

Electronic Tolling Continues to Increase: E-ZPass electronic toll collection is available at all Maryland toll facilities, as well as parts of the Midwest and most of the northeastern part of the United States. In fiscal 2015, MDTA collected 75% of tolls with E-ZPass and has set a goal of collecting 79% of tolls with E-ZPass by fiscal 2018.

Issues

MDTA Cuts Tolls Systemwide: MDTA cut tolls systemwide beginning on July 1, 2015, a move that MDTA estimated at the time would reduce revenue by $54.0 million in fiscal 2016 and by $335.0 million across the forecast period of fiscal 2016 to 2021. New estimates based on higher than expected traffic show revenue reductions of $241.6 million. While no large projects are expected in the current forecast period, the planning and engineering study currently underway for the replacement of the Harry W. Nice Memorial Bridge (Nice Bridge) anticipates construction to start between fiscal 2023 and 2025. That project is expected to cost approximately $1 billion. In its proposal to the MDTA board regarding the toll reductions, the agency noted the possibility of redecking the Nice Bridge and delaying its replacement. **MDTA should clarify its plans regarding a timeline and financing for replacement of the Nice Bridge as well as contingencies for any other large, unexpected capital projects. MDTA should also describe the functional capacity of this single lane crossing for the Nice Bridge if a replacement is not built. The Department of Legislative Services recommends that the legislature amend the Transportation Article so that the same public hearing and comment requirements pertain to both toll increases and reductions.**

ICC Usage Drops Below Initial Predictions: Since its opening in fiscal 2011 through 2014, the ICC had been generating revenue approximately in line with fiscal 2011 projections. However, beginning in fiscal 2015, the highway's revenue began to fall behind early estimates. This decline is due to both the reduction in tolls and lower than anticipated usage of the highway. **MDTA should comment on the lower than anticipated revenue of the ICC.**

All-electronic Tolling Put Off Until 2019: MDTA reports that it is revising its initial all-electronic tolling (AET) proposal by delaying implementation until at least fiscal 2019, after the contract for the next generation of its toll system is executed. The agency is incorporating what it has learned from its AET analysis into its Request for Proposals for its next generation toll system. **MDTA should comment on its next steps toward AET and if it supports the concept of legislation to address uncollected toll revenue from trucks.**

MDTA Reviews Unencumbered Cash Levels: MDTA sets an administrative benchmark of $350 million in unencumbered cash on hand. This benchmark became law at least through fiscal 2020 with the enactment of Chapter 489 of 2015 (the Budget Reconciliation and Financing Act). In addition, in the 2015 session, the committees requested a report on this benchmark and whether it should be more directly tied to the agency's operating costs. MDTA reports that it believes its $350 million benchmark is appropriate and that it consistently reviews its financial policies. **MDTA should comment on the benchmark and any factors that could lead the department to alter the policy.**

Operating Budget Recommended Actions

1. Nonbudgeted.

PAYGO Budget Recommended Actions

1. Nonbudgeted.

J00J00

Maryland Transportation Authority

Maryland Department of Transportation

Budget Analysis

Program Description

The Maryland Transportation Authority (MDTA) has exclusive authority relating to the financing, construction, operation, maintenance, and repair of Maryland's toll facilities and any other revenue-generating projects authorized under that title. MDTA divides its facilities into three regions and has jurisdiction over the following facilities:

- **Northern Region** – includes the Thomas J. Hatem Memorial Bridge (US 40), the John F. Kennedy Memorial Highway (I-95), and the newly opened Express Toll Lanes (ETL) on I-95;

- **Central Region** – includes the Baltimore Harbor (I-895) and Fort McHenry (I-95) tunnels and thruways, the Francis Scott Key Bridge (I-695), and I-395 leading to Baltimore City; and

- **Southern Region** – includes the Harry W. Nice Memorial Bridge (Nice Bridge) (US 301), the William Preston Lane, Jr. Memorial Bridge (Bay Bridge) (US 50/301), and the InterCounty Connector (ICC) (MD 200).

Membership of the MDTA board is comprised of eight members appointed by the Governor with the advice and consent of the State Senate. The Secretary of Transportation serves as the chairman of MDTA. MDTA's revenues are held separately from the Transportation Trust Fund (TTF), and the agency operates off budget.

MDTA's police force is responsible for security and law enforcement services at all of MDTA's toll facilities, except the northern region of I-95, which is patrolled by the Department of State Police. MDTA is also under contract with the Maryland Aviation Administration to provide law enforcement services at the Baltimore/Washington International Thurgood Marshall (BWI Marshall) Airport, and with the Maryland Port Administration (MPA) to provide law enforcement services at MPA-owned facilities at the Port of Baltimore.

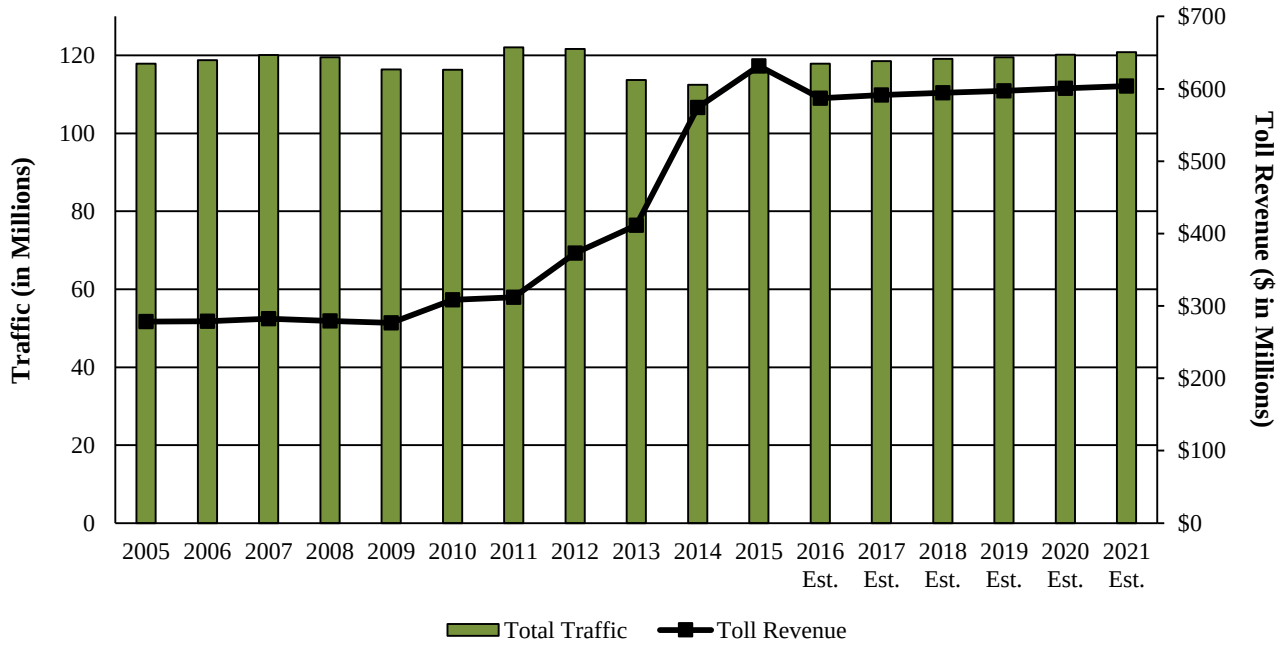
MDTA's goal is to be a financial steward of its dedicated revenue sources that are used to provide vital transportation links that move people and commerce in Maryland.

Performance Analysis: Managing for Results

1. Tolled Traffic Grows, Toll Revenue Sees One-year Decline

In order to achieve its vision of "creating E-Z passage throughout Maryland," the first goal of MDTA is to efficiently and effectively move people and goods across the State. **Exhibit 1** shows the annual tolled traffic and toll revenue at MDTA's legacy facilities from fiscal 2005 through 2021. This exhibit excludes new traffic and revenue from the ICC beginning in fiscal 2011 and the I-95 ETLs beginning in fiscal 2015. Inclusion of this data would skew historical comparisons.

Exhibit 1
Annual Tolled Traffic and Legacy Toll Revenue
Fiscal 2005-2021 Est.



Note: Traffic and revenue data are for "legacy" facilities and do not include the InterCounty Connector or express toll lanes on Interstate 95.

Source: Maryland Transportation Authority

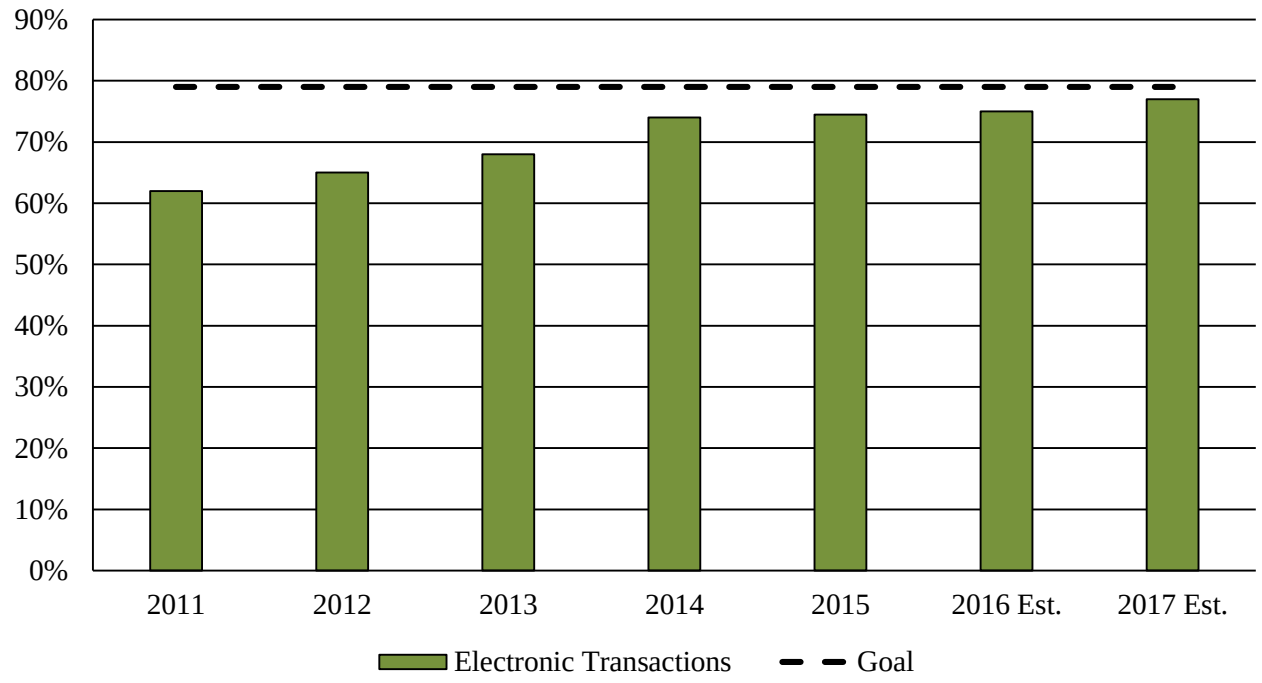
In fiscal 2015, traffic totaled 115.7 million vehicles, an increase of 2.8%. Toll revenue in fiscal 2015 totaled $631.9 million, a 10.1% increase from fiscal 2014. In fiscal 2016, revenues are estimated to total $586.9 million, a decrease of $45.0 million, or 7.1%, due to the reduction of toll rates,

which is discussed at length elsewhere in this analysis. Both revenue and traffic growth are projected to stabilize and grow approximately 0.6% per year throughout the forecast period. Fiscal 2021 revenues are estimated at $603.8 million. The total number of toll transactions on existing facilities is not expected to reach its prerecession fiscal 2007 peak until after the current forecast period.

2. Electronic Tolling Continues to Increase

Electronic toll transactions expedite the toll collection process; reduce delays at toll plazas; reduce vehicle idling time, thereby reducing emissions; and allow for the efficient movement of goods and people. E-ZPass electronic toll collection is available at all Maryland toll facilities, as well as parts of the Midwest and most of the northeastern part of the United States. The use of electronic tolling continues to increase. **Exhibit 2** shows the percentage of tolls collected with E-ZPass at all of MDTA's toll facilities. In fiscal 2015, MDTA collected 75% of tolls with E-ZPass and has set a goal of collecting 79% of tolls with E-ZPass by fiscal 2018.

Exhibit 2
Percentage of Tolls Collected Electronically
Fiscal 2011-2017 Est.



Source: Department of Budget and Management

Fiscal 2015 Closeout

Fiscal 2015 actual spending at MDTA totaled $382.9 million, or $26.4 million less than the legislative appropriation. The reductions in spending were:

- $17.6 million due to a decrease in debt service costs;
- $3.4 million due to lower than anticipated contractual services required for on-call roadway repairs;
- $2.2 million for lower than anticipated bridge inspection costs;
- $1.6 million due to MDTA holding vacant positions open in anticipation of fiscal 2016 position reductions, offset by the 2% cost-of-living adjustment on January 1, 2015;
- $1.2 million due to lower gas prices and vehicle maintenance costs;
- $1.0 million due to lower than anticipated equipment costs; and
- $900,000 due to lower than anticipated bridge and tunnel insurance costs.

The decreases were offset by a $1.5 million increase for replacement vehicles.

Proposed Budget

As shown in **Exhibit 3**, the fiscal 2017 allowance increases by $19.9 million compared to the current year working allowance, with most of the increase driven by an $11.5 million increase in debt service costs.

Personnel costs increase by $3.7 million, which is comprised of:

- an increase of $2.3 million in regular salaries that includes the annualization of a fiscal 2016 negotiated salary increase for unionized MDTA police officers, a change in budgeting methodology for the police academy class, and reductions due to 12 abolished positions;
- a decrease of $4.1 million in turnover to conform to the Department of Budget and Management policy, as well as turnover costs related to the police academy class; and
- a $5.5 million increase in health insurance and pension costs and other fringe benefit costs.

Other large changes include:

- an increase of $6.0 million to establish a facilities renewal fund to provide operating funds for maintenance and repair activities;
- a $2.6 million increase in various information technology expenses; and
- a $1.0 million reduction in E-ZPass service center costs due to reduced video toll citation changes after the implementation of Motor Vehicle Administration referrals for flagging and suspension of vehicle registration.

Exhibit 3
Proposed Budget
Maryland Transportation Authority
($ in Thousands)

How Much It Grows:	Nonbudgeted Fund	Total
Fiscal 2015 Actual	$382,861	$382,861
Fiscal 2016 Working Appropriation	403,384	403,384
Fiscal 2017 Allowance	423,275	423,275
Fiscal 2016-2017 Amount Change	$19,891	$19,891
Fiscal 2016-2017 Percent Change	4.9%	4.9%

Where It Goes:

Personnel Expenses	
Regular earnings	$2,300
Pension contributions	2,500
Employee and retiree health insurance	3,300
Workers' compensation premium assessment	-500
Social Security contributions	400
Turnover changes	-4,100
Other fringe benefit adjustments	-200
Other Changes	
Debt service	11,500
Establishment of Facilities Renewal Fund	6,000
Information technology	2,600
Replacement vehicles	900

Where It Goes:

Salt costs based on a three-year average	700
Vehicle maintenance based on actual spending	-100
Training based on actual spending	-200
Vehicle fuel based on actual spending	-200
Transponders	-200
Contractual payroll expenses	-300
E-ZPass credit card fees, lower due to toll decrease	-500
Other contractual expenses	-600
Replacement and additional equipment	-700
E-ZPass service center costs	-1,000
Insurance	-1,600
Other changes	-109
Total	**$19,891**

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

Financial Forecast

Section 4-313 of the Transportation Article establishes the Transportation Authority Fund, a nonlapsing fund into which all MDTA revenues flow except to the extent that they are pledged under a trust agreement. MDTA revenues come primarily from tolls but also from concession income from travel plazas that it owns along I-95, investment income, and payments from the Maryland Department of Transportation (MDOT). MDOT payments comprise a capital lease of the Masonville Auto Terminal and reimbursement for services provided at BWI Marshall Airport and the Port of Baltimore.

To support its capital program, MDTA may issue toll revenue bonds with a maturity up to 40 years. Typically, MDTA issues its toll revenue bonds with a 30- to 33-year maturity. Chapters 471 and 472 of 2005 established a finance plan for the ICC that included MDTA revenue bonds and a number of alternative funding sources specific to the ICC. These funding sources include Grant Anticipation Revenue Vehicle (GARVEE) bonds, federal funds, a Transportation Infrastructure Finance and Innovation Act (TIFIA) loan, transfers from the TTF, and funds from the State's General Fund or proceeds from general obligation bonds.

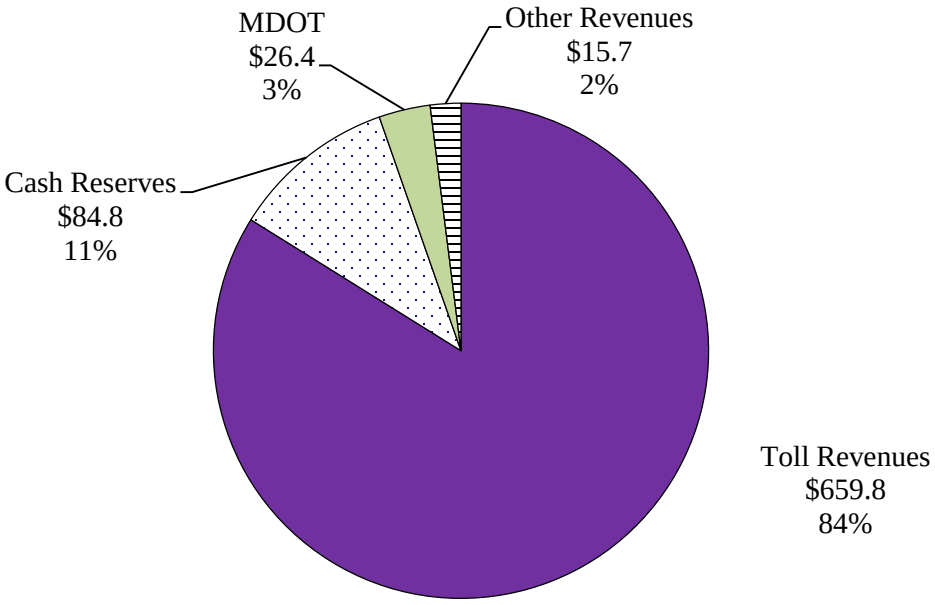
The terms of MDTA's trust agreement with its bondholders are the driving force in MDTA finances. Maintaining its bond coverage ratios is the primary concern, and all revenue adjustments and operating and capital expenditures are managed to maintain these ratios. To this end, MDTA develops and maintains a six-year financial forecast. Section 4-210 of the Transportation Article requires MDTA

to provide the legislature a copy of its financial forecast by July 1 each year and in conjunction with submission of the Governor's budget in January.

Sources and Uses of Funding

Exhibit 4 provides information on all of the funding supporting MDTA's fiscal 2017 operating and capital budgets. The primary source of fiscal 2017 funding is toll revenues, totaling $659.8 million. MDTA will not issue revenue bonds in fiscal 2017 and will use $84.8 million in cash reserves to make up the majority of the rest of its funding needs.

Exhibit 4
Fiscal 2017 Sources of Funding
($ in Millions)

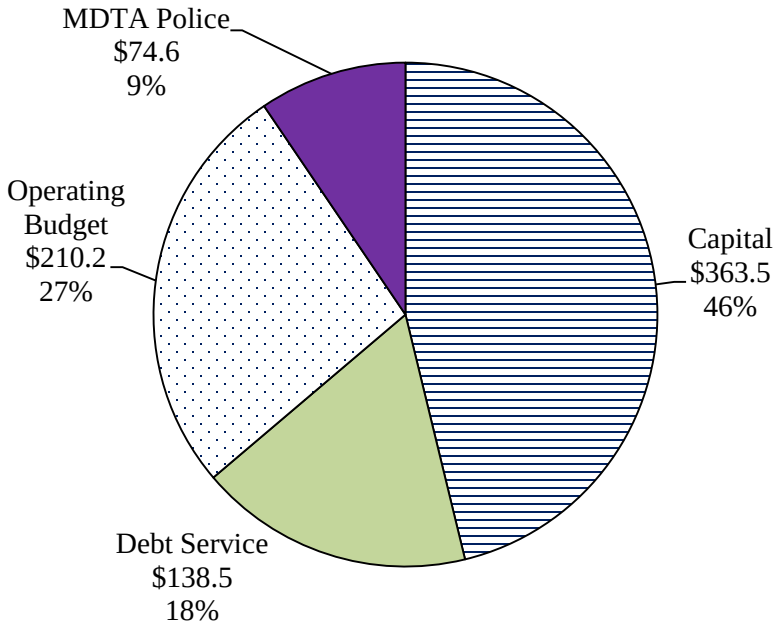


MDOT: Maryland Department of Transportation

Source: Maryland Transportation Authority's January 2016 Financial Forecast

Exhibit 5 provides a breakdown of fiscal 2017 spending by category. The capital program accounts for about 46% of all spending in fiscal 2017. The operating budget, including the operating budget for MDTA's police, accounts for about 36% of all spending. Debt service payments account for the remaining 18%.

Exhibit 5
Fiscal 2017 Uses of Funding
($ in Millions)



MDTA: Maryland Transportation Authority

Source: Maryland Transportation Authority's January 2016 Financial Forecast, Governor's Budget Books Fiscal 2017

Toll Revenues

Toll revenues are the primary revenue source for MDTA. The current forecast reflects the toll reductions implemented July 1, 2015, and does not foresee toll increases in the forecast period. Total toll revenue is expected to decrease from $694.1 million in fiscal 2015 to $652.9 million in fiscal 2016, a decrease of $41.2 million, with the effects of the toll reduction partially offset by higher than expected traffic volume. Toll revenues are expected to grow annually to $678.8 million in fiscal 2021.

Traffic growth is estimated to be about 0.6% per year over the period, reflecting recent national trends of slower rates of growth in vehicle miles traveled. ICC revenue is expected to total $59.9 million in fiscal 2017 and increase to $66.2 million in fiscal 2021. ICC traffic growth is much lower than previously anticipated; this is discussed later in this analysis.

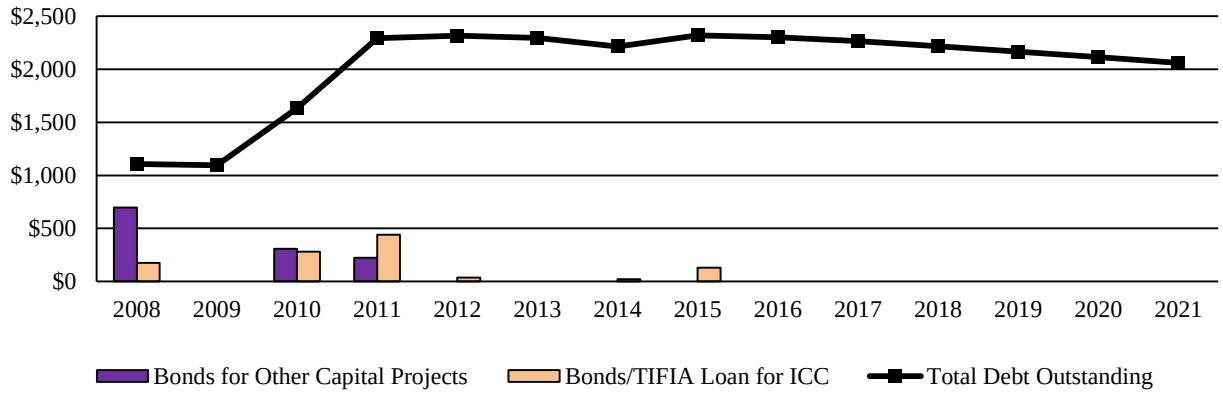
Debt Service

The reliance on debt to fund construction of a new facility and the major expansion of an existing toll facility resulted in significantly higher debt service payments over the next 30 years. Debt service increased from a low of $25.0 million in fiscal 2007 to annual debt service of $138.5 million in fiscal 2017. MDTA expects debt service costs to be approximately $139.0 million from fiscal 2017 to 2020, higher than previously expected due to foregoing a previously planned $193.6 million revenue bond defeasance in fiscal 2016. This level of debt service continues through the forecast period.

Revenue Bonds

After drawing down $132 million from the TIFIA loan in fiscal 2015, MDTA has no plans to issue debt in the rest of the forecast years, both because there are no major new projects planned and in order to reduce outstanding debt to allow for future projects. This returns MDTA to its traditional stance of using pay-as-you-go (PAYGO) funding for its capital program. All three rating agencies' most recent evaluation of MDTA have given the agency a stable outlook and categorize MDTA debt as investment grade. **Exhibit 6** shows the total debt outstanding in each year from fiscal 2008 through 2021 and debt issued or TIFIA loan draws. The $2.3 billion in outstanding debt in fiscal 2015 is the highest level in the forecast and remains below the statutory debt outstanding limit of $2.325 billion, which was implemented with Chapter 489, and it is lower than the $3.0 billion limit set in the Transportation Article. The $2.325 billion limit is in effect through fiscal 2020.

Exhibit 6
Bond Sales and Debt Outstanding
Fiscal 2008-2021
($ in Millions)



ICC: InterCounty Connector
TIFIA: Transportation Infrastructure Finance and Innovation Act

Source: Maryland Transportation Authority's January 2016 Financial Forecast

Debt Affordability

Statute provides that MDTA may issue bonds without obtaining the consent of any unit or agency in the State, as long as total bonds do not exceed $3.0 billion at the end of any fiscal year (or $2.325 billion until June 30, 2020, as noted above). MDTA debt backed by toll revenues is not considered State debt and, therefore, is not limited by the State's debt affordability measures. MDTA does, however, have its own measures to ensure that debt outstanding remains affordable. Coverage ratios include the following:

- The rate covenant compliance ratio, as stipulated in the trust agreement, requires that the ratio of net revenues (total revenues minus operating expenses) to the amount deposited into the Maintenance and Operating Reserve Account plus 120.0% of debt service must be at least 1.00. The additional bonds test requires the rate covenant to be met on a five-year prospective basis. The fiscal 2017 rate covenant compliance ratio is projected to be 2.42, and adequate coverage is provided through the forecast period.

- A second ratio is the debt service coverage ratio, which is a ratio of net revenues to debt service. Although the trust agreement stipulates that the ratio must be at least 1.20, MDTA maintains an administrative policy that requires it to be above 2.00. In fiscal 2017, the debt coverage ratio is 3.00 and decreases to 2.79 in fiscal 2021. While the debt service coverage ratio is met throughout the forecast period, debt service as a percent of revenues totals 19.4% in fiscal 2021. By way of comparison, the State's debt limit is that debt service should not exceed 8.0% of revenues. With debt service accounting for so much of available revenues, less cash is available for capital expenditures in the future.

- Chapter 489 put into law MDTA's previously stated administrative policy of maintaining an unencumbered cash balance of $350.0 million through June 30, 2020. Bond rating agencies view the amount of cash on hand relative to operating expenses as a liquidity measure to ensure operations can continue even if revenues are lower than expected, expenses are higher than expected, or if there is a temporary loss of revenue generation. MDTA reports that for AA-rated toll agencies, the median cash on hand should fund operations for 9 to 18 months. In fiscal 2017, operating expenses including debt service totals $423.3 million, and the cash balance is expected to be $686.1 million, or about 19 months of operating expenses. Minimum cash balance requirements are met throughout the forecast period. The agency produced a report on this benchmark, which is discussed later in this analysis.

Conduit Financing

In addition to its own revenue bonds, MDTA also issues debt on behalf of other entities, called conduit financing. The following projects were financed by MDTA using conduit financing:

- a total of $604.0 million of projects associated with the $1.4 billion expansion project at BWI Marshall Airport, including the Elm Road parking facility, pedestrian bridges, roadway

improvements, a central utility plant, and a new consolidated rental car facility, which are backed by fees at BWI Marshall Airport;

- $40.0 million for three parking facilities at Largo, New Carrollton, and College Park, which are backed by lease payments from the Washington Metropolitan Area Transit Authority;

- $23.8 million for the Calvert Street parking garage in Annapolis for State employees, which is backed by general fund lease payments from the Department of General Services; and

- $750.0 million in GARVEE bonds to fund construction of the ICC, which is backed by future federal highway aid with a secondary pledge from the TTF.

Exhibit 7 shows debt service and debt outstanding for MDTA's conduit financed bonds. In fiscal 2017, debt service on the conduit issuances will total $135.0 million with debt outstanding of $664.2 million. The debt service for these projects is paid by the revenues from the projects and does not affect MDTA's debt outstanding or its budget.

Exhibit 7
Debt Service Payments and Debt Outstanding on Conduit Projects
Fiscal 2015-2017
($ in Thousands)

	2015	2016[2]	2017[2]
Debt Service Payments			
2002 Series – BWI Marshall Airport Rental Car Facility	$8,985	$8,979	$8,971
2004 Series – WMATA Parking Garages	2,182	–	–
2005 Series – Calvert Street Parking Garage	1,517	1,132	–
2015 Series – Calvert Street Parking Garage Refunding	–	191	472
2007 and 2008 Series – GARVEE Bonds	87,454	87,450	87,452
2012 A&B Series – BWI Marshall Airport Refunding Elm Rd	19,766	19,798	18,558
2012 A Series – Various BWI Marshall Airport Projects	4,084	4,044	4,008
2012 B Series – Various BWI Marshall Airport Projects	7,970	7,969	7,969
2012 C Series – Various BWI Marshall Airport Projects[1]	29	2,170	2,170
2014 Series – WMATA Refunding Parking Garages	223	2,708	2,442
2014 Series – Various BWI Marshall Airport Projects	1,335	2,957	2,956
Total Debt Service Payments	**$133,545**	**$137,398**	**$134,998**

	2015	2016[(2)]	2017[(2)]
Debt Outstanding			
2002 Series – BWI Marshall Airport Rental Car Facility	$93,785	$90,900	$87,830
2004 Series – WMATA Parking Garages	–	–	–
2005 Series – Calvert Street Parking Garage	17,845	–	–
2015 Series – Calvert Street Parking Garage Refunding	–	18,011	18,011
2007 and 2008 Series – GARVEE Bonds	349,440	279,780	206,590
2012 A&B Series – BWI Marshall Airport Refunding Elm Rd	159,860	148,055	136,900
2012 A Series – Various BWI Marshall Airport Projects	45,405	43,500	41,535
2012 B Series – Various BWI Marshall Airport Projects	81,040	75,360	69,510
2012 C Series – Various BWI Marshall Airport Projects	43,400	43,400	43,400
2014 Series – WMATA Refunding Parking Garages	27,200	25,440	23,905
2014 Series – Various BWI Marshall Airport Projects	39,380	37,985	36,535
Total Debt Outstanding	**$857,355**	**$762,431**	**$664,216**

BWI Marshall Airport: Baltimore/Washington International Thurgood Marshall Airport
GARVEE: Grant Anticipation Revenue Vehicle
WMATA: Washington Metropolitan Area Transit Authority

(1) 2012 Series C bonds are variable rate.
(2) The fiscal 2016 and 2017 debt service payments are estimates only for the variable rate passenger facility charge revenue bonds, series 2012C.

Source: Maryland Transportation Authority's January 2016 Financial Forecast

Financial Outlook: Stable

After completing the ICC and the I-95 ETLs, two massive and costly projects financed with large amounts of debt, MDTA shifted to a posture of funding its capital program on a PAYGO basis and paying off debt in order to create capacity for long-range needs. The agency had planned on an early debt repayment of $193.6 million, or about 9.1%, of its outstanding debt in fiscal 2016. However, the toll reductions of 2015 signaled a shift from prioritizing debt reduction to prioritizing revenue reduction. While the financial outlook – helped by higher than anticipated revenue – remains stable, there are three concerns worth noting.

- First, neglecting to pay down debt early when MDTA had a significant cash surplus in hand meant foregoing significant savings in debt service payments. When combined with the revenue reduction, the two factors lead to high levels of debt service when compared to revenue – 19.4% in fiscal 2021, as noted above.

- Second, the pace of growth in operating expenses (3.81% from fiscal 2016 to 2021) is outpacing the pace of growth in revenue (0.89% over the same period). Even without considering the potential of a large capital project in years beyond the forecast period, toll increases are periodically necessary because toll revenue is not inflation sensitive.

- The final concern is that the revenue reduction has limited the capacity for future large capital projects. This issue is discussed further in the Issues section of this analysis.

PAYGO Capital Program

Program Description

MDTA's capital program involves the construction and maintenance of revenue-generating transportation facilities throughout the State. Currently, MDTA is not building any new facilities, and its capital program is focused on system preservation projects.

Fiscal 2015 Actual Spending

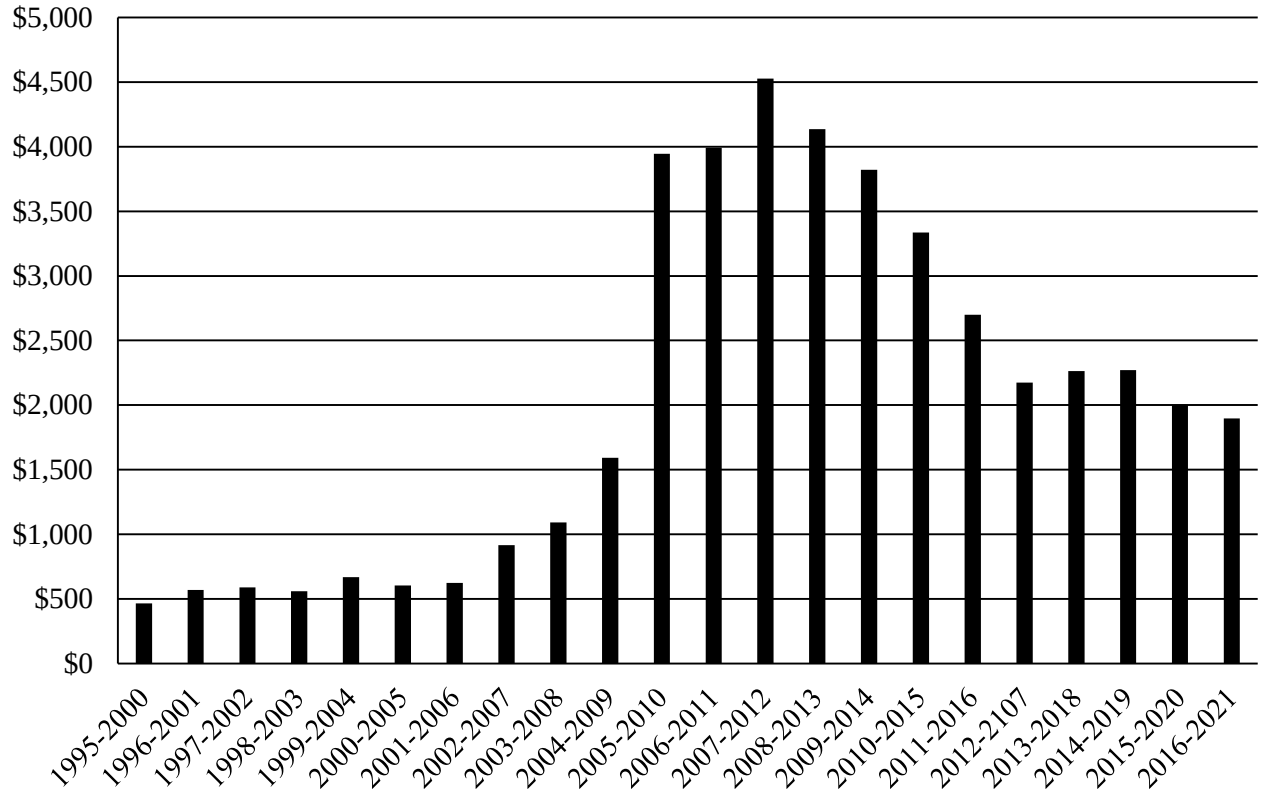
In fiscal 2015, actual spending was $325.9 million, a spend rate of about 79.1% of the originally anticipated $411.9 million during the 2015 session. The difference is largely due to cash flow and schedule changes, mainly on ICC and ETL projects. The fiscal 2013 spend rate for capital programs was 63.7% and 86.0% in fiscal 2014.

Fiscal 2016 to 2021 *Consolidated Transportation Program*

The six-year capital program totals $1.9 billion, a decrease of $107 million compared to the fiscal 2015 to 2020 *Consolidated Transportation Program* (CTP), with much of the change due to the near completion of the I-95 ETLs and ICC as well as reductions in minor system preservation projects.

Exhibit 8 shows the size of MDTA's six-year capital program from fiscal 1995 through the present. Prior to the construction of the ICC and the I-95 ETLs, MDTA's six-year capital program had historically been around $500 million. Construction of the two mega projects ballooned the CTP to a peak of $4.5 billion in the fiscal 2007 to 2012 CTP. The current CTP is at the lowest level since the inclusion of the ICC in the plan.

Exhibit 8
Size of Six-year *Consolidated Transportation Program*
Fiscal 1995-2021
($ in Millions)



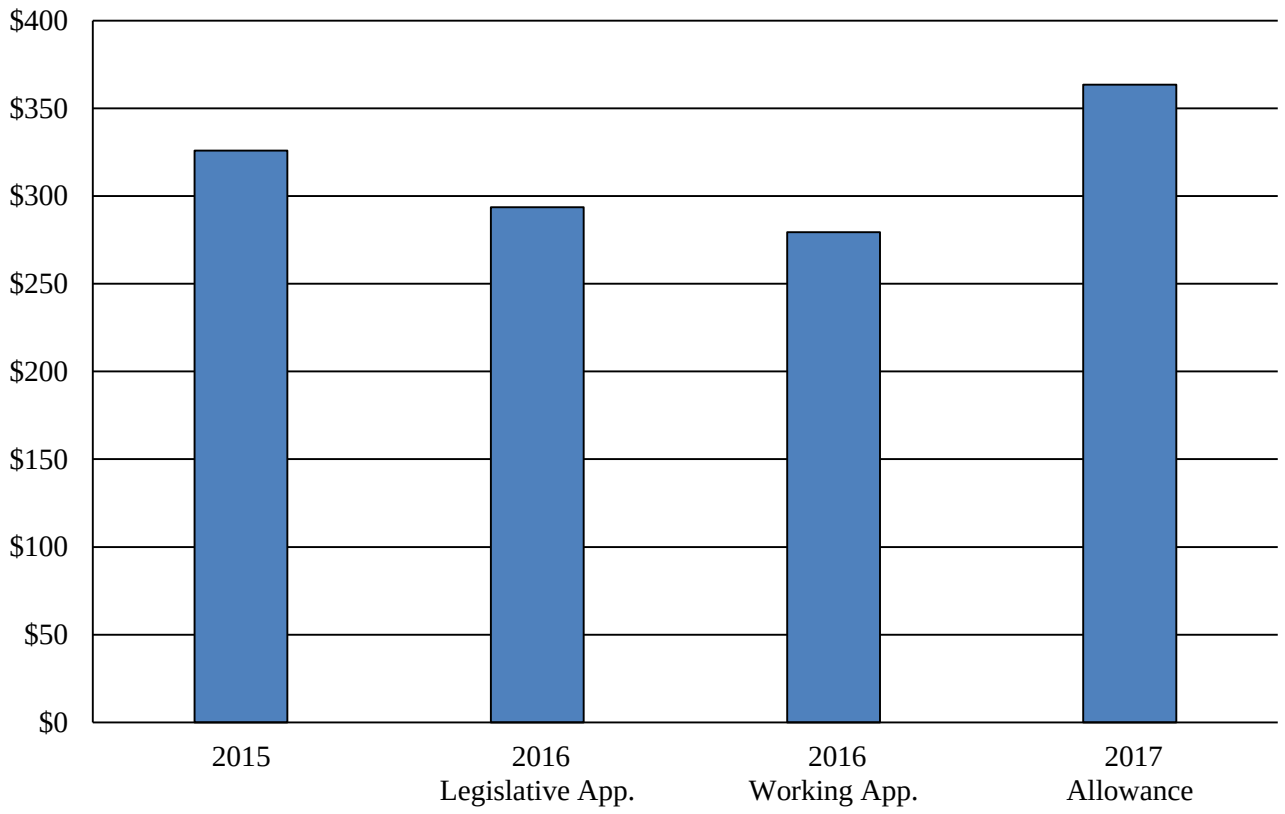
Source: Maryland Department of Transportation, 2016-2021 *Consolidated Transportation Program*

Fiscal 2016 and 2017 Cash Flow Analysis

The fiscal 2016 working appropriation is $14.1 million less than the legislative appropriation, as shown in **Exhibit 9**. System preservation minor projects declined by $44.1 million, and costs related to the I-95 ETL construction decreased by $11.2 million as the project winds down. Decreases are partially offset by an increase in ICC construction costs of $30.0 million due to cash flow changes.

The fiscal 2017 allowance grows by $84.1 million, or 30.1%, compared to the current year working appropriation. This change is largely driven by a $54.5 million increase in system preservation minor projects as well as larger increases as major rehabilitation projects at both the Fort McHenry Tunnel and the Baltimore Harbor Tunnel get underway.

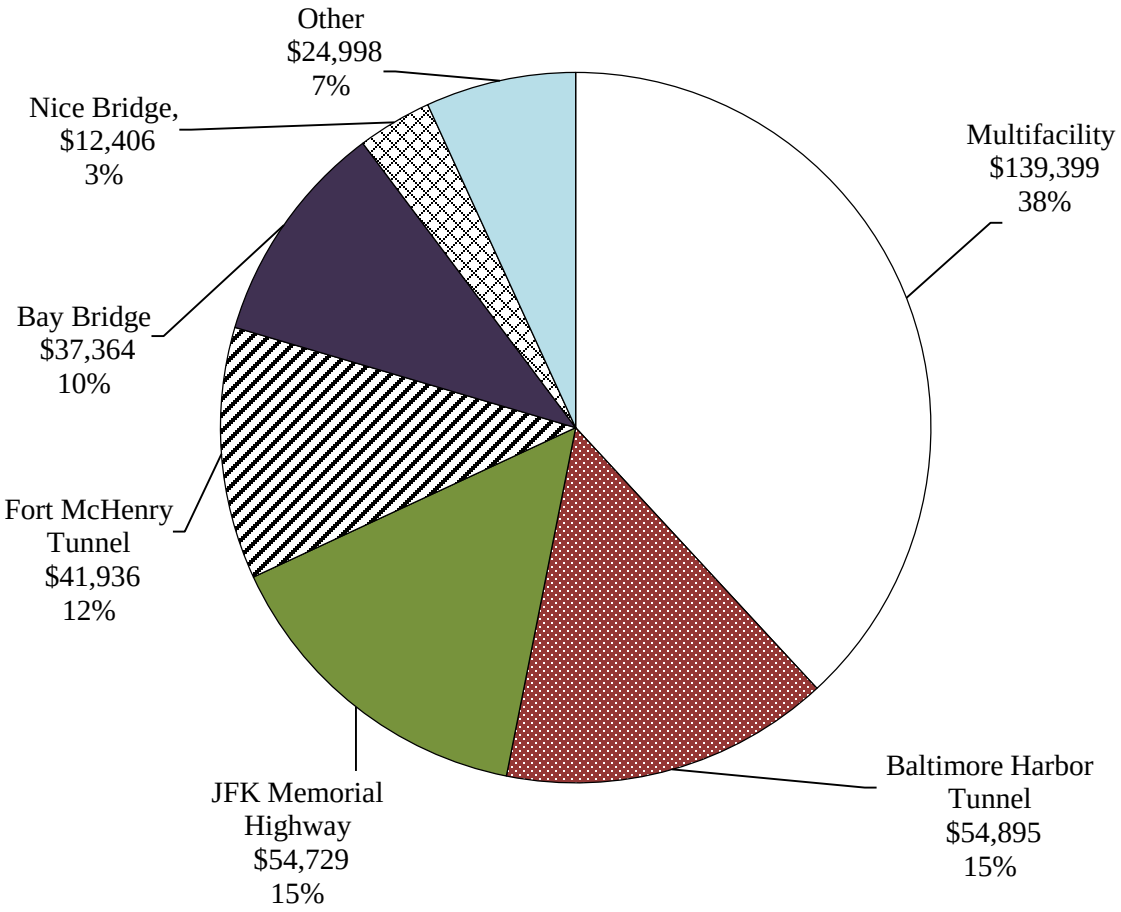
Exhibit 9
Cash Flow Changes
Fiscal 2015-2017
($ in Millions)



Source: Maryland Department of Transportation, 2016-2021 *Consolidated Transportation Program*

Exhibit 10 shows capital spending by facility in fiscal 2017. The largest share of spending is on multifacility projects, driven by $86 million allocated to the Long Range Capital Needs Reserve.

Exhibit 10
Capital Expenditures by Facility
Fiscal 2017
($ in Thousands)



Source: Maryland Department of Transportation, 2016-2021 *Consolidated Transportation Program*

Projects in the Construction Program

Exhibit 11 shows the projects included in the 2016 to 2021 CTP. The largest project in the six-year program is the replacement of the Canton Viaduct, which is the raised portion of I-895 from the tunnel to Holabird Avenue. It is the department's only structurally deficient bridge.

Exhibit 11
Maryland Transportation Authority PAYGO Capital Allowance
Fiscal 2017
($ in Thousands)

Facility	Project Description	2017	Total Cost	Six-year Total
Projects				
Baltimore Harbor Tunnel	Replace Canton Viaduct	$6,585	$273,097	$258,318
I-95 Express Toll Lanes (ETL)	I-95 ETL construction	50,000	1,097,719	74,693
Baltimore Harbor Tunnel	Replace deck and superstructure of bridge over Patapsco Flats	17,000	68,680	66,643
Authoritywide	Replace electronic toll collection and operating system	850	78,500	62,800
Baltimore Harbor Tunnel	Replace vent fans	18,684	63,646	61,300
Nice Bridge	Replace Nice Bridge	10,100	61,600	54,424
Bay Bridge	Rehabilitate suspension spans on westbound bridge	24,100	47,200	46,419
Baltimore Harbor Tunnel (1)	Rehabilitate various bridges	12,200	43,899	42,055
InterCounty Connector (ICC)	ICC construction	5,496	2,386,588	40,357
Fort McHenry Tunnel (1)	Replace tunnel lighting systems	20,000	40,075	39,472
Bay Bridge	Clean and paint structural steel on westbound bridge	2,500	104,452	27,319
Fort McHenry Tunnel	Rehabilitate decks and other repairs	2,961	93,955	22,520
Authoritywide (1)	Remove, replace, and upgrade sign structures	6,929	20,678	20,324
JFK Memorial Highway	Resurfacing	1,166	31,564	18,191
Bay Bridge	Structural repairs and modifications	4,134	17,710	13,972
Baltimore Harbor Tunnel (1)	Rehabilitate tunnel standpipe and sump pump systems	0	13,058	12,780
Fort McHenry Tunnel	Replace light poles	2,732	17,261	12,557
Point Breeze (1)	Renovate Point Breeze building	8,500	11,259	11,236

Facility	Project Description	2017	Total Cost	Six-year Total
JFK Memorial Highway, the Bay Bridge, and the Hatem Bridge	Upgrade truck weigh facilities	5,099	14,417	10,194
Bay Bridge	Rehabilitate eastbound bridge deck	4,500	10,700	9,005
Fort McHenry Tunnel	Rehabilitate concrete tunnel deck	1,837	36,438	8,837
JFK Memorial Highway	Clean and paint the Millard E. Tydings Memorial Bridge	1,254	10,582	8,453
Bay Bridge	Cable rewrapping and dehumidification	0	60,443	4,495
Key Bridge	Clean and paint approach spans on bridges over Curtis Creek	772	5,430	3,137
Authoritywide	Install security systems and video surveillance at major bridges	0	11,745	1,442
Nice Bridge	Clean and paint structural steel and miscellaneous repairs	0	13,186	1,206
Subtotal – Projects		***$207,399***	***$4,633,882***	***$932,149***
Programs				
Authoritywide	System preservation minor projects	$156,100	n/a	$961,800
Subtotal – Programs		***$156,100***	***$0***	***$961,800***
Total – Projects and Programs		**$363,499**	**$4,633,882**	**$1,893,949**

Bay Bridge: William Preston Lane, Jr. Memorial Bridge
Hatem Bridge: Thomas J. Hatem Memorial Bridge
JFK Memorial Highway: John F. Kennedy Memorial Highway
Key Bridge: Francis Scott Key Bridge
Nice Bridge: Harry W. Nice Memorial Bridge
PAYGO: pay-as-you-go

(1) Projects added to the construction program.

Source: Maryland Department of Transportation, 2016-2021 *Consolidated Transportation Program*

Issues

1. MDTA Cuts Tolls Systemwide

Beginning on July 1, 2015, MDTA cut tolls systemwide, a move that MDTA estimated at the time would reduce revenue by $54.0 million in fiscal 2016 and by $335.0 million across the forecast period of fiscal 2016 to 2021. More than half of the reduction comes from the Bay Bridge, where MDTA reduced base rates by 33.3% and single E-ZPass trips by 53.7%. As shown in **Exhibit 12**, increasing the E-ZPass discount at other facilities, reducing the mileage rate at the I-95 ETL and the ICC, and eliminating the monthly E-ZPass fee were also anticipated to result in significant revenue reductions.

Exhibit 12
Toll Reduction
Fiscal 2016 Estimated
($ in Millions)

Facility	Description	2016 Estimated Revenue Impact
Bay Bridge	Base rates reduced by 33.3% (from $6 to $4 for two-axle vehicles), discount plans reduced by 33.3%, E-ZPass rate reduced from $5.40 to $2.50, or 53.7%	$28.8
All except the Bay Bridge	Increase E-ZPass discount from 10.0% to 25.0%	9.0
I-95 ETL and the ICC	Reduction of mileage rate (approximately 12.0% reduction for full trip, peak period) (1)	7.5
All	Eliminate E-ZPass monthly maintenance fee	5.9
Harbor Tunnel	Decrease rates for trucks at Childs Street and I-685 turnaround exits (2)	1.0
Hatem Bridge	Create 30% E-ZPass discount for three- and four-axle vehicles at the Hatem Bridge	0.8
All	Increase volume discount for vehicles with five or more axles	0.4
Total		**$53.4**

Bay Bridge: William Preston Lane, Jr. Memorial Bridge
ETL: Express Toll Lanes
Hatem Bridge: Thomas J. Hatem Memorial Bridge
ICC: InterCounty Connector

(1) Revenue reduction does not include effect of reduced traffic estimates on the ICC.
(2) Took effect January 1, 2016.

Source: Maryland Transportation Authority

The toll reduction plan did not result in any changes to the bond ratings given by bond rating agencies; however, one agency noted that the plan had risks, while another called the plan a "departure from nonintervention in toll rate setting" and called it credit-negative.

MDTA planned to accomplish the toll reduction by foregoing a planned early debt repayment, increasing new debt, spending down cash reserves, reducing the capital program, and reducing operating spending. The increase in debt also increases debt service costs. Additionally, MDTA realized higher than expected revenue in fiscal 2015 and expects the same in fiscal 2016.

Actual results since the reduction in tolls have altered the outlook. **Exhibit 13** compares three different forecasts of the fiscal 2016 to 2021 period: an estimate prior to the toll reduction, the August 2015 forecast, and the January 2016 forecast. While toll revenues were originally estimated to decline by more than $400.0 million (when the ICC and the I-95 ETL revenue writedowns are included), new estimates show revenue reductions of only $241.6 million. The change is due to lower gas prices and an improving economy, as well as traffic not being impacted by the prior toll increases as much as expected. MDTA also restored capital funding that it had planned on cutting and eliminated $60.0 million in planned debt issuances.

Exhibit 13
Toll Reduction Impact on Financial Forecast
Fiscal 2016-2021
($ in Millions)

	May 2015, Before Reduction	Jul. 2015	Jan. 2016	Change from Before Toll Reduction to Jan. 2016 Forecast
Toll revenue fiscal 2016 to 2021	$4,239.2	$3,836.3	$3,997.6	-$241.6
Operating expenses fiscal 2016 to 2021	1,955.4	1,837.1	1,819.3	-136.1
Debt service fiscal 2016 to 2021	780.0	827.3	822.4	42.4
Capital expenses fiscal 2016 to 2021	1,882.6	1,849.7	1,895.8	13.2
Fiscal 2021 unencumbered cash balance	366.6	355.0	495.1	128.5
Debt issuances fiscal 2016 to 2021	0.0	60.0	0.0	0.0
Revenue bond defeasance	-193.6	0.0	0.0	193.6
Fiscal 2021 debt outstanding	1,873.1	2,118.4	2,058.4	185.3
Fiscal 2021 debt service coverage ratio	3.11	2.55	2.79	n/a

Source: Maryland Transportation Authority

The department will spend $42.4 million more over six years on debt service than anticipated prior to the reductions, and its outstanding debt in fiscal 2021 will be nearly $2.1 billion, or $185.3 million higher than planned before the reductions. However, the elimination of the early debt payment and significant operating expense reductions mean that MDTA's unencumbered cash balance is expected to be $495.1 million in fiscal 2021, or $128.5 million higher than planned prior to the toll reductions.

The capital program had previously been reduced by $32.9 million, but spending has now been restored to $13.2 million higher than prior to the toll reduction. MDTA had planned on reducing operating spending by $10.7 million in fiscal 2016. The agency eliminated 28.5 positions that were vacant or expected to become vacant. Other changes to the operating plan included the elimination of the fiscal 2016 salary step increase ($2.3 million), which had not been included in the fiscal 2016 budget, a deferment of a planned vehicle purchase ($1.8 million), and the elimination of the fiscal 2016 MDTA police academy class ($2.1 million).

BRFA Requirements

Anticipating a toll reduction, the legislature placed several fiscal requirements on MDTA in Chapter 489. **Exhibit 14** shows the requirements set forth in legislation and MDTA's projected amounts in each category. The requirements are met across all five years of the period specified in Chapter 489.

Exhibit 14
Chapter 489 of 2015 Requirements
Fiscal 2016-2020
($ in Millions)

	2016	2017	2018	2019	2020
Operating Expense: Minimum $275.0 Million	$276.4	$284.8	$296.2	$308.1	$320.5
Capital Expense: Minimum $275.0 Million	279.5	363.5	354.2	358.3	309.5
Unrestricted Cash Balance: Minimum $350.0 Million	770.9	686.1	603.4	509.6	463.5
Outstanding Debt: Maximum $2,325.0 Million	2,299.6	2,264.2	2,216.0	2,165.7	2,113.2
Debt Service Coverage Level: Minimum 2.50	3.29	3.00	2.95	2.90	2.89

Source: Maryland Transportation Administration

Capital Capacity

Now that the ICC and the I-95 ETLs are complete, MDTA's capital program consists of entirely system preservation and maintenance projects, with the largest being the replacement of the Canton Viaduct. While no large projects are expected in the current forecast period, there is a planning and engineering study currently underway for the replacement of the Nice Bridge. A replacement project, previously anticipated to begin around 2023, is expected to cost approximately $1 billion, although the department is working on design techniques that could lower the cost. In its proposal to MDTA's board regarding the toll reductions, the agency noted the possibility of redecking the Nice Bridge and delaying its replacement. The redecking and other major rehabilitation work would cost $150 million and extend the life of the bridge by 20 or more years but would not provide the safety and traffic benefits of a bridge replacement, which would still be needed. Legislators have shown considerable interest in prioritizing a replacement for the Nice Bridge. HB 672 and SB 907 would require the construction of a replacement for the Nice Bridge by fiscal 2030 funded by a $75 million annual contribution to a newly created bridge replacement fund using toll revenues.

Additionally, a life cycle cost analysis of the Bay Bridge commissioned by MDTA found that traffic backups at peak times could reach more than 10 miles by fiscal 2040, and that construction of a new span would cost between $2.3 billion and $5.6 billion. SB 56 would require the department to complete an environmental study on construction of a new span and to annually set aside $1 million, or 5% of the cost of the study toward completing it.

Prior to the toll reduction, MDTA anticipated to have $1.144 billion of capacity for capital spending beyond its existing program. After the reduction, MDTA anticipates $1.087 billion of unused capacity, as shown in **Exhibit 15**. However, that capacity is likely to diminish in subsequent years, as expense growth continues to outpace revenue growth. **MDTA should clarify its plans regarding a timeline and financing for replacement of the Nice Bridge as well as contingencies for any other large, unexpected capital projects. MDTA should also describe the functional capacity of this single lane crossing for the Nice Bridge if a replacement is not built.**

Exhibit 15
Capacity for Capital Program
Fiscal 2021
($ in Millions)

	Cash (in excess of $350 million benchmark)	Debt Capacity	Total Available
Pre-reduction	$16.6	$1,126.9	$1,143.5
January 2016 Forecast	145.1	941.6	1,086.7

Source: Maryland Transportation Authority

Notice of Toll Reduction

MDTA notified the budget committees of plans to reduce tolls the day before the MDTA Board voted for the reduction. Section 4-312 of the State Transportation Article provides a host of requirements for public meetings and comment periods if MDTA proposes to increase tolls, however, for toll reductions, there is only the informational requirement. HB 1394 would require MDTA to provide an opportunity for review and comment at public meetings prior to reducing tolls and require that certain requirements that pertain to toll increases also apply to toll reductions. **The Department of Legislative Services recommends that the legislature amend the Transportation Article so that the same public hearing and comment requirements pertain to both toll increases and reductions.**

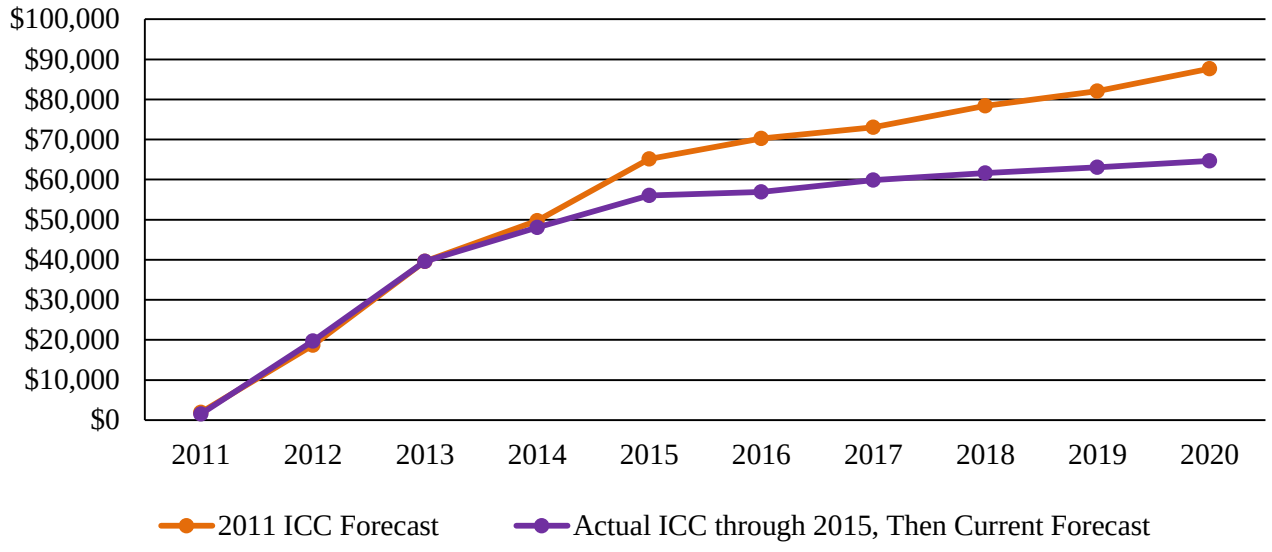
2. ICC Usage Drops Below Initial Predictions

MDTA opened the first segment of the ICC in calendar 2011. Tolls on the highway are set with the goal of congestion management and vary from lower prices during nights and other low-traffic times to higher tolls at peak traffic times. Through fiscal 2014, the ICC had been generating revenue approximately in line with fiscal 2011 projections. However, beginning in fiscal 2015, the highway's revenue began to fall below early estimates. This decline is due to both the reduction in tolls and lower than anticipated usage of the highway. MDTA has performed a comprehensive update to the ICC traffic and revenue study, which is reflected in the *Financial Forecast*. The update takes into account current assumptions about land use and development, economics, and travel demand. For example, the 2011 forecast assumed the Konterra development in Prince George's County would be more built out by this time, impacting ICC travel.

As shown in **Exhibit 16**, revenues fell about $9.1 million below the fiscal 2011 estimate in fiscal 2015 and are expected to miss the mark by $13.3 million in the current fiscal year. Through fiscal 2020, the department anticipates revenue to be about 18% to 26% lower than estimates, leading to a revenue shortfall of $95.5 million over the life of the highway through fiscal 2020. MDTA estimated at the time of the toll reductions that they would reduce revenues on the ICC by about $7.0 million per year.

It should also be noted that the I-95 ETLs, the other recently opened mega project of MDTA, had revenues reduced by about $1.0 million per year due to the toll rate reductions there. However, the current forecast calls for revenues higher than anticipated in the July 2015 forecast by $8.6 million over the fiscal 2016 to 2021 period. The department has found that drivers are using the ETLs even in times when there is not high congestion on I-95. **MDTA should comment on the lower than anticipated revenue of the ICC.**

Exhibit 16
InterCounty Connector Revenue Shortfall
Fiscal 2011-2020
($ in Thousands)



Years	ICC Forecast 2011	Actual ICC through 2015, Then Current Forecast	Percent Difference from 2011	Cumulative Difference from 2011	Cumulative Percent Difference from 2011
2011	$1,888	$1,474	-21.9%	-$414	-21.9%
2012	18,714	19,733	5.4%	605	2.9%
2013	39,557	39,586	0.1%	634	1.1%
2014	49,764	48,029	-3.5%	-1,101	-1.0%
2015	65,148	56,020	-14.0%	-10,229	-5.8%
2016	70,233	56,910	-19.0%	-23,552	-9.6%
2017	73,028	59,890	-18.0%	-36,690	-11.5%
2018	78,411	61,590	-21.5%	-53,511	-13.5%
2019	82,095	63,100	-23.1%	-72,506	-15.1%
2020	87,640	64,640	-26.2%	-95,506	-16.9%

ICC: InterCounty Connector

Source: Maryland Transportation Authority

3. All-electronic Tolling Put Off Until 2019

In response to MDTA efforts to expand the use of all-electronic tolling (AET) on its legacy facilities, Chapter 397 of 2014 required the agency to perform a study of AET, including its implementation in other states, interoperability with other states, an analysis of the costs and savings of video tolls, issues that must be addressed prior to AET implementation, and any legislation necessary before implementation. The following is a summary of the MDTA analysis.

Of the approximately 12 states that have AET, all but 1 charged a higher rate for video tolling, and every system uses transponders and/or video tolling. Most states provide free transponders if they are loaded with funds, although most agencies use sticker tags, which are less expensive than transponders. Virtually all agencies with transponders use video either as enforcement or as an alternative toll method.

While national interoperability will not be achieved this year, as required by federal law, a high level of national interoperability is possible in the near future.

Video tolls cost an estimated $3.20 per transaction due to MDTA staff and administrative costs and vendor contract costs. The analysis notes that this cost could be reduced with the use of a system in which accounts are tied to a license plate and credit or debit card, which would eliminate the need to identify the vehicle's owner.

The analysis also finds that, while truck traffic represents 7% of traffic on legacy facilities, trucks make up 18% of unpaid transactions and 55% of uncollected revenue. MDTA suggests that holding the trailer owner responsible for the unpaid toll and entering violator reciprocity agreements with neighboring states could mitigate these revenue losses. Shifting the liability of unpaid truck tolls is the only AET area that the agency believes would require legislation to implement.

MDTA identified several items that it would need to address prior to AET implementation. These include:

- providing options to convert cash customers to AET customers, including additional customer service at the beginning of implementation;

- adding transponder sales at toll booths immediately prior to implementation; and

- performing rigorous enforcement of in-state violators by withholding registration renewal and entering violator reciprocity agreements with neighboring states.

MDTA notes that it is revising its initial AET proposal by delaying implementation until at least fiscal 2019, after the contract for the next generation of its toll system is executed. The agency is incorporating what it has learned from its AET analysis into its Request for Proposals for its next generation toll system. **MDTA should comment on its next steps toward AET and if it supports the concept of legislation to address uncollected toll revenue from trucks.**

4. MDTA Reviews Unencumbered Cash Levels

MDTA sets an administrative benchmark of $350 million in unencumbered cash on hand. This benchmark became law at least through fiscal 2020 with the enactment of Chapter 489. In addition, in the 2015 session, the committees requested a report on this benchmark and whether it should be more directly tied to the agency's operating costs. Following is a summary of the MDTA report on the topic.

The department needs cash on hand to ensure that money is available to meet higher than expected expenses, lower than expected revenues, a temporary loss of revenue, or inability to access the capital market. The benchmark had previously been set as equal to the annual amount of toll revenues, but the department revised the benchmark in anticipation of the toll increases of fiscal 2011 and 2013. The current $350 million level would provide funding for approximately 16 months of operations in the case of an unexpected loss of revenue. MDTA notes that the choice of a benchmark is dependent on the investment environment, the potential for revenue losses, insurance availability, and the opinion of credit rating agencies.

The department also notes that other tolling agencies nationally have much different situations than MDTA, making comparisons difficult. For instance, the San Francisco Bay Area Toll Authority sets a $1 billion unrestricted cash target due to exposure to variable rate debt and large capital needs. The Florida Turnpike's requirement is much smaller than MDTA's requirement because its costs are paid by Florida's TTF, making all of its revenue available for debt service.

MDTA reports that it believes its $350 million benchmark is appropriate and that it consistently reviews its financial policies. **MDTA should comment on the benchmark and any factors that could lead the department to alter the policy.**

Operating Budget Recommended Actions

1. Nonbudgeted.

PAYGO Budget Recommended Actions

1. Nonbudgeted.

Appendix 1

Maryland Transportation Authority Financial Forecast
Fiscal 2015-2021
($ in Millions)

	2015	2016	2017	2018	2019	2020	2021
Revenues							
Toll Revenues	$694.1	$652.9	$659.8	$663.8	$668.5	$673.8	$678.8
Concessions	5.1	5.7	5.8	5.9	5.9	6.0	6.1
Investment Income and Other	7.6	10.2	9.9	9.2	8.3	13.3	13.0
Maryland Department of Transportation	26.6	26.5	26.4	27.4	28.4	29.5	28.9
Total Revenues	**$733.3**	**$695.3**	**$702.0**	**$706.2**	**$711.2**	**$722.6**	**$726.9**
Expenses							
Operations	$275.1	$276.4	$284.8	$296.2	$308.1	$320.5	$333.3
Debt Service	107.8	127.0	138.5	138.5	138.6	138.6	141.2
Capital Program	308.1	279.5	363.5	354.2	358.3	309.5	230.8
Total Expenses	**$691.0**	**$682.8**	**$786.8**	**$789.0**	**$805.0**	**$768.6**	**$705.3**
Capital Funding Sources							
Revenue Bond Proceeds	$132.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Seagirt/ICTF Proceeds	0.0	14.2	0.0	0.0	0.0	0.0	0.0
Accounting Reconciliation	-19.3	0.0	0.0	0.0	0.0	0.0	0.0
Annual Surplus/Deficit	**$155.0**	**$26.7**	**-$84.8**	**-$82.7**	**-$93.7**	**-$46.1**	**$21.6**
Total Cash Balance	**$823.4**	**$850.1**	**$765.2**	**$682.5**	**$588.8**	**$542.7**	**$564.3**
Debt							
Debt Outstanding	$2,318.3	$2,299.6	$2,264.2	$2,216.0	$2,165.7	$2,113.2	$2,058.4
Unencumbered Cash (Policy $350.0 million minimum)	$742.7	$770.9	$686.1	$603.4	$509.6	$463.5	$495.1
Debt Service Coverage (Policy 2.0)	4.24	3.29	3.00	2.95	2.90	2.89	2.79
Rate Covenant Compliance (Legal 1.0)	3.42	2.65	2.42	2.37	2.33	2.30	2.22

ICTF: Intermodal Container Transfer Facility

Object/Fund Difference Report
MDOT – Maryland Transportation Authority

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	1,779.50	1,761.00	1,749.00	-12.00	-0.7%
Total Positions	**1,779.50**	**1,761.00**	**1,749.00**	**-12.00**	**-0.7%**
Objects					
01 Salaries and Wages	$ 154,024,826	$ 156,604,184	$ 160,283,028	$ 3,678,844	2.3%
02 Technical and Spec. Fees	122,743	1,121,448	786,947	-334,501	-29.8%
03 Communication	1,071,326	887,946	1,065,276	177,330	20.0%
04 Travel	243,308	333,718	359,745	26,027	7.8%
06 Fuel and Utilities	4,858,335	5,113,141	4,975,181	-137,960	-2.7%
07 Motor Vehicles	10,686,012	8,589,908	9,147,271	557,363	6.5%
08 Contractual Services	86,867,166	87,272,609	93,214,313	5,941,704	6.8%
09 Supplies and Materials	7,949,343	7,398,159	8,179,646	781,487	10.6%
10 Equipment – Replacement	2,677,825	1,733,171	1,090,416	-642,755	-37.1%
11 Equipment – Additional	825,265	967,523	871,595	-95,928	-9.9%
13 Fixed Charges	113,535,180	133,362,346	143,301,627	9,939,281	7.5%
Total Objects	**$ 382,861,329**	**$ 403,384,153**	**$ 423,275,045**	**$ 19,890,892**	**4.9%**
Funds					
07 Nonbudgeted Fund	$ 382,861,329	$ 403,384,153	$ 423,275,045	$ 19,890,892	4.9%
Total Funds	**$ 382,861,329**	**$ 403,384,153**	**$ 423,275,045**	**$ 19,890,892**	**4.9%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
MDOT – Maryland Transportation Authority

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
0041 Operating and Debt Service	$ 382,861,329	$ 403,384,153	$ 423,275,045	$ 19,890,892	4.9%
0042 Capital	325,882,386	279,454,000	363,520,000	84,066,000	30.1%
Total Expenditures	**$ 708,743,715**	**$ 682,838,153**	**$ 786,795,045**	**$ 103,956,892**	**15.2%**
Nonbudgeted Fund	$ 708,743,715	$ 682,838,153	$ 786,795,045	$ 103,956,892	15.2%
Total Appropriations	**$ 708,743,715**	**$ 682,838,153**	**$ 786,795,045**	**$ 103,956,892**	**15.2%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

K00A
Department of Natural Resources

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$72,868	$56,487	$59,556	$3,069	5.4%
Deficiencies and Reductions	0	0	-145	-145	
Adjusted General Fund	**$72,868**	**$56,487**	**$59,411**	**$2,924**	**5.2%**
Special Fund	121,542	147,903	165,118	17,215	11.6%
Deficiencies and Reductions	0	1,114	-203	-1,317	
Adjusted Special Fund	**$121,542**	**$149,017**	**$164,915**	**$15,898**	**10.7%**
Federal Fund	26,824	28,426	28,969	543	1.9%
Deficiencies and Reductions	0	2,158	-28	-2,187	
Adjusted Federal Fund	**$26,824**	**$30,584**	**$28,940**	**-$1,644**	**-5.4%**
Reimbursable Fund	8,584	15,318	10,896	-4,422	-28.9%
Adjusted Reimbursable Fund	**$8,584**	**$15,318**	**$10,896**	**-$4,422**	**-28.9%**
Adjusted Grand Total	**$229,818**	**$251,405**	**$264,162**	**$12,757**	**5.1%**

- The Department of Natural Resources (DNR) budget includes fiscal 2016 deficiencies, which would increase DNR's special fund appropriation by $1,114,000 for purchasing intelligence sharing-related equipment and distributing gaming revenue, and increase the federal fund appropriation by $2,158,077 for forest-related activities, Wildlife Management Area operations, environmental monitoring, and watershed planning.

- The overall adjusted change in the DNR budget is an increase of $12.8 million, or 5.1%. The major change is a special fund increase of $13.7 million from the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund. Other major changes include an increase of general fund spending primarily as a result of the need to backfill Forest Service special funds from the Forest or Park Reserve Fund that are now dedicated to the Maryland Park Service by Chapter of 389 of 2015 (Maryland Park Service – Operations Revenue – Mandated Appropriation).

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

For further information contact: Andrew D. Gray Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	1,293.50	1,320.50	1,340.50	20.00
Contractual FTEs	360.76	446.62	423.33	-23.29
Total Personnel	**1,654.26**	**1,767.12**	**1,763.83**	**-3.29**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	82.27	6.23%
Positions and Percentage Vacant as of 12/31/15	68.50	5.19%

- DNR's regular positions increase by 20.0 between the fiscal 2016 working appropriation and the fiscal 2017 allowance. The 20.0 new regular positions are contractual conversions as follows: 15.0 are contractual conversions where currently there are filled contractual full-time equivalents (FTE) that will become regular positions, and 5 are for contractual FTEs that will be hired in fiscal 2016 for the opening of the Harriet Tubman Underground Railroad State Park and then will be converted to regular positions in fiscal 2017. All of the new positions are budgeted at 6.01% turnover because they are, or will be, filled.

- DNR's contractual FTEs decrease by a net of 23.29 in the fiscal 2017 allowance. The majority of the contractual FTEs reduced, 19.6 FTEs, reflect the conversion to regular positions.

- DNR's turnover rate decreased from 7.05% in the fiscal 2016 working appropriation to 6.23% in the fiscal 2017 allowance, which reflects a decrease from 93.10 necessary vacancies to 83.51 necessary vacancies (82.27 when new positions are excluded), which DNR may find difficult to handle given there only are 68.50 vacancies as of December 31, 2015.

- DNR has 4.0 regular positions that were moved to the Office of the Secretary as part of fiscal 2016 working appropriation actions. DNR notes that this move was to improve customer service by creating an Office of Citizen Services staffed with 3.0 regular positions and that an additional position was transferred to create a special assistant position for the Assistant Secretary for Lands.

- The Natural Resources Police had its fifty-seventh Academy Class in fiscal 2015. The academy began on April 1, 2015, with 22 recruits and ended on October 31, 2015, with the same number of officers. The next class of 30 is anticipated to start on March 30, 2016.

Analysis in Brief

Major Trends

No Apparent Correlation Between Harmful Algal Blooms and Fish Kills: There does not appear to be a clear correlation between harmful algal blooms and fish or human health events reported/responses. DNR notes that the harmful algal blooms may have one or more of the following impacts: fish kills, toxicity to humans, reduction in water clarity, submerged aquatic vegetation declines, and dissolved oxygen declines.

Power Plant Research Program Projects under Review Fluctuate Due to Electricity Demand and Incentives: DNR attributes the variability in the number of applications for certificates of public convenience and necessity for new/modified power plants/transmissions lines to two main factors: (1) electricity market deregulation in 1999, which resulted in merchant generators responding to electricity market demand; and (2) State and federal incentives such as the Production Tax Credit, Investment Tax Credit, and the Maryland Renewable Portfolio Standard.

Maryland Biological Survey Sampled Sites and Volunteer Samples Processed Are Inversely Correlated Starting in Fiscal 2014: There is an inverse relationship between Maryland Biological Stream Survey (MBSS) sites sampled and volunteer benthic samples. DNR notes that the MBSS competes for laboratory time with its volunteer component – the Stream Waders volunteer benthic sampling program. As a result, DNR notes that it has reduced its effort to process Stream Waders volunteer benthic sampling, primarily as a result of budget and staff limitations.

Female Spawning Crabs Are a Strong Indicator of Total Crab Abundance: Between calendar 1990 and 2015, the female spawning blue crabs were under the 70 million crab threshold in three years – 1999 (53 million), 2001 (61 million), and 2002 (55 million) – and were above the 215 million target in two years – 1991 (227 million) and 2010 (246 million). Of note, there appears to be a correlation between the number of female spawning blue crabs and the total number of crabs.

Issues

Fee Reductions Continue: The Administration implemented fee reductions on September 15, 2015. In addition, the Administration has introduced SB 389 and HB 459 (Fee, Surcharge, and Tax Reduction Act of 2016) in the 2016 session that would eliminate the electricity surcharge funding the Environmental Trust Fund and modify DNR's fishing license fees beginning in fiscal 2018. **DLS recommends that DNR comment on the long-term impact of funding the Power Plant Assessment Program with Strategic Energy Investment Fund revenues and the rationale for reducing angler and coastal sport fishing license fees in fiscal 2018 given the recent effort to make the Fisheries Service more self-sufficient through cost recovery.**

Maryland Park Service Experiences Special Fund Revenue Bump: The Maryland Park Service's revenues appear to have stabilized in the fiscal 2017 allowance. The two main special fund revenues

– the State transfer tax and Forest or Park Reserve Fund revenues – both increase in fiscal 2017. The increased revenues raise the question of whether the Maryland Park Service should pass along some of its new revenue to park users in the form of reduced park fees. **DLS recommends that DNR comment on the status of pursuing the revenue opportunities noted in the Land Preservation Workgroup report requested by the budget committees in the 2015 *Joint Chairmen's Report*. DLS also recommends that DNR comment on how full-service cabin, mini-cabin, individual and group camping site, electrical hookup, and park day use fees can be reduced.**

Chesapeake and Atlantic Coastal Bays 2010 Trust Fund Allocation Increases Due to the End of Transfers: The Chesapeake and Atlantic Coastal Bays 2010 Trust Fund is financed with a portion of existing revenues from the motor fuel tax and the sales and use tax on short-term vehicle rentals. Fiscal 2017 reflects the first time full funding is provided for the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund. The additional funding primarily will be used for cost-effective nonpoint source projects. **DLS recommends that DNR comment on how it will be using the Genuine Progress Indicator to measure the relative economic, environmental, and social benefits of the Cannery Project, whether the use of the Genuine Progress Indicator will have implications for future project selection; and any preliminary information about the cost-effective nonpoint source project competitive solicitation responses received to date.**

Recommended Actions

		Funds
1.	Reduce funding for vehicles in Natural Resources Police – Field Operations.	$ 382,500
2.	Reduce funding for the Maryland Energy Administration contingent on legislation.	
	Total Reductions	**$ 382,500**

Updates

Baltimore City Unrest Funding Update: In April 2015, there were protests and riots in Baltimore City. As authorized by Section 14-107 of the Public Safety Article, the Governor declared a State of Emergency. In response to the unrest, several State agencies were activated and involved in restoring the peace and promoting safety. Natural Resources Police officers provided assistance from April 27, 2015, to May 3, 2015. The Administration processed budget amendment 114-15, which transferred $20 million in special funds from the Revenue Stabilization Account (commonly referred to as the Rainy Day Fund) to the Board of Public Works Contingent Fund. The funds are to be used to reimburse State agencies for costs associated with protests and riots in Baltimore City and to aid in recovery. DNR received a transfer of $210,836 in cash in fiscal 2015 to reflect its eligible costs.

K00A
Department of Natural Resources

Operating Budget Analysis

Program Description

The Department of Natural Resources (DNR) preserves, protects, enhances, and restores the State's natural resources for the use and enjoyment of all citizens. To accomplish this mission, DNR is structured into the programmatic units described below.

- **Office of the Secretary:** Provides leadership, public outreach, customer service, legislative, financial, administrative, information technology (IT), legal services, and integrated policy and review.

- **Forest Service:** Manages the State forests and supports Maryland's forest and tree resources by providing private forestland management expertise, wildfire protection, and urban and community forestry assistance.

- **Wildlife and Heritage Service:** Provides technical assistance and expertise to the public and private sectors for the conservation of Maryland's wildlife resources, including the management of threatened and endangered species, game birds, and mammals, and the operation of over 123,000 acres of State-owned lands classified as Wildlife Management Areas.

- **Park Service:** Manages natural, cultural, historic, and recreational resources in parks across the State and provides related educational services.

- **Land Acquisition and Planning:** Administers diverse financial assistance programs that support public land and easement acquisitions and local grants and leads the preparation of the Maryland Land Preservation and Recreation Plan.

- **Licensing and Registration Service:** Operates seven regional service centers that assist the public with vessel titling and registration, off-road vehicle registration, commercial fishing licenses, and recreational hunting and fishing licenses.

- **Natural Resources Police:** Preserves and protects Maryland's natural resources and its citizens through enforcement of conservation, boating, and criminal law; provides primary law enforcement services for Maryland's public lands owned by DNR; and serves as the State's lead on maritime homeland security.

- **Engineering and Construction:** Provides engineering, project management, and in-house construction services.

- **Critical Area Commission for the Chesapeake and Atlantic Coastal Bays:** Implements the cooperative resource protection program between the State and local governments in the 1,000-foot wide Critical Area surrounding the Chesapeake Bay by reviewing local development proposals, providing technical planning assistance to local governments, approving amendments to local plans, and providing grants for the implementation of 64 local critical area programs.

- **Boating Services:** Coordinates the Clean Marina Initiative and Pumpout Program, oversees a State-owned and a State-leased marina; funds public boating access facilities and navigation channel dredging; and places regulatory markers and navigation aids in support of sustainable development, use, and enjoyment of Maryland waterways for the general boating public.

- **Resource Assessment Service:** Evaluates and directs implementation of environmental restoration and protection policy for tidal and nontidal ecosystems, ensures electricity demands are met at reasonable costs while protecting natural resources, and provides scientific assessments and technical guidance for the management of geologic and hydrologic resources.

- **Maryland Environmental Trust:** Negotiates and accepts conservation easements over properties with environmental, scenic, historic, or cultural significance and provides grants, loans, and technical assistance to local land trusts.

- **Chesapeake and Coastal Service (formerly Watershed Services):** Coordinates State efforts to restore and protect the Chesapeake and Atlantic Coastal Bays by providing technical assistance and financial resources to local governments, State government agencies, nonprofit organizations, and private landowners in order to restore local waterways and prepare for future storms and coastline changes.

- **Fisheries Service:** Manages commercial and recreational harvests to maintain sustainable fisheries and to optimize recreational and economic use of these resources.

DNR's goals included in the fiscal 2017 Governor's Budget Books reflect the removal of the goal to achieve a diverse workforce and efficient operations and the inclusion of the goal to protect Maryland's ecologically valuable lands and waters. DNR's modified goals are to achieve the following:

- accelerated recovery of coastal resources through improved water quality;

- healthy and productive Maryland watershed lands, ocean, estuaries, wetlands, streams, and rivers;

- improvement in environmental literacy to motivate individuals and groups to take actions that benefit Chesapeake, coastal, and ocean resources;

- a conserved and managed statewide network of ecologically valuable private and public lands;
- diverse outdoor recreation opportunities for Maryland citizens and visitors; and
- protection of Maryland's ecologically valuable lands and waters through effective project review, including permit applications, and policy strategies.

Performance Analysis: Managing for Results

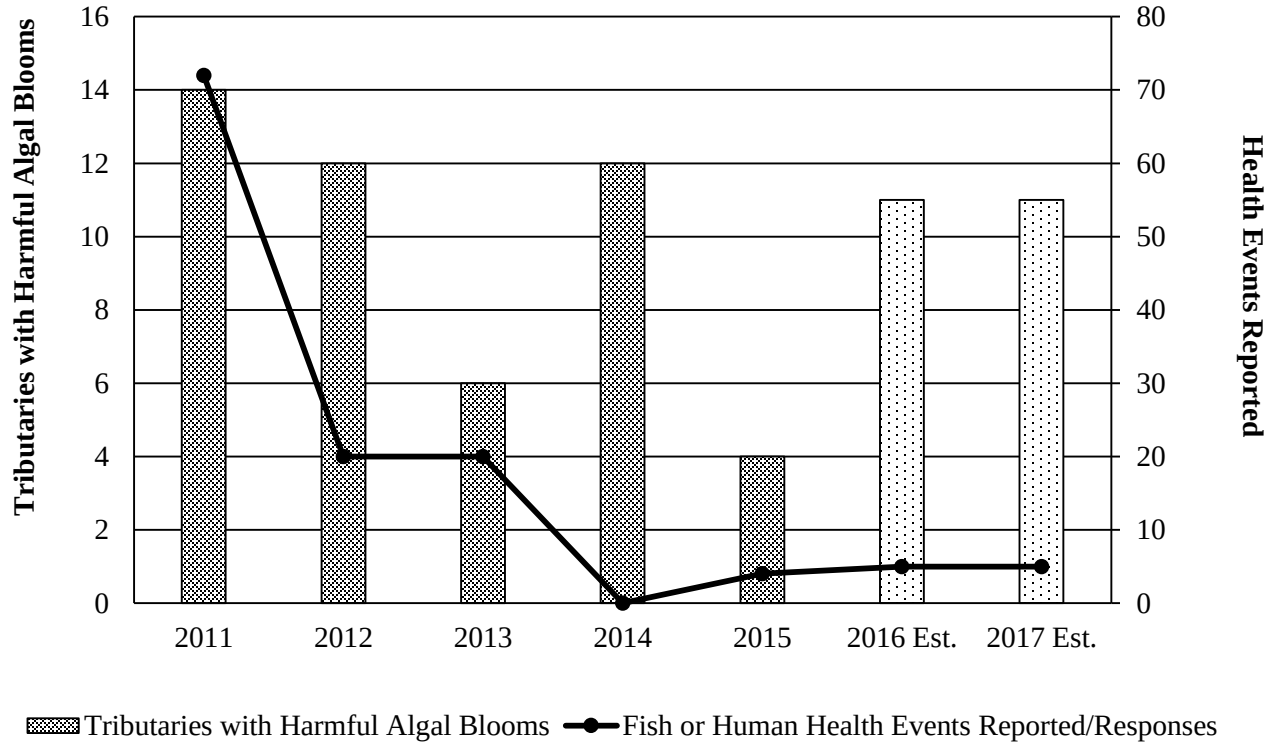
The Managing for Results analysis shows that (1) there is no apparent correlation between harmful algal blooms and fish kills; (2) Power Plant Research Program projects under review fluctuate due to electricity demand and incentives; (3) Maryland Biological Survey sampled sites and volunteer samples processed are recently inversely correlated; and (4) female spawning crabs determine total crab abundance.

1. No Apparent Correlation Between Harmful Algal Blooms and Fish Kills

DNR has the goal of accelerating the recovery of coastal resources through improved water quality. An objective under this goal is to produce technical assessments on harmful algal bloom distribution and prevalence for Maryland's waters, develop new management strategies, and provide timely information to the public and agencies charged with protecting public health. Performance measures under this goal and objective include (1) the number of tributaries with harmful algal blooms, and (2) the number of fish or human health events reported/responses.

Exhibit 1 reflects the data for both these measures between fiscal 2011 and the estimate for fiscal 2017. Over the time period time shown, there have been approximately 10 harmful algal blooms per year since fiscal 2011 while there were 72 fish kills in fiscal 2011, but then relatively few in recent years. While initially an attractive supposition, there does not appear to be a clear correlation between harmful algal blooms and fish or human health events reported/responses. DNR notes that the harmful algal blooms may have one or more of the following impacts: fish kills, toxicity to humans, reduction in water clarity, submerged aquatic vegetation declines, and dissolved oxygen declines.

Exhibit 1
Harmful Algal Blooms Impact on Health Events
Fiscal 2011-2017 Est.



Source: Department of Budget and Management

2. Power Plant Research Program Projects under Review Fluctuate Due to Electricity Demand and Incentives

DNR has the goal to achieve healthy and productive Maryland watershed lands, ocean, estuaries, wetlands, streams, and rivers. An objective under this goal is to annually issue assessments and recommendations to minimize the environmental, public health, and socioeconomic impacts of electric energy facilities. The performance measure for this objective is the number of new power plant/transmission line projects under review.

DNR notes that the Power Plant Research Program reviews four types of projects (example projects are described):

- **New Power Plants** – an application for a new 1,000 megawatt natural gas generator on a green-field site;

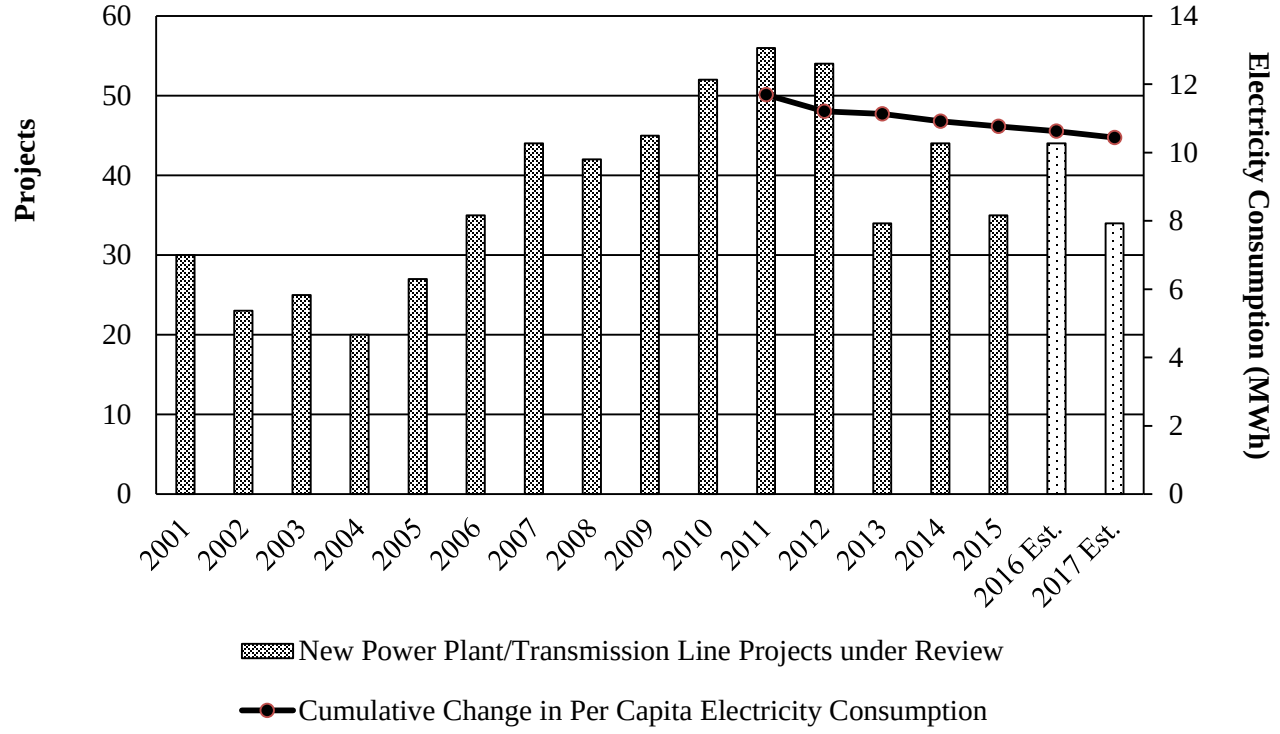
- **Modifications to Existing Power Plants** – an application for the installation of new equipment to accommodate new air quality regulations or a plant upgrade to improve the power output to meet projected economic upward trends;

- **New Transmission Lines –** an application for construction and operation of a new 500 kilovolt line; and

- **Modifications to Transmission Lines** – an application for a rebuild of an existing 138 kilovolt line to accommodate a second line or to upgrade it to a higher voltage to meet increased electrical demand.

As shown in **Exhibit 2**, the number of certificates of public convenience and necessity for new/modified power plants/transmission lines varies from year-to-year from a low of 20 in fiscal 2004 to a high of 56 in fiscal 2011. DNR attributes the variability to two main factors as follows: (1) electricity market deregulation in 1999, which resulted in merchant generators responding to electricity market demand; and (2) State and federal incentives such as the Production Tax Credit, Investment Tax Credit, and the Maryland Renewable Portfolio Standard. As a result of deregulation, recessions, which suppress electricity demand, also reduce the number of applications for certificates of public convenience and necessity. Other factors that reduce applications include tight financing conditions, reduced household growth, and increased implementation of energy efficiency measures. Conversely, State and federal incentives increase the number of applications for particular types of projects such as solar power facilities. Finally, DNR notes that PJM Interconnection, LLC – the regional grid operator – recently approved a performance incentive program, which rewards good plant performance and penalizes poor plant performance. This new program may induce merchant generators to retrofit units to ensure additional reliability during times of peak load or shortages in fuel supply.

Exhibit 2
Number of New Power Plant/Transmission Line Projects Under Review and Per Capita Electricity Consumption
Fiscal 2001-2017 Est.



MWh: megawatt hours

Note: The baseline is 2007 (12.3773 MWh).

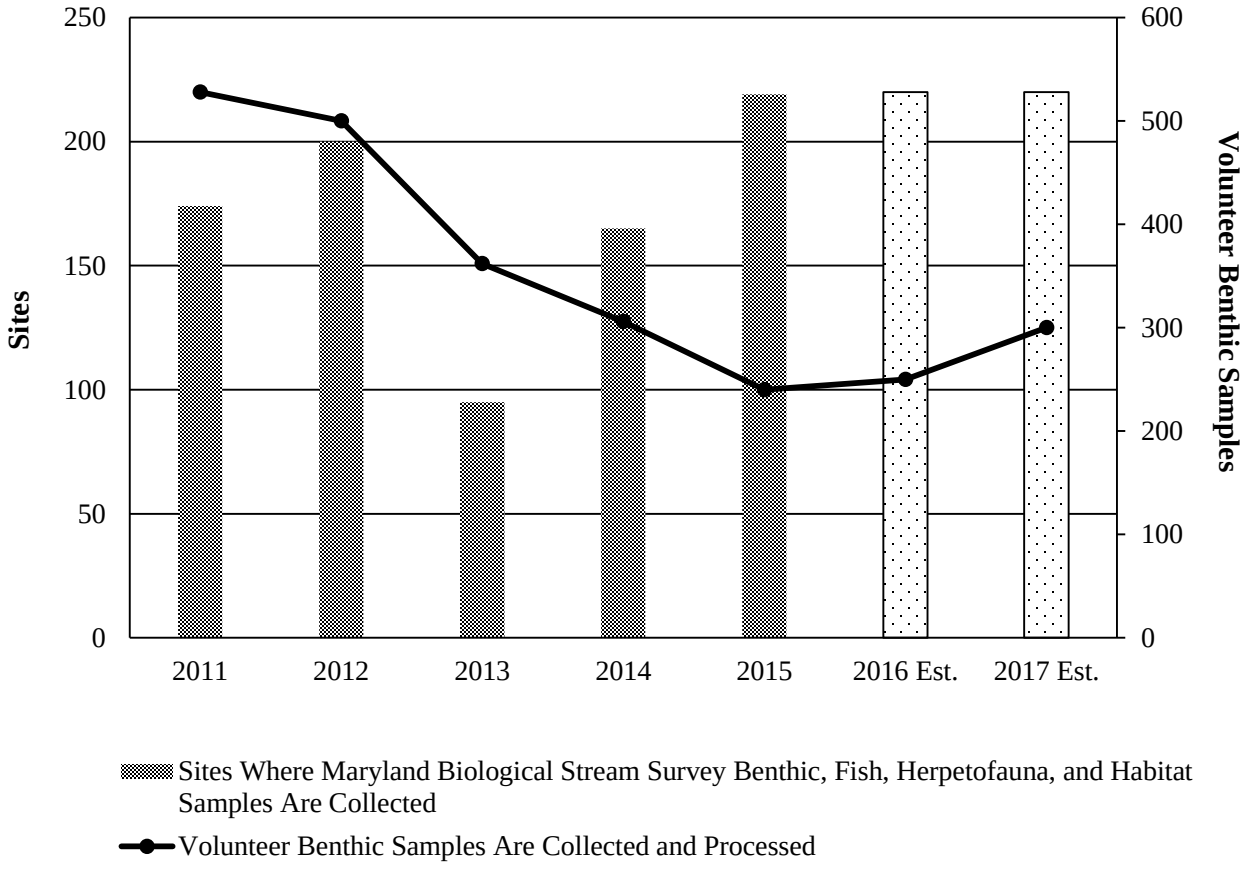
Source: Department of Budget and Management

3. Maryland Biological Survey Sampled Sites and Volunteer Samples Processed Are Inversely Correlated Starting in Fiscal 2014

Under the goal of accelerating the recovery of coastal resources through improved water quality, DNR also has the objective of assessing ecosystem components within nontidal waters to evaluate critical fisheries and habitat elements for protection and/or restoration. Two performance measures are relevant to this objective: (1) the number of sites where Maryland Biological Stream Survey (MBSS) benthic, fish, herpetofauna, and habitat samples are collected; and (2) the number of volunteer benthic samples collected and processed.

Exhibit 3 shows that recently there is an inverse relationship between MBSS sites sampled and volunteer benthic samples. DNR notes that the MBSS, which has been completed three times over multiple years since 1995 and was initiated again in 2014, competes for laboratory time with its volunteer component – the Stream Waders volunteer benthic sampling program. As a result, DNR notes that it has reduced its effort to process Stream Waders volunteer benthic sampling, primarily as a result of budget and staff limitations. DNR also notes that funding to support both the MBSS and the Stream Waders program sampling has declined due to the intent to contain costs. In order to handle this funding decrease, DNR has provided fewer training opportunities for volunteers, which, in turn, has led to fewer samples being submitted by volunteers to DNR's benthic laboratory.

Exhibit 3
Maryland Biological Stream Survey Sites and Samples Collected/Processed
Fiscal 2011-2017 Est.



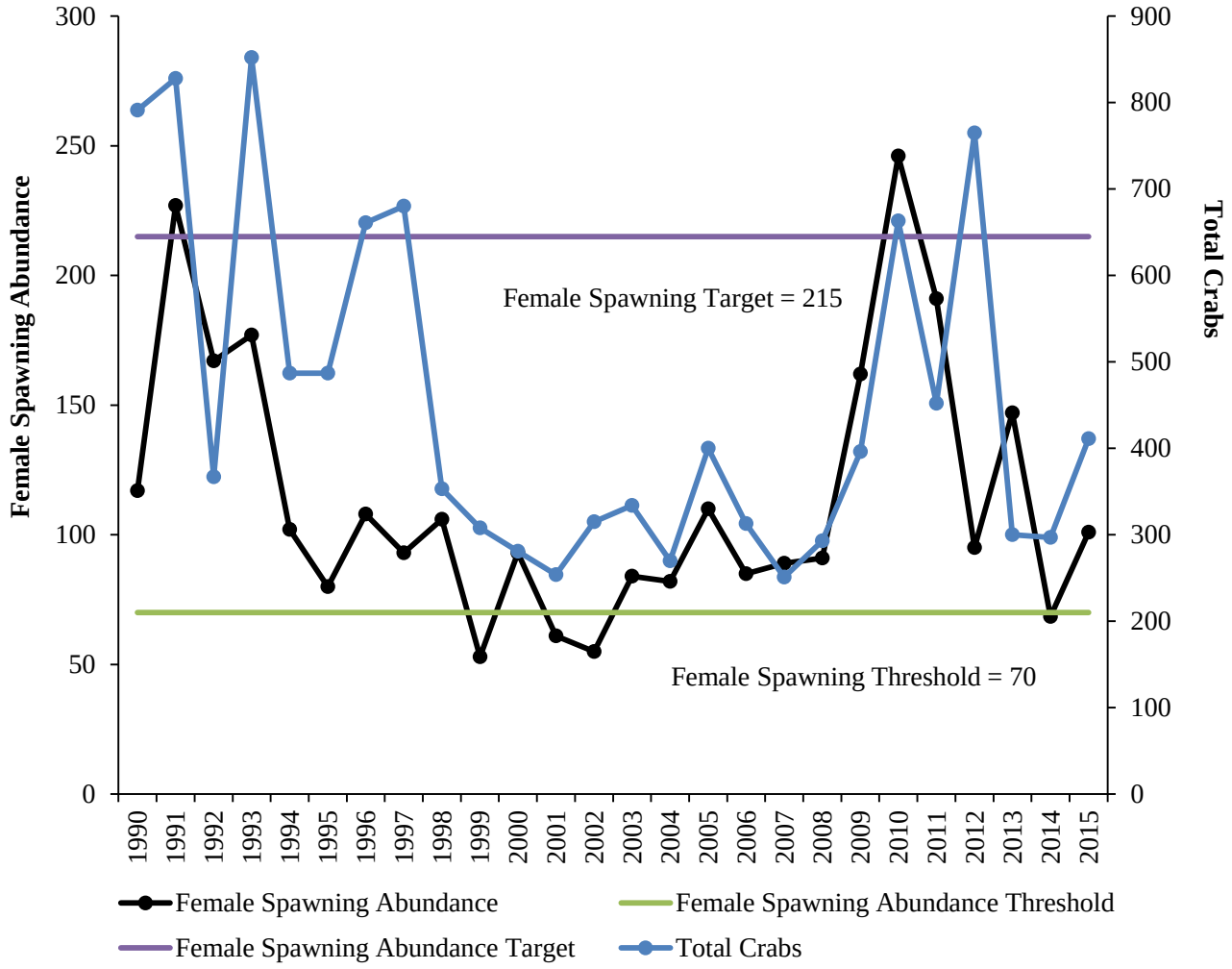
Source: Department of Budget and Management

4. Female Spawning Crabs Are a Strong Indicator of Total Crab Abundance

Under the goal of achieving healthy and productive Maryland watershed lands, ocean, estuaries, wetlands, streams, and rivers, DNR also has the objective annually to achieve fishery sustainability objectives (target fishing level and/or biomass threshold) for blue crab, striped bass, and oyster fisheries. While not included as part of DNR's performance measures, an alternative measure for blue crab sustainability is the goal of being above a threshold of 70 million female spawning crabs and meeting a target of 215 million crabs. More specifically, this measure accounts for female blue crabs bigger than 2.4 inches in carapace width, which are the females that will spawn in a given year and make up the female spawning stock for the Chesapeake Bay population.

Exhibit 4 reflects that between calendar 1990 and 2015, the female spawning blue crabs were under the 70 million crab threshold in three years – 1999 (53 million), 2001 (61 million), and 2002 (55 million) – and were above the target in two years – 1991 (227 million) and 2010 (246 million). Of note, as predicted there appears to be a correlation between the number of female spawning blue crabs and the total number of crabs. DNR notes that maintaining the female spawning stock abundance as close to the target is important for reducing the chances of a low recruitment of crabs. This is because, even though the blue crab has a high reproductive capacity, there are a large number of environmental factors that affect the crabs in the Chesapeake Bay each year.

Exhibit 4
Female Crab Spawning Abundance Impact on Total Crabs
Calendar 1990-2015
(Millions)



Source: Chesapeake Bay Program, *Winter Dredge Survey and Blue Crab Advisory Report*

Fiscal 2016 Actions

Two categories of actions impact the DNR fiscal 2016 budget: proposed deficiencies and a 2% across-the-board reduction.

Proposed Deficiency

The Governor has submitted five deficiency appropriations for the fiscal 2016 operating budget, which would increase DNR's special fund appropriation by $1,114,000 and increase the federal fund appropriation by $2,158,077. The appropriation changes would be as follows.

- **Forest Service** – There is an increase of $477,000 in federal funds for expenses associated with grants for Emerald Ash Borer treatment, technical assistance to increase forest buffer restoration, and wildlife risk reduction using U.S. Department of Agriculture funding from the Farm Service Agency's Conservation Reserve Program ($177,000), Forest Service's Cooperative Forestry Assistance ($270,000), and Forest Service's Forest Stewardship Program ($30,000).

- **Wildlife and Heritage Service** – Funding increases by $673,796 in federal funds for managing Wildlife Management Areas, conducting research studies and projects, and purchasing a dump truck from the U.S. Department of the Interior – Fish and Wildlife Service's Wildlife Restoration and Basic Hunter Education funding.

- **Land Acquisition and Planning** – Funding from the Calvert County Gaming Tax Fund is increased by $918,000 in special funds for revenue distributions to the Boys and Girls Club of North Beach ($50,000), the Town of North Beach ($276,000), and the Town of Chesapeake Beach ($592,000). This funding previously was not budgeted in the State budget but was instead paid directly by the Comptroller under Tax – General Article Section 2-202. On a separate but related note, the fiscal 2017 allowance includes an increase of $249,279 for a total of $945,242 that represents the funding typically granted by DNR to increase youth recreational opportunities in Calvert County from the State admissions and amusement tax on electronic bingo and electronic tip jars in Calvert County under Natural Resources Article Section 5-1901.

- **Natural Resources Police** – The special fund appropriation is increased by $196,000 from the donations account for purchasing intelligence sharing-related equipment.

- **Chesapeake and Coastal Service** – There is an increase of $1,007,281 in federal funds for passive acoustic monitoring of marine mammals as part of offshore wind studies from the U.S. Department of the Interior – Bureau of Ocean Energy Management's Environmental Studies Program ($768,718), and for assistance to local governments and communities for watershed planning and implementation efforts in the Chesapeake Bay watershed from the U.S. Environmental Protection Agency (EPA) – Office of Water's Chesapeake Bay Program funding ($238,563).

Cost Containment

The DNR fiscal 2016 budget is reduced by the across-the-board reduction implemented in the 2015 legislative session. The DNR share of the reduction was $1,126,000 as shown in **Exhibit 5**.

Exhibit 5
2% Across-the-board Cost Containment
Fiscal 2016

Program	Action	Funding
Agencywide	Reduce State-issued cell phones and delete mobile data plans for most tablet devices ($44,800), and reduce funds for network circuit costs shifted to a controlled object set by the Department of Information Technology ($487,557).	$532,357
Forest Service	Use increased special fund revenue from timber harvests on State lands in place of general funds for salaries.	200,000
Natural Resources Police – General Direction	Reduce water craft purchases.	118,763
Fisheries Service	Shift the fund source for the Seafood Marketing Program's Administrative Officer from general funds to special funds (seafood marketing surcharge funds – $45,000) and reduce planned offshore monitoring ($32,300).	77,300
Chesapeake and Coastal Services	Delete remaining funding for the Tributary and Wetland Restoration program dedicated to the on-the-ground wetland restoration projects that may be eligible for Chesapeake and Atlantic Coastal Bays 2010 Trust funding in the future.	54,000
Critical Area Commission	Reduce temporary office services and reduce mapping initiatives.	42,329
Wildlife and Heritage Service	Delete funding for print production of the annual guide to hunting and trapping.	40,000
Office of the Secretary – Audit and Executive Direction, Office of the Attorney General, Finance and Administrative Services	Reduce funding for travel ($2,500), contractual services ($6,200), supplies ($4,531), photocopier costs ($4,000), and Annapolis Data Center Charges ($22,000).	39,231
Resource Assessment Service: Maryland Geological Survey	Use Power Plant Research Program funds in place of general funds to support Maryland Geologic Survey salaries for carbon dioxide geologic sequestration activities.	20,000
Engineering and Construction	Reduce office supplies.	2,020
Total		**$1,126,000**

Source: Department of Budget and Management

Proposed Budget

DNR's fiscal 2017 adjusted allowance increases by $12.8 million, or 5.1%, relative to the fiscal 2016 adjusted working appropriation, as shown in **Exhibit 6**. The changes by fund in Exhibit 6 reflect a $2.9 million increase in general funds, an increase of $15.9 million in special funds, a decrease of $1.6 million in federal funds, and a $4.4 million decrease in reimbursable funds. The major change is an increase of $13.7 million in funding for nonpoint source pollution reduction from the Chesapeake and Atlantic Coastal Bays 2010 Trust. General fund spending increases primarily as a result of the personnel expense changes in the Natural Resources Police. Special fund spending increases due to the additional Chesapeake and Atlantic Coastal Bays 2010 Trust Fund spending as well as additional transfer tax special funds available in the Maryland Park Service. Changes in personnel funding are discussed first and then other changes.

Employee increments and associated expenses (including Social Security, retirement, unemployment compensation, and turnover) are included in the budget of the Department of Budget and Management (DBM), and $2,078,214 in total funds comprised of $1,048,397 in general funds, $825,793 in special funds, $137,935 in federal funds, and $66,090 in reimbursable funds will be distributed to DNR by budget amendment for the start of the fiscal year.

Exhibit 6
Proposed Budget
Department of Natural Resources
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$72,868	$121,542	$26,824	$8,584	$229,818
Fiscal 2016 Working Appropriation	56,487	149,017	30,584	15,318	251,405
Fiscal2017 Allowance	59,411	164,915	28,940	10,896	264,162
Fiscal 2016-2017 Amount Change	$2,924	$15,898	-$1,644	-$4,422	$12,757
Fiscal 2016-2017 Percent Change	5.2%	10.7%	-5.4%	-28.9%	5.1%

Where It Goes:

Personnel Expenses

Employee and retiree health insurance	$1,748
Contractual FTE conversions to 20.0 new positions	1,308
Employee retirement	1,282
Turnover adjustments	888
Other fringe benefit adjustments	-106
Workers' compensation	-228

Where It Goes:	
Salaries and other compensation	-2,018
Other Changes	
Land and Water Conservation	
Chesapeake and Atlantic Coastal Bays 2010 Trust Fund	13,650
State Highway Administration stormwater permit restoration funding	1,320
COMPASS phase II funding	-393
Harriet Tubman Underground Railroad State Park	-1,490
Natural Resources Police	
Vehicle expenses	882
Maritime Law Enforcement Information Network	-2,480
Routine Operations	
Department of Budget and Management paid telecommunications	798
Other	120
Contractual FTEs decrease by 23.29	-341
One-time deficiencies	-2,183
Total	**$12,757**

FTE: full-time equivalent

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

Personnel

Changes by Category

DNR's overall personnel expenditures increase by $2.9 million in the fiscal 2017 adjusted allowance. The personnel changes are as follows.

- **Employee and Retiree Health Insurance** – Health insurance costs increase by $1,748,080, which includes the across-the-board reduction for employee health insurance.

- **Contractual Full-time Equivalent Conversions to 20.0 New Positions** – There is an increase of $1,308,286 to reflect the conversion of 19.6 contractual full-time equivalents (FTE) to 20.0 new regular positions. The new positions are reflected in **Exhibit 7**. DNR notes that existing vacant positions were not used for the contractual conversions because each position has a designated set of duties and responsibilities and that using vacant positions would require hiring additional contractual FTEs to perform the work of the previously vacant position.

- **Employee Retirement** – Retirement contribution costs increase by $1,282,008.

Exhibit 7
Contractual FTE Conversions to New Positions
Fiscal 2017

Unit	Title	Fund Source	Number	Description
Human Resource Service	Administrative Officer III	SF	2	Ensure recruitment and staffing needs are met given the increase in applications by moving to the online application system JobAps in August 2012 and handle the increase in personnel transactions necessitated by the requirement that all contractual FTEs be processed in the human resources software Workday in November 2014.
Forest Service	Forester I, Administrative Specialist II, Office Secretary III, Natural Resources Technician III	RF, SF, FF	4	Convert employees with two to eight years of service.
Wildlife and Heritage Service	Natural Resources Technician II	FF	1	Convert incumbent who has been employed since March 2014 in order to administer annual hunting permits and daily registrations for several Wildlife Management Areas and State Parks in southern Maryland and to perform habitat management practices and maintenance projects on all Wildlife Management Areas in Southern Maryland.
Maryland Park Service	Park Services Supervisor, Park Services Associate Lead, Park Services Associate I, Administrative Specialist II, Park Technician III	SF	5	Assist with Harriet Tubman Underground Railroad State Park operations and general maintenance since the new visitor center and administrative buildings will be complete and occupied in March 2016.

Unit	Title	Fund Source	Number	Description
Engineering and Construction	Agency Project Engineer-Architect I	SF	2	Perform topographic surveys on land and hydrographic surveys on the water for meeting increasing demands from other programs.
Boating Services	Administrative Specialist III	SF	1	Maintain efficient operations of the Boat Tax Enforcement Division.
Chesapeake and Coastal Services	Natural Resources Planner III (2), and Administrative Officer III	SF	3	Accelerate and ensure the fiscal responsibility of Chesapeake and Atlantic Coastal Bays 2010 Trust Fund projects for Chesapeake Bay restoration over at least the next 10 years.
Fisheries Service	Natural Resources Technician III, Natural Resources Biologist II	FF	2	Support production and stocking needs at Albert Powell Hatchery including performing all trout husbandry duties that facilitate approximately 60 children's fishing rodeos throughout the State; and sample for resident and migratory fish, maintain two program databases, and analyze data collected for summer migratory species.
Total			**20**	

FF: federal funds
FTE: full-time equivalent
RF: reimbursable funds
SF: special funds

Source: Department of Natural Resources; Department of Legislative Services

- **Turnover Adjustments** – Turnover is reduced from 7.05% in the fiscal 2016 working appropriation to 6.23% in the fiscal 2017 allowance, which increases available funding by $887,875. The reduction in the turnover rate means that DNR will need to have 83.51 necessary vacancies instead of 93.10 vacancies. However, DNR only has 68.50 vacancies as of December 31, 2015. DNR notes that it monitors personnel expenditures on a monthly basis and makes strategic decisions related to the filling of vacant positions to ensure turnover is met. DNR's turnover rate for the new positions in the budget is 6.01%, which reflects the conversion of contractual FTEs to regular positions and thus no modification to turnover is necessary.

- **Workers' Compensation** – Workers' compensation funding decreases by $228,373 in the fiscal 2017 allowance.

- **Salaries and Other Compensation** – There is a decrease of $2,018,025 for salaries and other compensation, which may reflect a new statewide personnel system budgeting vacant positions at the base level.

Other Changes

Overall, the nonpersonnel portion of DNR's fiscal 2017 adjusted allowance increases by $9.9 million. The areas of change may be broadly categorized as land and water conservation, Natural Resources Police, and routine operations. The biggest change is an increase of $13.7 million for the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund. The nonpersonnel changes in DNR's fiscal 2017 budget are as follows.

Land and Water Conservation

- **Chesapeake and Atlantic Coastal Bays 2010 Trust Fund** – Funding for nonpoint source pollution reduction projects and related activities funded by the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund special funds increase by $13,649,778 in fiscal 2017. This funding increase reflects the first time that full funding has been provided and will be used to support a recently released competitive solicitation for cost-effective nonpoint source pollution reduction practices. Program funding is discussed further as an issue in this analysis.

- **State Highway Administration Stormwater Permit Restoration Funding** – There is an increase of $1,320,000 in reimbursable funds for the DNR/State Highway Administration (SHA) Restoration Partnership. The funding reflects the need for SHA to meet stormwater remediation goals in its municipal separate storm sewer system permit, which will be addressed by funding cost-effective restoration practices on State park land.

- **COMPASS Phase II Funding** – There is a decrease of $393,000 in special funds for one-time funding of Phase II enhancements of the Maryland Outdoor Customer Service Delivery System (COMPASS) IT project.

- **Harriet Tubman Underground Railroad State Park** – Funding decreases by $1,489,940 in reimbursable funds in Engineering and Construction due to one-time funding transferred from the SHA's Scenic Byways Program funding to DNR for the development of Harriet Tubman Underground Railroad State Park displays and videos.

Natural Resources Police

- **Vehicle Expenses** – Vehicle expenses increase agencywide by $882,461 primarily due to an increase of $765,000 in general funds in Natural Resources Police – General Direction for the purchase of vehicles.

- **Maritime Law Enforcement Information Network –** There is a decrease of $2,480,038 in reimbursable funds for radios and electronic equipment in the Office of the Secretary – Information Technology Service (ITS) for one-time Maritime Law Enforcement Information Network funding transferred from the Department of Information Technology's (DoIT) Major Information Technology Development Project Fund (MITDPF). The funding supported the upgrade of Natural Resources Police radios to Project 25 digital radio communications technology as part of the 700 megahertz (MHz) project implementation plan to ensure interoperability with local jurisdictions and other State law enforcement agencies.

Routine Operations

- **DBM Paid Telecommunications** – Paid telecommunications spending increases by $798,325, which reflects a $907,486 general fund increase offset partially by a $109,161 special fund decrease.

- **Contractual FTEs Decrease By 23.29 –** Contractual FTEs decrease by 23.29 for an overall reduction of $340,960. The changes are reflected in **Exhibit 8** and reflect the contractual conversion of 19.6 FTEs to 20.0 regular positions. DNR notes that the funding for contractual FTEs does not decrease by an amount roughly equivalent to the increase in salaries for regular positions because of the budgeting of contractual health insurance costs, which do not appear to have been budgeted previously and which increase the fiscal 2017 allowance for contractual FTEs by $327,621 and thus partially offset the reduction in funding as a result of the contractual conversions to regular positions.

- **One-time Deficiencies –** Funding decreases by $2,183,077 to reflect the one-time nature of all but one nonpersonnel deficiency for fiscal 2016. The Calvert County Gaming Tax Fund distributions of $918,000 in special funds to the Boys and Girls Club of North Beach ($100,000), the Town of North Beach ($226,000), and the Town of Chesapeake Beach ($592,000) carry over into fiscal 2017.

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. DNR's share of these reductions totals $376,362 comprised of $144,850 in general funds, $203,033 in special funds, and $28,479 in federal funds. There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

Exhibit 8
Contractual FTE Changes
Fiscal 2016-2017

Unit/Program	Change	Description
Maryland Park Service – Statewide Operations	-8.50	Reduction of 5.0 FTEs for contractual conversions, 2.0 FTEs for budgetary reasons, and 1.0 FTE for seasonal positions throughout the State parks.
Chesapeake and Coastal Service	-5.00	Reduction of 3.0 FTEs for contractual conversions, and 2.0 FTEs for Chesapeake and Atlantic Coastal Bays 2010 Trust Fund implementation activities.
Forest Service	-3.93	Reduction of 4.0 FTEs for contractual conversions, and 1.0 FTE for budgetary reasons; and increase of 1.07 FTEs for forest fire protection and Firewise programs.
Human Resource Service	-2.00	Reduction of 2.0 FTEs for contractual conversions.
Engineering and Construction	-2.00	Reduction of 2.0 FTEs for contractual conversions.
Fisheries Service	-1.79	Reduction of 2.0 FTEs for contractual conversions, 1.0 FTE supporting fish hatchery work; and increases of 0.91 FTE for the new Access Point Angler Intercept Survey Program from Atlantic States Marine Fisheries Commission funding, and 0.3 FTE for work at the Cooperative Oxford Laboratory.
Maryland Environmental Trust	-1.00	Reduction of 1.0 FTE due to budget constraints.
Wildlife and Heritage Service	-0.84	Reduction of 1.0 FTE for a contractual conversion and increase of 0.16 FTEs for a new project funded by a federal grant.
Boating Services	-0.60	Reduction of 0.6 FTE for a contractual conversion.
Power Plant Assessment Program	-0.20	Reduction of 0.2 FTE due to a student technical assistant being reduced from eight to seven months.
Chesapeake Bay Critical Area Commission	0.40	Increase of 1.0 FTE natural resources planner and reduction of 0.6 administrative aide not requested in fiscal 2017.
Information Technology Service	1.00	Increase of 1.0 FTE to handle work created by wireless projects including the 700 MHz conversion and the Maritime Law Enforcement Information Network information – camera and radar feeds – received by the Command Center.
Finance and Administrative Service	1.17	Increase of 1.0 FTE to assist with fleet maintenance and support, increase of 1.0 FTE for a management associate position to support the director; and reduction of 0.83 FTE for a position no longer needed.
Total	**-23.29**	

FTE: full-time equivalent
MHz: megahertz

Source: Department of Natural Resources

Issues

1. Fee Reductions Continue

The Administration implemented fee reductions on September 15, 2015. In addition, the Administration has introduced SB 389 and HB 459 (Fee, Surcharge, and Tax Reduction Act of 2016) in the 2016 session that would eliminate the electricity surcharge funding the Environmental Trust Fund (ETF) and instead fund the Power Plant Research Program from a $10.0 million allocation off the top of the Strategic Energy Investment Fund (SEIF). SB 389 and HB 459 would also strike the provision requiring the Maryland Energy Administration (MEA) to receive funding from the ETF, presumably because the ETF is now receiving funding from the SEIF and modifies DNR's fishing license fees beginning in fiscal 2018.

Exhibit 9 reflects the impact of the September 15, 2015 fee reductions. These reductions will have a nominal impact on agency operations, which is consistent with the projected fiscal 2016 ending balances for the two funds that receive funding from the fees that have been reduced.

Exhibit 9
Fee Reductions
September 15, 2015

Unit	Fees	DLS Estimated Amount of Revenue Reduction	Comment
Forest Service	Forestry-related	$11,250	The Forest Service is already receiving more general funds as a result of the mandated appropriation from the Forest or Park Reserve Fund to the Maryland Park Service; however, the overall impact to the programs is expected to be minimal. The Forest or Park Reserve Fund, used by both the Forest Service and the Maryland Park Service, has a fiscal 2016 ending balance of $1 million.
Maryland Park Service	Park-related	Unknown	
Wildlife and Heritage Service	Game-related	600	The Wildlife Management and Protection Fund has an estimated $1 million fiscal 2016 ending balance and so the reduction in revenue is not anticipated to impact operations.
	Total	**$11,850**	

DLS: Department of Legislative Services

Source: Department of Legislative Services

As introduced, SB 389 and HB 459 would eliminate the surcharge on electricity distributed to retail electric customers in Maryland that currently is placed in the ETF for the purposes of the DNR Power Plant Research Program. Instead, the Power Plant Research Program would be funded by a flat $10 million taken off the top of the Regional Greenhouse Gas Initiative (RGGI) carbon dioxide allowance revenues that are placed in the SEIF. In addition, the legislation would reduce fees beginning in fiscal 2018.

The implications of these changes appear to be as follows:

- **SEIF Activities** – there is a minimal reduction $0.15 per month for the average homeowner's electricity bill at the cost of a reduction of $10 million in revenue that otherwise would have gone toward the possibility of long-term energy efficiency actions for homeowners, although it is noted that the utilities do have a much larger role to play in the energy efficiency arena;

- **Flexibility Reduction** – the Power Plant Research Program funding is now part of the SEIF allocations as opposed to being a separate bill that is submitted at the end of every sunset period. This is of concern because SEIF funding is not a guarantee since the RGGI could be eliminated or incorporated into a national carbon dioxide trading strategy, or be successful in reducing carbon dioxide emissions and thus revenues decline; and

- **Revenue Stabilization** – the electricity surcharge is an unstable source of revenue given that it is based on kilowatt hour usage, which declined during the recent recession. A flat rate of funding could be an advantage except to the extent it limits funding going forward, unless the kilowatt hour surcharge were to be modified so that it provides the amount of funding needed.

Beginning in fiscal 2018, SB 389 and HB 459 as introduced would reduce several resident and nonresident fishing fees. The reduction of fishing fees reflects a change in policy from the intent to make the Fisheries Service self-sufficient by providing for cost recovery as envisioned by Chapter 435 of 2012 (Natural Resources – Commercial Fishing Licenses, Authorizations, and Permits), which required a fair and reasonable allocation of general fund appropriations for fishery management between the recreational and commercial fisheries and a report on cost recovery from the commercial sector. The fishing fees proposed to be reduced are as follows:

- **Angler's License (Resident)** – reduce from $20.50 to $10.50;

- **Angler's License (Nonresident)** – reduce from a greater of a calculation component of $30.50 to $20.50;

- **Coastal Sport Fishing License (Resident)** – reduce from $15.00 to $9.00;

- **Coastal Sport Fishing License (Nonresident)** – reduce from $22.50 to $14.00; and

- **Coastal Sport Fishing License (Boat Registered in Any State)** – reduce from $50.00 to $40.00.

DLS recommends that DNR comment on the long-term impact of funding the Power Plant Assessment Program with SEIF revenues and the rationale for reducing angler and coastal sport fishing license fees in fiscal 2018 given the recent effort to make the Fisheries Service more self-sufficient through cost recovery.

2. Maryland Park Service Experiences Special Fund Revenue Bump

The Maryland Park Service's revenues appear to have stabilized in the fiscal 2017 allowance. The two main special fund revenues – the State transfer tax and Forest or Park Reserve Fund revenues – both increase in fiscal 2017 due to a partial recovery of the real estate market and the own-sourced revenue mandate in Chapter of 389 of 2015 (Maryland Park Service – Operations Revenue – Mandated Appropriation). The increased revenues raises the question of whether the Maryland Park Service should pass along some of its new revenue to park users in the form of reduced park fees.

Chapter of 389 of 2015 Provision

Chapter 389 authorized the use of 60% of Maryland Park Service-sourced revenues in fiscal 2016, 80% in fiscal 2017, and 100% in fiscal 2018 for operating purposes. **Exhibit 10** reflects how this provision has been applied in the fiscal 2017 allowance. As can be seen, the Administration has first taken out the overhead costs for the Office of the Secretary before it has applied what appears to be an 83% allocation, which is greater than the 80% requirement. While DNR was able to handle the 60% mandate in fiscal 2016 without requiring general fund support, there is $3.9 million in general funds budgeted in the Forest Service for fiscal 2017 in order to maintain current service levels. As shown in **Exhibit 11**, the reason for this increase in general fund support is due to the reduction of $3.3 million in Forest or Park Reserve Fund special funds for the Forest Service between fiscal 2016 and 2017.

Exhibit 10
Allocation of Forest or Park Reserve Fund Revenues
Fiscal 2017

	Forest Service Revenue	Percent of Revenue
Available Revenue Net of Overhead	**$2,791,320**	
Revenue to the Forest Service	2,791,320	100%
	Park Service Revenue	**Percent of Revenue**
Available Revenue Net of Overhead	**$11,631,733**	
Revenue to the Park Service	9,692,179	83%
Revenue to the Forest Service	1,939,554	17%

Source: Department of Natural Resources; Department of Legislative Services

Exhibit 11
Maryland Park Service and Forest Service Funding Comparison
Fiscal 2016-2017

	2016		2017		Difference	
	Funding	Percent of Total	Funding	Percent of Total	Funding	Percent of Total
Forest Service						
General Funds	$667,746	6%	$3,915,781	31%	$3,248,035	26%
Forest or Park Reserve Fund	8,030,026	67%	4,761,562	38%	-3,268,464	-28%
All Other Funding	3,362,407	28%	3,776,197	30%	413,790	2%
Total	**$12,060,179**	**100%**	**$12,453,540**	**100%**	**$393,361**	**0%**
Maryland Park Service						
General Funds	$4,926,898	12%	$47,999	0%	-$4,878,899	-12%
Forest or Park Reserve Fund	6,775,760	17%	9,692,179	24%	2,916,419	6%
All Other Funding	27,749,927	70%	31,332,009	76%	3,582,082	6%
Total	**$39,452,585**	**100%**	**$41,072,187**	**100%**	**$1,619,602**	**0%**

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

Source: Governor's Budget Books, Fiscal 2017

Maryland Park Service Fee Reduction Possibility

Maryland Park Service fiscal 2017 funding reflects a substantial increase in transfer tax and Forest or Park Reserve Fund special funds, as shown in **Exhibit 12**. Overall, the Maryland Park Service's budget increases by $1.6 million between fiscal 2016 and 2017. This raises the question of whether there is the possibility to pass on any of the revenue enhancements provided for by Chapter 389 and the increase in transfer tax revenues due to the real estate market improving. One way this could be handled would be through a reduction of State park fees that were last raised in fiscal 2012. This could be handled in a graduated manner over the next couple of years as transfer tax revenues continue to increase, and the Forest or Park Reserve Fund provides a sound financial base for the Maryland Park Service. **DLS recommends that DNR comment on the status of pursuing the revenue opportunities noted in the Land Preservation Workgroup report requested by the budget committees in the 2015 *Joint Chairmen's Report*. DLS also recommends that DNR comment on how full-service cabin, mini-cabin, individual and group camping site, electrical hookup, and park day use fees can be reduced.**

Exhibit 12
Maryland Park Service Funding
Fiscal 2009-2017
($ in Thousands)

	2009	2010	2011	2012	2013	2014	2015	2016	2017	Difference 2016-2017
General Funds	$0	$0	$0	$370	$841	$2,492	$23,624	$4,927	$48	-$4,879
Special Funds										
Forest or Park Reserve Fund	7,788	6,706	6,558	8,024	6,123	5,834	5,340	6,776	9,692	2,916
POS Transfer Tax	22,200	22,200	22,204	22,200	22,200	24,927	5,135	24,090	27,568	3,478
Other	2,947	3,523	3,192	2,442	2,679	2,159	2,269	2,776	2,850	74
Subtotal	***$32,935***	***$32,429***	***$31,954***	***$32,666***	***$31,002***	***$32,920***	***$12,743***	***$33,642***	***$40,110***	***$6,468***
Federal Funds	461	574	738	685	278	54	208	134	135	1
Reimbursable Funds	409	278	339	355	543	720	601	749	779	30
Total	**$33,805**	**$33,280**	**$33,031**	**$34,076**	**$32,663**	**$36,186**	**$37,177**	**$39,453**	**$41,072**	**$1,620**

POS: Program Open Space

Note: The $23,624,420 in general funds in fiscal 2015 reflects funding to backfill a transfer tax revenue write-down. The fiscal 2016 funding primarily reflects funding for payment in lieu of taxes to local jurisdictions and Maryland Environmental Service charges.

Source: Governor's Budget Books, Fiscal 2011-2017

3. Chesapeake and Atlantic Coastal Bays 2010 Trust Fund Allocation Increases Due to the End of Transfers

Chapter 6 of the 2007 special session (HB 5) established a Chesapeake and Atlantic Coastal Bays 2010 Trust Fund to be used to implement the State's tributary strategy. The fund is financed with a portion of existing revenues from the motor fuel tax and the sales and use tax on short-term vehicle rentals. Subsequently, Chapters 120 and 121 of 2008 established a framework for how the trust fund money must be spent by specifying that it be used for nonpoint source pollution control projects and by expanding it to apply to the Atlantic Coastal Bays. Fiscal 2017 reflects the first time full funding is provided for the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund.

History

Exhibit 13 shows the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund history, including revenues, transfers, and expenditures. As noted previously, fiscal 2017 reflects the first year that funding has not been transferred and thus available revenues for programs have exceeded $50.0 million as originally projected for the fund. Of note, the fiscal 2016 revenue has declined from $52.71 million in last year's analysis to $51.42 million reflected in Exhibit 13; however, there was a $2.10 million opening balance for fiscal 2016 that was not previously accounted for that makes up for the lower revenue estimate.

Exhibit 13
Chesapeake and Atlantic Coastal Bays 2010 Trust Fund History
Fiscal 2009-2017 Est.
($ in Millions)

Appropriation	2009	2010	2011	2012	2013	2014	2015	Est. 2016	Est. 2017
Opening Balance	$0.00	$3.63	$5.84	$3.23	$3.43	$3.44	$0.00	$2.10	$0.84
Revenue	$38.23	$41.50	$43.10	$41.79	$44.29	$49.38	$52.85	51.42	$53.00
Transfers to the GF									
Chapter 414 of 2008	-$25.00								
Chapter 487 of 2009		-$21.49							
Chapter 484 of 2010		-10.50	-$22.10						
Chapter 397 of 2011			-0.97	-$20.17	-$15.08	-$11.54	-$8.05	-$4.62	
Chapter 1 of 2012 First Special Session					-8.00				
Chapter 464 of 2014						-10.40	-6.20		
BRFA of 2015								-8.64	
Subtotal GF Transfers	***-$25.00***	***-$31.99***	***-$23.07***	***-$20.17***	***-$23.08***	***-$21.94***	***-$14.25***	***-$13.26***	***$0.00***

Appropriation	2009	2010	2011	2012	2013	2014	2015	Est. 2016	Est. 2017
GF Deficiency					2.80				
Available Revenue	**$13.23**	**$13.14**	**$25.87**	**$24.85**	**$27.44**	**$30.88**	**$38.60**	**$40.26**	**$53.84**
Spending									
MDA	-$6.93	-$3.92	-$12.34	-$13.18	-$14.50	-$15.60	-$19.60	-$19.60	-$19.60
MDE	-1.83	-1.65	-2.10	0.00	0.00	-0.75	-0.75	-0.75	-0.75
DNR	-0.84	-1.73	-8.20	-10.40	-10.29	-14.75	-16.15	-19.07	-32.65
Subtotal Agency Spending	***-$9.60***	***-$7.30***	***-$22.64***	***-$23.58***	***-$24.79***	***-$31.10***	***-$36.50***	***-$39.42***	***-$53.00***
Encumbrance Cancellations				$2.16	$0.78	$0.11			
MDA Returned Revenue						0.11			
Available Balance	**$3.63**	**$5.84**	**$3.23**	**$3.43**	**$3.44**	**$0.00**	**$2.10**	**$0.84**	**$0.84**

BRE: Board of Revenue Estimates
BRFA: Budget Reconciliation and Financing Act
DNR: Department of Natural Resources
GF: General Fund
MDA: Maryland Department of Agriculture
MDE: Maryland Department of the Environment

Note: Under transfers, the $10.5 million transferred by the BRFA of 2010 included $8.0 million in fiscal 2010 revenues and $2.5 million in fund balance. Fiscal 2013 reflects a $2.8 million general fund deficiency appropriation in order to backstop an estimated decrease in revenues. The BRFA of 2014 transferred $2.4 million from fund balance and $8.0 million in revenues in fiscal 2014. Numbers may not sum due to rounding. Fiscal 2014 revenues have been adjusted to reflect the actual. Fiscal 2015 and 2016 revenue has been adjusted to reflect the current estimate.

Source: Department of Natural Resources; Department of Legislative Services

Fiscal 2017 Allocation

Exhibit 14 provides an overview of the currently planned trust fund allocations for fiscal 2017 as compared with fiscal 2016. Of note, Exhibit 14 only reflects special funds from the motor fuel tax and short-term rental vehicle tax since no general obligation bond capital funding, which was provided in fiscal 2013, 2014, and 2015, is provided in the Governor's capital budget. Final decisions on allocations typically are made by the BayStat agencies after the final funding levels have been determined.

Exhibit 14
Chesapeake and Atlantic Coastal Bays 2010 Trust Fund Planned Expenditures
Fiscal 2016-2017
($ in Millions)

	2016	2017	Difference 2016-2017
Maryland Department of Agriculture			
Agency Technical Assistance	$3.29	$3.29	$0.00
Cover Crops	11.25	11.25	0.00
Conservation Reserve Enhancement Program Incentive	0.50	0.50	0.00
Animal Waste Management	0.00	0.00	0.00
Manure to Energy Projects with Proven Technology	1.51	1.51	0.00
Manure Transport	0.75	0.75	0.00
Grants to Farmers	2.00	2.00	0.00
Governor's Phosphorus Management Tool	0.30	0.30	0.00
Subtotal	***$19.60***	***$19.60***	***$0.00***
Maryland Department of the Environment			
Urban/Suburban Stormwater management	$0.00	$0.00	$0.00
Stormwater Permit Expediters	0.75	0.75	0.00
Subtotal	***$0.75***	***$0.75***	***$0.00***
Department of Natural Resources			
Agency Direct Costs	$0.59	$0.75	$0.16
Strategic Monitoring (UM)	0.40	0.40	0.00
Implementation Tracking (DoIT)	0.20	0.20	0.00
Targeted Monitoring	0.30	0.30	0.00
Innovative Technology (UM)	1.00	1.00	0.00
Nutrient and Sediment Reduction on State Lands (Natural Filters)	6.03	6.00	-0.03
Capital Stormwater Infrastructure Projects (Local Governments)	0.00	0.00	0.00
Cost-effective Nonpoint Source Projects (Targeted)[1]	9.81	23.25	13.44
Field Restoration Specialist	0.75	0.75	0.00
Subtotal	***$19.08***	***$32.65***	***$13.57***
Total	**$39.43**	**$53.00**	**$13.57**

DoIT: Department of Information Technology
UM: University of Maryland

[1] Annually, the BayStat agencies issue competitive solicitations to target specific opportunities or challenges as identified. Historically, this included the Stream Restoration Challenge, Urban Tree Canopy, and Local Implementation grants.

Source: Department of Natural Resources; Department of Legislative Services

Soil Conservation District Staff Funding

Fiscal 2016 budget bill language restricted funding for the purpose of providing a grant to the Maryland Department of Agriculture (MDA) to cost-share funding of 14 district managers and 11 secretarial positions in soil conservation districts, due to a reduction in funding. DNR notes that this funding is reflected as the $3.3 million for agricultural technical assistance in fiscal 2016 and 2017 and that this allowed for the 25 cost-shared positions noted to be added to the 43 positions already funded by the State. In order to make this allocation, MDA decreased the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund appropriation for Manure to Energy Projects from $2.5 million to $1.51 million. This reduction allowed for the repurposing of $0.69 million for the soil conservation district positions and $0.3 million for the Governor's Phosphorus Management Tool initiative. In turn, the Manure to Energy program was backfilled with funding provided by MEA.

Fiscal 2017 Highlights

Overall, there is one major change in the fiscal 2016 and 2017 allocation of the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund, which is due to the additional revenue available. The primary changes are as follows.

- **Cost-effective Nonpoint Source Projects (Targeted)** – The largest funding change is an increase of $13.4 million for cost-effective nonpoint source projects. This funding represents competitively solicited projects and receives $23.3 million in fiscal 2017.

- **Agency Direct Costs Increase** – There is an increase of $159,000 for a total of $750,000 in agency direct costs, which reflects 1.4% of the $53.0 million revenue estimate. The funding is generally used to provide fiscal oversight; manage grant programs including solicitation development, project review, contract and project development and management; and coordination with the BayStat agencies, the BayStat Scientific Advisory Panel, DBM, and the General Assembly.

- **Nutrient and Sediment Reduction on State Lands** – There is a slight reduction of $28,340 for nutrient and sediment reduction on State lands. The types of projects funded include forested buffers, reforestation, wetland restoration, stream and floodplain restoration, stormwater retrofits, and other bioremediation projects.

- **Governor's Phosphorus Management Tool** – While not reflected as a change, there is $300,000 for the Governor's Phosphorus Management Tool in both fiscal 2016 and 2017 that was not reflected in last year's analysis. The funding is provided to support the economic study of utilization of the phosphorus management tool in multiple farm settings, technical assistance through nutrient management advisors for farmers to plan the transition to the phosphorus management tool, and implementation of management changes.

Genuine Progress Indicator to Evaluate Benefits of Restoration Project

The Genuine Progress Indicator was developed to be a more inclusive indicator of combined economic, environmental, and social benefits in contrast to the strictly economic indicator of State domestic product. DNR plans on using the Genuine Progress Indicator to evaluate the Cannery Park project – a recent Chesapeake and Atlantic Coastal Bays 2010 Trust Fund funded project – in Cambridge, Maryland.

The Cannery Park property was taken to the Board of Public Works (BPW) on January 7, 2015, for purchase. The 6.6-acre site is in the heart of Cambridge and is the former Phillips Packing Company site; it includes the headwater stream for Cambridge Creek. As of the January 7, 2015 BPW agenda, the ultimate park design was to be based on contest entries from University of Maryland architecture students. Overall the property purchase reflected a partnership between Cambridge, Dorchester County, DNR, and the Eastern Shore Land Conservancy. The acquisition was funded by $50,000 in POS – Local share and $50,000 in POS – State share funding for a total project cost of $210,550, of which the Eastern Shore Land Conservancy and Cambridge provided the balance of the $110,550 needed for the project. At the time of purchase, the plans for Cannery Park included stream restoration and development of both active and passive recreation, including nature trails to connect the property to Cambridge's growing pedestrian trail network.

Since the property purchase, the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund funded the Cannery Park Stream Restoration and Riparian Forest project in fiscal 2015. The project is a stream restoration project and the project partner is Cambridge. According to the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund project tracking website, the project is currently in the design/planning phase. **DLS recommends that DNR comment on how it will be using the Genuine Progress Indicator to measure the relative economic, environmental, and social benefits of the Cannery Project; whether the use of the Genuine Progress Indicator will have implications for future project selection; and any preliminary information about the cost-effective nonpoint source project competitive solicitation responses received to date.**

Recommended Actions

		Amount Reduction	
1.	Reduce funding for vehicles in Natural Resources Police – Field Operations. The fiscal 2017 allowance includes an increase of $765,000 for new vehicle purchases in the Natural Resources Police – Field Operations. This reduction reflects a more measured increase in funding for this purpose.	$ 382,500	GF

2. Add the following language to the special fund appropriation:

, provided that $250,000 of this appropriation made for the purposes of providing funding to the Maryland Energy Administration (MEA) for administrative and fiscal support for studies relating to the conservation or production of electric energy shall be reduced contingent upon the enactment of SB 389 or HB 459 repealing the requirement to provide support to MEA.

Explanation: SB 389 and HB 459 (Fee, Surcharge, and Tax Reduction Act of 2016) have been introduced in the 2016 legislative session to, among other actions, repeal the requirement that MEA receive annual funding from the Environmental Trust Fund (ETF) – up to $250,000 – for studies relating to the conservation or production of electric energy. This action reduces the funding the Power Plant Research Program provides MEA from the ETF contingent on the enactment of SB 389 or HB 459 repealing the requirement to provide the specified support to MEA.

Total General Fund Reductions	**$ 382,500**

Updates

1. Baltimore City Unrest Funding Update

In April 2015, there were protests and riots in Baltimore City. As authorized by Section 14-107 of the Public Safety Article, the Governor declared a State of Emergency. In response to the unrest, several State agencies were activated and involved in restoring the peace and promoting safety. Natural Resources Police officers provided assistance from April 27, 2015, to May 3, 2015. **Exhibit 15** reflects the eligible overtime, overtime shift differential, vessel and vehicle fuel costs, and the ineligible regular shift costs.

Exhibit 15
Natural Resources Police Costs for the Baltimore City Unrest
April 27, 2015, to May 3, 2015

	Amount	Cost
Eligible Costs		
Vessel Fuel (Gallons)	416	$1,664
Vehicle Fuel (Gallons)	2,781	7,001
Overtime (Hours)	4,394	196,655
Overtime Shift Differential (Hours)	3,685	5,516
Subtotal		***$210,836***
Ineligible Costs		
Regular Shift (Hours)	5,315	$170,135
Subtotal		***$170,135***
Total		**$380,971**

Source: Department of Natural Resources

The Administration processed budget amendment 114-15, which transferred $20 million in special funds from the Revenue Stabilization Account (commonly referred to as the Rainy Day Fund) to the BPW Contingent Fund. The funds were used to reimburse State agencies for costs associated with protests and riots in Baltimore City and to aid in recovery. DNR received a transfer of $210,836 in cash in fiscal 2015 to reflect the eligible costs in Exhibit 15.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
Department of Natural Resources
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$52,318	$150,327	$27,018	$10,117	$239,779
Deficiency Appropriation	22,784	-24,796	1,059	0	-953
Cost Containment	-2,683	0	0	0	-2,683
Budget Amendments	574	4,226	4,086	1,606	10,493
Reversions and Cancellations	-125	-8,215	-5,339	-3,138	-16,817
Actual Expenditures	**$72,868**	**$121,542**	**$26,824**	**$8,584**	**$229,818**
Fiscal 2016					
Legislative Appropriation	$55,769	$143,891	$26,049	$10,890	$236,599
Budget Amendments	718	4,012	2,377	4,427	11,534
Working Appropriation	**$56,487**	**$147,903**	**$28,426**	**$15,318**	**$248,133**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

DNR's general fund appropriation increased by $20,550,429 as follows.

- **Deficiency Appropriation** – An increase of $22,783,636 in order to backfill a shortfall in transfer tax revenue attainment in the Maryland Park Service; there is a corresponding action that reduces a greater amount of special funds.

- **Cost Containment** – A decrease of $2,682,780 to reflect July 2014 BPW actions that reduced funding across the agency for vehicle maintenance, vehicle replacement, IT costs, equipment, contractual services, maintenance, printing costs, routine travel, office supplies, harvest tags, training, and salaries by holding positions vacant, replaced general funds with Chesapeake and Atlantic Coastal Bays 2010 Trust Fund special funds in order to monitor funded projects, and replaced general funds with special funds to support positions in the Resource Assessment Service and Fisheries Service programs ($1,662,500); and the January 2015 BPW 2% reduction ($1,020,280).

- **Budget Amendments** – A net increase of $574,308 due to increases for budget amendments allocating the cost-of-living adjustment (COLA) effective January 1, 2015 ($358,849), and to realign appropriations between State agencies based on the fiscal 2015 estimated expenditures for telecommunications ($290,459), which were offset partially by a decrease to reflect the State Employee Voluntary Separation Program as authorized by Section 22 of the fiscal 2016 operating budget bill ($75,000).

- **Reversions** – A decrease of $124,735 due to funding not being needed in the Office of the Secretary – Finance and Administrative Services ($100,664), Critical Area Commission ($17,874), and Maryland Environmental Trust ($6,197).

DNR's special fund appropriation decreased by $28,784,887 as follows.

- **Deficiency Appropriation** – A net decrease of $24,795,636 primarily due to the shortfall in estimated transfer tax revenue attainment ($24,805,636), which was offset partially by an increase in the Chesapeake and Coastal Service to provide funds for support of the Explore and Restore Your Schoolshed Initiative, which involves approximately 110 teachers representing schools in 22 counties leading students in stream investigations ($10,000).

- **Budget Amendments** – An increase of $4,226,133 due to budget amendments. Funding is reflected for the proper accounting of the Shoreline Erosion Control Revolving Loan Fund since the program was moved out of the PAYGO budget in fiscal 2009, and funding was still encumbered in that former PAYGO program but is now budgeted in the Chesapeake and Coastal Services ($1,806,487); for DNR's COMPASS online licensing and registration system's Licensing and Registration Service application component due to a procurement delay in fiscal 2014 that required the cancellation of funding that is now available from a number of

funds and is budgeted in Office of the Secretary – ITS ($650,000); for allocation of the COLA effective January 1, 2015, ($486,980); for purchasing four patrol vessels for which procurement requests were initiated and awarded in fiscal 2015 in the Natural Resources Police – Field Operations program from the Private Donation account ($297,052); for tree planting crew contracting and tree planting material purchases in the Forest Service to mitigate State construction projects from the Restoration Fund ($220,800); for replacing general funds related to July 2014 and January 2015 cost containment actions for Chesapeake and Atlantic Coastal Bays 2010 Trust Fund project oversight monitoring, a 1% turnover increase departmentwide, and reductions to the Power Plant Research Program ($215,000); for costs incurred for personnel, overtime, and vehicles by the Natural Resources Police as part of the State's response to the civil unrest in Baltimore City during the period of April 27, 2015, to May 6, 2015 ($210,836); for park concession operations as a result of an increased number of seasonal staff and supplies needed to accommodate park visitors during the peak June 2015 attendance in the Maryland Park Service – Revenue Operations program ($189,000); for construction of a pole barn at the new Forest Service office in Rocky Gap State Park for storage and maintenance equipment associated with operations in Allegany County from the Forest or Park Reserve Fund ($101,000); and for allocation of the position classifications for Park Technicians as part of the Annual Salary Review ($48,978).

- **Cancellations** – A decrease of $8,215,384 as a result of cancellations primarily due to appropriations not being needed in Chesapeake and Coastal Service ($3,749,445), Wildlife and Heritage Service ($976,912), Boating Services ($941,882), Fisheries Service ($465,279), Natural Resources Police – Field Operations ($360,737), Maryland Park Service ($345,930), Land Acquisition and Planning ($292,684), and Office of the Secretary – Finance and Administrative Services ($250,997).

DNR's federal fund appropriation decreased by $193,919 as follows.

- **Deficiency Appropriation** – An increase of $1,058,745 in the Fisheries Service for contracted projects under the final year of National Oceanic and Atmospheric Administration's Blue Crab Disaster Assistance Grant.

- **Budget Amendments** – An increase of $4,085,952 for truck, tractor, outboard motor, and other vehicle-related purchases, contractual services for 11 animal research studies and construction of four buildings and a security gate, salary costs related to turnover, agricultural equipment purchases, and a seasonal bird monitoring data entry employee from the U.S. Department of the Interior's Wildlife Restoration and Basic Hunter Education funding in the Wildlife and Heritage Service ($1,629,146); for Maritime Law Enforcement Information Network vessel video project costs and Maritime Tactical Equipment Initiative purchases from the U.S. Department of Homeland Security's Port Security Grant Program in the Natural Resources Police – General Direction ($956,984); for the purchase of services and equipment and matching other federal awards as allowed for seized and forfeited asset revenue from the U.S. Department of Justice's Equitable Sharing Program (High Intensity Drug Trafficking Areas), for salary expenses from the U.S. Department of Homeland Security's Boating Safety Financial Assistance funding, and

for overtime expenses and equipment purchases as part of fishery law enforcement from the U.S. Department of Commerce's Financial Assistance for National Centers for Coastal Ocean Science in the Natural Resources Police – Field Operations ($919,858); for salaries and wages and motor vehicle operations related to covering a greater number of out-of-state fires than expected in the Forest Service – Headquarters program ($300,000); for salaries and wages, contractual services, and supplies and materials expenses that have been incurred for water quality sampling surveys and contracting for research studies in the Monitoring and Ecosystem Assessment program using EPA's Chesapeake Bay Program funding ($210,000); and for the allocation of the COLA effective January 1, 2015 ($69,964).

- **Cancellations** – A decrease of $5,338,616 as a result of cancellations primarily due to grants costs and revenues being less than anticipated in Fisheries Service ($2,442,328), Natural Resources Police – General Direction ($1,854,751), Natural Resources Police – Field Operations ($404,898), Chesapeake and Coastal Service ($353,024), and Maryland Park Service ($218,536).

DNR's reimbursable fund appropriation decreased by $1,532,038 as follows.

- **Budget Amendments** – An increase of $1,606,217 for the Saving Maryland's Critical Civil War Battlefields project as part of a multi-year grant to purchase six fee-simple acquisitions and one conservation easement in Frederick County transferred from SHA to the Maryland Environmental Trust ($742,703); for supporting local oyster restoration projects and oyster spat production in fiscal 2015 due to delays in fiscal 2014 using Maryland Port Administration funding ($400,000); for supporting AmeriCorps activities from funding transferred from the Governor's Office of Community Initiatives to the Maryland Park Service ($305,442); for the Horsebridge Creek Riparian Wetland Forest Enhancement, Phase II project from funding transferred internally from the Chesapeake and Coastal Service to Engineering and Construction ($63,706); for additional stream restoration monitoring assistance transferred internally from Monitoring and Ecosystem Assessment to the Maryland Geological Survey ($50,366); and for contractual services related to designing a new framework to address climate change as it relates to the water quality, habitat, and development goals of the Chesapeake Bay Critical Area Protection Act transferred internally from the Chesapeake and Coastal Service to the Critical Area Commission ($44,000).

- **Cancellations** – A decrease of $3,138,255 as a result of cancellations primarily due to grant costs and revenues being less than anticipated in Chesapeake and Coastal Service ($1,546,822), Maryland Environmental Trust ($756,004), Maryland Geological Survey ($191,626), Maryland Park Service ($172,558), Fisheries Service ($162,651), and Monitoring and Ecosystem Assessment ($132,163).

Fiscal 2016

DNR's general fund appropriation increases by $718,000 due to a budget amendment allocating the funding in Section 48 of the fiscal 2016 budget bill that restored the 2% State salary reduction.

DNR's special fund appropriation increases by $4,011,571 due to budget amendments. The budget amendments increase appropriation for allocating the funding in Section 48 of the fiscal 2016 budget bill that restored the 2% State salary reduction ($970,000); for covering Office of the Secretary contingent general fund reductions in administrative expenses allowed for by Chapter 489 using Waterway Improvement Fund funding ($875,000); for salary costs in the Office of the Secretary and Land Acquisition and Planning from transfer tax revenue authorized by Chapter 489 in order to allow an equivalent amount of Forest or Park Reserve Fund special fund revenue funding those programs to be available instead for the Maryland Park Service ($711,571); for hiring seasonal staff, additional equipment, and office supplies in the Maryland Park Service – Statewide Operations ($600,000); for Phase II of the Maryland Outdoor Customer Service Delivery System (COMPASS) IT project in the Office of the Secretary – ITS program ($393,000); for replacing general fund cost containment in the Forest Service with Forest or Park Reserve Fund special funds and in the Fisheries Service with Fisheries Research and Development Fund special funds ($245,000); for hiring seasonal workers and supplies in the Maryland Park Service – Revenue Operations program ($150,000); and for contractual services to complete construction of a pole barn for storage of supplies at the Pleasant Valley Forest Service Office ($67,000).

DNR's federal fund appropriation increases by $2,377,061 by budget amendment. Funding is reflected for additional equipment, motor vehicles, and travel in the Natural Resources Police – General Direction related to protecting critical port infrastructure from terrorism using funding from the U.S. Department of Homeland Security's Port Security Grant Program ($1,210,767); for additional equipment supported by the Asset Forfeiture and Seizure Program aimed at High Intensity Drug Trafficking, for motor vehicles supported by the U.S. Department of Homeland Security – U.S. Coast Guard's Boating Safety Financial Assistance funding, and fishery law enforcement salaries supported by U.S. Department of Commerce – National Oceanic and Atmospheric Administration's Financial Assistance for National Centers for Coastal Ocean Science funding ($1,030,294); and allocating the funding in Section 48 of the fiscal 2016 budget bill that restored the 2% State salary reduction ($136,000).

DNR's reimbursable fund appropriation increases by $4,427,478 by budget amendment. Funding is transferred from DoIT's MITDPF to DNR's Office of the Secretary – ITS for upgrading the Natural Resources Police to P25 radios as part of the 700 MHz project implementation plan to ensure interoperability with local jurisdictions and other State law enforcement agencies ($2,480,038); from the SHA to DNR's Engineering and Construction program for the development of the Harriet Tubman Underground Railroad State Park as part of the Scenic Byways Program ($1,489,940); from MEA to the Power Plant Assessment Program for identifying and evaluating potential sites for distributed generation development in Maryland ($300,000); from the Maryland Historical Trust to DNR's Engineering and Construction program for carrying out an Interdepartmental Agreement involving surveying and documenting historic structures located in State parks in the Eastern and Western regions which are owned and operated by DNR ($112,500); and transferred internally from the Chesapeake and Coastal Service to the Critical Area Commission for developing a local framework for climate change adaptation strategies for Critical Area jurisdictions ($45,000).

Object/Fund Difference Report
Department of Natural Resources

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	1,293.50	1,320.50	1,340.50	20.00	1.5%
02 Contractual	360.76	446.62	423.33	-23.29	-5.2%
Total Positions	**1,654.26**	**1,767.12**	**1,763.83**	**-3.29**	**-0.2%**
Objects					
01 Salaries and Wages	$ 114,695,337	$ 119,794,256	$ 123,215,469	$ 3,421,213	2.9%
02 Technical and Spec. Fees	10,239,079	12,502,867	12,161,907	-340,960	-2.7%
03 Communication	2,742,971	2,883,472	3,684,645	801,173	27.8%
04 Travel	463,839	738,473	546,051	-192,422	-26.1%
06 Fuel and Utilities	5,233,429	5,012,118	5,116,893	104,775	2.1%
07 Motor Vehicles	9,282,094	10,737,241	11,619,702	882,461	8.2%
08 Contractual Services	53,099,804	33,452,311	31,711,164	-1,741,147	-5.2%
09 Supplies and Materials	7,292,205	7,206,091	7,536,410	330,319	4.6%
10 Equipment – Replacement	1,312,478	3,764,057	1,548,885	-2,215,172	-58.9%
11 Equipment – Additional	804,365	2,618,406	1,217,355	-1,401,051	-53.5%
12 Grants, Subsidies, and Contributions	19,868,383	46,201,762	62,627,782	16,426,020	35.6%
13 Fixed Charges	4,411,855	3,105,001	3,206,589	101,588	3.3%
14 Land and Structures	372,345	117,172	345,502	228,330	194.9%
Total Objects	**$ 229,818,184**	**$ 248,133,227**	**$ 264,538,354**	**$ 16,405,127**	**6.6%**
Funds					
01 General Fund	$ 72,868,125	$ 56,486,661	$ 59,555,696	$ 3,069,035	5.4%
03 Special Fund	121,541,954	147,902,833	165,118,023	17,215,190	11.6%
05 Federal Fund	26,823,638	28,426,050	28,968,945	542,895	1.9%
09 Reimbursable Fund	8,584,467	15,317,683	10,895,690	-4,421,993	-28.9%
Total Funds	**$ 229,818,184**	**$ 248,133,227**	**$ 264,538,354**	**$ 16,405,127**	**6.6%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
Department of Natural Resources

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Office of the Secretary	$ 17,645,820	$ 20,991,329	$ 19,559,239	-$ 1,432,090	-6.8%
02 Forest Service	12,280,673	12,060,179	12,453,540	393,361	3.3%
03 Wildlife and Heritage Service	10,893,291	12,188,902	12,564,164	375,262	3.1%
04 Maryland Park Service	38,980,332	41,305,879	42,972,189	1,666,310	4.0%
05 Land Acquisition and Planning	4,965,940	5,068,644	5,982,619	913,975	18.0%
06 Licensing and Registration Service	3,713,715	3,794,515	3,850,568	56,053	1.5%
07 Natural Resources Police	38,689,627	44,353,630	45,637,652	1,284,022	2.9%
09 Engineering and Construction	4,432,097	6,282,129	5,912,699	-369,430	-5.9%
10 Chesapeake Bay Critical Area Commission	1,902,121	2,074,399	2,080,667	6,268	0.3%
11 Boating Services	5,972,537	7,057,164	7,314,439	257,275	3.6%
12 Resource Assessment Service	17,214,032	18,371,820	17,444,483	-927,337	-5.0%
13 Maryland Environmental Trust	823,318	1,357,559	1,372,742	15,183	1.1%
14 Chesapeake and Coastal Services	48,593,097	49,348,035	64,256,273	14,908,238	30.2%
17 Fisheries Service	23,711,584	23,879,043	23,137,080	-741,963	-3.1%
Total Expenditures	**$ 229,818,184**	**$ 248,133,227**	**$ 264,538,354**	**$ 16,405,127**	**6.6%**
General Fund	$ 72,868,125	$ 56,486,661	$ 59,555,696	$ 3,069,035	5.4%
Special Fund	121,541,954	147,902,833	165,118,023	17,215,190	11.6%
Federal Fund	26,823,638	28,426,050	28,968,945	542,895	1.9%
Total Appropriations	**$ 221,233,717**	**$ 232,815,544**	**$ 253,642,664**	**$ 20,827,120**	**8.9%**
Reimbursable Fund	$ 8,584,467	$ 15,317,683	$ 10,895,690	-$ 4,421,993	-28.9%
Total Funds	**$ 229,818,184**	**$ 248,133,227**	**$ 264,538,354**	**$ 16,405,127**	**6.6%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

L00A
Department of Agriculture

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$26,676	$26,967	$29,459	$2,492	9.2%
Deficiencies and Reductions	0	355	-75	-430	
Adjusted General Fund	**$26,676**	**$27,322**	**$29,384**	**$2,062**	**7.5%**
Special Fund	26,695	32,195	34,040	1,846	5.7%
Deficiencies and Reductions	0	0	-31	-31	
Adjusted Special Fund	**$26,695**	**$32,195**	**$34,009**	**$1,815**	**5.6%**
Federal Fund	3,819	4,482	3,630	-852	-19.0%
Deficiencies and Reductions	0	55	-4	-59	
Adjusted Federal Fund	**$3,819**	**$4,537**	**$3,626**	**-$912**	**-20.1%**
Reimbursable Fund	19,181	25,317	23,342	-1,975	-7.8%
Adjusted Reimbursable Fund	**$19,181**	**$25,317**	**$23,342**	**-$1,975**	**-7.8%**
Adjusted Grand Total	**$76,371**	**$89,371**	**$90,360**	**$990**	**1.1%**

- The Maryland Department of Agriculture (MDA) budget includes a fiscal 2016 deficiency of $410,243 (comprised of $354,960 in general funds and $55,283 in federal funds). The funding would be used to reimburse expenses related to preparation for a highly pathogenic avian influenza outbreak.

- The overall adjusted change in the MDA fiscal 2016 allowance is an increase of $990,000, or 1.1%. The major change is an increase of $2 million in general funds for the Rural Maryland Council to improve rural Maryland working and living conditions.

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

For further information contact: Andrew D. Gray Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	381.10	380.10	376.10	-4.00
Contractual FTEs	39.00	44.80	43.60	-1.20
Total Personnel	**420.10**	**424.90**	**419.70**	**-5.20**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	24.56	6.53%
Positions and Percentage Vacant as of 12/31/15	48.00	12.63%

- MDA regular positions decrease by 4.0 in Plant Protection and Weed Control in the fiscal 2017 allowance. The reductions are as follows: 1.0 weed control specialist IV, 2.0 administrative officer IIIs, and 1.0 administrator I. The reductions are due to the elimination of the Weed Control Program and all the positions are currently filled.

- MDA has 10.0 regular positions that have been vacant for more than a year.

- MDA contractual full-time equivalents (FTE) decrease by a net of 1.2 FTEs in the fiscal 2017 allowance. The changes are as follows: decreases of 2.0 in Watershed Implementation Program, 1.0 in Maryland Horse Industry Board, 0.8 FTEs in Plant Protection and Weed Management, which are offset partially by increases of 1.0 in Resource Conservation Grants, 0.7 in Forest Pest Management, 0.5 in Food Quality Assurance, 0.3 in Mosquito Control, and 0.1 in Animal Health.

- The MDA turnover rate decreased slightly from 6.54% in the fiscal 2016 working appropriation to 6.53% in the fiscal 2017 allowance, which reflects a decrease from 24.86 necessary vacancies to 24.56 necessary vacancies. MDA has 48.0 positions vacant as of December 31, 2015, which is relatively high at 12.63%, but this will allow MDA to meet turnover.

- MDA notes that 4.0 regular positions were reclassified and moved from policy programs to the Office of the Secretary as part of the fiscal 2016 working appropriation actions due to the upcoming retirement of senior staff.

Analysis in Brief

Major Trends

The Gypsy Moth Returns: The number of acres where protective treatment is environmentally and economically feasible for the gypsy moth increased to 9,000 acres in the fiscal 2017 estimate. MDA notes that 9,000 acres is a guess based on historical population trends and that actual acreage will be impacted by spring weather and disease. One indicator of likely need is that neighboring states are experiencing outbreak levels of the gypsy moth and have increased spraying programs. Therefore, it is highly likely that Maryland will become part of the same outbreak. A better estimate of the future will come in July/August 2016. **The Department of Legislative Services (DLS) recommends that MDA comment on long-term climatological impacts on gypsy moth numbers and the overall impact of the gypsy moth on Maryland forest health and productivity.**

Shelter/Animal Care Facility Data Shows Slight Decrease in Euthanasia: The overall euthanasia numbers over the past six quarters – not including the most recent quarter analyzed – have averaged 1,934 a quarter for dogs and 4,844 a quarter for cats, which combined is an average of 6,788 that were euthanized in each quarter. In the most recent quarter analyzed – the second quarter of 2015 – there were 1,771 dogs euthanized and 4,069 cats, which is a total of 5,840. The 5,840 euthanized in the second quarter of 2015 is less than the average number of dogs and cats euthanized in the prior six quarters and reflects a slight decrease in euthanasia. **DLS recommends that MDA comment on how it will use shelters/animal care facilities data to inform the allocation of resources for the Spay/Neuter Program in fiscal 2017.**

Highly Pathogenic Avian Influenza Spurs Preparations: Highly pathogenic avian influenza is a combination of Asian and North American influenza strains carried by wild birds and transmitted to domestic birds such as chickens. Through June 2015, it has been detected in 21 states, primarily in the West and Midwest, and a total of 211 commercial and 21 backyard poultry premises have been affected resulting in the depopulation of 7.5 million turkeys and 42.1 million egg-layer and pullet chickens, with a cost of over $950 million. **DLS recommends that MDA comment on its preparations for a highly pathogenic avian influenza outbreak and the possible economic impact on Maryland's poultry industry.**

Issues

Cover Crop Database and Mapping: Cover crops are one of the most effective best management practices for reducing nitrogen loads to the Chesapeake Bay and represent a substantial portion of the MDA operating budget. Given the funding level in the budget, it is imperative that funding be efficiently applied to the available cover crop acreage opportunities. **DLS recommends that MDA comment on how the geospatial data on cover crop applications can be used to optimize cover crop funding for nutrient loading reductions.**

Nutrient Trading Regulations Impact on MDA: On December 28, 2015, MDA published regulations in the *Maryland Register* that establish the requirements and standards for the generation and certification of nonpoint source nutrient and sediment credits on agricultural land under the Agricultural Nutrient and Sediment Certification Program. MDA indicated that the impact on the department is nominal because administrative and other program expenditures associated with the regulations are funded by federal grant money. However, the federal funding that it currently receives relating to nutrient and sediment trading ends in March 2016 and is not expected to be renewed in the immediate future. MDA anticipates using savings associated with the Agricultural Certainty Program to fund the work and position needs. **DLS recommends that MDA comment on what the likely methodology will be for incorporating inspections into the price of a nutrient credit and who will enforce the contractual instrument between the buyer and seller of credits.**

New and Proposed Fee Reductions Impact Revenues: The Administration implemented fee reductions on September 15, 2015, that impacted State Board of Veterinary Medical Examiner program veterinary fees. In addition, the Administration has introduced SB 389 and HB 459 (Fee, Surcharge, and Tax Reduction Act of 2016) in the 2016 legislative session that would reduce Weights and Measures program fees as well. **DLS recommends that MDA comment on the balances, revenues, and expenditures history for all funds receiving revenues from the fees reduced by the September 15, 2015 actions, and the proposed reductions in SB 389 and HB 459 and the impact on operations of both sets of fee reductions.**

New Rural Maryland Council Spending Guided by Legislation: The Rural Maryland Council receives a nonmandated $2,000,000 general fund enhancement in the fiscal 2017 allowance. This funding is budgeted in the Rural Maryland Prosperity Investment Fund to implement Chapter 469 of 2014 (Rural Maryland Prosperity Investment Fund – Revisions and Extension of Termination Date). The Rural Maryland Council and Maryland Agricultural Education and Rural Development Assistance Fund already each receive $167,000 in general funds for fiscal 2017. In addition, the assumption is that the Rural Maryland Council and Maryland Agricultural Education and Rural Development Assistance Fund receive allocations of $375,000 each from the Rural Maryland Prosperity Investment Fund. **DLS recommends that the $167,000 general fund appropriations for the Rural Maryland Council and Maryland Agricultural Education and Rural Development Assistance Fund each be deleted given the $375,000 that will be available to each from the $2,000,000 allocation of the Rural Maryland Prosperity Investment Fund. In addition, DLS recommends that $100,000 be restricted in the MDA budget pending the submission of a report on July 1, 2016, specifying the criteria and rationale for the allocation of funding from the Rural Maryland Prosperity Investment Fund and a report on January 1, 2016, specifying the actual allocation of fiscal 2017 funding.**

Recommended Actions

		Funds
1.	Reduce funding and restrict remaining funding pending submission of reports on the Rural Maryland Prosperity Investment Fund.	
2.	Reduce funding for the Maryland Agricultural Education and Rural Development Assistance Fund.	$ 167,000
	Total Reductions	**$ 167,000**

Updates

MDA Repeat Audit Findings Still in Limbo: Funding has been withheld in each of the MDA fiscal 2015 and 2016 budgets in order to compel resolution of repeat audit findings. For fiscal 2015, $100,000 in general funds was withheld and then not released because the findings were not resolved to the satisfaction of the Office of Legislative Audits (OLA). Similarly, $200,000 in general funds has been withheld in the MDA fiscal 2016 appropriation. As of this writing, OLA has received the status report from MDA and has completed its follow-up work but has not yet issued the draft letter to MDA for its review.

L00A
Department of Agriculture

Operating Budget Analysis

Program Description

The Maryland Department of Agriculture (MDA) supervises, administers, and promotes agricultural activities throughout the State. Its mission is to provide leadership and support to agriculture and the citizens of Maryland by conducting regulatory, service, and educational activities that assure consumer confidence, protect the environment, and promote agriculture. MDA is organized into four administrative units as described below.

- **Office of the Secretary:** Provides administrative support services; advises the Secretary on agricultural issues; and administers agricultural land preservation.

- **Office of Marketing, Animal Industries, and Consumer Services:** Provides weights and measures supervision; conducts inspection, grading, monitoring, and testing of agricultural product quality; generates agricultural statistics; protects animal health; regulates veterinarians; promotes the equine industry; assists in the development of agricultural markets; promotes agriculture through agricultural fairs, shows, and youth activities; supports the transition from tobacco production in Southern Maryland; and helps develop resource-based industries through the Maryland Agricultural and Resource-Based Industry Development Corporation, an independent agricultural development agency that is budgeted within MDA. The office also administers the Spay/Neuter Program.

- **Office of Plant Industries and Pest Management:** Manages forest pests; implements mosquito control services; regulates pesticides and pesticide applicators; administers nursery inspections, noxious weed control, nuisance bird control, and honey bee registration programs; regulates seed and sod labeling; and regulates the chemical components of pesticides, commercial fertilizers, feeds, pet foods, compost, soil conditioners, and liming materials.

- **Office of Resource Conservation:** Advises the Secretary on agricultural soil conservation and water quality; provides financial, technical, and staffing support to the State's 24 soil conservation districts; provides cost-share funding for best management practice implementation, manure transport, and nutrient management plan development; trains, certifies, and licenses nutrient management plan consultants; and oversees Maryland's certainty and nutrient trading programs as part of Chesapeake Bay restoration.

The primary goals of MDA are to:

- promote profitable production, use, and sale of Maryland agricultural products (goal 1);
- protect the health of the public, plant, and animal resources in Maryland (goal 2);
- preserve adequate amounts of productive agricultural land and woodland in Maryland (goal 3);
- provide and promote land stewardship, including conservation, environmental protection, preservation, and resource management (goal 4); and
- provide health, safety, and economic protection for Maryland consumers (goal 5).

Performance Analysis: Managing for Results

The analysis of the MDA fiscal 2017 Managing for Results (MFR) submission reflects that a gypsy moth outbreak is anticipated and euthanasia of dogs and cats in Maryland shelters has decreased slightly per second quarter data in calendar 2015. In addition, there is a discussion of the impact of the highly pathogenic avian influenza and the ensuing preparations in Maryland.

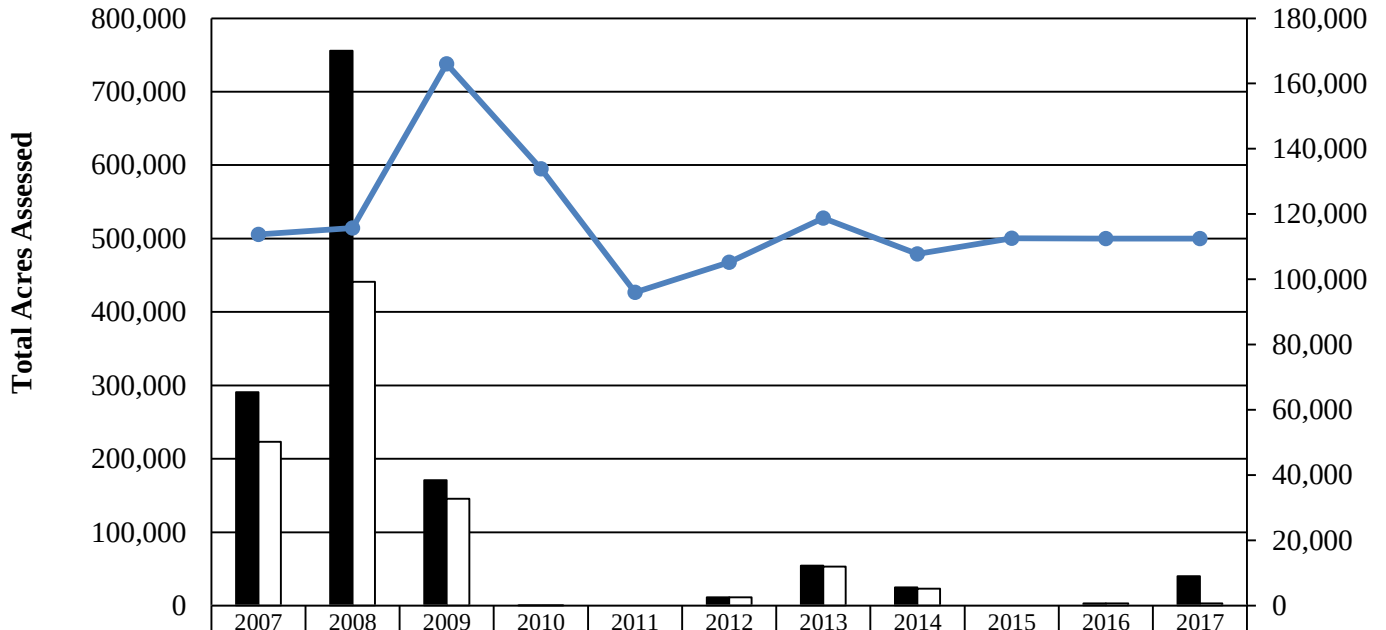
1. The Gypsy Moth Returns

The second MDA goal – protect the health of the public, plant, and animal resources in Maryland – has an objective to successfully complete gypsy moth and hemlock woolly adelgid pest management activities where economically and environmentally feasible. As shown in **Exhibit 1**, the number of acres where protective treatment is environmentally and economically feasible for the gypsy moth increased to 9,000 acres in the fiscal 2017 estimate. MDA notes that 9,000 acres is a guess based on historical population trends and that actual acreage will be impacted by spring weather and disease. One indicator of likely need is that neighboring states are experiencing outbreak levels of the gypsy moth and have increased spraying programs. Therefore, it is highly likely that Maryland will become part of the same outbreak. A better estimate of the future will come in July/August 2016. **The Department of Legislative Services (DLS) recommends that MDA comment on long-term climatological impacts on gypsy moth numbers and the overall impact of the gypsy moth on Maryland forest health and productivity.**

Exhibit 1

Gypsy Moth Outbreak Anticipated

Fiscal 2007-2017 Est.



	2007 Act.	2008 Act.	2009 Act.	2010 Act.	2011 Act.	2012 Act.	2013 Act.	2014 Act.	2015 Act.	2016 Est.	2017 Est.
Acres Where Protective Treatment Is Environmentally and Economically Feasible	65,431	170,000	38,454	144	0	2,530	12,289	5,594	0	700	9,000
Acres of Treatment Completed	50,173	99,222	32,722	144	0	2,530	11,994	5,164	0	700	700
Acres Assessed	505,734	514,403	737,944	595,033	426,679	467,815	527,837	479,198	500,254	500,000	500,000

Source: Department of Budget and Management

2. Shelter/Animal Care Facility Data Shows Slight Decrease in Euthanasia

The Spay/Neuter Program was initiated in fiscal 2015 but does not yet have any associated MFR measures. The most recent quarterly report covered April 1 to June 30, 2015, and was posted on September 24, 2015. Overall, the concern addressed by the Spay/Neuter Program is the amount of pet euthanasia being conducted in Maryland, which may be considered as part of goal 2 of MDA– to protect the health of the public, plant, and animal resources in Maryland.

As shown in **Exhibit 2**, the 30 shelters/animal care facilities required to report had a combined total of 3,266 cats and dogs at the beginning of April 2015. During the subsequent three-month period, the shelters/animal care facilities took in 19,990 cats and dogs, 612.1% of the beginning number of cats and dogs. Of the now 23,256 pets in their care, the shelters/animal care facilities disposed of 18,143 of the pets through a combination of 5,840 that were euthanized – both owner-requested and other types of euthanasia – and 12,303 noneuthanasia dispositions. The noneuthanasia dispositions include the following: adopted, returned to owner, transferred to other agency, died/lost in care, and other outcomes in which the pet lives. Finally, the shelters/animal care facilities ended the quarter with 5,113 cats and dogs, 156.6% of the beginning number of cats and dogs. The overall euthanasia numbers over the past six quarters – not including the most recent quarter analyzed – averaged 1,934 a quarter for dogs and 4,844 a quarter for cats, which combined is an average of 6,788 that were euthanized in each quarter. In the most recent quarter analyzed – the second quarter of 2015 – there were 1,771 dogs euthanized and 4,069 cats, which is a total of 5,840. The 5,840 euthanized in the second quarter of 2015 is less than the average number of dogs and cats euthanized in the prior six quarters and reflects a slight decrease in euthanasia. **DLS recommends that MDA comment on how it will use shelters/animal care facilities data to inform the allocation of resources for the Spay/Neuter Program in fiscal 2017.**

Exhibit 2
Combined Dog and Cat Statewide Numbers for Maryland Facilities
April 1 through June 30, 2015

	Cats and Dogs	Beginning Quarter
Beginning Quarter	3,266	100.0%
Intake	19,990	612.1%
Disposition		
Noneuthanasized	12,303	376.7%
Euthanized	5,840	178.8%
Total	**18,143**	**555.5%**
End Quarter	**5,113**	**156.6%**

Source: Maryland Department of Agriculture; Department of Legislative Service

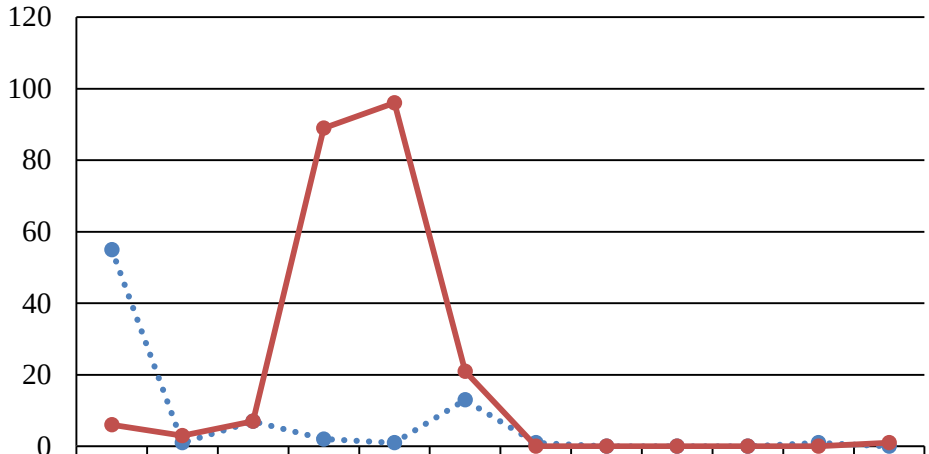
3. Highly Pathogenic Avian Influenza Spurs Preparations

Highly pathogenic avian influenza impacts two of the MDA goals: goal 1 of MDA – to promote profitable production, use, and sale of Maryland agricultural products; and goal 2 of MDA – to protect the health of the public, plant, and animal resources in Maryland. According to the U.S. Department of Agriculture – Animal and Plant Health Inspection Service's 2016 *HPAI Preparedness and Response Plan*, updated on January 11, 2016, highly pathogenic avian influenza is due to the commingling of migratory birds between northeast Asia and Alaska, which has allowed for the reassortment of Asian highly pathogenic avian influenza strains with North American low pathogenic avian influenza. The result is a virus that infects wild birds – primarily ducks, geese, and shorebirds – which is then transmitted to domestic chickens and other commercially grown birds.

The first identified case of highly pathogenic avian influenza was in December 2014 in the Pacific Northwest; the most recent case – confirmed on January 15, 2016 – was discovered in a commercial turkey flock in Dubois County, Indiana. Through June 2015, highly pathogenic avian influenza has been detected in 21 states, primarily in the West and Midwest, and a total of 211 commercial and 21 backyard poultry premises had been affected resulting in the depopulation of 7.5 million turkeys and 42.1 million egg-layer and pullet chickens, with a cost of over $950 million.

Exhibit 3 shows the calendar 2015 national data on wild bird and domestic flock cases of highly pathogenic avian influenza. As can be seen, there was a high of 55 wild bird infection cases in January 2015 and a high of 96 domestic flock cases in May 2015. The identification of highly pathogenic avian influenza in the Indiana turkey flock has raised concerns about the exposure of Maryland's poultry industry, especially since the Atlantic Flyway appears to be the only wild bird migration route that has not been impacted yet. As noted in the fiscal 2016 budget section of this analysis, there is a $410,243 deficiency appropriation for preparation for a highly pathogenic avian influenza outbreak. **DLS recommends that MDA comment on its preparations for a highly pathogenic avian influenza outbreak and the possible economic impact on Maryland's poultry industry.**

Exhibit 3
National Wild Bird and Domestic Flock
Highly Pathogenic Avian Influenza Infection Cases
Calendar 2015



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wild Bird Infection Cases	55	1	7	2	1	13	1	0	0	0	1	0
Domestic Flock Infection Cases	6	3	7	89	96	21	0	0	0	0	0	1

Source: U.S. Department of Agriculture, Animal, and Plant Health Inspection Service

Fiscal 2016 Actions

Two actions impact the MDA fiscal 2016 budget: a proposed deficiency and cost containment.

Proposed Deficiency

The Governor has submitted a $410,243 deficiency appropriation for the fiscal 2016 operating budget, which would increase the MDA appropriation in Animal Health by $354,960 in general funds and $55,283 in federal funds. The funding would be used to reimburse expenses related to preparation for a highly pathogenic avian influenza outbreak and consists of $250,556 for equipment replacement, $158,187 for supplies and materials, and $1,500 for travel. The federal funds come from the U.S. Department of Agriculture – Animal and Plant Health Inspection Service's Plant and Animal Disease, Pest Control, and Animal Care funding.

Cost Containment

The MDA fiscal 2016 budget is reduced by the 2% across-the-board reduction implemented in the 2015 legislative session. The MDA share of the reduction was $513,000 in general funds and 2 abolished positions as shown in **Exhibit 4**.

Exhibit 4
2% Across-the-board Reductions for MDA
Fiscal 2016

Program	Action	Funding	Position
Office of the Secretary – Central Services	Shift costs for utilities to available reimbursable funds, which is comprised of $100,000 from the Weights and Measures program and $50,000 from the State Board of Veterinary Medical Examiners.	$150,000	0.0
ORC – Nutrient Management	Reduce the nutrient management grant to the University of Maryland and replace with Chesapeake and Atlantic Coastal Bays 2010 Trust Fund funding originally allocated for the Cover Crop Program.	150,000	0.0
ORC – Resource Conservation Operations	Abolish a vacant program manager IV position.	114,841	1.0
Office of Plant Industries and Pest Management – Turf and Seed	Abolish a vacant laboratory position.	50,255	1.0
Office of the Secretary – Administrative Services	Reduce laptop purchases.	47,904	
Total		**$513,000**	**2.0**

MDA: Maryland Department of Agriculture
ORC: Office of Resource Conservation

Source: Department of Budget and Management

Proposed Budget

The MDA fiscal 2016 adjusted allowance increases by $990,000, or 1.1%, relative to the fiscal 2016 working appropriation, as shown in **Exhibit 5**. The changes by fund in Exhibit 5 reflect an

increase of $2.1 million in general funds, an increase of $1.8 million in special funds, a decrease of $0.9 million in federal funds, and a decrease of $2.0 million in reimbursable funds. Changes in personnel funding are discussed first and then other changes.

Exhibit 5
Proposed Budget
Department of Agriculture
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$26,676	$26,695	$3,819	$19,181	$76,371
Fiscal 2016 Working Appropriation	27,322	32,195	4,537	25,317	89,371
Fiscal 2017 Allowance	29,384	34,009	3,626	23,342	90,360
Fiscal 2016-2017 Amount Change	$2,062	$1,815	-$912	-$1,975	$990
Fiscal 2016-2017 Percent Change	7.5%	5.6%	-20.1%	-7.8%	1.1%

Where It Goes:

Personnel Expenses

Employee and retiree health insurance	718
Retirement contribution	543
Additional assistance	58
Reclassification	51
Turnover expectancy	35
Other fringe benefit adjustments	5
Salaries and other compensation	-527
Abolished 4.0 positions	-347

Other Changes

Agricultural Policy

Rural Maryland Council	2,000
Cover crops	1,040
Animal Waste Technology Fund	-1,034
One-time deficiency for highly pathogenic avian influenza	-410
Tobacco Transition Program	-400

Where It Goes:

Routine Operations	
Soil conservation district funding	-545
Electricity	-114
Gas and oil	-49
Contractual full-time equivalents decrease by 1.2	-17
Other	-17
Total	**$990**

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

Employee increments and associated expenses (including Social Security, retirement, unemployment compensation, and turnover) are included in the budget of the Department of Budget and Management, and $475,963 in total funds comprised of $320,935 in general funds, $120,554 in special funds, $14,833 in federal funds, and $19,641 in reimbursable funds will be distributed to MDA by budget amendment for the start of the fiscal year.

Personnel

- **Employee and Retiree Health Insurance:** Employee and retiree health insurance costs increase by $718,329.

- **Retirement Contribution:** Retirement contribution increases by $543,229.

- **Additional Assistance:** Additional assistance increases by $58,000. The fiscal 2015 actual appropriation was $28,075, which increased to the fiscal 2016 working appropriation of $56,000 and then increases again to the fiscal 2017 allowance of $114,000.

- **Reclassification:** There is a position reclassification that increases by $50,970.

- **Turnover Expectancy:** Turnover expectancy increases by $34,628.

- **Salaries and Other Compensation:** Salaries decrease by $526,849.

- **Abolished 4.0 Positions:** The reduction of 4.0 filled positions in the Weed Control Program reflects the end of the program and a reduction of $346,911. **DLS recommends that MDA comment on the rationale for and impact of the ending of the Weed Control Program.**

Other Changes

Overall, the nonpersonnel portion of the MDA fiscal 2017 adjusted allowance decreases by $0.5 million. The areas of change may be broadly categorized as agricultural policy and routine operations. The biggest change is an increase of $2,000,000 in general funds for the Rural Maryland Council. Larger changes include the following.

Agricultural Policy

- ***Rural Maryland Council:*** The Rural Maryland Council receives a nonmandated $2,000,000 general fund enhancement in the fiscal 2017 allowance. This funding is budgeted in the Rural Maryland Prosperity Investment Fund to implement Chapter 469 of 2014 (Rural Maryland Prosperity Investment Fund – Revisions and Extension of Termination Date) and is to be used to further the purposes of the legislation by encouraging and increasing entrepreneurism; reducing unemployment and underemployment; preserving valuable working landscapes; promoting intergovernmental cooperation and public-private partnerships throughout the State; and enhancing housing, transportation, water, wastewater, and broadband infrastructure and services. MDA notes that decisions on grant awards are determined by the Maryland Agricultural Education and Rural Development Assistance Board.

- ***Cover Crops:*** There is an increase of $1,040,000 ($840,000 in reimbursable funds from the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund and $200,000 special funds from the Bay Restoration Fund) for cover crops. Overall, there is a total of $22,650,000 for cover crops: $11,250,000 from the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund) and $11,400,000 from the Bay Restoration Fund.

- ***Animal Waste Technology Fund:*** The Animal Waste Technology Fund appropriation reflects a $1,033,728 decrease as a result of a reduction of $2,033,728 in reimbursable funds from the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund, which is partially offset by an increase of $1,000,000 from the Strategic Energy Investment Fund.

- ***One-time Deficiency for Highly Pathogenic Avian Influenza:*** The one-time deficiency to prepare for a highly pathogenic avian influenza outbreak accounts for a decrease of $410,243.

- ***Tobacco Transition Program:*** Tobacco Transition Program funding for infrastructure grants decreases by $400,000 in Cigarette Restitution Fund special funds in the fiscal 2017 allowance.

Routine Operations

- ***Soil Conservation District Funding:*** Soil conservation district funding for Western and Central Maryland decreases by $545,385 in reimbursable funds from the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund.

- ***Electricity:*** There is a decrease of $113,755 for Utilities – Electricity across the agency, primarily due to a reduction of one-time funding of $150,000 in reimbursable funds that were transferred internally from the State Board of Veterinary Examiners and Weights and Measures programs to the Central Services program in order to backfill the utilities funding reduced by the 2% cost containment reduction in Section 19 of the fiscal 2016 budget bill.

- ***Gas and Oil:*** Gas and oil costs decrease by $48,709 across the agency, primarily due to the reduction of $21,045 in general funds in the Weed Control Program as a result of the elimination of the program.

- ***Contractual Full-time Equivalents (FTE) Decrease by 1.2:*** The MDA contractual FTEs complement decrease by a net of 1.2 FTEs as shown in **Exhibit 6**.

Exhibit 6
Contractual Full-time Equivalent Changes
Fiscal 2017 Allowance

Program	Change	Explanation
Watershed Implementation Program	-2.0	Transfer to another program and end of a federal grant.
Maryland Horse Industry Board	-1.0	Fiscal constraints.
Plant Protection and Weed Management	-0.8	Reduction in federal funds.
Resource Conservation Grants	1.0	Enhancing the Manure Transport Program.
Forest Pest Management	0.7	Expectation of additional U.S. Forest Service funding to support gypsy moth suppression.
Food Quality Assurance	0.5	Additional on-call inspector.
Mosquito Control	0.3	Need to conduct field work at the Salisbury Regional Office.
Animal Health	0.1	
Total	**-1.2**	

Source: Maryland Department of Agriculture

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. The MDA share of these reductions totals $110,587 and is comprised of $75,273 in general funds, $31,338 in special funds, and $3,976 in federal funds. There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

Issues

1. Cover Crop Database and Mapping

Cover crops are one of the most effective best management practices for reducing nitrogen loads to the Chesapeake Bay and are a substantial portion of the MDA operating budget. Given the funding level in the budget, it is imperative that funding be efficiently applied to the available cover crop acreage opportunities.

Cover Crop Planting History

The Cover Crop Program appears to have plateaued at about 600,000 initial acres and 420,000 final paid acres. The 2015 to 2016 planting season, which reflects fiscal 2016 funding, has yielded an estimated final acreage of 448,700 acres. **Exhibit 7** shows the cover crop history. Since fiscal 2005, there has been an almost 700% increase in the amount of cover crop acres planted.

Exhibit 7
Cover Crop History
Fiscal 2005-2017 Est.

Fiscal Year	Initial Acres	Approved Acres	Fall Certification	Final Paid Acres	Final Paid Acres as a % Initial Acres
2005	106, 934	113,522	56,852	53,515	50%
2006	210,258	205,268	135,328	128,638	61%
2007	451,467	290,000	243,945	238,674	53%
2008	336,800	303,364	203,497	187,479	56%
2009	398,225	387,022	237,144	238,597	60%
2010	330,469	330,469	206,810	206,810	63%
2011	508,304	492,757	400,331	381,257	75%
2012	571,427	567,252	429,818	402,000	70%
2013	607,433	604,186	415,437	413,826	68%
2014	602,481	602,481	423,212	415,550	69%
2015	617,714	617,714	475,839	427,458	69%
2016 Est.	641,000	654,153	485,000	448,700	70%
2017 Est.	641,100	650,000	485,000	448,700	70%

Note: The data is as of January 28, 2016. For fiscal 2016, initial, approved, and fall certification acres are actuals but could still be adjusted. Final paid acres for fiscal 2016 is still an estimate. Fiscal 2017 figures are estimates.

Source: Maryland Department of Agriculture; Department of Legislative Services

Fiscal 2016 and 2017 Funding

Exhibit 8 reflects the estimated fiscal 2016 and 2017 funding need and availability. There appears to be sufficient funding from the Chesapeake and Atlantic Coastal Bays 2010 Trust Fund, the Bay Restoration Fund, and available fund balance to pay for the estimated 448,700 acres of cover crops in each year. Of note, the Bay Restoration Fund revenue estimate has increased by $200,000.

Exhibit 8
Cover Crop Funding
Fiscal 2016-2017

	Current 2016	Projected 2017
Projected Signup Acres	641,000	641,000
Retention Rate	70%	70%
Net Acres	448,700	448,700
Payment Per Acre	$50	$50
Total Projected Cost	$22,435,000	$22,435,000
Beginning Fund Balance	**$437,866**	**$252,866**
Revenues		
Projected Bay Restoration Fund	$11,200,000	$11,400,000
Projected 2010 Trust Fund	11,250,000	11,250,000
Total Resources Available	**$22,450,000**	**$22,650,000**
Expenditures		
Projected Cover Crop Cost	$22,435,000	$22,435,000
Administrative Cost	200,000	200,000
Surplus/Deficit	**$252,866**	**$267,866**

Source: Maryland Department of Agriculture; Department of Legislative Services

Cover Crop Targeting

MDA notes that in December 2015 it completed a task order with Towson University for the next phase of the online cover crop database, which will allow for the migration of historical cover crop and other Maryland Agricultural Cost-Share Program data into a Microsoft SQL database. There is $50,000 budgeted for the software as part of the operating costs from the Bay Restoration Fund. Ultimately, this database will allow for entering application data by soil conservation district with

implementation expected for the fiscal 2018 cover crop program year. MDA notes that it is in the midst of beta testing the mapping of cover crop applications. **DLS recommends that MDA comment on how the geospatial data on cover crop applications can be used to optimize cover crop funding for nutrient loading reductions.**

2. Nutrient Trading Regulations Impact on MDA

On December 28, 2015, MDA published regulations in the *Maryland Register* that establish the requirements and standards for the generation and certification of nonpoint source nutrient and sediment credits on agricultural land under the Agricultural Nutrient and Sediment Certification Program. MDA indicated that the impact on the department is nominal because administrative and other program expenditures associated with the regulations are funded by federal grant money. However, the federal funding that it currently receives relating to nutrient and sediment trading ends in March 2016 and is not expected to be renewed in the immediate future. Assuming that other funding is not available within the department's existing budget to replace the federal funding, State general fund expenditures increase by approximately $25,000 in fiscal 2016 and by $170,000 in fiscal 2017. These amounts reflect the cost of a program coordinator for the agricultural nutrient and sediment credit certification program ($25,000 for the final three months of fiscal 2016 and $100,000 annually thereafter) and the cost of contractual services for an upgrade to the online Maryland Nutrient Tracking Tool expected in fiscal 2017 ($65,000) and ongoing annual maintenance for the online tool ($5,000).

MDA notes that it intends to use the existing federal funding through the Natural Resources Conservation Service – Conservation Innovations Grant Program to fund the nutrient trading coordinator position through March 2016 and that, as a result of achieving general fund salary savings associated with the Agricultural Certainty Program, there will be general funds available to support the position through June 2016. For fiscal 2017, MDA intends to realign the Watershed Implementation Plan (WIP), combining the Nutrient Trading and Agricultural Certainty Programs, which will result in both programs being managed by a single general funded coordinator position. In addition, as the Maryland Nutrient Tracking Tool is now being used by other Chesapeake Bay jurisdictions, maintenance of the newly developed Chesapeake Bay Nutrient Tracking Tool will be funded jointly through additional federal grants secured by partner jurisdictions. Additionally, the costs of inspections associated with the Agricultural Nutrient and Sediment Certification Program will be incorporated into the price of a nutrient credit, and thus additional funding will not be needed for inspections. Finally, MDA notes that it will not be involved in the enforcement of credits, because enforcement will take place through the contractual agreement between the buyer and seller of credits. **DLS recommends that MDA comment on what the likely methodology will be for incorporating inspections into the price of a nutrient credit and who will enforce the contractual instrument between the buyer and seller of credits.**

3. New and Proposed Fee Reductions Impact Revenues

The Administration implemented fee reductions on September 15, 2015, that impacted State Board of Veterinary Medical Examiner program veterinary fees. In addition, the Administration has

introduced SB 389 and HB 459 (Fee, Surcharge, and Tax Reduction Act of 2016) in the 2016 legislative session that would reduce Weights and Measures program fees as well.

The September 15, 2015 fee reductions are estimated to have a $178,825 impact on State Board of Veterinary Medical Examiner program revenues. However, MDA notes that veterinary fee revenues have been increasing, and the special fund balance has been growing; therefore, the reduction in fees will not affect the program since the program has been generating more revenue than needed. DLS notes that fees were increased in fiscal 2012 in order to address revenues that have lagged expenditures in the State Board of Veterinary Medical Examiners program since fiscal 2009.

SB 389 and HB 459 as introduced, would reduce the fees for registering each weight and measure device used for commercial purposes. MDA indicates that the revenue reduction as a result of the bills would be $340,000 but that fiscal 2017 spending has not been adjusted. Of note, the fees are credited to a special fund, and any unspent funds collected revert to the General Fund. The proposed fee modifications are as follows:

- **Scales with a Capacity of up to 100 Pounds:** Reduce the maximum fee per business location from $375 to $325 and strike the provision for a $50 fee for each business location.

- **Scales with a Capacity of More Than 100 Pounds, up to 2,000 Pounds:** Reduce from $60 to $50.

- **Scales with a Capacity of More Than 2,000 Pounds:** Reduce from $100 to $75.

- **Vehicle Scales:** Reduce from $250 to $225.

- **Retail Motor Fuel Dispenser Meter of under 20 Gallons Per Minute:** Increase from $12.50 to $15.00, add a provision creating the maximum per business location fee of $375.00, and strike the provision for a $50.00 fee for each business location.

- **Retail Motor Fuel Dispenser Meter of 20 Gallons Per Minute or More:** Reduce from $45 to $35.

DLS recommends that MDA comment on the balances, revenues, and expenditures history for all funds receiving revenues from the fees reduced by the September 15, 2015 actions, and the proposed reductions in SB 389 and HB 459 and the impact on operations of both sets of fee reductions.

4. New Rural Maryland Council Spending Guided by Legislation

The Rural Maryland Council receives a nonmandated $2,000,000 general fund enhancement in the fiscal 2017 allowance. This funding is budgeted in the Rural Maryland Prosperity Investment Fund

to implement Chapter 469 of 2014 (Rural Maryland Prosperity Investment Fund – Revisions and Extension of Termination Date).

Chapter 621 of 2006 (Rural Maryland Prosperity Investment Fund) initially established the Rural Maryland Prosperity Investment Fund, and specified that it be administered by the Rural Maryland Council with the assistance of the Maryland Agricultural Education and Rural Development Assistance Board. The objective of the fund is to help raise the overall standard of living in rural areas to a level that meets or exceeds statewide benchmark averages by 2020, while preserving the best aspects of a pastoral heritage and rural way of life. The bill authorized the Governor, for fiscal 2008 through 2020, to include an appropriation in the budget bill for the fund. In addition, Chapter 621 allocated disbursements from the fund.

Chapter 469 of 2014 subsequently extended the authorization for annual appropriations to the fund, modified the allocation of disbursements from the fund, and extended the fund's termination date from June 30, 2020, to June 30, 2030. Under Chapter 469 one-third of appropriated funding is to be allocated equally to the five regional councils as grants for rural regional planning and development assistance. The remaining two-thirds is allocated equally as grants among (1) specified regional infrastructure projects; (2) rural entrepreneurship development; (3) rural community development, programmatic assistance, and education, divided equally between the Rural Maryland Council and the Maryland Agricultural Education and Rural Development Assistance Fund; and (4) rural health care organizations. If revenues appropriated to the fund in any fiscal year are insufficient to fully fund all grants, $500,000 must be allocated to Rural Maryland Council, with $250,000 used to support the operations of the council and $250,000 allocated to the Maryland Agricultural Education and Rural Development Assistance Fund. Any remaining funds must then be allocated as described above.

While the Rural Maryland Council has received a reimbursable fund appropriation from the Department of Commerce (formerly the Department of Business and Economic Development), including a $250,000 grant in fiscal 2012, and general fund appropriations since fiscal 2014 of approximately $167,000 per year, no funding has formally been provided for the Rural Maryland Prosperity Investment Fund.

Based on the fiscal 2017 allowance of $2,000,000, which triggers the provision that the alternative distribution plan be followed, it is assumed that the funding would be distributed as shown in **Exhibit 9**. Of note, the Rural Maryland Council and Maryland Agricultural Education and Rural Development Assistance Fund already each receive $167,000 in general funds for fiscal 2017 and the five regional councils receive $200,000 each in the Department of Commerce budget. In addition, the assumption is that the Rural Maryland Council and Maryland Agricultural Education and Rural Development Assistance Fund receive two allocations to be divided equally: $500,000 initially and $250,000 from the two-thirds remaining distribution. **DLS recommends that the $167,000 general fund appropriations for the Rural Maryland Council and Maryland Agricultural Education and Rural Development Assistance Fund each be deleted given the $375,000 that will be available to each from the $2,000,000 allocation of the Rural Maryland Prosperity Investment Fund. In addition, DLS recommends that $100,000 be restricted in MDA's budget pending the submission of a report on July 1, 2016, specifying the criteria to be used for allocating funding from the Rural**

Maryland Prosperity Investment Fund and a report on January 1, 2017, specifying the actual allocation of fiscal 2017 funding.

Exhibit 9
Rural Maryland Prosperity Investment Fund Distribution
Fiscal 2017 Allowance

Calculation	Recipient	Purpose	Amount
Initial $500,000	Rural Maryland Council	$250,000 for operations and $250,000 for the Maryland Agricultural Education and Rural Development Assistance Fund	$500,000
Remaining funding $1,500,000			
One-third of remaining funding:			
	Five Regional Councils	$100,000 for each regional council	500,000
Two-thirds of remaining funding, divided equally:			
	Regional Infrastructure Projects		250,000
	Rural Entrepreneurship Development		250,000
	Rural Community Development, Programmatic Assistance	$125,000 for Rural Maryland Council and $125,000 for Maryland Agricultural Education and Rural Development Assistance Fund	250,000
	Rural Health Care Organizations		250,000
Total			**$2,000,000**

Source: Department of Legislative Services

Recommended Actions

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

, provided that $167,000 of this appropriation made for the purpose of operating expenses in the Rural Maryland Council shall be reduced.

Further provided that $100,000 of the remaining appropriation shall be restricted pending the submission of a report on July 1, 2016, specifying the criteria and rationale for the allocation of the Rural Maryland Prosperity Investment Fund funding and a report on January 1, 2017, specifying the actual allocation of funding. The budget committees shall have 45 days to review and comment. Funding shall be released in $50,000 increments pending submission of each report. Funds restricted pending the receipt of the reports may not be transferred by budget amendment or otherwise to any other purpose and shall be reverted if the reports are not submitted to the budget committees.

Explanation: The fiscal 2017 allowance includes a $2,000,000 general fund appropriation to the Rural Maryland Prosperity Investment Fund. According to Chapter 469 of 2014 (Rural Maryland Prosperity Investment Fund – Revisions and Extension of Termination Date), the Rural Maryland Council and Maryland Agricultural Education and Rural Development Assistance Fund each receive $375,000 from the allocation, which is in addition to the $167,000 in general funds also budgeted for each program. This budget bill language reduces the $167,000 in general funds from the Rural Maryland Council's appropriation providing for a measured increase in funding. In addition, the budget bill language restricts $100,000 of the Rural Maryland Prosperity Investment Fund funding pending the submission of reports on the criteria and rationale for the allocation of the Rural Maryland Prosperity Investment Fund funding and the actual allocation of funding.

Information Request	**Authors**	**Due Date**
Report on the criteria and rationale for the allocation of the Rural Maryland Prosperity Investment Fund funding	Maryland Department of Agriculture (MDA)	July 1, 2016
Report on the actual allocation of Rural Maryland Prosperity Investment Fund funding	MDA	January 1, 2017

		Amount Reduction	
2.	Reduce funding for the Maryland Agricultural Education and Rural Development Assistance Fund. The fiscal 2017 allowance includes a $2,000,000 general fund appropriation to the Rural Maryland Prosperity Investment Fund. According to Chapter 469 of 2014 (Rural Maryland Prosperity Investment Fund – Revisions and Extension of Termination Date), the Rural Maryland Council and Maryland Agricultural Education and Rural Development Assistance Fund each receive $375,000 from the allocation, which is in addition to the $167,000 in general funds also budgeted for each program. This reduction of $167,000 in general funds from the Maryland Agricultural Education and Rural Development Assistance Fund's appropriation provides for a measured increase in funding.	$ 167,000	GF
	Total General Fund Reductions	**$ 167,000**	

Updates

1. MDA Repeat Audit Findings Still in Limbo

Funding has been withheld in each of the MDA fiscal 2015 and 2016 budgets in order to compel resolution of repeat audit findings. For fiscal 2015, $100,000 in general funds was withheld and then not released because the findings were not resolved to the satisfaction of the Office of Legislative Audits (OLA). Similarly, $200,000 in general funds has been withheld in the MDA fiscal 2016 appropriation. As of this writing, OLA has received the status report from MDA and has completed its follow-up work but has not yet issued the draft letter to MDA for its review.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
Department of Agriculture
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$27,795	$30,001	$4,240	$3,102	$65,138
Deficiency Appropriation	0	69	0	0	69
Cost Containment	-878	0	0	0	-878
Budget Amendments	69	2,190	180	20,371	22,811
Reversions and Cancellations	-310	-5,565	-601	-4,293	-10,769
Actual Expenditures	**$26,676**	**$26,695**	**$3,819**	**$19,181**	**$76,371**
Fiscal 2016					
Legislative Appropriation	$26,645	$32,081	$3,984	$22,736	$85,446
Budget Amendments	322	114	498	2,580	3,514
Working Appropriation	**$26,967**	**$32,195**	**$4,482**	**$25,317**	**$88,960**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

The general fund appropriation decreased by $1,119,010. The changes are as follows:

- **Cost Containment:** A decrease of $877,870 reflects the July 2, 2014, Board of Public Works (BPW) actions that reduced funding for a long-term vacant agricultural inspector II position (deleted), new vehicles, unneeded office space, contractual services in Forest Pest Management, operations funding to be replaced with special funds in the Weights and Measures Program, State cost-share assistance for development of nutrient management plans due to low demand in the Office of Resource Conservation – Resource Conservation Grants, a long-term vacant agricultural laboratory scientist III position (deleted), vehicle operations funding in the Animal Health Program, for new vehicles in Mosquito Control ($387,210), and the January 2015 2% reduction for contractual services across the agency ($490,660).

- **Budget Amendments:** A net increase of $68,865 to allocate the cost-of-living adjustment (COLA) effective January 1, 2015 ($160,565), which is offset partially by decreases to reflect the State Employee Voluntary Separation Program as authorized by Section 22 of the fiscal 2016 operating budget bill ($75,000), and to realign appropriation between State agencies based on the fiscal 2015 estimated expenditures for telecommunications ($16,700).

- **Reversions:** A decrease of $310,005 as a result of reversions, primarily in the Office of the Secretary – Executive Direction due to the reduction of funding since repeat audit findings were not corrected ($100,000), and for funding not being needed in Resource Conservation Operations ($80,316) and Animal Health ($79,114).

The special fund appropriation decreased by $3,306,442. The changes are as follows.

- **Deficiency Appropriation:** An increase of $68,614 for two separate purposes. There is an increase of $54,004 in the Office of Resource Conservation – Nutrient Management from the Chesapeake Bay Trust for the implementation, enforcement, and reporting of Chesapeake Bay watershed activities. In addition, there is $14,610 in the Office of Marketing, Animal Industries, and Consumer Services – Rural Maryland Council from the Regular Share of Racing Revenue in the Rural Maryland Council's balance for development grants to nongovernmental entities in rural jurisdictions.

- **Budget Amendments:** An increase of $2,190,415 for cover crop payments from Bay Restoration Fund revenues in Resource Conservation Grants ($1,200,000), for replacement laboratory equipment and other fixed costs from Registration and Inspection Fees in the State Chemist ($440,715), for replacing general fund reductions implemented as part of the July 2014 BPW cost containment and for replacement equipment costs from the Equipment Testing and Licensing and Registration funds in Weights and Measures ($234,122), for covering agricultural easement costs from the fund balance in the Maryland Agricultural Land Preservation Foundation ($107,454), for salaries and online registration and database development costs from License and Registration Fees in Pesticide Regulation ($102,741), for

allocating the COLA effective January 1, 2015 ($57,181), for animal disease testing laboratory costs from additional laboratory testing services revenue in Animal Health ($19,992), for salary and health insurance costs from the Maryland Horse Industry Board Fund in the Maryland Horse Industry Board ($14,660), and for replacing aging germination and labeling equipment from Seedman's Permit and Seed and Turf Testing funds in Turf and Seed ($13,550).

- **Cancellations:** A decrease of $5,565,471 primarily due to the Tobacco Transition Program bond repayment being offset against the revenue transfer instead of expenditures and Spay/Neuter Program appropriation not being needed ($3,657,885), revenue not being received in Resource Conservation Grants ($812,069), appropriation not being needed in the State Chemist ($298,249), racing revenue not being received in the Maryland Agricultural Fair Board ($244,813), and appropriation not being needed in the Weights and Measures program ($176,906).

The federal fund appropriation decreased by $421,013. The changes are as follows.

- **Budget Amendments:** An increase of $180,183 for salary and fringe benefit costs associated with animal disease surveillance from U.S. Department of Agriculture Plant and Animal Disease, Pest Control, and Animal Care funding in the Animal Health program ($74,566); for salary and fringe benefit costs related to implementation of an agricultural nutrient trading or offset program to manage nutrient loads from point and nonpoint sources from U.S. Department of Agriculture Environmental Quality Incentives Program funding in Resource Conservation Operations (District Operations) ($46,021); for salaries and fringe benefits from federal meat and egg shell inspections fee-for-service in Food Quality Assurance ($24,743); for salary and fringe benefit costs from U.S. Environmental Protection Agency Performance Partnership Grants funding in Pesticide Regulation ($16,113); for utility costs from federal indirect cost recovery due to additional federal awards in Central Services ($12,000); and for allocating the COLA effective January 1, 2015 ($6,740).

- **Cancellations:** A decrease of $601,196 primarily as a result of projected revenue not being received in the WIP ($151,817), Resource Conservation Operations ($130,051), Forest Pest Management ($112,921), and Plant Protection and Weed Management ($107,927).

The reimbursable fund appropriation increased by $16,078,770. The changes are as follows:

- **Budget Amendments:** An increase of $20,371,391 due to budget amendments for allocation of $19,600,000 in Chesapeake and Atlantic Coastal Bays 2010 Trust Fund funding transferred from the Department of Natural Resources (DNR) for cover crops in the Resource Conservation Grants Program ($11,250,000); for agricultural technical assistance in Resource Conservation Operations ($2,600,000); for animal waste technology programs in Resource Conservation Grants ($2,500,000); for grants to farmers in Resource Conservation Grants ($2,000,000); for the Manure Transport Program in Resource Conservation Grants ($750,000); for the Conservation Reserve Enhancement Program in Resource Conservation Grants ($500,000), for additional indirect revenue from MDA programs to cover heating, ventilation, and cooling and

other repair costs at the headquarters and Salisbury office locations ($369,443); for recognition of payments made to the University of Maryland, College Park in fiscal 2014 for providing nutrient management education and outreach programs as well as supporting nutrient management software development, revisions, and maintenance transferred from the Maryland Department of the Environment (MDE)/U.S. Environmental Protection Agency's Chesapeake Bay Regulatory and Accountability Program and used in the Office of Resource Conservation – Nutrient Management Program ($346,800); for development grants to nongovernmental entities in rural Maryland jurisdictions transferred from the Department of Commerce as the remaining balance of the fiscal 2012 $250,000 grant to the Rural Maryland Council ($42,686); for a no-cost extension to provide outreach for Conservation Reserve Enhancement Program signups and to support the Chesapeake Watershed Enhancement federal fiscal 2010 grant transferred from DNR and used in the Office of Resource Conservation – Program Planning and Development ($7,300); for increasing the annual grant for the Mosquito Control Program to conduct West Nile Virus and Arbovirus surveillance transferred from the Department of Health and Mental Hygiene and used in the Office of Plant Industries and Pest Management – Mosquito Control ($5,000); and for the full State Highway Administration grant funding for managing invasive weeds in the Plant Protection and Weed Management program ($162).

- **Cancellations:** A decrease of $4,292,621 primarily as a result of not spending the entire Chesapeake and Atlantic Coastal Bays 2010 Trust Fund money in Resource Conservation Grants ($2,500,374) and Resource Conservation Operations ($821,154), not receiving the entire revenue supporting the appropriation in Central Services ($528,858), and not being able to bill DNR because the University of Maryland was late billing MDA in the Nutrient Management program ($353,429).

Fiscal 2016

The MDA general fund appropriation increases by $322,000 due to a budget amendment allocating the funding in Section 48 of the fiscal 2016 budget bill that restored the 2% State salary reduction.

The MDA special fund appropriation increases by $114,000 due to a budget amendment allocating the funding in Section 48 of the fiscal 2016 budget bill that restored the 2% State salary reduction.

The MDA federal fund appropriation increases by $497,614 due to budget amendments. The budget amendments reflect appropriation increases for technical fees, grants and subsidies, contractual services, and supplies and materials in the Office of Resource Conservation – Watershed Implementation for innovative and emerging technologies in reducing nutrient and sediment runoff into the Chesapeake Bay ($263,291); for Office of Resource Conservation – Program Planning and Development disbursement of Regional Conservation Partnership Program funding to the Virginia Department of Conservation and Recreation and Delaware DNR and Environmental Control for accelerating the implementation of Chesapeake Bay watershed conservation measures ($222,323); and

for allocating the funding in Section 48 of the fiscal 2016 budget bill that restored the 2% State salary reduction ($12,000).

The MDA reimbursable fund appropriation increases by $2,580,463 due to budget amendments. The budget amendments transfer funding from DNR to the MDA Resource Conservation Grants reflecting carryover balances from fiscal 2015 Chesapeake and Atlantic Coastal Bays 2010 Trust Fund funding that is to be spent by the Animal Waste Technology Fund over the next two years and that is to be spent by the Manure Transport Program over the next year ($1,877,400); transfer from DNR to MDA WIP funding for the web-based Chesapeake Bay Nutrient Trading/Tracking Tool and Adapting Innovative Technologies to Mitigate Phosphorus from Dairy Effluent Grant ($430,517); transfer internally from both the State Board of Veterinary Examiners and Weights and Measures programs to the Central Services program funding to backfill the utilities funding reduced by the 2% cost containment in Section 19 of the fiscal 2016 budget bill ($150,000); transfer from MDE to MDA WIP funding from the grants titled Agricultural Best Management Practice Verification and Agricultural WIP Coordination ($59,631); transfer from the Department of Commerce to the Rural Maryland Council for providing the balance of the fiscal 2012 $250,000 grant that supports development grants to nongovernment entities in rural Maryland jurisdictions ($43,077); transfer from the Maryland State Department of Education to the MDA Marketing and Agricultural Development program funding for events promoting State agriculture and farm products to Maryland school children ($15,000); and transfer from the State Highway Administration to the MDA Plant Protection and Weed Management program funding for rearing, releasing, and monitoring biological controls for invasive species ($4,838).

Object/Fund Difference Report
Department of Agriculture

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	381.10	380.10	376.10	-4.00	-1.1%
02 Contractual	39.00	44.80	43.60	-1.20	-2.7%
Total Positions	**420.10**	**424.90**	**419.70**	**-5.20**	**-1.2%**
Objects					
01 Salaries and Wages	$ 28,734,018	$ 29,978,657	$ 30,625,384	$ 646,727	2.2%
02 Technical and Special Fees	1,419,398	1,515,633	1,498,220	-17,413	-1.1%
03 Communication	711,637	716,388	750,205	33,817	4.7%
04 Travel	332,822	398,633	350,669	-47,964	-12.0%
06 Fuel and Utilities	822,840	937,444	802,812	-134,632	-14.4%
07 Motor Vehicles	1,106,393	1,140,248	1,136,564	-3,684	-0.3%
08 Contractual Services	5,752,965	6,181,138	5,335,110	-846,028	-13.7%
09 Supplies and Materials	1,205,260	1,160,710	1,114,177	-46,533	-4.0%
10 Equipment – Replacement	673,906	361,416	203,309	-158,107	-43.7%
11 Equipment – Additional	54,035	40,145	64,199	24,054	59.9%
12 Grants, Subsidies, and Contributions	34,066,986	41,415,332	43,193,481	1,778,149	4.3%
13 Fixed Charges	1,065,734	4,909,678	5,061,181	151,503	3.1%
14 Land and Structures	424,758	205,000	335,484	130,484	63.7%
Total Objects	**$ 76,370,752**	**$ 88,960,422**	**$ 90,470,795**	**$ 1,510,373**	**1.7%**
Funds					
01 General Fund	$ 26,675,598	$ 26,967,219	$ 29,459,001	$ 2,491,782	9.2%
03 Special Fund	26,694,726	32,194,618	34,040,460	1,845,842	5.7%
05 Federal Fund	3,819,369	4,481,937	3,629,548	-852,389	-19.0%
09 Reimbursable Fund	19,181,059	25,316,648	23,341,786	-1,974,862	-7.8%
Total Funds	**$ 76,370,752**	**$ 88,960,422**	**$ 90,470,795**	**$ 1,510,373**	**1.7%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
Department of Agriculture

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
11 Office of the Secretary	$ 9,185,173	$ 8,371,525	$ 9,018,108	$ 646,583	7.7%
12 Office of Marketing, Animal Industries and Consumer Services	16,431,218	21,371,610	23,901,875	2,530,265	11.8%
14 Office of Plant Industries and Pest Management	10,711,125	10,942,233	10,721,324	-220,909	-2.0%
15 Office of Resource Conservation	40,043,236	48,275,054	46,829,488	-1,445,566	-3.0%
Total Expenditures	**$ 76,370,752**	**$ 88,960,422**	**$ 90,470,795**	**$ 1,510,373**	**1.7%**
General Fund	$ 26,675,598	$ 26,967,219	$ 29,459,001	$ 2,491,782	9.2%
Special Fund	26,694,726	32,194,618	34,040,460	1,845,842	5.7%
Federal Fund	3,819,369	4,481,937	3,629,548	-852,389	-19.0%
Total Appropriations	**$ 57,189,693**	**$ 63,643,774**	**$ 67,129,009**	**$ 3,485,235**	**5.5%**
Reimbursable Fund	$ 19,181,059	$ 25,316,648	$ 23,341,786	-$ 1,974,862	-7.8%
Total Funds	**$ 76,370,752**	**$ 88,960,422**	**$ 90,470,795**	**$ 1,510,373**	**1.7%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Department of Health and Mental Hygiene Fiscal 2017 Budget Overview

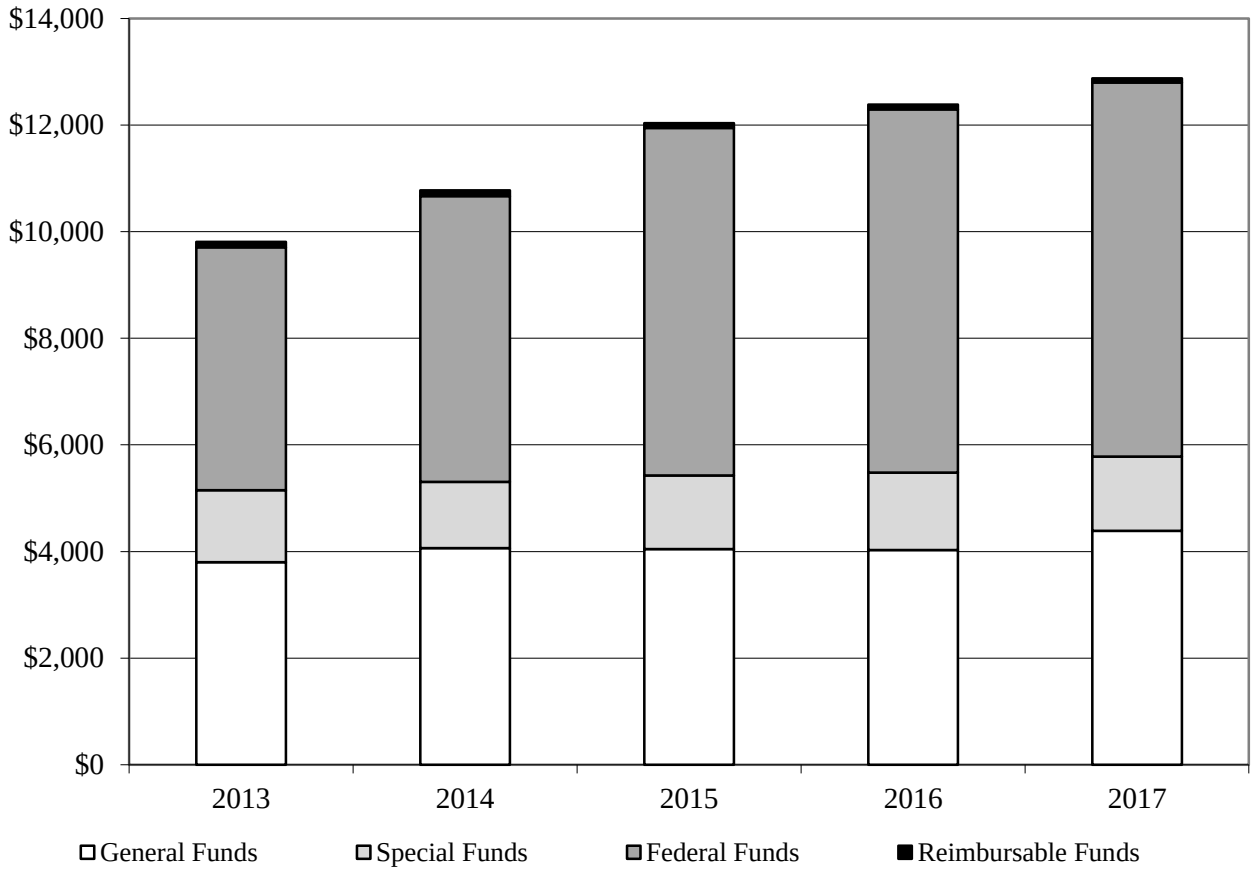
Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

January 2016

For further information contact: Jordan D. More Phone: (410) 946-5530

M00
Department of Health and Mental Hygiene
Fiscal 2017 Budget Overview

Department of Health and Mental Hygiene
Five-year Funding Trends
Fiscal 2013-2017
($ in Millions)



Note: Includes fiscal 2016 deficiencies and planned reversions as well as fiscal 2017 back of the bill reductions. Fiscal 2013 through 2017 data includes the funding for the Senior Prescription Drug Assistance Program, which is being transferred to the Department of Health and Mental Hygiene in fiscal 2017.

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

Department of Health and Mental Hygiene
Budget Overview
Fiscal 2013-2017
($ in Millions)

	2013	2014	2015	2016	2017	Change 2016-17
General Funds	**$3,811**	**$4,061**	**$4,078**	**$4,225**	**$4,389**	
Fiscal 2016 Deficiencies				2		
Planned Reversions and Back of Bill Reductions			-34	-200	-1	
Adjusted General Funds	**$3,811**	**$4,061**	**$4,044**	**$4,028**	**$4,387**	**$359**
Special Funds	**$1,353**	**$1,245**	**$1,380**	**$1,450**	**$1,392**	
Fiscal 2016 Deficiencies						
Back of Bill Reductions					0	
Adjusted Special Funds	**$1,353**	**$1,245**	**$1,380**	**$1,450**	**$1,391**	**-$59**
Federal Funds	**$4,554**	**$5,363**	**$6,523**	**$6,816**	**$7,021**	
Fiscal 2016 Deficiencies						
Back of Bill Reductions					0	
Adjusted Federal Funds	**$4,554**	**$5,363**	**$6,523**	**$6,816**	**$7,020**	**$204**
Reimbursable Funds	**$107**	**$105**	**$90**	**$95**	**$79**	**-$16**
Total	**$9,286**	**$10,774**	**$12,037**	**$12,389**	**$12,878**	**$489**
Annual % Change From Prior Year	**2.0%**	**9.6%**	**11.9%**	**2.9%**	**3.9%**	

Note: Includes fiscal 2016 deficiencies and planned reversions as well as fiscal 2017 back of the bill reductions. Fiscal 2013 through 2017 data includes the funding for the Senior Prescription Drug Assistance Program, which is being transferred to the Department of Health and Mental Hygiene in fiscal 2017.

Numbers may not sum to total due to rounding.

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

Department of Health and Mental Hygiene
Fiscal 2016 Deficiencies and Fiscal 2017 Back of the Bill Reductions

Program	Item	General Funds	Total Funds
Fiscal 2016 Deficiencies			
Prevention and Health Promotion Administration	Funding to cover the State share of Certificate of Need expenses for the proposed new Regional Medical Center in Prince George's County	$1,456,208	$1,456,208
Western Maryland Hospital Center	Funding to support the management staffing contract between Meritus and Western Maryland Hospital Center	829,114	829,114
Fiscal 2016 Deficiencies Total		**$2,285,322**	**$2,285,322**
Fiscal 2017 Back of the Bill Reductions			
DHMH	Reduction to reflect health insurance savings due to a revised collections estimate	-$1,424,451	-$1,808,029
Fiscal 2017 Back of the Bill Reductions Total		**-$1,424,451**	**-$1,808,029**

DHMH: Department of Health and Mental Hygiene

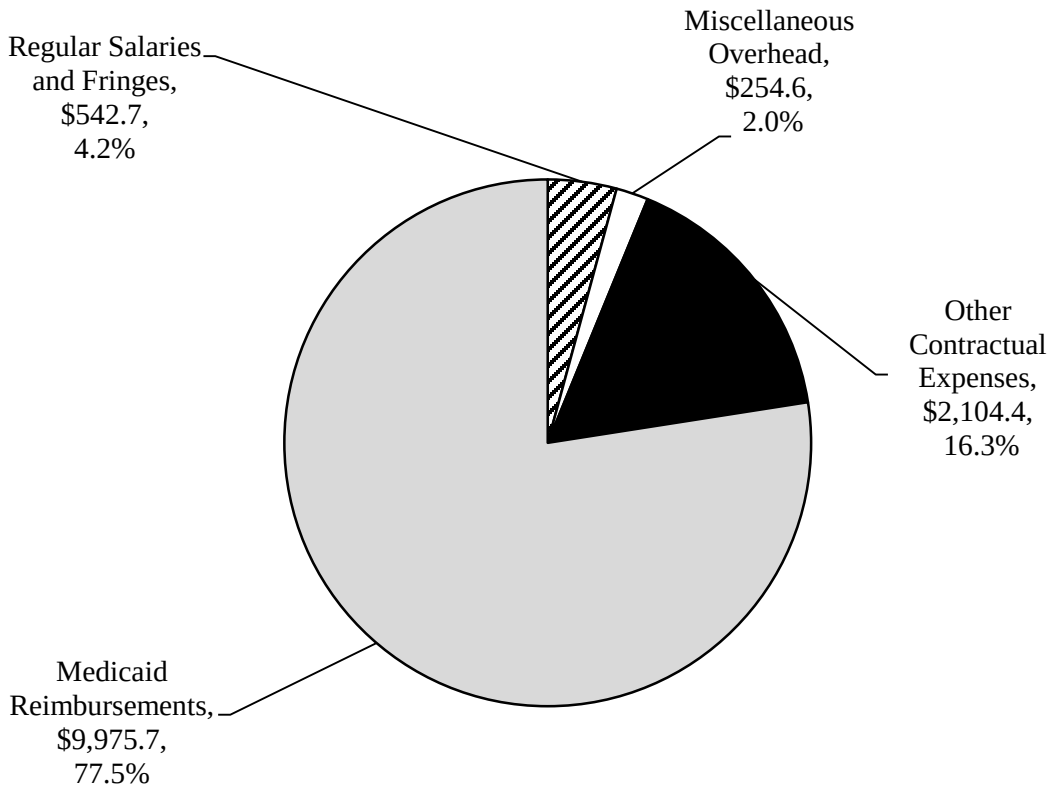
Source: State Budget

Department of Health and Mental Hygiene
Fiscal 2016 2% Across-the-board Reduction Allocation

Program	Item	General Funds	Total Funds
Administration	Reduction in minority health and health disparities grants ($500,000); reduction in various information technology contracts ($69,681); removal of 1 contractual position and a 50% reduction of another ($28,721)	-$723,402	-$735,529
Health Occupation Boards	Various operating expenses within the Nursing Home Administrators and Residential Child Care Administrations boards	-10,000	-10,000
Public Health Administration	Reduction in funding for grants for Baltimore City Child and Adolescent Health Advocacy Program ($60,000), school-based health center grant ($37,784), and other operating expenditures, mainly for utility expenditures ($215,932)	-313,716	-313,716
Prevention and Health Promotion	Elimination of grant to the University of Maryland Medical System for Montebello Rehabilitation Center	-442,730	-442,730
Chronic Hospitals	Reductions in laundry services ($26,735), security contract ($20,000), and transportation ($10,000)	-56,735	-56,735
Behavioral Health Administration	Fund swaps due to higher federal award attainment	-1,375,000	0
Behavioral Health Administration	Decrease for mental health uninsured services ($250,000) and substance use disorder services ($200,000)	-450,000	-450,000
Behavioral Health Administration	2% operating expenses cut at all institutions	-814,890	-981,628
Developmental Disabilities Administration	Reduce general funds in anticipation of increased federal fund attainment	-3,995,501	-200,000
Developmental Disabilities Administration	Reductions at institutions including eliminating 6 positions at Holly Center ($404,299) and other operating reductions ($484,235)	-888,534	-888,534
Medicaid	Fund swap with Rate Stabilization Fund	-11,013,633	0
Medicaid	Planned reversions	-7,762,068	-16,329,592
Medicaid	Lower Managed Care Organization rates in Children's Health Insurance Plan	-587,500	-2,500,000
Fiscal 2016 2% Across-the-board Reductions Total		**-$28,433,709**	**-$22,908,464**

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

Department of Health and Mental Hygiene
Functional Breakdown of Spending
Fiscal 2017 Allowance
($ in Millions)



Note: Medicaid reimbursements include Maryland Children's Health Program and Behavioral Health provider reimbursements.

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

Department of Health and Mental Hygiene
Budget Overview: All Funding Sources
Fiscal 2015-2017
($ in Thousands)

	Actual 2015	Working 2016	Allowance 2017	$ Change 2016-17	% Change 2016-17
Medical Programs/Medicaid	**$8,726,943**	**$8,731,801**	**$9,157,167**	**$425,366**	**4.9%**
Provider Reimbursements	8,367,709	8,358,737	8,727,660	368,923	4.4%
Maryland Children's Health Program	243,669	245,648	283,863	38,214	15.6%
Other	115,565	127,416	145,644	18,228	14.3%
Behavioral Health	**$1,547,108**	**$1,666,513**	**$1,681,053**	**$14,540**	**0.9%**
Program Direction	20,146	19,338	23,912	4,574	23.7%
Community Services	1,237,455	1,359,223	1,363,072	3,850	0.3%
Facilities	289,507	287,952	294,069	6,117	2.1%
Developmental Disabilities	**$978,359**	**$1,087,971**	**$1,151,460**	**$63,488**	**5.8%**
Program Direction	9,340	9,147	10,198	1,050	11.5%
Community Services	925,298	1,038,312	1,099,736	61,424	5.9%
Facilities	43,720	40,512	41,526	1,014	2.5%
Public Health Administration	**$124,934**	**$145,779**	**$139,874**	**-$5,905**	**-4.1%**
Targeted Local Health	46,236	50,157	53,981	3,825	7.6%
Other	78,698	95,622	85,893	-9,729	-10.2%
Prevention and Health Promotion Administration	**$331,570**	**$363,471**	**$360,917**	**-$2,553**	**-0.7%**
Women, Infants, and Children	106,466	115,250	115,436	186	0.2%
CRF Tobacco and Cancer	38,406	45,973	48,067	2,094	4.6%
Maryland AIDS Drug Assistance Program	37,749	57,628	45,296	-12,332	-21.4%
Other	148,949	144,619	152,118	7,499	5.2%
Other Budget Areas	**$327,620**	**$393,046**	**$388,845**	**-$4,202**	**-1.1%**
DHMH Administration	48,650	48,958	49,874	916	1.9%
Office of Health Care Quality	21,319	20,064	20,406	342	1.7%
Health Occupations Boards	30,560	37,256	38,160	904	2.4%
Chronic Disease Hospitals	49,320	50,290	49,896	-394	-0.8%
Health Regulatory Commissions	177,770	236,479	230,510	-5,969	-2.5%
Departmentwide Reductions	**$0**	**$0**	**-$1,808**	**-$1,808**	**n/a**
Total Funding	**$12,036,534**	**$12,388,581**	**$12,877,508**	**$488,927**	**3.9%**

CRF: Cigarette Restitution Fund
DHMH: Department of Health and Mental Hygiene

Note: For the purpose of this chart, fee-for-service community behavioral health expenditures for Medicaid recipients are shown under the Behavioral Health Administration as opposed to Medicaid where they are budgeted. Fiscal 2015 through 2017 funding includes funding for the Senior Prescription Drug Assistance Program, which is being transferred to DHMH in fiscal 2017. Includes fiscal 2016 deficiencies and planned reversions as well as fiscal 2017 back of the bill reductions. Numbers may not sum to total due to rounding.

Source: Department of Legislative Services; State Budget

Department of Health and Mental Hygiene
Budget Overview: General Funds Only
Fiscal 2015-2017
($ in Thousands)

	Actual 2015	Working 2016	Allowance 2017	$ Change 2016-17	% Change 2016-17
Medical Programs/Medicaid	**$2,403,394**	**$2,347,732**	**$2,640,262**	**$292,530**	**12.5%**
Provider Reimbursements	2,299,638	2,294,471	2,572,657	278,186	**12.1%**
Maryland Children's Health Program	72,430	21,676	33,925	12,249	**56.5%**
Other	31,326	31,585	33,680	2,095	**6.6%**
Behavioral Health	**$839,520**	**$856,743**	**$886,256**	**$29,513**	**3.4%**
Program Direction	15,072	15,319	19,084	3,766	**24.6%**
Community Services	544,616	564,016	582,387	18,370	**3.3%**
Facilities	279,833	277,408	284,785	7,377	**2.7%**
Developmental Disabilities	**$565,876**	**$602,913**	**$635,767**	32,854	**5.4%**
Program Direction	5,665	5,458	5,495	36	**0.7%**
Community Services	517,153	557,618	589,217	31,599	**5.7%**
Facilities	43,058	39,836	41,055	1,219	**3.1%**
Public Health Administration	**$98,809**	**$100,155**	**$105,104**	**$4,949**	**4.9%**
Targeted Local Health	41,743	45,664	49,488	3,825	**8.4%**
Other	57,066	54,491	55,615	1,124	**2.1%**
Prevention and Health Promotion Administration	**$53,261**	**$38,719**	**$37,510**	**-$1,209**	**-3.1%**
Women, Infants, and Children	51	65	65	0	**0.0%**
Cigarette Restitution Fund Tobacco and Cancer	0	0	0	0	
Maryland AIDS Drug Assistance Program	20	0	0	0	
Other	53,190	38,654	37,445	-1,209	**-3.1%**
Other Budget Areas	**$83,529**	**$81,772**	**$83,802**	**$2,030**	**2.5%**
DHMH Administration	24,462	24,207	25,057	850	**3.5%**
Office of Health Care Quality	13,803	11,816	12,575	759	**6.4%**
Health Occupations Boards	391	476	492	16	**3.4%**
Chronic Disease Hospitals	44,873	45,274	45,678	405	**0.9%**
Health Regulatory Commissions	0	0	0	0	
Departmentwide Reductions			**-$1,424**	**-$1,424**	**0.0%**
Total Funding	**$4,044,389**	**$4,028,034**	**$4,387,275**	**$359,242**	**8.9%**

DHMH: Department of Health and Mental Hygiene

Note: For the purpose of this chart, fee-for-service community behavioral health expenditures for Medicaid recipients are shown under the Behavioral Health Administration as opposed to Medicaid where they are budgeted. Includes fiscal 2016 deficiencies and planned reversions as well as fiscal 2017 back of the bill reductions. Numbers may not sum to total due to rounding.

Source: Department of Legislative Services; State Budget

Proposed Budget Changes
Department of Health and Mental Hygiene
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2016 Working Appropriation	$4,028,034	$1,449,919	$6,815,881	$94,748	$12,388,581
2017 Governor's Allowance	4,387,275	1,391,372	7,020,359	$78,502	12,877,508
Amount Change	359,242	-58,547	204,478	-16,246	488,927
Percent Change	8.9%	-4.0%	3.0%	-17.1%	3.9%

Where It Goes:		
Personnel	**$16,812**	
Employee and retiree health insurance		$12,078
Retirement contribution		9,316
Other fringe benefit adjustments		396
Regular earnings		580
Abolished positions from privatization of certain hospital functions		-5,558
Major Programmatic Changes (Excluding Medicaid)	**$56,238**	
Behavioral Health Administration		
Fee-for-Service Community Mental Health Services	***-$360***	
Regulated rate changes		$14,787
Rate adjustment for community providers (2% increase)		12,235
Enrollment and utilization for Medicaid State-funded and uninsured services		-5,529
Enrollment and utilization for Medicaid-eligible services		-21,853
Community Mental Health Grants and Contracts	***$3,764***	
Maryland Collaboration for Homeless Enhancement Services grant (federal funds)		$1,427
Rate increase for Core Service Agencies		1,273
Increase in Community Mental Health Service Block grant (federal funds)		1,064
Substance Abuse Services	***$687***	
Maryland Collaboration for Homeless Enhancement Services and Medication Assisted Treatment (federal funds)		$2,187
Increased block grant and other federal funding		1,112
Synar Amendment penalty		-2,612
Institutions	***$2,594***	
Privatization contracts		$4,491

Where It Goes:		
Operating costs		-1,897
Program Direction	***$3,059***	
Heroin Task Force initiatives		$3,059
Developmental Disabilities Administration	***$60,796***	
Rate increase for providers (3.5%)		$36,103
Additional funding for annualization and expansion		21,161
Utilization review and rate-setting study		3,532
Public Health Administration	***-$6,455***	
Core Local Public Health formula		$3,825
Reduced funding for Ebola-related programs (federal funds)		-10,279
Prevention and Health Promotion Administration	***-$2,994***	
Healthiest Maryland (federal funds)		$4,014
Affordable Care Act maternal infant and child care home visiting (federal funds)		1,794
Synar funding (special funds)		1,878
Maryland Aids Drug Assistance Program (special funds)		-10,680
Regulatory Commissions	***-$4,854***	
Integrated Care Networks (special funds)		$6,527
All-payer Model contracts (special funds)		1,186
Expiring grants at Maryland Health Care Commission (federal funds)		-2,492
Reduction in CRISP grants (special funds)		-10,075
Medicaid/Medical Care Programs Administration	**$424,200**	
Provider Reimbursements (Medicaid and MCHP)	***$404,941***	
Provider rate increases (Medicaid, MCHP, and Community First Choice)		$320,697
Enrollment and Utilization		124,772
Hepatitis C kick payments to MCOs		64,984
Medicare Part A&B Premiums		24,489
Medicare Part D Clawback payment		18,100
Autism spectrum disorder additional services		13,390
Community First Choice (excluding rate increase)		6,744
Transportation grants (align to actuals)		5,806
MMIS/Systems contracts		3,438
Health Homes		3,390
Miscellaneous adjustments		3,237
Graduate medical education payments		2,036
Nursing cost settlements		901

Where It Goes:		
Third-party Liability recovery contract		900
Supplemental payments to Federally Qualified Health Centers (align to actuals)		-1,831
School-based Services (reimbursable fund expenses)		-2,455
Balancing Incentive Payment Program administrative expenditures		-5,297
Money Follows the Person		-5,731
Waiver enrollment and eligibility services		-10,889
Hospital Presumptive Eligibility (federal funds only)		-18,060
Health Information Technology payments (federal funds, align to actual)		-26,740
Pharmacy rebates (federal funds only)		-116,940
Other Program Changes	***$19,259***	
Health Information Exchange/Electronic Health Record Funding		$13,802
Major Information Technology Development Projects		5,469
Kidney Disease Program		1,454
State Innovation Models (federal funds)		-2,844
Other		1,378
Back of the Bill Health Insurance Reduction	**-$1,764**	
Other	**-$6,559**	
Total		**$488,927**

CRISP: Chesapeake Regional Information System for our Patients
MCHP: Maryland Children's Health Program
MCO: managed care organization
MMIS: Medicaid Management Information System II

Note: For the purpose of this chart, fee-for-service community behavioral health expenditures for Medicaid recipients are shown under the Behavioral Health Administration as opposed to Medicaid where they are budgeted. Includes fiscal 2016 deficiencies and planned reversions as well as fiscal 2017 back of the bill reductions. Fiscal 2016 and 2017 data includes funding for the Senior Prescription Drug Assistance Program, which is being transferred to the Department of Health and Mental Hygiene in fiscal 2017. Numbers may not sum to total due to rounding.

Source: Department of Legislative Services; State Budget

Department of Health and Mental Hygiene
Regular Employees
Fiscal 2015-2017

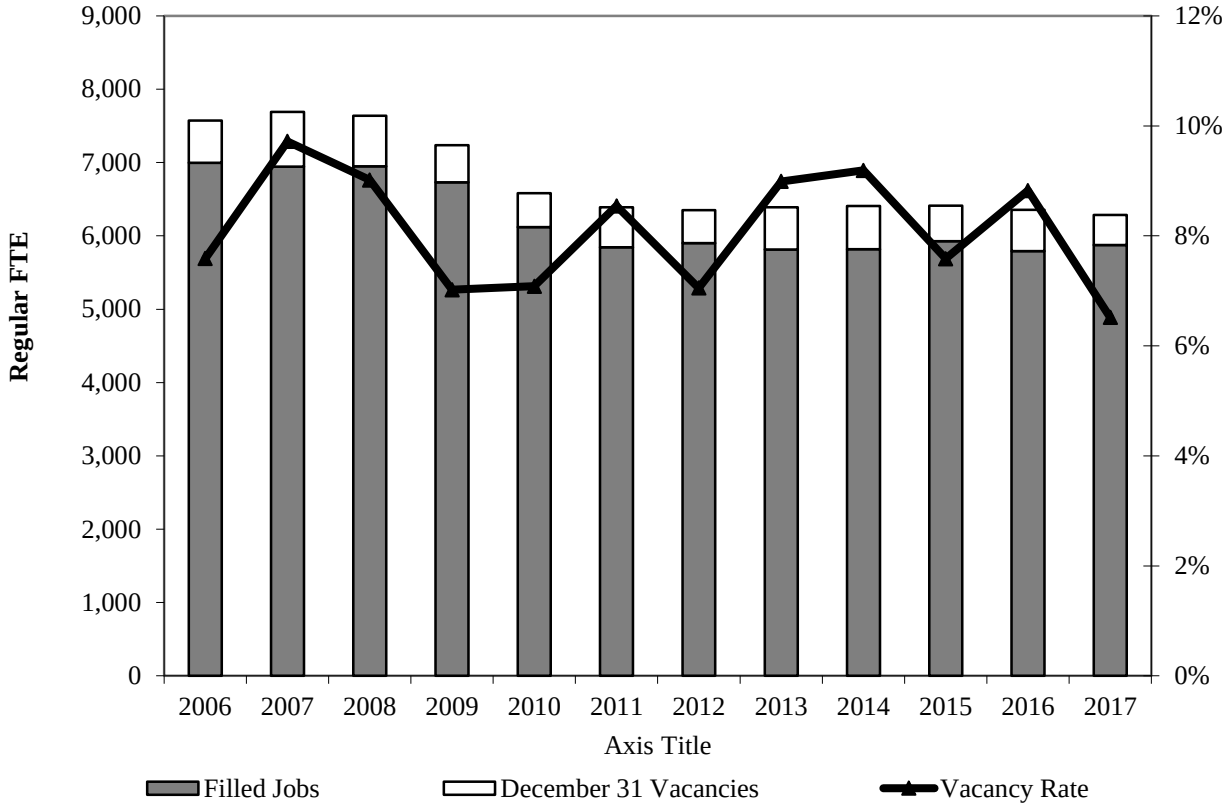
	Actual 2015	Working 2016	Allowance 2017	Change 2016-17	% Change 2016-17
DHMH Administration	**344.6**	**345.6**	**344.0**	**-1.6**	**-0.5%**
Office of Health Care Quality	**191.7**	**197.0**	**196.7**	**-0.3**	**-0.2%**
Health Occupations Boards	**268.7**	**282.7**	**279.7**	**-3.0**	**-1.1%**
Public Health Administration	**404.9**	**399.9**	**399.9**	**0.0**	**0.0%**
Prevention and Health Promotion Administration	**362.8**	**366.8**	**426.8**	**60.0**	**16.4%**
Chronic Hospitals	**511.8**	**510.8**	**495.3**	**-15.5**	**-3.0%**
Behavioral Health Administration	**2,900.9**	**2,900.6**	**2,800.9**	**-99.7**	**-3.4%**
Administration	155.4	157.9	158.9	1.0	0.6%
Institutions	2,745.5	2,742.7	2,642.0	-100.7	-3.7%
Developmental Disabilities Administration	**632.5**	**626.5**	**616.5**	**-10.0**	**-1.6%**
Administration	152.0	152.0	152.0	0.0	0.0%
Institutions	480.5	474.5	464.5	-10.0	-2.1%
Medical Care Programs Administration	**611.0**	**620.0**	**620.0**	**0.0**	**0.0%**
Health Regulatory Commissions	**102.7**	**103.7**	**103.7**	**0.0**	**0.0%**
Total Regular Positions	**6,331.6**	**6,353.6**	**6,283.5**	**-70.1**	**-1.1%**

DHMH: Department of Mental Health and Hygiene

Note: Fiscal 2015 through 2017 positions includes positions for the Senior Prescription Drug Assistance Program, which is being transferred to DHMH in fiscal 2017.

Source: State Budget

Department of Health and Mental Hygiene
Regular Employee Filled Jobs and Vacancy Rates
Fiscal 2006-2017



FTE: full-time equivalent

Note: Fiscal 2017 vacancy rate is based on budgeted turnover.

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

Department of Health and Mental Hygiene
Regular Employees – Vacancy Rates
December 31, 2015

	FTE Vacancies	FTE Positions	Vacancy Rate
DHMH Administration	37.6	345.6	10.9%
Office of Health Care Quality	6.9	197.0	3.5%
Health Occupations Boards	34.1	282.7	12.1%
Public Health Administration	36	399.9	9.0%
Prevention and Health Promotion Administration	14.8	366.8	4.0%
Chronic Hospitals	63.5	510.8	12.4%
Behavioral Health Administration	297.5	2,900.6	10.3%
Developmental Disabilities Administration	58	626.5	9.3%
Medical Care Programs Administration	0.5	620.0	0.1%
Health Regulatory Commissions	11.8	103.7	11.4%
Total Regular Positions	**560.7**	**6,353.6**	**8.8%**

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

Source: Department of Budget and Management

Department of Health and Mental Hygiene
Contractual Employees
Fiscal 2015-2017

	Actual 2015	Working 2016	Allowance 2017	Change 2016-17	% Change 2016-17
DHMH Administration	**5.77**	**7.55**	**7.56**	**0.01**	**0.1%**
Office of Health Care Quality	**8.75**	**5.50**	**5.00**	**-0.50**	**-9.1%**
Health Occupations Boards	**12.38**	**15.47**	**14.40**	**-1.07**	**-6.9%**
Public Health Administration	**11.43**	**14.10**	**14.30**	**0.20**	**1.4%**
Prevention and Health Promotion Administration	**3.96**	**6.11**	**6.12**	**0.01**	**0.2%**
Chronic Hospitals	**20.09**	**18.01**	**18.27**	**0.26**	**1.4%**
Behavioral Health Administration	**215.66**	**221.60**	**210.03**	**-11.57**	**-5.2%**
Administration	19.52	29.34	27.16	-2.18	-7.4%
Institutions	196.14	192.26	182.87	-9.39	-4.9%
Developmental Disabilities Administration	**23.84**	**25.25**	**27.94**	**2.69**	**10.7%**
Administration	3.95	8.00	10.00	2.00	25.0%
Institutions	19.89	17.25	17.94	0.69	4.0%
Medical Care Programs Administration	**82.85**	**125.92**	**125.21**	**-0.71**	**-0.6%**
Health Regulatory Commissions	**0.00**	**0.00**	**0.00**	**0.00**	**n/a**
Total Contractual Positions	**384.73**	**439.51**	**428.83**	**-10.68**	**-2.4%**

DHMH: Department of Health and Mental Hygiene

Source: Department of Budget and Management

Department of Health and Mental Hygiene
Budget Overview: Selected Caseload Measures
Fiscal 2013-2017

	Actual 2013	Actual 2014	Actual 2015	Working 2016	Allowance 2017	Change 2016-17	% Change 2016-17
Medical Programs/Medicaid							
Medicaid Enrollees	842,237	898,508	917,756	847,353	875,987	28,634	3.4%
Maryland Children's Health Program	111,132	114,648	122,955	136,980	146,031	9,051	6.6%
Affordable Care Act Medicaid Expansion		181,738	220,189	233,516	222,250	-11,266	-4.8%
Total	**953,369**	**1,194,894**	**1,260,900**	**1,217,849**	**1,244,268**	**26,419**	**2.2%**
Primary Adult Care[1]	73,464						
Developmental Disabilities Administration[2]							
Residential Services	6,040	6,107	6,209	6,445	6,502	57	0.9%
Day Services	13,353	13,810	14,133	14,638	14,937	299	2.0%
Support Services	8,011	8,259	8,306	9,141	8,931	-210	-2.3%
Total Services	**27,404**	**28,176**	**28,648**	**30,224**	**30,370**	**146**	**0.5%**
Resource Coordination	22,954	24,052	24,314	25,670	23,293	-2,377	-9.3%
Number of Individuals Served	24,445	25,183	25,315	26,705	28,205	1,500	5.6%
Average Daily Census at Institutions[3]	155	144	137	143	128	-15	-10.5%
Behavioral Health Administration							
Average Daily Populations at State-run Psychiatric Hospitals:							
Hospitals Excluding RICAs and Assisted Living	949	942	975	954	954	0	0.0%
RICAs	65	66	66	70	70	0	0.0%
Assisted Living	56	55	53	60	57	-3	-5.0%
Total	**1,070**	**1,063**	**1,094**	**1,084**	**1,081**	**-3**	**-0.3%**
Clients Receiving State-funded Community Mental Health Services	14,104	11,297	11,505	11,800	11,800	0	0.0%
Clients with Substance Abuse Served in Various Settings:	70,930	67,531	70,300	71,840	73,500	1,660	2.3%

RICA: Regional Institutions for Children and Adolescents

[1] Effective January 1, 2014, the Primary Adult Care program ended and recipients became eligible for full Medicaid benefits under the Medicaid expansion option provided in the federal Affordable Care Act.

[2] Residential services include community residential services and individual family care. Day services include activities during normal working hours such as day habilitation services, supported employment, and summer programs. Support services include individual and family support, Community Supported Living Arrangements, and self-directed services.

[3] The Developmental Disabilities Administration data includes secure evaluation and therapeutic treatment center units.

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

Issues

1. Cigarette Restitution Fund: Ongoing Litigation Has Significant Impact on Fiscal 2016 and 2017 Budget

Background

The Cigarette Restitution Fund (CRF) was established by Chapters 172 and 173 of 1999 and is supported by payments made under the Master Settlement Agreement (MSA). Through the MSA, the settling manufacturers pay the litigating parties – 46 states (Florida, Minnesota, Mississippi, and Texas had previously settled litigation), five territories, and the District of Columbia – substantial annual payments in perpetuity as well as conform to a number of restrictions on marketing to youth and the general public.

The distribution of MSA funds among the states is determined by formula, with Maryland receiving 2.26% of MSA monies, which are adjusted for inflation, volume, and prior settlements. In addition, the State collects 3.3% of monies from the Strategic Contribution Fund, distributed according to each state's contribution toward resolution of the state lawsuits against the major tobacco manufacturers.

The use of the CRF is restricted by statute. Activities funded through the CRF in fiscal 2015 include the Tobacco Use Prevention and Cessation Program; the Cancer Prevention, Education, Screening, and Treatment Program; substance abuse treatment and prevention; the Breast and Cervical Cancer Program; Medicaid; tobacco production alternatives; legal activities; and nonpublic school textbooks.

The Nonparticipating Manufacturer Adjustment

One of the conditions of the MSA was that the states take steps toward creating a more "level playing field" between participating manufacturers (PM) to the MSA (and thus subject to annual payments and other restrictions) and nonparticipating manufacturers (NPM) to the agreement. This condition is enforced through another adjustment to the states' annual payments, the NPM adjustment. The PMs have long contended that the NPMs have avoided or exploited loopholes in state laws that give them a competitive advantage in the pricing of their products. If certain conditions are met, the MSA provides a downward adjustment to the contribution made by PMs based on their MSA-defined market share loss multiplied by three. This adjustment is known as an NPM adjustment. The agreement also allows PMs to pursue this adjustment on an annual basis.

Under the MSA, PMs have to show three things in order to prevail and reduce their MSA payments:

- a demonstrable loss of market share of over approximately 2%;

- that the MSA was a significant factor contributing to that loss of market share; and

- a state was not diligently enforcing its qualifying statute.

The qualifying statute is intended to create a more level playing field with regard to the price between the PMs and the NPMs. Originally included in the MSA as a model statute, Maryland's qualifying statute was enacted in 1999 (Chapter 169), with subsequent revisions in the 2001 and 2004 sessions.

As shown in **Exhibit 1**, litigation regarding the NPM adjustment started in 2005, beginning with the NPM adjustment for sales year 2003. Arbitration regarding the "diligent enforcement" issue for 2003 commenced in July 2010. As further shown in the exhibit, Maryland was 1 of 15 states that did not settle with the PMs during the arbitration process and was 1 of 6 states that were found to not have diligently enforced its qualifying statute. Among the findings made by the arbitration panel were that Maryland lacked dedicated and trained personnel to conduct enforcement efforts and that the Comptroller's office, in particular, failed to meaningfully participate in enforcement efforts.

Exhibit 1
Nonparticipating Manufacturer Litigation Timeline

Date	Item
April 2004	PMs give notice to state attorneys general that they were pursuing an NPM adjustment with respect to a loss of market share in sales year 2003. A similar adjustment is sought for subsequent sales years. The PMs may place that portion of their annual payments they believe should be reduced under this process into an escrow account. Some PMs elect to do this, reducing the funding available to the states in any given year.
March 2006	An economic firm rules for PMs that MSA participation was a significant factor in the PMs' market share loss, which had previously been calculated by the MSA Independent Auditor. Similar rulings are made for subsequent sales years.
April 2006	Additional PMs place disputed payments related to 2003 NPM Adjustment into escrow account.
Calendar 2006-2009	Maryland (like many other states) argues that the issue of whether it diligently enforced its Qualifying Statute should be made in State courts. The PMs prevail in that the diligent enforcement issue is subject to the MSA's arbitration clause.
January 2009	Most states sign an agreement to enter into arbitration. The agreement includes a 20% refund of the liability of each joining state that is eventually determined to not have diligently enforced.
July 2010	Arbitration proceedings begin for 46 states, the District of Columbia, and various territories.
November 2011	PMs file statements of contest against all but 15 states in the arbitration.

Date	Item
March-June 2013	Twenty other states and the District of Columbia enter into a settlement agreement with the PMs – leaving 15 states, including Maryland, to proceed with arbitration.
September 2013	Six states (Indiana, Kentucky, Maryland, Missouri, New Mexico, and Pennsylvania) are determined to not have diligently enforced their qualifying statute for sales year 2003. These states not only lose payments from PMs that have been held in escrow for that sales year, but also see a reduction in their future MSA payments for the states that are found to have diligently enforced their qualifying statutes. In addition to the $16 million placed in escrow for that sales year, and after the 20% refund resulting from entering into arbitration, Maryland sees a reduction in its April 2014 MSA payment of $67 million.
November 2013	Maryland petitions the Baltimore City Circuit Court to vacate the arbitration award finding that Maryland did not diligently enforce its qualifying statute during 2003 as well as the arbitration panel's judgment reduction.
February 2014	A hearing is held in Baltimore City Circuit Court. Supplemental briefs are filed by both sides in March through May 2014.
July 2014	The Baltimore City Circuit Court denies Maryland's petitions.
August 2014	Maryland appeals the Baltimore City Circuit Court's decision to the Maryland Court of Special Appeals.
October 2015	The Court of Special Appeals finds that arbitration panel's judgement reduction was incorrect, resulting in a payment back to Maryland of approximately $40 million from the original $67 million reduction from April 2014. Meanwhile, arbitration regarding Maryland's diligent enforcement during sales year 2004 is expected to begin within calendar 2017.

MSA: Master Settlement Agreement
NPM: nonparticipating manufacturer
PM: participating manufacturer

Source: Office of the Attorney General; 2003 NPM Adjustment Arbitration Ruling, September 2013; Department of Legislative Services

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As also noted in the exhibit, Maryland not only forfeited $16 million that the PMs placed in escrow for the 2003 sales year, but under the MSA arbitration framework, also saw its fiscal 2014 payment reduced by $67 million based on the arbitration panel's assessment that those states which settled before arbitration could not be found as non-diligent. Thus, Maryland was found to be amongst a small handful of states that would have to cover the entire cost of the 2003 NPM settlement payment. In October 2015, the Maryland Court of Special Appeals determined that the arbitration panel erred in calculating Maryland's 2003 NPM adjustment liability, which could result in $50 million in relief within the fiscal 2016 budget, $40 million of which is already included in the current working appropriation for Medicaid. However, a *writ of certiorari* has been filed by the PMs with the Maryland Court of Appeals, who have yet to decide if they will now take up the decision.

Beyond the 2003 Sales Year

The NPM adjustment is in dispute for future years; thus, unless it is settled or Maryland's diligence is not contested, there will be future arbitrations assessing Maryland's enforcement for future years. It is worth noting that although the arbitration ruling found that Maryland was not diligent in enforcing its qualifying statute in the 2003 sales year, the ruling also notes that the State did take actions to position it "well for diligent enforcement in 2004." Data regarding the extent of noncompliant packs of cigarettes, NPM escrowing, and enforcement efforts support this comment not only for the 2004 sales year but also subsequent years.

Those states that did settle with the PMs realized a one-time cash windfall with the release of funds from disputed payments escrow accounts for sales years 2003 through 2012. However, under the terms of the settlement, the PMs were given credit for future payments from those states (*i.e.*, reducing the payments to those states), and those states had to enact new legislation and will be held to an enhanced standard in NPM adjustment disputes beginning in 2015.

The PMs have sought a multistate arbitration related to sales year 2004 for Maryland and those other states that did not settle the 2003 sales year litigation. Arbitration regarding Maryland's diligent enforcement during sales year 2004 is expected to begin within calendar 2017. Further, for each disputed year since 2004, an amount has been withheld and deposited into a disputed payments account. If the State were to be found to have diligently enforced the statute in subsequent years, a potential total of $120 million could be realized in revenue from the disputed payments account.

Fiscal 2015-2017 CRF Programmatic Support

Exhibit 2 provides CRF revenue and expenditure detail for fiscal 2015 to 2017.

Exhibit 2
Cigarette Restitution Fund Budget
Fiscal 2015-2017
($ in Millions)

	2015 Actual	2016 Working	2017 Allowance
Beginning Fund Balance	$9.3	$3.6	$16.3
Settlement Payments	131.2	130.8	130.8
NPM and Other Shortfalls in Payments[1]	-17.5	-17.5	-17.5
Awards from Disputed Account	0.0	0.0	0.0
Other Adjustments[2]	21.2	34.9	34.9
Tobacco Laws Enforcement Arbitration	0.0	50.0	0.0
Subtotal	***$144.2***	***$201.7***	***$164.5***

	2015 Actual	2016 Working	2017 Allowance
Prior Year Recoveries	$2.4	$1.1	$1.1
Total Available Revenue	**$146.6**	**$202.8**	**$165.6**
Health Uses			
Tobacco	$7.5	$9.7	$9.7
Cancer	18.9	25.1	25.1
Substance Abuse	21.0	21.0	21.0
Medicaid	70.7	104.4[3]	66.8
Breast and Cervical Cancer	12.0	13.2	13.2
Subtotal	***$130.2***	***$173.5***	***$135.9***
Other Uses			
Aid to Nonpublic School	5.7	6.1	11.1
Tobacco Transition Program	6.5	6.0	5.8
Attorney General	0.5	0.9	0.9
Subtotal	***$12.8***	***$13.0***	***$17.8***
Total Expenses	**$143.0**	**$186.5**	**$153.7**
Ending Fund Balance	**$3.6**	**$16.3**	**$11.9**

NPM: nonparticipating manufacturer

[1] The NPM adjustment represents the bulk of this total adjustment.
[2] Other adjustments include the strategic contribution payments and the National Arbitration Panel Award.
[3]The working appropriation includes $4 million of Cigarette Restitution Funds in Medicaid withheld for additional support for nonpublic schools. In this exhibit, that funding is assumed not to be spent and falls to balance.

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

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

The largest change for fiscal 2016 is in the revenue assumption related to the nonparticipating manufacturer litigation previously discussed. The revenue assumption related to the payback from the State's successful appeal of the prior arbitration ruling should result in a $50 million increase in revenue for fiscal 2016, which is higher than the anticipated increase of $40 million last year. However, with no significant increases in spending for fiscal 2016, other than $2 million for Synar-related tobacco

prevention activities, which is consistent with the intent of the General Assembly, these increased revenues flow through to the fund balance for fiscal 2016.

For fiscal 2017, CRF support is anticipated to remain similar to fiscal 2016, minus the one-time tobacco enforcement payment. Without that one-time funding, Medicaid expenditures decrease significantly in fiscal 2017. All other expenditures for fiscal 2017 are relatively the same as they were in fiscal 2016, with the exception of one new program receiving CRF support. The fiscal 2017 allowance contains $5 million for Student Assistance Organization Business Entity Grants. With this new funding, the projected ending fund balance for CRF at the end of fiscal 2017 is currently $11.9 million.

M00A01
Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$24,462	$24,207	$25,057	$850	3.5%
Deficiencies and Reductions	0	0	-81	-81	
Adjusted General Fund	**$24,462**	**$24,207**	**$24,976**	**$769**	**3.2%**
Special Fund	33	684	274	-410	-60.0%
Deficiencies and Reductions	0	0	0	0	
Adjusted Special Fund	**$33**	**$684**	**$274**	**-$410**	**-60.0%**
Federal Fund	15,533	16,101	16,483	381	2.4%
Deficiencies and Reductions	0	0	-8	-8	
Adjusted Federal Fund	**$15,533**	**$16,101**	**$16,474**	**$373**	**2.3%**
Reimbursable Fund	8,622	7,966	8,060	95	1.2%
Deficiencies and Reductions	0	0	0	0	
Adjusted Reimbursable Fund	**$8,622**	**$7,966**	**$8,060**	**$95**	**1.2%**
Adjusted Grand Total	**$48,650**	**$48,958**	**$49,784**	**$826**	**1.7%**

- The fiscal 2017 allowance for the Department of Health and Mental Hygiene (DHMH) Administration increases by approximately $826,000 net of back of the bill reductions, primarily due to increases in assigned costs such as the Statewide Personnel System, the Office of Administrative Hearings fee, and the new Enterprise Budget System fee.

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

For further information contact: Jordan D. More Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	344.60	345.60	344.00	-1.60
Contractual FTEs	5.77	7.55	7.56	0.01
Total Personnel	**350.37**	**353.15**	**351.56**	**-1.59**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	24.11	7.01%
Positions and Percentage Vacant as of 12/31/15	37.60	10.88%

- There is a reduction of 1.6 regular positions for DHMH Administration. Of this amount, 0.6 positions are being transferred to the Department of Information Technology, while 1.0 position is being abolished.

Analysis in Brief

Major Trends

Repeat Audit Findings Decrease: After a high mark of 30% in fiscal 2014, the percentage of repeat audit findings across the department declined to 18% in fiscal 2015.

Facility Infrastructure: While the condition of facility infrastructure systems in good/excellent condition remained the same in fiscal 2015 at 91%, the percentage of residential and program buildings meeting appropriate standards, codes, and client needs improved greatly from 40% to 54% in fiscal 2015. However, any further improvements will require significant capital spending, and last year's *Joint Chairmen's Report* requested information on how DHMH plans to address these needs. **The department should comment on the status of this report, and what plans they have to address the significant capital backlog that the DHMH-owned facilities face within the current capital budget environment.**

Workforce: The retention rate for workers within 20 key employment categories declined to a low of 84% in fiscal 2015, which is the lowest mark since fiscal 2002. This included a vacancy rate among skilled direct care workers of 21%.

Recommended Actions

1. Concur with Governor's allowance.

M00A01
Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Department of Health and Mental Hygiene (DHMH) Administration budget analysis focuses on the Office of the Secretary, which is divided into the Executive Direction and Operations functions. These offices establish policies regarding health services and supervise the administration of the health laws of the State and its subdivisions, while also providing for the main operations components of the entire department, including administrative, financial, information technology (IT), and general services (such as central warehouse management, inventory control, fleet management, space management, and management of engineering/construction projects). Other components of the Office of the Secretary include the Office of Minority Health and Health Disparities as well as special and federal fund major IT spending for the entire department excluding Medicaid.

Performance Analysis: Managing for Results

1. Repeat Audit Findings Decrease

The DHMH Administration Managing for Results (MFR) measures are administrative in nature. Selected measures are included in **Exhibit 1**. Reported MFR measures in this agency typically vary little from year to year. However, one measure that has seen significant variation is the number of repeat audit findings in audits conducted by the Office of Legislative Audits. After a steady decline to 11% in fiscal 2013, fiscal 2014 repeat findings increased to 30%, while in fiscal 2015, repeat findings declined again to 18%. The largest number of repeat findings were in the audit of DHMH Administration, which contained 3 repeat findings out of a total of 15.

2. Facility Infrastructure

In terms of facilities, as further shown in Exhibit 1, there continues to be some improvement in the condition of facility infrastructure systems and the number of residential and program buildings meeting licensing requirements, current building standards, and patient/client needs. As noted in prior analyses, new standards for patient safety goals for psychiatric hospitals established in 2008 by the Joint Commission resulted in a significant downgrading of the percentage of buildings in compliance with requirements, standards, and needs. Capital and operating funding was provided in fiscal 2010 to make some of the necessary improvements.

Exhibit 1
DHMH Administration Selected Program Measurement Data
Fiscal 2011-2015

	Actual 2011	Actual 2012	Actual 2013	Actual 2014	Actual 2015
Repeat OLA audit comments (%)	12	18	11	30	18
Condition of facility infrastructure systems (% in good/excellent condition)	89	89	89	91	91
Residential and program buildings meeting licensing standards, current building codes, and patient/client needs (%)	34	34	39	40	54
Retention rate within 20 key classifications (%)	88	88	86	88	84

DHMH: Department of Health and Mental Hygiene
OLA: Office of Legislative Audits

Note: OLA audit comments are based on the fiscal year within which the audit is published. OLA audits agencies on a three-year cycle.

Source: Department of Health and Mental Hygiene

However, as also noted in prior analyses, the department's goal for the percentage of residential and program buildings meeting licensing requirements, current building standards, and patient/client needs is still remarkably low – 65% by the end of fiscal 2017 – and will remain so until significant capital projects are completed. These projects include replacing Spring Grove Hospital Center, the renovation of the north wing at Clifton T. Perkins Hospital Center, the construction of the new Secure Evaluation and Therapeutic Treatment (SETT) Center, as well as significant improvements to buildings at the Holly Center, Potomac Center, and Western Maryland Hospital Center. However, the fiscal 2017 *Capital Improvement Program* (CIP) shows construction funding for the SETT deferred again from fiscal 2017 to 2018, while maintaining the scope of the project as a renovation of a building at Springfield Hospital Center rather than the construction of a new facility at Jessup. The CIP also includes the Clifton T. Perkins north wing renovation, but no funding is planned until fiscal 2019. There is no funding for other projects in the CIP, which begs the question on how DHMH will improve these facilities and bring them up to standard. The 2015 *Joint Chairmen's Report* requested from DHMH a plan to update these facilities and bring them up to appropriate standards. However, DHMH has yet to submit this report to the budget committees. **DHMH should comment on the status of this report, and what plans they have to address the significant capital backlog that the DHMH-owned facilities face within the current capital budget environment.**

3. Workforce

One measure of the department's ability to attract and retain a skilled workforce is the employment rate within 20 key classifications (see **Exhibit 2**). These 20 classifications are taken from over 750 classification levels used by DHMH and are considered by the department to be a representative sample of those classifications key to fulfilling the mission of the department. The employment rate is calculated by dividing the number of filled positions versus total positions on a monthly basis and then averaging for the year. This particular measure had essentially been flat since fiscal 2010 at 88%. However, fiscal 2015 is the lowest retention rate since fiscal 2002 at 84%.

Exhibit 2
DHMH MFR Retention Goal: 20 Key Classification Levels

Sanitarian IV/Environmental Sanitarian II	Direct Care Assistant II
Coordinator Special Programs Health Services/Developmental Disabilities	Community Health Nurse II
Medical Care Program Specialist II	Health Facility Surveyor Nurse I
Agency Procurement Specialist II	Registered Nurse
Office Secretary III	Computer Network Specialist II
Public Health Lab Scientist General and Lead	Fiscal Accounts Clerk II
Social Worker II, Health Services	Accountant II
Program Administrator II, Health Services	Physician Clinical Specialist
Alcohol and Drug Counselors	Physician Program Manager
Epidemiologist III	Health Policy Analyst, Advanced

DHMH: Department of Health and Mental Hygiene
MFR: Managing for Results

Source: Department of Health and Mental Hygiene

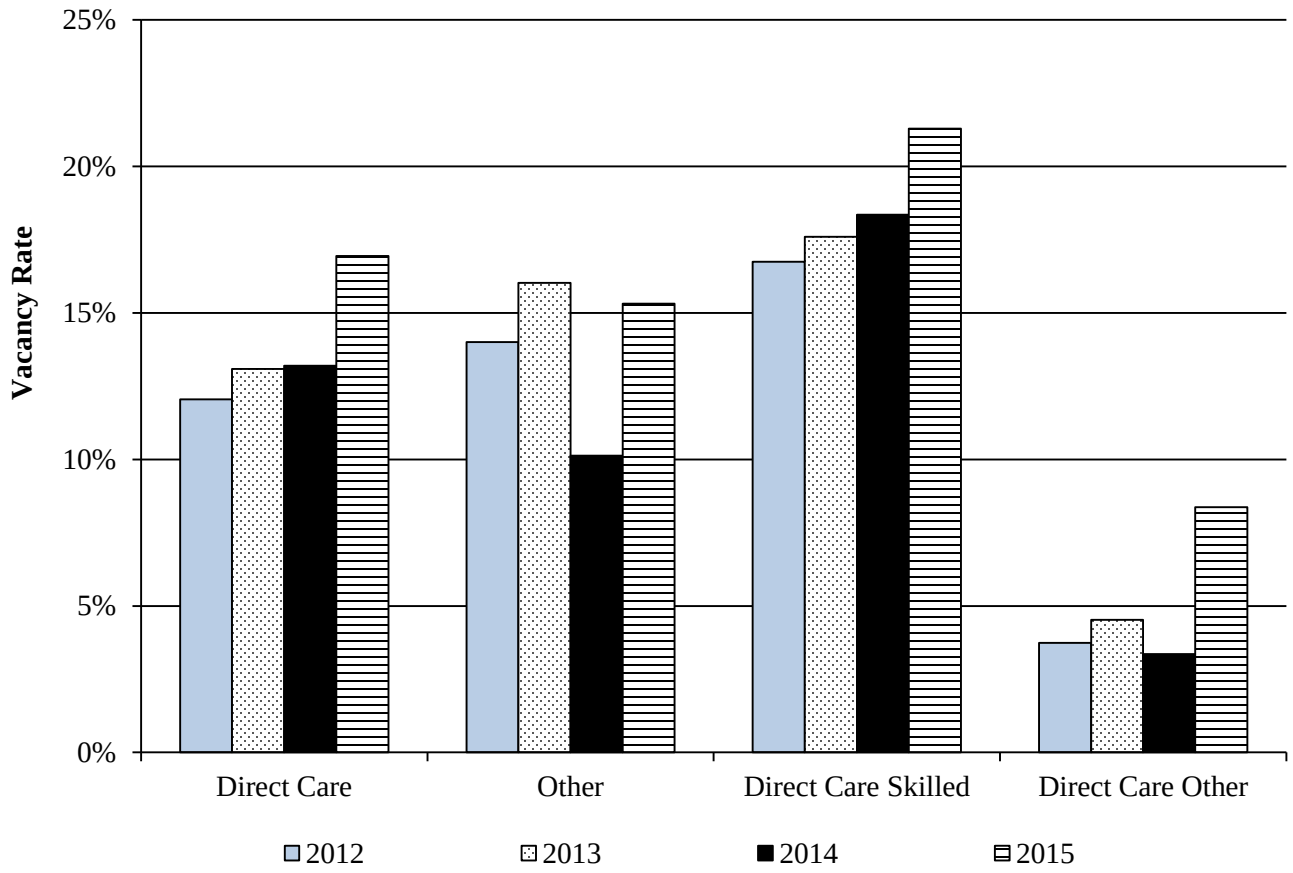
Exhibit 3 presents more detailed information from the same data and shows:

- The vacancy rate among the direct care categories has grown, from 12% to 17% between fiscal 2012 and 2015. This is despite a drop in the total number of positions in these categories from 1,336 to 1,199.

- Vacancies in nondirect care categories have remained relatively stationary, with a low of 10% in fiscal 2014, but a high of 15% in fiscal 2015.

- There continues to be a striking difference in terms of vacancy rates within the direct care category between skilled direct care workers (for example, nurses and physicians) and other direct care workers (in this instance, direct care assistants). The vacancy rate among skilled direct care workers is 21% in fiscal 2015, compared to 8% for other direct care workers. The disparity grew between fiscal 2013 and 2014, but growth in the vacancy rate in both categories for fiscal 2015 has maintained this difference. There does not appear to be any explanation for this difference other than the simple difficulty that the State has in hiring skilled direct care positions.

Exhibit 3
DHMH – 20 Key Classification Levels Vacancy Data
Fiscal 2012-2015



DHMH: Department of Health and Mental Hygiene

Source: Department of Health and Mental Hygiene

Fiscal 2016 Actions

Cost Containment

The fiscal 2016 budget contained an across-the-board general reduction for all State agencies, which resulted in a 0.6% across-the-board general fund reduction for DHMH totaling $27,215,000. Of this total amount, DHMH Administration was assigned a cost containment decrease of $723,402 in general funds. Actions undertaken to make up this cut include ending a demonstration grant through the Office of Minority Health and Health Disparities ($500,000); ending the subsidy to the Medical Marijuana Commission ($125,000); reducing the value of various IT contracts ($69,681); and reducing personnel by holding 1.0 position vacant for the year and reducing another contractual position to 50.0% ($28,721).

Proposed Budget

As shown in **Exhibit 4**, the budget for DHMH Administration grows by approximately $826,000 after back of the bill reductions. The majority of this increase is due to increases in assigned costs for the whole department.

Exhibit 4
Proposed Budget
DHMH – Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$24,462	$33	$15,533	$8,622	$48,650
Fiscal 2016 Working Appropriation	24,207	684	16,101	7,966	48,958
Fiscal 2017 Allowance	24,976	274	16,474	8,060	49,784
Fiscal 2016-2017 Amount Change	$769	-$410	$373	$95	$826
Fiscal 2016-2017 Percent Change	3.2%	-60.0%	2.3%	1.2%	1.7%

Where It Goes:

Personnel Expenses	
Employee and retiree health insurance	$492
Retirement contributions	442
Turnover adjustments	101
Abolished/transferred positions (1.6 full-time equivalent positions)	-136
Other fringe benefit adjustments	-258
Increments and other compensation	-318
Other Changes	
Statewide personnel system allocation	396
Office of Administrative Hearings fee	219
Enterprise budget system	194
Software licenses (Microsoft Office)	186
Department of Information Technology allocation fee	139
State Treasurer's Office insurance payment	109
Minority Health and Health Disparities grant	72
Contractual employee health insurance	44
Travel	-14
Office supplies	-59
Department of Budget and Management communications	-336
Board of Physicians major information technology project	-410
Other	-37
Total	**$826**

DHMH: Department of Health and Mental Hygiene

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

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. For DHMH, the amount of these reductions is $1,424,451 in general funds, $132,440 in special funds, and $251,138 in federal funds across the entire department, of which $89,000 is in DHMH Administration ($81,000 general funds, $8,000 federal funds). There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

Personnel

Personnel expenditures increase the fiscal 2017 allowance by approximately $323,000. The largest increases are for health insurance costs ($492,000) and retirement contributions ($442,000).

There are also 1.6 positions being abolished in the allowance, 1.0 position is a long-term vacancy, and 0.6 positions are transferred to the Department of Information Technology (DoIT), resulting in a decrease of approximately $136,000. Other regular earnings are the largest decrease in personnel costs ($318,000), mainly due to positions being reduced back to base salaries after being vacated.

Other Changes

Most of the other major budget changes in fiscal 2017 are fees and other payments that are assigned costs to the department. Major increases in assigned costs include the Statewide Personnel System ($396,000), the Office of Administrative Hearings fee ($219,000) and the new Enterprise Budget System fee ($194,000). There are some notable increases that are not assigned costs including $186,000 for Microsoft Office software licenses as well as $72,000 for a new grant program for the Office of Minority Health and Health Disparities. Specifically, the grant is for a local nonprofit to work with Morgan State University and the Prince George's County Health Department along with other providers, to educate newly insured individuals, improve access to primary care providers for preventative care, and reduce the use of emergency rooms for preventative care services.

The largest decrease is $410,000 due to delays in the Board of Physicians major IT project, which is budgeted within DHMH Administration (see **Appendix 2** for additional details). There is also one major decrease in assigned costs for communications paid for by the Department of Budget and Management ($336,000).

It should be noted that new funding is made available in fiscal 2017 for another major IT project, the Computerized Hospital Record and Information System, (see Appendix 2 for details). This project was proposed some years ago but never went beyond the planning phase. Fiscal 2017 funding for the project is budgeted with DoIT.

Recommended Actions

1. Concur with Governor's allowance.

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$23,802	$575	$16,081	$8,273	$48,730
Deficiency Appropriation	0	0	0	0	0
Cost Containment	-508	0	0	0	-508
Budget Amendments	1,169	0	386	736	2,291
Reversions and Cancellations	0	-542	-934	-387	-1,863
Actual Expenditures	**$24,462**	**$33**	**$15,533**	**$8,622**	**$48,650**
Fiscal 2016					
Legislative Appropriation	$23,941	$684	$16,056	$7,966	$48,647
Budget Amendments	266	0	45	0	311
Working Appropriation	**$24,207**	**$684**	**$16,101**	**$7,966**	**$48,958**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

Actual spending in fiscal 2015 for DHMH Administration was $79,895 below the legislative appropriation.

General fund spending increased by $660,660 over the legislative appropriation in fiscal 2015. Increases for general funds were provided to cover lower than expected indirect cost recovery revenue ($1,159,162), the 2015 cost-of-living adjustment (COLA) and annual salary review ($202,007), health insurance realignment ($134,497), and lower than expected employee turnover ($129,676). These increases were offset by fiscal 2015 cost containment measures ($507,838), which for DHMH Administration were mainly achieved through increased turnover as well as some contractual employment and supplies reductions. Other offsets also included a telecommunications expenditure realignment ($426,844), and a decrease in minority health grants ($30,000).

Special fund spending decreased by $541,844 from the legislative appropriation, mainly due to delays in the Board of Physicians major IT project.

Federal fund spending decreased by $547,888 from the legislative appropriation. Budget amendments added a total of $386,093, which included $312,540 for new recovery systems and software upgrades, $50,728 for the Developmental Disabilities Administration (DDA) major IT project, and $22,825 for the 2015 COLA. These increases were more than offset, however, by cancellations totaling $933,981 which were mostly due to lower than expected indirect cost recovery on federal grants throughout the department.

Reimbursable fund spending increased by $349,177 over the legislative appropriation. Budget amendments added a total of $736,167, which included $361,950 for the DDA major IT project and $81,611 for the Maryland FiRST radio project, both of which came from DoIT, as well as $276,443 from the Department of Public Safety and Correctional Services, and $16,163 from the Health Professional Boards and Commissions. These increases were partially offset by a cancellation totaling $386,990.

Fiscal 2016

To date, the working appropriation for DHMH Administration has been increased by $310,956, including $265,760 in general funds and $45,196 in federal funds. The largest increase is to offset the proposed 2% salary reduction, which increased the appropriation by $416,421 in general funds and $45,196 in federal funds. Reallocation of funds both from and to the administration budget from other parts of DHMH added $44,106 in general funds as well. However, the implementation of the cost containment strategy, which was previously discussed, resulted in a decrease of general funds totaling $194,767.

Major Information Technology Projects

Department of Health and Mental Hygiene – Administration
Maryland Board of Physicians Integrated Software System

Project Status[1]	Planning.	**New/Ongoing Project:**	New.
Project Description:	Development of a new, more fully integrated medical licensure and investigation software system to replace the board's existing system.		
Project Business Goals:	Correction of deficiencies in the board's existing software system and improvement of board's efficiency.		
Estimated Total Project Cost[1]:	$2,124,224	**Estimated Planning Project Cost[1]:**	$223,648
Project Start Date:	November 2014.	**Projected Completion Date:**	April 2017.
Schedule Status:	A project manager has been hired and system concept development and planning are underway. Fiscal 2017 funding reflects general delays in the project.		
Cost Status:	Fiscal 2017 funding included in the Department of Health and Mental Hygiene administration budget.		
Scope Status:	n/a.		
Project Management Oversight Status:	Department of Information Technology project oversight is now in place.		
Identifiable Risks:	Moderate identifiable risks are the large scale of the project and the need to familiarize staff with a new system.		
Additional Comments:	Shortcomings of the board's outdated software systems were noted in the 2011 Sunset Evaluation of the board, as well as in a report prepared by an independent consultant, pointing to the need for the replacement of the board's existing systems.		

Fiscal Year Funding ($ in Thousands)	**Prior Years**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**Balance to Complete**	**Total**
Personnel Services	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Professional and Outside Services	684.0	273.6	1,105.8	0.0	0.0	0.0	0.0	2,124.2
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$684.0**	**$273.6**	**$1,105.8**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$2,124.2**

[1] Initially, an agency submits a Project Planning Request. After the requirements analysis has been completed and a project has completed all of the planning required through Phase Four of the Systems Development Lifecycle (Requirements Analysis), including a baseline budget and schedule, the agency may submit a Project Implementation Request and begin designing and developing the project when the request is approved. For planning projects, costs are estimated through planning phases. Implementation projects are required to have total development costs.

Department of Health and Mental Hygiene – Administration
Computerized Hospital Record & Information System (CHRIS)

Project Status[1]	Planning.	**New/Ongoing Project:**	New.
Project Description:	Replacement of the current hospital management information system (HMIS) with a new commercial off-the-shelf (COTS) electronic health record (EHR) HMIS.		
Project Business Goals:	Re-design the system to accommodate new EHR technologies that foster better patient safety and patient care and reduce the potential for medical errors.		
Estimated Total Project Cost[1]:	n/a.	**Estimated Planning Project Cost[1]:**	$550,000
Project Start Date:	December 2013.	**Projected Completion Date:**	June 2017.
Schedule Status:	New funding will allow the project to get underway once again. Prior to funding cuts in prior years, a Request for Proposals had started to be developed.		
Cost Status:	Fiscal 2017 funding included in the Department of Information Technology (DoIT) budget.		
Scope Status:	n/a.		
Project Management Oversight Status:	DoIT project oversight is now in place.		
Identifiable Risks:	High risks include unknown costs and funding availability beyond fiscal 2017 as well as limited direct interdependencies, achieving user acceptance, and maintaining flexibility for the COTS system to achieve compatibility with Department of Health and Mental Hygiene requirements.		
Additional Comments:	n/a.		

Fiscal Year Funding ($ in Thousands)	**Prior Years**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**Balance to Complete**	**Total**
Personnel Services	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Professional and Outside Services	0.0	550.0	0.0	0.0	0.0	0.0	0.0	550.0
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$0.0**	**$550.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$550.0**

[1] Initially, an agency submits a Project Planning Request. After the requirements analysis has been completed and a project has completed all of the planning required through Phase Four of the Systems Development Lifecycle (Requirements Analysis), including a baseline budget and schedule, the agency may submit a Project Implementation Request and begin designing and developing the project when the request is approved. For planning projects, costs are estimated through planning phases. Implementation projects are required to have total development costs.

Object/Fund Difference Report
DHMH – Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	344.60	345.60	344.00	-1.60	-0.5%
02 Contractual	5.77	7.55	7.56	0.01	0.1%
Total Positions	**350.37**	**353.15**	**351.56**	**-1.59**	**-0.5%**
Objects					
01 Salaries and Wages	$ 30,265,020	$ 30,507,269	$ 30,919,055	$ 411,786	1.3%
02 Technical and Spec. Fees	355,311	446,229	485,653	39,424	8.8%
03 Communication	1,305,587	1,679,311	1,180,783	-498,528	-29.7%
04 Travel	139,215	136,694	122,745	-13,949	-10.2%
06 Fuel and Utilities	179,187	196,641	184,563	-12,078	-6.1%
07 Motor Vehicles	58,134	65,811	62,654	-3,157	-4.8%
08 Contractual Services	11,913,661	11,963,788	12,820,928	857,140	7.2%
09 Supplies and Materials	668,011	621,476	563,527	-57,949	-9.3%
10 Equipment – Replacement	487,718	338,030	336,639	-1,391	-0.4%
11 Equipment – Additional	261,493	280,591	315,177	34,586	12.3%
12 Grants, Subsidies, and Contributions	1,078,040	649,161	712,953	63,792	9.8%
13 Fixed Charges	1,938,680	2,072,945	2,168,855	95,910	4.6%
Total Objects	**$ 48,650,057**	**$ 48,957,946**	**$ 49,873,532**	**$ 915,586**	**1.9%**
Funds					
01 General Fund	$ 24,462,432	$ 24,206,875	$ 25,056,872	$ 849,997	3.5%
03 Special Fund	33,156	684,000	273,648	-410,352	-60.0%
05 Federal Fund	15,532,706	16,101,340	16,482,767	381,427	2.4%
09 Reimbursable Fund	8,621,763	7,965,731	8,060,245	94,514	1.2%
Total Funds	**$ 48,650,057**	**$ 48,957,946**	**$ 49,873,532**	**$ 915,586**	**1.9%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Executive Direction	$ 13,898,598	$ 14,025,193	$ 14,262,529	$ 237,336	1.7%
02 Financial Management Administration	34,007,214	34,248,753	35,337,355	1,088,602	3.2%
08 Major IT Projects	744,245	684,000	273,648	-410,352	-60.0%
Total Expenditures	**$ 48,650,057**	**$ 48,957,946**	**$ 49,873,532**	**$ 915,586**	**1.9%**
General Fund	$ 24,462,432	$ 24,206,875	$ 25,056,872	$ 849,997	3.5%
Special Fund	33,156	684,000	273,648	-410,352	-60.0%
Federal Fund	15,532,706	16,101,340	16,482,767	381,427	2.4%
Total Appropriations	**$ 40,028,294**	**$ 40,992,215**	**$ 41,813,287**	**$ 821,072**	**2.0%**
Reimbursable Fund	$ 8,621,763	$ 7,965,731	$ 8,060,245	$ 94,514	1.2%
Total Funds	**$ 48,650,057**	**$ 48,957,946**	**$ 49,873,532**	**$ 915,586**	**1.9%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

M00B0103
Office of Health Care Quality
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$13,803	$11,816	$12,575	$759	6.4%
Deficiencies and Reductions	0	0	-36	-36	
Adjusted General Fund	**$13,803**	**$11,816**	**$12,539**	**$723**	**6.1%**
Special Fund	780	343	535	193	56.3%
Adjusted Special Fund	**$780**	**$343**	**$535**	**$193**	**56.2%**
Federal Fund	6,737	7,905	7,296	-609	-7.7%
Deficiencies and Reductions	0	0	-17	-17	
Adjusted Federal Fund	**$6,737**	**$7,905**	**$7,279**	**-$626**	**-7.9%**
Adjusted Grand Total	**$21,319**	**$20,064**	**$20,353**	**$289**	**1.4%**

- After adjusting for a back of the bill reduction to health insurance, the Governor's fiscal 2017 allowance increases by $289,000, or 1.4%, over the fiscal 2016 working appropriation, primarily due to personnel costs.

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

For further information contact: Lindsey B. Holthaus Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	191.70	196.70	196.70	0.00
Contractual FTEs	8.75	5.50	5.00	-0.50
Total Personnel	**200.45**	**202.20**	**201.70**	**-0.50**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions		13.85	7.04%
Positions and Percentage Vacant as of 12/31/15		40.90	20.76%

- The fiscal 2017 allowance includes 0.5 fewer contractual full-time equivalents in the Developmental Disabilities Unit.

- As of December 31, 2015, there were 40.9 vacant positions, a large increase from 22.4 vacant positions in the prior year. The agency expects to fill 16.0 positions in March 2016.

Analysis in Brief

Major Trends

Staffing Deficits and Increased Workload Limit the Agency's Efficacy: The Office of Health Care Quality (OHCQ) has faced chronic staffing shortages over the past few years due to the combination of an increased workload, a structural deficiency in positions allotted for survey and inspection activities, and chronic vacancies among surveyor positions. In fiscal 2015, the agency continued to fall short of its Managing for Results performance measures.

Recommended Actions

1. Concur with Governor's allowance.

Issues

Staffing Deficits and Federal Fund Attainment: Chronic vacancies in the agency's fiscal department have impinged upon the agency's ability to submit timely federal fund claims, resulting in the loss of federal funds. Additionally, the agency risks the loss of federal funds from its inability to meet federal statutory mandates.

Updates

Impact of Chapter 41 of 2015 on Staffing Concerns: A bill passed in the 2015 session modifies the frequency at which OHCQ must conduct surveys (or external reviews) of (1) freestanding ambulatory care facilities; (2) freestanding birthing centers; (3) home health agencies; (4) health maintenance organizations; and (5) nursing homes. This bill could address staffing concerns.

OHCQ Fee Reductions: On September 15, 2015, the Governor announced a plan to reduce a number of fees across State government. A number of fee reductions in OHCQ were part of that plan.

M00B0103
Office of Health Care Quality
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Office of Health Care Quality (OHCQ) is the agency within the Department of Health and Mental Hygiene (DHMH) mandated by State and federal law to determine compliance with the quality of care and life standards for a variety of health care services and programs. Facilities and services are reviewed on a regular basis for compliance with the *Code of Maryland Regulations* (COMAR), as well as for compliance with federal regulations in those facilities participating in Medicare and Medicaid. The types of facilities licensed and regulated by OHCQ include nursing homes, hospitals, ambulatory surgical centers, endoscopic centers, birthing centers, home health agencies, health maintenance organizations (HMO), hospice care, physical therapy centers, developmental disability homes and facilities, mental health facilities, substance abuse treatment facilities, and forensic laboratories.

Performance Analysis: Managing for Results

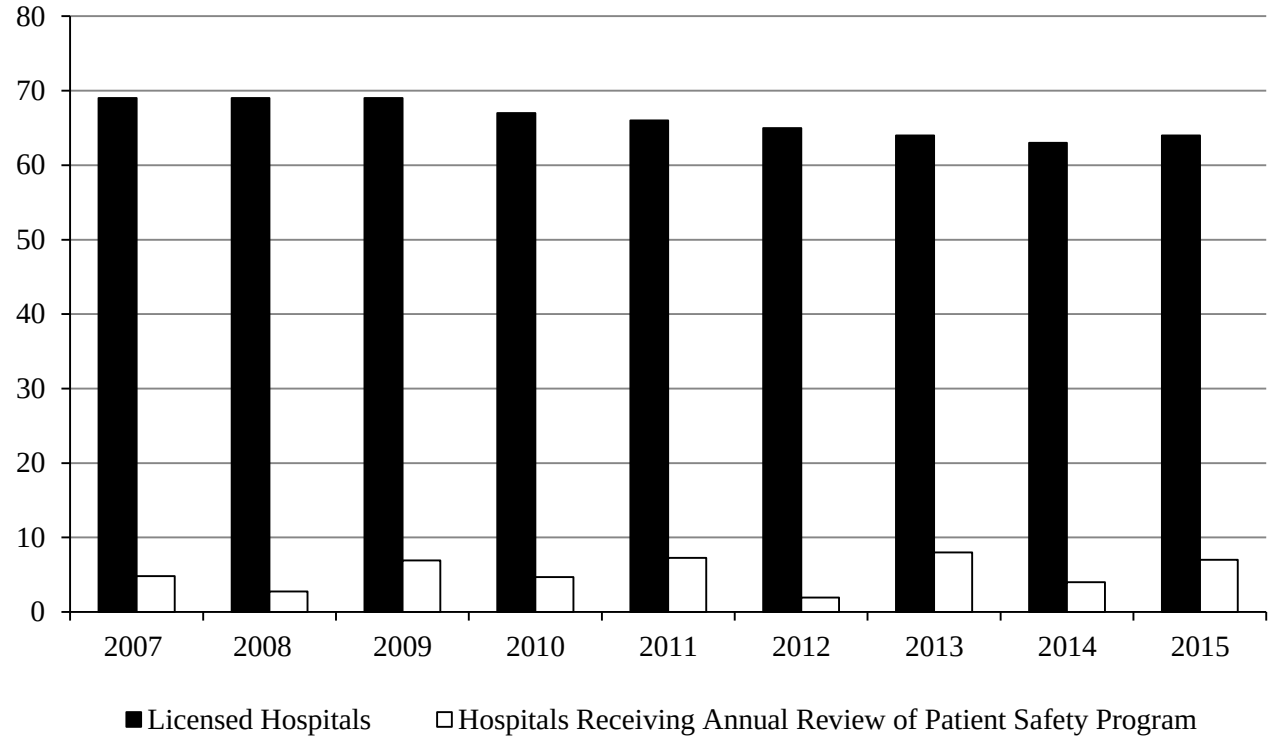
1. Staffing Deficits and Increased Workload Limit the Agency's Efficacy

Hospitals and Patient Safety

OHCQ protects the safety of consumers through a survey and enforcement process of a variety of health-related entities. It also protects the public and ensures the health of Marylanders through the timely resolution of consumer complaints. However, staffing deficiencies have hampered the agency's ability to meet its Managing for Results (MFR) performance measures.

In fiscal 2004, OHCQ assumed responsibility for the implementation of the Maryland Patient Safety Program (part of the Hospital and HMO Quality Assurance units at OHCQ), which requires hospitals to establish an internal patient safety program that tracks adverse events and near misses. OHCQ has struggled to meet its MFR goal and has consistently reviewed fewer than 10 of more than 60 programs. As shown in **Exhibit 1**, the agency reviewed 7 programs in fiscal 2015, up from 4 in fiscal 2014. Staff resources continue to be limited; the program was formerly budgeted for 2 nurse surveyors to conduct onsite surveys of patient safety review programs but is currently budgeted for only 1 surveyor. The agency notes that conducting annual reviews of hospital patient safety programs in a certain percentage of all licensed hospitals is not mandated by statutes or regulations.

Exhibit 1
Licensed Hospitals and Annual Review of Patient Safety Program
Fiscal 2007-2015



Source: Department of Health and Mental Hygiene

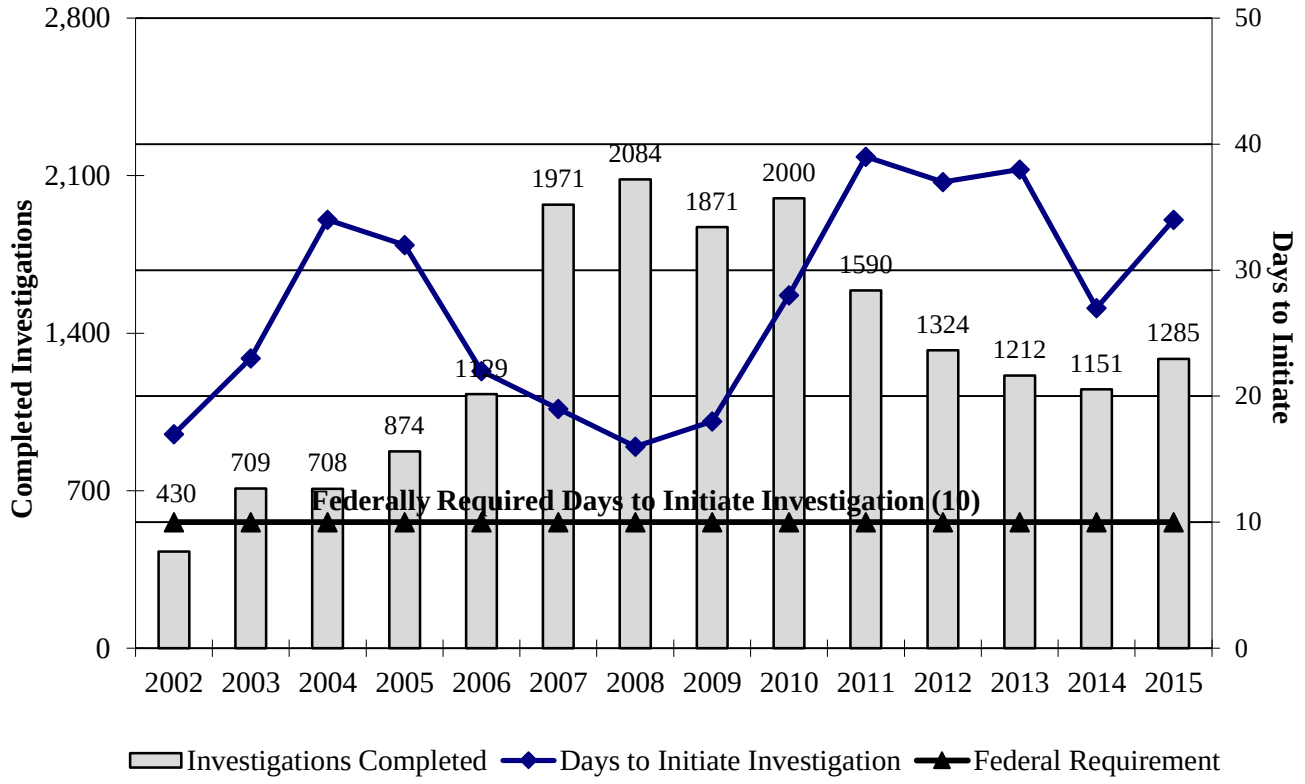
Hospitals are required to report to OHCQ Level 1 adverse events, including events that result in death or serious disability, retained foreign bodies after a surgery, or wrong-side/wrong-person surgery. For each adverse event, hospitals submit a root cause analysis (RCA) that is reviewed by OHCQ and logged into a database. Despite struggling to reach its patient safety program review goals consistently, OHCQ has consistently managed to conduct timely RCA reviews.

Nursing Homes

Federal and State regulations require the investigation of complaints and incidents (as reported by facilities, consumers, or advocates) alleging actual harm. The OHCQ Long Term Care Unit evaluates, monitors, licenses, and certifies all nursing homes in the State. One of the performance goals of OHCQ is to minimize delays in handling complaint investigations in nursing homes. Specifically, the MFR goal is to initiate investigations of complaints alleging actual harm within 10 working days of receipt of the complaint (consistent with requirements set forth in federal regulations for Medicare and Medicaid). **Exhibit 2** shows the number of complaint investigations, alleging actual harm,

completed by OHCQ annually, as well as the average number of days for OHCQ to initiate an investigation.

Exhibit 2
Nursing Home Complaint Investigations
Fiscal 2002-2015



Source: Department of Health and Mental Hygiene

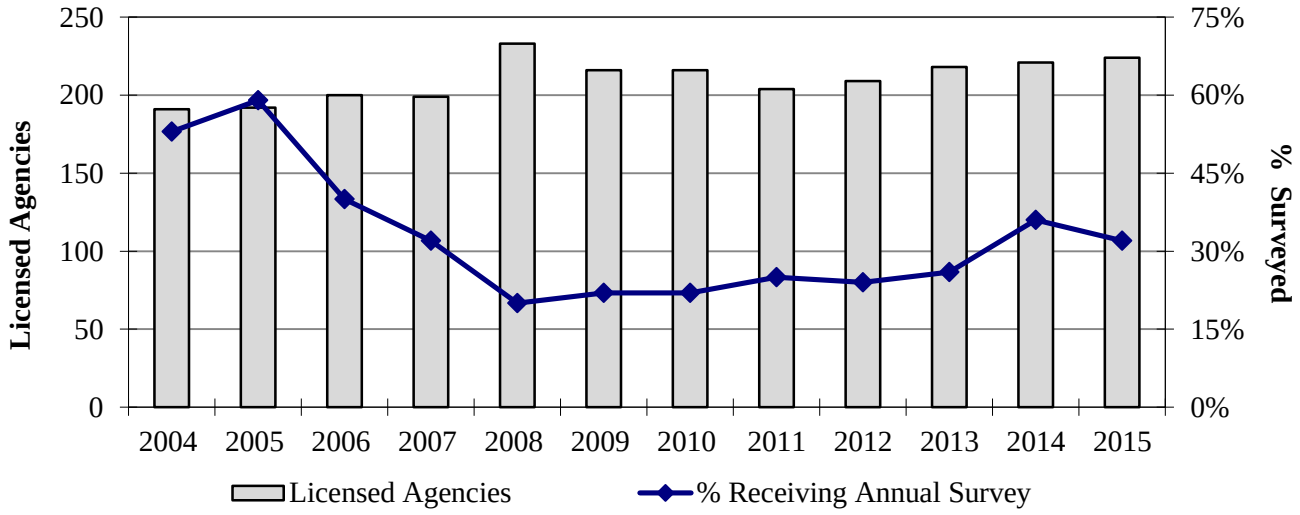
As Exhibit 2 demonstrates, OHCQ had made progress toward reaching its goal of initiating onsite investigations within 10 days from fiscal 2004 through 2008. However, the average number of days to initiate an investigation subsequently increased from 16 days in fiscal 2008 to 39 days in fiscal 2011 (a 144% increase) and remained relatively constant until a significant improvement in fiscal 2014. However, this decrease is at least partly attributable to a drop in total complaint investigations. The agency notes that Maryland adopted the federal Quality Indicator Survey (QIS) process in nursing homes beginning in fiscal 2010 with the full implementation in fiscal 2011. This QIS process increases the amount of time to complete each annual and complaint survey. In fiscal 2015, the number of days to initiate an investigation (34) was more consistent with higher levels from fiscal 2013. OHCQ attributed this increase to staffing delays from a hiring freeze. Limited staff resources continue to not only prevent the agency from reaching its goal but also put the State out of

compliance with federal performance standards. It is important to note that it is difficult to assess the agency's ability to meet mandates at its current staffing level when the vacancy rate remains high.

Developmental Disabilities Facilities

The OHCQ Developmental Disabilities Unit (DDU) evaluates, monitors, and recommends licensure for all community residential, day habilitation, vocational, and support services provided for individuals receiving funding through the Developmental Disabilities Administration (DDA). In fiscal 2015, there were over 200 agencies operating in more than 3,100 sites throughout the State. The unit's goal is to provide timely and comprehensive relicensure surveys for agencies providing services to developmentally disabled individuals, as required by COMAR. **Exhibit 3** shows the total number of licensed agencies and the percentage of those receiving an annual survey. All new sites are required to have an initial survey prior to operation.

Exhibit 3
Survey of Developmental Disabilities Agencies
Fiscal 2004-2015



Source: Department of Health and Mental Hygiene

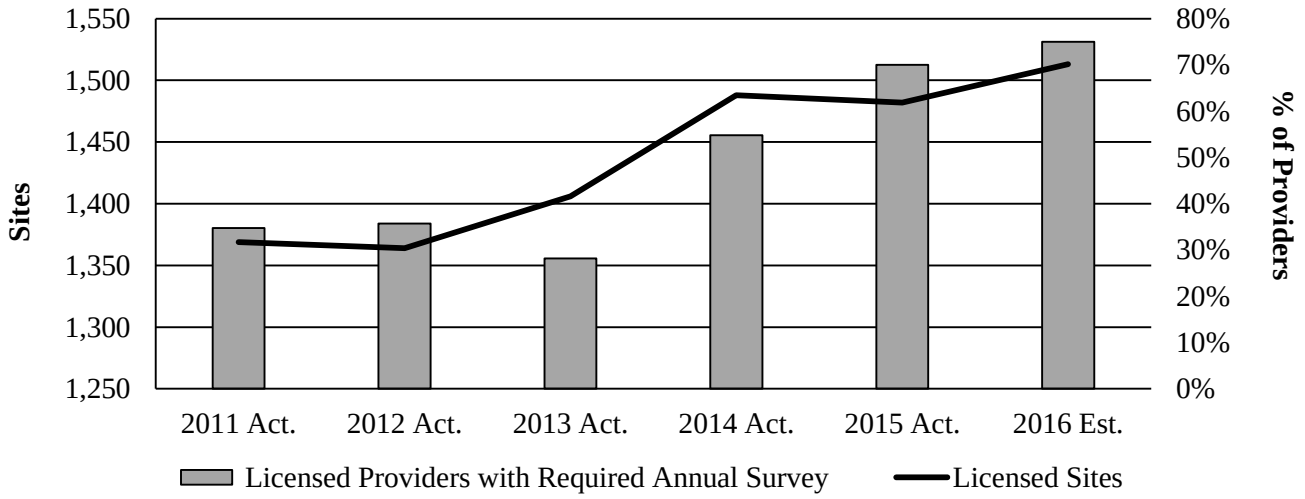
The percentage receiving annual surveys declined sharply between fiscal 2005 and 2008. Specifically, OHCQ conducted as many as 59% of relicensure surveys in fiscal 2005 but only 20% in fiscal 2008. The agency's DDU has struggled to meet its MFR goal and had previously reduced the goal from 27% to 25% of required annual relicensure surveys. After failing to meet even this reduced goal in fiscal 2012 (during which only 24% of annual relicensure surveys were completed), the agency completed 26% of annual relicensure surveys to meet its goal in fiscal 2013.

In fiscal 2015, the agency completed 32% of annual relicensure surveys, fewer than fiscal 2014 and falling short of its revised goal (45%). OHCQ advises that it has implemented a targeted survey process that has increased the number of surveys completed. However, challenges continue to face the unit. The growing number of individuals receiving DDA-funded support and the corresponding increase in the total number of agencies serving these individuals has placed a greater burden on OHCQ. The closing of State Residential Centers (and subsequent relocation of most individuals into community placements) has also contributed to the increase in community providers (as well as the increase in sites operated by those providers). There was a deficiency appropriation for fiscal 2015 to fund 5 new positions to support DDU. However, the unit continues to face vacancies among current administrative, managerial, and investigator positions. Furthermore, it must be noted that, while the agency's current goal is to complete 45% of annual relicensure surveys, it should ultimately be the agency's goal to complete 100% of annual relicensure surveys, consistent with its statutory mandate.

Assisted Living Facilities

The OHCQ Assisted Living Unit (ALU) surveys all assisted living providers in the State. The unit's goal is to provide timely and comprehensive initial and annual renewal surveys of assisted living sites for the protection of individuals receiving services from assisted living providers. In fiscal 2015, there were 1,482 licensed sites. **Exhibit 4** shows the number of licensed sites in the State receiving initial and renewal surveys. In 2015, ALU completed 70% of licensed provider surveys falling short of its 80% goal.

Exhibit 4
Licensed Assisted Living Sites Surveyed
Fiscal 2011-2016 Est.



Source: Department of Health and Mental Hygiene

Fiscal 2016 Actions

Cost Containment

In 2016, DHMH received a 0.6% across-the-board general fund reduction totaling $27.2 million. The agency's proportion of this reduction was allocated in other areas within DHMH as OHCQ cannot fulfill its mission with its existing resources.

Proposed Budget

As shown in **Exhibit 5**, after adjusting for deficiencies and contingent reductions, the fiscal 2017 allowance for OHCQ is $289,000 (1.4%) over the fiscal 2016 working appropriation. This increase is due primarily to personnel costs. Special funds increase by $193,000 due to an increase in grants to fund studies that benefit nursing home residents. Federal funds decrease by $626,000 primarily due to salaries and wages in the long-term care unit.

Exhibit 5
Proposed Budget
DHMH – Office of Health Care Quality
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Total
Fiscal 2015 Actual	$13,803	$780	$6,737	$21,319
Fiscal 2016 Working Appropriation	11,816	343	7,905	20,064
Fiscal 2017 Allowance	12,539	535	7,279	20,353
Fiscal 2016-2017 Amount Change	$723	$193	-$626	$289
Fiscal 2016-2017 Percent Change	6.1%	56.2%	-7.9%	1.4%

Where It Goes:

Personnel Expenses

Employee and retiree health insurance	$326
State retirement contribution	251
Turnover adjustment	225
Reclassifications	99
Unemployment and workers' compensation	-26
Social Security contributions	-53
Regular earnings and accrued leave	-611

Where It Goes:	
Operating Expenses	
Grant to fund studies to benefit nursing home residents (special funds)	200
Payments to Montgomery County for surveyors	35
Contractual health insurance	33
Reduction in laboratory and library supplies	-9
Special payments payroll	-18
Reduction in information technology (IT) software, contractual repairs, and maintenance	-19
Computer lease reduction	-40
Reduction in car purchases	-43
Rent reductions (mostly IT and administration)	-60
Total	**$289**

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

Personnel Expenses

Personnel expenses rise in the fiscal 2017 budget by $211,000 and represent the majority of budgetary change in the agency. Regular earnings, reclassifications, and accrued leave payout reduces the budget by $512,000. Regular earnings decreased as employees in the long-term care unit retired and new employees were hired at lower pay grades. In addition, workers' compensation and Social Security contributions collectively reduce the budget by $79,000. These decreases are offset by a budget increase of $326,000 for employee and retiree health insurance and $251,000 for employee retirement.

In addition, turnover relief increases the budget by $225,000. The agency's fiscal 2017 vacancy rate of 7.04% approximates the agency's three-year average. However, turnover is currently 20.76% and even with the estimated regular position increase in March 2016, the vacancy rate will be 12.6%, so the agency will have more than enough vacancies to meet turnover.

Operating Expenses

Grants to fund studies that benefit nursing home residents increase the budget by $200,000 in special funds from an increase in civil money penalties. Additionally, the grant provided to Montgomery County surveyors increases for fiscal 2017 due to a step increase for Montgomery County employees. Contractual health insurance increases the budget by an additional $33,000 as several of the office's contractual employees took advantage of State subsidized health insurance coverage offered beginning January 1, 2015.

These increases were offset by a $60,000 reduction in rent as OHCQ reduced the number of files needing storage by archiving or relocating them, reducing rent at Spring Grove Hospital Center.

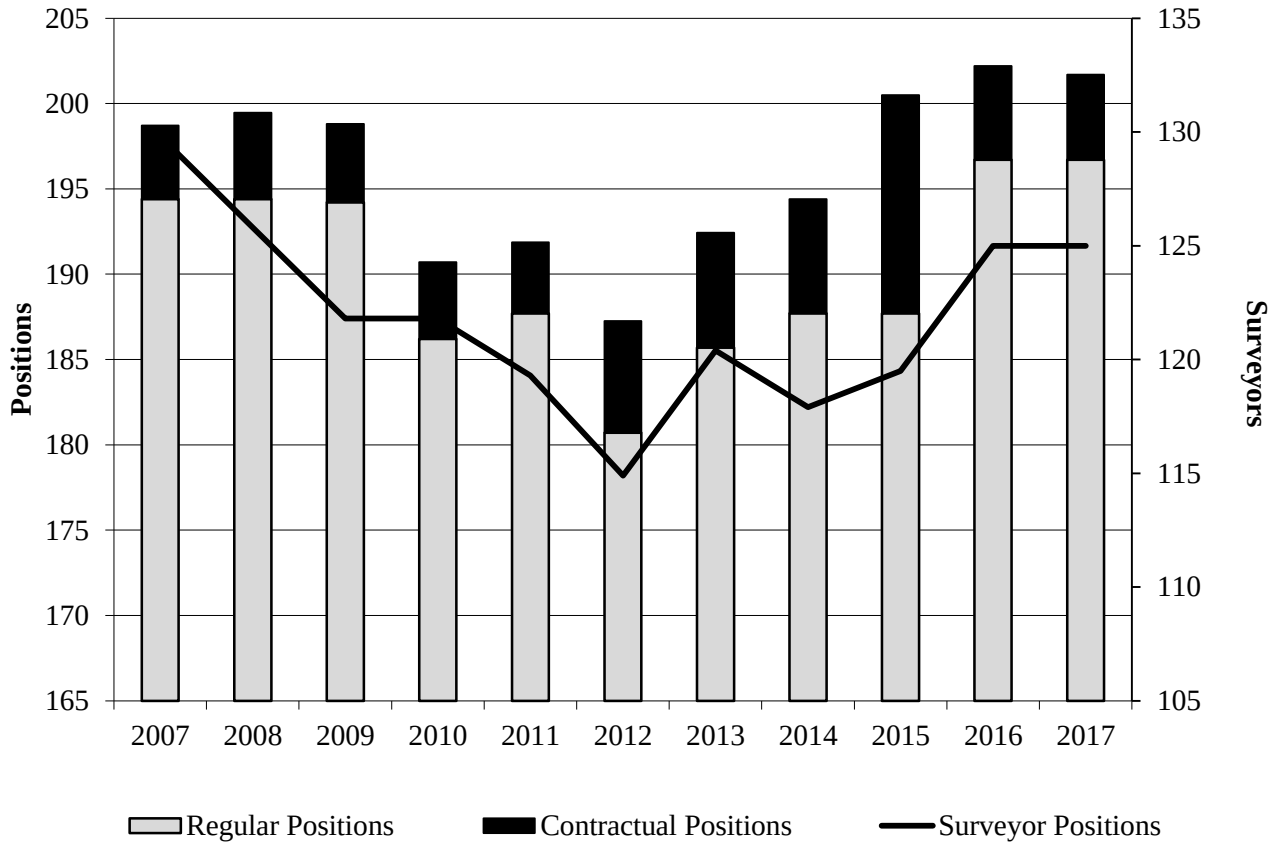
The number of cars purchased in fiscal 2017 decreased, reducing the budget by $43,000. Additional decreases include $8,000 for reductions in information technology software, a $40,000 reduction for computer leases, $11,000 for contractual repairs and maintenance and, $18,000 for a reduction in contractual employees.

Issues

1. Staffing Deficits and Federal Fund Attainment

As demonstrated in **Exhibit 6**, OHCQ staffing levels have fluctuated slightly in recent years but decreased overall by 4.6 total positions between fiscal 2007 and 2014, during which period the agency continuously struggled to meet its statutory mandates. However, total positions increased to 202.2 in fiscal 2016 due to multiple contractual conversions (196.7 + 5.5 contractual), their highest point in the period shown. The fiscal 2017 budget includes 0.5 fewer full-time equivalent positions.

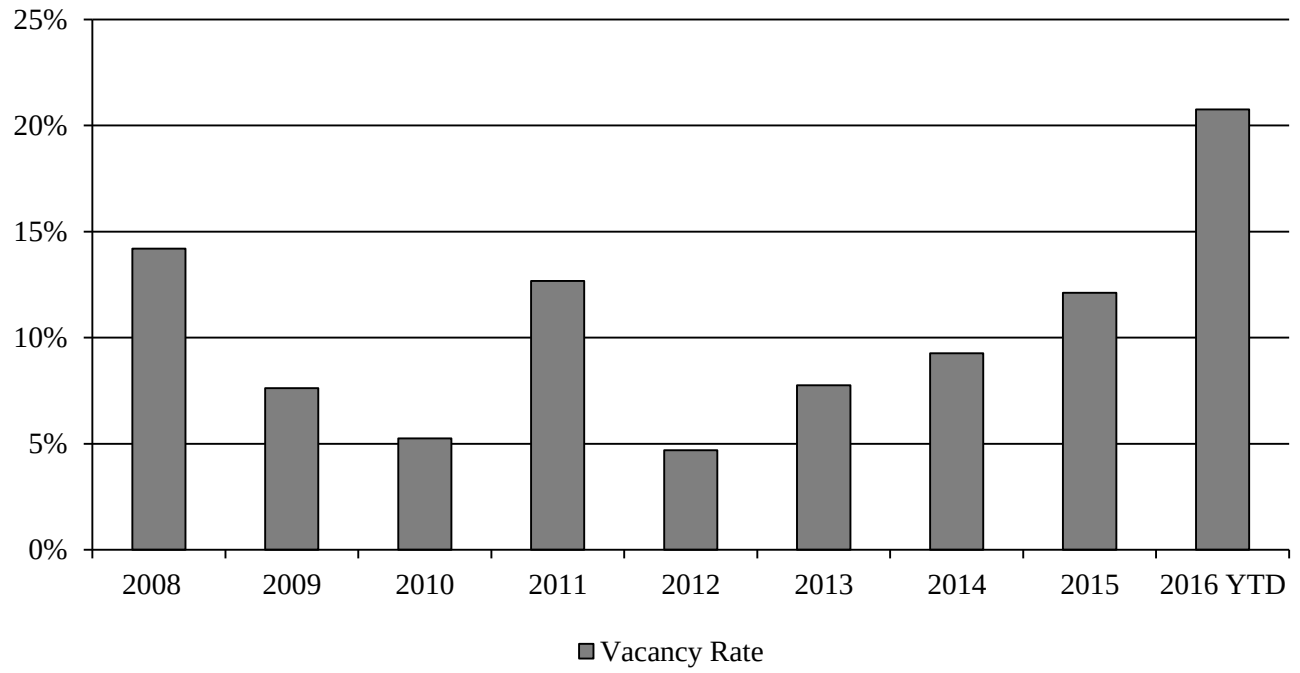
Exhibit 6
Staffing Levels in the Office of Health Care Quality
Fiscal 2007-2017



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

After reaching historically low staffing levels in fiscal 2012, the fiscal 2013 budget included 5 new nurse surveyor positions to help address longstanding budgetary constraints, low employee retention rates, a loss of positions through an earlier Voluntary Separation Program, and an influx of new providers in community-based programs (including residential service agencies, assisted living providers, and homes for individuals with developmental disabilities). However, the agency's vacancy rate also rose during that period – and continues to rise. As demonstrated in **Exhibit 7**, the OHCQ vacancy rate – which has generally fluctuated in recent years – increased from 4.7% at the beginning of calendar 2012 to 12.21% for fiscal 2015. The agency attributes the vacancy rate to several senior management and nonsurveyor professional positions that it hopes to fill during fiscal 2016. However, the fiscal 2016 year-to-date vacancy rate is 20.76%. In addition to high vacancy rates, the agency advises that 51.0 % of employees will be up for retirement in five years. It is probably the case that a significant number of employees of OHCQ could earn higher salaries elsewhere but remain because of looming retirement. Once this cohort retires, retention may become more difficult. **The agency should comment on how it intends to recruit staff after half of the workforce retires.**

Exhibit 7
Vacancy Rates in the Office of Health Care Quality
Calendar 2008-2016 Year-to-date



YTD: year-to-date

Note: Graph reflects vacancy rates at the beginning of each calendar year.

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

OHCQ Staffing Issues Impact Agency Performance

As discussed in the Performance Analysis section of this document, inability of OHCQ to meet its statutory mandates has been felt across its various units – including notably, in DDU, which evaluates, monitors, and recommends licensure for all community, residential, day habilitation, vocational, and support services provided for individuals receiving funding through DDA. In fiscal 2015, more than 200 such agencies operated over 3,100 sites throughout the State. As indicated in the Performance Analysis section of this document, the agency completed 32% of annual relicensure surveys for these facilities, less than fiscal 2014 and again falling short of its goal (45%).

As noted in more detail in Update 1, Chapter 41 of 2015 reduced the level of certain inspections and survey activities, but OHCQ indicates it will do little to improve its staffing situation. The agency's own analysis reveals a deficiency of 52.15 surveyor positions in fiscal 2016. While this is an improvement from fiscal 2013 when the deficit was 107, it is still significant. **The Department of Legislative Services recommends that the agency include in its annual statutory report for each program (1) the federal and statutory mandate; (2) if the program met the federal and statutory mandate; and (3) the resulting loss of overall federal funds if the program is not meeting federal mandates.**

OHCQ Staffing Issues Also Impact Fiscal Operations

While much attention has been given to the difficulty that OHCQ has had in meeting required inspection levels, staffing issues have also impacted its fiscal operations. Although the agency has struggled to meet its federal statutory mandates, it has continued to receive payments from the Centers for Medicare and Medicaid Services, which uses its own discretion in determining whether to allow full payments when mandates have been unmet by OHCQ. However, in fiscal 2014 federal funds were reduced by $17,000 for OHCQ not having met performance measures. Additionally, OHCQ had become multiple quarters behind in federal claims, risking the loss of indirect costs associated with timely claims. DHMH attributes this to both turnover and payroll not being automated, of which DHMH has attempted to correct. As of December 2015, the OHCQ fiscal unit was also severely understaffed with no accountants or fiscal officers. Previously, OHCQ had 3 positions, director of administration, fiscal officer, and advanced accountant. OHCQ has been without both a fiscal officer and director of administration since May 2015 and without an accountant since November 2015. As a result, OHCQ had no staff to process federal claims. A chief accountant started on January 20, 2016, although the agency is still short on finance staff. **The agency should comment on its plans to fully staff the finance unit and maintain timely federal claims.**

Recommended Actions

1. Concur with Governor's allowance.

Updates

1. Impact of Chapter 41 of 2015 on Staffing Concerns

Health-General 19-308 (b) (4) requires DHMH to submit a report on the inspection of health care facilities in the State. Accordingly, OHCQ publishes the *Annual Report and Staffing Analysis* annually to report on the activities of each licensure unit. The report includes a labor-hour analysis that compares the number of surveyors assigned to each unit with the number of surveyors needed to perform all of the inspections and surveys required. Based on an analysis of the number of surveyors needed to perform all of the agency's mandated inspections and surveys, the projected surveyor staffing deficit for fiscal 2016 is 52.15. As shown in **Exhibit 8**, this deficit, while significant, reflected a significant improvement over fiscal 2013, when the deficit was 107.1. The agency advises that the staffing deficit does not assume turnover, and while the number of surveyors has increased, the number of administrators for program support has not increased.

Exhibit 8
Surveyor Staffing Deficits
Fiscal 2005-2016

Year	Staffing Deficit
2005	55.42
2006	70.98
2007	67.10
2008	67.20
2009	83.10
2010	91.90
2011	92.32
2012	95.63
2013	107.09
2014	67.90
2015	52.50
2016	52.15

Source: Department of Health and Mental Hygiene

In addition to implementing programmatic changes to address OHCQ staffing deficit, Chapter 41 of 2015 may lessen the OHCQ burden with respect to mandated inspection and survey activities. Among other changes, the bill requires that (1) nursing homes be surveyed once, rather than

twice, annually; and (2) home health agencies be inspected on a triennial, rather than annual, basis. However, OHCQ advises that these changes will not improve its staffing deficit as it never completed a second survey of nursing homes and never completed annual surveys of the home health agencies.

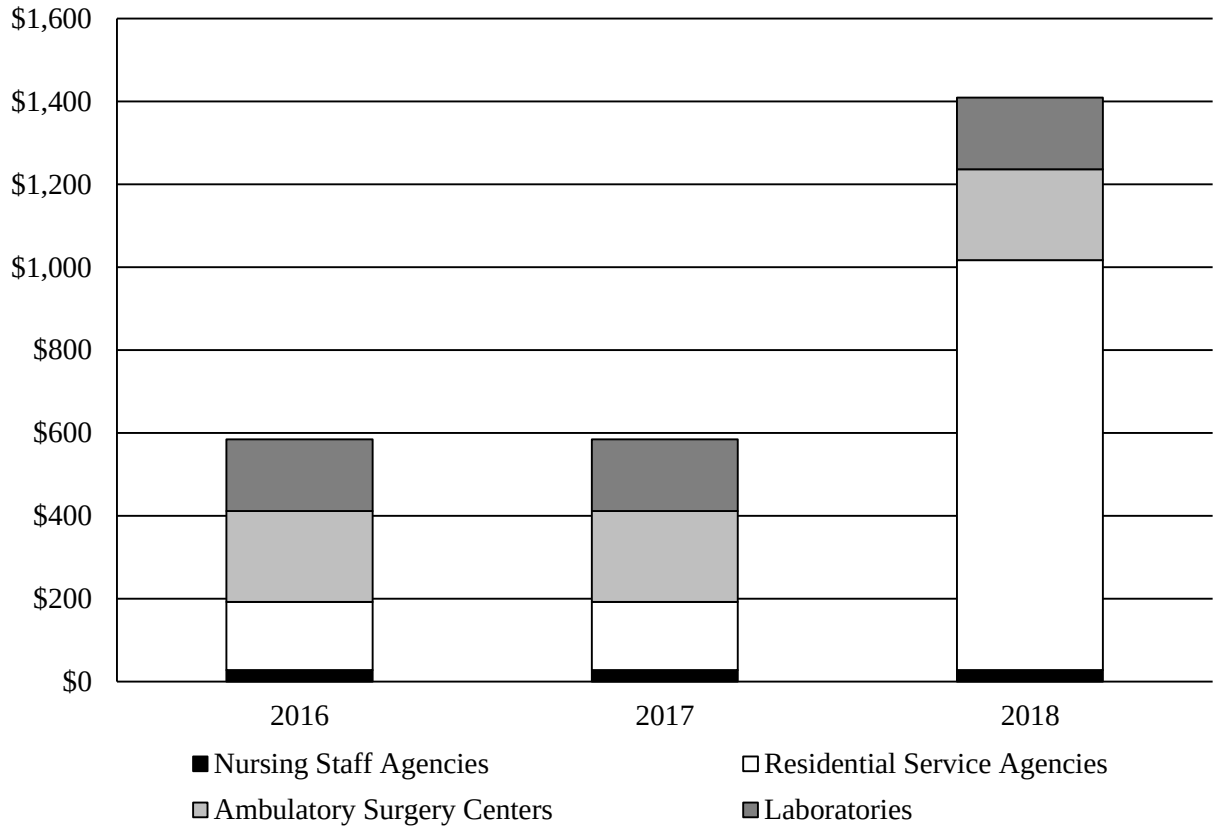
2. OHCQ Fee Reductions

On September 15, 2015, the Governor announced a plan to reduce a number of fees across State government. A number of regulations for fee reduction in OHCQ were part of that plan, including:

- nursing staff agencies;
- adult medical day care facilities (visit fee);
- residential service agencies (license);
- ambulatory surgery centers (initial license and renewal license); and
- letter of exceptions/labs (initial and renewal).

In total, the regulated fee reductions would reduce general fund revenue by $584,883 in fiscal 2016 and 2017 and $1.4 million in fiscal 2018, as shown in **Exhibit 9**. The fee reductions do not impact the ability of OHCQ to license and survey staff agencies as the fees do not directly fund the agency.

Exhibit 9
Fee Reduction Fiscal Impact Estimates
Fiscal 2016-2018
($ in Thousands)



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

Nursing Staff Agencies

If a health care staff agency is to be licensed by OHCQ, it is required to submit certain information to the agency when seeking licensure and is required to pay to OHCQ a renewal fee that is set by OHCQ. The regulation reduces the annual license fee for health care staff agencies from $150 to $100. Before this reduction, the most recent change included an increase from $25 to $150 in December 2007. The department advises that there are 545 active health care staff agencies in Maryland; thus, general fund revenues decrease by an estimated $27,250 annually.

Adult Medical Day Care Facilities

The regulation eliminates the fee of $100 per site visit that is imposed on adult medical day care programs when more than two site visits are required before issuance of a license due to significant regulatory violations. The department advises that the fee is rarely charged, with assessments totaling between $100 and $300 annually for the past several years. Thus, general fund revenues decrease negligibly ($200) due to the elimination of the fee beginning in fiscal 2016.

Residential Service Agencies

The regulation reduces the initial and renewal licensure fees for residential service agencies from $2,100 to $1,000 for a three-year licensure period (a reduction of $1,100 for each residential service agency, equating to $366.66 on an annualized basis). Approximately 1,200 residential service agencies operate in Maryland at any time, and about 150 new applications for licensure (the midpoint between 120 and 180 new applications) are received annually, reflecting significant turnover. Through fiscal 2014, the licensure period for residential service agencies was one year. However, effective July 1, 2014, the licensure period was extended to three years, with a commensurate change in the licensure fee from $700 annually to $2,100 triennially. Thus, a majority of residential service agencies have already transitioned to a triennial licensure period, with their renewal not due until fiscal 2018 or 2019. Accordingly, general fund revenues decline by approximately $165,000 in fiscal 2016 and 2017, due to reduced licensure fees paid by about 150 new residential service agencies each year. Beginning in fiscal 2018, general fund revenues decrease by approximately $990,000, representing the remaining 75% of licensees renewing and accounting for replacement of some of them due to continued attrition. The impact over the three-year licensure period totals $1,320,000.

Ambulatory Surgery Centers

The regulation reduces the initial and renewal licensure fees for freestanding ambulatory surgical facilities from $3,000 to $1,000 for a three-year licensure period. The department advises that as there are 329 freestanding ambulatory surgical facilities in Maryland, general fund revenues decline by a total of $658,000 over each triennial licensure period, or approximately $219,333 annually beginning in fiscal 2016. The estimate assumes a full year of implementation in fiscal 2016. The most recent change before this regulation was in August 2013 and increased the initial and renewal licensure fees from $700, to $3,000.

Laboratories: Medical Laboratories

The department advises that general fund revenues decrease by approximately $173,000 annually. This estimate reflects the decrease in the biennial fee for a letter of exception for a physician from $200 to $100 for an office laboratory or a point-of-care laboratory for limited testing for rare diseases. The fee reduction affects approximately 3,642 providers. Renewals are processed on a rolling basis and approximately one-half are processed every year. Thus, there should be a relatively consistent annual fiscal impact. The most recent change before this regulation was in August 2013 and increased the fee from $100 to $200.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Office of Health Care Quality
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$11,271	$343	$7,266	$0	$18,881
Deficiency Appropriation	90	0	30	0	120
Cost Containment	-284	0	0	0	-284
Budget Amendments	2,725	446	51	0	3,222
Reversions and Cancellations	0	-9	-610	0	-619
Actual Expenditures	**$13,803**	**$780**	**$6,737**	**$0**	**$21,319**
Fiscal 2016					
Legislative Appropriation	$11,390	$342	$7,307	$0	$19,040
Budget Amendments	426	1	598	0	1,024
Working Appropriation	**$11,816**	**$343**	**$7,905**	**$0**	**$20,064**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

The budget for OHCQ closed at $21.3 million, $2.4 million above the original legislative appropriation.

A Board of Public Works cost containment reduced general funds by $283,856. The agency reduced salaries and fringe benefits for this amount. A deficiency appropriation added $119,648 ($89,737 in general funds and $29,911 in federal funds) to fund 5 new positions to support DDU.

Budget amendments increased the budget by an additional $3.2 million, including $2.7 million in general funds. The budget increased by $138,000 ($86,583 in general funds, $50,808 in federal funds, and $289 in special funds) relating to the fiscal 2015 cost-of-living adjustment approved during the 2014 session but not included in the fiscal 2015 allowance. General funds were increased by $10,662 to realign health insurance costs within DHMH and an additional $104,330 to cover salaries and contractual services. General funds increase by $2.5 million to cover the cost of salaries and contractual services amassed from fiscal 2012 to 2014 that had been charged to federal funds but for which no federal funds would be claimed. Special funds (available from Civil Money Penalty Fees) increased by $427,755 to issue grants to benefit nursing home residents and assisted living residents. Special funds (available from the Health Services Cost Review Commission in uncompensated care) increased by an additional $17,755 to issue a grant to Towson University for emergency preparedness conference for nursing home and assisted living administrators.

At the end of the year, approximately $609,602 of the federal fund appropriation was canceled due to budgeting for an over attainment of federal funds. An additional $9,087 in special funds were canceled due to a contract with Towson University that was fully budgeted for in fiscal 2015, but funds will instead be spent in fiscal 2016.

Fiscal 2016

To date, the fiscal 2016 legislative appropriation for OHCQ has been increased by $1.02 million ($425,774 in general funds, $597,776 in federal funds, and $617 in special funds). Of this amount, $181,461 in general funds, $99,529 in federal funds and $617 in special funds relates to the restoration of the 2% salary reduction. Federal funds increase by $498, 237 (provided by a federal State Survey Grant) to cover salary and fringe benefits. General funds increase by $244,313 to realign the 2% fiscal 2016 cost containment with the agency's containment plan.

Object/Fund Difference Report
DHMH – Office of Health Care Quality

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	191.70	197.00	196.70	-0.30	-0.2%
02 Contractual	8.75	5.50	5.00	-0.50	-9.1%
Total Positions	**200.45**	**202.50**	**201.70**	**-0.80**	**-0.4%**
Objects					
01 Salaries and Wages	$ 17,024,323	$ 17,378,977	$ 17,642,578	$ 263,601	1.5%
02 Technical and Spec. Fees	383,873	223,659	238,201	14,542	6.5%
03 Communication	58,942	65,426	63,462	-1,964	-3.0%
04 Travel	315,999	341,651	337,727	-3,924	-1.1%
07 Motor Vehicles	127,743	181,325	131,304	-50,021	-27.6%
08 Contractual Services	2,183,857	1,069,047	1,050,735	-18,312	-1.7%
09 Supplies and Materials	53,573	62,505	53,582	-8,923	-14.3%
10 Equipment – Replacement	25,786	10,066	9,390	-676	-6.7%
11 Equipment – Additional	34,423	5,159	4,364	-795	-15.4%
12 Grants, Subsidies, and Contributions	744,750	300,000	500,000	200,000	66.7%
13 Fixed Charges	366,214	425,861	374,345	-51,516	-12.1%
Total Objects	**$ 21,319,483**	**$ 20,063,676**	**$ 20,405,688**	**$ 342,012**	**1.7%**
Funds					
01 General Fund	$ 13,802,605	$ 11,816,198	$ 12,574,769	$ 758,571	6.4%
03 Special Fund	780,172	342,532	535,294	192,762	56.3%
05 Federal Fund	6,736,706	7,904,946	7,295,625	-609,321	-7.7%
Total Funds	**$ 21,319,483**	**$ 20,063,676**	**$ 20,405,688**	**$ 342,012**	**1.7%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

M00B0104
Health Professional Boards and Commissions
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$391	$476	$492	$16	3.4%
Deficiencies and Reductions	0	0	-1	-1	
Adjusted General Fund	**$391**	**$476**	**$491**	**$15**	**3.2%**
Special Fund	29,702	36,241	37,129	888	2.4%
Deficiencies and Reductions	0	0	-79	-79	
Adjusted Special Fund	**$29,702**	**$36,241**	**$37,050**	**$808**	**2.2%**
Reimbursable Fund	467	539	539	0	
Deficiencies and Reductions	0	0	0	0	
Adjusted Reimbursable Fund	**$467**	**$539**	**$539**	**$0**	**0.0%**
Adjusted Grand Total	**$30,560**	**$37,256**	**$38,079**	**$824**	**2.2%**

- After adjusting for a back of the bill increase in health insurance, the Governor's proposed allowance for the boards increases by approximately $824,000 (2.2%) over the fiscal 2016 working appropriation. The majority of the increase ($833,000) is for personnel-related expenses.

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

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Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	268.70	282.70	279.70	-3.00
Contractual FTEs	12.38	15.47	14.40	-1.07
Total Personnel	**281.08**	**298.17**	**294.10**	**-4.07**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions		15.36	5.49%
Positions and Percentage Vacant as of 12/31/15		34.10	12.06%

- The fiscal 2017 allowance includes a decrease of 3.0 regular positions. Of these, 2.0 positions are being transferred from the Board of Nursing to the Department of Information Technology, while 1.0 position is being abolished within the Board of Dental Examiners.

- The decrease of 1.07 contractual full-time equivalents (FTE) is a combination of a 2.16 FTE decrease across numerous boards combined with an increase of 1.09 FTE for the Board of Physicians.

Analysis in Brief

Major Trends

Most Boards Are Able to Meet Processing Goals for Licensees: In fiscal 2015, all but three of the boards met their goals for processing licenses in a timely manner. The total number of licenses issued in fiscal 2015 range from 92,877 by the Board of Nursing to 10 by the Board of Residential Child Care Program Professionals.

Complaint Processing: In fiscal 2015, four of the boards were unable to process complaints according to their respective target timeframes. Three of these boards (Pharmacy, Dental Examiners, and Social Work) were also unable to process complaints within their respective timeframes in fiscal 2014.

Issues

Sunset Evaluation for the State Board of Environmental Health Specialists: During the 2015 interim, the Department of Legislative Services (DLS) completed a full sunset evaluation of the State Board of Environmental Health Specialists (BEHS). DLS recommends that statute should be amended to repeal BEHS and the requirement for a State license. Instead, statute should require individuals practicing the duties of an environmental health specialist in the State to obtain and maintain a Registered Environmental Health Specialist/Registered Sanitarian credential issued by the National Environmental Health Association.

Recommended Actions

		Funds
1.	Reduce funding for grants within the Medical Cannabis Commission.	$ 500,000
	Total Reductions	**$ 500,000**

Updates

Report on Health Board Fund Balances: The 2015 *Joint Chairmen's Report* requested the Department of Health and Mental Hygiene and the boards to perform an individual financial analysis on the current fee structure and to submit a report on how current licensing fee levels, for each health professional board and commission, relate to the corresponding expenditures and fund balances. This report was submitted on December 2, 2015.

M00B0104
Health Professional Boards and Commissions
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

Within the Department of Health and Mental Hygiene (DHMH), there are 21 boards (including two commissions) that regulate health professionals. These boards license and certify health professionals, resolve consumer complaints, and assist in establishing parameters for each profession through regulation.

In general, each board has the following goals to:

- protect the public by ensuring that practicing health professionals are properly credentialed and licensed to provide high-quality services to the citizens of Maryland; and

- receive, investigate, and resolve complaints in a timely manner.

Performance Analysis: Managing for Results

1. Most Boards Are Able to Meet Processing Goals for Licensees

The first goal of the boards is to protect the public by ensuring that licensees are properly credentialed. Each board has different procedures for issuing initial and renewal licenses. Some renew every two years, while others stagger renewals so that they are completed at a continual pace throughout the year. **Exhibit 1** shows the number of initial and renewal licenses processed by each board in fiscal 2014 and 2015. The total number of licenses issued in fiscal 2015 range from 92,877 by the Board of Nursing to 10 by the Board of Residential Child Care Program Professionals.

The boards generally aim to process 100% of new licenses within 10 days of receipt of a complete application. Similarly, the boards aim to process 100% of licensure renewals within 5 days. All but three of the boards met their respective targets in fiscal 2015 for issuing licenses in a timely manner. Both the Board of Morticians and Board of Pharmacy fell just short of their goal for issuing licenses within a timely manner, issuing 98% and 94%, respectively. Similarly, the Board of Physicians missed its goal of completing 95% of initial licenses within 10 days for allied health applications (90%), but it did meet the same goal for physician applications.

Exhibit 1
Number of Licenses Processed
Fiscal 2014-2015

Board/Commission	2014	2015
Nurses*	91,467	92,877
Physicians*	21,271	30,023
Pharmacy*	13,088	10,902
Social Work*	6,447	6,058
Dental Examiners*	4,619	4,750
Chiropractic and Massage Therapy Examiners*	1,475	4,572
Physical Therapy Examiners*	4,026	4,122
Occupational Therapists	3,907	4,103
Professional Counselors and Therapists*	2,635	3,904
AUD/HAD/SLP*	4,166	2,544
Pyschologists*	1,547	1,436
Morticians*	557	1,339
Dietetic Practice*	829	914
Acupuncture*	513	524
Podiatric	488	490
Environmental Health Specialists	21	479
Optometry*	564	420
Nursing Home Administrators	253	274
Kidney Disease	123	127
Residential Child Care Program Professionals	104	10

AUD/HAD/SLP: Audiology, Hearing Aid Dispensers, Speech-Language Pathologists

*Boards with a biennial renewal cycle. Allied health practitioners licensed by the Board of Physicians are also on a biennial renewal cycle.

Source: Department of Health and Mental Hygeine

2. Complaint Processing

The other primary goal of the boards is to protect the public and promote the delivery of quality health care by receiving and resolving complaints lodged against licensees in a timely manner. Of the 21 boards, 4 were unable to process complaints within their respective timeframes, as shown in

Exhibit 2. The chart shows the total number of complaints, the goals that the boards have for timely complaint resolution, and the percentage of complaints that were processed according to their goals. Three of these boards (Pharmacy, Dental, and Social Work) fell short in the processing of complaints last year as well, while the drop for the Board of Nursing marks a sharp decline from fiscal 2014 when 90% of complaints were resolved within the respective timeframe.

Exhibit 2
Complaints Not Processed in a Timely Manner
Fiscal 2015

Board/Commission	Complaints Investigated	Goal	2015
Nursing	2,629	90% in 270 days	79%
Pharmacy	323	100% in 180 days	90%
Dental	274	100% in 180 days	99%
Social Work	63	100% in 180 days	95%

Source: Department of Health and Mental Hygeine

Fiscal 2016 Actions

Cost Containment

The fiscal 2016 budget contained an across-the-board general reduction for all State agencies, which resulted in a 0.6% across-the-board general fund reduction for DHMH totaling $27,215,000. Of this total amount, the Board of Nursing Home Administrators and the Board of Residential Child Care Program Professionals were assigned a cost containment decrease of $5,786 and $4,214 in general funds, respectively. The reduction for the Board of Nursing Home Administrators included an out-of-state conference, office supplies, and other operating costs while the reduction for the Board of Residential Child Care Program Professionals included office equipment, supplies, and required the board to shift software maintenance costs into fiscal 2017.

Additionally, on September 15, 2015, the Administration proposed numerous fee reductions through regulations. Of these reductions, one fee within the boards was reduced, which is the Examination Equivalency Review fee by the Board of Acupuncture. This fee was reduced, from $500 to $250. However, this fee reduction is estimated to have no impact upon the board's special fund because this service is rarely used.

Proposed Budget

As shown in **Exhibit 3**, the fiscal 2017 allowance increases by approximately $824,000 (2.2%) over the fiscal 2016 working appropriation net of back of the bill reductions. Special funds make up the majority of the increase ($808,000) since the boards (except for the State Board of Examiners of Nursing Home Administrators and the State Board of Residential Child Care Program Professionals) are almost completely funded with special funds.

Exhibit 3
Proposed Budget
DHMH – Health Professional Boards and Commissions
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$391	$29,702	$467	$30,560
Fiscal 2016 Working Appropriation	476	36,241	539	37,256
Fiscal 2017 Allowance	491	37,050	539	38,079
Fiscal 2016-2017 Amount Change	$15	$808	$0	$824
Fiscal 2016-2017 Percent Change	3.2%	2.2%		2.2%

Where It Goes:

Personnel Expenses	
Employee and retiree health insurance	$430
Retirement contributions	416
Regular earnings and other compensation	336
Social Security and other fringe benefit adjustments	9
Turnover adjustments	-83
Abolished/transferred positions (3.0 FTE)	-276
Board of Physicians	
Criminal background check rap back services	344
Contractual health insurance	11
Travel	6
Contractual positions	-63
Board of Nursing	
Contractual positions	111
Per diems	65
Investigator training conference	27
Printing costs	-45
Telecommunications	-111
Imaging software upgrades	-494

Where It Goes:	
Other Changes	
Board of Pharmacy new licensing system	568
Medical Cannabis Commission grants	500
Board of Pharmacy law books	106
Contractual health insurance	44
Travel expenses	43
Board of Dental Examiners technical fees	36
Other	31
Contractual positions	-107
Board of Dental Examiners new licensing system	-319
Medical Cannabis Commission one-time expenses	-762
Total	**$824**

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

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. For DHMH the amount of these reductions is $1,424,451 in general funds, $132,440 in special funds, and $251,138 in federal funds across the entire department, of which $80,189 is in the Health Professional Boards and Commissions ($1,104 general funds, $79,085 special funds). There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

Personnel

Personnel expenditures increase by approximately $833,000 net of the back of the bill reduction. Consistent with other State agencies, the largest changes are for employee and retiree health insurance ($430,000) and retirement contributions ($416,000). There is also a large increase in regular earnings and other compensation ($336,000), mainly due to salary enhancements at two of the boards. The Natalie M. LaPrade Medical Cannabis Commission budget includes approximately $175,000 for salary reclassifications, mostly due to the fact that positions hired within the last year were hired above the base salary for that position. The Board of Physicians budget also includes salary increases totaling $133,000, mainly due to promotions and other increases in compensation.

However, these increases are partially offset by the transfer of 2 positions from the Board of Nursing to the Department of Information Technology (DoIT) as well as the abolition of 1 position from the Board of Dental Examiners. Both the position transfers and abolition are due to the

consolidation plan being executed by DoIT. These actions decrease the allowance for the boards by approximately $276,000.

Board of Physicians

Major nonpersonnel changes within the Board of Physicians include an increase of $344,000 for rap back services as part of the new criminal history records checks that are required by statute. Rap back services provide notification to the board if additional information is reported, concerning an individual, after the initial criminal history records check. The largest decrease is for contractual positions, at $63,000. While the full-time equivalent (FTE) count for the board increases by 1.09, the current working appropriation is funded for a total of 6.30 FTEs while only accounting for 4.41 FTEs. The fiscal 2017 FTE count is 5.50, which is below the amount funded in fiscal 2016 but above the official FTE count.

Not contained within this budget, but worth noting, is the Board of Physicians integrated software system, which is a major information technology project contained within the DHMH – Administration budget. In prior years, the expectation was that the project would be completed in fiscal 2017. However, due to delays in hiring a project manager, the project has been delayed once again. A project manager was hired in June 2015, and a formal Request for Proposals is being prepared. Given these developments, the project now appears to be on pace to be completed in fiscal 2018. Funding for fiscal 2017 is at $274,000 to continue planning, with the majority of the funding, $1.1 million, planned for fiscal 2018 when the project will be completed. More information on this project can be found in **Appendix 2**.

Board of Nursing

The largest increase in the Board of Nursing is for additional contractual positions, at $111,000. Again, this is due to a funding level in the working appropriation that is different than the actual FTE count within the board. While the FTE count is 3.0 in both the working appropriation and the allowance, the working appropriation is only funded for 1.0 FTE. Thus, the increase in funds support an additional 2.0 FTEs.

There are also some large decreases within the Board of Nursing, including $494,000 in lower software costs that were for upgrades in fiscal 2016 as well as $111,000 in lower telecommunications costs.

Other Changes

There are numerous large increases and decreases across the other health professional boards and commissions. The largest increase is for a new licensing system for the Board of Pharmacy, at $568,000. Other large increases include $500,000 in new grants to be distributed by the Medical Cannabis Commission as well as $106,000 for law books for new licensees at the Board of Pharmacy. However, these increases are offset by the expiration of other one-time spending from fiscal 2016

including a new licensing system for the Board of Dental Examiners ($319,000), and the start-up costs associated with the first year of operations for the Medical Cannabis Commission ($762,000).

There is also a decrease in contractual position costs of approximately $107,000 due to a decrease of 2.16 FTEs. These positions come from the Board of Examiners of Professional Counselors, the Board of Chiropractic and Massage Therapy Examiners, and the Board of Physical Therapy Examiners. However, there is an expectation that these positions will be restored at a later time.

Issues

1. Sunset Evaluation for the State Board of Environmental Health Specialists

The State Board of Environmental Health Specialists (BEHS) underwent a full sunset evaluation in the 2015 interim. The Department of Legislative Services (DLS) recommends that statute should be amended to repeal BEHS and the requirement for a State license. Instead, statute should require individuals practicing the duties of an environmental health specialist in the State to obtain and maintain a Registered Environmental Health Specialist/Registered Sanitarian (REHS/RS) credential, issued by the National Environmental Health Association (NEHA).

Report Summary

DLS found that, while BEHS generally complies with its statutory mandate and credentialing of environmental health specialists continues to be appropriate to protect public health, a State-administered licensing program is no longer necessary. Furthermore, while the board adequately fulfills its licensing role, the need for the board's enforcement role remains nominal, and the board continues to face serious administrative challenges despite a shift from the Department of the Environment to DHMH. As such, it does not appear that licensees are realizing additional benefits beyond the basic licensing services provided by the board.

This is even more apparent when the current licensing procedure is compared to the process of obtaining the REHS/RS credential issued by NEHA. This credential is recognized throughout the country and is already held by many Maryland environmental health specialists. The education and training standards required to obtain the NEHA REHS/RS credential are similar to the current stringent requirements to obtain a State license, and although the initial cost of obtaining the REHS/RS credential is higher than the cost of obtaining a State license under current law, NEHA offers more online services and discounts for members on study and resource materials. This, along with other benefits including reciprocity credentialing of current State licensees and other streamlined benefits of NEHA membership, makes required credentialing for environmental health specialists an appropriate alternative.

Other DLS recommendations regarding the repeal of BEHS in lieu of requiring environmental health specialists to obtain the REHS/RS credential include that:

- statute should be amended to apply the current list of statutory exemptions to licensure to the requirement that environmental health specialists obtain and maintain a NEHA REHS/RS credential;

- all currently issued and valid State licenses held on termination of the board remain in effect until their printed expiration date;

- DHMH should work with NEHA to secure a window of opportunity to allow individuals who hold a State license to obtain the appropriate credential; and

- statute be amended to continue to allow for a training period to provide time for any individuals joining the field and working towards the credential to complete that task.

Should the General Assembly decide to maintain BEHS, DLS also made additional recommendations including that continuing education unit regulations be improved, the website be overhauled, more useful education tools be provided, and the termination date be extended by 10 years while enhancing the board's annual reporting requirement to incorporate its plans to increase special fund revenues and improve the continuing education process.

In conducting the evaluation, DLS sent out surveys to both the members of the Maryland Conference of Local Environmental Health Directors and to the environmental health specialists and specialists-in-training that are regulated by the board. DLS received responses from the health departments in 21 counties, 311 of the total 528 licensed specialists, and 19 of the 84 specialists-in-training.

Legislation has been introduced this session (SB 200 and HB 497) that would implement the DLS recommendations.

Recommended Actions

		Amount Reduction	
1.	Reduce funding for grants within the Medical Cannabis Commission. These grants were requested in order to leverage additional research funds. However, the availability of these matching funds is in doubt, making this funding no longer necessary for the operation of the commission.	$ 500,000	SF
	Total Special Fund Reductions	**$ 500,000**	

Updates

1. Report on Health Board Fund Balances

Based on concerns about various fee levels and their relation to the fund balances of each of the boards, the 2015 *Joint Chairmen's Report* requested DHMH and the boards to perform an individual financial analysis on the current fee structure and to submit a report on how current licensing fee levels for each health professional board and commission relate to the corresponding expenditures and fund balances. DHMH submitted this report on December 2, 2015.

In the report, DHMH reiterates that each of the boards has a recommended fund balance level target between 20% and 30%. These levels are necessary since unexpected expenditures, such as legal expenses, can severely limit the ability of the boards to function since, by law, no other State money is available to the boards in the case of an emergency or unanticipated expense. Based on these recommended levels, boards undertake three- to five-year projections of expected revenues and expenditures and try to maintain a fund balance of around that level throughout the projection. DHMH further reports that when fund balances drop below the target, boards are directed to first reduce expenditures. Only in the event that cost reduction efforts are not enough for a board to meet the recommended target are fee increases considered.

The report also provides the revenue and spending projections, as well as fund balances, for each board from the fiscal 2014 actual through 2019 projected. Of the 18 boards, only 1 board (Acupuncture) met the 20% to 30% fund balance target for fiscal 2015, while for fiscal 2016 and 2017, 3 (Chiropractic and Massage Therapy Examiners, Nursing, and the State Commission on Kidney Disease) and 1 (Examiners in Optometry) board, respectively, are projected to meet the target. By the end of fiscal 2017, 8 boards are projected to be below the 20% target (Environmental Health Specialists, Morticians and Funeral Directors, Nursing, Physicians, Podiatric Medical Examiners, Examiners of Psychologists, Examiners for Audiologists/Hearing Aid Dispensers/Speech Language Pathologists, and the State Commission on Kidney Disease).

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Health Professional Boards and Commissions
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$385	$32,291	$0	$518	$33,194
Deficiency Appropriation	0	0	0	0	0
Cost Containment	0	0	0	0	0
Budget Amendments	7	170	0	0	177
Reversions and Cancellations	0	-2,760	0	-50	-2,810
Actual Expenditures	**$391**	**$29,702**	**$0**	**$467**	**$30,560**
Fiscal 2016					
Legislative Appropriation	$451	$34,890	$0	$539	$35,880
Budget Amendments	25	1,351	0	0	1,376
Working Appropriation	**$476**	**$36,241**	**$0**	**$539**	**$37,256**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

Actual spending for the DHMH Health Professional Boards and Commissions was $2,633,356 below the legislative appropriation. Budget amendments increased the appropriation by $176,585 ($170,065 in special funds and $2,202 in general funds) for the 2015 cost-of-living adjustment and $31,803 in general funds to realign health insurance costs across the department. The general fund increase was also partially offset by budget amendments removing $27,485 in general funds due to higher than expected turnover.

Cancellations totaled $2,809,941, including $2,759,537 in special funds and $50,404 in reimbursable funds. These cancellations were primarily due to higher than expected turnover.

Fiscal 2016

To date, the working appropriation for the boards and commissions has increased by $1,376,010, including $1,351,219 in special funds and $24,791 in general funds. Of this amount, the largest increase is $1,011,523 in special funds for the Medical Cannabis Commission to replace general funds that were reduced by the General Assembly with the intent that the commission be entirely special funded. Other increases include $339,696 in special funds and $4,946 in general funds to offset a 2% salary reduction, and $19,845 in general funds to realign funds related to the 2% across-the-board operating reduction, which was previously discussed.

Major Information Technology Projects

Department of Health and Mental Hygiene – Administration
Maryland Board of Physicians Integrated Software System

Project Status[1]	Planning.	**New/Ongoing Project:**	New.
Project Description:	Development of a new, more fully integrated medical licensure and investigation software system to replace the board's existing system.		
Project Business Goals:	Correction of deficiencies in the board's existing software system and improvement of board's efficiency.		
Estimated Total Project Cost[1]:	$2,124,224	**Estimated Planning Project Cost[1]:**	$223,648
Project Start Date:	November 2014.	**Projected Completion Date:**	April 2018.
Schedule Status:	A project manager was hired in June 2015, system concept development and planning are underway, and a Request for Proposal is being developed. Fiscal 2017 funding reflects a delay in hiring the project manager, which has pushed the schedule out one additional year.		
Cost Status:	Fiscal 2017 funding included in the Department of Health and Mental Hygiene – Administration budget.		
Scope Status:	n/a.		
Project Management Oversight Status:	Department of Information Technology project oversight is not in place.		
Identifiable Risks:	Moderate identifiable risks are the large scale of the project and the need to familiarize staff with a new system.		
Additional Comments:	Shortcomings of the board's outdated software systems were noted in the 2011 Sunset Evaluation of the board, as well as in a report prepared by an independent consultant, pointing to the need for the replacement of the board's existing systems.		

Fiscal Year Funding ($ in Thousands)	**Prior Years**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**Balance to Complete**	**Total**
Personnel Services	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Professional and Outside Services	684.0	273.6	1,105,8	0.0	0.0	0.0	0.0	2,124.2
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$684.0**	**$273.6**	**$1,105.8**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$2,124.2**

[1] Initially, an agency submits a Project Planning Request. After the requirements analysis has been completed and a project has completed all of the planning required through Phase Four of the Systems Development Lifecycle (Requirements Analysis), including a baseline budget and schedule, the agency may submit a Project Implementation Request and begin designing and developing the project when the request is approved. For planning projects, costs are estimated through planning phases. Implementation projects are required to have total development costs.

Object/Fund Difference Report
DHMH – Health Professional Boards and Commissions

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	268.70	282.70	279.70	-3.00	-1.1%
02 Contractual	12.38	15.47	14.40	-1.07	-6.9%
Total Positions	**281.08**	**298.17**	**294.10**	**-4.07**	**-1.4%**
Objects					
01 Salaries and Wages	$ 20,092,065	$ 22,810,146	$ 23,723,600	$ 913,454	4.0%
02 Technical and Spec. Fees	1,468,088	1,740,873	1,870,003	129,130	7.4%
03 Communication	462,267	628,717	540,552	-88,165	-14.0%
04 Travel	383,309	569,598	641,387	71,789	12.6%
07 Motor Vehicles	18,068	67,462	22,252	-45,210	-67.0%
08 Contractual Services	5,976,207	9,115,659	8,758,456	-357,203	-3.9%
09 Supplies and Materials	335,617	307,793	339,087	31,294	10.2%
10 Equipment – Replacement	194,085	160,056	124,594	-35,462	-22.2%
11 Equipment – Additional	125,828	337,886	97,348	-240,538	-71.2%
12 Grants, Subsidies, and Contributions	24,000	24,000	524,000	500,000	2083.3%
13 Fixed Charges	1,480,784	1,493,641	1,518,354	24,713	1.7%
Total Objects	**$ 30,560,318**	**$ 37,255,831**	**$ 38,159,633**	**$ 903,802**	**2.4%**
Funds					
01 General Fund	$ 391,296	$ 475,824	$ 492,013	$ 16,189	3.4%
03 Special Fund	29,701,874	36,241,068	37,128,639	887,571	2.4%
09 Reimbursable Fund	467,148	538,939	538,981	42	0%
Total Funds	**$ 30,560,318**	**$ 37,255,831**	**$ 38,159,633**	**$ 903,802**	**2.4%**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Health Professional Boards and Commissions

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
04 Health Professional Boards and Commission	$ 14,686,472	$ 18,087,638	$ 18,818,536	$ 730,898	4.0%
05 Board of Nursing	7,546,215	9,654,711	9,168,107	-486,604	-5.0%
06 Maryland Board of Physicians	8,327,631	9,513,482	10,172,990	659,508	6.9%
Total Expenditures	**$ 30,560,318**	**$ 37,255,831**	**$ 38,159,633**	**$ 903,802**	**2.4%**
General Fund	$ 391,296	$ 475,824	$ 492,013	$ 16,189	3.4%
Special Fund	29,701,874	36,241,068	37,128,639	887,571	2.4%
Total Appropriations	**$ 30,093,170**	**$ 36,716,892**	**$ 37,620,652**	**$ 903,760**	**2.5%**
Reimbursable Fund	$ 467,148	$ 538,939	$ 538,981	$ 42	0%
Total Funds	**$ 30,560,318**	**$ 37,255,831**	**$ 38,159,633**	**$ 903,802**	**2.4%**

DHMH: Department of Health and Mental Hygeine

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

M00F
Public Health Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$98,809	$100,155	$105,104	$4,949	4.9%
Deficiencies and Reductions	0	0	-90	-90	
Adjusted General Fund	**$98,809**	**$100,155**	**$105,014**	**$4,859**	**4.9%**
Special Fund	876	7,509	7,448	-61	-0.8%
Deficiencies and Reductions	0	0	-10	-10	
Adjusted Special Fund	**$876**	**$7,509**	**$7,438**	**-$71**	**-0.9%**
Federal Fund	24,525	37,396	26,512	-10,884	-29.1%
Deficiencies and Reductions	0	0	-16	-16	
Adjusted Federal Fund	**$24,525**	**$37,396**	**$26,497**	**-$10,899**	**-29.1%**
Reimbursable Fund	724	719	811	91	12.7%
Deficiencies and Reductions	0	0	0	0	
Adjusted Reimbursable Fund	**$724**	**$719**	**$811**	**$91**	**12.7%**
Adjusted Grand Total	**$124,934**	**$145,779**	**$139,759**	**-$6,020**	**-4.1%**

- After adjusting for a back of the bill reduction in health insurance, the fiscal 2017 allowance decreases by $6 million (4.1%), mainly due to a decrease in federal funds for Ebola Preparedness programs in the Office of Preparedness and Response.

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

For further information contact: Lindsey B. Holthaus Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	404.90	399.90	399.90	0.00
Contractual FTEs	11.43	14.10	14.30	0.20
Total Personnel	**416.33**	**414.00**	**414.20**	**0.20**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	31.27	7.82%
Positions and Percentage Vacant as of 12/31/15	36.00	9.00%

- The fiscal 2017 allowance includes the same number of regular full-time equivalents (FTE) as the fiscal 2016 working appropriation and 0.2 more contractual FTEs.

- As of December 31, 2015, there were 36 vacant positions, more than enough to meet budgeted turnover.

Analysis in Brief

Major Trends

Division of Vital Records: The Division of Vital Records has a goal to file 97% of birth certificates within five days of the birth date and 65% of death certificates within 72 hours of death. In fiscal 2015, the agency met its goal with respect to birth certificates. The agency estimated it fell short of its goal with respect to death certificates as it transitioned to the new electronic death registration system.

Office of the Chief Medical Examiner – Ratio of Cases Per Examiner: The ratio of autopsies to medical examiners remained steady in fiscal 2015 and is estimated to increase in fiscal 2016. The agency completed 73% of autopsy reports within 60 days in 2015, an increase from 2014, yet still falling short of its goal (90%).

Division of Drug Control – Increase of Nonpharmacy Inspections: The Division of Drug Control has decreased the number of routine pharmacy inspections and special investigations. However, the number of total inspections has increased with growth in controlled dangerous substances inspections of dispensing practitioners.

Office of Population Health Improvement – Number of Local Health Departments with Accreditation Increases: There is currently no required national accreditation for local health departments (LHD). However, LHDs have been encouraged to apply for the voluntary national accreditation. Although the process requires a financial commitment, as of November 2015, four LHDs are now accredited, with nine others going through the process.

Issues

Racial and Geographic Disparities in Quality Preventative Care: In 2011, the Department of Health and Mental Hygiene (DHMH) launched Maryland's State Health Improvement Process to improve accountability and reduce health disparities in Maryland by 2014 through implementing local action and engaging the public. The State improved on many measures, however, preventative care measures showed little improvement and worsened in some cases. These measures, which include emergency department visits related to noncommunicable disease, such as hypertension and diabetes, also include large disparities by both race and geographic location.

Recommended Actions

1. Concur with Governor's allowance.

Updates

Potential Claims for Delayed Laboratory Opening: Due to the delay in the opening of the new laboratory facility, DHMH has potential claims against the contractor for design issues that resulted in additional work. The agency also anticipates claims from the contractor.

Report on Workforce Development for Community Health Workers: In response to Chapters 181 and 259 of 2014, DHMH and the Maryland Insurance Administration established the Workgroup on Workforce Development for Community Health Workers (CHW) to study and make recommendations regarding workforce development for CHWs in Maryland. In June 2015, the workgroup issued a report to the General Assembly on Workforce Development for CHWs.

M00F
Public Health Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Department of Health and Mental Hygiene's (DHMH) Public Health Administration (PHA) budget analysis includes the following offices within the department:

- Deputy Secretary for Public Health Services;
- Office of Population Health Improvement;
- Office of the Chief Medical Examiner;
- Office of Preparedness and Response; and
- Laboratories Administration.

The **Deputy Secretary for Public Health Services** is responsible for policy formulation and program implementation affecting the health of Maryland's citizens through the actions and interventions of various public health administrations and offices within the department. The Deputy Secretary for Public Health Services mission is to improve the health status of individuals, families, and communities through prevention, early intervention, surveillance, and treatment.

The **Office of Population Health Improvement** (OPHI) contains offices that maintain and improve the health of Marylanders by assuring access to primary care services and school health programs, by assuring the quality of health services, and by supporting local health systems' alignment to improve population health. OPHI offices define and measure Maryland's health status, access, and quality indicators for use in planning and determining public health policy. The agency improves access to quality health services in Maryland by developing partnerships with agencies, coalitions, and councils; funding and supporting local public health departments through the Core Funding Program; collaborating with the Maryland State Department of Education to assure the physical and psychological health of school-aged children through adequate school health services and a healthy school environment; and seeking public health accreditation of State and local health departments (LHD).

The mission of the **Office of the Chief Medical Examiner** (OCME) is to:

- provide competent, professional, thorough, and objective death investigations in cases mandated in Maryland statute that assist State's Attorneys, courts, law enforcement agencies, and families;

- strengthen partnerships between federal, State, and local governments through training and education of health, legal, and law enforcement professionals;

- support research programs directed at increasing knowledge of pathology of disease; and

- protect and promote the health of the public by assisting in the development of programs to prevent injury and death.

The **Office of Preparedness and Response** (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 (CDC) Public Health Preparedness and Response for Bioterrorism Grant; (2) the CDC Cities Readiness Initiative; and (3) the Department of Health and Human Services' National Bioterrorism Hospital Preparedness Program.

The mission of the **Laboratories Administration** is to promote, protect, and preserve the health of the people of Maryland from the consequences of communicable diseases, environmental factors, and unsafe consumer products through the following measures:

- adopting scientific technology to improve the quality and reliability of laboratory practice in the areas of public health and environmental protection;

- expanding newborn hereditary disorder screening;

- maintaining laboratory emergency preparedness efforts; and

- promoting quality and reliability of laboratory data in support of public health and environmental programs.

DHMH has regional laboratories in Salisbury and Cumberland, in addition to the central laboratory in Baltimore.

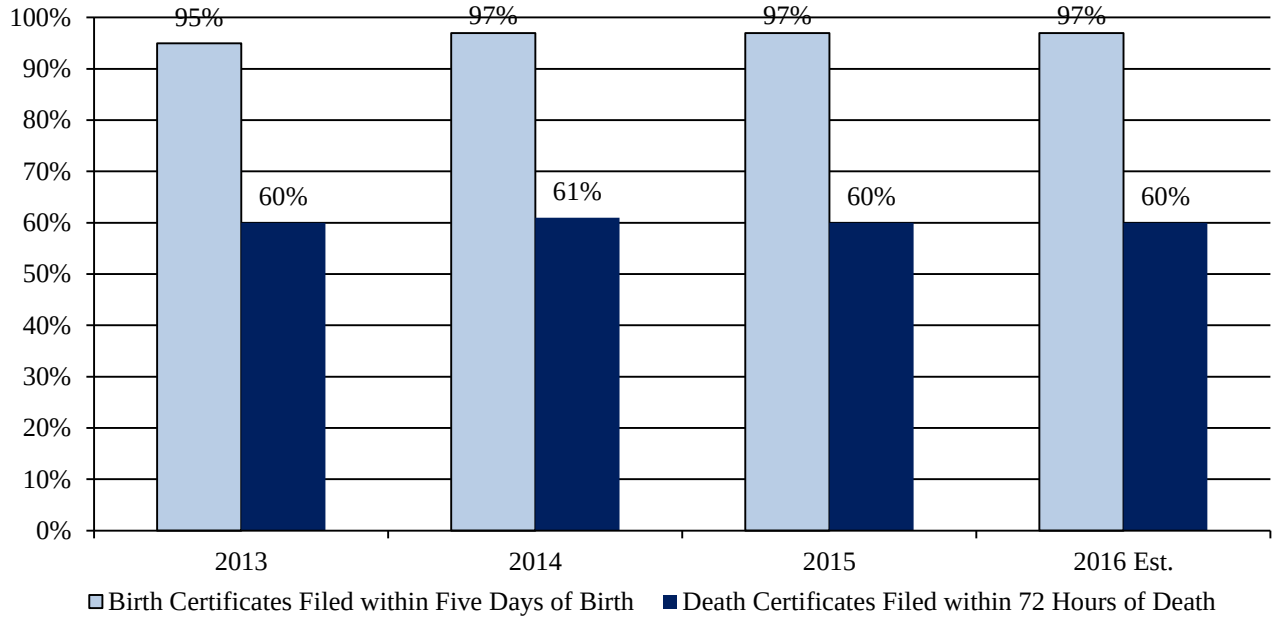
Performance Analysis: Managing for Results

1. Division of Vital Records

The Division of Vital Records has a goal to file 97% of birth certificates within five days of the birth date and 65% of death certificates within 72 hours of death. As shown in **Exhibit 1**, the percentage of birth certificates filed within five days stayed constant at 97% in fiscal 2015 meeting the agency's goal. The percentage of death certificates filed within 72 hours decreased slightly, from 61% in fiscal 2014 to 60% in fiscal 2015, and fell short of the agency's goal (65%). However, this percentage

is estimated as the agency moved to an Electronic Vital Records System (EVRS) for death certificates in January 2015 and therefore data for January through March 2015 was not available. The agency estimates that by 2017 it will meet the goal of 65%. The agency moved to the EVRS for birth records in calendar 2010.

Exhibit 1
Percentage of Birth and Death Certificates Timely Filed with the Division of Vital Records
Fiscal 2013-2016 Est.



Note: Prior to fiscal 2015, 92% of all birth certificates were to be filed within 72 hours of the time of birth. However, data reflecting the percentage of birth certificates filed within five days of birth in fiscal 2013 and 2014 is available, as shown above.

Source: Department of Health and Mental Hygiene

The Division of Vital Records in DHMH maintains a statewide system for registering, indexing, filing, and protecting all records of birth, death, fetal death, marriage and divorce, adoption, and legitimation and adjudication of paternity for events occurring in Maryland. LHDs may also process and issue a birth certificate, a death certificate, or a report that a search of the files was made and the requested record is not on file. The Budget Reconciliation and Financing Act of 2011 (Chapter 397) increased the fee for a copy, search, or change to birth certificates, from $12 to $24, and increased the fee that must be remitted by a LHD to the State in connection with the processing and issuing or searching for a birth certificate, from $10 to $20. Prior to that increase, the fees had not been altered since 2003.

Legislation introduced in the 2016 legislative session proposes to reduce fees for birth and death certificates. The proposed legislation would reduce fees for birth and death certificates from $24 to $12 and payments for those issued at a local health department from $20 to $10. The Department of Legislative Services (DLS) estimates that the proposed fee reduction would result in a $3.3 million annual reduction to the general fund, as shown in **Exhibit 2**. Expenditures for the Medicaid program decrease by an estimated $1.0 million (50/50 shared between general funds and federal funds), as that program uses birth certificates to confirm applicants' citizenship. Federal fund revenues decrease correspondingly.

Exhibit 2
Fiscal Effect of Proposed Fee Reduction for Birth and Death Certificates
Fiscal 2017-2021

	2017	2018	2019	2020	2021
General Fund Revenues	-$3,264,844	-$3,264,844	-$3,264,844	-$3,264,844	-$3,264,844
Federal Fund Revenues	-498,000	-498,000	-498,000	-498,000	-498,000
General Fund Expenditures	-498,000	-498,000	-498,000	-498,000	-498,000
Federal Fund Expenditures	-498,000	-498,000	-498,000	-498,000	-498,000

Source: Department of Legislative Services

2. Office of the Chief Medical Examiner – Ratio of Cases Per Examiner

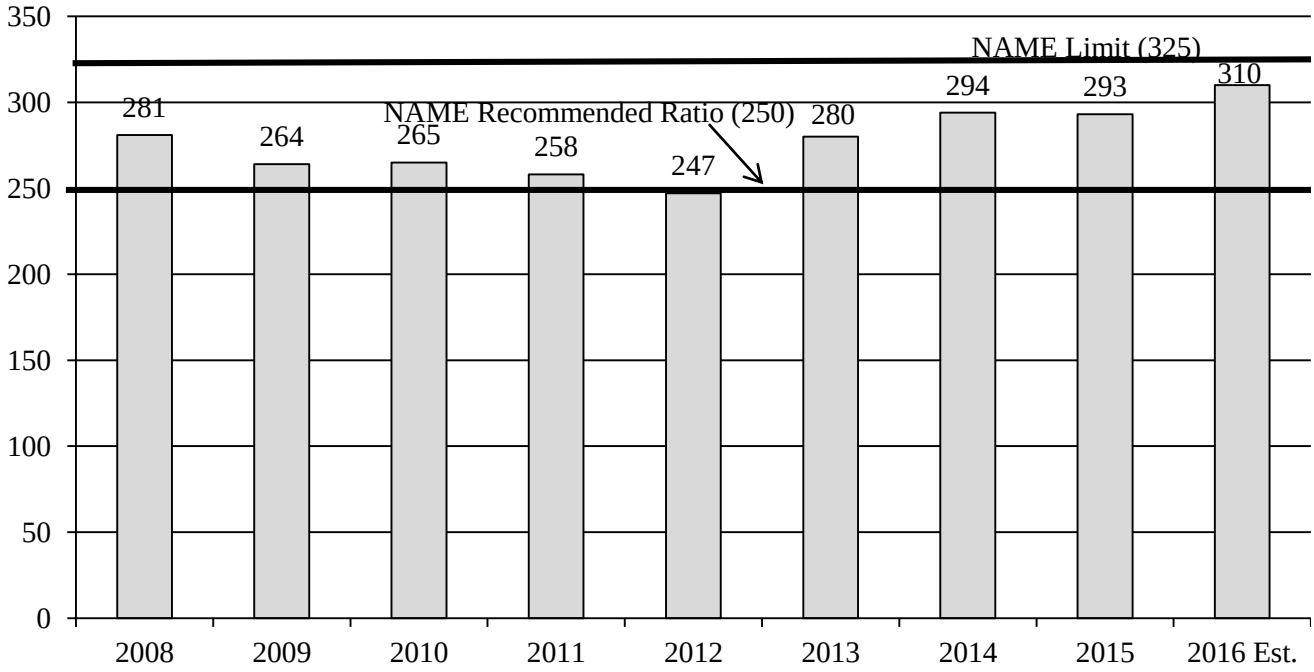
OCME is required to investigate all violent or suspicious deaths, including all deaths unattended by a physician. If the cause of death cannot be established during the initial investigation, a pathologist must perform an autopsy on the deceased.

In fiscal 2007, OCME changed reporting techniques to better reflect the caseload facing pathologists. The agency reports not only the number of autopsies performed but also the total number of cases presented for investigation. Not every death that is presented for investigation will be autopsied, but the agency reports the total number presented for investigation as it adds to the office's caseload. This change was precipitated by a change in the allowable caseload as identified by the National Association of Medical Examiners (NAME), which now includes external examinations in the total number of allowable autopsies per examiner.

Exhibit 3 shows the caseload per examiner, as well as the NAME limit of 325 and the NAME recommended maximum of 250 cases per examiner. The number of medical examiners allocated to the office increased from 13.5 to 15.6 between fiscal 2006 and 2009, causing the ratio of cases per examiner to drop significantly. Further, the total number of investigations dropped in fiscal 2009, leading to another reduction in the ratio of cases per examiner. The ratio of cases per examiner was

relatively stable from fiscal 2009 to 2011 and, due to a decline in the total deaths investigated in fiscal 2012, declined to 247 cases per medical examiner in fiscal 2012. However, the ratio of cases per examiner increased in each of the next two fiscal years, reaching 294 in fiscal 2014 (well above the NAME recommended limit). This ratio was estimated to decrease in 2015 but remained relatively constant at 293. Examinations performed are expected to continue to rise, and OCME expects caseload levels to stay above the recommended limit, increasing the estimated ratio of cases per examiner to 310 in 2016. Additionally, the agency advises the ratio can be misleading as some Medical Examiners may be examining up to 400 cases while others are focused on more time consuming cases. OCME attributes the rising caseloads to an upward cycle in the economy, where individuals may be traveling more. Individuals may also have more disposable income to spend on items detrimental to their health such as cigarettes, alcohol, or other drugs.

Exhibit 3
Cases Per Medical Examiner
Fiscal 2008-2016 Est.



NAME: National Association of Medical Examiners

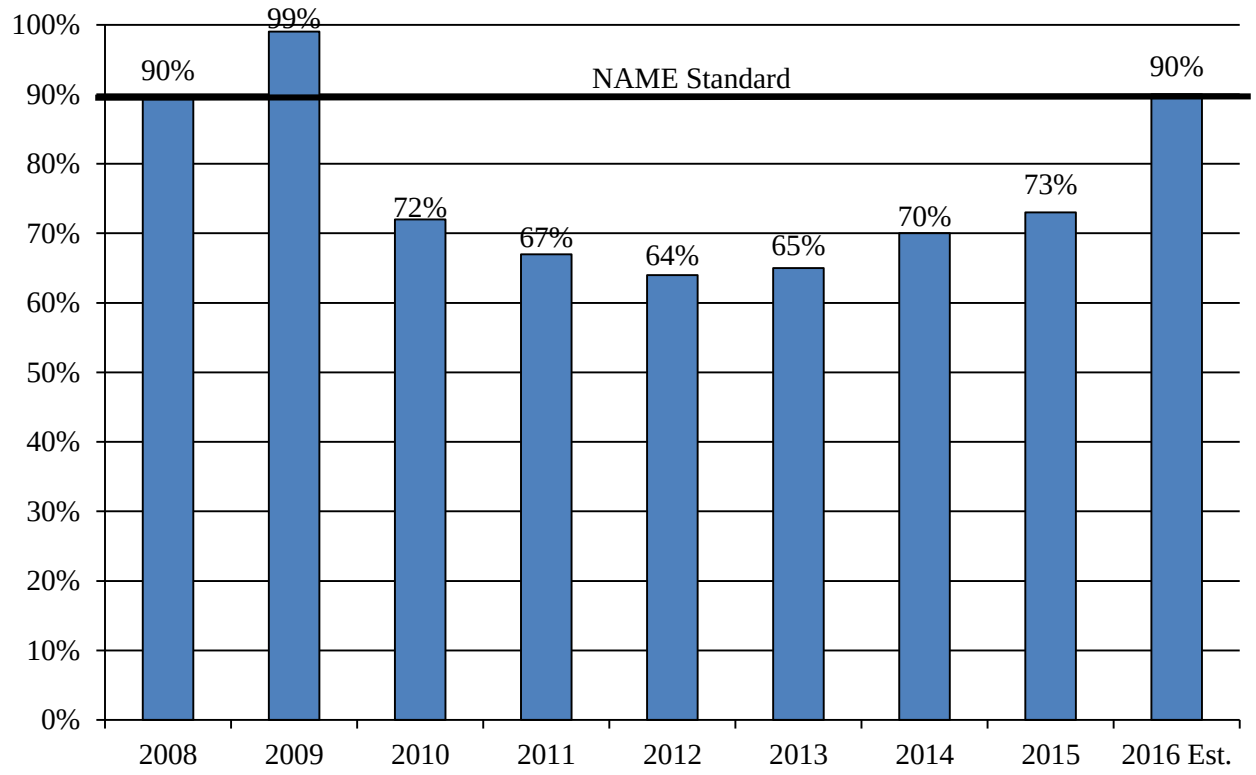
Source: Department of Health and Mental Hygiene

The agency notes the rising caseloads are consistent with national trends. Many offices saw autopsy caseload increases of 10% or more in 2015. In addition to the increased caseload, there is currently a nationwide shortage of trained medical examiners. In 2015, the National Commission on Forensic Science reported that there are only about 500 board-certified pathologists in the entire United

States, less than half the amount of medical examiners needed. The increased caseload and medical examiner shortage may contribute to delays in payouts of benefits to relatives as well as delays in solving criminal cases. In August 2015, the federal government approved new measures that will increase salaries and forgive student loans. According to the agency, 7 medical examiners are within five years of retirement. **The agency should comment on its plan to recruit medical examiners with the national shortage.**

Another goal of OCME is to complete and forward autopsy reports to the State's Attorney's Office within 60 working days following an investigation. NAME accreditation standards specify that 90% of all cases should be completed within 60 working days, and 100% of cases should be completed in 90 working days. **Exhibit 4** shows the percent of autopsy reports completed within 60 days and forwarded to the State's Attorney's Office.

Exhibit 4
Percentage of Autopsies Reported within 60 Days
Fiscal 2008-2016 Est.



NAME: National Association of Medical Examiners

Source: Department of Health and Mental Hygiene

The addition of a new office secretary in fiscal 2008, helped the agency approach the goal of 90% of cases completed within 60 days and in fiscal 2009, the agency exceeded this goal by completing 99% of cases within 60 days. However, OCME fell short of this goal in fiscal 2011, as only 67% of autopsy reports were completed within 60 days. The office attributed this failure to insufficient transcription support, as OCME lost two office secretaries – one through the Voluntary Separation Program and one to retirement. The agency replaced one secretary position in fiscal 2012, but still did not meet its 90% goal. Subsequently, in fiscal 2012, only 64% of autopsy reports were completed within 60 days. In fiscal 2013, five new positions (including two secretaries) were added, and although the agency reported delays in recruitment and hiring for those positions, the agency's performance has since trended upward. Though still short of its goal, the agency completed 73% of autopsy reports in fiscal 2015. The agency estimates that it will meet its goal of completing 90% of cases within 60 days in fiscal 2016. However, it should be noted that this mirrors what the agency had previously estimated it would achieve in prior fiscal years and OCME recently lost one secretary position with additional staff expected to retire by July of 2016.

During a NAME inspection, facilities are judged against two standards – Phase I and Phase II. Phase I standards are not considered by NAME to be absolutely essential requirements; violations in these areas will not directly or seriously affect the quality of work or significantly endanger the welfare of the public or staff. Phase II standards are considered by NAME to be essential requirements; violations in these areas may seriously impact the quality of work and adversely affect the health and safety of the public or staff. To maintain full accreditation, an office may have no more than 15 Phase I violations and no Phase II violations. Provisional accreditation may also be awarded for a 12-month period if an office is found to have fewer than 25 Phase I violations and fewer than 5 Phase II violations. If awarded provisional accreditation, an office must address deficiencies that prevented it from achieving full accreditation.

Currently, it is a Phase I violation if 90% of all cases are not completed within 60 days of examination, and it is a Phase II violation if 90% of all cases are not completed within 90 days. Although OCME fell short of its goal in fiscal 2015, the agency advises that over 90% of cases are now being completed within 90 days. OCME learned in October 2014 that it had successfully attained full NAME accreditation through May 14, 2019. However, OCME advised that NAME is voluntary and the Attorney General of the United States approved a policy in 2015 requiring all offices, facilities, or institutions performing medicolegal death investigation activities be accredited by the year 2020. Currently, NAME is not formally recognized by an external standards organization to be in compliance with international standards such as the International Organization for Standardization (ISO) 17011 accreditation. NAME has decided to contract out its inspection to an organization that is ISO 17011 accredited and will move from a five- to a four-year cycle. Consequently, the process will require more resources and funding (likely federally funded) for the additional ISO portion of the inspection to bring NAME up to ISO standards. Additionally, the agency notes that in order to become ISO accredited, there will be an additional cost of $3,000 to $7,000 per year and a quality assurance (QA) manager will need to be hired. **The agency should brief the committees on its plan to apply for federal funding to cover the costs of accreditation and its timeline for hiring a QA manager.**

3. Division of Drug Control – Increase of Nonpharmacy Inspections

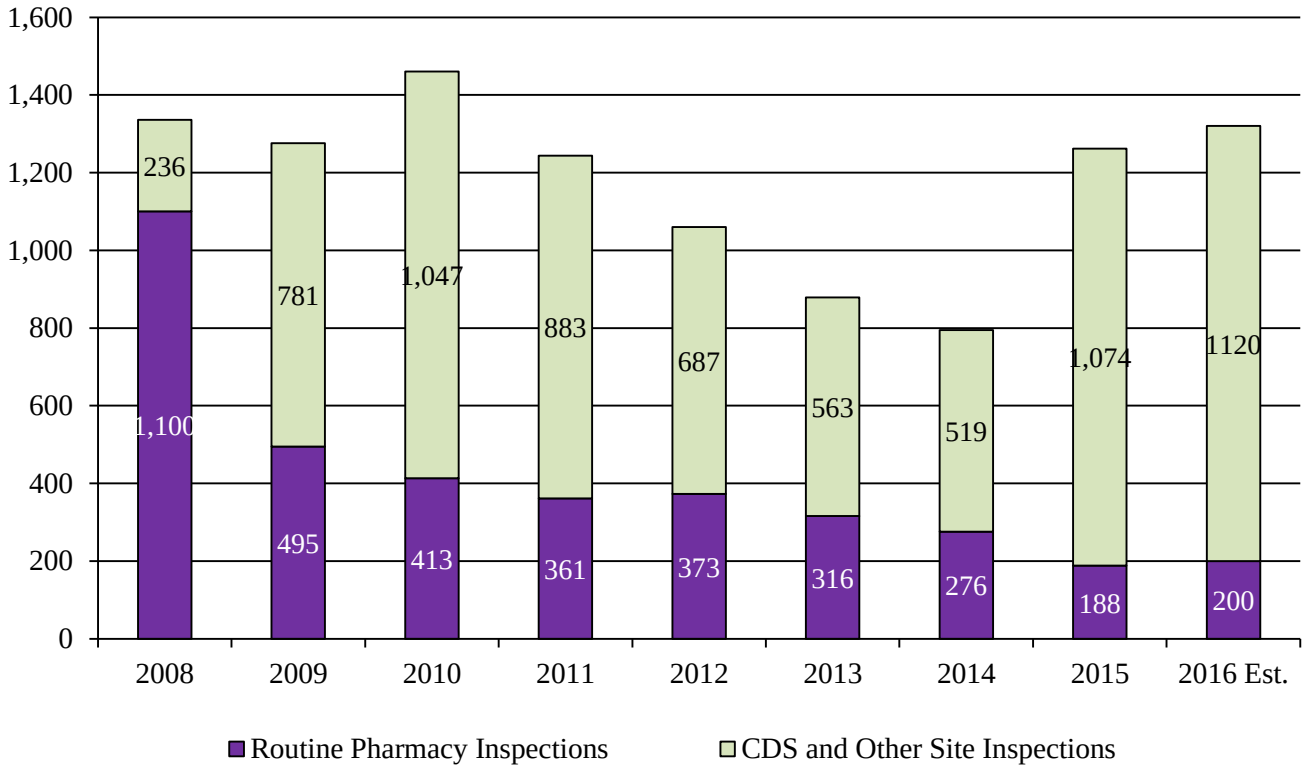
The Division of Drug Control (DDC) registers practitioners and establishments to legally manufacture, distribute, dispense, or otherwise handle controlled dangerous substances (CDS) in Maryland. The federal Controlled Substances Act of 1970 (CSA) authorizes federal regulation of the manufacture, importation, possession, and distribution of certain drugs. Under the CSA, various drugs are listed on Schedules I through V and generally involve drugs that have a high potential for abuse. Schedule I drugs have no acceptable medical use in the United States, and prescriptions may not be written for these substances. Morphine and amphetamines (such as Adderall) are examples of Schedule II drugs; anabolic steroids and hydrocodone are examples of Schedule III drugs; and benzodiazepines (such as Valium or Xanax) are Schedule IV drugs. Schedule V drugs include cough suppressants containing small amounts of codeine and the prescription drug Lyrica, an anticonvulsant and pain modulator.

CDS permits are issued by DDC on a biennial basis, and the number of permits issued annually fluctuates slightly from year to year but generally averages between 18,000 and 19,000 permits. DDC processed 20,464 permits in fiscal 2015. On September 15, 2015, the Governor announced a plan to reduce a number of fees across the State government. CDS permits were part of that plan. Before the plan, the current fees were $120 or $60 annualized. The proposed plan continued the same fees but extended the license term to three years, with an annualized fee of $40 annualized. DLS estimates that doing so would reduce general fund revenues by approximately $800,000 annually.

Exhibit 5 shows the number of CDS inspections at pharmacies and nonpharmacy sites. In fiscal 2009, the Board of Pharmacy assumed responsibility for conducting routine annual inspections of pharmacies, which freed DDC to focus on other responsibilities, such as inspecting dispensing practitioners and auditing methadone programs and long-term care and assisted living facilities that possess CDS. However, the division still conducts closing inspections of pharmacies as well as CDS inspections of pharmacies. Pharmacies are required to perform an internal audit of their CDS inventory annually. When performing an inspection, the Board of Pharmacy documents the date of the most recent internal CDS audit and forwards the audit date to DDC. This allows DDC to set priorities for follow-up on CDS inspections of pharmacies. The work of the Board of Pharmacy enabled DDC to dramatically increase the number of CDS inspections that it performs annually for nonpharmacy entities, from 236 in fiscal 2007 to a high of 1,047 in fiscal 2010.

The number of nonpharmacy inspections declined steadily from 2010 to 2014. The agency attributes this decline to the retirements of 2 pharmacist inspectors, 1 in July 2014 and 1 in January 2015, and a decrease in referrals from health occupation boards, the Drug Enforcement Administration, OCME, and other State and federal agencies. The agency expected to increase the number of inspections once the new staff were trained and experienced. In 2015, CDS inspections for nonpharmacy entities increased to 2010 levels and are expected to continue to increase in 2016. Investigations were at a low of five in 2015, however it's DDC's long-term goal to have a decreased need for investigations by continuing to maintain a full staff of trained pharmacist inspectors, prioritizing at-risk practitioners and establishments, and providing concurrent education to CDS registrants during inspection.

Exhibit 5
Division of Drug Control Inspections
Fiscal 2008-2016 Est.



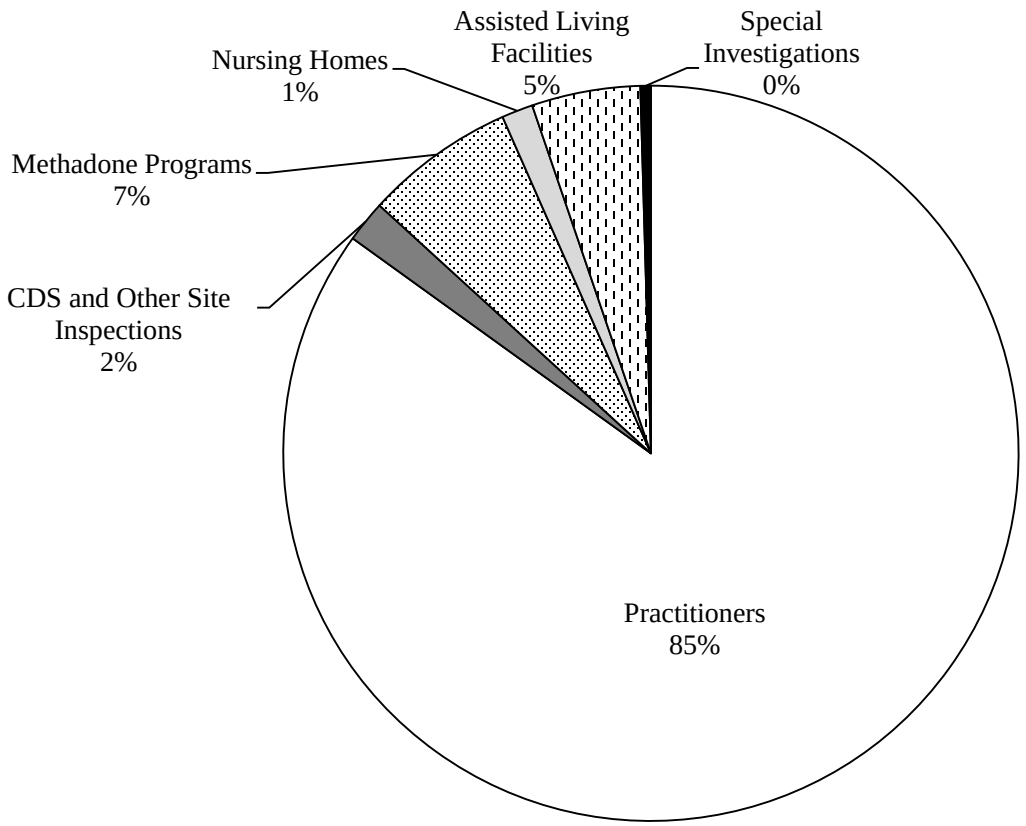
CDS: controlled dangerous substance

Note: CDS and other site inspections include special investigations.

Source: Department of Health and Mental Hygiene

According to the respective health occupations boards, approximately 1,500 dispensing permits are held by nonpharmacist practitioners in Maryland. The fiscal 2014 budget included funds to implement Chapter 267 of 2012, which required DDC to inspect the office of a dispensing practitioner at least two times within the duration of their five-year CDS permit. To meet this requirement, the agency must inspect an average of about 500 practitioners annually. The agency exceeded 500 practitioner inspections in fiscal 2015. **Exhibit 6** shows that practitioners (physicians, podiatrists, and dentists) accounted for almost all nonpharmacy inspections in fiscal 2015 with 925 out of 1,089 total inspections. This represents more than a 200% increase over the fiscal 2014 level (278).

Exhibit 6
Nonpharmacy CDS Inspections
Fiscal 2015



CDS: controlled dangerous substance

Source: Department of Health and Mental Hygiene

4. Office of Population Health Improvement – Number of Local Health Departments with Accreditation Increases

The U.S. Centers for Disease Control and Prevention, in partnership with the Robert Wood Johnson Foundation, are supporting the implementation of a national voluntary accreditation program for local, state, territorial, and tribal health departments. The Public Health Accreditation Board (PHAB) is a nonprofit entity which was established to serve as the independent accrediting body.

Among other issues, PHAB accreditation standards address areas related to population health, environmental health, wellness promotion, community outreach, and the enforcement of public health laws. PHAB's scope of accreditation authority does not extend to mental health, substance abuse, primary care, human services, and social services (including domestic violence) that may be provided by some public health departments. Standards also focus on improving access to health care services, maintaining a competent public health workforce, evaluating and improving health department programs, and applying evidenced-based public health practices. This is done through accreditation assessments, which provide measureable feedback to LHDs on the aforementioned standards. In order to be eligible for accreditation, a LHD must have three documents that have been updated in the last five years: (1) a community health assessment; (2) a community health improvement plan; and (3) a strategic plan. These three documents are prerequisites in the application process.

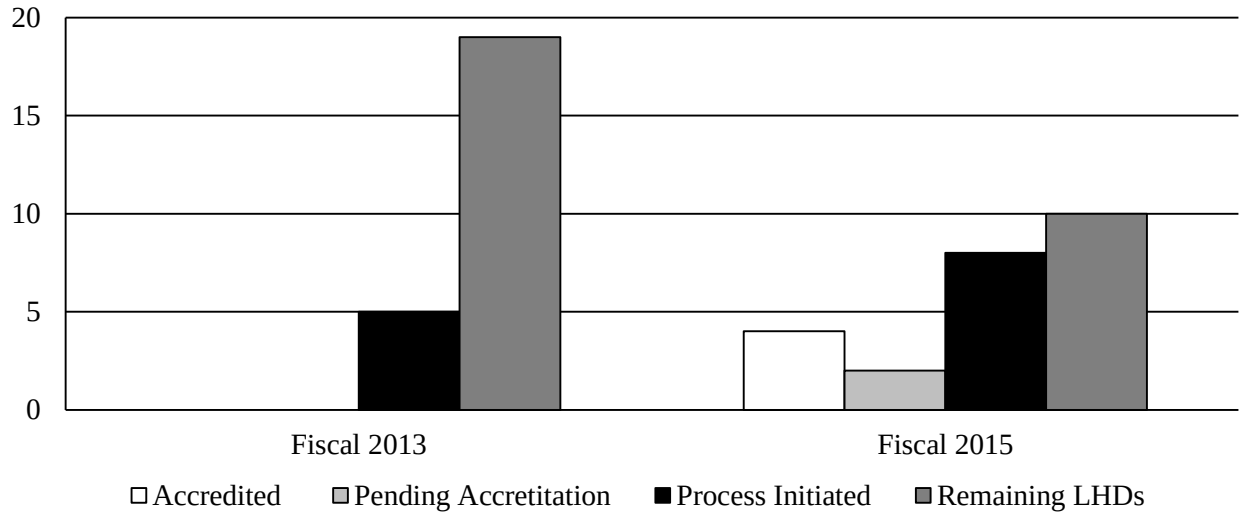
The accreditation process includes seven steps: (1) pre-application, which includes submitting a statement of intent and online orientation; (2) application, which requires a health department to submit application forms and the applicable fee; (3) document selection and submission, which requires a health department to demonstrate its conformity with accreditation measures; (4) site visit by PHAB trained site visitors; (5) accreditation decision by PHAB; (6) reports, which are required on an annual basis if accreditation is received; and (7) reaccreditation.[1]

While accreditation is focused on improving the quality of public health departments, it is important to note that accreditation also highlights the capacity and capability of a health department, which may result in increased opportunities for resources. PHAB advises that potential resources may include funding to support quality and performance improvement; funding to address infrastructure gaps identified through the accreditation process; opportunities for pilot programs; streamlined application processes for grants and programs; and acceptance of accreditation in lieu of other accountability processes.

In fiscal 2013, 5 of Maryland's 24 LHDs had submitted prerequisites for public health accreditation. As shown in **Exhibit 7**, in fiscal 2015, 4 LHDs are accredited (Allegany, Frederick, Harford, and Worcester), 2 are awaiting accreditation decisions, and 8 others have initiated the process. LHDs have been encouraged by DHMH to pursue accreditation – and most have indicated that they are either considering or actively pursuing accreditation. However, some LHDs have noted a lack of funding as a primary barrier to accreditation. The fees are mostly administrative, paying for a specialist, and a site visit of peer review experts and support for re-accreditation, which must happen every five years. Competing priorities and lack of staff time were also cited as barriers. According to the agency, the submission of annual reports and reaccreditation every five years would require a full-time accreditation coordinator for some LHDs. **The agency should comment on efforts to encourage accreditation for LHDs in smaller jurisdictions.**

[1] The cost of accreditation varies based on the size of the jurisdictional population served by the health department. Fees range from approximately $13,000 for populations less than 50,000 to approximately $100,000 for populations greater than 15 million.

Exhibit 7
Status of LHD National Accreditation
February 2015



LHD: local health department

Source: Department of Health and Mental Hygiene

With the enactment of the Affordable Care Act (ACA) and subsequent reduction in the uninsured populations, there may be the potential for LHDs to provide a new stream of revenue by billing for services provided to their insured population that have traditionally been provided free of charge. Vaccinations, for example, are frequently provided free of charge by health departments yet costs continue to increase as new, more expensive vaccines are added to the recommended immunization schedule. A report by DHMH in January 2014, assessed the ability of Maryland LHDs to bill providers for such services. According to the report, LHDs vary widely in their capacity to bill for vaccination services as well as other clinical services such as family planning. In assessing the overall readiness of each LHDs to bill for services, 8 of the 24 LHDs were rated with a high level of readiness, which includes the ability to perform billing for vaccination and other services, having written policies and procedures in place for billing, having staff with billing experience, and performing checks on insurance eligibility.

Some LHDS with low-readiness assessment levels identified low-patient volumes as a barrier to setting up billing systems as they would not be cost effective. Additionally, limited access to third-party and managed care organization contracts was cited as a significant barrier to billing. Access was limited, in part, due to standard provisions in health plan contracts that conflict with State law regarding contracts with governmental agencies. DHMH and LHDs, in conjunction with the Office of the Attorney General, are in the process of negotiating contracts with several insurance plans, which

must comply with legal contracting requirements applicable to State of Maryland governmental agencies. These contracts are intended to cover the full range of clinical services provided by LHDs, not solely immunizations. Additionally, the Maryland Health Benefit Exchange, in drafting the 2017 Certification Standards, expanded the definition of "Essential Community Provider" to include LHDs. **The agency should brief the committees on the progress of LHDs in billing third-party and MCOs for services.**

Fiscal 2016 Actions

Cost Containment

The fiscal year 2016 budget bill contained a 0.6% across-the-board fund reduction to DHMH totaling $27.2 million. This administration's proportion of the cut totaled $313,000 including:

- $18,000 from the Vital Statistics Administration due to reduced printing costs and information technology staff training;

- $60,000 to OPHI due to a reduction in a grant to a Baltimore City child and adolescent health advocacy program, $44,000 due to the elimination of funding for an annual conference, and $38,000 due to a reduction in a school-based health center grant; and

- $35,000 from OCME due to a reduction in equipment service contracts and $118,000 due to utility savings.

- An additional reduction of $4.6 million was included in fiscal 2016 for the Newborn Screening program in the Laboratory Administration to be backfilled with special funds.

Proposed Budget

As shown in **Exhibit 8**, after adjusting for a back of the bill reduction in health insurance, the fiscal 2017 allowance falls by $6.1 million, or 4.1%, over the fiscal 2016 working appropriation. General fund support increases by $4.9 million, primarily due to an increase in grant funding to LHDs. Federal fund support decreases by $10.9 million, primarily due to reduced funding for Ebola preparedness activities within OPR. Special fund support decreases by $71,000 and reimbursable fund support increases by $91,000.

Exhibit 8
Proposed Budget
DHMH – Public Health Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$98,809	$876	$24,525	$724	$124,934
Fiscal 2016 Working Appropriation	100,155	7,509	37,396	719	145,779
Fiscal 2017 Allowance	105,014	7,438	26,497	811	139,759
Fiscal 2016-2017 Amount Change	$4,859	-$71	-$10,899	$91	-$6,020
Fiscal 2016-2017 Percent Change	4.9%	-0.9%	-29.1%	12.7%	-4.1%

Where It Goes:

Personnel Expenses	
Retirement	$634
Employee and retiree health insurance	441
Other fringe benefit adjustments	85
Miscellaneous adjustments	82
Regular earnings	-136
Turnover adjustments	-262
Office of Population Health Improvement	
Core local public health funding	3,825
Reduction to SIM grant fund	-700
Office of the Chief Medical Examiner	
Laboratory equipment for substance abuse testing	122
Office of Preparedness and Response	
BioSense	-137
2-1-1 Call Center	-183
Maryland Bioterrorism Hospital Preparedness Program	-855
Reduced funding for Ebola-related preparedness programs	-9,391
Laboratory Administration	
New building rent	353
STARLIMS upgrade	250
Reduced laboratory equipment – Newborn Screening Program	-437

Where It Goes:

Other Changes

Drug control online application system	200
Technical support for Electronic Death Registry System	70
Transportation and cremations at State Anatomy Board	36
Other	-16
Total	**-$6,020**

DHMH: Department of Health and Mental Hygiene
SIM: State Innovation Models
STARLIMS: STAR Laboratory Information Management System (LIMS)

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

Personnel Expenses

Personnel expenses for PHA increase by $844,000 over the fiscal 2016 working appropriation. Major changes include increases of $441,027 for employee and retiree health insurance and $633,628 for employee retirement. Significant declines include regular earnings, $136,000, and turnover expectancy, $262,000.

Operating Expenses

Office of Population Health Improvement

The fiscal 2017 budget for core local public health funding increases by $3.8 million, bringing total funding to $49.4 million, all general funds. This funding increases due to the formula adjustment factor ($420,000) and to account for fiscal 2017 salary increments ($3.4 million). The formula adjustment factor is mandated under Health-General § 2-302 and is calculated by combining an inflation factor with a population growth factor.[2] Statute mandates that for fiscal 2013 and each subsequent fiscal year, the formula adjustment factor be applied to the $37.3 million base level. The formula does not account for ongoing expenditures related to the annual cost-of-living adjustments (COLA) or salary increments. This additional funding is not mandated by statute and is instead budgeted at the discretion of the Administration.

[2] Current regulations provide that the annual formula adjustment and any other adjustment for local health services must be allocated to each jurisdiction based on its percentage share of State funds distributed in the previous fiscal year and to address a substantial change in community health need, if any, as determined at the discretion of the Secretary after consultation with local health officers.

Additionally, the fiscal 2017 budget for OPHI falls by $700,000 due to a decrease in State Innovation Models grant funding. OPHI received a planning grant in fiscal 2016 to design various delivery reform initiatives, including an Accountable Care Organization (ACO) for Medicaid/Medicare dual eligibles and an Integrated Delivery Network. Fiscal 2017 funding will be used to support research and planning on population health finance, development of health measures, and development of patient care plan sharing across Maryland's health information exchange.

Office of the Chief Medical Examiner

The fiscal 2016 allowance increases by $122,000 for laboratory equipment. This includes the purchase of a Gas Chromatograph Mass Spectrometer (GC-MS) used for drug testing procedures, $105,000. The agency advises that greater than 95% of the drugs the lab tests require GC-MS analysis for identification.

Office of Preparedness and Response

The budget for the Office of Preparedness and Response decreases by $10.6 million in fiscal 2017, primarily due to less federal funding for Ebola preparedness and response activities, $9.4 million. Additionally, support for the Maryland Bioterrorism Hospital Program, which provides funds to the State's health care system for emergency preparedness, planning, and response to incidents with a public health impact, falls $855,000. This decrease is primarily due to a decrease in federal grant funding provided to the Maryland Hospital Association to improve and enhance medical surge capabilities of Maryland acute care hospitals and a decrease in regional grant funding to other vendors for partnership coalition building.

Funding for BioSense, a program promoting the exchange of electronic health-related information between providers and public health authorities, falls $137,418 in fiscal 2017 as the program ends in fiscal 2016. Funding for the 2-1-1 program, a 24/7 community health and human service call center, falls by $183,000.

Laboratories Administration

Increases to the budget for the Laboratories Administration in fiscal 2017 include $250,000 to cover the cost of upgrading the STARLIMS laboratory information management system as the current version is not compatible with newer versions of Windows after Windows XP. Laboratory equipment decreases by $437,000 in fiscal 2017 in the Newborn and Childhood Screening program due to a one-time purchase in 2016 for Severe Combined Immunodeficiency (SCID) testing equipment. Rent payments to MEDCO for the new laboratory building increase by $352,000 for additional maintenance, security, and management fees.

Other Changes

The budget for DDC increases by $200,000 to cover the cost of a web-based online application, fee payment, and collection system. The agency advises the system will allow practitioners, researchers, and establishments to apply for new or renewal CDS registration/certification. This system

will be accessible through DDC's webpage. Information provided in the web-based online application, fee payment, and collection system will be uploaded to STARLIMS eliminating the need to process checks and making deposits to the bank account. The budget increases by $70,000 for the Office of Vital Statistics to provide technical assistance to support Maryland's electronic death registry system. An additional increase of $36,000 is included for the State Anatomy Board for transporting and cremating unclaimed donated bodies from the place of death.

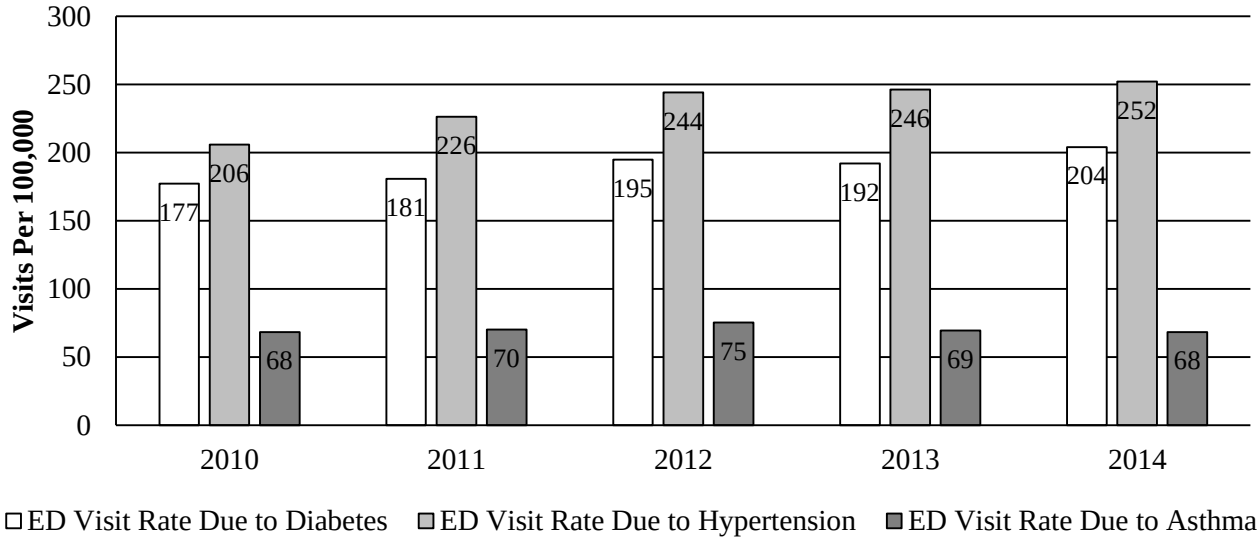
Issues

1. Racial and Geographic Disparities in Quality Preventative Care

In 2011, DHMH launched the Maryland State Health Improvement Process (SHIP) to improve accountability and reduce health disparities in Maryland by 2014 through implementing local action and engaging the public. The State improved on many measures. However, the preventative care measures showed little improvement and worsened in some cases. These measures, which include emergency department visits related to noncommunicable diseases such as hypertension and diabetes, also include large disparities by both race and geographic location. The worsened rates in many cases are driven by racial and geographic disparities, and are unlikely to improve without addressing these disparities.

A review of emergency department (ED) visit rates due to asthma, diabetes, hypertension, addictions, and mental health, for example, shows that ED visit rates for diabetes, hypertension, and mental health increased between 2010 and 2014. This analysis will focus on ED visit rates for diabetes, hypertension, and asthma. **Exhibit 9** shows ED visit rates for diabetes increasing 15% from 2010 to 2014, and ED visit rates for hypertension increasing 22% over the same period. Asthma visits were flat.

Exhibit 9
Emergency Department Visit Rates
Calendar 2010-2014

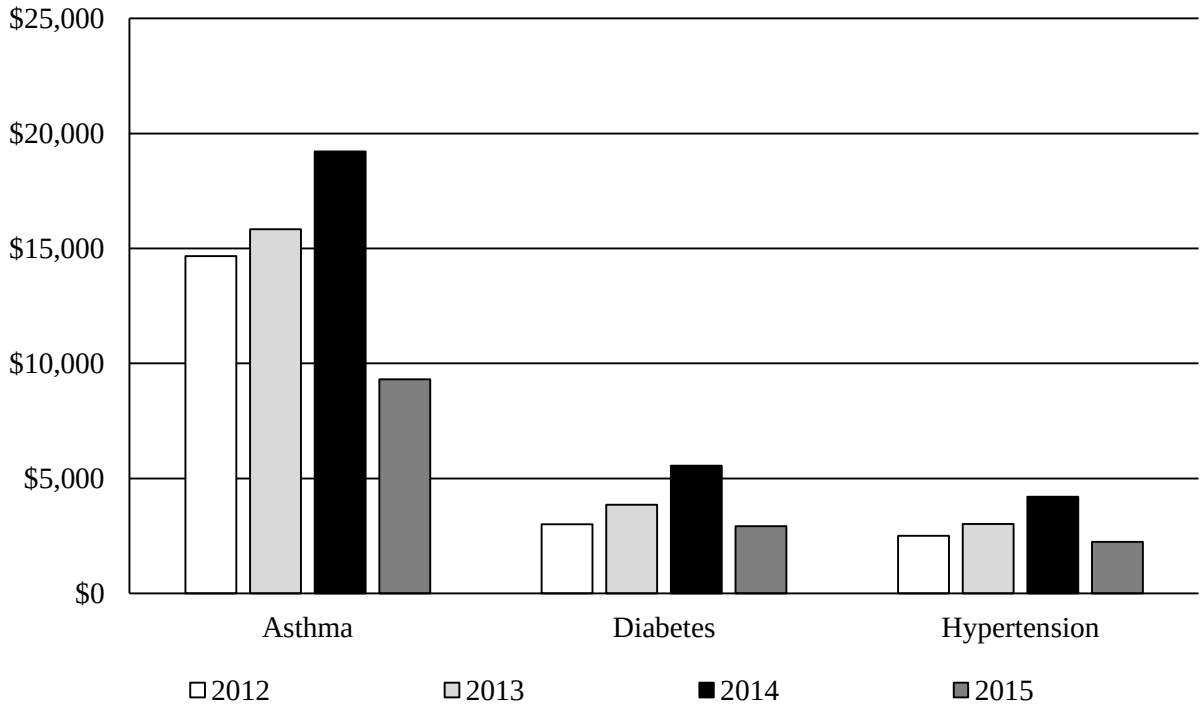


ED: emergency department

Source: Department of Health and Mental Hygiene

Exhibit 10 shows ED visits for various conditions that are charged to Medicaid. In calendar 2014, the charges to Medicaid for ED visits due to asthma, for example, totaled nearly $20 million. It should be noted that currently there is no dedicated State funding for asthma-related activities as Maryland's competitive application for renewal was not successful, resulting in the loss of all funding for asthma control in the State.

Exhibit 10
Emergency Department Visit Medicaid Charges
Calendar 2012-2015
($ in Thousands)

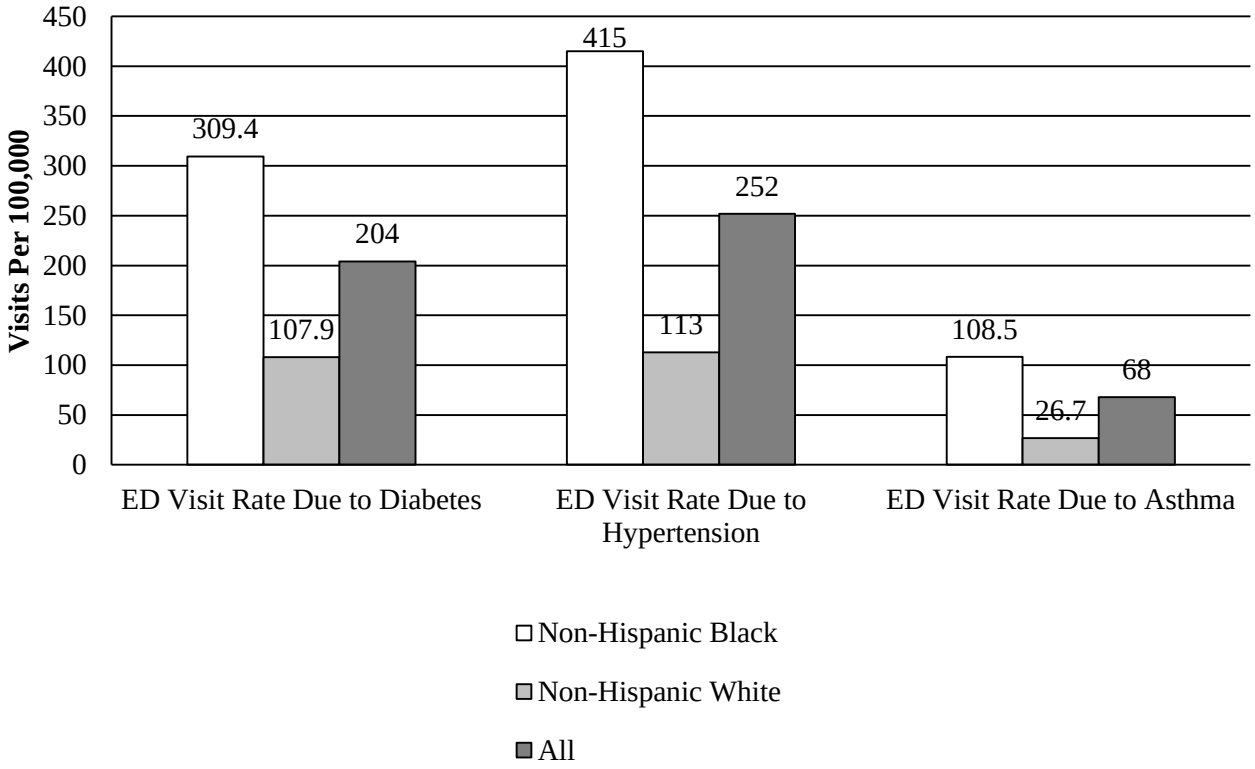


Note: 2015 may not include all charges, actuals as of January 2016.

Source: Maryland Health Care Commission

Many of these rates are driven by high rates among the non-Hispanic Black population. As shown in **Exhibit 11**, non-Hispanic Black ED visit rates are three to four times higher than Whites for diabetes, hypertension, and asthma.

Exhibit 11
Emergency Department Visit Rates by Race
Calendar 2014



ED: emergency department

Source: Department of Health and Mental Hygiene

There are also significant geographic disparities, which underscore the racial disparities noted earlier. Baltimore City consistently ranks the highest for ED visit rates for diabetes, hypertension, and asthma, with Dorchester County following second. Both Baltimore City (74.4%) and Dorchester County (74.5%) have the lowest percentage of the population with access to a primary care doctor, after Prince George's County (73.5%). Primary care physicians are key to the management of conditions to reduce the dependency on the ED. Community Health Workers (CHW) can also be employed to help individuals access health insurance, connect individuals to a primary care provider, and help in the education and management of chronic disease including compliance with medication. More information on CHWs is provided in Update 1.

Current Dedicated Funding for Reducing Racial Health Disparities

Health Enterprise Zones (HEZ), within the Maryland Community Health Resources Commission, were funded to reduce health disparities among racial and ethnic minority populations and among geographic areas. The fiscal 2017 budget includes no funding for the zones as the four-year pilot program winds down.

The Office of Minority Health and Health Disparities in the Office of the Secretary, currently targets reducing racial health disparities. Half of their $1.1 million budget is dedicated to grant funding through the University of Maryland, including the U.S. Office of Minority Health's Embracing Minorities of Benefits Received After Consumer Enrollment. An additional $500,000 in grant funding is awarded through the Minority Outreach Technical Assistance (MOTA) program. It should be noted that $500,000 in grant funding was cut as part of DHMH's fiscal 2016 cost containment and was not included in the fiscal 2017 allowance. This funding was used to educate the newly insured to improve access to primary care providers for preventative care and reduce the use of emergency rooms for preventative care services. This office has worked with other offices within DHMH to develop *A Maryland Plan to Eliminate Minority Health Disparities*. The last plan was for calendar 2010 through 2014, however health disparities in quality preventative care continue to be prevalent. **The agency should brief the committees on its plan to eliminate minority health disparities to improve quality preventative care as the HEZ pilot ends.**

Recommended Actions

1. Concur with Governor's allowance.

Updates

1. Potential Claims for Delayed Laboratory Opening

Due to the delay in the opening of the new laboratory facility, DHMH has potential claims against the contractor for design issues that resulted in additional work. During the 2014 legislative session, it had been expected that the new laboratory would become operational in June 2014. This date was delayed to September 2014, and then to January 2015. As of January 2015, the agency had accepted the new building. The contractor asserted that it had been damaged by repeated project delays caused by the agency. The agency, in turn, asserted that the contractor was to blame for the delays and that the delays caused substantial costs. The agency advised that its construction contract required an informal effort by both sides to resolve disputes followed by formal mediation before any action in court.

Under the terms of the construction contract, the contractor agrees that, for payment it will have recourse only against the bond proceeds and MEDCO's interest in the building. DHMH and MEDCO claimed $14.0 million in damages from asserted contractor caused delays. The contractor, in turn, claimed $15.4 million in damages from asserted agency caused delays. In August 2015, DHMH and MEDCO came to a mediated resolution of the dispute with the contractor. MEDCO would pay the contractor $8.25 million, of which $4.0 million was money owed under the contract. The additional $4.25 million would be paid for out of the bond proceeds.

2. Report on Workforce Development for Community Health Workers

In response to Chapters 181 and 259 of 2014, DHMH and the Maryland Insurance Administration established the Workgroup on Workforce Development for Community Health Workers to study and make recommendations regarding workforce development. In June 2015, the workgroup issued a report to the General Assembly on Workforce Development for CHWs. The report made recommendations regarding training and credentialing required for CHWs to be certified as nonclinical health care providers and reimbursement and payment policies for CHWs through the Maryland Medicaid Assistance Program and private insurers.

The report identifies CHWs as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate health care and a resource for combating health disparities by promoting and supporting healthy behaviors in underserved communities. In 2013, there were approximately 1,430 CHWs working in the State from community-based to hospital-based to primary care-team based. Organizations employing and training CHWs include HEZ grantees, universities/community colleges, area health education centers, MOTA grantees, and some LHDs.

There is no current standardization for training requirements, curricula, and other professional requirements across CHW programs within the State. States currently vary in their credentialing process as to who certification is required for, what kind of governance is needed, whether there is a defined scope or practice for CHWs, and the extent and location of training (hospitals vs colleges). States also vary in

the standards they require. Based on an examination of different state approaches, the report identifies critical areas of decision making and development needing further exploration including:

- the development of a statewide scope of practice, core competencies, and curriculum for CHWs;
- a decision about who certification will be required for (all CHWs in the State or only those operating in teams where reimbursement is agreed upon);
- a decision about educational prerequisites for entry into certification training, including how experience may substitute for education;
- the development of education training opportunities for delivery of the curriculum;
- the development of oversight mechanisms for certification;
- a decision about the supervision and oversight of CHWs;
- decisions about how the developing infrastructure will be resourced; and
- decisions about how best to provide for a CHW career ladder, and in particular whether this is to be built into the structure of the curriculum (as in tiers of optional competencies to supplement the core competencies) or the structure of the health delivery system (as in tiers of job level).

The workgroup reached agreement on final recommendations on many of the critical areas necessary for a certification process for Maryland including: the definition of a CHW; the 10 roles of the CHW; and the 11 core competencies of a CHW. The group recommended certification be considered to meet future professional validation and that certification should have two tiers. Tier 1 (pre-certified Community Health Worker) would be made up of 80 hours of training curriculum, and may lead to Tier II training. Tier II (Certified Community Health Worker) would be rendered via a 160-hour training curriculum that could be a flexible combination of classroom and practicum (experience). The option of grandfathering in individuals with 80 hours of training and 4,000 hours of CHW experience (within two to four years) was recommended after establishing a State certification program. The workgroup recommended the creation of an oversight body to house a certification board that would approve the CHW curriculum and CHW training programs.

The report did not issue a recommendation related to reimbursement. The group did discuss the importance of considering and promoting multiple sources of payment for CHWs in the future, not just reimbursement by public and private payers. This includes promoting direct hiring of and/or contractual payment to CHWs by providers operating in risk-based payment structures, such as hospitals under the All Payer Model, ACOs, and patient centered medical homes. The group did not recommend where the training would take place (*i.e.*, college or hospital) or how the developing infrastructure would be resourced.

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$106,958	$946	$27,706	$845	$136,454
Deficiency Appropriation	0	0	0	0	0
Cost Containment	-8,815	0	0	0	-8,815
Budget Amendments	679	44	-1,895	117	-1,055
Reversions and Cancellations	-13	-114	-1,285	-237	-1,650
Actual Expenditures	**$98,809**	**$876**	**$24,525**	**$724**	**$124,934**
Fiscal 2016					
Legislative Appropriation	$104,973	$965	$25,688	$719	$132,345
Budget Amendments	-4,818	6,543	11,708	0	13,433
Working Appropriation	**$100,155**	**$7,509**	**$37,396**	**$719**	**$145,779**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

The budget for PHA closed at $125.0 million, $11.5 million below the original legislative appropriation. The fiscal 2015 budget for PHA decreased by $8.8 million in general funds due to statewide cost containment actions in July 2014 and January 2015. This includes $2.2 million for the delayed opening of the new public health laboratory, $5.9 million for the leveling of core public health funding to the fiscal 2014 level, reduced salaries and fringe benefits for the Laboratories Administration ($207,316), OCME ($161,942), and the Office of the Deputy Secretary for Public Health ($76,546). Other reductions from the cost containment include $30,000 for the 2-1-1 program at the Office of Preparedness and Response, $135,669 at OCME for reductions in equipment service contracts and utilities, reduced printing and telecommunication costs at the Vital Statistics Administration ($25,061), and an elimination of the Netsmart contract at the Vital Statistics Administration ($115,360).

Budget amendments further reduced the budget by $1.0 million. Federal funds reductions included planned ACA expenditures ($3.0 million) and the transfer of appropriations for the Behavioral Risk Factor Surveillance System from PHA to the Prevention and Health Promotion Administration (PHPA) ($432,768). This transfer reduced general funds by $192,064. General funds decreased by an additional $555,385 due to the decreased rent and utilities from the delayed lab opening.

General funds increased by $150,316 for supplies at OCME ($116,272), a contract to support the SHIP website ($18,067) and the PHAB fee ($15,977). A budget amendment increased funds by $1.1 million ($1,025,374 in general funds and $40,937 in federal funds), relating to the fiscal 2015 COLA and increments approved during the 2014 session but not included in the fiscal 2015 allowance. Federal funds increased by $1.5 million to cover the cost of the Electronic Death Registry System ($457,415), primarily Ebola-related preparedness and response activities ($639,477), and laboratory supplies and equipment ($400,000). In addition general funds increased by $223,625 and $25,540, respectively, to realign health insurance costs and the Department of Budget and Management Telecommunication appropriations within DHMH. An amendment to cover the increased cost of a contract with Donate Life to provide organ and tissue donation awareness increased special funds by $43,880.

At the end of fiscal 2015, $1.7 million of the agency's appropriation was cancelled. Of the cancelled federal funds ($1.3 million), OPR cancelled $916,857 due to issuing fewer grants for the Hospital Preparedness Program, higher turnover than expected, and reduced spending on software. In the Office of Population Health Improvement $253,382 of federal funds were cancelled due to higher turnover in leadership positions, and the reorganization of the Office of Primary Care into PHPA. In the Division of Vital Records in Executive Direction, $35,571 of federal funds were cancelled due to higher than expected turnover in special payments payroll. In the Laboratory Administration, $79,533 in federal funds were cancelled due to a decreased grant award for Tuberculosis control. The largest special fund cancellation was $98,049 from the Laboratory Administration due to a decrease in the number of samples for Chlamydia testing and viral load testing for Montgomery and Prince George's counties. Finally, $237,038 of the agency's reimbursable fund appropriation was cancelled, primarily due to competitive grant funds applied for, but not awarded to OCME under the Coverdell Forensic Sciences Improvement Grant ($181,729) and the absence of recreational water testing from labs ($50,280).

Fiscal 2016

To date, budget amendments have added $13.4 million to the budget. The budget was increased by $12.0 million in federal funds and $6.5 million in special funds to cover Ebola-related and other preparedness and response activities and laboratory supplies for newborn screening and SCID testing. The budget also increased by $479,847 in general funds and $86,844 in federal funds, which restored the 2% pay reduction. This was offset by a reduction in general funds of $4,602,544 to realign the fiscal 2016 2% cost containment reductions in accordance with agency cost containment plans. An additional reduction in federal funds ($770,040) and general funds ($695,127) was the result of the transfer of 4 positions and other responsibilities from OPHI to PHPA.

Appendix 2

Audit Findings

Health Systems and Infrastructure Administration and Office of Preparedness and Response

Audit Period for Last Audit:	July 1, 2012 – October 27, 2013
Issue Date:	March 2015
Number of Findings:	0
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

The audit did not disclose any findings.

Object/Fund Difference Report
DHMH – Public Health Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	404.90	399.90	399.90	0.00	0%
02 Contractual	11.43	14.10	14.30	0.20	1.4%
Total Positions	**416.33**	**414.00**	**414.20**	**0.20**	**0%**
Objects					
01 Salaries and Wages	$ 33,733,451	$ 33,851,869	$ 34,811,091	$ 959,222	2.8%
02 Technical and Spec. Fees	856,108	917,885	948,950	31,065	3.4%
03 Communication	517,731	626,820	589,283	-37,537	-6.0%
04 Travel	144,024	400,484	128,196	-272,288	-68.0%
06 Fuel and Utilities	1,308,328	3,003,930	3,026,725	22,795	0.8%
07 Motor Vehicles	21,174	57,160	25,578	-31,582	-55.3%
08 Contractual Services	15,132,057	18,004,291	15,980,869	-2,023,422	-11.2%
09 Supplies and Materials	5,987,654	6,792,138	6,054,168	-737,970	-10.9%
10 Equipment – Replacement	105,277	32,483	202,504	170,021	523.4%
11 Equipment – Additional	307,703	520,583	22,000	-498,583	-95.8%
12 Grants, Subsidies, and Contributions	49,321,320	62,508,052	58,726,622	-3,781,430	-6.0%
13 Fixed Charges	17,499,500	19,063,121	19,358,097	294,976	1.5%
Total Objects	**$ 124,934,327**	**$ 145,778,816**	**$ 139,874,083**	**-$ 5,904,733**	**-4.1%**
Funds					
01 General Fund	$ 98,808,732	$ 100,154,836	$ 105,103,502	$ 4,948,666	4.9%
03 Special Fund	875,721	7,508,599	7,447,502	-61,097	-0.8%
05 Federal Fund	24,525,478	37,395,922	26,512,288	-10,883,634	-29.1%
09 Reimbursable Fund	724,396	719,459	810,791	91,332	12.7%
Total Funds	**$ 124,934,327**	**$ 145,778,816**	**$ 139,874,083**	**-$ 5,904,733**	**-4.1%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Public Health Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Executive Direction	$ 6,712,466	$ 6,520,022	$ 6,872,301	$ 352,279	5.4%
01 Health Systems and Infrastructure Administration	2,642,661	2,070,027	1,477,591	-592,436	-28.6%
07 Core Public Health Services	46,236,209	50,156,898	53,981,474	3,824,576	7.6%
01 Post Mortem Examining Services	11,428,595	11,493,150	12,053,911	560,761	4.9%
01 Office of Preparedness and Response	15,116,933	28,178,248	17,877,200	-10,301,048	-36.6%
01 Laboratory Services	42,797,463	47,360,471	47,611,606	251,135	0.5%
Total Expenditures	**$ 124,934,327**	**$ 145,778,816**	**$ 139,874,083**	**-$ 5,904,733**	**-4.1%**
General Fund	$ 98,808,732	$ 100,154,836	$ 105,103,502	$ 4,948,666	4.9%
Special Fund	875,721	7,508,599	7,447,502	-61,097	-0.8%
Federal Fund	24,525,478	37,395,922	26,512,288	-10,883,634	-29.1%
Total Appropriations	**$ 124,209,931**	**$ 145,059,357**	**$ 139,063,292**	**-$ 5,996,065**	**-4.1%**
Reimbursable Fund	$ 724,396	$ 719,459	$ 810,791	$ 91,332	12.7%
Total Funds	**$ 124,934,327**	**$ 145,778,816**	**$ 139,874,083**	**-$ 5,904,733**	**-4.1%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

M00F03
Prevention and Health Promotion Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$53,261	$37,262	$37,510	$247	0.7%
Deficiencies and Reductions	0	1,456	-40	-1,496	
Adjusted General Fund	**$53,261**	**$38,719**	**$37,469**	**-$1,249**	**-3.2%**
Special Fund	92,669	111,779	113,958	2,179	1.9%
Deficiencies and Reductions	0	0	-6	-6	
Adjusted Special Fund	**$92,669**	**$111,779**	**$113,952**	**$2,174**	**1.9%**
Federal Fund	183,087	206,619	206,974	355	0.2%
Deficiencies and Reductions	0	0	-72	-72	
Adjusted Federal Fund	**$183,087**	**$206,619**	**$206,901**	**$283**	**0.1%**
Reimbursable Fund	2,553	6,355	2,476	-3,879	-61.0%
Adjusted Reimbursable Fund	**$2,553**	**$6,355**	**$2,476**	**-$3,879**	**-61.0%**
Adjusted Grand Total	**$331,570**	**$363,471**	**$360,799**	**-$2,672**	**-0.7%**

- There is one proposed deficiency for fiscal 2016 of $1.5 million to provide funds to pay the State share of Certificate of Need expenses for the proposed new regional medical center in Prince George's County.

- After adjusting for a fiscal 2016 deficiency appropriation and a back of the bill reduction in health insurance, the Governor's fiscal 2017 allowance decreases by $2.7 million (0.7%) over the fiscal 2016 working appropriation.

- Supplemental budget number one, not included in the table, adds a $15.0 million operating grant to the University of Maryland Medical System to ease the transition to the new regional medical center in Prince George's County.

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

For further information contact: Lindsey B. Holthaus Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	362.80	366.80	426.80	60.00
Contractual FTEs	3.96	6.11	6.12	0.01
Total Personnel	**366.76**	**372.91**	**432.92**	**60.01**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	18.78	5.12%
Positions and Percentage Vacant as of 12/31/15	14.80	4.03%

- The fiscal 2017 allowance includes an increase of 60.0 regular full-time equivalents (FTE) over the fiscal 2015 working appropriation but the same number of contractual FTEs. Of the 60.0 new FTEs, 58.0 are federally funded and are contract conversions of individuals currently employed through the Maryland Institute for Policy Analysis and Research. The other additional new FTEs are added for Synar Tobacco enforcement.

- As of December 31, 2015, there were 14.8 vacant positions, less than the number of positions needed to meet turnover.

Analysis in Brief

Major Trends

Infant Mortality Rates Decrease for Whites, Increase for African Americans: Maryland's infant mortality rate for calendar 2012 represents the lowest rate ever recorded in Maryland. Following national trends, Maryland's infant mortality rate among African Americans has consistently been disproportionally high but has declined in the past several years (driving the overall reduction in the infant mortality rate). In calendar 2014, infant mortality increased slightly for African Americans for the second year in a row, while overall infant mortality rates decreased slightly from calendar 2013. Infant mortality rates continue to vary widely by geographic region, likely driven by racial disparities.

Cancer Mortality Rates Continue to Improve: Both the overall cancer mortality rate and the breast cancer mortality rate continue to decline steadily in Maryland. The prevalence of cigarette smoking among all ages has continued to decrease.

Childhood Vaccination Rates Decrease, Remain Above National Average: In calendar 2014, 74% of children in Maryland received the typical coverage of vaccinations – a slight decrease from the previous calendar year. The Maryland rate remains above the national average of 72%.

Syphilis Rates Remain High, While Chlamydia Rates Increase: In calendar 2014, the Centers for Disease Control and Prevention reported a statewide infection rate of primary and secondary syphilis in Maryland of 7.6 cases per 100,000 population. This rate, driven by high primary and secondary syphilis rates in Baltimore City, is the eighth highest in the nation and has remained relatively constant since the calendar 2011 rate. Meanwhile, chlamydia rates statewide have continued to approximate the national average and increased slightly in 2014 from the previous calendar year. Chlamydia continues to be driven by high rates among women, with the highest rates among African American women.

HIV and AIDS Cases, High among States, Continue to Decline: Despite a steady decline in newly reported Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) cases, Maryland's incidence of new cases remains high compared with other states. According to the most recent national data, Maryland had the seventh highest number of newly reported HIV cases among states.

Maryland AIDS Drug Assistance Program Enrollment Continues to Decline: The Maryland AIDS Drug Assistance Program (MADAP) and MADAP-Plus enrollment reached an estimated 7,759 and 3,313 enrollees, respectively, in calendar 2012. However, the fiscal 2017 allowance reflects the decline in MADAP program enrollment in more recent years due to the implementation of federal health care reform.

Issues

Increasing Prevalence of Diabetes and Obesity: The percent of Marylanders considered overweight or obese (a body mass index greater than or equal to 25) reached 65.0% in calendar 2014. Being overweight or obese puts individuals at risk for a number of diseases, including diabetes. The prevalence of diabetic adults in Maryland has also grown from 6.8% in 1999 to 10.0% in 2014. Among the Maryland diabetic population, co-morbidities such as high blood pressure, high cholesterol, obesity, and smoking increase mortality, complications, hospitalization, and cost of treatment.

Underutilization of Providers Accepting Practice Obligations: The State Loan Repayment Program (SLRP) offers providers an opportunity to practice their profession in a community that lacks adequate primary and/or mental health services while also receiving funds to pay their educational loans. The Department of Health and Mental Hygiene has identified areas with critical shortages of primary care physicians. However, the number of providers accepting a SLRP obligation has remained underutilized and static since 2012.

Recommended Actions

1. Adopt narrative requesting a report on obesity and diabetes initiatives.

Updates

Fee Reduction Fiscal Impact: On September 15, 2015, the Governor announced a plan to reduce a number of fees across State government. A number of fee reductions in the Prevention and Health Promotion Administration were part of that plan.

M00F03
Prevention and Health Promotion Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The mission of the Prevention and Health Promotion Administration (PHPA) is to protect, promote, and improve the health and well-being of Marylanders and their families through the provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community-based organizations, and public- and private-sector agencies.

PHPA accomplishes this by focusing, in part, 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. Additionally, the administration works to assure the availability of quality primary prevention and specialty care health services with special attention to at-risk and vulnerable populations. Finally, the administration aims to prevent and control chronic diseases, engage in disease surveillance and control, prevent injuries, provide health information, and promote health behaviors. The administration was formed from the integration of the former Infectious Disease and Environmental Health Administration and the Family Health Administration on July 1, 2012.

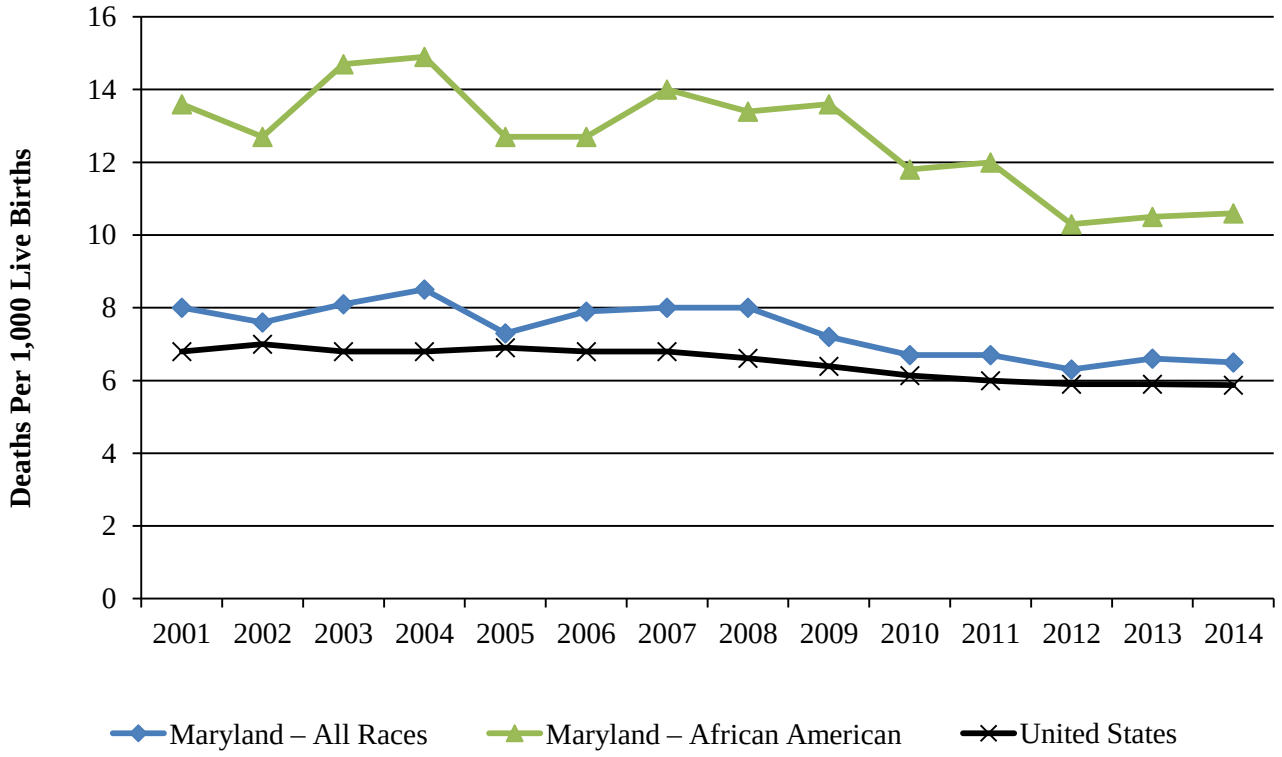
Performance Analysis: Managing for Results

1. Infant Mortality Rates Decrease for Whites, Increase for African Americans

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

In calendar 2002, the U.S. infant mortality rate increased for the first time since 1958. According to the National Center for Health Statistics, infant mortality rates were the highest among mothers who smoked, had no prenatal care, were teenagers, were unmarried, and had less education. Following the national trend, Maryland's overall infant mortality rate increased from calendar 2002 through 2004 to 8.5 deaths per 1,000 live births. Since that time, Maryland has made steady progress to reduce its infant mortality rate, reaching a low of 6.3 in calendar 2012 (the lowest rate ever recorded in Maryland) as shown in **Exhibit 1**. Following national trends, Maryland's African American infant mortality rate has consistently been higher than other races. This rate has generally declined in the past several years – driving the overall reduction in the infant mortality rate – but increased slightly in both calendar 2013 and 2014. Interestingly, in calendar 2014, overall infant mortality rates decreased slightly from calendar 2013 (to 6.5) in spite of the increase in the infant mortality rate among African Americans.

Exhibit 1
Infant Mortality Rates
Calendar 2001-2014

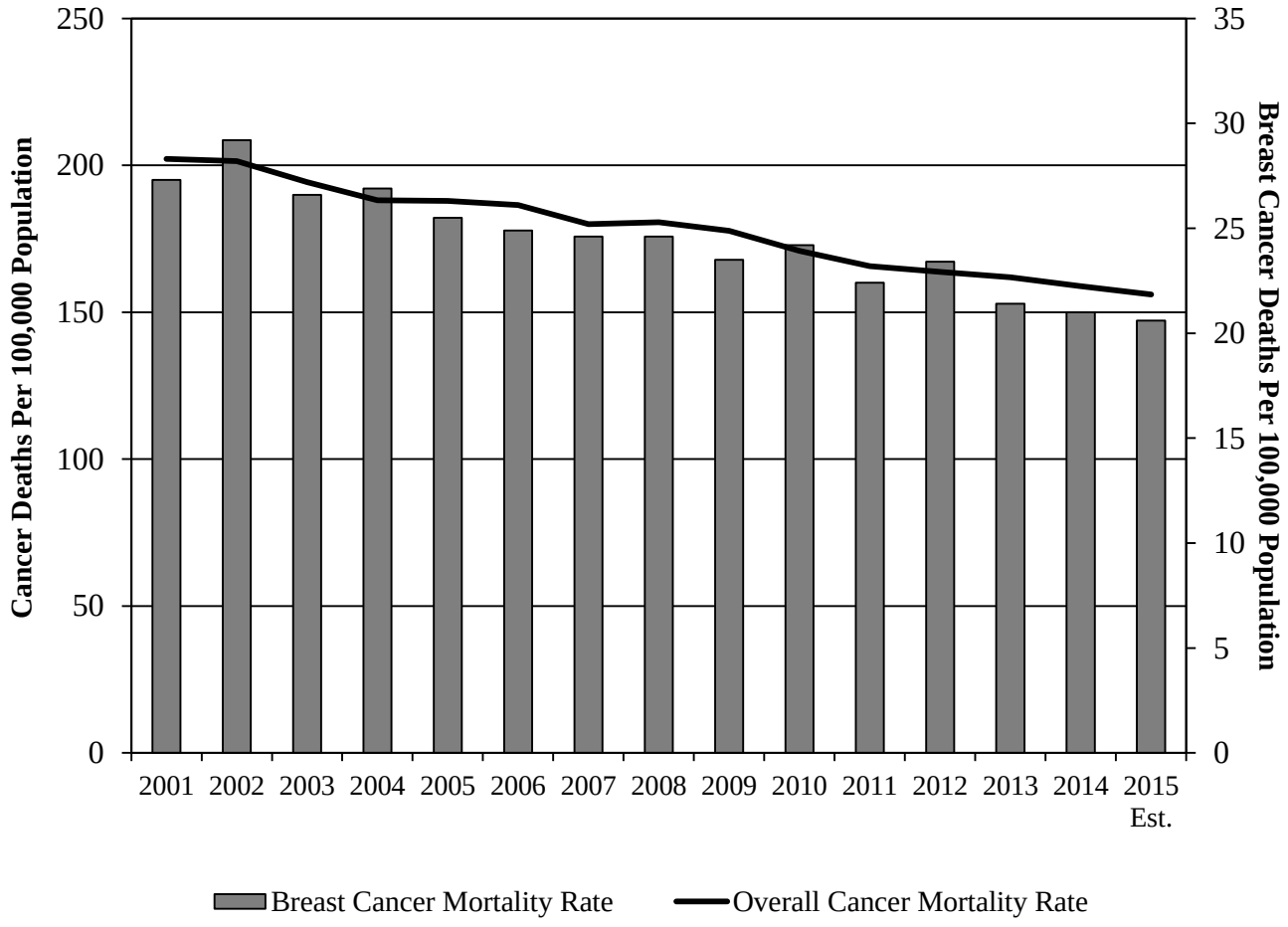


Source: Department of Health and Mental Hygiene

2. Cancer Mortality Rates Continue to Improve

One of the main functions of the Cancer Prevention, Education, Screening, and Treatment Program is to fund community-based programs that prevent, detect, and treat cancer. The mission of the program is to reduce the burden of cancer among Maryland residents by reducing overall cancer mortality in the State. **Exhibit 2** shows that there has been a steady decline in both the overall cancer mortality rate and the breast cancer mortality rate in Maryland. The cancer programs within the Cigarette Restitution Fund (CRF) target colorectal cancer and cancers associated with tobacco use.

Exhibit 2
Cancer Mortality Rates
Calendar 2001-2015 Est.

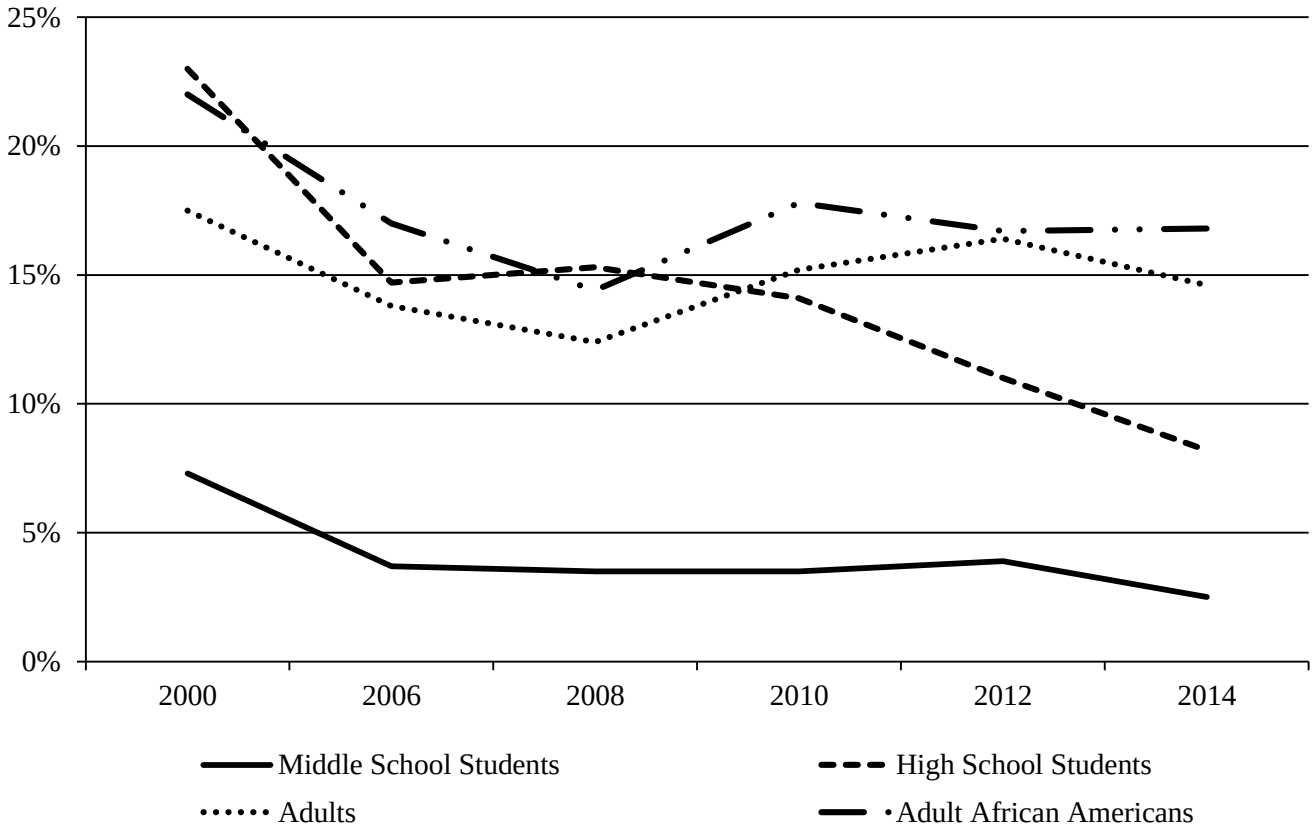


Source: Department of Health and Mental Hygiene

Tobacco Use Prevention and Cessation Program

The mission of the Tobacco Use Prevention and Cessation Program is to reduce the use of tobacco products and to reduce the burden of tobacco-related morbidity and mortality in the State. One of the goals of the program is to reduce the proportion of Maryland youth and adults who currently smoke cigarettes. Surveys funded with CRF revenue are intended to track smoking preferences and usage among Marylanders. As shown in **Exhibit 3**, the prevalence of cigarette smoking has decreased by 66.0% among public middle school students (from 7.3% in calendar 2000 to 2.5% in calendar 2014) and by 64.0% among underage public high school students (from 23.0% in calendar 2000 to 8.2% in calendar 2014).

Exhibit 3
Tobacco Usage Rates
Calendar 2000-2014



Note: See text for discussion of survey methodology.

Source: Department of Health and Mental Hygiene

It should be noted that the Behavioral Health Administration (BHA) and PHPA have traditionally undertaken a variety of activities to ensure compliance with State tobacco laws and federal funding requirements (the Synar amendment) as they pertain to minors, including merchant compliance checks. As a result of an audit revealing that the State was out of compliance with federal Synar inspection outcomes, the State had penalty requirements of $1.4 million and $3.9 million in fiscal 2015 and 2016, respectively. The penalties equated to additional level of State spending on compliance activities. The education and enforcement programs funded reduced the noncompliance rate to 13.8% in federal fiscal 2016. Although the noncompliance rate fell below the threshold that would result in a penalty of 20.0%, the fiscal 2017 allowance includes $2 million and 2 new positions in PHPA to provide retailer education and some local enforcement responsibilities.

The Department of Legislative Services (DLS) notes that although in Exhibit 3 it appears that the percentage of adults who smoke cigarettes increased significantly from calendar 2008 through 2012, this is misleading. Beginning in calendar 2011, the Centers for Disease Control and Prevention (CDC) began using a new, more comprehensive weighting methodology that generates more accurate estimates of adult tobacco use in Maryland. Thus, higher estimates of tobacco use among adults result, at least in part, from changes in survey methodology and not necessarily from any increase in tobacco use. However, since calendar 2012, while tobacco use among all adults has fallen, it has risen among African Americans.

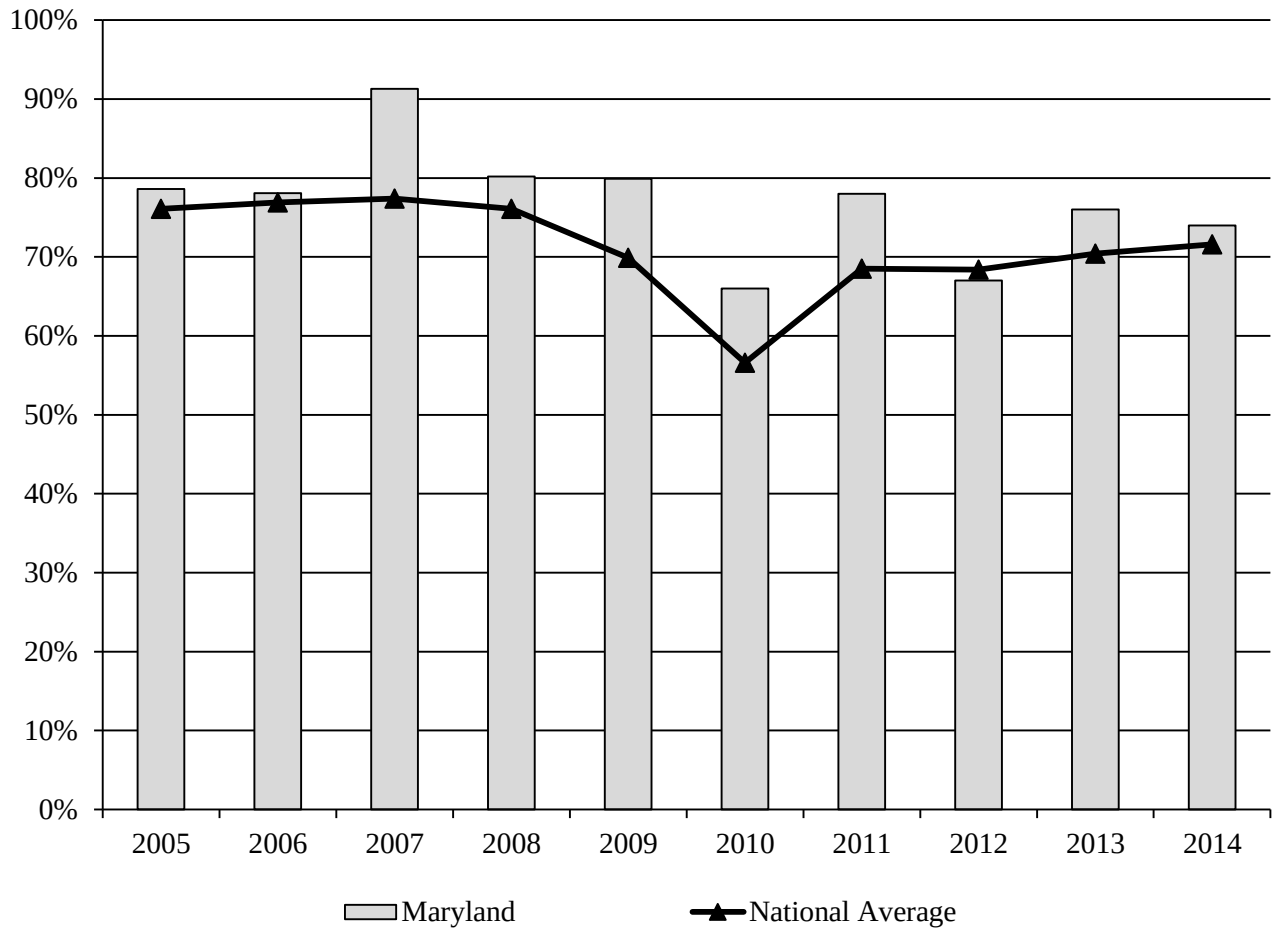
3. Childhood Vaccination Rates Decrease, Remains Above National Average

As shown in **Exhibit 4**, 74% of children in Maryland received the typical coverage of vaccinations in calendar 2014, which is above the national average of 70%. Between calendar 2006 and 2007, the rate of immunizations jumped 13 percentage points, although, reasons for this increase were unclear. In calendar 2008, the vaccination rate returned to historic levels. Low points in calendar 2010 and 2012 resulted, in both cases, from nationwide vaccine shortages. Maryland's childhood vaccination rates have generally remained slightly above national rates.

Maryland is able to keep its vaccination rates relatively high for several 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 850 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 Medicaid eligible;
- are uninsured;
- are Native American or Alaskan Native; or
- are underinsured.

Exhibit 4
Rates of Children, Ages 19 to 35 Months, with Up-to-date Immunizations
Calendar 2005-2014



Source: Department of Health and Mental Hygiene

4. Syphilis Rates Remain High, While Chlamydia Rates Increase

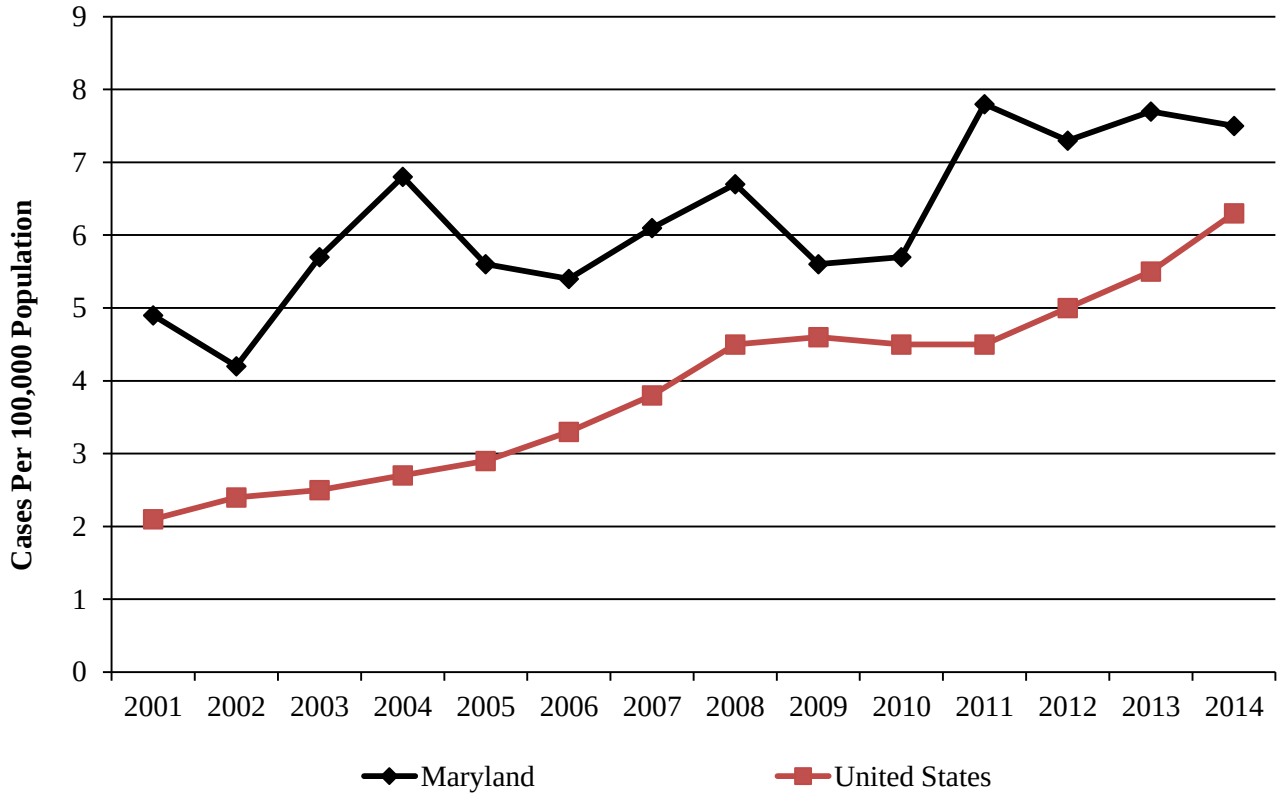
Syphilis Infection Rates

PHPA is charged with preventing and controlling the transmission of infectious diseases, including sexually transmitted infections (STI). The administration has developed initiatives to reduce the spread of STIs, with an emphasis on at-risk populations, such as economically disadvantaged and

incarcerated populations. Syphilis continues to be a major concern in the State, with the rate of infection in Maryland among the highest in the nation. Untreated syphilis in pregnant women can result in infant death in up to 40% of cases. In addition to its primary effects, syphilis presents public health concerns for its role in facilitating transmission of Human Immunodeficiency Virus (HIV).

Exhibit 5 shows syphilis rates in Maryland compared with the national average. In calendar 2014, CDC reported a statewide infection rate of primary and secondary syphilis in Maryland of 7.5 cases per 100,000 population. The primary and secondary stages are curable, yet extremely contagious. If left untreated the disease may progress into the tertiary stage, which may not be curable. This rate, driven by high primary and secondary syphilis rates in Baltimore City (30.9 cases per 100,000 population), is one of the highest in the nation (eighth) and has remained relatively constant since calendar 2011.

Exhibit 5
Rates of Primary/Secondary Syphilis
Calendar 2001-2014



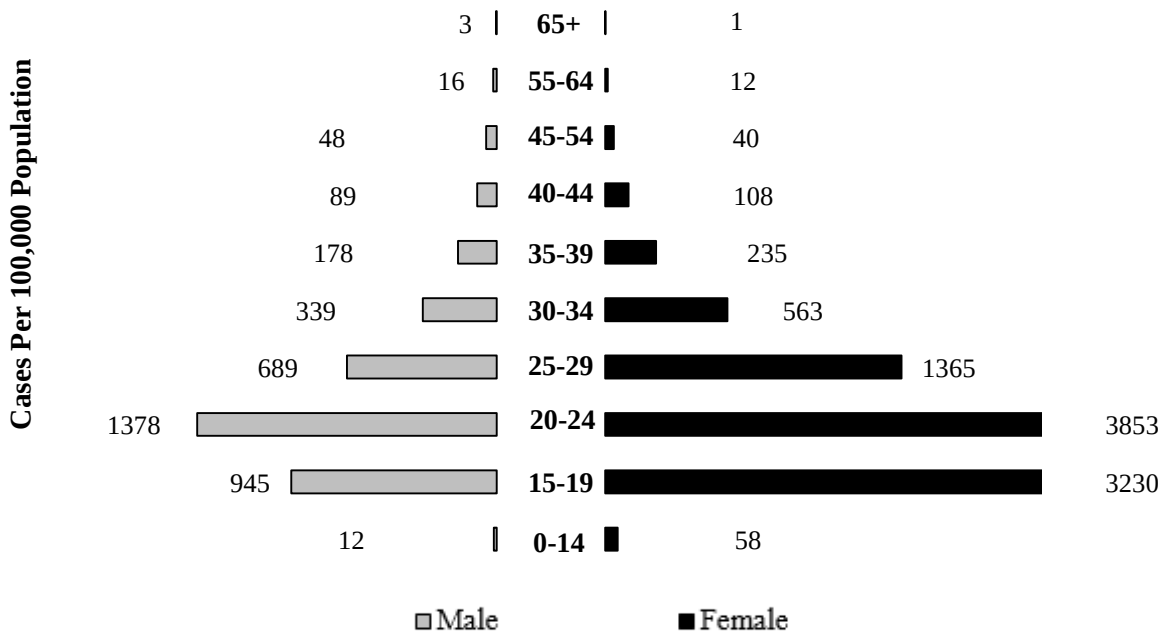
Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

CDC has indicated that syphilis remains a major health problem, with increases in rates persisting among men who have sex with men (who account for a majority of all primary and secondary syphilis cases). Moreover, cases that involve men who have sex with men have been characterized by high rates of HIV co-infection. DHMH advises that these trends are consistent with infection rates seen in Maryland. Accordingly, the Baltimore City Health Department (BCHD) has implemented programs to specifically target this population.

Chlamydia Infection Rates

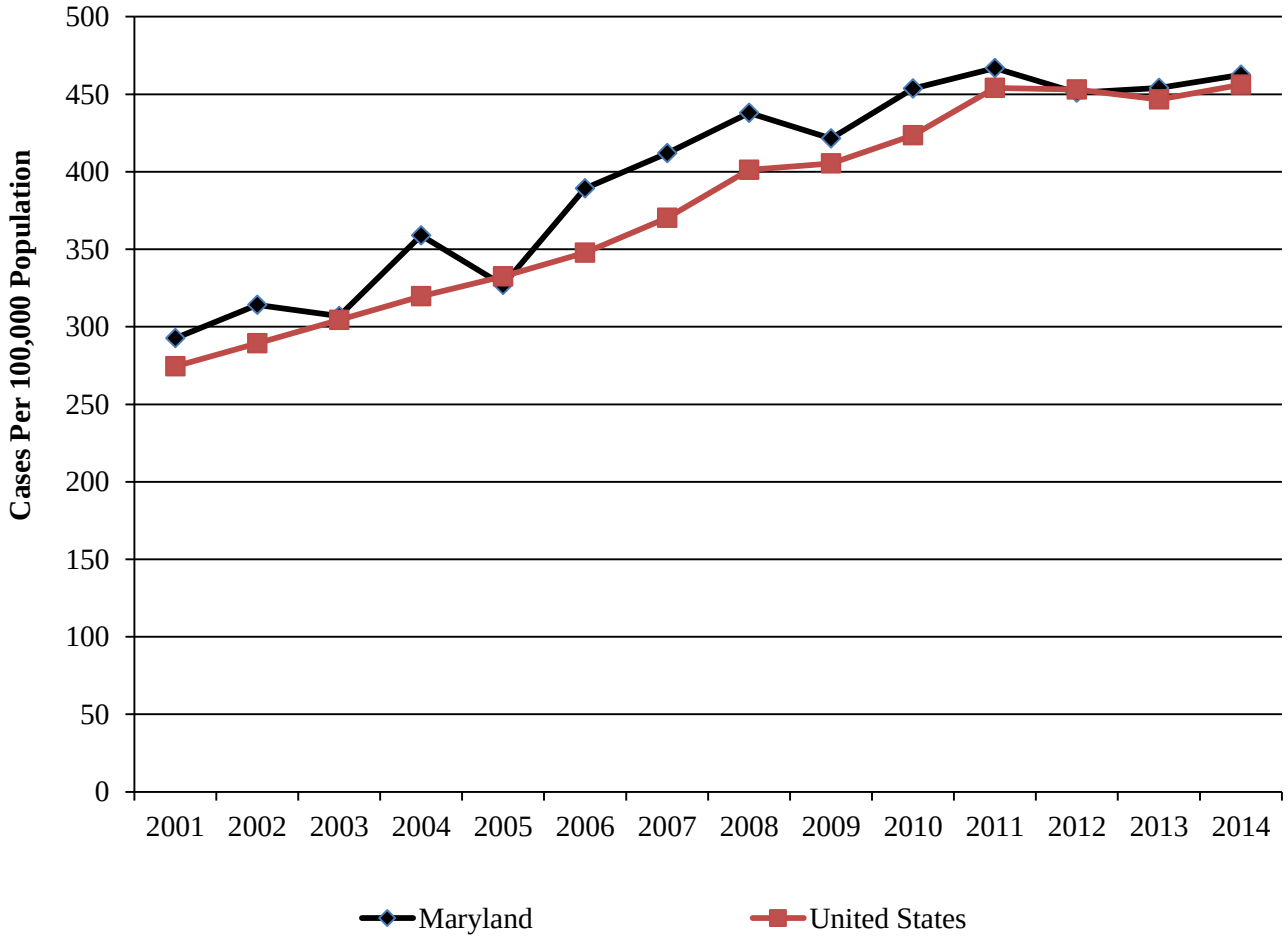
Chlamydia rates statewide have continued to increase and approximate the national average. Consistent with national trends, chlamydia rates for females are two and a half times greater than those for males. **Exhibit 6** shows rates are driven by high rates among 15- to 24-year olds, where rates for females are three times greater than those for males. The rates among both male and female 15- to 24-year olds are driven by high rates among the African American population where rates are nearly six times as high as those for whites. Chlamydia rates increased slightly in 2014 from the previous year, as shown in **Exhibit 7**.

Exhibit 6
Rate of Chlamydia by Age
Calendar 2014



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

Exhibit 7
Rate of Chlamydia
Calendar 2001-2014



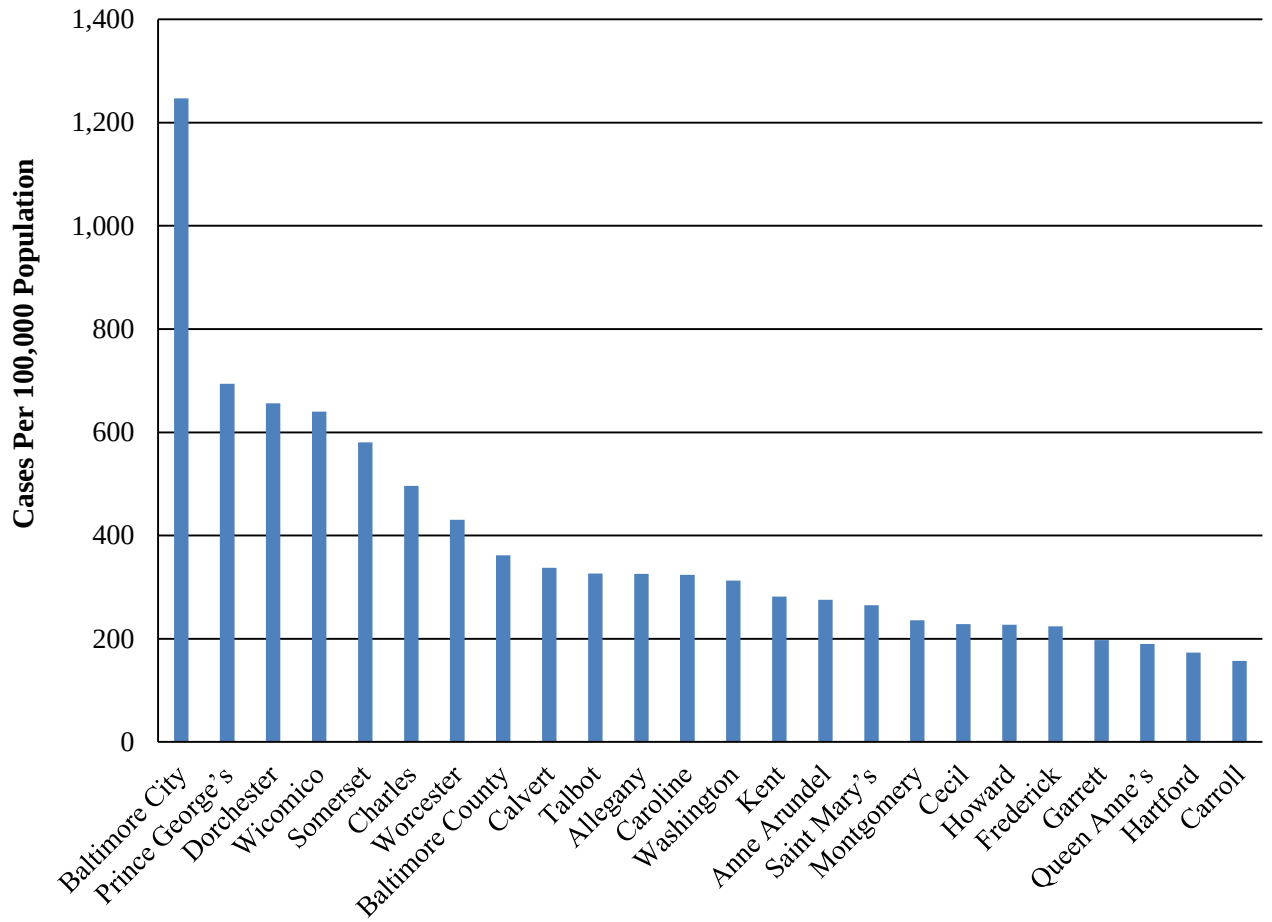
Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

In Baltimore City, where rates for all STIs are the highest in the State, BCHD receives funding directly from CDC to respond to STIs. Among other activities, Baltimore City has an active outreach program to find and test high-risk individuals, including commercial sex workers. It also has a STI clinic that provides free testing and treatment, as well as school-based clinics that test for chlamydia and gonorrhea. In addition, BCHD works with the Baltimore City central booking and intake facility to link inmates who are HIV positive to care prior to their release. Finally, the city has an expedited partner therapy (EPT) pilot project for chlamydia and gonorrhea, which allows individuals with these STIs to distribute antibiotics to their sexual partners. Patients can deliver antibiotics to up to three of their partners without a prescription and without the health care provider first examining their partners.

By treating individuals and their partners, the EPT pilot project aims to prevent individuals from being reinfected with the disease by their partners.

In addition to Baltimore City, other counties also have consistently high rates of chlamydia including (cases per 100,000 population) Prince George's (694.0), Dorchester (656.0), Wicomico (646.0), Somerset (580.0), and Charles counties (496.4), as shown in **Exhibit 8. The agency should comment on initiatives aimed at preventing chlamydia in the other high rate counties.**

Exhibit 8
Rate of Chlamydia by County
Calendar 2013

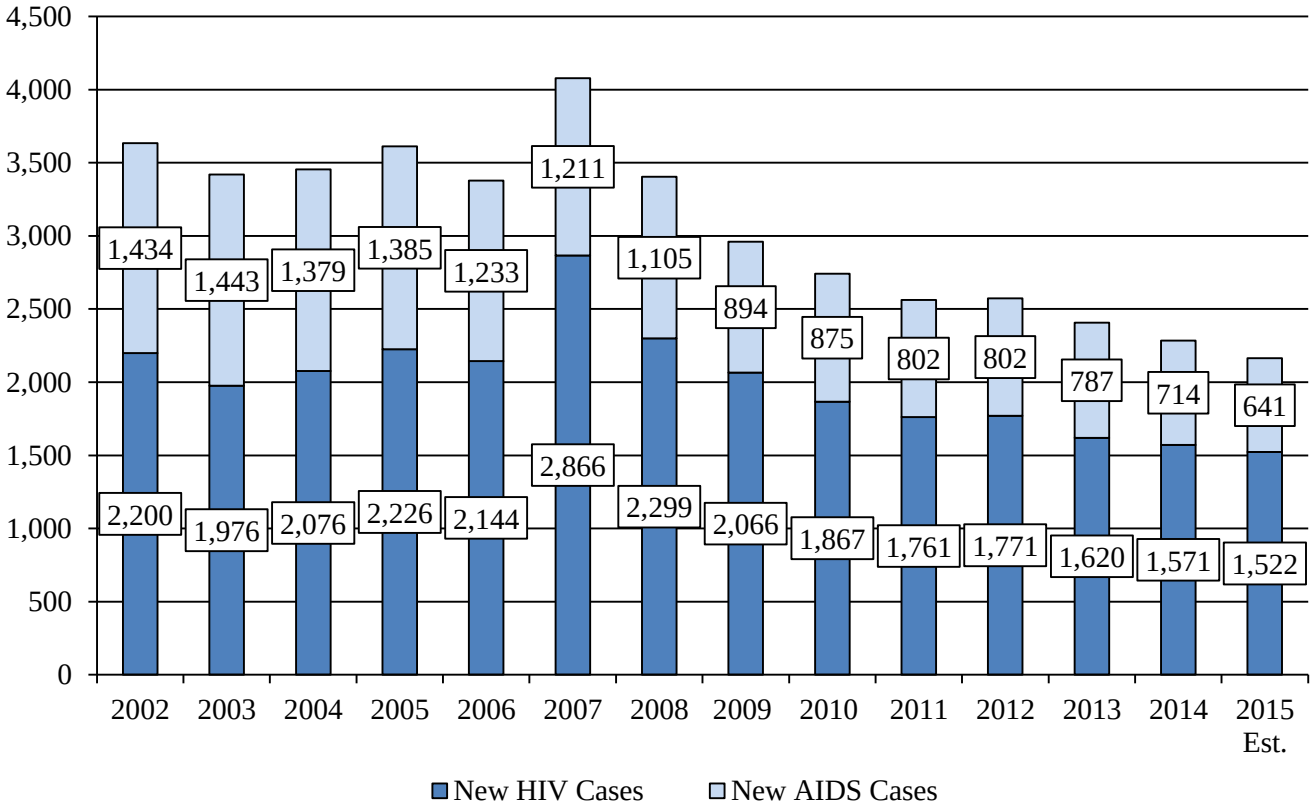


Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

5. HIV and AIDS Cases, High among States, Continue to Decline

Exhibit 9 details the continued decline in newly reported cases of HIV and AIDS in Maryland. As the chart demonstrates, after stalling in calendar 2012, that decline continued in 2013 and 2014.

Exhibit 9
Incidence of New HIV and AIDS in Maryland
Calendar 2002-2015 Est.



AIDS: Acquired Immunodeficiency Syndrome
HIV: Human Immunodeficiency Virus

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

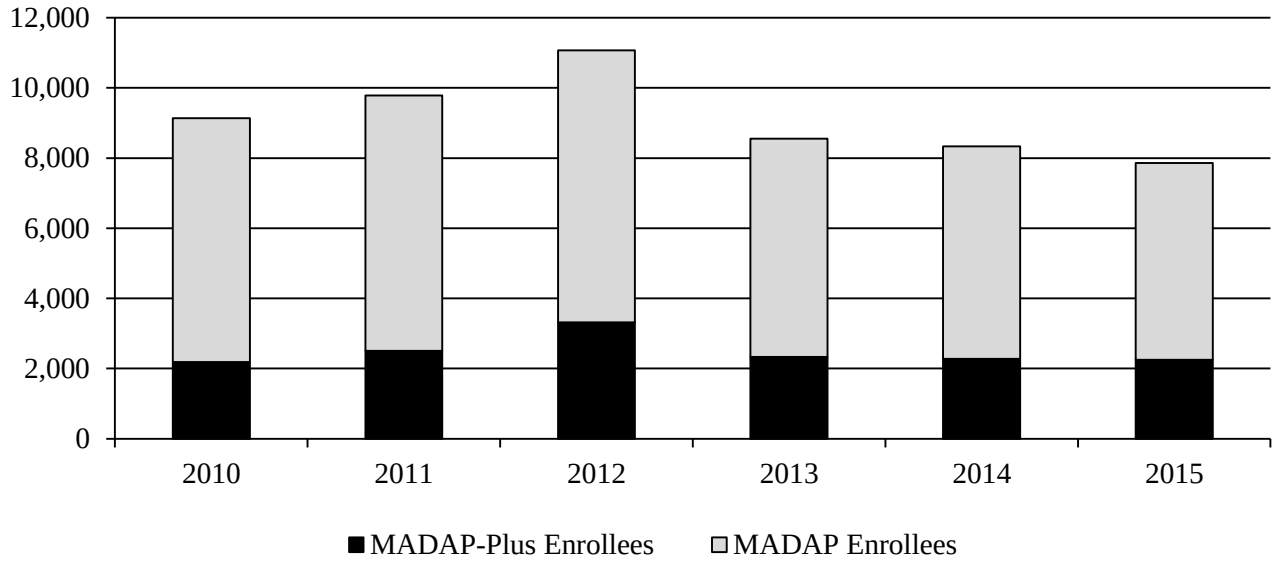
Despite the downward trend, the number of newly reported HIV cases in Maryland remains high compared with other states. According to the most recent national comparison conducted by CDC (based on calendar 2013 data), Maryland had the seventh highest number of newly reported HIV cases among states.

6. Maryland AIDS Drug Assistance Program Enrollment Continues to Decline

PHPA provides two major health services programs related to HIV/AIDS: the Maryland AIDS Drug Assistance Program (MADAP) and MADAP-Plus. MADAP is the larger of the two programs with an estimated 5,611 enrollees in fiscal 2015. MADAP helps Maryland residents pay for certain drugs prescribed to treat HIV/AIDS. Clients are certified eligible for MADAP for a one-year period, after which time they may reapply for certification. MADAP eligibility requirements are up to 500% of the federal poverty level, along with extremely generous drug coverage. MADAP-Plus offers health insurance assistance to individuals living with HIV/AIDS at the same income levels and had 2,252 enrollees in fiscal 2015.

As shown in **Exhibit 10**, both MADAP and MADAP-Plus experienced enrollment growth in fiscal 2010 through 2012. In particular, MADAP-Plus enrollment increased due to the elimination of the Maryland AIDS Insurance Assistance Program in June 2009 and due to the recession (as a higher number of individuals were in need of health insurance). In fiscal 2012, MADAP and MADAP-Plus enrollment reached highs of 7,759 and 3,313 enrollees, respectively. However, MADAP enrollment has since declined, due to the implementation of federal health care reform.

Exhibit 10
MADAP and MADAP-Plus Enrollment
Fiscal 2010-2015



MADAP: Maryland AIDS Drug Assistance Program

Note: An individual must be enrolled in MADAP in order to be enrolled in MADAP-Plus.

Source: Department of Health and Mental Hygiene

Fiscal 2016 Actions

Cost Containment

The fiscal 2016 budget bill contained a 0.6% across-the-board general fund reduction to DHMH totaling $27.2 million. The agency's proportion of the cut amounted to $442,730 due to the elimination of a grant to the University of Maryland Medical System (UMMS) for the Montebello Rehabilitation Center at Kernan Hospital to support 50.0% of annual debt service on bonds issued in fiscal 2004. The grant was also cut as part of the fiscal 2015 cost containment, and the annual agreement was not renewed in anticipation of the fiscal 2016 reduction.

Deficiencies

There is a general fund deficiency for fiscal 2016 of $1.5 million to pay the State share of Certificate of Need (CON) expenses for the proposed new regional medical center in Prince George's County. **The agency should comment on the reason the State is providing funding for the CON and whether the State covers a portion of the costs of other CON applications. The agency should also comment on what entity will receive the funds.**

Proposed Budget

As shown in **Exhibit 11**, after adjusting for a fiscal 2016 deficiency appropriation and a back of the bill reduction in health insurance, the fiscal 2017 allowance decreases by $2.7 million from the fiscal 2016 working appropriation, primarily due to a reduction in HIV health services and a reduction in reimbursable funds for Synar Tobacco enforcement from BHA. General funds and reimbursable funds decrease by $1.4 million (-3.2%) and $3.9 million (61%), respectively. Federal fund support increases by $0.3 million (0.1%) while special funds increase by $2.2 million (1.9%).

Exhibit 11
Proposed Budget
DHMH – Prevention and Health Promotion Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$53,261	$92,669	$183,087	$2,553	$331,570
Fiscal 2016 Working Appropriation	38,719	111,779	206,619	6,355	363,471
Fiscal 2017 Allowance	37,469	113,952	206,901	2,476	360,799
Fiscal 2016-2017 Amount Change	-$1,249	$2,174	$283	-$3,879	-$2,672
Fiscal 2016-2017 Percent Change	-3.2%	1.9%	0.1%	-61.0%	-0.7%

Where It Goes:

Personnel Expenses	
New positions (60 full-time equivalent)	$4,442
Retirement	707
Employee and retiree health insurance	686
Turnover adjustment	74
Overtime	31
Regular earning and adjustment	-115
Workers' compensation premium assessment	-117
Other fringe benefits	-11
HIV/AIDS Programs	
Housing Opportunities for Persons with AIDS	923
Infectious disease prevention and care – HIV	-240
Expiration of HIV Prevention funding (SAMHSA)	-401
HIV Health Services (federal and special funds)	-10,566
Healthiest Maryland Programs	
Healthiest Maryland local health department funding (PPHF)	3,500
Healthiest Maryland Statewide funding (PPHF)	550
Healthiest Maryland non-PPHF Funding	-240
Other Changes	
Affordable Care Act maternal infant and childcare (federal funds)	1,794
Children's medical services	616
Spinal Cord Injury Trust Fund	500
Other	-54
Women, Infants, and Children	-289
Immunization	-301

Where It Goes:

Breast and cervical cancer early detection	-352
Reversal of deficiency for Certificate of Need for Prince George's Hospital Center System	-1,456
Synar and Tobacco Prevention	-2,354
Total	**-$2,672**

AIDS: Acquired Immunodeficiency Syndrome
HIV: Human Immunodeficiency Virus
PPHF: Prevention and Public Health Funding
SAMHSA: Substance Abuse and Mental Health Services Administration

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

Personnel Expenses

Personnel expenses for the agency increase by $5.7 million over the fiscal 2016 general fund appropriation, primarily due to an increase of 60 positions ($4.4 million). Of the 60 positions, 58 were originally funded through a contract with the Maryland Institute for Policy Analysis and Research (MIPAR). These positions are federally funded, and by insourcing these positions, DHMH can recover indirect costs instead of MIPAR, estimated at $0.8 million in fiscal 2017.

Exhibit 12 shows the fiscal 2016 costs of the employees (contracted through MIPAR) at $3.4 million. The fiscal 2017 cost for the employees' increases to $4.2 million, however, the State now receives $0.8 million of federal indirect cost revenues associated with employing those individuals. In fiscal 2016, overhead costs were included in the contract with University of Maryland. The increase in personnel costs in the PHPA budget are offset by decreases in contract expenses in 26 programs throughout PHPA, the largest of which being HIV-related programs, which received 24 employees who were currently employed through the contract with MIPAR.

Exhibit 12
Cost of Insourcing MIPAR Employees
Fiscal 2016-2017

	Total 2016 Costs	2017 Costs	Difference
MIPAR Employees (FF)	$3,415,475.00	$4,150,211.45	$734,736.45
GF Savings from Indirect Cost Recoveries			-$783,785.22

FF: federal funds
GF: general funds
MIPAR: Maryland Institute for Policy Analysis and Research

Source: Department of Legislative Services

The last time DHMH insourced jobs from MIPAR, 2005 legislation was enacted to ensure MIPAR employees were placed in a comparable classification in the State Personnel Management System without going through the hiring process and received a salary level comparable to the salary under MIPAR. Similar legislation will need to be introduced during the 2016 session to accomplish the same thing.

An additional 2 positions were added for Synar tobacco enforcement to aid in retailer compliance. Outside of the new positions, major personnel changes are increases of $686,000 for employee and retiree health insurance and $707,000 for employee retirement.

HIV Programs

Funds for HIV programs decrease by $11.1 million. Of this amount, $400,000 is due to the expiration of HIV prevention and Substance Abuse and Mental Health Services Administration funding. The remaining $10.7 million reflects a reduction in expenditures for Ryan White Part B covered services. The fiscal 2016 budget reflected additional funding for HIV programs following the enactment of Chapter 384 of 2015, which became effective July 1, 2015. Chapter 384 expanded the authorized use of pharmaceutical rebates to include all Ryan White Part B covered services including outreach services and medical transportations. Ryan White Part B funding is required to be the payer of last resort; if another payer can be identified for services, then that payer must be billed. As a greater proportion of individuals are served within the Medicaid program or private insurance due to the full implementation of federal health care reform, the agency realized that it could not achieve the level of expenditures originally envisioned in fiscal 2016 and, therefore, revised down estimated expenditures for fiscal 2017.

An increase in funding for Housing Opportunities for People with AIDS (HOPWA) partially offsets the decrease by adding $920,000 to the budget in fiscal 2017. The agency is implementing a spending plan to reduce previously unexpended HOPWA funds and to ensure greater access to housing for persons with HIV by providing 3 housing case managers to serve clients in the Western Region and St. Mary's County. This funding will provide:

- tenant-based rental assistance to 39 households;
- short-term rent, mortgage and utility assistance to 102 households; and
- permanent housing placement assistance to 44 households.

Rebate dollars can be used to provide assistance once all of the spend-down funds have been exhausted. Funding for infectious disease prevention, care planning, and quality improvement falls by $240,000 in the fiscal 2017 budget. The decrease reflects a reduction for services related to quality improvement activities that are required for Ryan White funded HIV health services.

Prevention and Public Health Funding

The Affordable Care Act established the Prevention and Public Health Fund (PPHF) to provide national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. The budget increases by $3.5 million in federal funds for Healthiest Maryland local health department funding using the PPHF and $550,000 in federal funds for Healthiest Maryland statewide funding. This funding includes:

- $1.6 million for Heart Disease and Stroke Prevention (HDSP) funding to local health departments and $116,000 for statewide HDSP initiatives;
- $1.6 million for diabetes initiative funding to local health departments and $252,000 for statewide diabetes funding;
- $182,000 for funding statewide Nutrition Physical Activity and Obesity initiatives; and
- $309,000 for school health funding to local health departments.

The grant funding for HDSP and diabetes supports local health departments in nine identified counties – Allegany, Caroline, Dorchester, Garrett, Somerset, Washington, Worcester, Wicomico and Baltimore City – to implement evidence-based chronic disease strategies targeting disparate populations and maintain the infrastructure and partnerships to implement the CDC State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke grant in their community. The grant funding for school health includes initiatives (such as increasing access to healthy foods and beverages) aimed to reduce gaps in health status by focusing efforts on specific population subgroups disproportionately affected by chronic disease. The fiscal allowance included a $240,000 decrease in funding for non-PPHF funded Healthiest Maryland programs.

Synar Enforcement and Tobacco Prevention

Due to noncompliance, the State was required to enhance funding for Synar enforcement and tobacco prevention in fiscal 2015 and 2016 or risk losing additional federal substance abuse prevention and treatment block grant funding. PHPA received $4 million in reimbursable funds from BHA for enforcement activities in fiscal 2016. The noncompliance rate improved, and the State received no penalty in fiscal 2016. The allowance includes $2 million in special funds for the continuation of enforcement activities to reduce the risk of a penalty in the future. However, PHPA is no longer receiving funds from BHA, and overall spending declines by $2 million. Funding for the tobacco use and prevention program falls by $370,000 in federal funds. This reflects a reduction in contract funding for smoking cessation program awareness.

Maternal, Infant, and Early Childhood Home Visiting Programs

Maternal, Infant, and Early Childhood Home Visiting programs increase by $1.8 million in federal funds in the fiscal 2017 allowance. This is primarily due to an increase in funding awarded to

the University of Maryland to evaluate program managers and home visitors to improve coordination practices, $849,000. The funding to the University of Maryland Baltimore County Training Institute also increased by $522,000 to support the development of a Home Visiting Certificate Program. Additional funding is also provided to fund evidenced based home visiting programs in Prince George's County, $430,000.

Other Changes

Funding for children's medical services increases the fiscal 2017 budget by $616,000 due to an increase of children financially eligible for the program and an increase in clinic exams and hospitalizations for this population. Funding for the Special Supplemental Food and Nutrition Program falls in the budget by $300,000, reflecting a reduction in the average monthly food package from $66.42 to $64.10 and an estimated 1,000 fewer participants (to 143,000). The budget decreases $300,000 for the immunization program due to lower costs for the immunization registry maintenance. There is also a $356,000 reduction in grants to local health departments for breast and cervical cancer early detection due to less utilization of the services.

The fiscal 2017 allowance include $500,000 in special funds for the Spinal Cord Injury Trust Fund. Since fiscal 2011, monies have been unavailable to convene the board and to fund grants for spinal cord research. The Budget Reconciliation and Financing Act of 2015 (Chapter 489) authorized the transfer to the General Fund, on or before June 30, 2016, of $500,000 from the Spinal Cord Injury Research Trust Fund. **DLS recommends DHMH comment on plans for spending from the fund.**

Supplemental Funding for Prince George's Regional Medical Center

Not included in Exhibit 6 is $15 million of general funds included by the Governor in supplemental budget number one to provide an operating grant in fiscal 2017 to the Board of Directors of UMMS to assist in the transition to a new Prince George's County Regional Medical System. Intent language also commits the State to an additional $15 million to be provided in 2018 and 2019 and $5 million to be provided in fiscal 2020 and 2021 for a total of $55 million.

In accordance with a Memorandum of Understanding (MOU) between the State, Prince George's County, and Dimensions Health Corporation, in 2008, a financial commitment of $150 million in operating funds was to be provided over five years, split equally between each party and $24 million in State capital funding over three years. The MOU was updated in calendar 2011 to include UMMS and the University of Maryland. This support was on top of other spending provided since fiscal 2013. **Exhibit 13** details the recent financial support. A more detailed discussion on the new regional medical system will be included in the capital budget analysis.

Exhibit 13
Operating and Capital Support Provided to Prince George's Hospital System
Fiscal 2009-2016
($ in Millions)

	2009	2010	2011	2012	2013	2014	2015	2016	Total
State									
Operating Subsidy	$12	$12	$15	$15	$15	$15	$15	-	$99
General Obligation Bonds	-	-	-	4	10	30	15	30	89
Prince George's County									
Operating Subsidy	12	12	15	15	15	15	15	15	114
Total	**$24**	**$24**	**$30**	**$34**	**$40**	**$60**	**$45**	**$45**	**$302**

Note: This exhibit does not capture the operating and capital support provided by the State to the Prince George's Hospital System prior to the 2008 Memorandum of Understanding. Between fiscal 2002 and 2007, $15.8 million and $13.0 million were provided to the hospital system in operating and capital funding, respectively.

Source: Department of Legislative Services

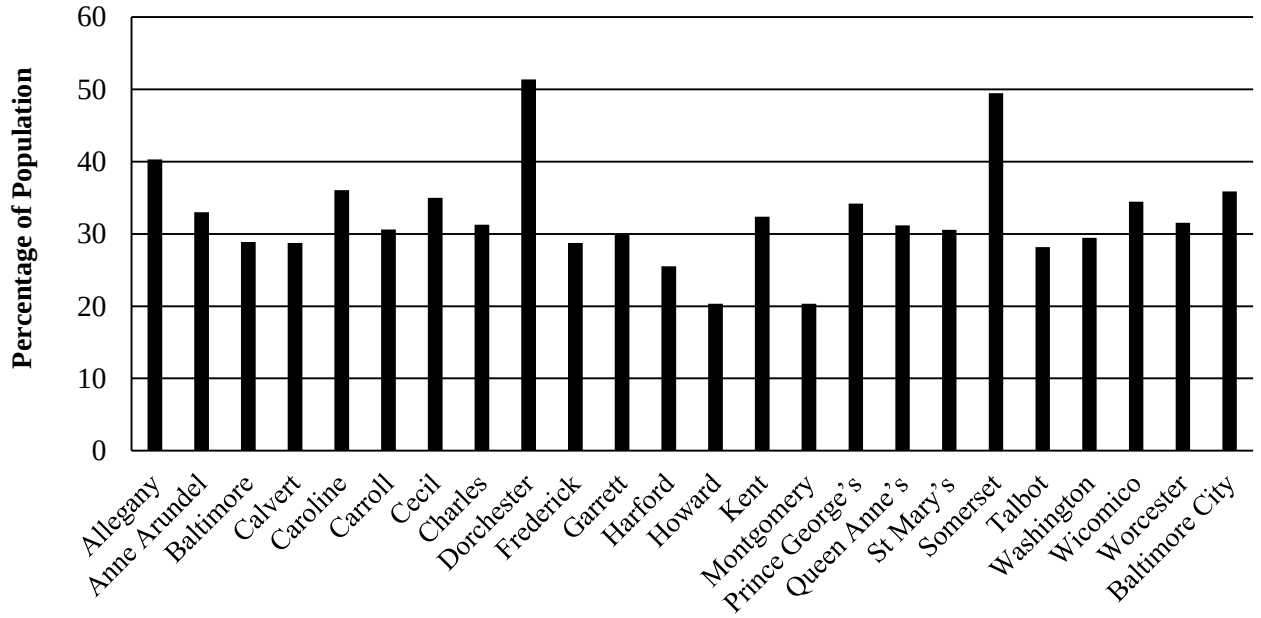
Issues

1. Increasing Prevalence of Diabetes and Obesity

In calendar 2013, 35% of Marylanders were considered to have a healthy weight (a body mass index (BMI) equal or less than 24.9). This percentage has continued to decrease, while the percent of Marylanders considered overweight or obese (a BMI greater than or equal to 25) has increased to 65% of the population. Of the 65% overweight or obese, 35% are considered overweight (BMI 25.0 to 29.9), and 30% are considered obese (BMI 30.00 and above).

Obesity increases risk of chronic diseases such as diabetes, hypertension, high blood cholesterol, coronary heart disease, stroke, arthritis, and some cancers (breast, colorectal, endometrial, and kidney). From calendar 1995 to 1997, only 1 of 24 Maryland jurisdictions had a prevalence of obesity greater than 25.0%, but by calendar 2014, this increased to 22 jurisdictions, shown in **Exhibit 14**. No Maryland jurisdiction has reached the Healthy People 2010 target for adult obesity prevalence less than 15.0%. The prevalence varies largely across jurisdictions with the highest obesity rates of 51.4% and 49.5% in Dorchester and Somerset counties.

Exhibit 14
Percentage of Population with BMI 30 and Above by County
Calendar 2014

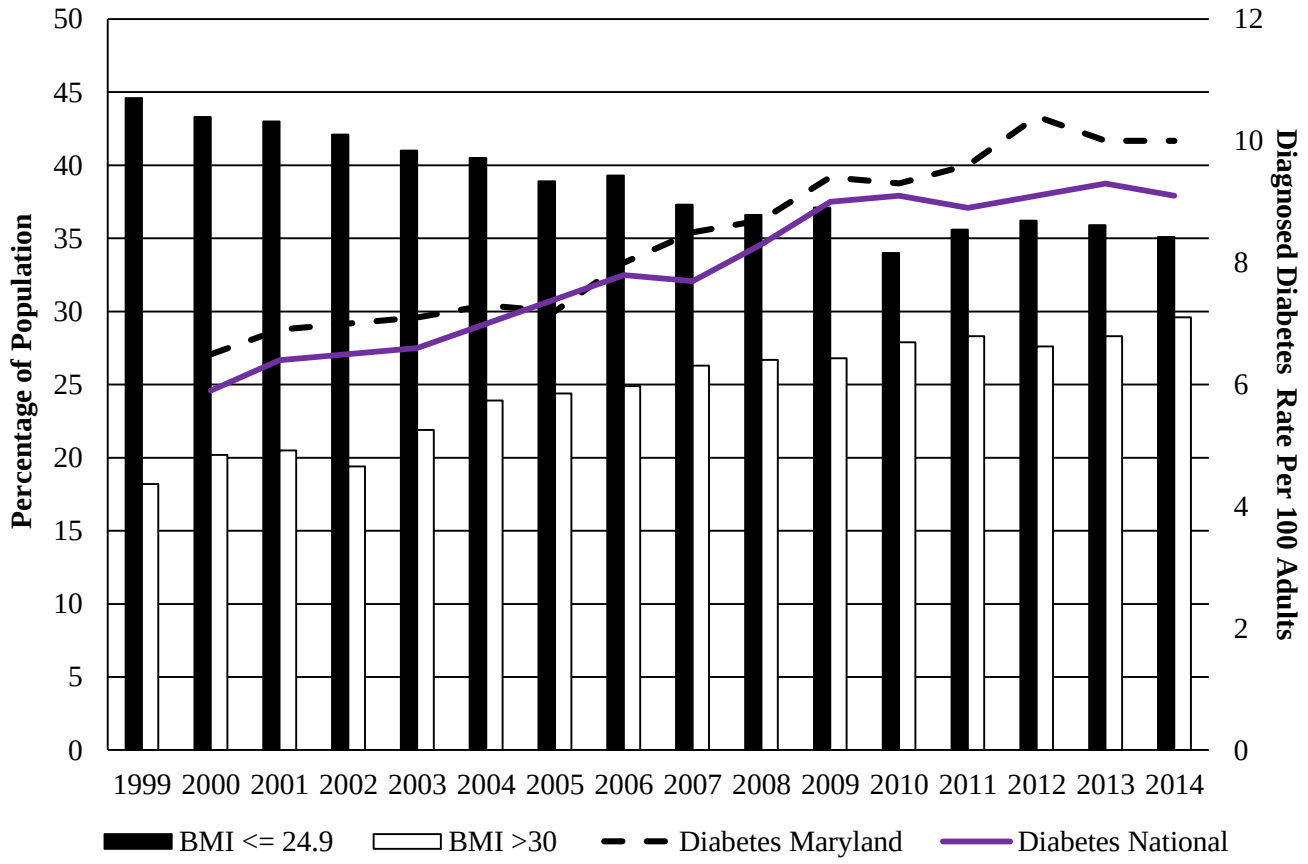


BMI: body mass index

Source: Department of Health and Mental Hygiene

The prevalence of diabetic adults in Maryland has also grown, from 6.8% in calendar 1999 to 10.0% in calendar 2014, and is above the national level, as shown in **Exhibit 15**. As with obesity, the prevalence follows a similar variation across jurisdictions with Dorchester County having the highest prevalence at 19.8%. Among the Maryland diabetic population, comorbidities such as high blood pressure, high cholesterol, obesity, and smoking increase mortality, complications, hospitalization, and cost of treatment. In calendar 2014, individuals with diabetes were more likely to have a stroke (10.3%) or a heart attack (11.0%) compared to individuals without diabetes (2.3 % and 3.0%, respectively).

Exhibit 15
Percentage of Population Considered a Healthy Weight or Obese
Calendar 1999-2014



BMI: body mass index

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

Economic Cost of Diabetes in Maryland

According to a report prepared by DHMH entitled, *Summary: Burden of Diabetes in Maryland*, the annual age-adjusted hospital discharge rates for diabetics between calendar 2004 to 2008 increased from 222.0 per 10,000 to 268.3. The annual total hospital charges for diabetic Marylanders during that same time increased by $45 million. In calendar 2008, the amount of hospital expenses on patients with diabetes as a comorbidity was $1.7 billion, which represents almost a quarter of the total hospital charges ($7.9 billion). The total cost of diabetes in Maryland was estimated to be $5.1 billion in 2012 (medical and indirect).

Although diabetes is widely associated with old age, the older working age population (ages 50 to 64) represents the fastest growing diabetic group in Maryland. Additionally, in calendar 2014, 10.5% of the adult population, excluding those with diabetes, had pre-diabetes, an elevated blood sugar level, which greatly raises their risk of developing Type 2 diabetes. Without proper prevention and management these individuals may add to the State's increasing diabetic population.

Current Funding for Chronic Diseases

The State's current dedicated funding for diabetes includes $100,000 in general funds for diabetes evidenced-based programming, in addition to $500,000 in general funds to fund 3 positions in the Chronic Disease Control program. In addition to the $600,000 in general funds, the agency received PPHF funding as discussed above to aid local health departments in 9 counties. An additional $1.3 million in non-PPHF federal funding is used to control and manage chronic diseases. This funding includes aid to local health departments in all counties, including the 15 that do not receive funding from PPHF. In total, the fiscal 2017 budget includes $5.9 million in federal funds and $600,000 in general funds for diabetes and other chronic illness related programs.

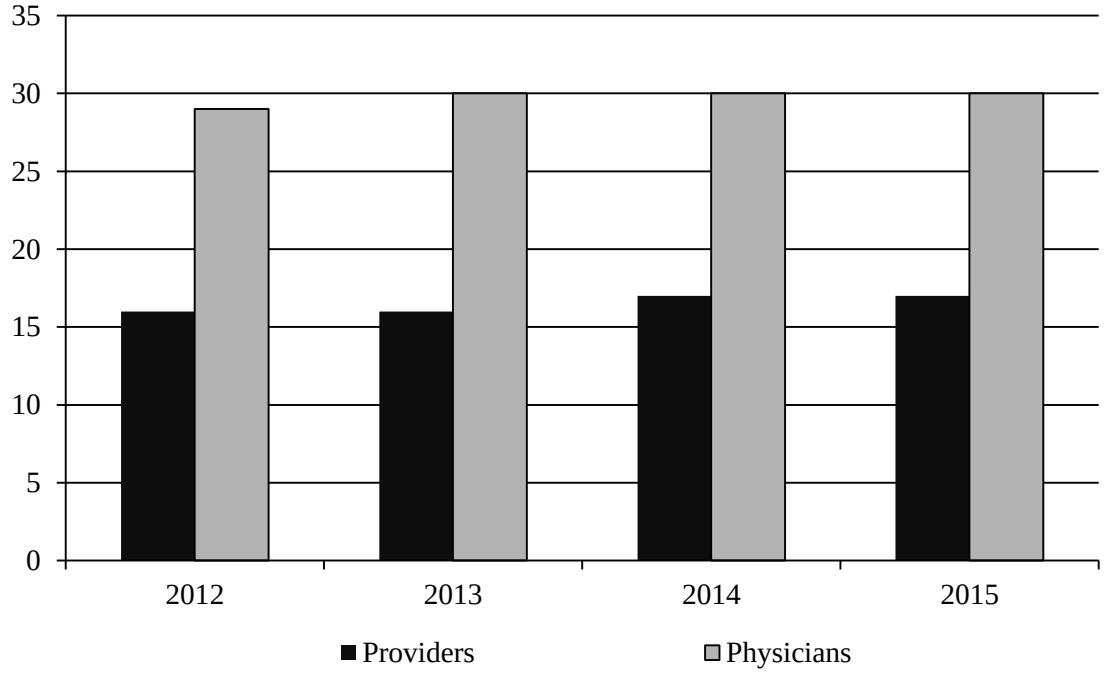
Although the fiscal 2017 allowance includes $5.9 million in federal funds, this may not be a long-term funding source for what is a chronic public health problem. In the long term, the agency may need to identify dedicated sustainable funding streams to address both obesity and diabetes**. DLS recommends narrative to request a response including a detailed analysis of the agency's current initiatives for addressing obesity and diabetes statewide and by county, and identification of potential long-term dedicated funding streams for programs aimed at reducing diabetes and obesity.**

2. Underutilization of Providers Accepting Practice Obligations

The Office of Population Health Improvement aims to maximize the number of health care providers accepting a practice obligation in Maryland under the State Loan Repayment Program (SLRP) and the number of physicians accepting a practice obligation under the J-1 Visa Waiver Program. The SLRP offers providers an opportunity to practice their profession in a community that lacks adequate primary and/or mental health services, while also receiving funds to pay their educational loans. An eligible practice site is a clinic that is public or nonprofit, that treats all persons

regardless of their ability to pay, and is located in a geographic region of Maryland that has been designated as a health professional shortage area. A provider accepting a new SLRP practice obligation is defined as a health care provider who signs the Maryland Higher Education Commission Promissory Note and Obligation Agreement that obligates the provider to serve under the SLRP. Similarly, physicians can accept a practice obligation under the J-1 Visa Waiver Program, which enables foreign physicians to improve access to health care in federally designated shortage areas. As shown in **Exhibit 16**, in fiscal 2015, the number of health care providers and physicians accepting a practice obligation in Maryland remained static, although that number had been predicted to increase slightly. (As of September 2012, providers include nurse practitioners, physician assistants, dentists, and social workers.)

Exhibit 16
Health Care Providers and Physicians Accepting a Practice Obligation
Fiscal 2012-2015



Source: Department of Health and Mental Hygiene

In addition to remaining static, the SLRP is underutilized with more money available than is being used. Demand for loan repayment assistance may be limited due to other outside incentives that might offer more appeal to potential recipients: for example, income driven loan repayment plans, which are pegged to a low percentage of salary, allow loan forgiveness after 10 years of payment while working for government or nonprofit entities.

The SLRP is intended to address the shortage of health professionals in designated areas; however, physicians accepting a practice obligation have to serve only a minimum of two years. The take-up rate is also higher for physicians practicing in urban areas, such as Baltimore City, rather than rural areas which may have a far greater physician shortage. In fiscal 2010, Garrett, Queen Anne's, and Worcester counties had 100% of their populations residing in a primary care health professional shortage area (HPSA). Although Baltimore City had 18 of the State's 47 HSPA designations, these designations encompassed only about 29% of the city's population.

In fiscal 2010, Maryland had 41 dental HPSAs, covering nearly 625,000 people and 44 mental health HPSAs covering more than one million residents, or 18% of the State's population. Jurisdictions with 100% of their populations residing in a mental health HPSA included Calvert, Caroline, Cecil, Charles, Dorchester, Garrett, Kent, Queen Anne's, Somerset, Wicomico, and Worcester counties. The Office of Primary Care within PHPA conducts the Primary Care Needs Assessment. This assessment reports on health care access throughout Maryland in addition to summarizing federal shortage designations, which include HPSA and medically underserved areas. The last assessment was conducted in fiscal 2010 and the next assessment is currently underway. **Given the underutilization of the practice obligations and the percentage of the population living in HPSAs, the agency should comment on workforce programs to recruit and retain physicians in underserved areas, including financial incentives for physicians.**

Recommended Actions

1. Adopt the following narrative:

   Diabetes and Obesity Initiatives and Funding: The committees are interested in efforts to reduce the growing problem of obesity in Maryland. The Department of Health and Mental Hygiene (DHMH) is requested to provide a detailed analysis of the agency's (1) current initiatives for addressing obesity and diabetes statewide and by county; (2) spending by county on initiatives addressing obesity and diabetes; and (3) identification of potential long-term dedicated funding streams for programs aimed at reducing diabetes and obesity.

Information Request	**Author**	**Due Date**
Report on diabetes and obesity initiatives and funding	DHMH	November 1, 2016

Updates

1. Fee Reduction Fiscal Impact

On September 15, 2015, the Governor announced a plan to reduce a number of fees across State government. A number of fee reductions in PHPA were part of that plan, including:

- food manufacturing plants (bakery, cannery, confectionary, crab meat, ice, bottled water, soft drink, frozen food);
- shellfish shipping or reshipping plant (license);
- shellfish shucking, packing, or repacking plant (license);
- food warehouse/distribution center that distributes potentially hazardous food (license); and
- food warehouse/distribution center that distributes only nonpotentially hazardous food (license).

Exhibit 17 shows the current and proposed fees and the estimated general fund revenue loss for each fee. In total, the regulated fee reductions would reduce general fund revenue by $152,500 annually. However, as the legislation will likely be effective for only the second half of fiscal 2016, the general fund revenues decrease by approximately $76,250 in fiscal 2016 and $152,500 in fiscal 2017 and annually thereafter. Costs associated with annual food processing plant licensing are general funded, and the collected fees accrue to the General Fund. Thus, the revenue reductions have no direct programmatic impact.

Exhibit 17

General Fund Revenue Reductions Related to Proposed Changes to Annual License Fees in COMAR 10.01.017.02

Fee Type	Current Fee	Proposed Fee	Revenue Reduction
Food Processing Plants			
Bakery	$400	$150	*
Cannery	400	150	*
Confectionary	400	150	*
Crab Meat	400	150	*
Ice Manufacturing	400	150	*
Food Manufacturing	400	150	*
Bottled Water	400	150	*
Soft Drink Manufacturing	400	150	*
Frozen Food Manufacturing	400	150	*
Subtotal			***$81,000***
Shellfish Plants			
Shucking, Packing, or Repacking	400	150	9,000
Shipping or Reshipping	200	150	3,800
Subtotal			***$12,800***
Food Warehouse/Distribution Centers that			
Distribute Potentially Hazardous Food	400	150	49,000
Distribute Nonpotentially Hazardous Food	200	150	9,700
Subtotal			***$58,700***
Total			**$152,500**

COMAR: *Code of Maryland Regulations*

*unknown.

Source: Department of Legislative Services

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Prevention and Health Promotion Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$53,997	$83,715	$216,886	$2,392	$356,989
Deficiency Appropriation	0	0	0	0	0
Cost Containment	-1,059	-7,450	0	0	-8,509
Budget Amendments	323	19,705	-7,046	162	13,144
Reversions and Cancellations	0	-3,301	-26,753	0	-30,054
Actual Expenditures	**$53,261**	**$92,669**	**$183,087**	**$2,553**	**$331,570**
Fiscal 2016					
Legislative Appropriation	$35,903	$91,017	$205,562	$2,495	$334,977
Budget Amendments	1,359	20,762	1,057	3,860	27,038
Working	**$37,262**	**$111,779**	**$206,619**	**$6,355**	**$362,014**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding

Fiscal 2015

The budget for PHPA closed at $331.6 million, $25.4 million below the original legislative appropriation. Cost containment actions reduced general and special funds by $1,059,000 and $7,450,000, respectively. A Board of Public Work's action taken in January 2015 reduced cancer research grants to academic health centers (funded with CRF dollars) to fiscal 2013 levels and substituted those special funds for general funds in Medicaid. The general fund reduction included an elimination of State support for the Cord Blood Transplant Program ($100,000), elimination of a grant to UMMS for the Montebello Rehabilitation Center at Kernan Hospital for annual debt service on revenue bonds (442,799), $125,000 for savings from level funding medical day care programs to fiscal 2014 levels, hiring freeze savings of $146,978, and administrative efficiency reductions of $244,600.

Budget amendments increased the budget by $13.1 million, primarily in special funds. A budget amendment to reflect the fiscal 2015 cost-of-living adjustment increased general funds by $116,868, federal funds by $146,849, and special funds by $13,772. Federal funds increased by $432,768 and general funds increased by $192,064 to cover the cost of the Behavioral Risk Factor Surveillance System, transferred from Executive Direction under the Public Health Administration. General funds increased $23,700 to cover the cost of Synar activities. Special funds increased $19,691,364 (available from MADAP rebates) to cover the cost of providing HIV formulary pharmaceuticals to eligible individuals.

These increases were offset by reductions of $7.6 million in federal funds to reflect reduced expenditures in the Women, Infants, and Children (WIC) program. General funds were reduced by $9,039 to realign health insurance costs within DHMH.

At the end of fiscal 2015, approximately $27.0 million of the agency's federal fund appropriation was cancelled due to lower than anticipated participation in the WIC ($6.8 million) and MADAP programs ($20.1 million). Special funds of $3.3 million were cancelled made up primarily of MADAP rebates ($2.8 million). In the Maryland Cancer Fund administered by PHPA, $203,802 of the special funds were cancelled. Grants from the fund are given for periods spanning several fiscal years. Since funding is dependent on State income tax check-off participation, which may vary from year to year, it is beneficial for some special funds to be carried over from one year to the next. The additional $282,000 in special funds were cancelled from CRF programs: cancer administration ($101,802), statewide public health ($150,141), and surveillance ($30,352).

Fiscal 2016

To date, the fiscal 2016 legislative appropriation for PHPA has been increased by $27 million through budget amendments. Federal funds increased by $286,538, general funds increased by $235,056, and special funds increased by $24,639 to reflect the restoration of the 2% pay reduction. A full-time equivalents (FTE) transfer from the Office of Population Health Improvement into Infectious Disease and Environmental Health Services (1 FTE) along with the transfer of funds for the Office of Primary Care Services (2 FTEs) and Office of Rural Health (1 FTE) from the Office of Population

Health Improvement into Family Health and Chronic Disease services increased federal funds by $770,040 and general funds by $695,127. Special funds increased by $20.7 million to cover the cost of medicine, drugs, and chemicals for MADAP. General funds increased by $303,908 to realign the 2% cost containment with the agency's cost containment plan and an additional $125,000 to provide support for children's medical day care services to reflect legislative priorities. Reimbursable funds increase by $3.9 million to reflect funds from BHA for Synar Tobacco Enforcement.

Appendix 2

Audit Findings

Audit Period for Last Audit:	July 1, 2012 – October 27, 2013
Issue Date:	March 2015
Number of Findings:	5
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: PHPA did not use available resources to verify applicant income and to identify possible third-party insurance for certain programs.

Finding 2: PHPA did not always consider critical information when redetermining applicant eligibility for one program.

Finding 3: Access to systems used to maintain critical information and process related claims for certain programs was not adequately restricted.

Finding 4: PHPA did not always obtain certain necessary documents to establish provider eligibility and did not conduct periodic eligibility reassessments.

Finding 5: PHPA lacked adequate procedures and controls over certain collections.

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

Object/Fund Difference Report
DHMH – Prevention and Health Promotion Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	362.80	366.80	426.80	60.00	16.4%
02 Contractual	3.96	6.11	6.12	0.01	0.2%
Total Positions	**366.76**	**372.91**	**432.92**	**60.01**	**16.1%**
Objects					
01 Salaries and Wages	$ 31,412,315	$ 33,549,297	$ 39,364,090	$ 5,814,793	17.3%
02 Technical and Spec. Fees	204,110	302,122	303,866	1,744	0.6%
03 Communication	626,183	713,420	787,509	74,089	10.4%
04 Travel	547,590	606,601	631,369	24,768	4.1%
07 Motor Vehicles	129,894	123,203	122,767	-436	-0.4%
08 Contractual Services	221,983,533	254,995,674	240,248,354	-14,747,320	-5.8%
09 Supplies and Materials	40,623,484	41,722,261	45,546,175	3,823,914	9.2%
10 Equipment – Replacement	106,566	0	0	0	0.0%
11 Equipment – Additional	402,420	530,781	358,972	-171,809	-32.4%
12 Grants, Subsidies, and Contributions	35,349,056	29,074,352	33,423,069	4,348,717	15.0%
13 Fixed Charges	184,962	396,675	131,121	-265,554	-66.9%
Total Objects	**$ 331,570,113**	**$ 362,014,386**	**$ 360,917,292**	**-$ 1,097,094**	**-0.3%**
Funds					
01 General Fund	$ 53,260,656	$ 37,262,310	$ 37,509,572	$ 247,262	0.7%
03 Special Fund	92,669,367	111,778,550	113,957,938	2,179,388	1.9%
05 Federal Fund	183,086,902	206,618,535	206,973,579	355,044	0.2%
09 Reimbursable Fund	2,553,188	6,354,991	2,476,203	-3,878,788	-61.0%
Total Funds	**$ 331,570,113**	**$ 362,014,386**	**$ 360,917,292**	**-$ 1,097,094**	**-0.3%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Prevention and Health Promotion Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Administrative, Policy, and Management Systems	$ 113,187,970	$ 141,615,843	$ 134,164,914	-$ 7,450,929	-5.3%
04 Famly Health and Chronic Disease Services	218,382,143	220,398,543	226,752,378	6,353,835	2.9%
Total Expenditures	**$ 331,570,113**	**$ 362,014,386**	**$ 360,917,292**	**-$ 1,097,094**	**-0.3%**
General Fund	$ 53,260,656	$ 37,262,310	$ 37,509,572	$ 247,262	0.7%
Special Fund	92,669,367	111,778,550	113,957,938	2,179,388	1.9%
Federal Fund	183,086,902	206,618,535	206,973,579	355,044	0.2%
Total Appropriations	**$ 329,016,925**	**$ 355,659,395**	**$ 358,441,089**	**$ 2,781,694**	**0.8%**
Reimbursable Fund	$ 2,553,188	$ 6,354,991	$ 2,476,203	-$ 3,878,788	-61.0%
Total Funds	**$ 331,570,113**	**$ 362,014,386**	**$ 360,917,292**	**-$ 1,097,094**	**-0.3%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

M00I
Chronic Hospitals
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$44,873	$44,444	$45,678	$1,234	2.8%
Deficiencies and Reductions	0	829	-137	-966	
Adjusted General Fund	**$44,873**	**$45,274**	**$45,541**	**$268**	**0.6%**
Special Fund	3,637	4,122	3,301	-820	-19.9%
Deficiencies and Reductions	0	0	-6	-6	
Adjusted Special Fund	**$3,637**	**$4,122**	**$3,295**	**-$827**	**-20.1%**
Reimbursable Fund	810	895	916	21	2.4%
Adjusted Reimbursable Fund	**$810**	**$895**	**$916**	**$21**	**2.4%**
Adjusted Grand Total	**$49,320**	**$50,290**	**$49,753**	**-$538**	**-1.1%**

- The fiscal 2017 allowance decreases by $538,000, or 1.1%, below the fiscal 2016 working appropriation.

- There is one proposed deficiency for fiscal 2016 of $829,114 to provide funds to support the management staffing contract between Meritus and the Western Maryland Hospital Center (WMHC).

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

For further information contact: Lindsey B. Holthaus Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	511.80	510.80	495.30	-15.50
Contractual FTEs	20.09	18.01	18.27	0.26
Total Personnel	**531.89**	**528.81**	**513.57**	**-15.24**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	40.47	8.17%
Positions and Percentage Vacant as of 12/31/15	63.50	12.43%

- The fiscal 2017 allowance includes 15.5 fewer regular full-time equivalent (FTE) positions, primarily due to the closing of the renal dialysis unit at WMHC, and 0.26 in additional contractual FTEs from Deer's Head Hospital Center (DHHC).

- Turnover expectancy is increased in the fiscal 2017 allowance, from 6.0% to 8.17%. However, the agency currently has more than enough vacancies to meet turnover with a vacancy rate of 12.43%.

Analysis in Brief

Major Trends

Average Length of Stay Continues to Decline in State Chronic Disease Hospital Centers: Due to changes in federal reimbursement rates for patient days, the State chronic disease hospital centers are working to efficiently treat patients so that they can be moved to a setting that requires a lower level of care.

Number of Renal Dialysis Patients Declines in Both Hospital Centers: DHHC continues to serve more patients than WMHC, yet the number of patients continues to decline at both centers. Indeed, the renal dialysis unit at WMHC is closing July 1, 2016. Although the number of patients is declining, the number of treatments per patient has increased at both hospital centers.

Issues

Western Maryland Hospital Center Strategic Plan: Due to a review by the Office of Health Care Quality identifying serious deficiencies in 2014, the Department of Health and Mental Hygiene (DHMH) hired a consultant to provide recommendations to address the identified deficiencies. Based on the consultant's assessments that the WMHC executive management was not able to effectively implement the changes necessary to address the deficiencies, DHMH hired a contractor to provide professional personnel to replace 3 executive management positions. The contract was extended to June 30, 2018. The long-term management of the hospital has not yet been decided, however DHMH has many different options.

Recommended Actions

1. Concur with Governor's allowance.

M00I
Chronic Hospitals
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The State's two chronic disease hospital centers – Western Maryland Hospital Center (WMHC) and Deer's Head Hospital Center (DHHC) – provide specialized services for those in need of complex medical management, comprehensive rehabilitation, long-term care, or dialysis. Specifically, both centers provide:

- chronic care and treatment to patients requiring acute rehabilitation (at a level greater than that available at a nursing home) for management of complex medical issues such as respiratory, coma, traumatic brain injury, spinal cord injury, wound management, dementia, cancer care, and quarantined tuberculosis;

- long-term nursing care for patients who do not need hospital-level care but are unable to function in traditional nursing homes; and

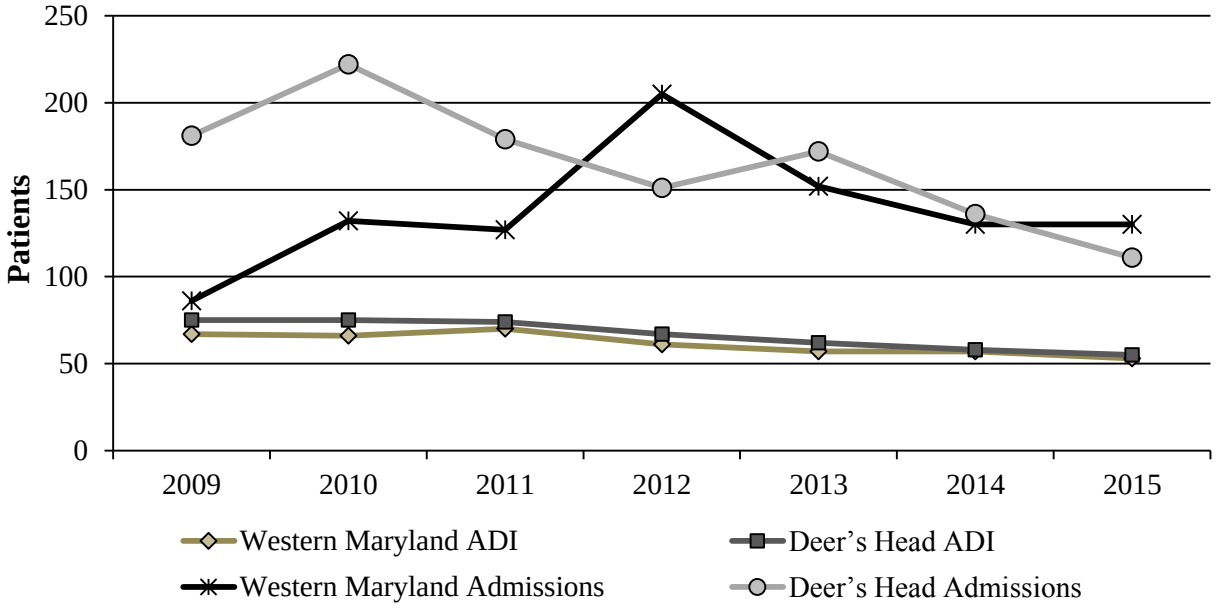
- inpatient and outpatient renal dialysis services.

Performance Analysis: Managing for Results

1. Average Length of Stay Continues to Decline in State Chronic Disease Hospital Centers

Due to changes in reimbursement for patient days, the State chronic disease hospitals are working to efficiently treat patients and allow them to move to a lower level of care as soon as is medically possible. **Exhibit 1** shows that while admissions have fluctuated year to year at both State chronic disease hospitals, the average daily number of patients has declined since fiscal 2009 at both facilities. The hospitals attribute this decrease to an increase in costs associated with caring for patients without a corresponding increase in funding, allowing them to care for fewer patients. Specifically, DHHC attributes the increased costs to higher costs for medicine and higher acuity patients.

Exhibit 1
Average Daily Inpatients and Admissions
Fiscal 2009-2015



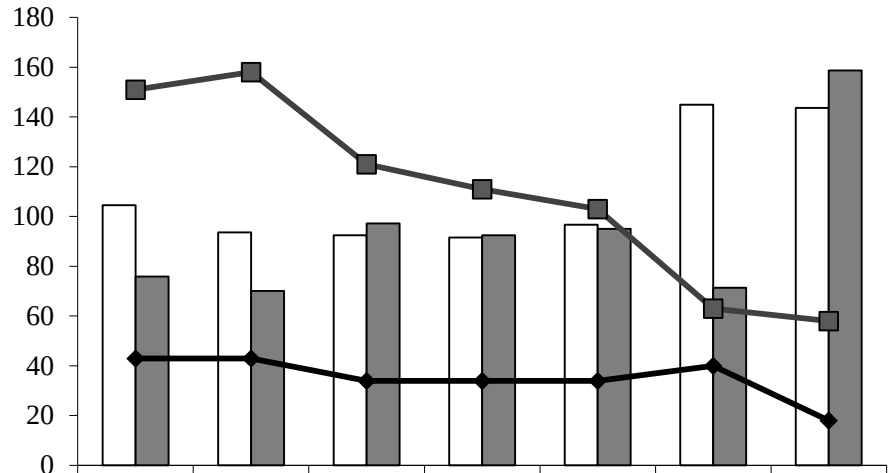
ADI: Average Daily Inpatients

Source: Department of Health and Mental Hygiene

2. Number of Renal Dialysis Patients Declines in Both Hospital Centers

Both hospitals strive to provide quality care to patients. Renal dialysis is offered at WMHC and DHHC; **Exhibit 2** shows the number of patients treated at both hospitals between fiscal 2009 and 2015. DHHC continues to serve a greater number of patients than WMHC, but its numbers have fallen steadily throughout the period. The agency reports that when DHHC first opened, it was the only place for renal dialysis on the Eastern Shore. Since then, a number of new facilities have opened and expanded. While the number of patients receiving renal dialysis declines, the number of treatments per patient increases 50% from fiscal 2013 to 2014 and remains steady in fiscal 2015. The number of renal dialysis patients served at WMHC fell sharply in 2015 due to a declining population and an increase in providers in the area. As a result, the Department of Health and Mental Hygiene (DHMH) has announced the closure of the unit at WMHC for July 1, 2016.

Exhibit 2
Renal Dialysis Patients
Fiscal 2009-2015



	2009	2010	2011	2012	2013	2014	2015
Treatments/Patient DHHC	104.5	93.6	92.4	91.6	96.7	144.9	143.7
Treatments/Patient WMHC	75.9	70.1	97.3	92.4	95.1	71.4	158.7
Deer's Head Patients Treated	151	158	121	111	103	63	58
Western Maryland Patients Treated	43	43	34	34	34	40	18

DHHC: Deer's Head Hospital Center
WMHC: Western Maryland Hospital Center

Source: Department of Health and Mental Hygiene

Fiscal 2016 Actions

Proposed Deficiency

There is one proposed general fund deficiency for fiscal 2016 of $829,114 to provide funds to support the management staffing contract between Meritus and WMHC.

Cost Containment

The fiscal 2016 budget bill contained a 2.0% across-the-board general fund reduction, which included a 0.6% across-the-board fund reduction to DHMH totaling $27,215,000. The Chronic

Hospital's allocation of the reduction is $56,735 including $20,000 in reduced security costs due to staggered coverage by contractual security personnel at WMHC, $10,000 in reduced transportation costs due to in-house clinics at WMHC, and $26,735 reduced spending on laundry at DHHC.

Proposed Budget

As shown in **Exhibit 3**, the Governor's fiscal 2016 allowance decreases by $538,000 (1.1%) over the fiscal 2015 working appropriation net of contingent and across-the-board reductions, primarily due to the closing of the renal dialysis unit at WMHC.

Exhibit 3
Proposed Budget
DHMH – Chronic Hospitals
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$44,873	$3,637	$810	$49,320
Fiscal 2016 Working Appropriation	45,274	4,122	895	50,290
Fiscal 2017 Allowance	45,541	3,295	916	49,753
Fiscal 2016-2017 Amount Change	$268	-$827	$21	-$538
Fiscal 2016-2017 Percent Change	0.6%	-20.1%	2.4%	-1.1%

Where It Goes:

Personnel Expenses

Employee and retiree health insurance	$804
Retirement	694
Overtime	321
Workers' compensation premium assessment and unemployment	210
Turnover adjustments	163
Other fringe benefit adjustments	-10
Regular Earnings and Miscellaneous Adjustments	-280
Abolished positions (15.5 FTE)	-1,170

Where It Goes:

Other Changes

Vehicle replacements (WMHC)	$103
Other	-11
Respiratory Therapy medicine and supplies (WMHC)	-57
Comprehensive care contractual nurses (WMHC)	-78
Utilities and equipment repair reductions plant maintenance DHHC	-123
Patient Care unit (WMHC) (lab services, outpatient care, medical supplies)	-171
Phsyiatry in Brain Trauma Unit (WMHC)	-177
Hemiodialysis (medicine and supplies)	-755
Total	**-$538**

DHHC: Deer's Health Hospital Center
DHMH: Department of Health and Mental Hygiene
FTE: full-time equivalent
WMHC: Western Maryland Hospital Center

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

Personnel

Personnel expenditures decrease by $732,000 for the chronic hospitals. The largest decrease is due to the abolition of 15.5 positons at WMHC, reducing the budget by $1.2 million. Of the 15.5 abolished positions, 8.5 positions (7.5 filled and 1.0 vacant) were a result of closing the renal dialysis unit at WMHC. This unit was closed due to the declining population and an increase in private providers in the area. Of the 7.5 filled positions in the renal dialysis unit, 5.0 were given the option of transferring to another vacant position within the hospital. Two other filled positions were abolished: (1) 1 position was reduced due to contracting out for x-ray services; and (2) an additional therapeutic recreater filled position was abolished. The remaining abolished positions, 5.0, were all vacant.

This decrease is offset by large increases in health insurance ($804,000) and retirement ($693,533). While the fiscal 2017 allowance saw an increase for turnover relief, the vacancy rates at both hospitals are higher than budgeted. WMHC has a vacancy rate of 14.6% before the position reductions and 13.1% after, 7.4% higher than budgeted, while DHHC has a vacancy rate of 10.1%. While vacancy rates remain so high, unsurprisingly overtime has increased in the fiscal 2017 allowance. DHMH attributes high turnover to difficulty filling the highly specialized positions in facilities that are remote.

Renal Dialysis Closure

Operating expenditures decreased by $755,000 due to the closure of the renal dialysis unit at WMHC and medicine and supplies reductions at DHHC. Both hospitals have had lower utilization of the renal dialysis units than expected.

Other Changes

The fiscal 2017 allowance includes reductions to the brain trauma and patient care unit at WMHC of $347,000. Other reductions at WMHC included comprehensive care contractual nurses ($78,000) and medicine and supplies ($57,000). Vehicle replacements at WMHC increased the budget by $102,765.

Issues

1. Western Maryland Hospital Center Strategic Plan

In May 2014, the Office of Health Care Quality (OHCQ), on behalf of the federal Centers for Medicare and Medicaid Services (CMS), conducted a review of the WMHC nursing home facilities and operations. This review identified serious deficiencies, resulting in substantial noncompliance with Medicaid and Medicare requirements. For example, deficiencies identified included the failure to report and investigate allegations of abuse and the failure to administer medications as ordered. WMHC paid associated fines totaling $375,100 and was denied Medicaid and Medicare reimbursement for new nursing home admissions beginning August 7, 2014, until the deficiencies were determined to be satisfactorily corrected.

In response to the review, DHMH hired a consultant, at a cost of $288,000, to provide recommendations to address the identified deficiencies. DHMH concluded, based on the consultant's assessments, that the WMHC executive management was not able to effectively implement the changes necessary to address the deficiencies. In June 2014, DHMH hired a contractor to provide professional personnel to replace 3 executive management positions to lead WMHC and implement the necessary corrective actions for six months. On September 22, 2014, CMS and OHCQ determined that the deficiencies were satisfactorily corrected and that Medicaid and Medicare reimbursement could resume. During the period from August 7, 2014, through September 21, 2014, there were no new admissions to WMHC. DHMH extended the contract for an additional six months with the contractor, and then extended the contract for an additional three years through June 30, 2018. As of January 28, 2016, WMHC made payments to the contractor totaling approximately $1.5 million.

WMHC devised a three-year strategic plan with targets for year one and year three. The focus areas consist of workforce, quality, customer, and finance. One goal for the customer focus area is to identify and diversify the service portfolio to meet market demand, measured by the number of admissions. Some of the key initiatives for this goal are to evaluate joint ventures, expand current program capacity, develop business plans for new services, and optimize utilization of current programs. WMHC recently increased patient capacity for the Brain Injury program by two, from seven to nine patients. A strategic objective for the finance focus area is to generate enough financial resources to ensure sustainability.

Beyond the three-year contract, the future of WMHC has not yet been decided. The following is a non-exhaustive list of options for the future management of WMHC:

- **State Executive Management** – choose not to renew the contract with the current contractor and return executive management back to the State for WMHC;

- **Continue Contracting Management** – extend the current contract for executive management of WMHC or enter into a contract with a different contractor; and

- **Transitioning Care to a Private Provider** – shift clinical and support services to a private provider, with the State's support providing a grant to the contractor.

Status of the Western Maryland Hospital Capital Building

In any of the options, as stated in the three-year strategic plan, the financial impact of a new building versus maintaining the current building should be evaluated. The current facility was built in 1957 and the heating, ventilation, and air-conditioning system needs replacement. The original design of WMHC, with large multiple-occupancy bedrooms and group toilet rooms for the patient units, is outdated and out of compliance with modern hospital design standards and regulations. The facility is also oversized for the population that it currently serves. A new building was part of a prior *Capital Improvement Program* (CIP) and was scheduled to begin receiving funding in fiscal 2009. The estimated cost to demolish and rebuild the hospital was estimated at $58 million. However, the project was moved out of the CIP to make way for the new public health laboratory and never put back in.

Depending upon how the hospital is run (contract management, State-run, grant to private contractor), different parties may be responsible for any new building. If the facility continues to be State-owned and operated or if management continues to be contracted out, the State would likely need to pay for a new building. If a contractor manages and staffs the hospital, with a grant from the State, either the State would need to build the new facility or a private company could build the new facility or find existing space to move patients into, in which case the current building would likely be sold or demolished.

Considerations for Transitioning Care to a Private Provider

If transitioning care to a private provider or a similar scenario were to occur, certain considerations should be made including:

- the requirements for the contractor to offer employment to current employees, including pay rates, pensions, and benefits;

- options for employees who are unable to secure employment with the contractor; and

- the amount of funding required for the population served by the contractor and accountability measures for ensuring quality of service.

One potential issue is aligning the incentive for the contractor to care for the same population that was cared for by the State-owned hospital. Many of the patients are insured, and the hospital receives payment for services given. Serving this population often costs more than the insurance that reimburses the hospital. These costs can stem from increased staff required and special equipment for obese patients that other nursing homes are not equipped with. Other patients are unable to obtain insurance and, therefore, have their services fully covered by the hospital. Due to increased costs without subsequent increases in funding over the years, the hospital has been unable to service all of the patients who need services. **DHMH should comment on plans for WMHC at the end of the**

three-year contract. DHMH should also comment on the accountability measures if care is transitioned to a private provider.

Recommended Actions

1. Concur with Governor's allowance.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Chronic Hospitals
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$42,945	$4,429	$0	$779	$48,153
Deficiency Appropriation	0	0	0	0	0
Cost Containment	-175	0	0	0	-175
Budget Amendments	2,103	13	0	50	2,167
Reversions and Cancellations	0	-806	0	-19	-824
Actual Expenditures	**$44,873**	**$3,637**	**$0**	**$810**	**$49,320**
Fiscal 2016					
Legislative Appropriation	$43,048	$4,098	$0	$895	$48,041
Budget Amendments	1,396	23	0	0	1,420
Working Appropriation	**$44,444**	**$4,122**	**$0**	**$895**	**$49,461**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

Actual expenditures for Chronic Hospitals were $1.2 million above the legislative appropriation. Cost containment and subsequent realignments reduced general funds by $175,213. WMHC reduced on-call contractual physician coverage by having staff physicians cover weekends for remainder of the year ($23,927), and the rest of the reduction came from salaries and fringe benefits. In addition, general funds were reduced by $34,478 through a budget amendment due to higher than budgeted turnover.

These reductions were offset by budget amendments adding $2.2 million including $2.1 million in general funds, $13,287 in special funds, and $50,091 in reimbursable funds. Increases related to the fiscal 2015 cost-of-living adjustment ($271,449) and annual salary review ($360,335) totaled $618,497 in general funds and $13,287 in special funds. Health insurance adjustments for the third quarter increased general funds by $421,680. General funds increased $1.1 million to cover the cost of management fees and medical supplies. Reimbursable funds increased by $50,091 to cover increased cost of providing dietary services from WMHC to Potomac Center.

Cancellations totaled $824,238, including $805,549 in special funds and $18,689 in reimbursable funds, due to lower than expected special fund collections, primarily from renal dialysis and nursing home provider fees.

Fiscal 2016

To date, $1,419,738 has been added to the legislative appropriation, including $1.4 million in general funds and $23,260 in special funds. General funds were increased by $860,030 to realign the 2% cost containment with the agency's cost containment plan. General funds ($536,448) and special funds ($23,260) also increased related to the restoration of the 2% pay reduction.

Appendix 2

Audit Findings

Western Maryland Hospital Center

Audit Period for Last Audit:	May 7, 2012 – March 29, 2012
Issue Date:	October 2015
Number of Findings:	2
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: WMHC did not perform a sufficient verification of pharmaceutical contractor invoices prior to payment.

Finding 2: WMHC did not adequately review and approve labor hours billed by a contractor providing professional management personnel.

Object/Fund Difference Report
DHMH – Chronic Hospitals

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	511.80	510.80	495.30	-15.50	-3.0%
02 Contractual	20.09	18.01	18.27	0.26	1.4%
Total Positions	**531.89**	**528.81**	**513.57**	**-15.24**	**-2.9%**
Objects					
01 Salaries and Wages	$ 36,098,999	$ 37,282,710	$ 38,157,966	$ 875,256	2.3%
02 Technical and Spec. Fees	1,482,580	1,235,970	1,068,292	-167,678	-13.6%
03 Communication	97,135	98,652	98,556	-96	-0.1%
04 Travel	28,057	18,049	13,330	-4,719	-26.1%
06 Fuel and Utilities	1,277,307	1,358,267	1,283,216	-75,051	-5.5%
07 Motor Vehicles	28,454	105,076	188,291	83,215	79.2%
08 Contractual Services	5,182,784	3,568,308	4,135,383	567,075	15.9%
09 Supplies and Materials	4,706,197	5,501,322	4,714,356	-786,966	-14.3%
10 Equipment – Replacement	183,588	46,070	44,102	-1,968	-4.3%
11 Equipment – Additional	35,645	75,000	0	-75,000	-100.0%
12 Grants, Subsidies, and Contributions	2,529	25,000	15,000	-10,000	-40.0%
13 Fixed Charges	188,752	146,806	177,542	30,736	20.9%
14 Land and Structures	7,900	0	0	0	0.0%
Total Objects	**$ 49,319,927**	**$ 49,461,230**	**$ 49,896,034**	**$ 434,804**	**0.9%**
Funds					
01 General Fund	$ 44,872,933	$ 44,444,453	$ 45,678,436	$ 1,233,983	2.8%
03 Special Fund	3,636,764	4,121,610	3,301,146	-820,464	-19.9%
09 Reimbursable Fund	810,230	895,167	916,452	21,285	2.4%
Total Funds	**$ 49,319,927**	**$ 49,461,230**	**$ 49,896,034**	**$ 434,804**	**0.9%**

Note: The fiscal 2016 appropriation does not include deficiencies. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Chronic Hospitals

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Western Maryland Hospital Center	$ 25,744,326	$ 25,495,823	$ 25,443,947	-$ 51,876	-0.2%
01 Deer's Head Hospital Center	23,575,601	23,965,407	24,452,087	486,680	2.0%
Total Expenditures	**$ 49,319,927**	**$ 49,461,230**	**$ 49,896,034**	**$ 434,804**	**0.9%**
General Fund	$ 44,872,933	$ 44,444,453	$ 45,678,436	$ 1,233,983	2.8%
Special Fund	3,636,764	4,121,610	3,301,146	-820,464	-19.9%
Total Appropriations	**$ 48,509,697**	**$ 48,566,063**	**$ 48,979,582**	**$ 413,519**	**0.9%**
Reimbursable Fund	$ 810,230	$ 895,167	$ 916,452	$ 21,285	2.4%
Total Funds	**$ 49,319,927**	**$ 49,461,230**	**$ 49,896,034**	**$ 434,804**	**0.9%**

Note: The fiscal 2016 appropriation does not include deficiencies. The fiscal 2017 allowance does not include contingent reductions.

M00L
Behavioral Health Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$839,520	$868,243	$886,256	$18,013	2.1%
Deficiencies and Reductions	0	-11,500	-820	10,680	
Adjusted General Fund	**$839,520**	**$856,743**	**$885,437**	**$28,693**	**3.3%**
Special Fund	50,035	60,462	53,806	-6,655	-11.0%
Deficiencies and Reductions	0	0	-1	-1	
Adjusted Special Fund	**$50,035**	**$60,462**	**$53,805**	**-$6,657**	**-11.0%**
Federal Fund	649,268	738,564	733,195	-5,369	-0.7%
Deficiencies and Reductions	0	0	-12	-12	
Adjusted Federal Fund	**$649,268**	**$738,564**	**$733,183**	**-$5,381**	**-0.7%**
Reimbursable Fund	8,284	10,744	7,796	-2,948	-27.4%
Adjusted Reimbursable Fund	**$8,284**	**$10,744**	**$7,796**	**-$2,948**	**-27.4%**
Adjusted Grand Total	**$1,547,108**	**$1,666,513**	**$1,680,220**	**$13,708**	**0.8%**

- After adjusting for fiscal 2016 reversions and a back of the bill reduction in health insurance, total funding for the Behavioral Health Administration (BHA) increases by $13.7 million (0.8%) over the fiscal 2016 working appropriation.

- There is a specified reversion of $11.5 million out of Medicaid reimbursements for behavioral health providers in fiscal 2016 due to lower than anticipated enrollment within the traditional Medicaid eligibility categories.

- A supplemental budget increases the fiscal 2017 allowance by $2.3 million to provide for a 2% community provider rate increase for substance use disorder treatment services to the uninsured to mirror the rate increase granted to other community behavioral health providers. That funding is not reflected in the data shown in the analysis.

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

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Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	2,900.85	2,900.55	2,800.85	-99.70
Contractual FTEs	215.66	221.60	210.03	-11.57
Total Personnel	**3,116.51**	**3,122.15**	**3,010.88**	**-111.27**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	192.07	6.86%
Positions and Percentage Vacant as of 12/31/15	297.50	10.26%

- The fiscal 2017 allowance contains a total reduction of 99.7 positions for BHA. One position is being added to Program Direction through a contractual conversion, while 100.7 positions are being abolished.

- The position abolitions are due to the privatization of the dietary and housekeeping functions at Springfield Hospital Center (56.0 and 21.0 positions, respectively), the privatization of the dietary function at the John L. Gildner Regional Institute for Children and Adolescents (RICA) (14.0 positions), a reduction from 38 to 34 beds at RICA – Baltimore (8.5 positions), and the transfer of 1.0 position to the Department of Information Technology. The remaining 0.2 position is a reduction of a partial position for dental services at Spring Grove Hospital Center. However, the privatization of the housekeeping function at Springfield is no longer moving forward, so these position reductions will be absorbed through vacancies throughout the rest of the department.

- Contractual employment decreases by 11.57 full-time equivalents (FTE) due to a number of changes. Student training food service positions and direct care aides each increase by 4.0 FTEs, while other food service staff decrease by 6.0 FTEs and security staff decrease by 4.5 FTEs. Other contractual reductions are for patient-based jobs and other employment.

- The overall vacancy rate for BHA increased between fiscal 2016 and 2017, mostly due to the hiring freeze instituted by the department for cost containment purposes in fiscal 2015. Budgeted turnover also increased by 0.94% in the allowance.

Analysis in Brief

Major Trends

Substance Use Prevention: The number of people served by prevention programming grew by 79,100 (19.7%) compared to fiscal 2014. The growth was in single service programming.

Substance Use Disorder Treatment Financing Driven by the Affordable Care Act Expansion: The expansion of eligibility for adults under the federal Affordable Care Act (ACA) has greatly increased the federal fund financing available for substance use disorder (SUD) treatment.

Community Mental Health Fee-for-service System – Enrollment and Utilization Trends: Enrollment growth in the fee-for-service (FFS) community mental health system was 9.2% in fiscal 2015, which is slightly under the enrollment growth over a five-year period from fiscal 2011 through 2015. Individuals eligible for Medicaid under the traditional eligibility categories have declined between fiscal 2014 and 2015, while adults newly eligible under the ACA expansion continue to increase. However, the growth in total service units, while strong, was below enrollment growth in fiscal 2015.

Community Mental Health Fee-for-service System – Expenditure Trends: Expenditures grew at 12.0% in fiscal 2015, outpacing growth over the last five years of 6.9%. This trend is due to an annualization of first-year costs associated with the ACA expansion population, the increasing number of individuals newly eligible for mental health services, as well as the fact that these individuals tend to be utilizing those services, such as inpatient psychiatric services, which are more expensive. However, the 100.0% federal funding rate for the ACA expansion population has limited the amount of State funds expended.

Outcomes for Community Behavioral Health Services: Outcome measures derived from interviews with clients served in outpatient settings for both mental health and SUD treatment vary depending on the condition of the client. Those clients with a co-occurring mental health and SUD exhibit the highest levels of homelessness, while clients with a SUD are more likely to be arrested and clients with a mental health condition are more likely to be unemployed.

Issues

The Heroin Epidemic: The use of heroin and heroin-related substances continues to be an epidemic in the State with heroin-related overdose deaths continuing to climb in fiscal 2015. Numerous efforts have focused on this issue, including most recently the Governor's Heroin and Opioid Emergency Task Force which issued its final recommendations in December 2015. There is a total of $4.8 million in the State budget related to these recommendations, including $3.1 million within BHA. However, funding for SUD treatment continues to be relatively flat, even with the provider rate increases provided by the Administration, and there is an especially acute need for more funding for residential treatment for those individuals committed to the Department of Health and Mental Hygiene (DHMH) under Section 8-507 of the Health – General Article. **The Department of Legislative Services (DLS) thus**

recommends that the funding appropriated for the Center of Excellence, as well as funding within the Department of Human Resources and the Department of Juvenile Services for a heroin screening tool, instead be utilized to fund residential treatment under Section 8-507. The department should also comment on the funding levels and bed availability that would be required under the Justice Reinvestment Coordinating Council bills.

Behavioral Health Integration – Furthering Financial Alignment: The integration of State mental health and SUD agencies and services is continuing, with FFS payments for SUD services being carved-out of HealthChoice under a single administrative service organization (ASO) since January 1, 2015. New information sharing arrangements have also been worked out between the ASO and the Medicaid Managed Care Organizations. However, SUD services for the uninsured continue to be financed on a grant-based system as opposed to FFS under the ASO, which is how mental health services for the uninsured are financed. The department has recently indicated that ambulatory SUD services will be transitioned within fiscal 2017, but other services will still remain in a grant-based system. **The department should comment on how it plans to ensure a smooth transition of ambulatory SUD treatment services to the ASO, and what plans it has for transferring the remaining grant-based funding to the ASO.**

Funding for Institutions for Mental Disease: The Medicaid Institutions for Mental Disease exclusion prohibits the use of federal Medicaid financing for care provided to most adult patients between the ages of 21 and 65 in mental health and SUD residential treatment and inpatient facilities larger than 16 beds. The State in prior years has used numerous waivers to seek federal reimbursement for these services. However, all waivers and programs have expired since the end of fiscal 2015. Currently, the department is seeking individual waivers for SUD services and mental health services, but neither waiver currently has a timeline for approval. **The department should comment on the current status of these waiver applications, and how it plans to fund inpatient psychiatric services without federal funds in fiscal 2017.**

Recommended Actions

1. Add language restricting Medicaid behavioral health provider reimbursements to that purpose.

2. Add budget bill language restricting funds for specified Heroin and Opioid Emergency Task Force Initiatives to only be spent on residential treatment services for Section 8-507 of the Health – General Article commitments.

Updates

Synar Compliance Improves Dramatically: A report was submitted in response to budget bill language from the 2015 *Joint Chairmen's Report* (JCR) on how the State would spend the Synar penalty funding in fiscal 2016 to ensure that no further penalty would be realized for the State. Based

on the most recent federal audit, the State's retailer violation rate has dropped so dramatically that the State will not incur a penalty within the fiscal 2017 budget.

Reports on Behavioral Health Expenditures by Medicaid Eligibility Improve, but More Needs to Be Done: A report was submitted in response to budget bill language within the 2015 JCR providing information on the utilization and expenditures for behavioral health services based upon the user's eligibility group under Medicaid. While this report is useful, more work needs to be done to produce a comprehensive report that would allow DLS to prepare more robust and confident expenditure projections. **Thus, DLS and DHMH will continue to work together throughout the 2016 interim to come up with a more comprehensive and complete dataset and reporting structure.**

M00L
Behavioral Health Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Behavioral Health Administration (BHA) is responsible for the treatment and rehabilitation of the mentally ill; individuals with drug, alcohol, and problem gambling addictions; and those with co-occurring addiction and mental illness. BHA reflects a merger of the former Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA).

In fiscal 2015, funding for Medicaid-eligible services for the mentally ill was moved from MHA into the Medical Care Programs Administration (MCPA). Further, in fiscal 2016 funding for substance use disorder services were transferred within MCPA from Program M00Q01.03 to M00Q01.10. However, for the purpose of reviewing the fiscal 2017 budget, the funding that is budgeted in M00Q01.10 is reflected in this analysis.

BHA will continue to perform the functions previously undertaken by MHA and ADAA. Namely:

- **For Mental Health Services –** planning and developing a comprehensive system of services for the mentally ill; supervising State-run psychiatric facilities; reviewing and approving local plans and budgets for mental health programs; providing consultation to State agencies concerning mental health services; establishing personnel standards; and developing, directing, and assisting in the formulation of educational and staff development programs for mental health professionals. In performing these activities the State will continue to work closely with local core service agencies (CSAs) to coordinate and deliver mental health services in the counties. There are currently 19 CSAs, some organized as part of local health departments, some as nonprofit agencies, and 2 as multicounty enterprises.

- **For Substance Use Disorder Services –** developing and operating unified programs for substance use disorder (SUD) research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies.

Performance Analysis: Managing for Results

1. Substance Use Prevention

State prevention services are provided through two types of programs:

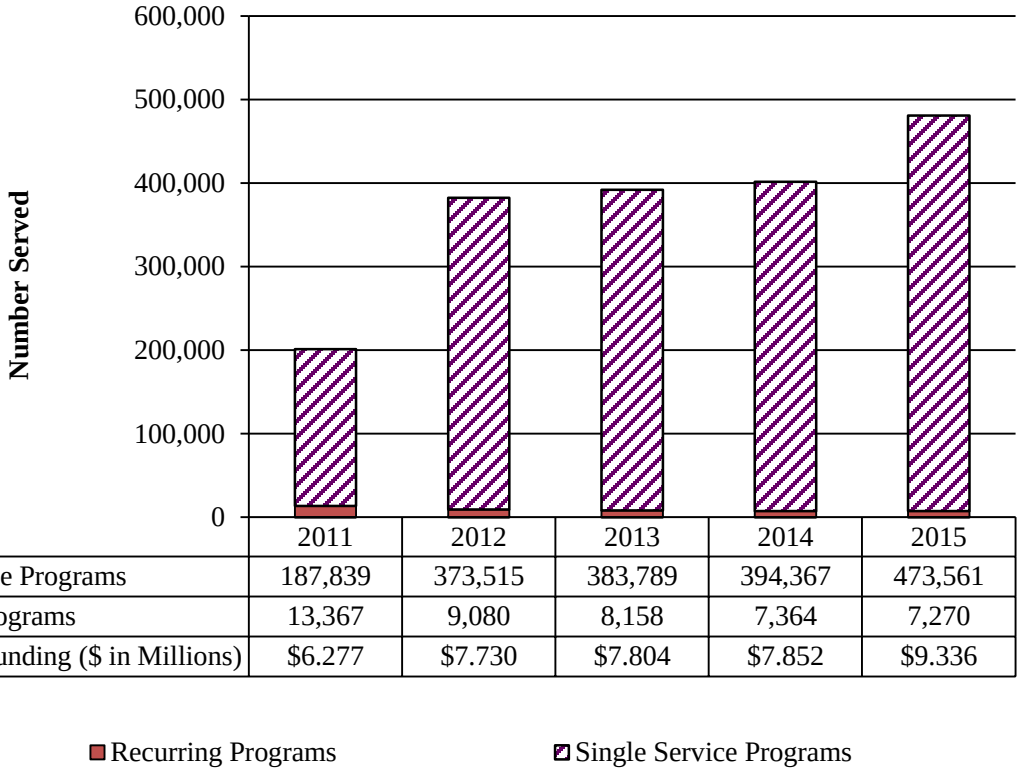
- **Recurring Prevention Programs –** *i.e.*, with the same group of individuals for a minimum of four separate occasions and with programming that is an approved Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based model. In fiscal 2015, a total of 284 recurring prevention programs were offered across the State, an increase of 27 from the prior year.

  Statewide, the successful completion rate for these types of programs is reported at 86%, a number that has varied little over the past decade. There is variation by county among programs in terms of successful completion. In fiscal 2015, for example, the successful completion rate varied from 100% in Caroline and Cecil counties to 83% in Washington County. It should be noted that since programming varies from one jurisdiction to the next, there is no universal definition of what is considered a "successful completion."

- **Single Service Programs –** such as presentations, speaking engagements, training, *etc*., that are provided to the same group on less than four separate occasions. Participant numbers are either known or estimated. In fiscal 2015, 1,294 single service prevention activities were offered in Maryland, an increase of 39 from the prior year.

As shown in **Exhibit 1**, prevention programming served almost 481,000 participants in fiscal 2015, 79,100 (19.7%) higher than served in fiscal 2014. Recurring programs continue to see a drop in people served, down 94 participants (1.3%) between fiscal 2014 and 2015, a decline that somewhat eased off from the prior year. Conversely, the number of participants served in single service programs grew by 79,194 between fiscal 2014 and 2015, or 20.1%.

Exhibit 1
Behavioral Health Administration-funded Prevention Programs
Fiscal 2011-2015



	2011	2012	2013	2014	2015
Single Service Programs	187,839	373,515	383,789	394,367	473,561
Recurring Programs	13,367	9,080	8,158	7,364	7,270
Prevention Funding ($ in Millions)	$6.277	$7.730	$7.804	$7.852	$9.336

Source: Behavioral Health Administration

In essence, after the significant growth in single service programming between fiscal 2011 and 2012 to reflect the change in program focus from individual-based programming to population-based programming/activities, prevention programming has somewhat stabilized in terms of activities funded. The change in focus required jurisdictions to spend 50% of their prevention award on "environmental strategies," *i.e.*, the establishment of, or changes to, written and unwritten community standards, codes, and attitudes influencing the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs. Environmental strategies tend to be primarily single service activities, limiting the funding available for recurring programs. The broader reach of environmental programming, including mass media campaigns, boosts exposure to single service activities.

Prevention funding continues to increase because of the availability of federal Strategic Prevention Framework State Incentive Grant funds. This grant expired at the end of fiscal 2015.

However, BHA has been awarded new funding under the SAMSHA Partnership for Success grant that will allow them to continue and enhance the State prevention infrastructure and services provided through this program.

2. Substance Use Disorder Treatment Financing Driven by the Affordable Care Act Expansion

Exhibit 2 provides the number of adults who were recorded as receiving treatment through the Administrative Service Organization (ASO) during fiscal 2015, which was the first fiscal year within which reimbursement for services provided to individuals receiving care for a SUD condition through the Medicaid program was provided by the ASO as opposed to through the Medicaid Managed Care Organizations (MCO). As seen in the exhibit, almost half of the individuals receiving SUD treatment in fiscal 2015 were eligible for Medicaid under the Affordable Care Act (ACA) expansion, which increased the federal poverty level under which adults are eligible for Medicaid to 138%. While these individuals did receive SUD treatment prior to the ACA expansion, they did so under the Primary Adult Care (PAC) program, which was entirely financed by the State. Under ACA, these services are entirely financed by the federal government. This is especially significant since, as also seen in Exhibit 2, adults make up the vast majority of the population receiving SUD treatment.

Exhibit 2
SUD Treatment Data by Medicaid Eligibility and Age
Fiscal 2015

	Medicaid Eligibility			
Age	**Traditional***	**ACA Expansion**	**Total**	**% Expansion**
0-17	2,070	1	2,071	0.05%
18-64	23,486	25,425	48,911	51.98%
65 and Over	212	2	214	0.93%
Totals	**25,768**	**25,428**	**51,196**	**49.67%**
% Adult	91.14%	99.99%	95.54%	

ACA: Affordable Care Act
SUD: substance use disorder

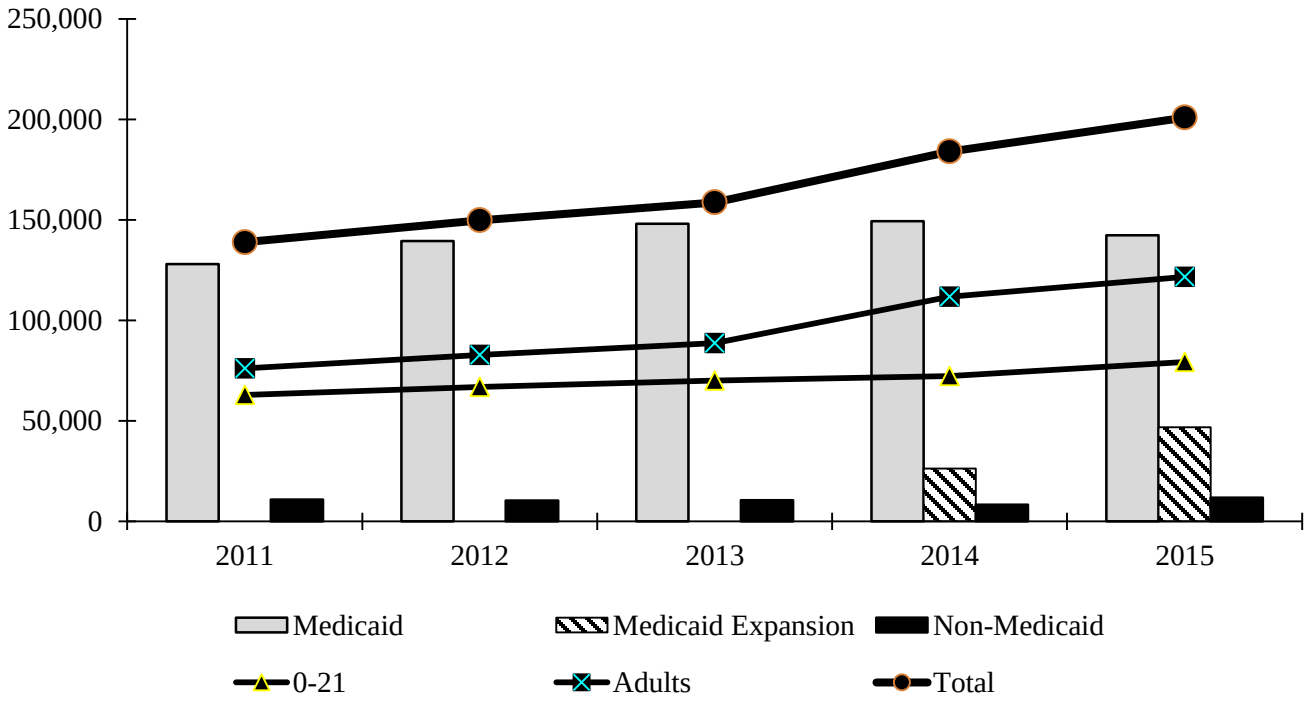
*Traditional includes all Medicaid coverage groups from before the ACA expansion.

Source: Behavioral Health Administration

3. Community Mental Health Fee-for-service System – Enrollment and Utilization Trends

As shown in **Exhibit 3**, total enrollment in the fee-for-service (FFS) community mental health system (Medicaid and non-Medicaid) has increased at an average annual rate of 9.7% between fiscal 2011 and 2015, which is similar to the 9.2% growth between fiscal 2014 and 2015.

Exhibit 3
Community Mental Health Services
Enrollment Trends
Fiscal 2011-2015



Note: Data for fiscal 2015 is incomplete. Enrollment counts may be duplicated across coverage types. Baltimore City capitation project is included.

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

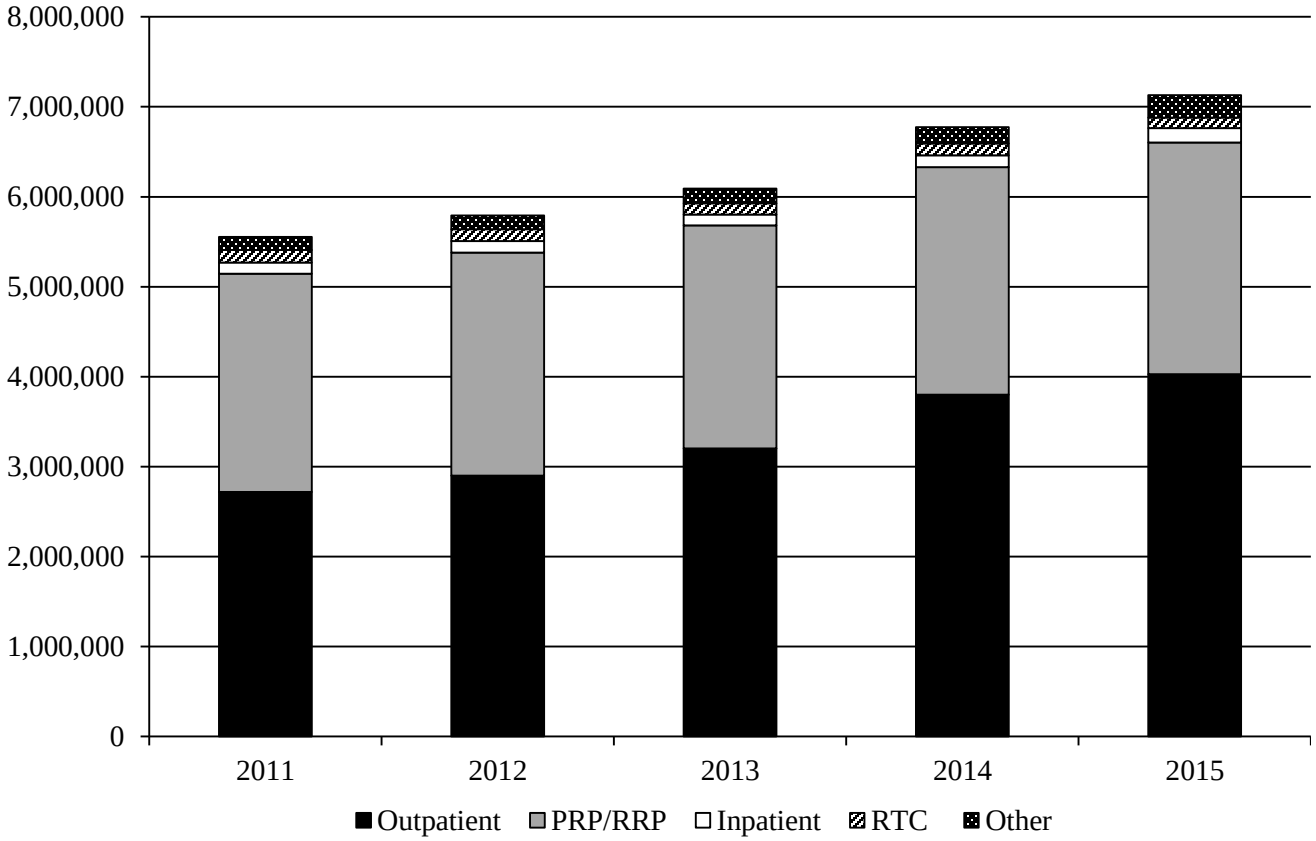
One major change in fiscal 2015 is the drop in the traditional Medicaid population. This eligibility category decreased by 4.7% between fiscal 2014 and 2015. This is most likely attributable to the Medicaid redeterminations which have resulted in fewer people renewing their Medicaid eligibility. However, this decrease was more than made up for in increases for the new ACA expansion population. This difference is particularly interesting because in the overall Medicaid program,

redetermination impacted the traditional and expansion populations alike. When both populations are blended together, the number of consumers using mental health services with some form of Medicaid coverage increases by 7.6% between fiscal 2014 and 2015. More potentially concerning, the non-Medicaid population rises by 1.9% over the period shown, with a sharp increase between fiscal 2014 and 2015 of 42.2%. Most of this increase is from children using services.

The exhibit also shows that enrollment growth over the period has been driven by adults (12.4% between fiscal 2011 and 2015), reflecting both prior strong growth in the PAC program, the State's fiscal 2009 expansion to parents of children in Medicaid, as well as the fiscal 2014 ACA expansion. Over the period shown, the number of adults in the program increases by 12.4% while the number of children increases by 6.0%. Adults make up 60.5% of total enrollment in fiscal 2015, compared to 54.8% in fiscal 2011. However, enrollment growth for children outpaces enrollment growth for adults between fiscal 2014 and 2015 at 9.7% compared to 8.8%, mostly due to the increase in uninsured children. **BHA should comment on the reasons why the number of uninsured children rose so dramatically in fiscal 2015.**

In terms of utilization of services, trends are shown in **Exhibit 4**. The exhibit shows that over the five-year period, total service units are up at an average annual rate of 6.4%. In fact, fiscal 2015 had the largest number of total service units in over 10 years, and the growth between fiscal 2014 and 2015 was 5.2%. This increase has been driven by increases in both outpatient services (up 10.3% over the period and 6.0% over the prior year) as well as other services including crisis, supported employment, and respite care (up 13.8% over the period and 35.7% over the prior year). In fact, all service types had increases in the total number of services over the prior year in fiscal 2015, with the exception of residential treatment, mainly reflecting the fact that the ACA expansion increased the number of services available to a population that previously had largely been unable to obtain them.

Exhibit 4
Community Mental Health Fee-for-service
Service Utilization Trends
Fiscal 2011-2015
(Units of Service)



PRP: Psychiatric Rehabilitation Program
RRP: Residential Rehabilitation Program
RTC: Residential Treatment Center

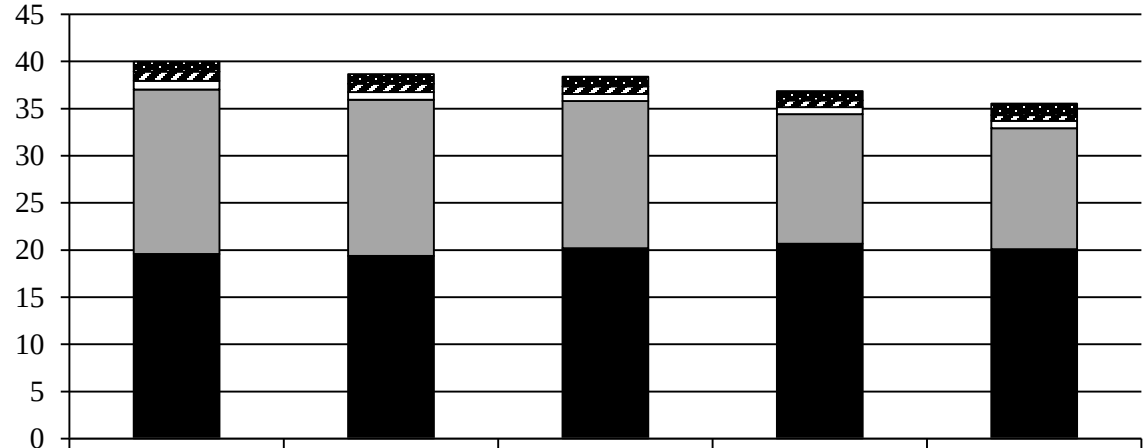
Note: Data for fiscal 2015 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

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

It is worth noting the difference between the enrollment growth in the system between fiscal 2011 and 2015 and contrasting that with the total service units provided in the same period. Over the time period, there has been a decline in the average number of services per capita for most of the more intensive services, such as inpatient, psychiatric and residential rehabilitation, and residential treatment, as seen in **Exhibit 5**. Traditional outpatient services increase over the time period by 0.7%, however, they decrease in fiscal 2015 by 2.9%. The largest increases in services per capita over the

time period by far are for the other services category at 3.8%, with a jump in fiscal 2015 of 24.2%. This includes mainly wraparound services such as crisis and respite care as well as supported employment. One notable trend in fiscal 2015, however, is the increase in inpatient services provided. While inpatient services declined over the period shown by 3.2%, they increased in fiscal 2015 by 10.0%, reversing a decline which had been occurring since fiscal 2009. This is concerning since inpatient services are the most expensive services on a per service basis and potentially are not eligible for federal match depending on the facility where the services are provided.

Exhibit 5
Community Mental Health Fee-for-service
Service Utilization Trends
Fiscal 2011-2015
(Services Per Capita)



	2011	2012	2013	2014	2015
Other	1.06	1.02	1.03	0.99	1.23
RTC	0.98	0.88	0.79	0.71	0.59
Inpatient	0.90	0.84	0.75	0.72	0.79
PRP/RRP	17.46	16.55	15.63	13.75	12.82
Outpatient	19.57	19.38	20.18	20.68	20.09

PRP: Psychiatric Rehabilitation Program
RRP: Residential Rehabilitation Program
RTC: Residential Treatment Center

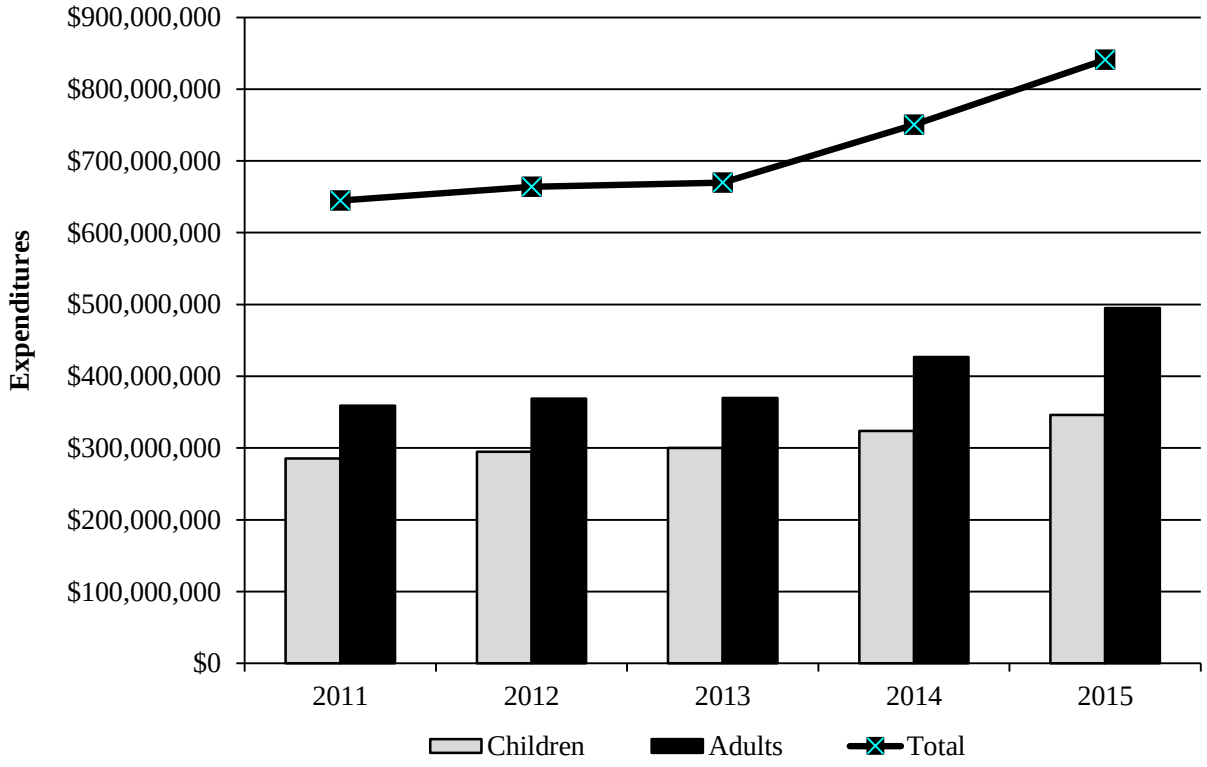
Note: Data for fiscal 2015 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

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

4. Community Mental Health Fee-for-service System – Expenditure Trends

Expenditure patterns historically mirror enrollment growth (**Exhibit 6**). Average annual expenditure growth over the fiscal 2011 to 2015 period is 6.9%. However, growth between fiscal 2014 and 2015 is 12.0%, which is mainly driven by the first full year of costs for the ACA expansion population and the increase in demand for services noted in the previous section.

Exhibit 6
Community Mental Health Fee-for-service Expenditures
Fiscal 2011-2015



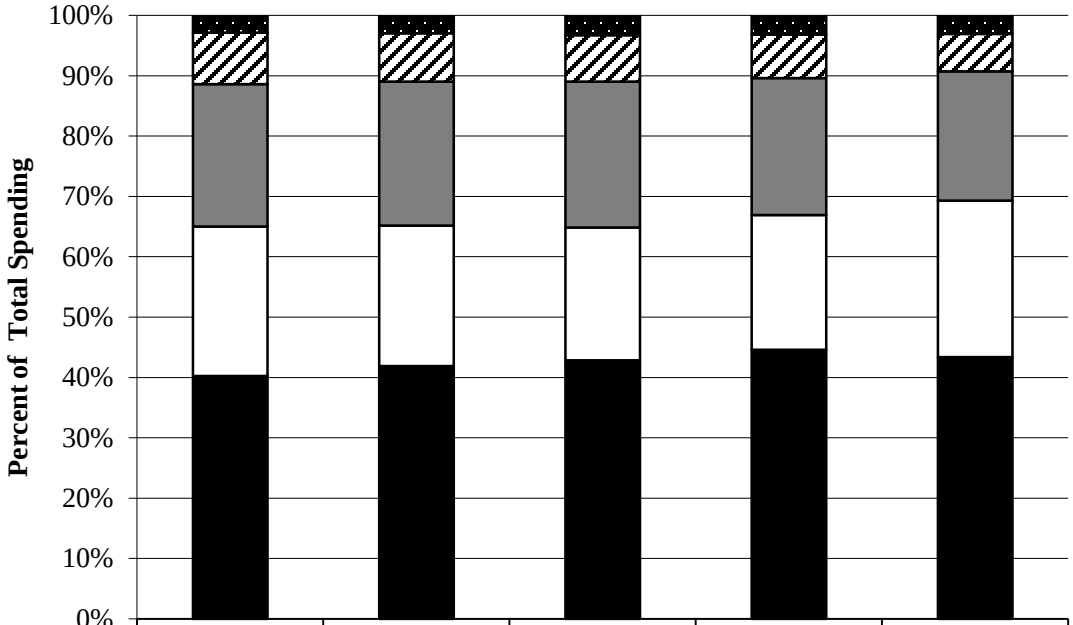
Note: Data for fiscal 2015 is incomplete. Total expenditure data includes expenditures for the Baltimore City capitation project.

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

Reflecting the changes in service utilization noted above, there has been a corresponding change in expenditure patterns between different services (**Exhibit 7**). All services, with the exception of residential treatment, had expenditure growth between fiscal 2014 and 2015, with the largest growth

being in inpatient services expenditures at 30.3%. This is mostly attributable to the ACA expansion population which, under the old PAC program, did not have access to these services. This growth is particularly troubling since, as explained in more detail in Issue 3, the State does not receive federal matching funds for inpatient services if they are provided within a specialty psychiatric hospital.

Exhibit 7
Community Mental Health Service Expenditures by Service Type
Fiscal 2011-2015



	2011	2012	2013	2014	2015
Other	$18,329,753	$19,699,732	$21,588,505	$23,761,643	$25,886,279
RTC	$55,193,989	$53,243,697	$50,740,960	$54,304,385	$52,303,651
PRP and RRP	$152,065,731	$158,366,382	$159,771,844	$170,161,634	$179,756,021
Inpatient	$159,818,003	$154,515,302	$145,656,749	$167,598,555	$218,298,269
Outpatient	$259,343,588	$277,934,562	$283,015,346	$334,820,189	$364,517,517

PRP: Psychiatric Rehabilitation Program
RRP: Residential Rehabilitation Program
RTC: Residential Treatment Center

Note: Data for fiscal 2015 is incomplete.

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

5. Outcomes for Community Behavioral Health Services

Outcome data from BHA's Outcomes Measurement System continues to be limited to outpatient clinics. However, they have now begun to collect information on those receiving outpatient services with both mental health and SUD conditions. The data presented in **Exhibit 8** is based on the most recent interview of clients, and in each situation asks whether or not the individual has either been homeless, arrested, or unemployed within the last six months. The percentages are the number of individuals who answered yes to these questions. As seen in the exhibit, the greatest problems are split amongst various populations. Homelessness and criminal justice involvement are highest amongst those with a SUD condition, with homelessness being especially acute for those with a co-occurring disorder. However, those with a mental health diagnosis are the most likely to be unemployed.

Exhibit 8
Outcome Measurement System Data
Fiscal 2015

	Homeless	Criminal Justice Involvement	Unemployment
Adult			
All	12.4%	6.7%	66.4%
MH	2.3%	3.5%	87.0%
SUD	12.9%	20.2%	54.3%
Co-occuring	18.2%	16.0%	64.5%
Children			
All	2.3%	4.1%	87.0%
MH	2.3%	3.5%	87.0%
SUD	4.2%	35.4%	85.8%
Co-occuring	3.1%	27.8%	89.2%

MH: mental health
SUD: substance use disorder

Source: Behavioral Health Administration

Fiscal 2016 Actions

Cost Containment

The fiscal 2016 budget contained an across-the-board reduction for all State agencies, which resulted in a 0.6% across-the-board general fund reduction for the Department of Health and Mental Hygiene (DHMH) totaling $27,215,000. Of this total amount, BHA was assigned a cost containment decrease of $2,639,890 in general funds. Actions undertaken to make up this cut include utilizing additional federal fund attainment in lieu of general funds ($1,375,000), decreasing funds for services for the uninsured ($450,000), and a 2% operating expenses reduction at all of the State psychiatric institutions ($814,890).

Further, there is a specified reversion in the Governor's fiscal 2017 budget plan of $11,500,000 from Medicaid behavioral health in fiscal 2016. These funds are available due to lower than anticipated spending on the traditional Medicaid population, due to declining enrollment within that population.

Proposed Budget

As shown in **Exhibit 9**, after adjusting for the fiscal 2016 specified reversion as well as fiscal 2017 back of the bill reductions, the fiscal 2017 allowance for BHA grows by $13.7 million (0.8%) over the fiscal 2016 working appropriation. Not included in these numbers is $2.3 million from Supplemental Budget No. 2. Including this amount, expenditures increase by $16.0 million, or 1.0%.

Exhibit 9
Proposed Budget
Department of Health and Mental Hygiene
Behavioral Health Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$839,520	$50,035	$649,268	$8,284	$1,547,108
Fiscal 2016 Working Appropriation	856,743	60,462	738,564	10,744	1,666,513
Fiscal 2017 Allowance	885,437	53,805	733,183	7,796	1,680,220
Fiscal 2016-2017 Amount Change	$28,693	-$6,657	-$5,381	-$2,948	$13,708
Fiscal 2016-2017 Percent Change	3.3%	-11.0%	-0.7%	-27.4%	0.8%

Where It Goes:

Personnel Expenses	
Employee and retiree health insurance	$4,299
Retirement contributions	3,899
Overtime	731
Workers' compensation premium assessment	433
Turnover adjustments	188
New position (1.0 full-time equivalent (FTE))	77
Other compensation	48
Other fringe benefit adjustments	-275
Abolished positions (100.7 FTEs)	-5,844
Community Behavioral Health Services	
Fee-for-Service Expenditures	
Regulated rate increase assumptions	14,787
Community provider rate increase (2%)	12,248
Enrollment and utilization: uninsured and State-funded	-5,551
Enrollment and utilization: Medicaid	-21,853
Grants and Contracts – Mental Health	
Care Management Entity funding	1,610
Maryland Collaboration for Homeless Enhancement Services Grant	1,427
Core Service Agency rate increase (2%)	1,260
Increase in Community Mental Health Service Block Grant (federal funds)	1,064
Administrative Service Organization contract	247
Expiring federal grants	-1,013
Core Service Agency various programming	-1,471
Grants and Contracts – Substance Use Disorders	
New federal grant funding	2,187
Increased federal grant funding	1,112
Synar penalty	-2,612
Program Direction	
Heroin Task Force initiatives	3,059
Prescription Drug Monitoring Program	441
Maryland Institute for Policy Analysis and Research	204
Facilities	
Privatization contracts	4,492
Purchase of care contracts at Spring Grove Hospital Center	701
Crownsville Hospital Center facility maintenance	-690
Non-personnel operating costs from privatized functions	-1,726
Other Changes	228
Total	**$13,708**

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

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. For DHMH, the amount of these reductions is $1,424,451 in general funds, $132,440 in special funds, and $251,138 in federal funds across the entire department, of which $832,865 is in the BHA budget ($819,526 general funds, $1,266 special funds, $12,073 federal funds). There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

Personnel

Personnel expenditures net of back of the bill reductions increase by $3.6 million. The largest increases, consistent with other State agencies, are for employee and retiree health insurance contributions as well as retirement contributions at $4.3 million and $3.9 million, respectively. One new position within Program Direction also adds $76,936. This position is a contractual conversion of a program administrator position which assists homeless and mentally ill individuals with accessing entitlements and other supportive programs.

There is also an increase of $730,986 in overtime expenses. However, it should be noted that the current allowance for overtime is still below the most recent actual from fiscal 2015. During that year, overtime expenses across the agency totaled $13.7 million, which is in line with other recent historical trends. However, the current allowance only allots $9.6 million. This is problematic, both because the State hospital centers continue to be over capacity and because vacancy rates within the hospitals continue to be quite high. According to the most recent vacancy data, vacancy rates at the two largest hospital centers, Springfield and Spring Grove, are 13.8% and 11.9%, respectively.

The largest change in personnel expenditures is the decrease of $5.8 million for abolished positions. There are 100.7 positions abolished within BHA for a variety of reasons. A total of 77.0 positions are being abolished at Springfield Hospital Center due to the privatization of the dietary and housekeeping functions at the hospital. The position abolitions due to these privatizations are 56.0 and 21.0, respectively, with the majority of these positions being currently filled. However, due to an error in the calculations for the cost of the outsourced housekeeping contract, DHMH is no longer pursuing this specific privatization. The 21.0 position reduction, however, will still be made up with vacancies from throughout the department. More information on this is provided under the discussion of changes within the facilities.

There is also a decrease of 14.0 positions at the John L. Gildner Regional Institute for Children and Adolescents (RICA) due to the privatization of the dietary function at that facility as well. Personnel savings from all of the privatizations totals $5.5 million. A further 8.5 positions are being reduced at RICA – Baltimore due to a residential bed reduction from 38 to 34 beds, and 1.0 position is being transferred to the Department of Information Technology as part of the centralization of information technology functions across the State. The remaining 0.2 position is a reduction of a partial position for dental services at Spring Grove Hospital Center.

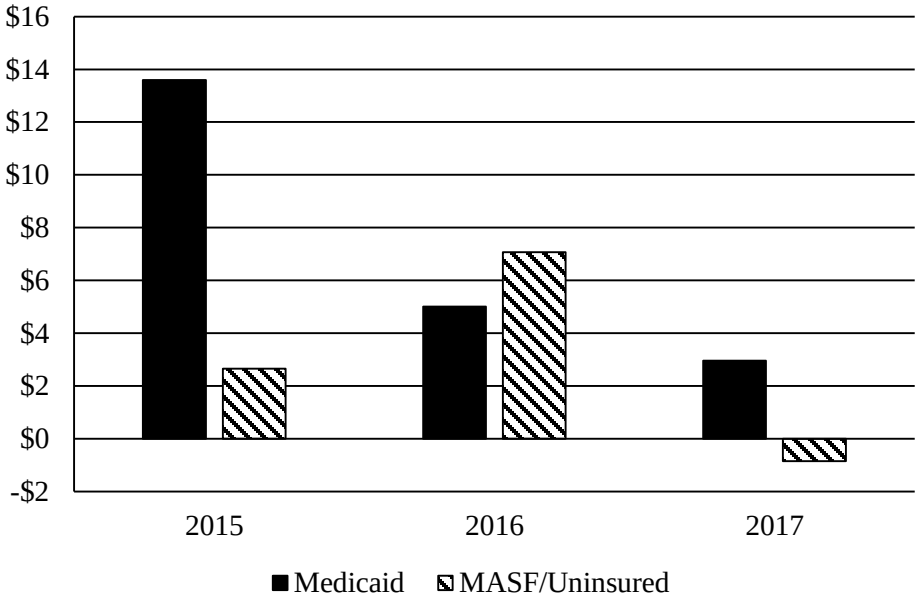
Community Behavioral Health Services

Fee-for-service Expenditures

Overall spending on FFS expenditures for behavioral health treatment, including services for those within the Medicaid program as well as the uninsured and State-funded services for the Medicaid-eligible, decreases by approximately $369,000. Most of this is due to reduced expenditures related to enrollment and utilization trends, falling $21.9 million, with a particularly sharp decrease in federal funds. There is also an assumed decrease of $5.6 million for the uninsured and State-funded services budget, which declines due to the fact that an extra $10.0 million added to the budget via budget amendment from the Maryland Health Insurance Plan (MHIP) fund is not continued into fiscal 2017. Beyond these reductions, there are rate increases for behavioral health providers. Regulated rate increase assumptions add $14.8 million to the budget, while a 2% community provider rate increase adds $12.2 million.

The Department of Legislative Services (DLS) estimate of the adequacy of State-supported funds to meet demand for FFS community behavioral health services is provided in **Exhibit 10**. Overall, the budget for Medicaid-eligible spending looks to be in balance when it comes to State-supported funding. Based on the most recent spending projections for fiscal 2015 and using projected enrollment growth, current utilization trends, and provider rate increases, it appears that the fiscal 2016 budget for behavioral health Medicaid services is slightly overfunded by $5.0 million in terms of State funding after taking into consideration the $11.5 million targeted reversion. The current fiscal 2015 accrual levels appear to be well above the level needed to closeout fiscal 2015, with a $13.6 million surplus projected. The fiscal 2017 budget also has a projected surplus of State funding at $3.0 million. However, for both fiscal 2016 and 2017, given the overall level of State funding, the surplus represents a variance of only 1.4% and 0.8%, respectively.

Exhibit 10
Projected General Fund Balances
Fiscal 2015-2017
($ in Millions)



MASF: Medical Assistance State Funded

Note: Excludes the Baltimore Capitation Project.

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

Funding for the uninsured as well as State-funded services for Medicaid-eligible individuals looks to be adequate as well. While there is a projected deficit within fiscal 2017, this represents only a 1.1% variance from the amount contained within the allowance. **Over the three years, there is a surplus of $30.4 million including Medicaid, Medicaid State-funded, and uninsured services.** However, there are two trends that happened within fiscal 2015 that could affect funding adequacy in both fiscal 2016 and 2017. First, as noted previously, the number of individuals receiving services for the uninsured increased dramatically in fiscal 2015, particularly for children. At this time, it is unclear why this increase occurred since there was not a corresponding decrease of children enrolled in Medicaid utilizing behavioral health services.

Second, within fiscal 2015 there was an unusually high utilization of inpatient mental health services within specialty psychiatric hospitals. Due to the federal exclusion of reimbursement for mental health or SUD services within an institution for mental disease (IMD), these inpatient services

must be entirely funded by the State. In fiscal 2015, inpatient utilization within an IMD was especially acute for the former PAC population, which prior to the ACA expansion did not have access to inpatient psychiatric services. Once that access was granted, these patients began presenting at much greater numbers at both acute care hospitals as well as psychiatric hospitals throughout the State. For those presenting at acute care, since they are within the ACA expansion population, the State was reimbursed at 100%. However, for those presenting at a specialty psychiatric hospital, the only federal reimbursement available was through a federal demonstration project, which only reimbursed at 50% and ended at the conclusion of fiscal 2015. In order to prevent spending from inflating at this rate again, BHA is currently monitoring the number of patients which can be admitted to a private psychiatric facility and encouraging those facilities to seek placement for patients within an acute care hospital prior to admission to the IMD facility. Without BHA utilizing this procedure, or obtaining additional federal funding through one of the waivers discussed in Issue 3, it is possible that the deficit in fiscal 2017 presented in Exhibit 10 could become much larger.

It is also worth noting that the Administration has utilized special funds from the surplus within the Senior Prescription Drug Assistance Program fund to offset general funds within the FFS programs for the uninsured. Currently, the appropriation is $8.3 million. However, DLS estimates that there is only $6.0 million available for this purpose (see the Medical Care Programs Administration analysis for additional detail). BHA will have to find additional sources of revenue in order to make up for this difference in fiscal 2017.

Grants and Contracts – Mental Health

Various grants and contracts for mental health providers increase by $3.1 million above the current working appropriation. The largest increase is $1.6 million for the Care Management Entity (CME) function. Previously, the Governor's Office for Children (GOC) ran a program that provided wraparound services for children with severe emotional disturbance in order to keep these children out of residential treatment facilities and in their homes and communities. During fiscal 2016, a budget amendment was processed which transferred $2.8 million for this program from GOC to BHA. For fiscal 2016, BHA will continue funding the contract that is currently in use by the State. However, in fiscal 2017, $4.4 million has been provided to the CSAs in order to switch from the current CME to a Targeted Case Management (TCM) system.

In particular, this switch seeks to take advantage of the State Plan Amendments that redefined TCM for children and adolescents and created the 1915(i) service array. The current TCM system already provides care coordination to youth with intensive needs who are eligible for Medicaid, and in particular the 1915(i) service array is available to support home and community-based plans of care for youth in the highest level of intensity who also meet financial eligibility requirements. By eliminating the CME and redirecting funds to the TCM system, the State intends to establish a more efficient system that also draws down the federal Medicaid match for TCM services for Medicaid-eligible children. The funding included in the fiscal 2017 allowance is to support the continuation of services at varying intensity levels for youth that are both eligible and ineligible for Medicaid, similar to those services provided by the CME, and is based on the historical costs of youth served by the CME.

Grants and Contracts – Substance Use Disorders

The major increases in grants and contracts for SUD services are for federal funding that is either new or enhanced in fiscal 2017. New grants total $2.2 million and include the Maryland Collaboration for Homeless Enhancement Services grant at $1.4 million (with an additional $1.4 million for the mental health component of this grant as well) and a grant of $794,300 for medication assisted treatment for heroin and prescription opioid addiction. Also, not included in these numbers, is an additional $2.3 million from Supplemental Budget No. 2. This supplemental added funds due to the fact that SUD services for the uninsured, which are currently provided through grants and contracts and not on a FFS basis, were not calculated into the rate increase for community providers in the allowance as originally submitted. These increases are partially offset by the decrease of $2.6 million for the Synar penalty. However, the State intends to continue funding the Synar program within the Prevention and Health Promotion Administration (PHPA) of DHMH. More on the Synar program and penalty can be found in Update 1.

Program Direction

The largest increase for Program Direction is $3.1 million for initiatives related to the Governor's Heroin and Opioid Emergency Task Force recommendations. The largest part of this funding at $1.0 million is to establish the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council in order to further study issues surrounding SUD and especially heroin and opioid addiction. Other major uses of these funds include a Good Samaritan Law Public Awareness Campaign ($700,000), providing recovery support specialists to assist pregnant women with substance use disorders ($622,000), and requiring mandatory registration and querying of the Prescription Drug Monitoring Program (PDMP) ($522,000). More on these items, including other items funded as part of the task force recommendations, can be found in Issue 1.

Facilities

The largest increase in the budgets for the State-operated hospital centers and facilities is $4.5 million for the privatization contracts for Springfield Hospital Center and RICA – Gildner. Overall, the cost of the contracts minus the savings from the abolished positions as well as the operating costs of those functions lowers the fiscal 2017 allowance by $2.7 million. However, some issues have been noticed with the privatization process for these contracts, in particular with the housekeeping contract at Springfield.

According to DHMH, both of the dietary contracts at Springfield and RICA – Gildner have been reviewed and certified by the Department of Budget and Management that they will save the amounts mandated by statute. However, at this time the amounts included in the budget are projections based on the costs of privatized food services at other State hospital centers. Since a Request for Proposals (RFP) cannot be issued until 60 days after employees have been notified, the actual costs of the contracts are unknown at this time.

One privatization has already been pulled back, which is the contract for housekeeping services at Springfield Hospital Center. This privatization is no longer moving forward due to an error in the

calculation of the costs of the contract based on the square footage of the facility. The State did not include in its estimate the correct size of the facility that would need to be maintained, and based on a revised cost estimate it is no longer feasible to privatize this service. However, while the Administration does not intend to move forward with the privatization of housekeeping services at this time, the reduction of 21 positions, as well as the cost differential, will now be absorbed through other vacancies throughout the department. **BHA should comment on the status of these contracts, when the RFP will be released by the State, and how the department intends to absorb the position reductions and other costs now that the housekeeping privatization is no longer moving forward.**

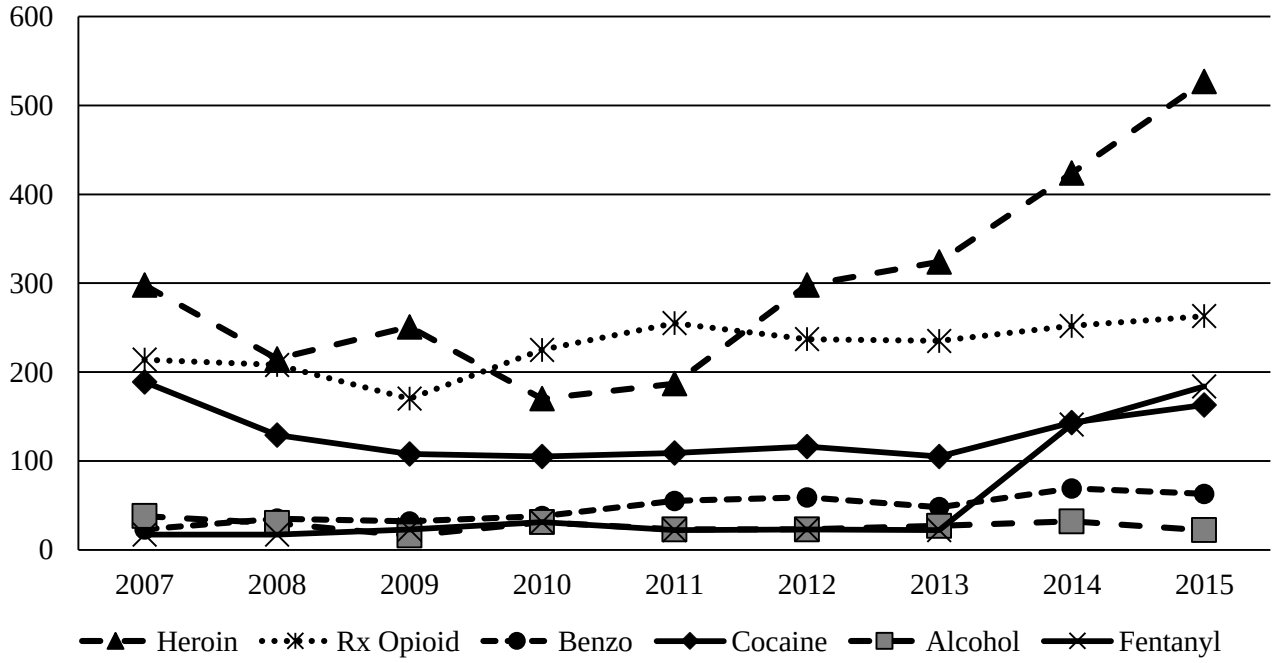
There is also a decrease of $690,000 in operating costs for the closed Crownsville Hospital Center. After a task force in the interim did not determine a reasonable use of the property, it is unclear how BHA and DHMH intend to dispose of the property to such an extent that no more upkeep will be necessary in fiscal 2017. **The department should comment on its future plans for the Crownsville Hospital Center.**

Issues

1. The Heroin Epidemic

Opioid use and overdose continues to be a serious and urgent public health issue. As seen in **Exhibit 11**, since 2007 heroin and/or prescription opioid drugs have been involved in the majority of the State's overdose deaths, with deaths related to fentanyl also increasing in 2014 and 2015. In fact, 2015, on a January through September year-to-date basis, is the highest year for overdose deaths in the time period shown. Various actions have been taken in an attempt to combat overdose deaths as well as heroin and opioid use throughout the State in recent years.

Exhibit 11
Overdose Deaths by Related Substance
January-September 2007-2015*



Rx: medical prescriptions

*2015 counts are preliminary.

Source: Department of Health and Mental Hygiene

Prescription Drug Monitoring Program

The PDMP, established by Chapter 166 of 2011, aims to reduce prescription drug misuse and diversion by creating a secure database of all Schedule II through V controlled dangerous substances prescribed and dispensed in the State. PDMP can make data on prescription opioids available to health care providers, pharmacists, patients, health occupations licensing boards, specific DHMH administrations, law enforcement, and PDMPs in other states. PDMP is integrated with Chesapeake Regional Information System for our Patients, the State-designated health information exchange.

According to DHMH, as of November 1, 2015, PDMP has 14,258 registered users and is averaging 20,000 patient queries per week. PDMP is interoperable with PDMPs in Virginia and West Virginia. In October 2015, PDMP began analyzing data to identify patients getting controlled substances from multiple providers and alerting providers. In December 2015, the PDMP Advisory Board made recommendations in its annual report regarding mandatory registration and use of PDMP by health care providers. The recommendations call for phasing in mandatory registration and use after taking steps to streamline user registration, educate providers, support provider workflow integration, and improve system capacity and data quality. A similar recommendation was provided by the Governor's Heroin and Opioid Emergency Task Force and would be implemented by HB 456 or SB 382.

Overdose Response Program

Chapter 299 of 2013 established the Overdose Response Program in DHMH to authorize certain individuals, through the issuance of a certificate, to administer naloxone to an individual experiencing opioid overdose when medical services are not immediately available. DHMH authorizes private and public entities to train and certify individuals to administer naloxone. As of June 2015, over 8,700 individuals were trained (34% of whom are law enforcement). In addition, over 8,000 doses of naloxone were dispensed and 145 administrations were reported. Chapter 356 of 2015 expanded the program to authorize standing orders for naloxone and provided additional legal protections for prescribers and administrators of naloxone.

Joint Committee on Behavioral Health and Opioid Use Disorders

Chapter 464 of 2015 established the Joint Committee on Behavioral Health and Opioid Use Disorders, comprising five senators and five delegates, to oversee the State's PDMP and State and local programs to treat and reduce opioid use disorders. The joint committee must review the final report of the Heroin and Opioid Emergency Task Force and review and monitor the activities of the Governor's Inter-Agency Heroin and Opioid Coordinating Council. The joint committee must also monitor the effectiveness of the State Overdose Prevention Plan; local overdose prevention plans and fatality review teams; strategic planning practices to reduce prescription drug abuse; and efforts to enhance overdose response laws, regulations, and training.

The joint committee has received briefings on the DHMH overdose prevention strategy; the Screening, Brief Intervention and Referral to Treatment Program; the funding of behavioral health

services; opioid use disorders and treatments; the activities of the Justice Reinvestment Coordinating Council (JRCC); the Baltimore Mayor's Heroin and Treatment Task Force; and the Heroin and Opioid Emergency Task Force.

Inter-Agency Heroin and Opioid Coordinating Council

In response to the State's heroin and opioid epidemic, the Governor issued an executive order in February 2015 establishing the Governor's Inter-Agency Heroin and Opioid Coordinating Council. The council, which is chaired by the Secretary of Health and Mental Hygiene, consists of representatives of the departments of State Police, Public Safety and Correctional Services, Juvenile Services, Education, and the Maryland Institute for Emergency Medical Services Systems. The council's duties include developing recommendations for policy, regulations, or legislation to facilitate improved sharing of public health and public safety information among State agencies. The council must update the Governor biannually on each agency's efforts to address heroin and opioid education, treatment, interdiction, overdose, and recovery. On behalf of the council, DHMH must submit an annual report to the Governor and the public in the form of the Inter-Agency Heroin and Opioid Coordination Plan. The council met on four occasions in 2015.

Heroin and Opioid Emergency Task Force

In February 2015, the Governor also established, by executive order, the Heroin and Opioid Emergency Task Force, which consists of the Lieutenant Governor; an appointee of the President of the Senate, the Speaker of the House, and the Attorney General; and seven members of the public. The task force must assist the Governor in establishing a coordinated statewide and multijurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse and advise the Governor and the Director of Homeland Security on immediate steps to improve coordination between federal, State, and local law enforcement regarding the trafficking and distribution of heroin and opioids in the State. The task force held six regional summits throughout the State to hear input from concerned Marylanders who have been impacted by the heroin epidemic. Based on information provided at the summits, the task force established five workgroups: Access to Treatment and Overdose Prevention; Quality of Care and Workforce Development; Intergovernmental Law Enforcement Coordination; Drug Courts and Reentry; and Education, Public Awareness, and Prevention.

In August 2015, the task force submitted an interim report, which contained 10 recommendations for immediate implementation including earlier and broader incorporation of heroin and opioid prevention into the health curriculum, implementation of emergency department opioid prescribing guidelines, training for the Maryland State Police on the Good Samaritan Law, and establishing a faith-based addiction treatment database. The report also detailed how $2 million in additional treatment and prevention funding, earmarked by the legislature and released by the Governor for fiscal 2016, will be spent, including naloxone training and distribution to local health departments and local detention centers; overdose survivor outreach programs in hospital emergency departments; prescriber education; recovery housing and detoxification services for women with children; and increased bed capacity at the A.F. Whitsitt Center, a partially State-financed residential treatment facility on the Eastern Shore. Most of this funding is continued in the fiscal 2017 allowance.

On December 1, 2015, the task force submitted its final report to the Governor which included 33 recommendations in response to 7 key goals of the task force. Those recommendations are provided in **Exhibit 12**. Furthermore, approximately $4.8 million in general funds has been added to various agencies throughout the State to support some of the recommendations of the task force, including almost $3.1 million within BHA, as shown in **Exhibit 13**. Beyond this funding, the one recommendation that could greatly affect funding for SUD treatment is to review Medicaid rates for SUD treatment services every three years. DHMH indicates that they are currently working towards beginning this review. However, what is most troubling about the recommendations and the funding provided for the task force initiatives is how little of the funding is directed towards basic SUD treatment services, especially in areas where the State is aware that there are funding shortfalls. Outside of the rate increase for providers, State-supported funding for SUD treatment is entirely flat in fiscal 2017. Meanwhile, the recommendations would instead fund a new research entity with the Center of Excellence as well as screening tools at the Department of Human Resources (DHR) and the Department of Juvenile Services (DJS), all of which are either duplicative of State services already offered or should not be necessary given the resources that the State has already committed to these functions within the fiscal 2017 allowance.

Exhibit 12

Heroin and Opioid Emergency Task Force Recommendations

Expanding Access to Treatment

Implementing a Statewide Buprenorphine Access Expansion Plan

Reviewing the Substance Use Disorder Reimbursement Rates Every Three Years

Expanding Access to Treatment through Payments to Noncontracting Specialists and to Noncontracting Nonphysician Specialists

Improving Provider Panel Lists

Expanding Access to Training for Certified Peer Recovery Specialists

Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders

Transitioning Inmates to Outpatient Addictions Aftercare and Community Providers

Incentivizing Colleges and Universities to Start or Expand Collegiate Recovery Programs

Enhancing Quality of Care

Requiring Mandatory Registration and Querying of the Prescription Drug Monitoring Program

Authorizing the Opioid-associated Disease Prevention and Outreach Program

Requiring and Publishing Performance Measures on Addiction Treatment Providers

Requiring Continuing Professional Education on Opioid Prescribing for the Board of Podiatric Medical Examiners and Board of Nursing and on Opioid Dispensing for the Board of Pharmacy

Requiring Drug Monitoring for Medicaid Enrollees Prescribed Certain Opioids Over an Extended Time

Boosting Overdose Prevention Efforts

Expanding Online Overdose Education and Naloxone Distribution

Implementing a Good Samaritan Law Public Awareness Campaign

Escalating Law Enforcement Options

Enacting a Maryland Racketeer Influenced and Corrupt Organization Statute

Creating a Criminal Penalty for Distribution of Heroin or Fentanyl Resulting in Fatal or Nonfatal Overdose

Creating a Multijurisdictional Maryland State Police Heroin Investigation Unit

Designating the High Intensity Drug Trafficking Area's Case Explorer the Central Repository for Maryland Drug Intelligence

Enhancing Interdiction of Drug-Laden Parcels

Strengthening Counter-Smuggling Efforts in Correctional Facilities

Reentry and Alternatives to Incarceration

Establishing a Day Reporting Center Pilot Program to Integrate Treatment into Offender Supervision

Expanding the Segregation Addictions Program in Correctional Facilities

Implementing a Swift and Certain Sanctions Grid for Probation and Parole

Institutionalizing a Substance Use Goal into the Maryland Safe Streets Initiative

Establishing a Recovery Unit at Correctional Facilities

Studying the Collateral Consequences of Maryland Laws and Regulations on Employment of Ex-offenders

Promoting Educational Tools for Youth, Parents, and School Officials

Creating a User-friendly Educational Campaign on School Websites

Training for School Faculty and Staff on Signs of Student Addiction

Promoting Evidence-based Prevention Strategies that Develop Refusal Skills

Support Student-based Film Festivals on Heroin and Opioid Abuse

Improving State Support Services

Implementing Comprehensive Heroin and Opioid Abuse Screening at the Department of Juvenile Services and the Department of Human Resources

Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council

Source: *Final Report of the Governor's Heroin and Opioid Emergency Task Force*

Exhibit 13
Funded Recommendations of the Heroin and Opioid Emergency Task Force
Fiscal 2017

Department of Health and Mental Hygiene	
Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council	$1,000,000
Implementing a Good Samaritan Law Public Awareness Campaign	697,653
Providing recovery support specialists to assist pregnant women with substance use disorders	622,622
Requiring mandatory registration and querying of the prescription drug monitoring program	522,245
Implementing a Statewide Buprenorphine Access Expansion Plan	206,480
Expanding online overdose education and naloxone distribution	10,000
Subtotal	***$3,059,000***
Department of Public Safety and Correctional Services	
Day reporting center through the Division of Parole and Probation – Central Region	540,000
Outpatient addictions aftercare at the Metropolitan Transition Center	358,000
Expand the segregated addictions program at the Maryland Correctional Training Center	138,000
Subtotal	***$1,036,000***
State Police (included within Supplemental Budget No. 2)	
Multi-jurisdictional State Police Heroin Investigation Unit	200,000
Designating HIDTA the Central Repository for Maryland drug intelligence	75,000
Subtotal	***$275,000***
Governor's Office of Crime Control and Prevention	
Safe Streets	180,000
Maryland State Department of Education	
Local school websites to promote drug and heroin awareness	100,000
Department of Juvenile Services and Department of Human Resources	
Screenings	100,000
Grand Total	**$4,750,000**

HIDTA: High Intensity Drug Trafficking Area

Source: State Budget

Justice Reinvestment Coordinating Council

Chapter 42 of 2015 established JRCC in the Governor's Office of Crime Control and Prevention (GOCCP). JRCC was tasked with convening a stakeholder workgroup and, using a data-driven approach, to develop a statewide framework of sentencing and corrections policies to further reduce the State's incarcerated population, reduce spending on corrections, and reinvest in strategies to increase public safety and reduce recidivism. JRCC's final report in December 2015 contained numerous recommendations and reinvestment strategies, and one of the major reinvestment priorities includes SUD and mental health treatment. SB 1005 and HB 1312 seek to codify many of these recommendations and reinvestment strategies.

One area in particular that these bills address is the process by which drug offenders can be committed to SUD treatment within DHMH under Section 8-507 of the Health – General Article. In particular, the legislation would change the timing by which defendants would be placed into treatment from "prompt placement" to 30 days. Based on a report requested through the 2014 *Joint Chairmen's Report* (JCR), it currently takes on average approximately 120 days to place a defendant into a residential treatment facility. Thus, if either of these bills were to be enacted into law as written, DHMH would need to place defendants about four times as quickly as they currently do. Further, it should be noted that the providers delivering the residential treatment have indicated that they could increase their intake of patients if appropriate funding were provided within the State budget. Currently, only $6 million is allocated for forensic placements into residential treatment under Section 8-507, which serves approximately 360 people. Even without a change in statute, it is apparent that there is not adequate funding within the current allowance to meet the demand for residential SUD treatment under this procedure. **DLS thus recommends that the funding appropriated for the Center of Excellence, as well as funding within DHR and DJS for a heroin screening tool, instead be utilized to fund residential treatment under Section 8-507. The department should also comment on the funding levels and bed availability that would be required under the JRCC bills.**

2. Behavioral Health Integration – Furthering Financial Alignment

For the past several years, DHMH has been working on the issue of integrating mental health and SUD care. The need to do this was prompted by observations that the previous service delivery system for mental health and SUD services was fragmented and suffered from a lack of connection (and coordination of benefits) with general medical services; had fragmented purchasing and financing systems with multiple, disparate public funding sources, purchasers, and payers; had uncoordinated care management including multiple service authorization entities; and had a lack of performance risk with payment for volume, not outcomes.

As part of the integration process, the State chose to move forward with an expanded carve-out of behavioral health services from the managed care system with added (though limited) performance risk. Specifically, all SUD services would be carved out from the MCOs and delivered as FFS through an ASO, joining specialty mental health services, which were already carved-out from managed care. The ASO contract includes limited risk for performance against set targets.

Some of the most visible signs of the integration include the merger of the former MHA and ADAA into the newly created BHA, as codified in Chapter 460 of 2014, as well as the reconfiguration of funding streams so that beginning with the fiscal 2016 budget funds for Medicaid-eligible specialty mental health and SUD services for Medicaid-eligible individuals are located in the Medicaid program, with funding for the uninsured/underinsured and for Medicaid-ineligible services located in BHA. Further, BHA finalized, and the Board of Public Works (BPW) approved, a contract for the new ASO, which took effect January 1, 2015.

The ASO is responsible for coordination with both local agencies and the MCOs in order to ensure appropriate referrals from the MCOs and coordination between the MCOs and behavioral health providers. The ASO is responsible for providing additional training to providers in terms of developing and enhancing provider competency in the areas of mental health and SUD services and how to seek authorizations and payments though the ASO.

The ASO contract contains various outcome-based standards, which the ASO will be held responsible for upholding. Beginning in year three of the contract, BHA will employ appropriate Healthcare Effectiveness Data and Information Set (HEDIS) measures in order to track the performance of the ASO against other states. There will be seven measures, six of which will be HEDIS-based, and a seventh that is State specific. For each measure, the State must be at or above the fiftieth percentile (or 70.0% for the State-specific measure). For each outcome standard not met, the ASO will repay to the State 0.0714% of the invoice amounts for the preceding 12 months. Thus, if all seven measures are missed, the total amount of damages is capped at 0.5% of the total contract. The measures to be used include:

- adherence to antipsychotic medications for individuals with schizophrenia;
- follow-up care for children prescribed attention deficit and hyperactive disorder medication;
- antidepressant medication management;
- plan all-cause readmission;
- mental health utilization – inpatient;
- initiation and engagement of alcohol and other drug dependence treatment; and
- the percentage of people in the specialty behavioral health system who have a primary care physician visit within a year (State specific).

Reporting on these standards is set for the beginning of fiscal 2017, with the average for each outcome standard determined at the end of 2016 and similar averages established each year thereafter. Further, it should be noted that while there are penalties for not performing to the outcome-based standards, there are no bonuses or inducement payments for exceeding them.

Two pieces of legislation enacted last session also further advanced the process of behavioral health integration in Maryland. The first, Chapter 328 of 2015, merged the Maryland Advisory Council on Mental Hygiene and the State Drug and Alcohol Abuse Council into the Behavioral Health Advisory Council in October 2015. The second, Chapter 469 of 2015, included numerous technical and clarifying changes to statute which were recommended by the BHA Integration Stakeholder Workgroup. These changes included a series of technical, clarifying, and updated changes related to the powers, duties, and responsibilities of BHA, as well as removing obsolete references to programming that is no longer administered by BHA and language that is no longer commonly used in the behavioral health community. Other changes included technical changes to eliminate inconsistencies between mental health and SUD services.

Information Sharing

One of the early issues with the integration process concerned the sharing of specialty behavioral health information between the MCOs and the ASO. The use and disclosure of protected health information (PHI) is governed, generally, by the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, PHI may be disclosed for purposes of treatment, payment, and health care operations without patient consent. However, in nearly all cases, the disclosure of SUD treatment and prevention records is subject to the more restrictive and stringent standard of 42 Code of Federal Regulations (CFR) Part 2, which prohibits the disclosure of PHI absent specific authorization from the patient. With the transfer of SUD services from the MCOs to the ASO, HIPAA and 42 CFR Part 2 prevented the sharing of SUD treatment information without specified authorization between the MCOs and the ASO. In response to concerns about how this would impact care coordination activities for Medicaid members, the 2015 JCR required DHMH to describe the efforts conducted by the ASO and the MCOs to improve the exchange of information and coordination of care for Medicaid-eligible individuals who use specialty behavioral health services in the context of federal regulations governing data-sharing. This report was submitted to the budget committees on November 9, 2015.

In the report, DHMH notes that given the federal requirement on health information sharing, and in particular SUD treatment information, the department made the decision to obtain individual Release of Information (ROI) forms from Medicaid beneficiaries accessing SUD services. The ASO and the MCOs have worked collaboratively with SUD providers toward a goal of obtaining a signed consent form from every SUD services recipient willing to provide consent. All SUD programs and providers – as well as mental health providers delivering SUD services to Maryland Medicaid members – have been instructed to request an ROI form prior to the provision of SUD services. Completed forms allow the ASO to release authorization and claims data to the enrollee's MCO – along with providers specified by the patient – and thereby coordinate care across the continuum of care. The consent form is required to be updated by the patient annually. As of mid-September 2015, 78% of patients accessing SUD services had completed an ROI form, and only 1% of patients had elected not to consent and declined to complete the ROI.

Financing for SUD Services to the Uninsured

For the most part, the change to a FFS system under an ASO did not require any change to the specialty mental health services for the uninsured since this model is the same as the previous delivery model. However, it will create a significant change in the way in which SUD services for the uninsured are delivered throughout the State. Currently, these services are provided on a grant-based system through the Local Addictions Authorities (LAAs), who then either provide the services themselves or contract with other providers. With the transition of Medicaid-reimbursable SUD services from the MCOs to the ASO, the SUD services grants for the uninsured are the only treatment funds which are not reimbursed by the ASO on a FFS basis. Alignment of financing is a major goal of behavioral health integration, as this change will effectively create treatment on demand for eligible individuals for those services within the FFS model, which is much different from the previous grant-based and managed care system.

The transfer from the grant-based system to FFS for SUD services has been repeatedly pushed back. Currently, BHA has developed a plan to transfer the financing of some of these services from grants to FFS within fiscal 2017. The first half of fiscal 2017 will provide for a transition period where LAAs and other providers will have the opportunity to either switch to FFS or develop plans to help them prepare for the switch. Then, beginning on January 1, 2017, SUD ambulatory services will be moved to the ASO and a FFS model. These services include ambulatory withdrawal management, assessment, Level I Outpatient, Level II.1 Intensive Outpatient, and opioid treatment services. The estimated dollar amount of the transfer is approximately $25.2 million, which is approximately 30% of the amount of the grants. However, at this time there is currently no plan for the transfer of the other services and funding to the ASO, meaning that financing for these services will remain on a grant-based structure for the near future. **The department should comment on how it plans to ensure a smooth transition of ambulatory SUD treatment services to the ASO, and what plans it has for transferring the remaining grant-based funding to the ASO.**

3. Funding for Institutions for Mental Disease

The Medicaid IMD exclusion prohibits the use of federal Medicaid financing for care provided to most adult patients between the ages of 21 and 65 in mental health and SUD residential treatment and inpatient facilities larger than 16 beds. In the past, Maryland has used numerous waivers to allow for some federal funding to be used to reimburse IMD facilities for serving Medicaid eligible patients. The State has also used State-only funds to purchase bed capacity. However, recently some issues with IMD funding have emerged.

Last year, one of the first issues to arise was with the payment for residential SUD detoxification treatment. Previously, providers throughout the State had reported being paid for this service under the MCOs. However, once the ASO took over the payment system in January 2015, Medicaid began denying payments to these providers saying that under federal guidelines these facilities count as IMDs and are thus not eligible for Medicaid reimbursement. This caused numerous providers to lose their ability to claim reimbursement for these services. Last year, BHA and DHMH in a letter to the budget and policy committees noted that they would take numerous steps to help these providers, including

implementing another level of payment for partial hospitalization, which is a federally reimbursable service, as well as providing technical assistance to these providers and encouraging them to decrease their size to fit under the IMD exclusion. Since that time, the State has also been actively working to secure a waiver for residential SUD treatment within an IMD. DHMH and Medicaid have also been meeting biweekly with the federal Centers for Medicare and Medicaid Services (CMS) and their outside technical assistance consultants about the breadth and depth of services provided by Medicaid, and they note that the discussions have been productive and encouraging. Further discussions on the IMD waiver for SUD residential treatment services will also be a part of the renewal of the larger Medicaid HealthChoice waiver.

Beyond SUD services, the IMD exclusion also affects the ability of psychiatric inpatient and residential programs from claiming federal reimbursement for their services. The State recently sought a waiver from CMS for reimbursement for services rendered within an IMD for both mental health and SUD services, but was informed that CMS would only consider such a waiver for SUD services at this time. The State also participated in a program which provided federal reimbursement for inpatient mental health services, which was known as the ACA Emergency Psychiatric Demonstration (EPD). However, this program, as originally designed, expired at the end of fiscal 2015, resulting in funding shortfalls for private hospitals specializing in behavioral health treatment within the fiscal 2016 budget. In order to address this shortfall in fiscal 2016, DHMH authorized a transfer of $10 million from the MHIP fund balance to BHA to cover costs for this purpose. However, as mentioned earlier, BHA is still actively managing the number of patients who are admitted to a private psychiatric facility in order to keep spending contained.

CMS also recently promulgated new regulations where the federal government would provide reimbursement for services rendered within an IMD for the first 15 days of service for a particular individual for both SUD and mental health services. However, the regulations stipulated that this would only be for services financed through an MCO. While Maryland does have an MCO structure, the FFS behavioral health carve-out prevents Maryland from taking advantage of this new regulation.

Separately, the State is actively seeking to be involved with – and participate once again in – the EPD program now that it has been extended by Congress. One difficulty, however, is that CMS is currently working on how they will determine the cost neutrality of the EPD program, which is a new requirement within the extension of the EPD program. Without guidance from CMS on how cost neutrality is going to be determined, it is still unclear how the State would participate in the program and begin once again to draw down on EPD federal funds.

If the State is not able to participate in the EPD program within fiscal 2017 and no further IMD waiver is granted by CMS, it is unclear how the State will be able to continue to support inpatient and residential treatment for the Medicaid-eligible population without rationing these services. **The department should comment on the current status of these waiver applications and how it plans to fund inpatient psychiatric services without federal funds in fiscal 2017.**

Recommended Actions

1. Add the following language:

   All appropriations provided for program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.

   Explanation: The language restricts Medicaid behavioral health provider reimbursements to that purpose.

2. Add the following section:

   SECTION XX: AND BE IT FURTHER ENACTED, That $1,000,000 of the general fund appropriation in Program M00L01.02 Community Services made for the purpose of establishing a Center of Excellence for Prevention and Treatment, $50,000 of the general fund appropriation in Program N00B00.04 General Administration – State made for the purpose of implementing a heroin screening tool, and $50,000 of the general fund appropriation in Program V00D02.01 Departmental Support made for the purpose of establishing a heroin screening tool may not be expended for those purposes and instead may only be transferred to, and expended in, Program M00L01.02 Community Services for the purpose of funding residential treatment services for defendants committed to the Department of Health and Mental Hygiene under Section 8-507 of the Health – General Article.

   Explanation: This section fences off appropriations made to implement recommendations from the Governor's Heroin and Opioid Emergency Task Force for the purpose of establishing the Center of Excellence for Prevention and Treatment as well as implementing heroin screening tools within the Department of Human Resources (DHR) and the Department of Juvenile Services (DJS), and restricts those funds to be expended only on residential treatment services for defendants committed to the Department of Health and Mental Hygiene under Section 8-507 of the Health – General Article. Both DHR and DJS already have screening tools for heroin, and the Center of Excellence is not necessary. Funding for commitments under Section 8-507 is currently not enough to meet the demands from the State courts for those placements.

Updates

1. Synar Compliance Improves Dramatically

As part of the agreement for accepting the federal Substance Abuse Prevention and Treatment (SAPT) block grant, the State has agreed to have federal regulators audit the State on the extent to which tobacco retailers are selling tobacco to minors in the State. This program is known as the Synar program. The limit on the retailer violation rate (RVR) is 20.0%. If a state exceeds this percentage, it must either pay an alternate penalty amount based on the RVR above the 20.0% limit or surrender SAPT funding. In the past two federal fiscal years, the State had an RVR of 24.1% and 31.4%, which resulted in alternative penalty payments in State fiscal 2015 and 2016, essentially requiring higher State expenditures on retail tobacco enforcement.

In response to these penalties, the fiscal 2016 budget bill included language which withheld $100,000 in general funds within BHA pending a report from DHMH containing information on the funding and outcome measures for Synar compliance programs. In particular, the report needed to include information on how funds related to the penalty were expended, the structure and nature of tobacco retailer compliance programs that utilize the penalty funds, how programs ensured future compliance with the federal Synar inspections of tobacco retailers, and whether additional regulatory or statutory changes are needed to ensure compliance. The report was submitted on December 16, 2015.

In the report, DHMH and BHA detailed how BHA jointly implemented compliance activities with PHPA, and developed a program through which local health departments (LHD) received grant funding based on the RVR, number of tobacco sales outlets, and population size of each jurisdiction. Through these grants, LHDs further partnered with local nongovernmental organizations to conduct education campaigns, increase awareness, and promote store-level staff training and compliance with the State youth access law. Minority Outreach and Technical Assistance organizations from the Office of Minority Health and Health Disparities were also funded to support LHD activities. Further partnerships were developed with the Legal Resource Center for Public Health Policy and the University of Maryland Carey School of Law, as well as with the Maryland Office of the Comptroller to further coordinate and facilitate better enforcement and educational outreach efforts. One full-time equivalent contractual position was also hired within PHPA to oversee Synar-related activities.

Compliance activities are expected to continue into the future to ensure that the State remains in compliance with the federal Synar statute. Funding has been placed within the PHPA budget utilizing funds from the Cigarette Restitution Fund to continue the program in fiscal 2017. DHMH also recently completed the required federal fiscal 2016 audit and the non-compliance rate was 13.8%, which is down from the previous year mark of 31.4%, demonstrating that the efforts of DHMH are having a positive effect.

2. Reports on Behavioral Health Expenditures by Medicaid Eligibility Improve, but More Needs to Be Done

With the numerous changes that have occurred within the Medicaid program, with different federal matching rates for different eligibility populations, it has become more difficult and complex to project spending, and especially the general/federal funding splits, for the behavioral health carve-out services, particularly with the reports that BHA previously provided for this purpose. Due to these concerns, the fiscal 2016 budget bill included language which withheld $100,000 in general funds within BHA pending a report from DHMH containing information on the utilization and expenditures for behavioral health services based upon the user's eligibility group under Medicaid. The language further stipulated that, beginning with the period ending June 30, 2015, the quarterly report that is produced by the ASO which oversees the public behavioral health system include a breakdown of data based on the user's eligibility group under Medicaid.

On September 1, 2015, DHMH submitted the report, which contained a new quarterly report that provided a breakdown of claims data based on some broad eligibility categories, including a breakout of adults who qualify for Medicaid under the federal ACA expansion. However, due to data limitations and timing, no data on SUD claims was included in the report. Since the initial report, DLS has received two other reports which seek to provide more detailed information on the behavioral health services. Medicaid has provided a report that contains both mental health and SUD treatment data on a monthly basis by eligibility category. Further, a quarterly report containing SUD services data was recently submitted separately to DLS. Both of these reports will continue to help DLS analysts prepare more robust and confident expenditure projections. However, more work needs to be done to produce a more comprehensive report and data set that serves the interests of all parties involved. **Thus, DLS and DHMH will continue to work together throughout the 2016 interim to come up with a more comprehensive and complete dataset and reporting structure.**

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$812,166	$46,020	$513,232	$8,467	$1,379,885
Deficiency Appropriation	0	0	0	0	0
Cost Containment	-21,963	0	0	0	-21,963
Budget Amendments	49,974	4,823	142,705	600	198,102
Reversions and Cancellations	-656	-808	-6,669	-782	-8,915
Actual Expenditures	**$839,520**	**$50,035**	**$649,268**	**$8,284**	**$1,547,108**
Fiscal 2016					
Legislative Appropriation	$847,497	$48,452	$738,513	$7,944	$1,642,406
Budget Amendments	20,746	12,009	51	2,800	35,607
Working Appropriation	**$868,243**	**$60,462**	**$738,564**	**$10,744**	**$1,678,013**

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

Fiscal 2015

BHA's fiscal 2015 budget ended $167,223,158 above the legislative appropriation. General funds increased by $27,354,111, mostly through budget amendments. Large general fund budget amendments included the following:

- $33,098,243 in provider reimbursements tied to the migration of SUD services from the MCOs to the behavioral health carve-out;
- $7,742,155 for increased costs at State hospital centers, including costs for off grounds outpatient services, increased overtime, and other expenses;
- $5,220,516 for increased Medicaid State-funded services;
- $3,296,006 related to the fiscal 2015 cost-of-living adjustment (COLA) and annual salary review;
- $1,378,382 for centrally budgeted employee health insurance adjustments; and
- $729,351 for increases in the ASO contract.

These increases were offset by some decreases in general funds, including $21,963,184 for 2015 cost containment. Cost containment actions included:

- $11,381,536 in 2014 accrual that was no longer necessary either due to greater federal fund attainment or underspent general funds, which were credited towards the 2015 2% general reduction amount;
- $7,009,531 due to the January 2015 BPW action which lowered provider reimbursement rates increases from 4% to 2%, lowered the psychiatrist evaluation and management rates from 100% to 87% of Medicare, and swapped general funds for special funds from the Maryland Community Health Resources Commission;
- $2,880,017 removed by BPW in July 2014 to remove funding for inpatient hospital services no longer needed and to swap general funds with federal funds under the EPD waiver;
- $685,822 for a hiring freeze conducted across DHMH to obtain the amount necessary under the 2% general reduction; and
- $6,278 in lower operations costs for the office of the Deputy Secretary for Behavioral Health.

Budget amendments also removed general funds totaling $1,491,001 for contractual expenses, legal service costs and other adjustments in the central office and grant-based programs. A further

$656,357 in general funds were reverted in fiscal 2015, mostly due to increased federal fund revenue obtained through Medicaid-related administrative work.

Special funds increased by $4,014,923 above the legislative appropriation. This is mostly due to increases through budget amendments, including $3,000,000 to backfill cost containment actions, $1,529,071 in additional funding for the Supplemental Security Income/Social Security Disability Insurance, Outreach, Access, and Recovery housing initiative, and $294,115 for both the COLA and other miscellaneous expenses. These increases were partially offset by $808,263 in cancellations at the end of the year mainly due to lower than expected special fund revenue within the institutions.

Federal funds increased by $136,036,469 above the legislative appropriation. The largest increase was $114,308,443 in relation to the transfer of SUD services to the behavioral health carve-out. Other increases included $11,365,605 in additional SAPT block grant funding, $10,030,000 in additional funding under the EPD waiver, $6,974,283 in increased Medicaid provider reimbursements and federal matching activities, and $26,695 for the COLA. Of this amount, $6,668,557 was canceled at the end of the fiscal year mainly due to the end of the Alternatives to Psychiatric Residential Treatment Facilities for Children federal grant.

Reimbursable funds decreased by $182,345 from the legislative appropriation. Cancellations totaled $782,014 which were all tied to lower than expected expenditures on special populations. One reimbursable budget amendment added $599,669 to cover the cost of emergency preparedness enhancements for DHMH institutions.

Fiscal 2016

To date, the budget for BHA has increased by $35,606,944 above the legislative appropriation for fiscal 2016. General funds have increased by $20,746,188, of which the largest increase is for funds authorized through Section 48 of the fiscal 2016 budget bill. This includes $7,600,000 to maintain provider rates for community-based mental health providers as well as $2,000,000 for heroin treatment. Other general fund increases include $7,603,810 to realign funds with the cost containment strategy which was previously discussed, and $3,592,630 to restore the 2% salary reduction. There is one general fund decrease of $50,252 due to the transfer of funds for an assigned subobject.

Special funds increase by $12,009,488 above the legislative appropriation. This is due to an increase of $10,000,000 from the MHIP fund to pay for inpatient services which were previously covered under the EPD waiver, as well as $2,000,000 for the Synar penalty, which is consistent with the 2015 JCR. The remainder of the increase at $9,488 is for the 2% salary restoration. Federal funds also increase by $51,268 for the same reason. Reimbursable funds increase by $2,800,000 to cover costs related to the CME.

Appendix 2

Audit Findings

Thomas B. Finan Hospital Center

Audit Period for Last Audit:	July 1, 2011 – September 21, 2014
Issue Date:	February 5, 2015
Number of Findings:	0
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

The audit did not disclose any findings.

Clifton T. Perkins Hospital Center

Audit Period for Last Audit:	February 17, 2012 – April 28, 2015
Issue Date:	September 18, 2015
Number of Findings:	1
Number of Repeat Findings:	1
% of Repeat Findings:	100%
Rating: (if applicable)	n/a

Finding 1: **Internal controls were not sufficient to ensure that all collections were deposited.**

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

Springfield Hospital Center

Audit Period for Last Audit:	July 29, 2011 – January 27, 2015
Issue Date:	October 6, 2015
Number of Findings:	1
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: A management employee exercised virtually complete control over all aspects of the procurement and related invoice approvals for maintenance contracts, resulting in questionable activity with one contractor.

Spring Grove Hospital Center

Audit Period for Last Audit:	January 18, 2012 – February 16, 2015
Issue Date:	October 15, 2015
Number of Findings:	2
Number of Repeat Findings:	1
% of Repeat Findings:	50%
Rating: (if applicable)	n/a

Finding 1: **Controls were not established to ensure collections were properly accounted for and deposited.**

Finding 2: Spring Grove recordkeeping procedures for equipment were not in compliance with certain requirements.

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

Object/Fund Difference Report
DHMH – Behavioral Health Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	2,900.85	2,900.55	2,800.85	-99.70	-3.4%
02 Contractual	215.66	221.60	210.03	-11.57	-5.2%
Total Positions	**3,116.51**	**3,122.15**	**3,010.88**	**-111.27**	**-3.6%**
Objects					
01 Salaries and Wages	$ 241,095,287	$ 242,819,891	$ 247,208,258	$ 4,388,367	1.8%
02 Technical and Spec. Fees	12,582,054	10,600,242	14,797,978	4,197,736	39.6%
03 Communication	533,070	463,869	453,759	-10,110	-2.2%
04 Travel	214,653	311,956	247,860	-64,096	-20.5%
06 Fuel and Utilities	10,327,257	10,702,122	9,292,114	-1,410,008	-13.2%
07 Motor Vehicles	733,464	793,962	722,727	-71,235	-9.0%
08 Contractual Services	1,267,226,605	1,398,423,628	1,395,921,448	-2,502,180	-0.2%
09 Supplies and Materials	13,063,358	12,551,416	11,343,762	-1,207,654	-9.6%
10 Equipment – Replacement	372,167	277,599	184,396	-93,203	-33.6%
11 Equipment – Additional	129,792	5,543	9,630	4,087	73.7%
12 Grants, Subsidies, and Contributions	264,524	438,620	348,481	-90,139	-20.6%
13 Fixed Charges	565,713	623,888	522,814	-101,074	-16.2%
Total Objects	**$ 1,547,107,944**	**$ 1,678,012,736**	**$ 1,681,053,227**	**$ 3,040,491**	**0.2%**
Funds					
01 General Fund	$ 839,520,284	$ 868,243,374	$ 886,256,297	$ 18,012,923	2.1%
03 Special Fund	50,034,908	60,461,818	53,806,432	-6,655,386	-11.0%
05 Federal Fund	649,268,397	738,563,772	733,194,629	-5,369,143	-0.7%
09 Reimbursable Fund	8,284,355	10,743,772	7,795,869	-2,947,903	-27.4%
Total Funds	**$ 1,547,107,944**	**$ 1,678,012,736**	**$ 1,681,053,227**	**$ 3,040,491**	**0.2%**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Behavioral Health Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Deputy Secretary for Behavioral Health	$ 2,102,472	$ 1,929,618	$ 2,093,256	$ 163,638	8.5%
01 Behavioral Health Administration	327,924,246	338,600,797	342,440,306	3,839,509	1.1%
04 Thomas B. Finan Hospital Center	19,636,238	20,291,057	21,024,601	733,544	3.6%
05 Regional Institute For Children and Adolescents – Baltimore City	13,605,962	14,149,882	13,627,337	-522,545	-3.7%
07 Eastern Shore Hospital Center	19,524,451	19,532,938	20,142,104	609,166	3.1%
08 Springfield Hospital Center	74,806,549	75,247,099	74,760,356	-486,743	-0.6%
09 Spring Grove Hospital Center	84,667,087	81,793,842	86,142,716	4,348,874	5.3%
10 Clifton T. Perkins Hospital Center	63,284,983	62,900,708	65,423,977	2,523,269	4.0%
11 John L. Gildner Regional Institute for Children and Adolescents	11,721,627	12,104,730	11,661,246	-443,484	-3.7%
15 Services and Institutional Operations	2,260,384	1,931,769	1,286,737	-645,032	-33.4%
01 Medical Care Programs Administration	927,573,945	1,049,530,296	1,042,450,591	-7,079,705	-0.7%
Total Expenditures	**$ 1,547,107,944**	**$ 1,678,012,736**	**$ 1,681,053,227**	**$ 3,040,491**	**0.2%**
General Fund	$ 839,520,284	$ 868,243,374	$ 886,256,297	$ 18,012,923	2.1%
Special Fund	50,034,908	60,461,818	53,806,432	-6,655,386	-11.0%
Federal Fund	649,268,397	738,563,772	733,194,629	-5,369,143	-0.7%
Total Appropriations	**$ 1,538,823,589**	**$ 1,667,268,964**	**$ 1,673,257,358**	**$ 5,988,394**	**0.4%**
Reimbursable Fund	$ 8,284,355	$ 10,743,772	$ 7,795,869	-$ 2,947,903	-27.4%
Total Funds	**$ 1,547,107,944**	**$ 1,678,012,736**	**$ 1,681,053,227**	**$ 3,040,491**	**0.2%**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

M00M
Developmental Disabilities Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$565,876	$602,913	$635,767	$32,854	5.4%
Deficiencies and Reductions	0	0	-153	-153	
Adjusted General Fund	**$565,876**	**$602,913**	**$635,614**	**$32,701**	**5.4%**
Special Fund	4,917	6,503	6,230	-273	-4.2%
Adjusted Special Fund	**$4,917**	**$6,503**	**$6,230**	**-$273**	**-4.2%**
Federal Fund	407,536	478,524	509,434	30,910	6.5%
Deficiencies and Reductions	0	0	-17	-17	
Adjusted Federal Fund	**$407,536**	**$478,524**	**$509,417**	**$30,893**	**6.5%**
Reimbursable Fund	30	33	30	-3	-9.1%
Adjusted Reimbursable Fund	**$30**	**$33**	**$30**	**-$3**	**-9.1%**
Adjusted Grand Total	**$978,359**	**$1,087,971**	**$1,151,289**	**$63,318**	**5.8%**

- After adjusting for a back of the bill reduction in health insurance, the fiscal 2017 allowance for the Developmental Disabilities Administration (DDA) increases by $63 million (5.8%) over the fiscal 2016 working appropriation. The increase is primarily due to a fiscal 2017 expansion of services, annualization of the fiscal 2016 expansion of services, and a 3.5% provider rate increase.

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

For further information contact: Lindsey B. Holthaus Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	632.50	626.50	616.50	-10.00
Contractual FTEs	23.84	25.25	27.94	2.69
Total Personnel	**656.34**	**651.75**	**644.44**	**-7.31**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	34.59	5.61%
Positions and Percentage Vacant as of 12/31/15	58.00	9.26%

- The fiscal 2017 allowance includes 10.0 fewer regular full-time equivalents (FTE) due to a reduction in the number of employees at the Holly Center as the average daily population (ADP) declines. An additional 2.69 contractual FTEs are included in the allowance.

- The agency currently has 58.0 vacant positions and a vacancy rate of 9.26%. After accounting for the abolition of 10 vacant positions proposed in the allowance, the vacancy rate would be 7.8%, still more vacancies than needed to meet turnover.

Analysis in Brief

Major Trends

Community-based Services Continue to Be the Agency's Preferred Model of Service Delivery: DDA aims to serve individuals in the community rather than in institutions. In fiscal 2015, 25,315 individuals were served in the Community Services Program within DDA. The agency expects that number to increase to 28,205 by fiscal 2017, although numbers have been revised downward from the prior year. Meanwhile, the State Residential Centers' ADP continued to decline.

Population in Secure Evaluation and Therapeutic Treatment Units for Court-committed Individuals Remains Below Capacity: Both Secure Evaluation and Therapeutic Treatment Units (at Jessup and Sykesville) reached full capacity in fiscal 2011. After declining in both fiscal 2012 and 2013, the ADP at both locations increased slightly in both fiscal 2014 and 2015 but remains below capacity at both locations.

Waiver Enrollment Increases: In fiscal 2013, the agency reported for the first time in its annual budget the percentage of individuals receiving services through the Home and Community-based Services Waiver. Waiver enrollment continued to increase in fiscal 2015 to 88%, from 86% in the prior fiscal year.

Issues

Rate Setting and Payment System Reform: When the inadequacy of financial oversight at DDA was first reported, the agency became focused primarily on stabilizing, rather than overhauling, operations. Major structural changes for the agency – including rate setting and payment system reform, financial system changes, and reorganization of operations – are now underway. Legislation in the 2014 session required the department to conduct an independent rate-setting study as a prerequisite to the development and implementation of a new payment system. DDA is currently working with a selected contractor to conduct this study. The implementation of rates will be coordinated with the transition to the Long Term Services and Supports Tracking System (LTSS) platform from the Provider Customer Service Information System 2. The rate-setting study and the transition to the LTSS platform will facilitate the move to a new payment system.

Federal Audit Disallowances: The agency has had two recent federal audit disallowances, one for claiming room and board when it should not have and a second for the federal claiming of add-on services for certain individuals. The former, for $20.6 million has been repaid. DDA has disagreed with the finding for the second disallowance of $34.0 million.

Rosewood Center Operating Costs: The Rosewood Center was the largest State-operated facility for individuals with developmental disabilities until the center's closure in June 2009. Closure came after repeated findings by the Office of Health Care Quality concerning safety issues related to the buildings and grounds of the facility, which threatened to violate the conditions for Medicaid funding. A

2008 *Joint Chairmen's Report* (JCR) evaluated alternative uses of the property. Ultimately, Stevenson University was to acquire a portion of the property. However, the environmental concerns with the grounds of the facility have stalled further discussions. Meanwhile, the fiscal 2017 allowance includes $1.4 million in operating costs for the closed facility.

Supports Intensity Scale Funding: The fiscal 2015 budget included funds to hire a consultant for DDA to pursue the use of the Supports Intensity Scale (SIS). The SIS is a nationally recognized and person-centered assessment tool developed by the American Association on Intellectual and Developmental Disabilities that measures the supports needed to meet an individual's needs. New DDA leadership decided not to pursue SIS to determine the cost of service, based on mixed results from other states, and to only use the SIS as an assessment tool in the person-centered planning process.

Delayed Regional Office Reorganization: In addition to hiring a number of key staff, DDA has implemented a new organizational structure in its headquarters that is designed to increase focus on program leadership, provider relations, and quality. With that realignment recently completed, the agency has now turned its attention to standardizing operations at its four regional offices (each of which currently has a different organizational structure). The regional offices will mirror headquarters for more consistency across State policy and procedures. The agency intended to have the organizational plan for the regional offices approved by the beginning of fiscal 2016. However, in November 2015, DDA advised the Department of Legislative Services that this may occur in the next six months.

Recommended Actions

		Funds
1.	Reduce funding for the Supports Intensity Scale and Individual Indicator Rating Scale.	$ 500,000
2.	Adopt narrative requesting a report on placements into community services.	
	Total Reductions	**$ 500,000**

Updates

Emergency and Crisis Resolution Placements Report: The 2015 JCR requested a report on the definition of "emergency" used by DDA to determine funding for emergency placements and the methods used by DDA to determine who is selected to receive funding for crisis resolution placements.

Changes to Community Pathways Waiver and Requirements for Meeting Community Settings Rule: States must apply to the federal Centers for Medicare and Medicaid Services through a Home and Community-based Service waiver application to obtain permission to operate a waiver program. Maryland submitted a transition plan on March 12, 2015, as to how the State will adhere to the new rule. DDA is currently conducting public meetings to provide information about the Community Settings Rule and conducting site assessments to determine which settings need to be transitioned.

M00M
Developmental Disabilities Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

A developmental disability is a condition attributable to a mental or physical impairment that results in substantial functional limitations in major life activities and is likely to continue indefinitely. Examples include autism, blindness, cerebral palsy, deafness, epilepsy, intellectual disability, and multiple sclerosis. The Developmental Disabilities Administration (DDA) provides direct services to developmentally disabled individuals in two State Residential Centers (SRC), two Secure Evaluation and Therapeutic Treatment (SETT) units, and through funding of a coordinated service delivery system that supports the integration of these individuals into the community. The State receives federal matching funds for services provided to the Maryland Medical Assistance Program (Medicaid) enrolled individuals (who make up the vast majority of individuals served by the agency).

Goals of the administration include:

- empowerment of developmentally disabled individuals and their families;
- integration of developmentally disabled individuals into community life;
- provision of quality support services that maximize individual growth and development; and
- establishment of a responsible, flexible service system that maximizes available resources.

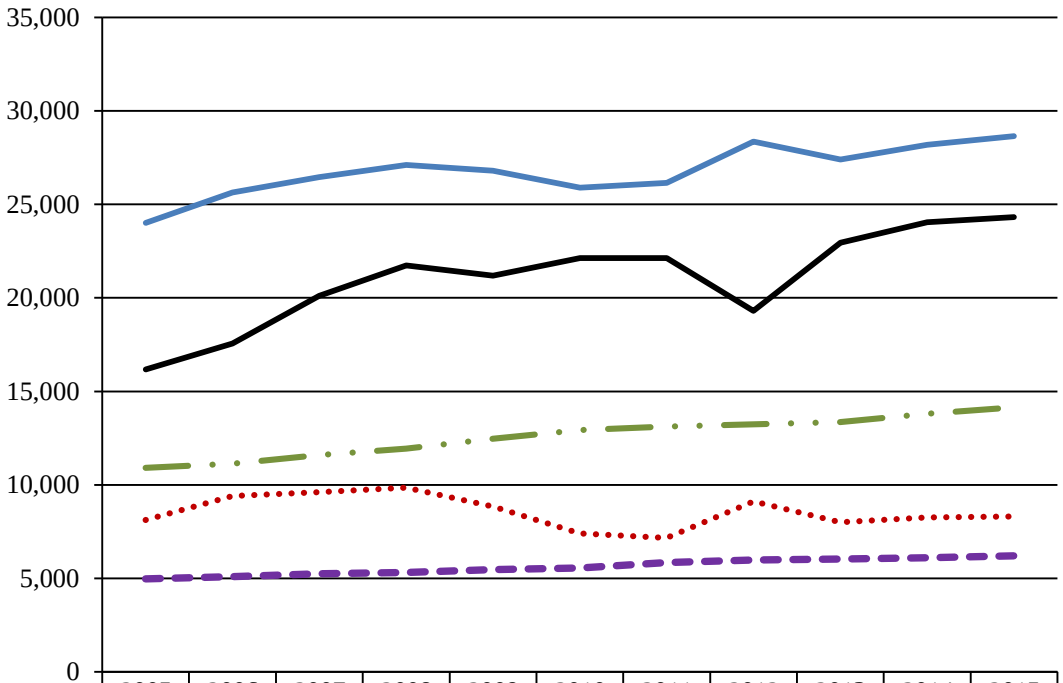
Performance Analysis: Managing for Results

1. Community-based Services Continue to Be the Agency's Preferred Model of Service Delivery

One of DDA's performance goals is to serve individuals in the community rather than in institutions. In fiscal 2015, 25,315 unique individuals were served in the Community Services Program within DDA. The agency expects that number to increase to over 28,205 by fiscal 2017. The Community Services Program offers a variety of services to individuals, including residential, day, and support services. Examples of residential services include community residential services and individual family care. Examples of day services (which provide activities during normal working hours) include day habilitation services, supported employment, and summer programs. Finally,

examples of support services include individual and family support, targeted case management (TCM), community supported living arrangements, and self-directed services. **Exhibit 1** shows the number of individuals receiving each of the major services. For purposes of this exhibit, TCM (formerly known as resource coordination) is shown separately from the support services category, as TCM is available to all individuals in the system.

Exhibit 1
Individuals Receiving Community Services
Fiscal 2005-2015



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Residential Services	4,973	5,095	5,249	5,315	5,474	5,550	5,849	5,990	6,040	6,107	6,209
Day Services	10,913	11,139	11,592	11,935	12,476	12,934	13,123	13,246	13,353	13,810	14,138
Support Services	8,120	9,403	9,614	9,860	8,844	7,405	7,171	9,115	8,011	8,259	8,306
Total Services (excl. TCM)	24,006	25,637	26,455	27,110	26,794	25,889	26,143	28,351	27,404	28,176	28,653
TCM	16,166	17,566	20,108	21,728	21,192	22,132	22,132	19,298	22,954	24,052	24,314

TCM: Targeted Case Management

Note: Duplicated count as individuals can be counted in multiple categories.

Source: Department of Health and Mental Hygiene

As Exhibit 1 shows, DDA provided residential services to 6,209 individuals, day services to 14,138 individuals, and support services to 8,306 individuals in fiscal 2015. (It should be noted that individuals receiving services through DDA may receive more than one type of service.) As shown in the exhibit, the number of support services decreased between fiscal 2008 and 2010 due to cost containment actions limiting support for general-funded support services. However, the number of individuals receiving support services increased sharply in fiscal 2012 due to the inclusion of individuals receiving services of short duration (supported by one-time funding from the increase in the alcohol tax), before falling again fiscal 2013.

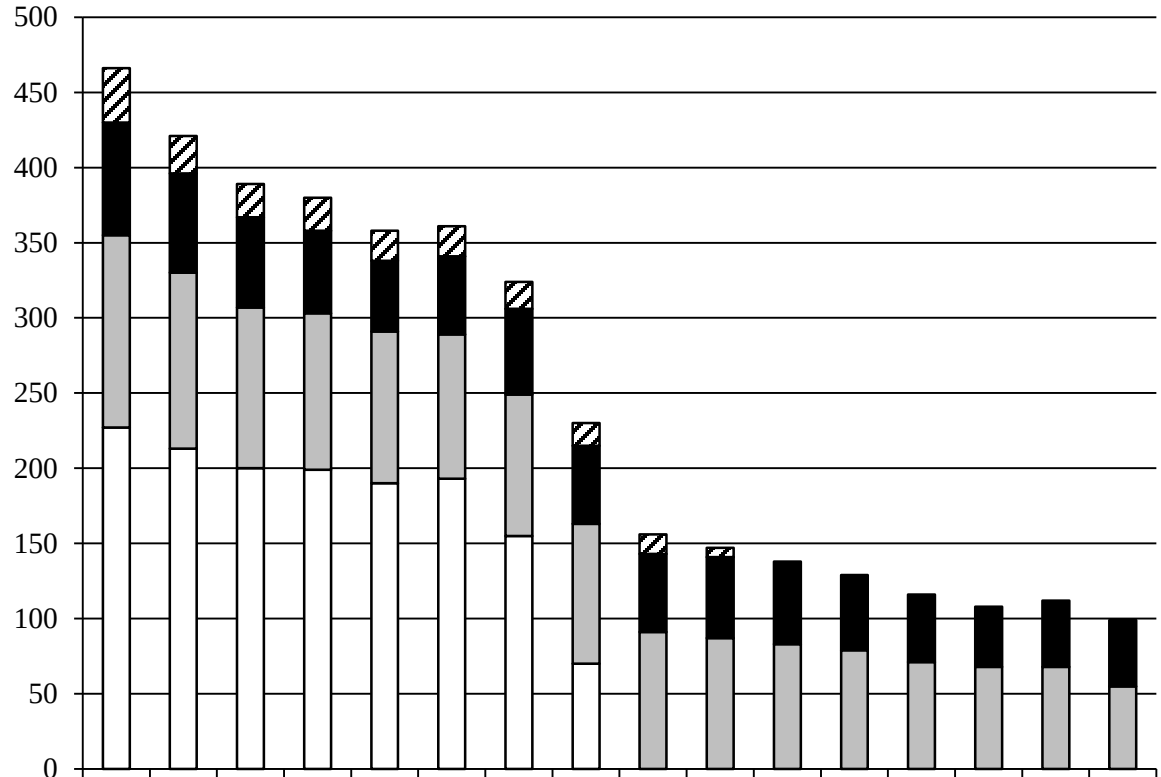
The number of individuals receiving TCM also returned to historic levels in fiscal 2013. In fiscal 2010, the Board of Public Works (BPW) reduced funding for TCM (then called resource coordination) by 15% on an ongoing basis. Subsequently, DDA modified its contracts to limit these services to individuals served in facilities, those receiving community-based services, and those in the highest category of the waiting list. DDA advises that this change continued to be felt in fiscal 2012, when the number of individuals receiving these services declined by 13% over the previous year. From fiscal 2012 to 2015, however, the number of individuals receiving TCM increased.

State Residential Centers

Part of DDA's mission is to serve individuals in the least restrictive setting possible. In most cases, this means serving individuals in the community instead of in institutional settings. As a result, the number of individuals served in SRCs is far fewer than the number of individuals served in the community. As shown in **Exhibit 2**, the average daily population (ADP) has steadily declined since fiscal 2002.

As shown in **Exhibit 3**, as ADP continues to decline, the average annual cost per client in residential services continues to increase. This is particularly true for the Potomac Center. The average annual cost per client for the Potomac Center increased from $170,000 in 2009 to $318,000 in 2015. Staff have been relocated from the centers to other parts of the agency to coincide with the decrease in ADP in order to lower costs. However, individuals continuing to live in the center may also require higher levels of care and, therefore, greater resources, increasing the average cost.

Exhibit 2
Average Daily Population of State Residential Centers
Fiscal 2002-2017 Est.

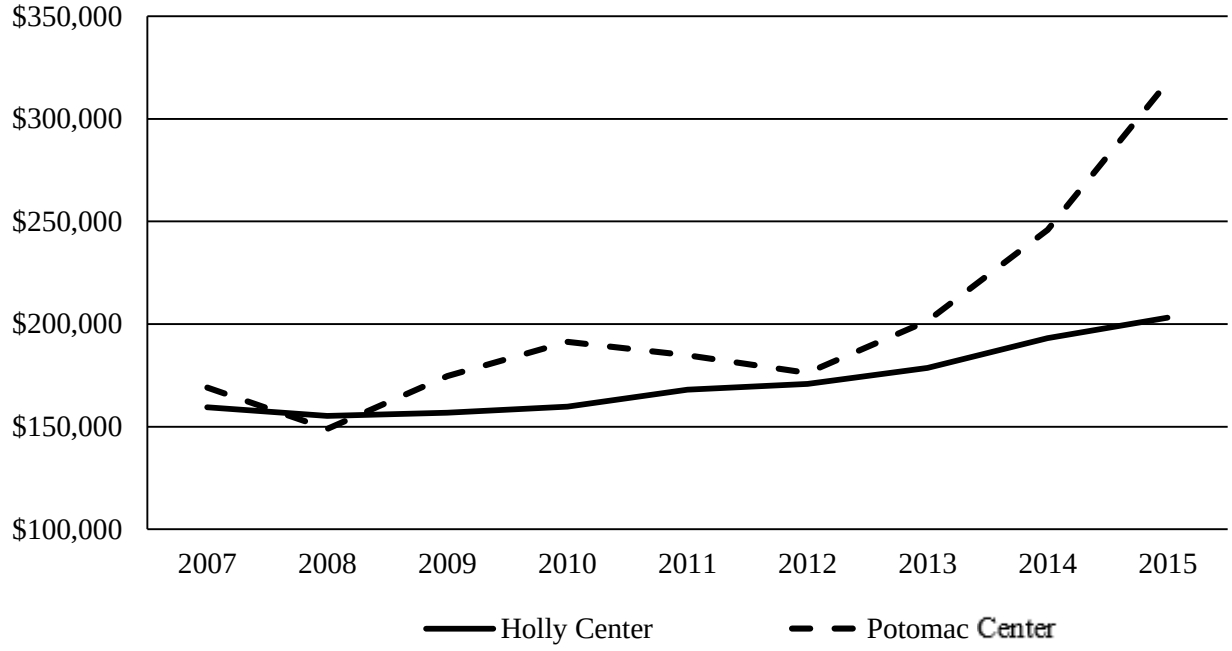


	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016 Est.	2017 Est.
Brandenburg	36	25	22	22	20	20	18	15	13	6	0	0	0	0	0	0
Potomac	75	66	60	55	47	52	57	52	52	54	55	50	45	40	44	44
Holly Center	128	117	107	104	101	96	94	93	91	87	83	79	71	68	68	55
Rosewood	227	213	200	199	190	193	155	70	0	0	0	0	0	0	0	0

Note: Does not include individuals in Secure Evaluation and Therapeutic Treatment units. See Exhibit 4.

Source: Department of Health and Mental Hygiene

Exhibit 3
Annual Cost Per Average Daily Client for Residential Services
Fiscal 2007-2015



Source: Department of Health and Mental Hygiene

The closure of one or both of these facilities could generate operating savings that could be reinvested in community services (consistent with the agency's mission to serve individuals in community-based settings rather than in institutions) as well as offer potential for site redevelopment. However, many other factors including access to, and availability of, community-based services, and the impact to residents and staff must also be considered. It should be noted that more than 10 states and the District of Columbia no longer maintain any large institutions for people with developmental disabilities. **The agency should comment on the increased cost per client at the Potomac Center and brief the committees on the community's ability to provide the necessary supports in order to phase out one or both of the facilities.**

2. Population in Secure Evaluation and Therapeutic Treatment Units for Court-committed Individuals Remains Below Capacity

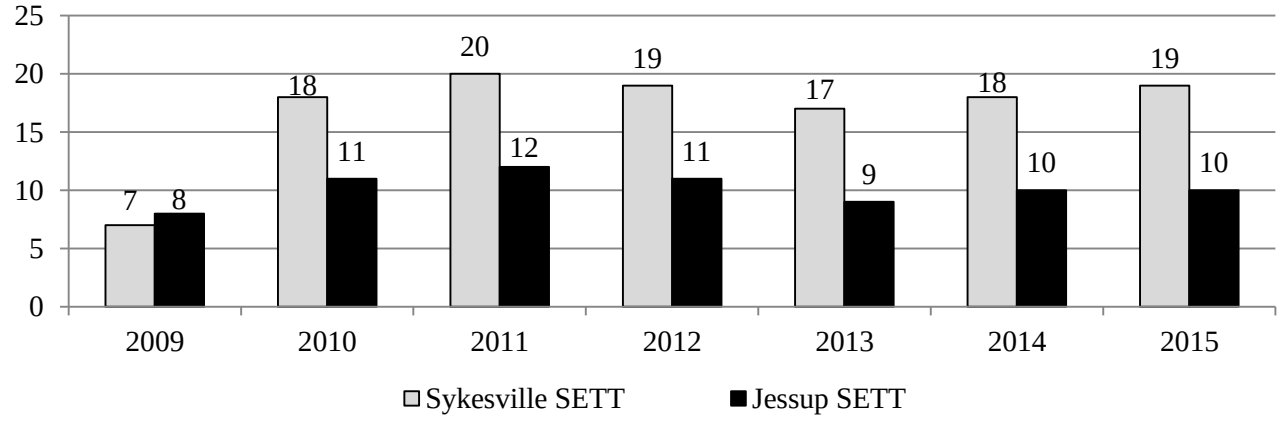
Since fiscal 2009, DDA has served court-ordered individuals in specialized centers – called SETT units – instead of in SRCs. Two SETT units are operated by DDA: one for evaluation and short-term treatment and one for treatment on a longer-term basis.

The evaluation and short-term treatment unit is a secure facility located on the grounds of the Clifton T. Perkins Hospital in Jessup. This unit houses a maximum of 12 individuals for 21 to 90 days. During the evaluation phase, DDA completes competency and behavioral evaluations and develops individual, comprehensive service plans.

The longer-term therapeutic treatment facility is also a secure facility located on the grounds of Springfield Hospital in Sykesville. This unit has capacity for 20 individuals who have been appropriately identified through evaluation at the Jessup unit.

Exhibit 4 shows the ADP of each unit. As the exhibit demonstrates, both SETT units were at full capacity in fiscal 2011. After slightly declining at both locations in fiscal 2012 and 2013, ADP increased at both locations in fiscal 2014. The ADP at Sykesville increased again in fiscal 2015, while Jessup ADP remained static. The agency advises that this is a result of increased efforts to serve a greater number of individuals in the community.

Exhibit 4
Average Daily Population of SETT Units
Fiscal 2009-2015



SETT: Secure Evaluation and Therapeutic Treatment

Source: Department of Health and Mental Hygiene

Due to safety and capacity concerns, DDA received capital funding in fiscal 2011 to begin planning and design of a new, consolidated SETT unit to replace both existing units, and had advised that the renovation and consolidation of the Sykesville Unit would provide sufficient residential and program space to effectively provide secure evaluation and therapeutic treatment, 54 beds. The construction was to originally begin in fiscal 2014 and be completed in fiscal 2015. This project has been delayed multiple times, most recently to conduct a building feasibility study to identify whether or not the project should include renovation and new construction or solely new construction. The fiscal 2017 *Capital Improvement Program* de-authorizes all prior authorizations for design of SETT units and repurposes the funds for use beginning fiscal 2018. **The agency should comment on the status of the building feasibility study and the timeline for the design phase of the new SETT.**

3. Waiver Enrollment Increases

Another performance goal for DDA is to increase the percentage of individuals receiving services through the Home and Community-based Services Waiver. **Exhibit 5** shows the percentage of individuals enrolled in the waiver. As shown, waiver enrollment increased 2.14% from fiscal 2014 to 2015. The Department of Health and Mental Hygiene (DHMH) advises that 92.0% of DDA clients are likely Medicaid eligible.

Exhibit 5
Individuals Enrolled in DDA's Home and Community-based Services Waiver
Fiscal 2013-2016 Est.

	2013	2014	2015	2016 Est.
Percent of Individuals in Waiver	84.35%	85.85%	87.69%	88.14%
Percent Increase Over Previous Year	n/a*	1.78%	2.14%	0.51%

DDA: Developmental Disabilities Administration

*The agency did not report waiver enrollment prior to its latest budget submission.

Source: Department of Health and Mental Hygiene

The agency's latest Managing for Results submission is the second in which the agency has provided this data. The agency's newly established goal with respect to waiver enrollment is to increase the percentage of individuals enrolled in the waiver by 0.3% in each of the next two fiscal years.

Fiscal 2016 Actions

Cost Containment

In fiscal 2016, the Administration proposed a rate decrease for community providers from 3.5% to 3.0%, resulting in savings of $2.6 million in general funds (and $4.7 million in total funds). In addition, the Administration implemented a general 0.6% across-the-board reduction for DHMH totaling $27.2 million. The DDA's proportion of this allocation totaled $4.9 million including:

- $3.9 million in the Community Services Program due to greater federal fund attainment from the increased proportion of individuals in the waiver program and an additional $100,000 in Program Direction due to greater federal fund attainment from waiting list case management;

- $100,000 for the closure of the therapy pool and $404,000 for the elimination of 6 positions at the Holly Center; and

- $244,000 for overtime reductions at the SETT units, $40,000 for a reduction in the pharmacy contract due to underutilization, and $100,000 for decreased hospitalization costs by enabling fiscal agents to bill Medicare for hospitalization greater than 24 hours.

Proposed Budget

As shown in **Exhibit 6**, after adjusting for a back of the bill reduction in health insurance, the fiscal 2017 allowance for DDA is $63.3 million (5.8%) over the fiscal 2016 working appropriation, primarily due to a fiscal 2017 expansion of services, a 3.5% provider rate increase, and annualization of the fiscal 2016 expansion of services. General fund support increases by $32.7 million (5.4%), while federal support increases by $30.9 million ($6.5%).

Exhibit 6
Proposed Budget
DHMH – Developmental Disabilities Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$565,876	$4,917	$407,536	$30	$978,359
Fiscal 2016 Working Appropriation	602,913	6,503	478,524	33	1,087,971
Fiscal 2017 Allowance	635,614	6,230	509,417	30	1,151,289
Fiscal 2016-2017 Amount Change	$32,701	-$273	$30,893	-$3	$63,318
Fiscal 2016-2017 Percent Change	5.4%	-4.2%	6.5%	-9.1%	5.8%

Where It Goes:

Personnel Expenses	
Employee and retiree health insurance	$1,015
Overtime	734
Retirement contributions	725
Turnover adjustments	705
Shift differential and miscellaneous adjustments	-116
Regular earnings	-123
Workers' compensation premium assessment	-383
Abolished positions (10 full-time equivalents)	-558
Other fringe benefit adjustments	14
Community Services	
Fiscal 2017 provider rate increase (3.5%)	36,196
Fiscal 2017 expansion and annualization of fiscal 2016 expansion	16,130
Fiscal 2017 expansion of transitioning youth	8,888
Family Support Services and Resource Coordination (Targeted Case Management)	-3,950
Utilization Review Services	
Utilization review	2,893
Health Risk Screening Tool	957
Rate-setting study	178
Supports Intensity Scale	-667
Program Direction	
Financial restructuring contract	529
Security and renewal software and server replacement (regional offices)	375
Consumer satisfaction survey	168
Other Operational	
Reduction in utility and maintenance (residential facilities)	-206
Other	-184
Total	**$63,318**

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

Personnel Expenses

Personnel expenses increase the fiscal 2017 budget by $2 million. The increase in overtime, $734,000, is primarily due to increased usage by the Potomac Center for the patient care and transitions program. This and other increases are partially offset by decreases including $558,000 for 10 abolished vacant full-time equivalent (FTE) positions at the Holly Center due to a decrease in ADP.

Community Services

Transitioning Youth Program

The fiscal 2017 allowance includes $8.9 million for the expansion of the Transitioning Youth Program, which identifies individuals graduating from the public school system, nonpublic school placements, and the foster care system, who are eligible for DDA services such as supported employment. The program is intended to ease the transition of such individuals into the DDA system. In fiscal 2017, DDA expects to serve 602 additional individuals (449 FTEs) through the program.

The 2015 *Joint Chairmen's Report* (JCR) requested a report on the number of transitioning youth exiting the educational system but who remain without DDA-funded services and DDA's plan to ensure that transitioning youth services are provided in a timely manner for individuals who exit the education system in 2015. As of this writing, the agency has yet to submit this report. **The agency should comment on its timeline for submitting this report to the committees.**

Fiscal 2017 Expansion and Annualization of Fiscal 2016 Expansion

As shown in Exhibit 6, the fiscal 2017 budget includes an additional $16.1 million for the expansion of services in fiscal 2017 and the annualization of the fiscal 2016 service expansion. Individuals come into services at different times during the fiscal year. When an individual is placed in community services for the first time in any fiscal year, annualized costs of servicing that individual in the subsequent fiscal year are included as part of the base budget.

Expansion funds will be spent to fund the following estimated placements:

- ***Emergency Placements:*** Emergency services are provided when an individual becomes homeless, the caregiver of an individual dies, or any other situation arises that threatens the life and safety of the individual. The budget estimates that DDA will provide residential and day services to approximately 161.0 additional individuals (75.9 FTEs) in emergency situations in fiscal 2017.

- ***Crisis Services:*** Crisis services are provided for individuals in the crisis resolution category of the waiting list. The budget estimates that DDA will provide residential and day services to 113.0 individuals (83.0 FTEs) on the waiting list.

- ***Court-involved Placements:*** DDA is charged with serving individuals identified through the court system in either a community placement or at one of the SETT units. In fiscal 2017, DDA expects to serve 17.0 court-referred individuals (9.0 FTEs) in community settings.

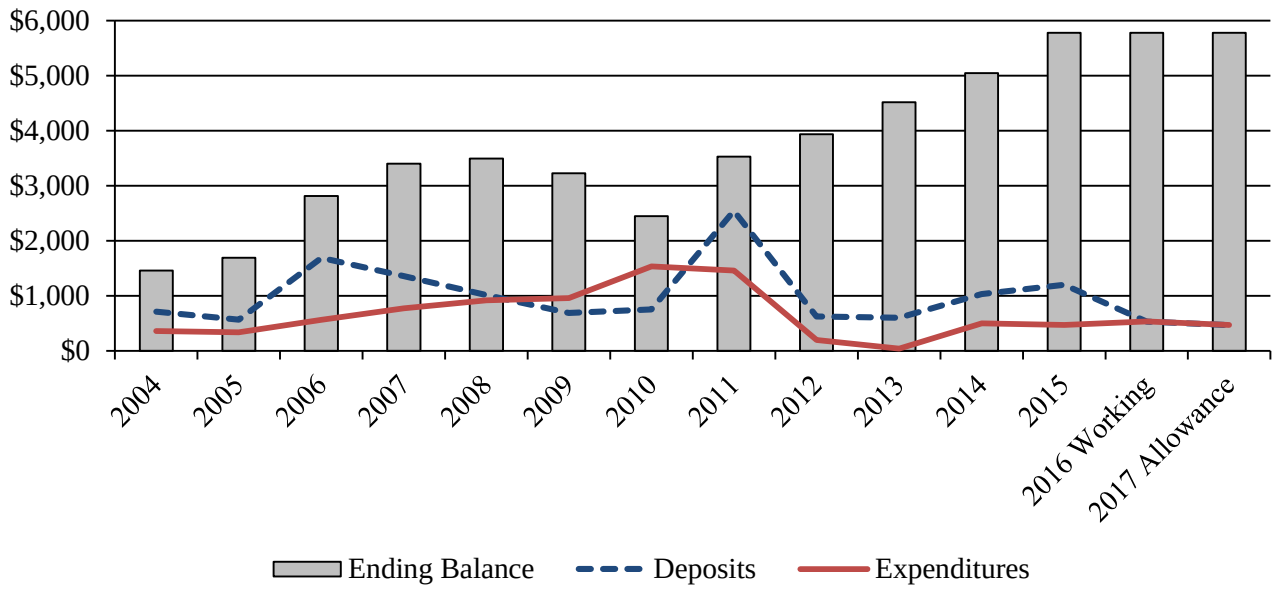
- ***Waiting List Equity Fund Placements:*** The Waiting List Equity Fund (WLEF) is supported through a State income tax check-off, investment earnings from the sale of properties owned by DDA, and savings associated with the movement of an individual from institutional care to

community care. The allowance includes $466,330 in special funds from the WLEF expansion of residential services for 24.0 individuals (12.0 FTEs) on the waiting by the end of fiscal 2017.

The WLEF was established to ensure that funding associated with serving individuals in an SRC follows them to the community when they are transitioned to a community-based care setting and that any funds remaining be used to provide community-based services to individuals on the waiting list. According to statute, WLEF funds may not be used to supplant funds for emergency placements or Transitioning Youth. The WLEF funds only the first year of placement after which those individuals become part of the base.

Exhibit 7 shows the ending fund balance of the WLEF, the deposits made to the fund, and the expenditure or placement costs incurred by the fund between fiscal 2004 and the estimate for fiscal 2017. Deposits include the balance of funds available due to a discharge from an SRC as well as interest earned by the Community Service Trust Fund and the WLEF. The Community Services Trust Fund holds the proceeds from the sale or long-term lease of a DDA facility after it has closed. The interest earned on those funds is then transferred to the WLEF annually.

Exhibit 7
Waiting List Equity Fund Balance
Fiscal 2004-2017 Allowance
($ in Thousands)



Source: Department of Health and Mental Hygiene

After reaching $3.5 million in fiscal 2008, the fund balance of WLEF declined in fiscal 2009 and 2010 due in large part to expenditures exceeding deposits to the fund. Since 2011, the reverse has been true, with expenditures below deposits, and the balance has grown. **The agency should comment on how it intends to spend down the balance of the fund and whether there may be a better use of the fund.**

Rate Increases for Community Service Providers

Chapter 262 of 2014 mandated a 3.5% provider rate increase in fiscal 2016 through 2019. As discussed previously, a contingent reduction and subsequent back of the bill language reduced the fiscal 2016 rate increase to 3.0%. The fiscal 2017 allowance includes $36.2 million for the 3.5% provider rate increase.

It should be noted that Chapter 648 of 2014, along with requiring DDA to conduct an independent study to set provider rates for community-based services, also established certain requirements with respect to wages paid by providers to direct support employees. Specifically, DHMH must report to the General Assembly by December 15, 2015, summarizing the range of total funding (based on wage surveys required to be submitted by providers) spent by providers on direct support employee wages and benefits, as a percentage of total operating expenses for fiscal 2014. Beginning in fiscal 2015 (and before the earlier of either the implementation of a new DDA payment system or the end of fiscal 2019), the percentage of a community provider's total reported operating expenses that is spent on direct support wages and benefits for a fiscal year may not be less than the percentage that was spent in fiscal 2014. If DHMH determines that this requirement is not met (and does not find mitigating circumstances or accept a plan of correction), the department must recoup funds from a community provider that have not been expended as required. As of this writing, DHMH has not submitted this report. **The agency should comment on the status of the report.**

Resource Coordination (TCM)

Resource coordination is a service under Medicaid for persons with developmental disabilities receiving residential, day, supported employment, and Community Support Living Arrangement services funded under the Medicaid Waiver. Other individuals within the State system receive resource coordination as needed.

On December 28, 2015, DDA promulgated regulations to update payment rates for TCM services, altering the process for service authorization, and limiting waiting list coordination services and transition coordination services to individuals who meet DDA's definition of an individual with a developmental disability. Individuals who do not meet the criteria for determination of a developmental disability, but instead are eligible only for individual support services, will have waiting list coordination and transition coordination services discontinued. Due to the discontinuation of services to non-DDA-eligible individuals, the fiscal 2017 budget for resource coordination falls by $1.75 million. However, the Joint Committee on Administrative, Executive, and Legislative Review requested a delay in the regulation to identify whether the regulation conforms to legislative intent. **The agency should comment on the impact of the proposed regulation on support-only eligible individuals.**

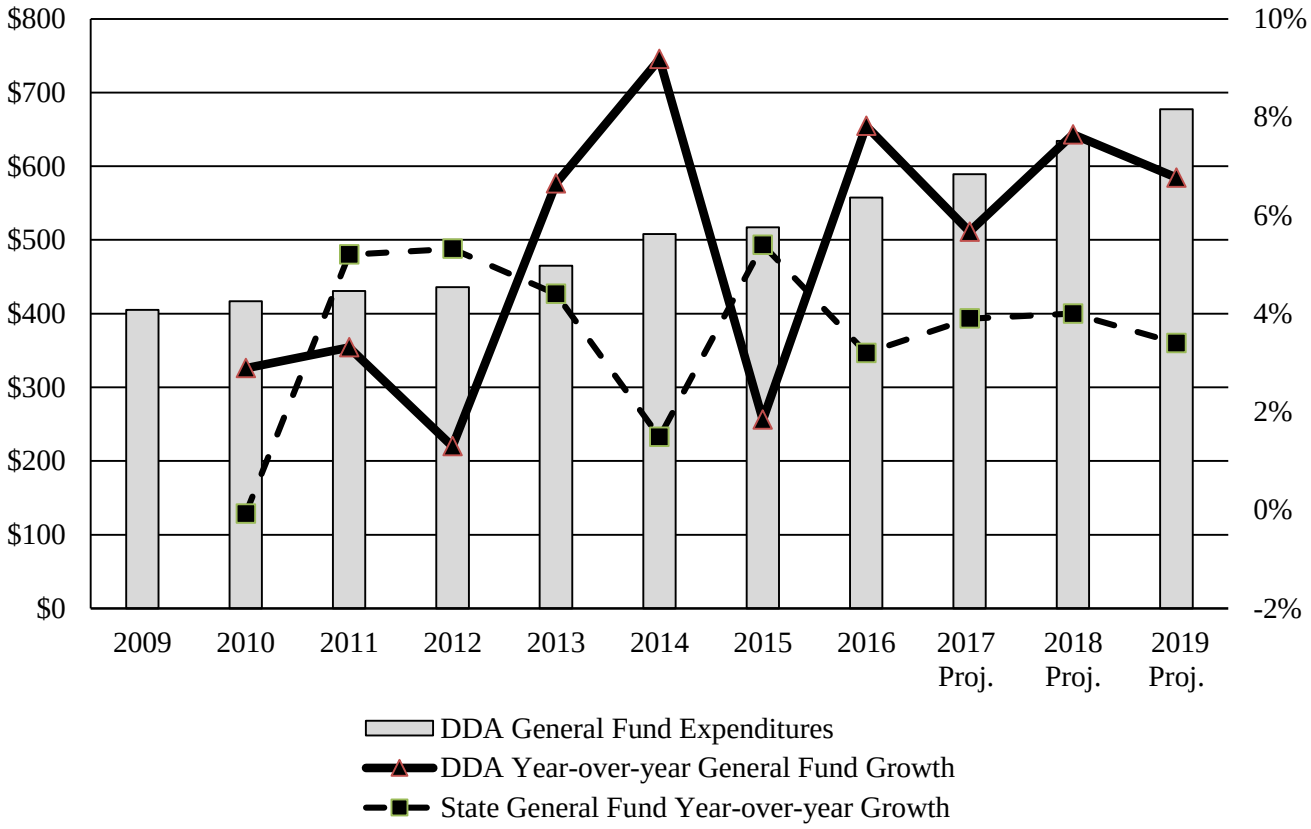
Family Support Services and Individual Support Services

The purpose of family support services is to provide adequate resources within the community so that families with a child with a disability may keep that child at home and avoid disruption to the family unit. This program includes support services that a person with a disability and their families require for normal community living that would not be available under already existing programs. Examples of family support services include help with activities of daily living, medical equipment purchases and rental, respite services, removal of architectural barriers, family training, and transportation. DDA proposed eliminating $4.4 million for these services in the fiscal 2016 budget. However, Section 48 of the fiscal 2016 budget bill identified $2.2 million to continue partial support for the services. The fiscal 2017 allowance eliminates the $2.2 million in funding for family support services. The agency advises that a review of its existing contracts for these services revealed that they did not align with the agency's current service delivery model.

General Fund Support for DDA Community Services Outpaced State General Fund Growth

Exhibit 8 shows general fund growth in the Community Services Program compared with general fund growth statewide. After far exceeding the rate of statewide general fund growth in fiscal 2013 and 2014, the agency's general fund growth rate fell below that of the State General Fund in fiscal 2015. General fund growth in the program again outpaces statewide growth beginning in fiscal 2016 and is projected to continue to do so through fiscal 2019 due to statutorily mandated 3.5% annual provider rate increases as well as anticipated service expansions.

Exhibit 8
General Fund Growth in Community Services Compared with the State
Fiscal 2009-2019 Projected
($ in Millions)



DDA: Developmental Disabilities Administration

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

Utilization Review Services

In fiscal 2016, DDA transitioned from the paper version of the Health Risk Screening Tool (HRST), a screening tool for health risks associated with disabilities (*e.g.*, developmental disabilities, physical disabilities), to the web-based version. This tool assesses the medical needs of an individual, and moving to a web-based version will provide DDA with the ability to track and analyze data, which was not possible with the paper version. The agency notes that the web-based HRST version will improve the determination of clinical support and services. In fiscal 2017, the budget included $957,000 for the HRST assessment. The fiscal 2017 allowance falls by $667,000 for Supports Intensity Scale (SIS) assessments and the Individual Indicator Rating Scale (IIRS). Both will be used simultaneously until SIS is fully implemented. This includes annual IIRS assessments, emergency IIRS assessments, routine SIS assessments, and emergency SIS assessments.

An additional $2.9 million is included in the fiscal 2017 allowance for medical and utilization review services. Utilization review services include determining a level of need for all individuals who are newly entering services funded by the DDA fee payment system, which includes residential, day, and supported employment services. DDA will now contract with a Quality Improvement Organization to conduct utilization reviews. This includes conducting utilization review audits of DDA-funded services to ensure that funded services are provided and to evaluate consumer satisfaction with services. If the services are not provided as funded, as documented in the individual plan or as documented in the Service Funding Plan, the State can recover funds. Utilization review services include routine performance audits, on-demand performance audits, and review of request for service change and add-on services. It should be noted that no funding was appropriated in either fiscal 2015 or 2016 for utilization review audits. The agency notes that a vendor was hired, but the contract was terminated three months later by mutual agreement, and a solicitation was issued in fall 2014 but was canceled in March 2015. Therefore, no utilization review audits have been performed since fiscal 2013. **The agency should comment on how it ensured that funded services were actually provided when no utilization review audits have been performed since fiscal 2013.**

Rate-setting Study

Chapter 648 of 2014 requires DDA to conduct "an independent cost-driven, rate-setting study to set provider rates for community-based services that includes a rate analysis and an impact study that considers the actual cost of providing community-based services." DDA contracted with a vendor through a competitive procurement process in fiscal 2016 and work is expected to continue through fiscal 2018. Tasks in the base year include (1) performing rate-setting analysis of all DDA-funded services; (2) developing a schedule of uniform fixed rates by service type; (3) providing guidance on reimbursement strategies to incentivize outcomes; (4) analyzing unmet needs in proposed rate if higher than current rate; (5) justifying recommendations on proposed rates based on geographic regions; and (6) providing DDA with a rate maintenance process. Work in the latter part of fiscal 2017 through 2018 will include developing and supporting an implementation plan; updating service rates as necessary based on cost changes, funding availability, and any new data; conducting an analysis to determine working capital requirements; and developing updates for rate publications in regulations. In fiscal 2017, the funding for the rate-setting study increases by $177,500.

Program Direction

Expenses for Program Direction, the administrative arm of the agency, increase by $1.1 million due to an increase in the financial restructuring contract of $529,000, security and renewal software and server replacement at the regional offices ($375,000), and an increase in the cost of the national core indicators consumer satisfaction survey ($168,000). The National Core Indicators Survey is a new tool implemented by DDA in fiscal 2013 to determine the satisfaction level of DDA service recipients.

Issues

1. Rate Setting and Payment System Reform

Current Payment System Weaknesses

The Department of Legislative Services (DLS) has long cited inherent weaknesses in DDA's current payment system, which is prospective in nature; that is, the system estimates the costs that a provider will incur in the coming fiscal year to serve its clients. DDA pays these costs to providers upfront (before the services are actually provided). Providers then submit documentation of their expenses and, at the end of the year, providers and DDA use audited cost reports to reconcile actual costs with the prospective payments. If actual costs were less than the prospective payments, a provider must reimburse DDA; conversely, if actual costs were greater than the prospective payments, DDA must reimburse the provider. The prospective nature of DDA's provider payment process makes budget forecasting more difficult. Because payments are issued one quarter in advance, payments may differ from actual expenses. Inevitably, DDA will have overpaid or underpaid providers at the close of each year. It is not surprising that since the current system was adopted, DDA has encountered significant budgeting difficulties – resulting in significant surpluses (and, correspondingly, the reversion and/or cancellation of funds), as well as significant deficits. Efforts to improve DDA's payment system are multi-pronged.

Transition to Long Term Supports and Services Tracking System Financial Platform

In January 2013, Alvarez and Marsal (A&M), an independent consulting firm, was tasked by the agency to recommend draft specifications to solicit the modification or replacement of the agency's existing financial platform. The firm was also required to advise how the new system will address the major underlying inefficiencies in DDA's current system and to identify any barriers to adopting a new financial management system.

Ultimately, the Provider Consumer Information System 2 (PCIS 2) currently used by DDA was found to have significant weaknesses with regard to data, reporting, and system functionality. Weighing the relative benefits and disadvantages of modifying or replacing PCIS 2, A&M ultimately recommended replacing the system with DHMH's Long Term Supports and Services Tracking System (LTSS), an integrated care management tracking system currently used by multiple waiver programs and Community First Choice. A&M highlighted the desirability of utilizing a departmentwide system to support all of DHMH's waiver programs and streamline interactions between programs. A&M further advised that implementing LTSS is a less expensive option than either enhancing PCIS 2 or developing a new DDA system.

Furthermore, of the options examined by A&M, LTSS is expected to offer the greatest ability to support A&M's key recommendation regarding billing and payment process options; namely, the direct submission of Medicaid claims by providers to the Maryland Medicaid Management Information System (MMIS) for payment processing. Currently, invoicing and payment activity is separate from

DDA generation of Medicaid claims. A&M advised that the leveraging of existing DHMH investments in LTSS and MMIS – in coordination with reengineered processes – will improve fiscal controls, increase transparency, and reduce DDA's liability for uncollected federal funds.

Dual-operating Environment

A&M identified a number of system dependencies and timeline considerations impacting the adoption of a new financial management system. Chief among these was the completion of a rate-setting study, as described previously. Because the rate-setting study is not required to be complete until September 30, 2017, A&M advised that a dual-operating environment will likely be required for a period of time, as nonpayment functionality is migrated to LTSS in advance of the study's completion. A&M reported that, with LTSS as the selected option, a plan to support the implementation of the system will be developed. The transition from PCIS 2 to LTSS is staggered and began January 2015. According to the agency, related processes were grouped into seven chapters: eligibility and placement; individual plan (IP) and budgeting; quality assurance; provider billing and payment; individuals in institutions; coordination of community services; and appeals.

Rate-setting Process

DDA is currently working with a selected contractor to conduct an independent cost-driven rate-setting study, developing a strategy for assessing the needs of individuals receiving services, developing a sound fiscal billing and payment system, and obtaining input from stakeholders including individuals receiving services and providers. The contractor began the rate-setting process in September 2015 and is currently in the third step of an eight step process:

- gathering the service information – September 2015 through March 2016;
- identifying the cost categories to use – September 2015 through March 2016;
- gathering all financial information and accounting data – November 2015 through March 2016;
- coding and analyzing all financial data – December 2015 through April 2016;
- studying direct care/support hourly wage – December 2015 through April 2016;
- analyzing demographic/acuity/scale differences – January through August 2016;
- compiling the value of the support hour ("brick method") – March through August 2016; and
- performing budget impact analyses – May 2016 through December 2016.

DDA held a town hall meeting with providers that included a presentation by the contractor of the process and will continue to hold additional meetings and webinars with stakeholders. The contractor will use the "Brick Method" to calculate rates, which is an architecture for standard rates for social and clinical services funded by the government sector. It begins by identifying cost categories from historical spending and then creates a value of an hour of direct support time that includes each component, added to the wage of the direct support individual (the "Brick"). It then sets rates based on the number of support hours needed by the person who will use the service.

The contractor is collecting general ledgers of the cost accounts (expressed as a percentage of total costs) for all DDA providers. It will then choose 60 providers with geographic variation, to follow up with an in-depth discussion. There will be a "program support" component to include ambulation and acuity issues. These costs will be compared with an outside system, using the Bureau of Labor Statistics data and accelerated to the year it will be imposed using the Medicaid Consumer Price Index. Transportation will be established as a separate component. The rates will also incorporate absence days by calculating an absence factor to be calculated in the proposed rates.

The agency has advised DLS that the rate-setting study and the payment system reform will be complete at the end of fiscal 2017, and fiscal 2018 will be a transition year as DDA continues to work on regulation changes. The implementation of rates will be coordinated with the transition to the LTSS platform from PCIS 2. However, the agency advises that the contract with A&M ended, and the new one has not yet been approved**. The agency should comment on how this break between contracts will impact the current timeline for financial system restructuring.**

2. Federal Audit Disallowances

The agency has had two recent federal audit disallowances. In an audit report released in September 2013, the Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services (HHS) documented an overclaiming of funds by DDA, resulting in a recommendation that the State refund $20.6 million to the federal government. The audit report alleged that DDA claimed unallowable costs for residential habilitation services, such as for room and board, not covered under the waiver by Medicaid. DDA concurred with the OIG recommendations and encumbered funds to pay back the $20.6 million. DHMH attributed the findings to inadequate controls between MMIS and DDA's PCIS 2. DHMH advised that edits were completed in the systems to reduce claims for federal reimbursement and DDA issued additional guidance to providers.

In an audit report released in June 2015, OIG at HHS documented an additional overclaiming of federal funds, resulting in a recommendation that the State refund $34.0 million to the federal government. This $34.0 million represents the federal share of services provided over a three-year period (July 1, 2010, to June 30, 2013) to individuals with developmental disabilities who, because of their high degree of need, were provided additional services beyond residential habilitation services (add-on services). During this same time period, the department claimed $329.0 million ($178.7 million federal share) for all add-on waiver services.

OIG reviewed $34.2 million of the federal share and concluded that virtually every claim that it reviewed was not consistent with waiver criteria. The audit alleges that DDA claimed add-on services for beneficiaries who did not meet the waiver's level-of-need requirement for those services under its Community Pathways waiver program. According to the audit, the waiver allowed add-on services for beneficiaries who met three requirements, including a level of need of 5 on the State agency's Individual Indicator Rating Scale. However, the State agency did not consider the beneficiary's level-of-need score when approving add-on services.

DHMH did not concur with the OIG recommendation or its interpretation that the Community Pathways waiver requires individuals receiving the services to meet three separate requirements. The department has, in the past, interpreted the waiver and operated its program such that an individual who meets any one of the three conditions is eligible for add-on services. The department believes it is entitled to deference for its interpretation of its waiver language. OIG responded that the agency's interpretation of its waiver (that only one of the three requirements be met) would have been unallowable because it would not require evidence that there was a need for add-on services or that additional payment was necessary to cover the cost of those services.

During the audit, the agency significantly amended this provision in its waiver, eliminating the requirement that an individual must have a level of need of 5 on the rating scale. However, OIG noted that the amended waiver was not in effect during the audit period and does require providers to document both medical necessity and financial need to receive add-on payments. After reviewing the State agency's comments, OIG believes a recommendation for a refund is valid. DDA accrued $3.4 million in general funds to repay a portion of the disallowed claims using general funds. (It should be noted that no payments will be made until DHMH receives a disallowance letter from the federal government.) However, the General Accounting Division of the Comptroller of Maryland recorded a decrease to the General Fund in the State's fiscal 2015 *Comprehensive Annual Financial Report* to recognize these disallowances. **The agency should comment on the potential payout and timing of the federal funds claim.**

3. Rosewood Center Operating Costs

Amid repeated findings by the Office of Health Care Quality concerning safety issues related to the buildings and grounds of the facility, Rosewood Center closed in June 2009. A 2008 JCR required the department to submit a report evaluating the possible uses of the property.

The original Rosewood campus included approximately 690 acres of land. Since 1978, the State has disposed of approximately 434 acres, of which roughly one-third is protected by the Maryland Environmental Trust Conservation Easement. The proceeds from all sales of the property are deposited into the Community Services Trust Fund to benefit individuals on DDA's waiting list.

The property at Rosewood contains three parcels. The Maryland Department of Veterans Affairs (MDVA) is interested in Parcel 3 (61 acres) and possibly Parcel 2 (16 acres) for the Garrison Forest Veteran Cemetery. Of the three parcels, Parcel 3 would require major remediation,

with some remediation of Parcel 2, and a little of Parcel 1. All parcels contain deteriorated, asbestos-filled buildings.

DHMH submitted a report in August 2009 in response to the 2008 JCR request that addressed the use of the remaining 178 acres and 37 buildings that make up the Rosewood Center campus. After the announcement of the closure, an interagency committee was formed by the Maryland Department of Planning to review the possible uses of the campus and to set agreed upon principles for the disposition of the property. The State Clearinghouse completed its review of the property in December 2009 and recommended that the State declare the 178 acres and 37 buildings to be surplus to the State and to offer to sell the property to Stevenson University.

BPW approved 117 acres on Parcel 1 to be disposed of to Stevenson University to expand the university with educational offices and open space use. However, the status of the adjacent parcels may hinder the university from acquiring the site. Previously, the State had planned to demolish the asbestos-contaminated buildings, remove and dispose of hazardous debris, and generally restore the site prior to disposition at an estimated cost of $8.1 million. However, no funding is included in the capital budget for remediation. It is unclear whether the property can be disposed of without resolving the demolition and remediation issue.

Exhibit 9 shows the operating expenditures since the closure of the Rosewood Center in 2009, primarily due to maintenance and personnel. The agency will have spent more than $17.0 million over the eight-year period. **The agency should brief the committees on the timeline for disposing of the property to MDVA and what the cost would be to remediate Parcels 2 and 3 for that use.**

Exhibit 9
Rosewood Operating Funds Since Closure
Fiscal 2010-2017
($ in Thousands)

Fiscal Year	General Fund Support
2010	$3,638
2011	2,643
2012	1,992
2013	2,036
2014	1,900
2015	2,212
2016 Appropriation	1,541
2017 Allowance	1,386
Total	**$17,348**

Note: A share of the total costs each year is due to workers' compensation payments ($5.6 million over an eight-year period).

Source: Department of Health and Mental Hygiene

4. Supports Intensity Scale Funding

A task force to study the DDA rate payment system for community providers was formed in 2007. The task force was directed to review the existing rate system for community-based services funded by DDA and determine its strengths and weaknesses, compare the cost of current mandates for service delivery to the level of funding provided by the State, consider best practices from other states, identify changes in the reimbursement system, and develop recommendations to address the problem of the structural underfunding of community services.

Current Payment System

Maryland switched to a Fee Payment System (FPS) in 1998, which was modeled after the previously used Prospective Payment System. The FPS has two rate components that determine a provider's reimbursement: a consumer component based on a 5x5 matrix of health/medical needs and supervision/assistance needs; and a provider component based on administrative, general, capital, and transportation costs.

The provider component is a flat rate per client based on a congregate services model that may present barriers to effectively delivering individualized services. As an example, if a provider is staffing a three-person alternative living unit (ALU) and one person moves out, the provider still has the full expenses for the ALU but one-third less revenue.

The consumer component is a 5x5 matrix, called the IIRS, which assesses an individual's health and supervision needs to determine how much a provider will be reimbursed for services. For nearly three decades, DDA has been using the IIRS to assess the level of need for individuals receiving DDA-funded services. The matrix assessment is based on documentation from multiple sources including medical professionals, education professionals, and families. However, in 1997, a freeze was put on matrix levels indicating that an individual would have the same matrix score for as long as they were in the DDA system, even if their service needs changed. Instead of updating the matrix, add-on rates are used to account for additional support needs. The current system does not taken into account inflation, increased needs, unfunded mandates such as nursing requirements, and increased transportation costs.

Functional Assessment

The task force explored measures of functional status used in other states that might be applicable to Maryland. Examples included the SIS, Inventory for Client and Agency Planning (ICAP), Developmental Disabilities Profile, and Support Needs Assessment Profile. Domains that are common across the functional tools include health and safety, home or daily living skills, social/relationship skills, behavior support needs, and communication. The task force identified the two most popular tools from other states – the SIS and the ICAP – used to assess consumers receiving DDA-funded services.

SIS Pilot Project

One of the final recommendations of the task force was for DDA to assess consumers receiving DDA-funded services on a regular basis using a reliable assessment tool. In fiscal 2010, DDA established a stakeholder group to determine a new tool to assess the needs of DDA clients. The SIS was chosen to replace the IIRS. The SIS is an individual client assessment and planning tool developed by the American Association on Intellectual and Developmental Disabilities. It is presently used by a number of states and Canadian provinces. Some states also use SIS measures as a basis for payment of providers. DDA implemented a pilot project to complete SIS assessments for individuals within the Community Service program. The assessment encompassed people entering DDA funded services for the first time, and the agency completed the assessment June 30, 2013. This pilot was intended to be used to hire a consulting firm to develop a resource allocation algorithm based on the sample assessments. To gauge the usefulness of the SIS, DDA contracted with the Human Service Research Institute to analyze a pilot sample of individuals. Upon determining that the SIS would, in fact, address the gaps in the IIRS, DDA authorized the analysis of a larger sample in order to create a resource allocation model. Subsequently, a statewide contractor has conducted approximately 1,226 SIS interviews, satisfying the need for a more reliable, useful sample to create a resource allocation model.

The next steps for the agency were to have the results of these SIS reports analyzed, develop a resource allocation model, and create a plan to transition from the IIRS to the SIS. DDA intended to prepare a Request for Proposals to secure a vendor to perform these tasks in conjunction with a rate-setting study and anticipated having a vendor on board by the start of fiscal 2015. The fiscal 2015 budget included funds to hire a consultant for DDA to pursue the use of the SIS to determine the cost of service. However, new DDA leadership decided not to pursue the SIS to determine the cost of service, based on mixed results from other states, and to only use the SIS as an assessment tool in the person-centered planning process.

Although money was appropriated in fiscal 2014 through 2016 for the SIS, the agency advises that no spending actually occurred for this purpose**.** **Exhibit 10** shows the appropriation and actual expenditures for the SIS and the IIRS. During fiscal 2014 and 2015, the agency underspent appropriations by a total of $1.5 million.

Exhibit 10
Supports Intensity Scale and
Individual Interrater Reliability System Expenditures
Fiscal 2013-2017
($ in Thousands)

Fiscal Year	Appropriation	Expenditures
2013	$1,138,250	$1,138,250
2014	1,438,250	657,995
2015	1,228,900	555,375
2016	3,106,046	-
2017 Allowance	2,213,922	-
Total	**$9,125,368**	**$2,351,620**

Source: Department of Health and Mental Hygiene

The fiscal 2017 allowance includes $2.2 million for a contract with a vendor that will continue to simultaneously use the IIRS until the SIS is fully implemented in fiscal 2018. The implementation of SIS does not require payment system reform, but integrating SIS in a new payment methodology may yield a better alignment of payments with costs and incentivize effective service delivery. **Given the actual IIRS expenditures from fiscal 2013 to 2015, the fiscal 2016 and 2017 appropriation for the IIRS and the SIS appears be overbudgeted. DLS recommends reducing the fiscal 2017 appropriation for the SIS and the IIRS by $500,000.**

5. Delayed Regional Office Reorganization

Beginning July 1, 2013, DHMH planned to reorganize DDA to improve accountability within the Community Service Program. Among other things, it anticipated that the reorganization would increase clinician involvement at the regional level and redefine the responsibilities of DDA's four regional offices.

DDA's regional teams establish individual eligibility and control, access to services, manage available funding, and monitor service provision to ensure quality of services. Moreover, add-ons are negotiated at the regional level with each provider. Add-ons are meant to accommodate temporary needs for unique or more intensive supports but they can be extended. Subsequently, this has resulted in inconsistencies across regions. The department planned to reassess the duties of the regional offices and determine whether certain responsibilities needed to be transferred to Program Direction.

In addition to hiring a number of key staff, DDA has implemented a new organizational structure in its headquarters that is designed to increase focus on program leadership, provider relations, and quality. With that realignment recently completed, the agency has now turned its attention to standardizing operations at its four regional offices (each of which currently has a different organizational structure). The regional offices will mirror headquarters for more consistency across State policy and procedures. The agency intended to have the organizational plan for the regional offices approved by the beginning of fiscal 2016, however in November 2015, DDA advised DLS that this may occur in the next six months. The agency now advises that work continues on the reorganization of the regional offices. Functional areas that align with functions at headquarters have been identified and staffing ratios are being developed. The staffing ratios will enable DDA to identify gaps in both the number of staff and the skill set required. **The agency should comment on its timeline for regional office reorganization.**

Recommended Actions

		Amount Reduction	
1.	Reduce funding for the Supports Intensity Scale and the Individual Indicator Rating Scale to align with most recent actual spending.	$ 287,500 $ 212,500	GF FF

2. Adopt the following narrative:

New Placements Within the Community Services Program: The committees request the Department of Health and Mental Hygiene (DHMH) to report, by each program within community services, on the number of new individuals placed into services from the following funding categories within the Community Services program: emergency, Waiting List Equity Fund, court-involved crisis services, and Transitioning Youth. The number of requests for services change should also be reported, and to the extent possible, the costs associated with changes in services should be identified. The report should be submitted on August 1, 2016, with fiscal 2016 actuals and on January 15, 2017, with year-to-date fiscal 2017 data.

Information Request	Author	Due Date
Reports on new placements within the Community Services Program	DHMH	August 1, 2016, and January 15, 2017

Total Reductions	**$ 500,000**
Total General Fund Reductions	**$ 287,500**
Total Federal Fund Reductions	**$ 212,500**

Updates

1. Emergency and Crisis Resolution Placements Report

The 2015 JCR requested a report on the definition of "emergency" used by DDA to determine funding for emergency placements and the methods used by DDA to determine who is selected to receive funding for crisis resolution placements. A report was submitted by DDA on January 4, 2016.

Under the current process, a coordinator of community services (CCS) or the local Department of Social Services contacts the DDA regional office with a request to initiate services due to an emergency situation with no other immediate resolution being available. The regional office then gathers information on the individual including their waiting list status, priority category, and eligibility determination. DDA assigns a category to an individual based on their priority. The DDA waiting list includes the following priority categories – crisis resolution, crisis prevention, and current need. The highest priority category is crisis resolution. The regional office then sends this information to the regional director to make a decision on whether or not the situation constitutes an emergency.

DDA determines placement eligibility based on an evaluation of criteria in Health-General Article, 7-101(f) and 7-404, Annotated Code of Maryland. An individual's request for emergency placement is determined by the regional director based on the following criteria:

- homelessness or housing that is explicitly time limited, with no viable non-DDA-funded alternative;
- serious risk of physical harm in the current environment:
    - has recently received severe injuries due to the behavior of others in the home or community;
    - has recently been the victim of sexual abuse;
    - has been neglected to the extent that the individual is at serious risk of sustaining injuries which are life threatening or which substantially impair functioning;
    - engages in self-injurious behavior which puts the individual at serious risk of sustaining injuries which are life threatening or which substantially impair functioning; or
    - is at serious risk of sustaining injuries which are life threatening or which substantially impair functioning due to the physical surroundings;
- serious risk of causing physical harm to others in the current environment; or

- living with a caregiver who is unable to provide adequate care due to the caregiver's impaired health, which may place the applicant at risk of serious physical harm.

If the regional director considers the situation an emergency, a DDA Regional Director Recommendation for Emergency Funding (request form) is completed and submitted it to the Deputy Secretary for Developmental Disabilities for denial or approval based on the circumstances described in the request form. In fiscal 2015, services were initiated for 97 people who were approved for emergency placements.

When funds are appropriated to support the placement of people from the waiting list, individuals are contacted based on the highest priority category and the length of time on the waiting list. The fiscal 2016 operating budget for DDA includes $3 million in general funds to facilitate services for people in the crisis resolution category on the waiting list, which consisted of 109 people as of August 8, 2015. Of the 109 people, 16 have initiated services as emergency placements, 7 have been approved as emergency placements but are pending start dates, and 47 have been contacted by CCS to inform them of funding availability (37 of which were in the waiver/placement process as of October 30, 2015).

2. Changes to Community Pathways Waiver and Requirements for Meeting Community Settings Rule

States must apply to the federal Centers for Medicare and Medicaid Services (CMS) through a Home and Community-based Service waiver application to obtain permission to operate a waiver program. The department is making several changes to its waiver program to align services to comply with a new federal Community Settings Rule issued in January 2014 (as well as to implement other recommendations to improve the Community Pathways waiver). The Community Settings Rule states that services provided in facilities, congregate settings, farmsteads, and/or services that have the effect of isolating individuals from the broader community are considered to have institutional qualities and therefore may not be in compliance.

To comply with the Community Settings Rule, individuals being served in these types of settings will need to be transitioned to more integrated community settings. States were required to submit a Statewide Transition Plan to CMS outlining strategies to come into compliance. Maryland submitted its plan on March 12, 2015. States must be in full compliance with the new rules by March 17, 2019.

The agency will be conducting provider surveys and onsite assessments to confirm the type of setting and the number of people served in these settings. The survey and assessment will also be used to determine which settings need to be transitioned and determine the potential fiscal impact of implementing the Community Settings Rule. For example, in Residential Services, group homes located on the same street of a cul de sac or in a farmstead type setting may have the effect of isolating people from the larger community and violate the rule. The CMS Community Rule allows states to establish that certain settings currently in use may continue as long as they will be able to meet the

minimum standards set in the rule. These standards are referred to as tiered standards. The agency advises it has formed a workgroup to develop tiered standards.

The agency is implementing other changes to improve the Community Pathways waiver based on recommendations by the National Association of State Directors of Developmental Disabilities Services. These changes require sequencing, therefore amendments will occur in stages. The department has proposed the first of two (or potentially three) Community Pathways waiver amendments and closed the public comment period January 31, 2016. The first amendment proposes the following changes:

- ***Personal Support:*** Remove the 82-hour service pre-authorization requirement and remove support staff hour requirements and restrictions including pre-authorization requirement for more than 40-hour work week, 8 consecutive hours, time off between shifts, and time spent sleeping. Change personal supports unit of service from an hour to 15 minutes.

- ***Program Capacity:*** Adjust projections for the number of unduplicated participants based on current trends, new reserved capacity, and legislative appropriation to support new participants each year.

- ***Reserved Capacity:*** Update and establish new reserve waiver capacity for waiver participants.

- ***Projected Services Cost:*** Update projected service cost based on adjustments to unduplicated participant count and current service utilization.

- ***Active Treatment:*** Remove requirement for active treatment in order to be eligible for the waiver.

- ***Terminology and Language:*** Update terminology, language, and calculations in various sections.

DDA advises that the introduction of waiver amendment 2 will come in the second half of fiscal 2016.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Developmental Disabilities Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$574,302	$3,720	$418,473	$27	$996,522
Deficiency Appropriation	1,104	2,700	818	0	4,623
Cost Containment	-16,204	0	0	0	-16,204
Budget Amendments	7,117	651	2,392	3	10,163
Reversions and Cancellations	-443	-2,154	-14,148	0	-16,745
Actual Expenditures	**$565,876**	**$4,917**	**$407,536**	**$30**	**$978,359**
Fiscal 2016					
Legislative Appropriation	$590,152	$6,503	$462,684	$33	$1,059,371
Budget Amendments	12,761	0	15,839	0	28,600
Working Appropriation	**$602,913**	**$6,503**	**$478,524**	**$33**	**$1,087,971**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

The budget for DDA closed at $978.4 million, $18.2 million below the original legislative appropriation.

Deficiency appropriations increased the agency's budget by $4.6 million – $2.7 million in special funds to recognize funds collected from local governments for day services and $1.9 million ($818,461 in federal funds and $1.1 million in general funds) to cover consultant services needed to implement new financial management and reforms. Statewide cost containments by BPW reduced general funds by $16.2 million, which includes $2.7 million to correct underbudgeted special fund revenues collected from local governments for day services, $2.5 million to reflect actual utilization of support coordination services and ramping up of a fee-for-service model, $1.6 million to reflect changes in resource coordination that resulted in more services being eligible for a federal match and improved federal claiming for behavioral services, $1.0 million to reflect additional individuals reapplying and being deemed eligible for the federal waiver, $250,00 in assumed savings from utilization review, $5.2 million from lowering the fiscal 2015 mid-year provider rate increase from 4% to 2% and eliminating funding for the nonoperation Community Services Reimbursement Rate Commission, $2.7 million for a reversion from a prior year budget, and $253,630 for reductions in salaries and fringe benefits.

Budget amendments over the course of fiscal 2015 added $10.2 million to DDA's budget. The reallocation of fiscal 2015 budgeted funds for the 2015 cost-of-living adjustment (COLA) and salary increment increases for State employees resulted in the transfer of funds to DDA ($293,001 in general funds and $42,325 in federal funds). Budget amendments realigning health insurance costs within DHMH increased general funds by $656,390. In addition, reallocation of the Annual Salary Review increased general and federal funds by $277,507 and $2,256 respectively. Federal funds increased by $2,347,675 to cover increased Medicaid-eligible community service expenditures. General funds increased by $8,634,562 including $7.4 million to cover increased community residential services contract (audit payback), $168,292 to cover waiting list equity funds, and $1.4 million to cover overtime and electricity costs. These increases were offset by a reduction of $322,989 due to a decrease in contractual positions and a decreased cost of a fiscal consulting contract. Special funds increased by $650,946 to cover the increased cost of waiting list equity fund expenditures.

These increases were offset by a reduction in general funds of $42,331 to realign 15 FTEs from the Holly Center to other programs within DDA, $451,722 due to decreased contractual services, $776,650 due to a decrease in anticipated provider services, and $1.4 million due to the allocation of a funding reduction related to the Voluntary Separation Program implemented during fiscal 2015.

At the end of the year, the agency reverted $443,377 in general funds primarily due to the federal administrative claim rate increasing from a budgeted 38% to an actual of 42%, resulting in a surplus of general funds. Of the reverted general funds, $103,595 was a result of the Holly Center overestimating the deficit in third quarter projections and receiving too much general funds to cover that deficit by budget amendment. The agency cancelled $14.2 million in federal funds, primarily ($13.8 million) to cover an audit penalty from HHS. In addition, $2.2 million of DDA's special fund appropriation was canceled due to less than realized projected special fund attainment during the fiscal year.

Fiscal 2016

To date, the fiscal 2016 budget for DDA has increased by $28.6 million ($15.8 million in federal funds and $12.8 million in general funds). A budget amendment increased general funds by $6,146 to transfer the Maryland Environmental Services fee from the Office of the Secretary to DDA facility maintenance. General funds increased by an additional $7.0 million to realign the DHMH fiscal 2016 2% cost containment. General funds also increased $5.2 million for individual and family support services and crisis resolution services reflecting legislative priorities. Federal funds increased $15.8 million due to higher than anticipated Medicaid waiver participation. An additional $598,821 in general funds and $89,794 in federal funds were added to restore the 2 % pay cut.

Appendix 2

Audit Findings

Holly Center

Audit Period for Last Audit:	May 5, 2011 – June 30, 2014
Issue Date:	March 2015
Number of Findings:	2
Number of Repeat Findings:	1
% of Repeat Findings:	50%
Rating: (if applicable)	n/a

Finding 1: The Holly Center paid pharmaceutical invoices without verification of the items received and the costs charged.

Finding 2: **Physical inventories of equipment were not documented by the Holly Center and reconciliations of equipment records were not performed in a timely manner.**

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

Object/Fund Difference Report
DHMH – Developmental Disabilities Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	632.50	626.50	616.50	-10.00	-1.6%
02 Contractual	23.84	25.25	27.94	2.69	10.7%
Total Positions	**656.34**	**651.75**	**644.44**	**-7.31**	**-1.1%**
Objects					
01 Salaries and Wages	$ 46,341,542	$ 44,861,037	$ 47,044,042	$ 2,183,005	4.9%
02 Technical and Spec. Fees	1,458,735	1,396,235	1,453,846	57,611	4.1%
03 Communication	223,959	267,220	213,278	-53,942	-20.2%
04 Travel	56,294	59,372	49,485	-9,887	-16.7%
06 Fuel and Utilities	2,216,092	1,868,807	1,524,587	-344,220	-18.4%
07 Motor Vehicles	143,920	197,497	144,257	-53,240	-27.0%
08 Contractual Services	925,106,705	1,036,581,810	1,098,494,148	61,912,338	6.0%
09 Supplies and Materials	1,342,336	1,381,469	1,208,875	-172,594	-12.5%
10 Equipment – Replacement	36,788	45,929	2,848	-43,081	-93.8%
11 Equipment – Additional	38,838	0	14,109	14,109	N/A
12 Grants, Subsidies, and Contributions	730,485	730,000	730,000	0	0%
13 Fixed Charges	662,929	581,981	580,213	-1,768	-0.3%
Total Objects	**$ 978,358,623**	**$ 1,087,971,357**	**$ 1,151,459,688**	**$ 63,488,331**	**5.8%**
Funds					
01 General Fund	$ 565,875,527	$ 602,912,539	$ 635,766,883	$ 32,854,344	5.4%
03 Special Fund	4,917,332	6,502,585	6,229,576	-273,009	-4.2%
05 Federal Fund	407,535,774	478,523,687	509,433,632	30,909,945	6.5%
09 Reimbursable Fund	29,990	32,546	29,597	-2,949	-9.1%
Total Funds	**$ 978,358,623**	**$ 1,087,971,357**	**$ 1,151,459,688**	**$ 63,488,331**	**5.8%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Developmental Disabilities Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Program Direction	$ 9,339,926	$ 9,147,286	$ 10,197,630	$ 1,050,344	11.5%
02 Community Services	925,298,438	1,038,312,154	1,099,736,038	61,423,884	5.9%
01 Services and Institutional Operations	18,207,906	17,660,750	17,561,407	-99,343	-0.6%
01 Court-involved Service Delivery	8,898,454	8,584,270	8,975,621	391,351	4.6%
01 Services and Institutional Operations	14,372,316	12,694,728	13,578,201	883,473	7.0%
01 Services and Institutional Operations	2,241,583	1,572,169	1,410,791	-161,378	-10.3%
Total Expenditures	**$ 978,358,623**	**$ 1,087,971,357**	**$ 1,151,459,688**	**$ 63,488,331**	**5.8%**
General Fund	$ 565,875,527	$ 602,912,539	$ 635,766,883	$ 32,854,344	5.4%
Special Fund	4,917,332	6,502,585	6,229,576	-273,009	-4.2%
Federal Fund	407,535,774	478,523,687	509,433,632	30,909,945	6.5%
Total Appropriations	**$ 978,328,633**	**$ 1,087,938,811**	**$ 1,151,430,091**	**$ 63,491,280**	**5.8%**
Reimbursable Fund	$ 29,990	$ 32,546	$ 29,597	-$ 2,949	-9.1%
Total Funds	**$ 978,358,623**	**$ 1,087,971,357**	**$ 1,151,459,688**	**$ 63,488,331**	**5.8%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

M00Q01
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$2,437,394	$2,535,919	$2,640,262	$104,342	4.1%
Deficiencies and Reductions	0	-188,187	-67	188,120	
Adjusted General Fund	**$2,437,394**	**$2,347,732**	**$2,640,194**	**$292,462**	**12.5%**
Special Fund	1,020,579	988,464	938,487	-49,977	-5.1%
Adjusted Special Fund	**$1,020,579**	**$988,464**	**$938,486**	**-$49,977**	**-5.1%**
Federal Fund	5,234,691	5,328,281	5,520,717	192,437	3.6%
Deficiencies and Reductions	0	0	-109	-109	
Adjusted Federal Fund	**$5,234,691**	**$5,328,281**	**$5,520,609**	**$192,328**	**3.6%**
Reimbursable Fund	68,279	67,325	57,702	-9,623	-14.3%
Adjusted Reimbursable Fund	**$68,279**	**$67,325**	**$57,702**	**-$9,623**	**-14.3%**
Adjusted Grand Total	**$8,760,943**	**$8,731,801**	**$9,156,991**	**$425,190**	**4.9%**

- The Governor's fiscal 2017 budget plan assumes a total of $222.2 million in reversions in the Medicaid program. Of this amount, $34.0 million is attributed to fiscal 2015 and $188.2 million to fiscal 2016.

- After accounting for reversions attributable to fiscal 2016 and a back of the bill reduction in health insurance, the fiscal 2017 allowance for Medicaid increases by $425.2 million, 4.9%, over the fiscal 2016 working appropriation. Budget growth is driven by provider rate increases totaling $326.7 million.

- General fund growth in fiscal 2017 is $292.5 million, 12.5%. Reliance on special funds drops to its lowest point since fiscal 2014, a decline of $50.0 million, 5.1%, compared to the fiscal 2016 working appropriation.

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

For further information contact: Simon G. Powell Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	611.00	620.00	620.00	0.00
Contractual FTEs	82.85	125.92	125.21	-0.71
Total Personnel	**693.85**	**745.92**	**745.21**	**-0.71**
Vacancy Data: Regular Positions				
Turnover and Necessary Vacancies, Excluding New Positions		47.79	7.72%	
Positions and Percentage Vacant as of 2/1/16		72.60	11.7%	

- There is virtually no change in the personnel resources available to the Medical Care Programs Administration in fiscal 2017.

- Vacancy levels in the program remain high, with 72.6 full-time equivalent regular position vacancies as of February 1, 2016, 11.7%. The agency notes that a departmentwide hiring freeze as part of cost containment is a major contributor to this high vacancy rate. The level of vacancies easily exceeds that required to meet the budgeted turnover rate.

Analysis in Brief

Major Trends

Measures of Managed Care Organization Quality Performance: The department expanded the number of Health Care Effectiveness Data and Information Set (HEDIS) components used to evaluate managed care organizations (MCO) in Maryland. In calendar 2014, Maryland MCOs outperformed their peers nationally on 63.7% of HEDIS components. While lower than the prior year, the expanded data set, as well as more participating MCOs, may have lowered relative scores.

MCO Value-based Purchasing: For calendar 2014, the department expanded its Value-based Purchasing program to include 13 measures, up from 10. The total amount of the capitation payment at risk, however, remained at 1%. For the first time in several years, the amount of incentives paid exceeded funds available from penalties. However, the department will make up the difference to fully reward those MCOs who earned incentive payments.

Rebalancing: In fiscal 2015, some of the positive trends seen in rebalancing long-term care services away from institutional care faltered. The total number of nursing home bed-days actually increased for the first time since 2004. Fiscal 2016 year-to-date data suggests the downward trend has resumed, albeit modestly.

Issues

HealthChoice: The number of MCOs open for enrollment in calendar 2016 remains at historically high levels and virtually unchanged from calendar 2015. However, after having record profits in calendar 2014, MCOs appear to be on pace to have record losses in calendar 2015; losses fueled by the significant enrollment in calendar 2015 associated with the requirement that most existing enrollees had to reenroll in the Maryland Health Benefit Exchange (MHBE) enrollment system. MCOs have expressed concern that, despite a rate increase of 5.9% in calendar 2016, rates are inadequate. On February 29, 2016, the Department of Health and Mental Hygiene (DHMH) announced an additional increase, bringing the calendar 2016 rate increase to 7.3%.

Department of Health and Mental Hygiene Formally Terminates the Contract for the Medicaid Enterprise Restructuring Project: In October 2015, DHMH finally terminated the contract for the Medicaid Enterprise Restructuring Project, something that has appeared inevitable for over a year. The fiscal 2017 budget focuses on bringing the existing legacy Medicaid Management Information System II into compliance with several federal requirements as well as planning for some system enhancements.

Medicaid Coverage for Lead Poisoning: Maryland has placed particular emphasis in the HealthChoice program on ensuring children receive appropriate testing for blood lead levels. However, there is still room for improvement.

Senior Prescription Drug Assistance Program: Change in Gap Subsidy and Overcommitment of Fund Balance: The Senior Prescription Drug Assistance Program (SPDAP) is budgeted in Medicaid beginning in fiscal 2017. The program recently altered its coverage gap subsidy for eligible enrollees from 5% coinsurance on total prescription costs incurred in the coverage gap to a $600 subsidy per eligible individual. While the SPDAP fund has often run a large balance, the fiscal 2017 allowance uses $8.7 million to fund community mental health services. Based on recent estimates of expenditures, the SPDAP fund cannot provide that level of support and meet the demands of its own program.

A Single Point of Entry for State Health and Social Services Programs: One of the promises of the original MHBE eligibility determination system was that it would be a platform for a single point of entry for all health and social services programs. With the failure of that system, that promise was put aside. However, now MHBE has what appears to be a successful system, the question of if and/or how to move to a single point of entry has re-emerged.

Recommended Actions

		Funds
1.	Add language restricting Medicaid provider reimbursements to that purpose.	
2.	Add language withholding funds pending a report on strategies to improve the level of lead screening of children enrolled in Medicaid.	
3.	Add language withholding funds for an independent review on the organization of entry points for health and social services in other states.	
4.	Reduce funding for provider reimbursements based on current estimates of enrollment, utilization, costs, and special fund availability.	$ 116,200,000
5.	Adopt narrative concerning the proposed impact of federal changes to Medicaid managed care organization regulations.	
	Total Reductions	**$ 116,200,000**

Updates

Medical Assistance Expenditures on Abortions: Various data for fiscal 2013 to 2015 is provided.

Dental Spending: Since the carve-out of dental services from MCOs in calendar 2009, expenditures on dental services have increased significantly, reaching $159.0 million in calendar 2014. In the same year, MCOs spent an additional $16.5 million on adult benefits (spending not reimbursed by Medicaid).

Proposed Overhaul of Medicaid and the Children's Health Insurance Program Managed Care Rules: In the 2015 interim, the Centers on Medicare and Medicaid Services proposed the first significant overhaul of managed care regulations since 2002. Key changes are summarized but have yet to be finalized.

Evaluation of Health Homes: The 2015 *Joint Chairmen's Report* (JCR) asked for an update on the implementation of the health homes initiative. Part of the Affordable Care Act, this initiative is intended to provide additional services to individuals in Medicaid with certain chronic conditions. Initial data points to incremental progress, but data limitations prevent definitive conclusions at this time.

Access to Pharmacy Networks: Chapter 309 of 2015 required DHMH to develop a plan to ensure MCO enrollees have adequate access to pharmacy services. The department's response is summarized.

Community First Choice Program and Community Options Waiver: The 2015 JCR asked for various data on the Community First Choice program and Community Options waiver. The data included a review of budget guidelines and actual budgets provided using resource utilization groups.

Medicaid Inpatient and Outpatient Savings Required in Chapter 489 of 2015 (Budget Reconciliation and Financing Act of 2015): Chapter 489 of 2015 required the Health Services Cost Review Commission to adopt policies to achieve general fund savings of at least $16.7 million in Medicaid in fiscal 2016. The reasoning behind how those savings were achieved is outlined.

M00Q01
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

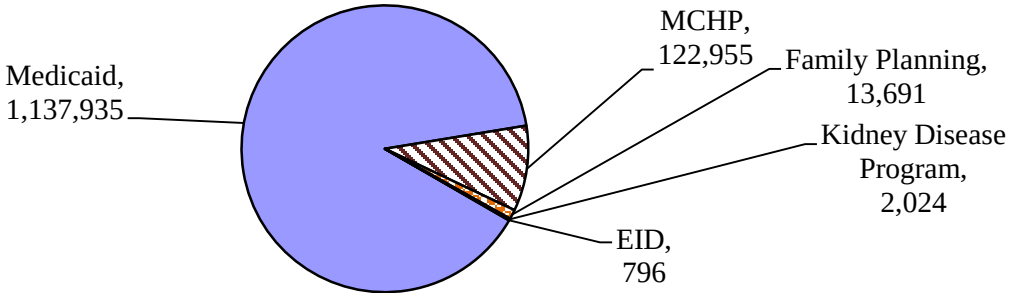
Program Description

The Medical Care Programs Administration (MCPA), a unit of the Department of Health and Mental Hygiene (DHMH), is responsible for administering the Medical Assistance Program (Medicaid), the Maryland Children's Health Program (MCHP), the Family Planning Program, the Kidney Disease Program (KDP), and the Employed Individuals with Disabilities Program (EID). In fiscal 2017, the Senior Prescription Drug Assistance Program (SPDAP), which had been a part of the Maryland Health Insurance Plan, is budgeted in Medicaid.

Beginning in fiscal 2015, funding for fee-for-service (FFS) Medicaid-eligible community mental health services for Medicaid-eligible recipients has also been transferred to MCPA. However, for the purpose of this budget analysis, that funding is excluded from this discussion and is included in the discussion of funding under the Behavioral Health Administration (BHA). Further, effective January 1, 2015, substance abuse services were carved out of the HealthChoice program. While that funding remains in the MCPA program budget, it is co-located with the funding for FFS community mental health services and will also be discussed under the BHA analysis.

The enrollment distribution of MCPA programs for fiscal 2015 is shown in **Exhibit 1**. It should be noted that the Primary Adult Care (PAC) program, a limited benefits program for childless adults up to 116% of the federal poverty level (FPL), ended effective January 1, 2014. All the enrollees in that program were moved into the Medicaid program under the expansion authorized by the federal Patient Protection and Affordable Care Act of 2010 (ACA).

Exhibit 1
Average Monthly Enrollment for Each Program
In the Medical Care Programs Administration
Fiscal 2015



EID: Employed Individuals with Disabilities Program
MCHP: Maryland Children's Health Program

Source: Department of Health and Mental Hygiene

Medicaid

Medical Assistance (Title XIX of the Social Security Act) is a joint federal and state program that provides assistance to indigent and medically indigent individuals. In Maryland, the federal government generally covers 50% of Medicaid costs. Medical Assistance eligibility is limited to children, pregnant women, elderly or disabled individuals, low-income parents, and childless adults. To qualify for benefits, applicants must pass certain income and asset tests.

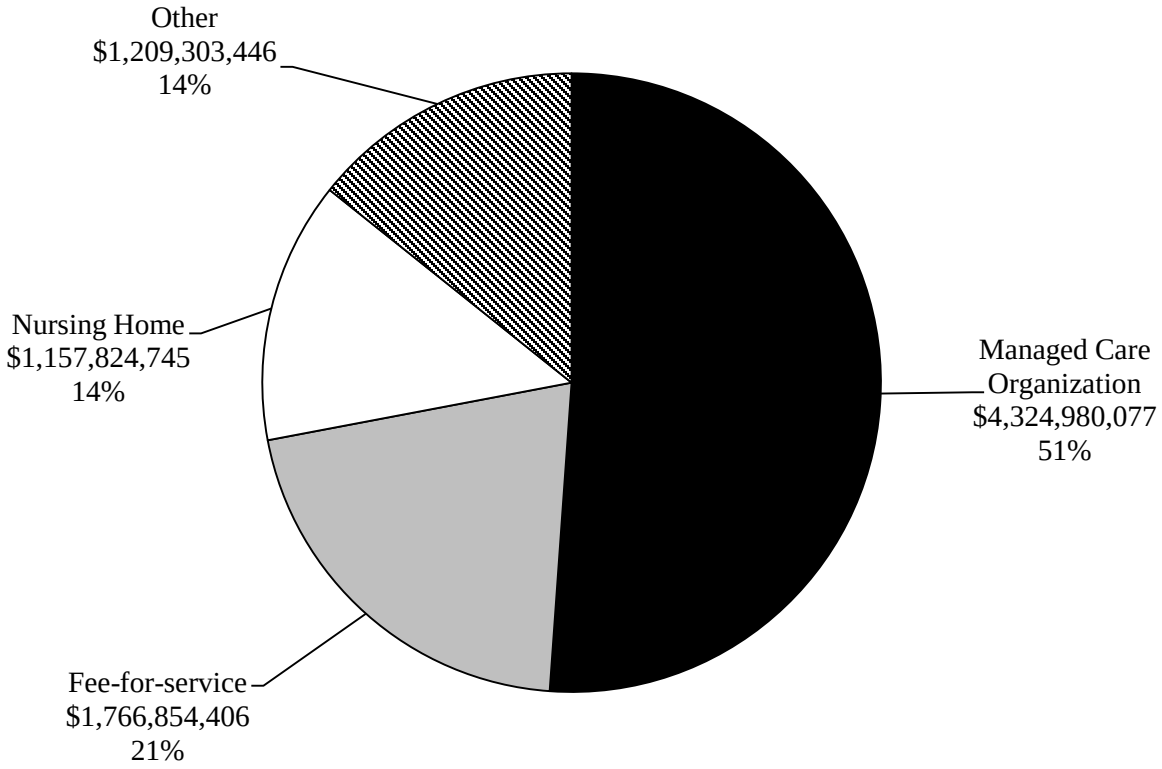
Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income program automatically qualify for Medicaid benefits. People eligible for Medicaid through these programs comprise most of the Medicaid population and are referred to as categorically needy. The U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility standards through the Pregnant Women and Children Program. Federal law also requires the Medicaid program to assist Medicare recipients with incomes below the FPL in making their coinsurance and deductible payments. In addition, the State provides Medicaid coverage to parents below 116% of the FPL. Effective January 1, 2014, Medicaid coverage was expanded to persons below 138% of the FPL, provided for in the ACA. In the initial years, the federal government will cover 100% of the costs with this expansion population with the federal match declining ultimately to 90%. (The most current FPL guide is listed in **Appendix 4**.)

Another major group of Medicaid-eligible individuals is the medically needy. The medically needy are individuals whose income exceeds categorical eligibility standards but are below levels set by the State. People with incomes above the medically needy level may reduce their income to the requisite level through spending on medical care.

Medicaid funds a broad range of services. The federal government mandates that the State provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family planning services; transportation services; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government also allows optional services, which Maryland provides, that include vision care; podiatric care; pharmacy; medical supplies and equipment; intermediate-care facilities for the developmentally disabled; and institutional care for people over age 65 with mental diseases.

Most Medicaid recipients are required to enroll in HealthChoice, which is the name of the statewide mandatory managed care program that began in 1997. Populations excluded from the HealthChoice program are covered on a FFS basis, and the FFS population generally includes the institutionalized and individuals who are dually eligible for Medicaid and Medicare. The breakdown of program spending by broad service category in Medicaid is provided in **Exhibit 2.** As shown in the exhibit, the greatest proportion of funding is being used for capitated payments to managed care organizations (MCO) through HealthChoice.

Exhibit 2
Medicaid Program Spending by Service Type
Fiscal 2015



Note: Program spending for Medicaid provider reimbursements only. Exhibit excludes spending on the Maryland Children's Health Program. The other category includes such things as Medicare Part A/B premium subsidies and administrative programs.

Source: Department of Health and Mental Hygiene

Maryland Children's Health Program

MCHP is Maryland's name for medical assistance for low-income children. The State is normally entitled to receive 65% federal financial participation for children in this program, although beginning in fiscal 2016, a temporary enhanced match of an additional 23% is available through the ACA. Those eligible for the higher match are children under age 19 living in households with an income below 300% of the FPL but above the Medicaid income levels. MCHP provides all the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% of the FPL.

Family Planning

The Family Planning Program provides medical services related to family planning for women who lose Medicaid coverage after they were covered for a pregnancy. The covered services include medical office visits; physical examinations; certain laboratory services; family planning supplies; reproductive education, counseling, and referral; and tubal ligation. Coverage for family planning services continues until age 51 with annual redeterminations unless the individual becomes eligible for Medicaid or MCHP, no longer needs birth control due to permanent sterilization, no longer lives in Maryland, or is income-ineligible. Chapters 537 and 538 of 2011 extended coverage under the program to women under 200% of the FPL.

Kidney Disease Program

The KDP is a last-resort payer that provides reimbursement for approved services required as a direct result of end-stage renal disease (ESRD). Eligibility for the KDP is offered to Maryland residents who are citizens of the United States or aliens lawfully admitted for permanent residence in Maryland, diagnosed with ESRD, and receiving home dialysis or treatment in a certified dialysis or transplant facility. The KDP is State funded.

Employed Individuals with Disabilities Program

The EID extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program lets disabled individuals return to work while maintaining health benefits by paying a small fee. Individuals eligible for the EID may make more money or have more resources in this program than other Medicaid programs in Maryland. The services available to EID enrollees are the same as the services covered by Medicaid. The federal government covers 50% of the cost for the EID.

Senior Prescription Drug Assistance Program

Beginning in the fiscal 2017 budget, the SPDAP is moved administratively into Medicaid from the Maryland Health Insurance Plan (MHIP). For the purpose of this analysis, fiscal 2015 and 2016 funding associated with the SPDAP is also incorporated into the data used throughout. The SPDAP provides Medicare Part D premium and coverage gap assistance for the purchase of outpatient prescription drugs for moderate-income (at or below 300% of the FPL) Maryland residents who are eligible for Medicare and are enrolled in certain Medicare Part D Prescription Drug Plans. The SPDAP receives $14 million in special funds from a portion of the value of CareFirst's premium tax exemption and $4 million, also from CareFirst, for the coverage gap subsidy when CareFirst's surplus reaches certain statutory levels.

Performance Analysis: Managing for Results

1. Measures of Managed Care Organization Quality Performance

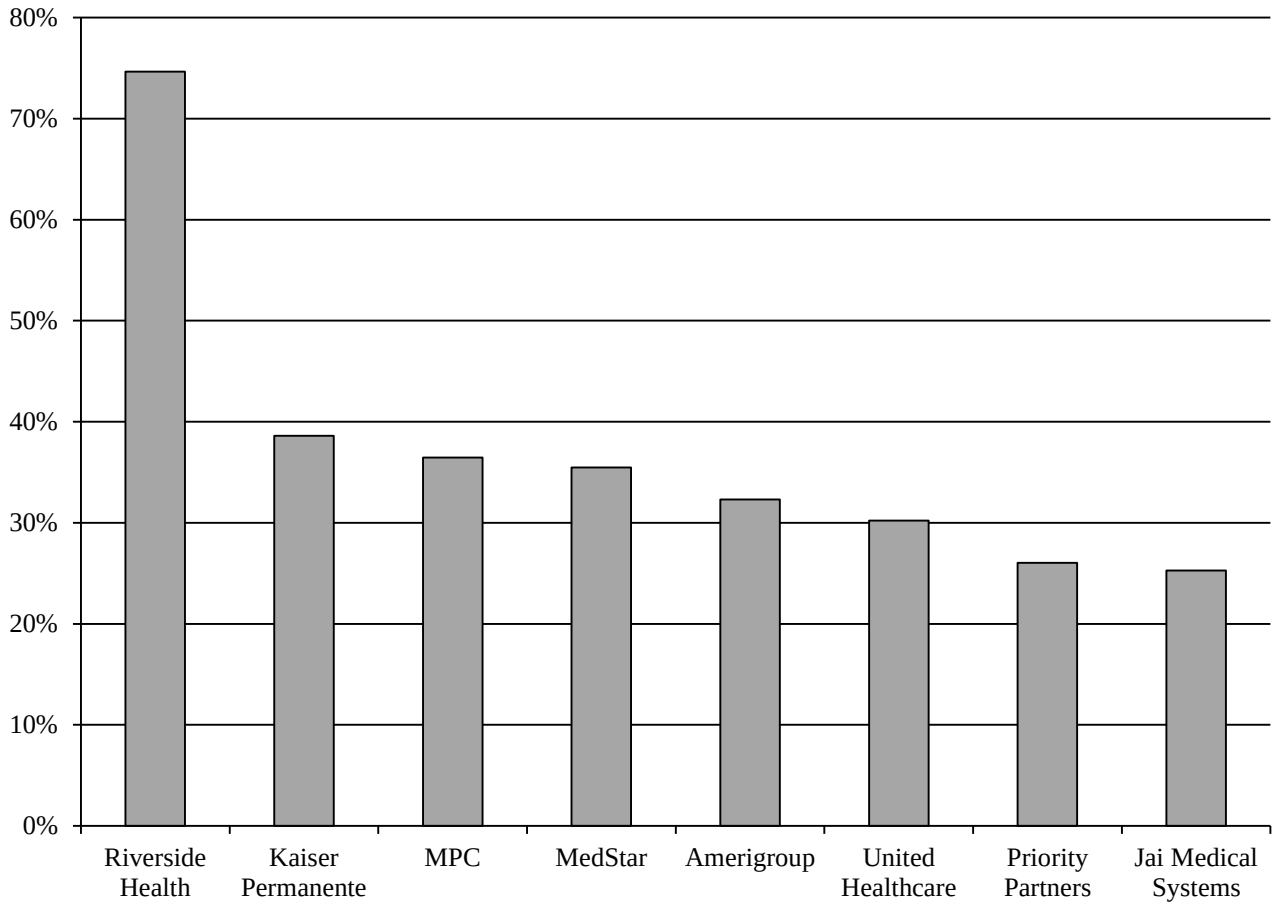
The department conducts numerous activities to review the quality of services provided by MCOs participating in HealthChoice. One such activity is the review of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a standardized set of 81 performance measures across five health care domains developed by the National Committee for Quality Assurance to measure health plan performance for comparison among health systems, and this tool is used by more than 90% of health plans across the country.

In Maryland, in calendar 2014, 53 HEDIS measures were used in the evaluation of Maryland MCOs, with a total of 105 components. The State added 21 measures for reporting in calendar 2014: lead screening in children, human papillomavirus vaccine for female adolescents, non-recommended cervical cancer screening in adolescent females, cardiovascular monitoring for people with cardiovascular disease and schizophrenia, diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, diabetes monitoring for people with diabetes and schizophrenia, antidepressant medication management, follow-up care for children prescribed attention deficit hyperactivity disorder medication, adherence to antipsychotic medications for individuals with schizophrenia, follow-up care after hospitalization for mental illness, frequency of selected procedures, inpatient utilization-general hospital/acute care, mental health utilization, antibiotic utilization, board certification, enrollment by product line, enrollment by State, language diversity of membership, race/ethnicity diversity of membership, weeks of pregnancy at the time of enrollment, and total membership. Of these measures, 7 (board certification, enrollment by product line, enrollment by state, language diversity of membership, race/ethnicity diversity of membership, weeks of pregnancy at the time of enrollment, and total membership) are descriptive in nature and not used in the following analysis.

Historically, Maryland's MCOs collectively outperformed their peers nationally. In calendar 2014, Maryland MCOs outperformed their peers nationally on 63.7% of the HEDIS components examined by the Department of Legislative Services (DLS). While this was considerably lower than in calendar 2013, it should be noted that the calendar 2014 analysis accounted for all eight MCOs including two, Riverside Health and Kaiser Permanente, that are relative newcomers to the program, and Riverside Health, in particular, had a relatively high number of HEDIS measures below the national HEDIS mean. Additionally, calendar 2014 is based on a significantly larger number of HEDIS components (96) than 2013.

Exhibit 3 shows the percentage of measures below the national HEDIS mean for those components for which a national HEDIS mean was available and for which an individual MCO had a HEDIS score. On this measure, lower scores imply better performance. It should be noted that the department considers the first year of reporting on the new measures and components to be a baseline. Nevertheless, in the exhibit, all measures and components are used. As will be discussed further, in the context of the Value-based Purchasing (VBP) program, Riverside Health's performance under the HEDIS measures is a concern.

Exhibit 3
Percent of Measurable Components Below National HEDIS Mean
Calendar 2014



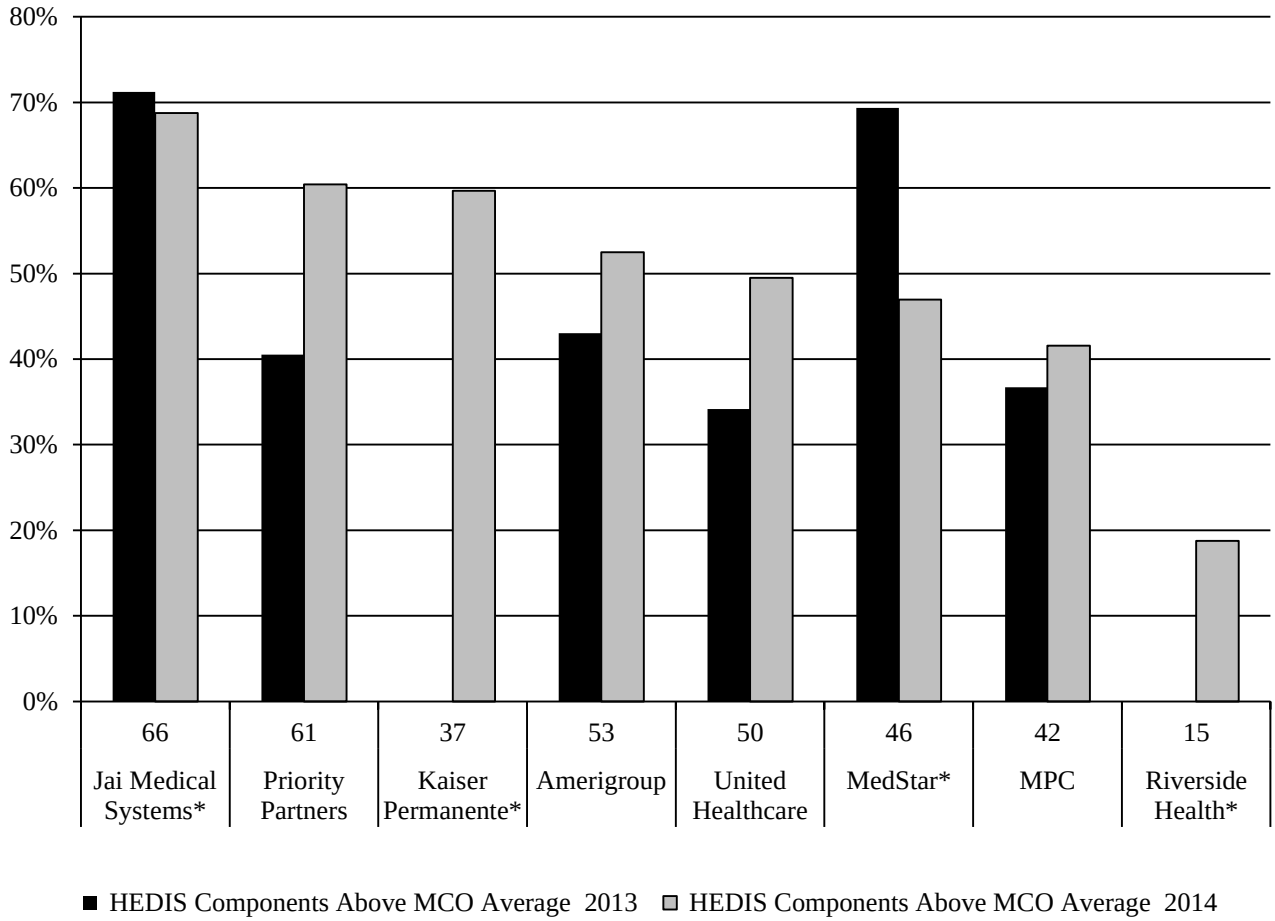
HEDIS: Healthcare Effectiveness Data and Information Set
MPC: Maryland Physician Care

Note: Lower scores imply better performance. Of the 96 HEDIS measures used in the analysis, 39 were not applicable to Kaiser Permanente, 21 to Riverside Health, 5 to Jai Medical Systems, and 3 to MedStar.

Source: Department of Health and Mental Hygiene; Healthcare Data Company; Department of Legislative Services

Exhibit 4 shows the percent of components for which each MCO scored above the average score for all of the HealthChoice MCOs. Here, the higher scores are the better performances. This data is based on calendar 2013 and 2014 and includes 79 HEDIS components in calendar 2013 and 101 components in calendar 2014. Data was either unavailable or insufficient for Riverside Health and Kaiser Permanente in calendar 2013.

Exhibit 4
Percentage of Each MCO HEDIS Components Above the Maryland MCO Average
Calendar 2013 and 2014



HEDIS: Healthcare Effectiveness Data and Information Set
MCO: Managed Care Organization
MPC: Maryland Physicians Care

*Data shown are the number of components above the Maryland MCO average in calendar 2014 for that MCO. Of the HEDIS measures used in the analysis, 39 were not applicable to Kaiser Permanente, 21 to Riverside Health, 5 to Jai Medical Systems, and 3 to MedStar.

Source: Department of Health and Mental Hygiene; Healthcare Data Company; Department of Legislative Services

Comparisons between calendar 2013 and 2014 are imperfect because the size of the data set increased significantly between the two years. Nevertheless, the following observations can be made:

- Four of the MCOs reporting data in calendar 2013 and 2014 saw an improvement in the percentage of measures with scores above the Maryland MCO average. The most significant improvement was shown by Priority Partners, a 19 percentage point increase, reversing its performance in the prior calendar year.

- Jai Medical Systems, even though its overall percentage of scores above the statewide average fell from 71% to 69%, still remains the MCO with the best overall relative performance. Medstar also saw a drop in the percentage of measures with scores above the statewide average, from 69% to 47%, undoing the significant improvement shown in the prior calendar year.

- While one of the new MCOs, Kaiser Permanente, performed well relative to other MCOs, the other relative newcomer, Riverside Health, did not. Riverside Health only had 19% of its measures above the statewide average. It should also be noted that the inclusion of Riverside Health in the analysis also would tend to lower the overall statewide averages for most measures, which might overstate the gains experienced by some MCOs relative to calendar 2013.

2. MCO Value-based Purchasing

The department uses the information collected through quality assurance activities in a variety of ways. Of particular interest is VBP. VBP is a pay-for-performance effort with the goal of improving MCO performance by providing monetary incentives and disincentives. For calendar 2014, 13 measures were chosen for which DHMH sets targets, up from 10 the prior year. Of the 10 measures from the prior year:

- 8 measures (adolescent well care, 2 ambulatory care visit measures for certain children and adults, 2 immunizations measures for certain age groups, early childhood lead screenings, postpartum care, and well-child visits for certain children) were retained;

- 2 measures (cervical cancer screening and adult eye exams for diabetics) were dropped; and

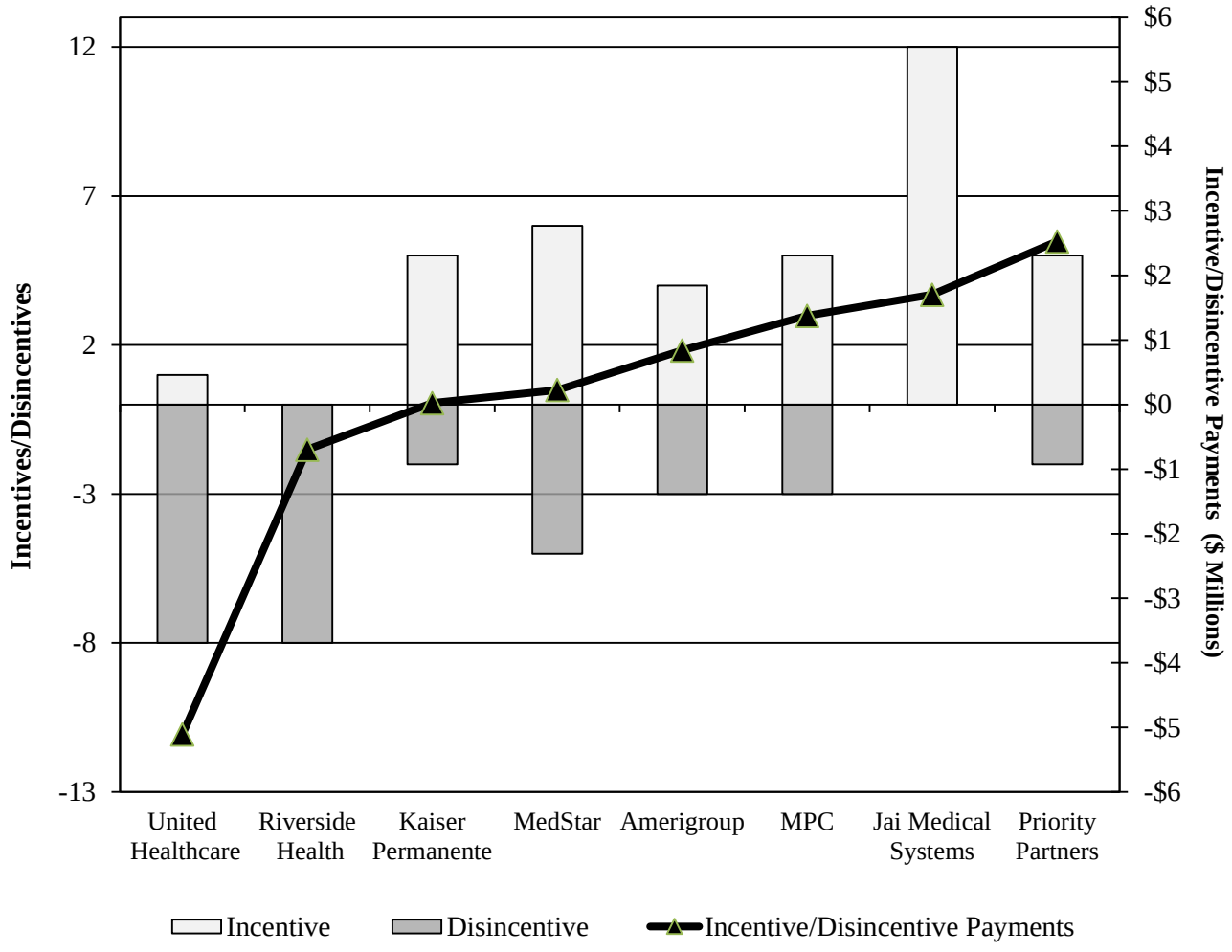
- 5 measures were added (adult body mass index assessment, breast cancer screening, comprehensive diabetes care, controlling high blood pressure, and medication management for people with asthma).

New measures were prioritized by DHMH as being consistent with core performance measures identified by the federal government for adults, reflecting the wave of adult enrollment since the expansion of Medicaid under the ACA.

MCOs with scores exceeding the target receive an incentive payment, while MCOs with scores below the target must pay a penalty. There is also a midrange target for which an MCO receives no incentive payment, but neither does it pay a penalty. Similarly, plans that do not have a sufficient population (30 participants) for any particular measure cannot earn an incentive or be penalized.

Incentive and penalty payments equal up to one-thirteenth of 1% of total capitation paid to an MCO during the measurement year per measure, with total penalty payments not to exceed 1% of total capitation paid to an MCO during the measurement year. The penalty payments are used to fund the incentive payments. If collected penalties exceed incentive payments, the surplus is distributed in the form of a bonus to the four highest performing MCOs. The results of the calendar 2014 VBP (the most recent available data), including penalty and bonus distributions, are shown in **Exhibit 5**.

Exhibit 5
Results of Value-based Purchasing
Calendar 2014



MPC: Maryland Physicians Care

Source: Department of Health and Mental Hygiene

In all, there were 38 incentive payments against 30 disincentive payments. For the first time in some years, the amount of funding to be paid out in incentives was actually above the level of disincentives collected. In total, $6.7 million in incentives are owed, with collections of $5.8 million, leaving a shortfall of $895,000. The department indicates that it will cover the shortfall to ensure that all MCOs eligible for payments receive their full payment. Obviously there was also no secondary distribution.

It is interesting to note:

- Two MCOs performed particularly poorly: United Healthcare and Riverside Health. United Healthcare has always been among the largest of MCOs, while Riverside Health, as noted above, is a relative newcomer to HealthChoice. For United Healthcare, this is the fourth consecutive year of poor performance relative to the three other large MCOs and also the fourth consecutive year where it has been the highest payer of disincentives.

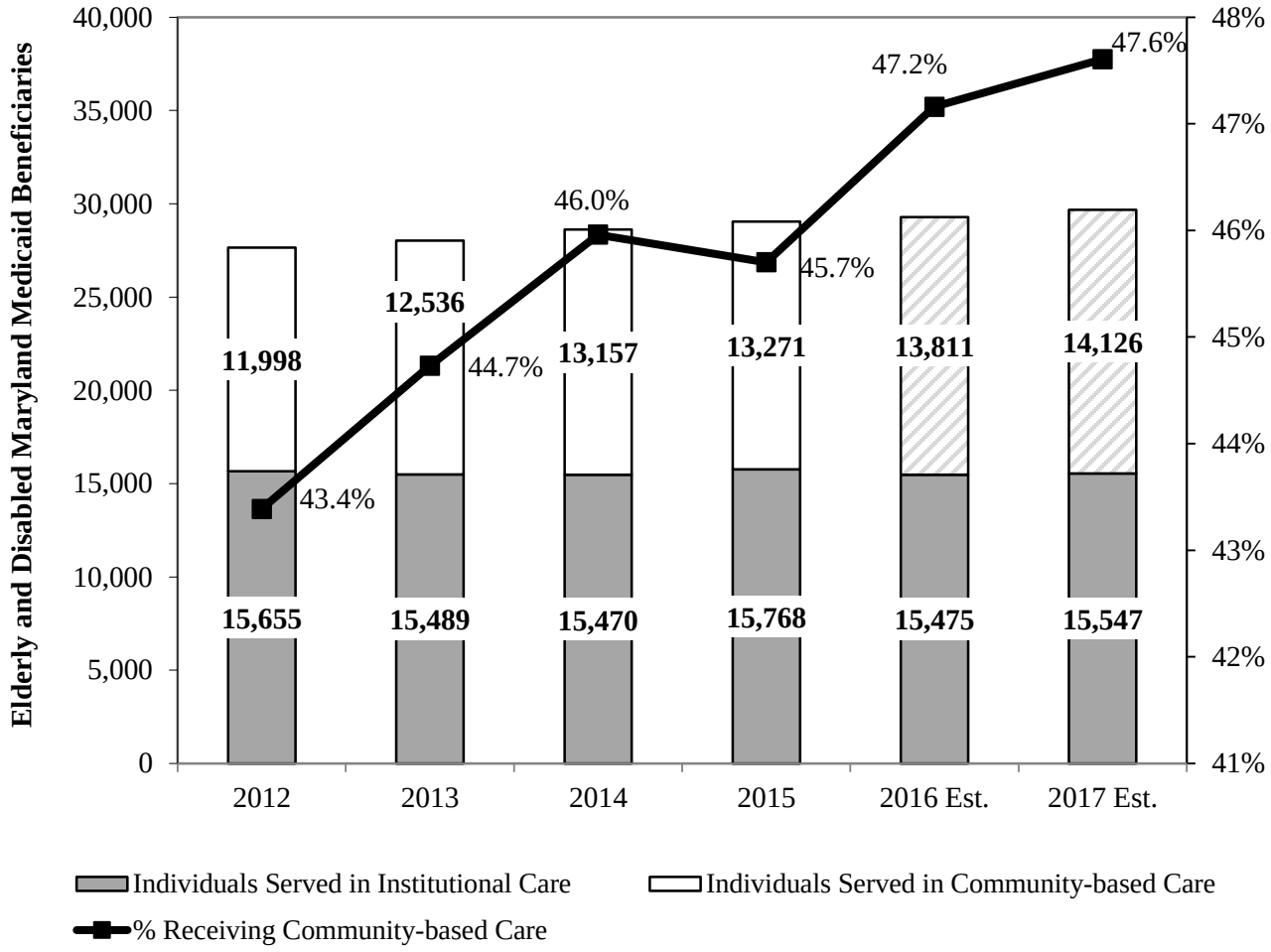
- For Riverside Health, calendar 2014 was the first year it participated in the VBP program. This MCO argued that it should not yet be considered as part of the program and cited such extenuating factors as newness and the length of time required to build the structures necessary to meet current targets; the fact that for some long-standing measures, targets have increased over time to reflect prior MCO performance; and their membership was disproportionately drawn from individuals new to Medicaid and also often new to the health care system, which created particular issues for measures that are set over a longer period as well as getting them engaged in the health care system. DHMH maintained that is was important that all MCOs participate in the program, as it represents an important measure of the quality of care being provided in HealthChoice.

- On one of the measures new to the VBP (medication management for people with asthma), none of the MCOs achieved either an incentive payment or disincentive payment for those with sufficient membership to be measured.

3. Rebalancing

In the past few fiscal years, the Medicaid program has devoted considerable effort to rebalancing long-term care services away from institutional care (nursing homes) to community-based settings. Much of this effort has been underwritten by the availability of enhanced federal funding in the ACA, including the Balancing Incentive Payment Program (enhanced funding which ended in fiscal 2016) and the Community First Choice (CFC) program. As shown in **Exhibit 6**, the rebalancing efforts that the department is undertaking appear to be generally bearing fruit in terms of the proportion of those receiving long-term care in a community-based setting. However, as shown in the exhibit, in fiscal 2015, the percentage of those receiving long-term care in a community-based setting fell slightly from fiscal 2014, although it is still higher than in fiscal 2013.

Exhibit 6
Medicaid Beneficiaries Receiving Long-term Care
By Community-based and Institutional Care
Fiscal 2012-2017 Est.

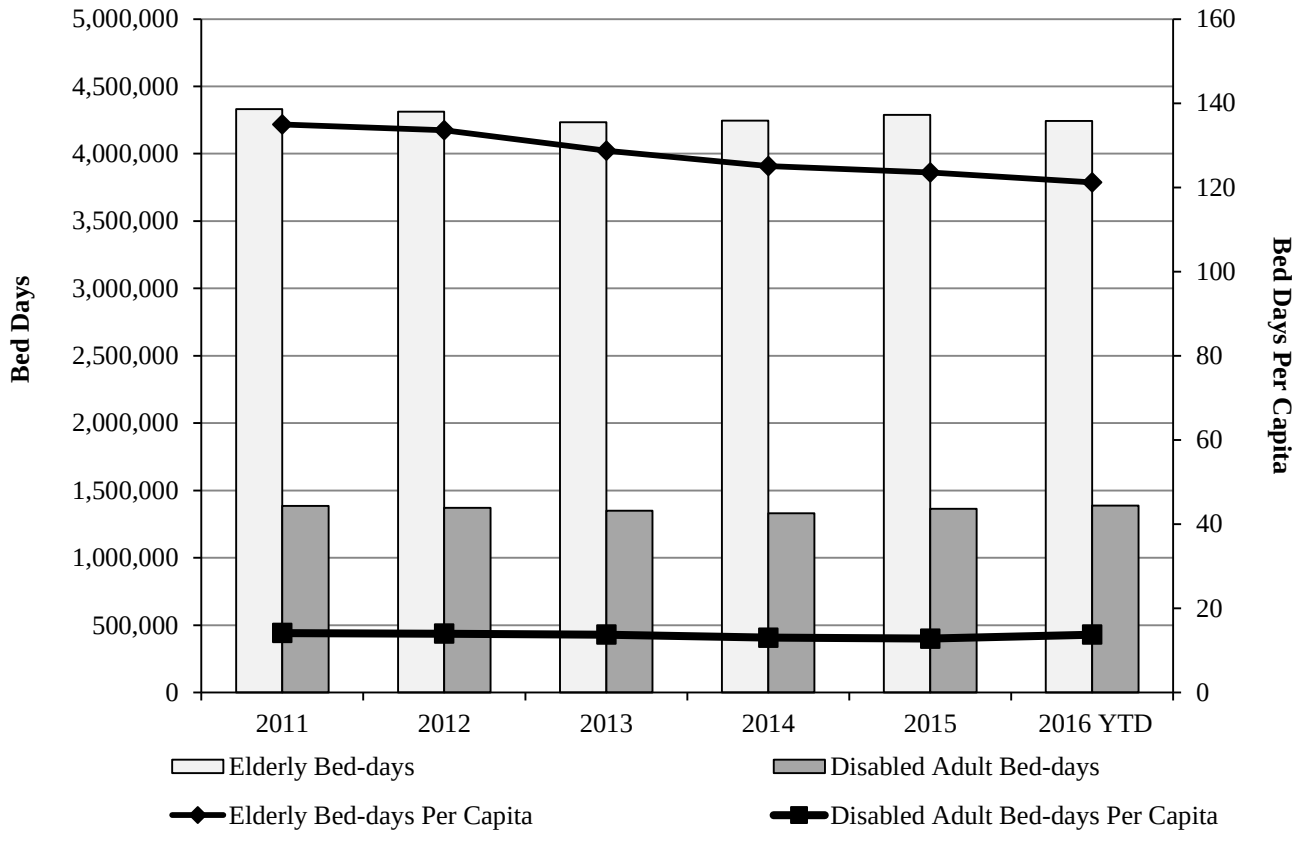


Note: Data is as reported in the first month of the fiscal year. This chart includes data for the Medical Care Programs Administration only. Long-term care funded by Medicaid is also provided through the Developmental Disabilities Administration.

Source: Department of Health and Mental Hygiene

Similarly, trends in the actual use of nursing homes by Medicaid recipients are also generally positive, although again, fiscal 2015 deviated from trends in recent fiscal years. **Exhibit 7** details trends in nursing home bed-days among the two largest Medicaid user groups of nursing home care – the elderly and disabled adults (combined using 99.3% of Medicaid-funded nursing home bed-days).

Exhibit 7
Nursing Home Utilization
Elderly and Disabled Adult Medicaid Beneficiaries
Fiscal 2011-2016 (YTD Projections)



YTD: year-to-date

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

As shown in the exhibit:

- The number of nursing home bed-days has declined by 1.5% between fiscal 2011 and 2016 year-to-date.

- Between fiscal 2014 and 2015, the total number of nursing home bed-days actually increased slightly, 78,480, or 1.4%, the first increase since fiscal 2004. The increase was exhibited among the elderly and disabled adult population. The department was unable to offer any specific

explanation for this uptick in utilization. However, between fiscal 2015 and 2016 year-to-date, the downward trend has resumed, albeit modestly at 0.43%.

- The decline in bed-days over the period fiscal 2011 to 2016 year-to-date has been among the elderly (2.0%), while utilization by disabled adults is flat.

- On a per capita basis, utilization of nursing home beds among the elderly declines by 1.9% between fiscal 2015 and 2016 year-to-date and has declined 10.2% between fiscal 2011 and 2016.

- Over the longer term, per capita utilization by disabled adults has also declined but by a lower rate, 2.8%. Although per capita utilization by the disabled appears to increase significantly in fiscal 2016, it should be noted that enrollment data for disabled adults in both fiscal 2014 and 2015 was suspect, likely overstating actual enrollment and, therefore, artificially reducing per capita utilization. Comparing fiscal 2013 to 2016, per capita utilization is flat.

Fiscal 2016 Actions

Reversions

The Governor's fiscal 2017 budget plan assumes a total of $222.2 million in reversions from the Medicaid program (excluding Medicaid behavioral health).

Reversions Attributable to Fiscal 2015

Of the total reversion amount, $34.0 million is attributed to fiscal 2015. At the end of each fiscal year, Medicaid accrues funds to pay prior year bills in the current fiscal year as providers have up to one year from the date of service to submit bills for payment. In fiscal 2015, Medicaid accrued $252.3 million to cover bills from that year to be paid in fiscal 2016. Based on data through January 2015 and recent payment history, DLS estimates that the fiscal 2015 accrual is overestimated by $38.7 million, or $4.7 million above that assumed in the Governor's budget plan. The reasons for this overestimate are similar to those discussed below with regard to fiscal 2016 reversions.

Reversions Attributable to Fiscal 2016

Of the total reversion amount, $188.2 million relates to the estimate of spending in the current fiscal year. **Exhibit 8** provides a broad explanation of the changes in the Medicaid program since the 2015 session that have resulted in the surplus of funds identified in the Governor's fiscal 2017 budget plan. This exhibit is drawn from the DLS estimate of fiscal 2016 spending in the 2015 session compared to that prepared for the current session. As shown, the most significant change is driven by enrollment and utilization. In addition to reflecting the most recent cost and utilization data, two distinct factors influence this change:

Exhibit 8
Medicaid: What Changed Since the 2015 Session
General Funds
($ Millions)

Proposed Fiscal 2016 Reversions	**$188.2**
Expenditure Changes	
Impact of Original 5.9% Calendar 2016 MCO Rate Increase on Fiscal 2016	$61.2
Impact of February 29, 2016 Additional MCO Rate Increase (to 7.3%)	14.9
Other Changes	-2.5
Department of Legislative Services Estimate of Higher than Budgeted Available Special Funds	-22.2
Higher than Anticipated Pharmacy Rebates	-36.5
Impact of July 2015 Mid-year MCO Rate Adjustment	-39.6
Lower Enrollment and Utilization	-192.1
Subtotal	***-$216.8***
Projected DLS Surplus Over Proposed Reversions	**$28.6**

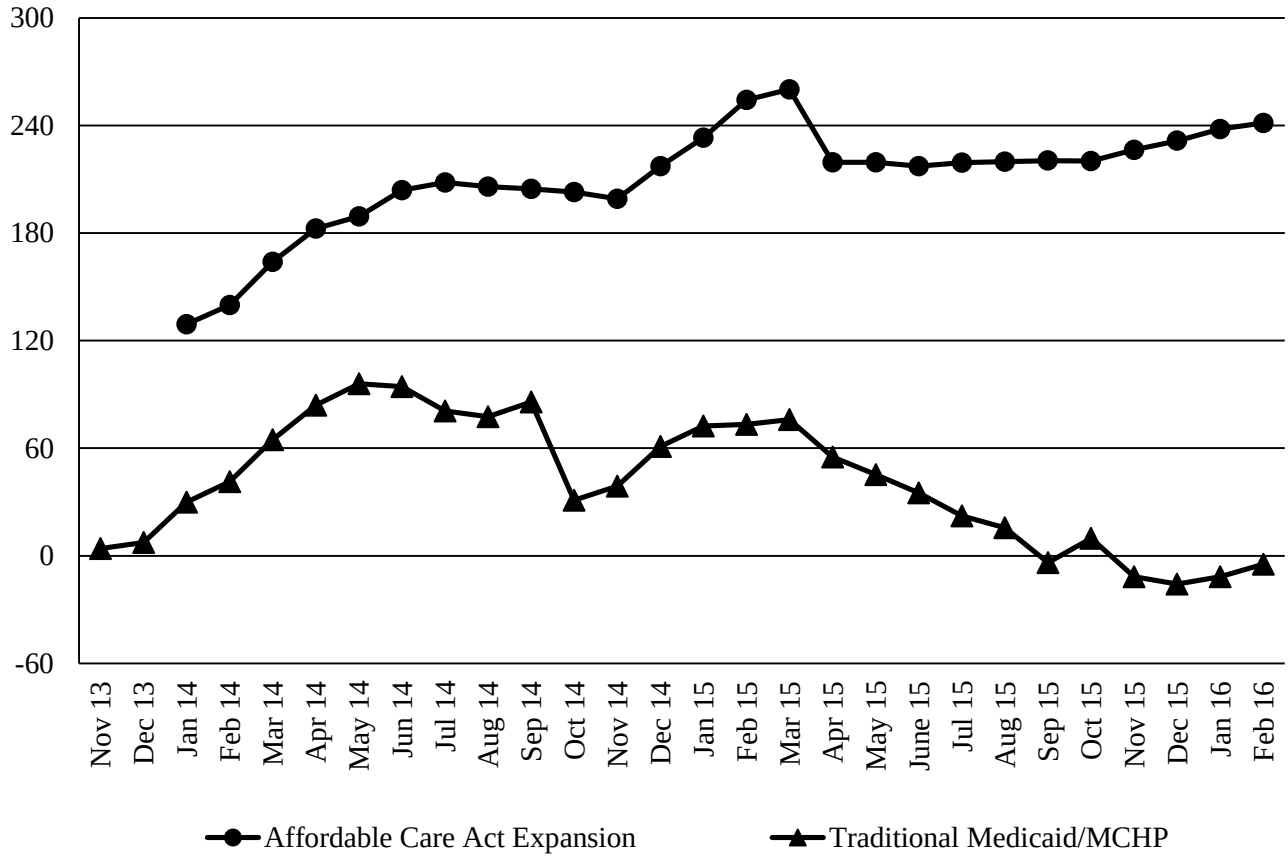
MCO: managed care organization

Source: Department of Legislative Services

- The elimination of categorization errors within the disabled adult population, which served to artificially boost the estimate of the number of disabled adults enrolled in the program. Specifically, during the 2015 session, it was assumed that there would be almost 108,000 disabled adult enrollees in fiscal 2016, and the budget was built to reflect that. Enrollment year-to-date is averaging just under 101,000. Given the relative cost of serving this population, this different assumption results in significant savings.

- The drop in the modified adjusted gross income (MAGI) population resulting from the requirement to reenroll in the new Maryland Health Benefit Exchange (MHBE) eligibility system (HBX) as enrollees in the original MHBE eligibility determination system (HIX) and in the Department of Human Resources (DHR) enrollment system (Client Automated Resource and Eligibility System) come up for annual eligibility redetermination. That process, which represents a transition from a primarily paper-based process system to a web-based, phone-assisted process, began in March 2015 and will be virtually complete by April 2016. The process has resulted in a significant drop in total enrollment as shown in **Exhibit 9**. Specifically, it is the decline in the traditional Medicaid population that has resulted in savings to the Medicaid program. As also shown in Exhibit 9, enrollment in the traditional Medicaid program has essentially returned to the Medicaid enrollment level of immediately prior to the implementation of the ACA.

Exhibit 9
Medicaid Enrollment: Cumulative Enrollment Gain/Loss
November 2013-February 2016
(in Thousands)



MCHP: Maryland Children's Health Program

Source: Department of Legislative Services

Even though the total drop in Medicaid enrollment is obviously much more significant numerically than the revision of the disabled adult population, approximately half of the savings attributable to enrollment and utilization accrues to this revision in the disabled adult enrollment. Similarly, about half of the savings are found in FFS expenditures and half in the HealthChoice program. In the HealthChoice program, approximately $60 million of the general funds savings relate to the MAGI-eligible population.

Beyond enrollment and utilization, compared to the 2016 session, significant savings were generated from a mid-year rate adjustment. The total fund impact of that adjustment was anticipated to be an increase in expenditures of $150.0 million. However, that reflected an increase in the rates for the ACA expansion population totaling $250.0 million (100.0% federal funds) offset by $100.0 million ($50.0 million general funds and $50.0 million federal funds) in reductions for the traditional Medicaid population. Some of that reduction was reflected in the fiscal 2016 allowance, but approximately $39.6 million in general fund savings were not. Other savings were generated from higher than estimated pharmacy rebates and higher estimates of special fund availability. The calendar 2016 MCO rate increase (overall 5.9% but with higher rates provided in the traditional Medicaid enrollment categories) adds $61.2 million in general fund expenditures. The department raised rates on the traditional Medicaid population by a further 2.0% on February 29, 2016, adding $14.9 million in general fund expenditures, raising overall MCO rates in calendar 2016 to 7.3%.

Taken together, as shown in Exhibit 8, DLS estimates that even with the Governor's proposed reversions, the fiscal 2016 budget is still overfunded by $28.6 million in general funds.

Cost Containment

The fiscal 2016 budget included an across-the-board general fund reduction to State agencies equivalent to 2% of general fund support. DHMH entitlement spending was excluded in calculating the amount of the cut apportioned to DHMH, which totaled just over $28.4 million. Although entitlement expenditures were excluded from the calculation of the reduction, Medicaid ultimately provided $19.4 million, 68%, of the total general fund reduction. Of this amount, $11.0 million was a fund swap in MCHP to recognize higher than anticipated revenues in the Rate Stabilization Fund. A planned reversion totals $7.8 million (which is included in the total planned reversion assumed by the Governor in his fiscal 2017 budget plan), with the remaining $587,500 in reductions from rate reductions in MCHP.

Proposed Budget

As shown in **Exhibit 10**, after adjusting for fiscal 2016 reversions and a fiscal 2017 back of the bill reduction in health insurance ($176,000 in total funds), the fiscal 2017 allowance increases by $425.2 million, 4.9%. There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency. For the purpose of Exhibit 10, DLS has allocated the general fund savings in fiscal 2016, which make up the reversions to three areas: enrollment and utilization, hospital presumptive eligibility, and pharmacy rebates.

Exhibit 10
Proposed Budget
DHMH – Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$2,437,394	$1,020,579	$5,234,691	$68,279	$8,760,943
Fiscal 2016 Working Appropriation	2,347,732	988,464	5,328,281	67,325	8,731,801
Fiscal 2017 Allowance	2,640,194	938,486	5,520,609	57,702	9,156,991
Fiscal 2016-2017 Amount Change	$292,462	-$49,977	$192,328	-$9,623	$425,190
Fiscal 2016-2017 Percent Change	12.5%	-5.1%	3.6%	-14.3%	4.9%

Where It Goes:		
Personnel	***$998***	
Employee and retiree health insurance		$1,088
Retirement contribution		997
Other fringe benefit adjustments		-111
Miscellaneous adjustments		-237
Regular earnings		-740
Provider Reimbursements (Medicaid and MCHP)	***$404,932***	
Provider rate increases (Medicaid, MCHP, and Community First Choice)		$326,689
Enrollment and Utilization		117,772
Hepatitis C kick payments to MCOs		64,984
Medicare Part A & B Premiums (increase driven by higher Part B premium costs)		24,489
Medicare Part D Clawback payment		18,100
Autism spectrum disorder additional services		13,390
Community First Choice (excluding rate increase)		7,752
Transportation grants (align to actuals)		5,806
MMIS/Systems contracts, including $2 million for modifications to the current eMedicaid portal to improve provider enrollment capabilities to allow use of the portal for new enrollments and re-validations		3,438
Health Homes (see update 4 for additional detail)		3,390
Miscellaneous adjustments to capture expenses not included in enrollment/utilization data		3,237
Graduate medical education payments		2,036
Nursing home cost settlements		901
Third-party liability recovery contract		900
Supplemental payments to Federally Qualified Health Centers (align to actuals)		-1,831

Where It Goes:		
School-based Services (reimbursable fund expenses)		-2,455
Balancing Incentive Payment Program administrative expenditures, with reductions in support for conflict free case management, training and various assessment instruments partially offset by funding for 200 new registry slots		-5,297
Money Follows the Person (alignment to fiscal 2013 and 2014 funding levels)		-5,731
Waiver enrollment and eligibility services (technical adjustment to reflect the budgeting of the Rare and Expensive Case Management as a provider reimbursement as opposed to a contract)		-10,899
Hospital Presumptive Eligibility (federal fund change only, align to actual)		-18,060
Health Information Technology payments (federal funds, align to actual)		-26,740
Pharmacy rebates (federal fund change only, align to actual rebates which have increased with the addition of Hepatitis C drugs to the list of drugs for which rebates are received)		-116,940
Other Program Changes	***$17,881***	
Health Information Exchange/Electronic Health Record Funding (federal funds)		$13,802
Major Information Technology Development Projects (see Issue 2 and Appendix 2 for additional information)		5,469
Kidney Disease Program (align to actuals)		1,454
State Innovation Models (expiration of federal grant)		-2,844
Other		1,379
Total		**$425,190**

MCHP: Maryland Children's Health Program
MCO: managed care organization
MMIS: Medicaid Management Information System II

Note: For the purpose of this chart, fee-for-service community behavioral health expenditures for Medicaid recipients are shown under the Behavioral Health Administration as opposed to Medicaid where they are budgeted. Includes fiscal 2016 deficiencies and planned reversions as well as fiscal 2017 back of the bill reductions. Fiscal 2016 and 2017 data includes funding for the Senior Prescription Drug Assistance Program, which is being transferred to the Department of Health and Mental Hygiene in fiscal 2017. Numbers may not sum to total due to rounding.

Rate Actions

As shown in **Exhibit 11**, growth in the fiscal 2017 Medicaid budget is driven by rate increases, $326.7 million. Rate increases vary by provider group. To the extent that some provider rates are not set by Medicaid, for example the Health Services Cost Review Commission (HSCRC) regulated providers, the data in Exhibit 11 reflects assumptions of rate increases.

Exhibit 11
Medicaid Provider Rates and Rate Assumptions
($ in Thousands)

Rate	Assumption
MCO Calendar 2016 Rate Increase (5.9%)	$231,295
Other Rates (Medicare, Pharmacy, and Other Services)	33,001
Inpatient and Outpatient Rate Assumption (2.85%)	23,967
Nursing Homes (2%)	23,315
Physicians (1% Increase In Evaluation And Management Codes FFS and MCO)	7,291
Community First Choice Services (1.1%)	2,771
Medical Day Care (2%)	2,404
Private Duty Nursing (2%)	2,241
Home and Community-Based Waiver Services (1.1%)	404
Total	**$326,689**

FFS: fee-for-service
MCO: managed care organization

Note: Data does not include February 29, 2016 additional rate increase.

Source: Department of Legislative Services

Unsurprisingly, the largest change is in MCO rates, $231.3 million, which primarily represents the fiscal 2017 impact of a 5.9% calendar 2016 rate increase. As is customary, no provision is made in the allowance for any calendar 2017 rate adjustment. As will be discussed in Issue 1, MCOs experienced significant losses in calendar 2015 and have expressed concern that the 5.9% rate increase in the current calendar year is inadequate. On February 29, 2016, the Administration announced an additional rate increase, bringing the overall rate increase for calendar 2016 to 7.3%. This increase adds $64.0 million in expenditures into the fiscal 2017 budget.

HSCRC-regulated inpatient and outpatient rates are budgeted to grow at 2.85%, the actual rate increase provided in fiscal 2016. The actual growth rate will be determined by HSCRC after the legislative session.

Physician rates increase $7.3 million to reflect a 1% increase in evaluation and management rates. According to Medicaid, this increase keeps those rates at 92% of the Medicare rate, which was the level at which the legislature asked the Governor to set those rates in the fiscal 2016 budget and to which the Governor ultimately agreed. However, even at 92% of Medicare, this still represents a reduction from the evaluation and management rates paid for two years when the availability of

additional federal fund support allowed the State to match the Medicare rate. Indeed, Maryland supported the rate increase for both primary care and specialty rates, although the additional federal support was only for primary care physicians (an effort to spur program participation to accommodate the growth in enrollment anticipated after January 1, 2014).

As noted in the fiscal 2016 Medicaid analysis, one measure of the adequacy of primary care networks in HealthChoice is the requirement that each MCO has a ratio of 1 primary care physician to every 200 participants within each of the 40 local access areas. However, in some areas, because of the presence of high-volume providers (*e.g.*, federally qualified health centers), that ratio can be increased to 1:2,000 adult participants and 1:1,500 for participants aged 0 to 21. The data available to assess adequacy is not perfect: it is aggregate data from all MCOs and does not allow a single provider who contracts with multiple MCOs to be counted twice; and it does not include physicians that are located in Washington, DC and since some MCOs include physicians from DC in their networks, this tends to somewhat undercount physician availability in the Washington suburbs.

These caveats aside, while not necessarily useful to see how the program truly measures up against the 1:200 primary care physician:participant standard, the data does provide some indication of where primary care networks might be considered stretched. **Exhibit 12** shows data for December 2014, after one year of expansion and prior to the announcement of the cut in physician rates. **Exhibit 13** shows the same data for December 2015 when HealthChoice enrollment was 55,000 lower than at the same point in December 2014 and after the recent cut in physician rates.

Exhibit 12
Primary Care Physician Capacity by Local Access Area
December 2014

Local Access Area	Enrollees In Excess of 1:200 Participant Ratio
Frederick	-168
Somerset	-427
Harford – East	-487
Cecil	-748
Washington	-1,246
Allegany	-1,546
Caroline	-3,079
Dorchester	-4,158
Montgomery – Silver Spring	-4,500
Baltimore City – South	-4,686
Montgomery – North	-5,239
Baltimore City – Northeast	-5,867
Wicomico	-6,944
Baltimore County – Northwest	-11,364
Prince George's – Southwest	-22,130
Prince George's – Northwest	-30,068

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

Exhibit 13
Primary Care Physician Capacity by Local Access Area
December 2015

Local Access Area	Enrollees In Excess of 1:200 Participant Ratio
Prince George's – Southeast	-132
Kent	-549
Queen Anne's	-639
Garrett	-641
Worcester	-943
Harford – East	-1,132
Prince George's – Northeast	-1,672
Somerset	-1,683
St. Mary's	-2,350
Charles	-2,850
Allegany	-4,954
Frederick	-4,976
Cecil	-5,394
Caroline	-5,492
Dorchester	-6,248
Washington	-7,422
Baltimore City – South	-7,423
Baltimore City – Northeast	-10,060
Wicomico	-10,957
Montgomery – North	-12,903
Montgomery – Silver Spring	-15,945
Baltimore County – Northwest	-17,873
Prince George's – Southwest	-25,792
Prince George's – Northwest	-42,023

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

As shown in the data, despite the drop in HealthChoice enrollment, primary care physician capacity was not as robust in December 2015 as the year before. Again, it is impossible to attribute this change to any particular factor but certainly underpins the Administration's desire to at least maintain primary care physician evaluation and management rates.

For the most part, other rates set by Medicaid increase by 2.0%, consistent with provider rate increases being provided in other areas of the budget. Interestingly, CFC and Home and Community-Based waiver service rates are budgeted to grow at a lower level, 1.1%, based on

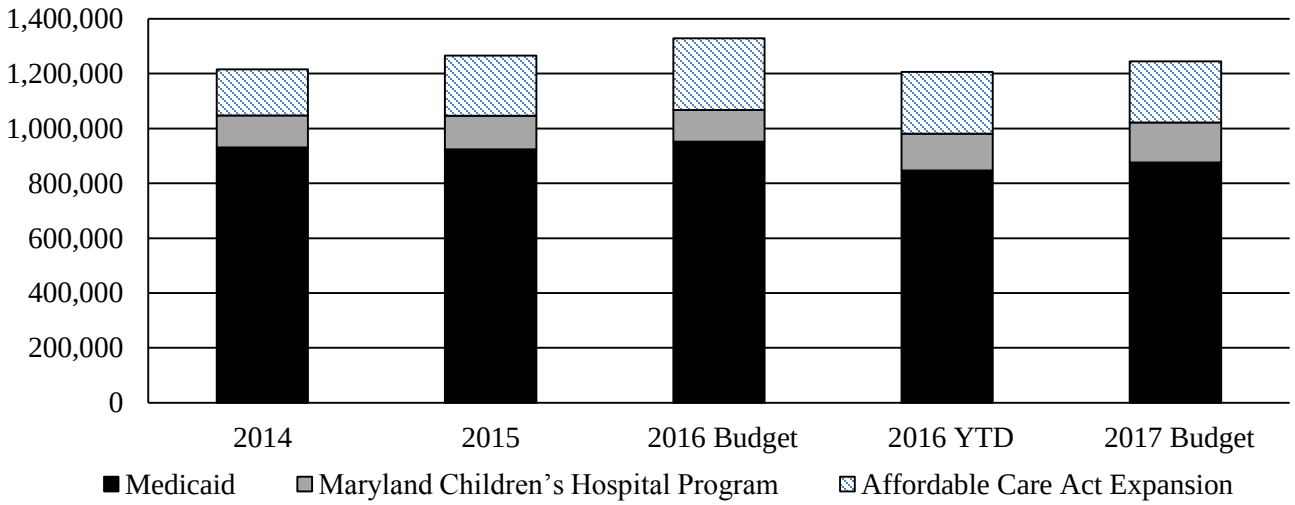
inflationary adjustments provided in regulation. In recent years, CFC and waiver services have seen rate increases above that of providers of nursing home, medical day care, and private duty nursing services. In fiscal 2017, that trend is reversed.

Enrollment

As noted above, coincident with the requirement for MAGI-eligible enrollees upon redetermination to enroll via the HBX, enrollment fell sharply in the Medicaid program beginning in March 2015. While the initial drop in enrollment was somewhat artificially enhanced by a decision to extend eligibility redetermination by three months during the second open enrollment period (to avoid issues with Qualified Health Plan (QHP) enrollment), that drop continued through November 2015 before enrollment stabilized in December 2015 and grew slightly in January 2016, the most recent data available at the time of writing. From the peak of 1.32 million in March 2015 to the low point of 1.2 million in November 2015, total Medicaid enrollment dropped by 122,000, 9.2%.

As shown in **Exhibit 14**, based on data through January 2016, Medicaid average monthly enrollment in fiscal 2016 is likely to be below the 1.26 million average monthly enrollment of fiscal 2015 and certainly well below the 1.33 million average monthly enrollment originally budgeted for fiscal 2016. The fiscal 2017 allowance assumes an average monthly enrollment of just over 1.24 million, 39,000 or 3.2% above the fiscal 2016 year-to-date average.

Exhibit 14
Medicaid Enrollment
Fiscal 2014-2017



YTD: year-to-date

Source: Department of Legislative Services

Exhibit 15 details the DLS enrollment estimate for fiscal 2016 and 2017 compared to the Administration's revised estimates for fiscal 2016 and 2017. As shown in the exhibit, DLS is projecting a slightly lower drop in total enrollment between fiscal 2015 and 2016 compared to the Administration. The DLS estimate for fiscal 2017 is a little above the Administration's, but the growth rate between fiscal 2016 and 2017 is lower.

Exhibit 15
Administration and DLS Medicaid Enrollment Estimates
Fiscal 2015-2017

	2015	Revised 2016	DLS 2016	Budget 2017	DLS 2017	Difference between Administration and DLS 2016	Difference between Administration and DLS 2017
Traditional Medicaid	917,746	847,354	861,795	875,988	878,314	-14,441	-2,326
ACA Expansion	220,189	233,516	228,434	222,250	233,003	5,082	-10,753
MCHP	122,955	136,980	135,251	146,031	139,308	1,729	6,723
Total	**1,260,890**	**1,217,850**	**1,225,480**	**1,244,269**	**1,250,625**	**-7,630**	**-6,356**

ACA: Affordable Care Act
DLS: Department of Legislative Services
MCHP: Maryland Children's Health Program

Source: Department of Legislative Services

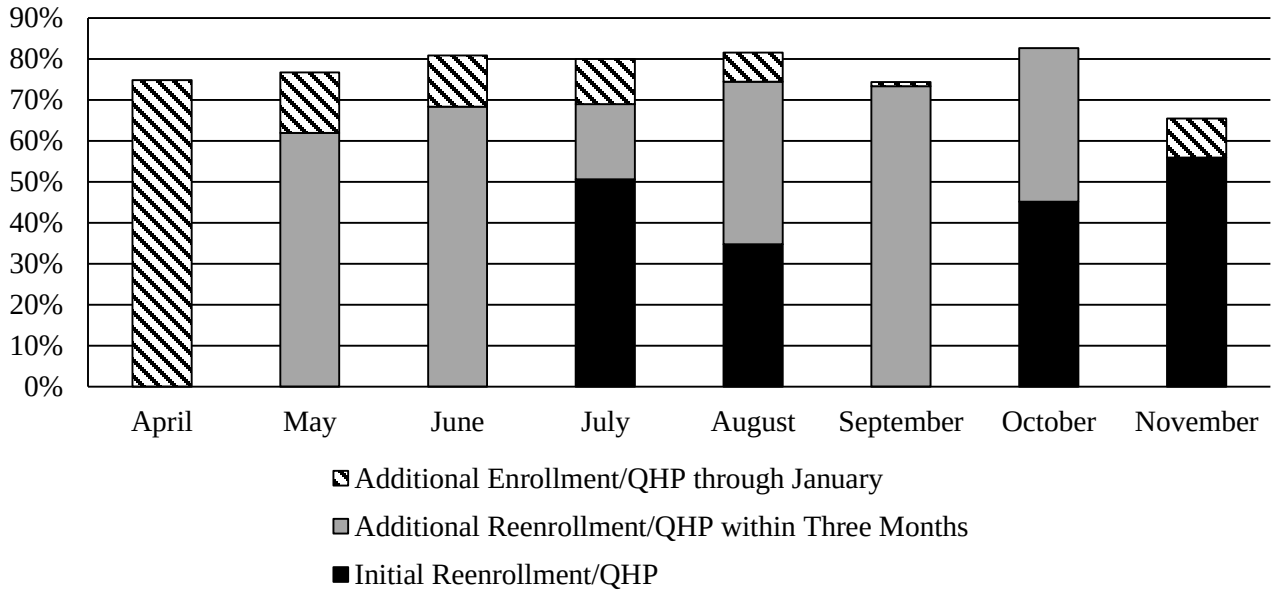
Although the two enrollment estimates do not differ tremendously, there is some difference between the various enrollment categories. In fiscal 2016, the Administration's projections in the traditional Medicaid program are over 14,000 lower than the DLS projections. In contrast, the Administration assumes higher enrollment in MCHP and in the ACA expansion category. In fiscal 2017, the difference between the two estimates in the traditional population is small. However, the Administration assumes almost 11,000 fewer enrollees in the ACA expansion category (in fact the projection is significantly lower than their fiscal 2016 estimate). Conversely, the Administration is projecting a stronger growth in the MCHP population.

One of the most frequently asked questions about the most recent enrollment decline is the extent to which those individuals who are not reenrolling in Medicaid will eventually return. An analysis of the status as of December 2015 of the April through December cohorts who have gone through the redetermination process reveals that of the 525,916 who have come up for redetermination: 392,410, 74.6%, have reenrolled; 5,954, 1.1%, were enrolled in a QHP; and 127,552, 24.3% were not

enrolled in the program. Of those enrolled in a QHP, MHBE indicates that it cannot confirm how many actually paid their first premium. Typically, about 75% of enrollees make that first payment.

As shown in **Exhibit 16**, for months when data is available, initial reenrollment rates in either Medicaid or a QHP have varied from 34.8% with the August cohort to 56.0% with the November cohort. Over time, reenrollment rates in Medicaid or a QHP vary by cohort but reach as high as 82.7% with the October cohort. What this data shows is that a significant percentage of enrollees are in fact returning to the program. Unfortunately, there is no data to compare the reenrollment rates in the period before the required reenrollment in HBX with that shown in Exhibit 16. Anecdotally, it was estimated that the average initial attrition rate was much lower (30.0%) and that about half of the attrition cases returned within three months. That would translate to a reenrollment rate over three months closer to 85.0%, about 10.0% higher than experienced in terms of returns within three months for the earlier cohorts shown in Exhibit 16, but not much different from those of later months (as high as 82.7%).

Exhibit 16
Medicaid Enrollment by Redetermination Cohort
April to November 2015



QHP: Qualified Health Plan

Note: Medicaid extended eligibility for redetermination beginning in September. The one-month data for September is unreliable and not used in this chart. Data for subsequent months appears more reliable.

Source: Department of Legislative Services

The exhibit also shows that efforts by the various State agencies involved in enrollment (DHMH, DHR, and MHBE) to facilitate reenrollment at redetermination seem to be bearing some fruit. As shown in Exhibit 16, reenrollment rates within one month and within three months have been increasing with successive cohorts.

Perhaps the most significant response on the part of the Administration came in September with a decision to extend redeterminations by one month, *i.e.*, somebody with an end of September deadline was pushed to the end of October. This one-month delay will continue through May and affords the department additional time to seek out those who have not reenrolled.

Other efforts to facilitate reenrollment have ranged from extending business hours, expanding capacity at the MHBE call center, using text messages, and making website changes. The department has also begun automatic enrollment for individuals who come up for redetermination once they are in the HBX. Automatic enrollment, as the name implies, automatically reenrolls an individual at redetermination provided that a search of various income databases affirms that the individual is still eligible for Medicaid. This should significantly increase reenrollment as individuals come up for redetermination.

For new enrollees, while some may still find the system cumbersome and time consuming to use (something that the department has publically acknowledged), automatic enrollment should also reduce the volume of activity among the various agencies and organizations involved in enrollment activity freeing up resources to assist those who need additional help. There have been calls by some groups to use paper applications for eligibility. In fact, paper applications can be used, but the nature of the HBX means that the application must be tailored to the individual applicant (*i.e.*, it is a unique application). The department indicates that few individuals have taken advantage of this application method.

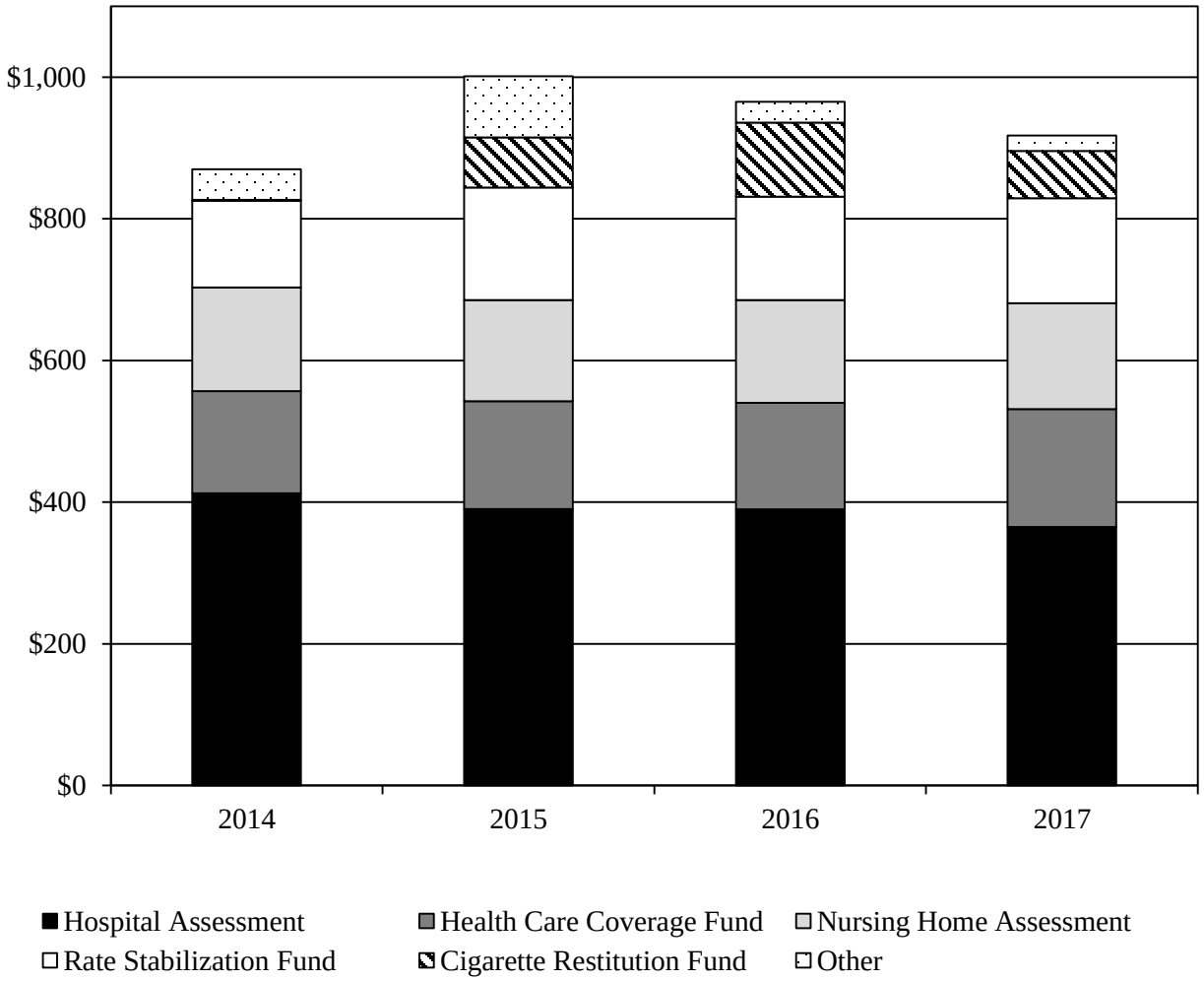
It should be noted that all of the additional efforts that have been undertaken to facilitate reenrollment as individuals come up for redetermination have also increased costs in fiscal 2016. These include, for example, the fiscal 2016 deficiency appropriations being provided to MHBE for the call center, what appear to be significantly higher than budgeted overtime costs in DHR, and the additional capitated payments resulting from redetermination delays. However, these costs certainly are below the level of savings the program has experienced as a result of lower enrollment.

In summary, with regard to enrollment moving forward, there are clearly individuals who were enrolled in March 2015 who have not reenrolled and are likely still eligible for Medicaid. This is particularly true for children, of whom there are 39,000 fewer enrolled in Medicaid and MCHP in February 2016 compared to March 2015. Some of the enrollees who have dropped off of the program are part of the normal churn seen in Medicaid and will come back onto the program as circumstances change, a small number have moved into QHPs, others may be benefiting from Maryland's relatively low unemployment rate, and some were likely ineligible in the first place.

Reliance on Special Funds Falls

As shown in **Exhibit 17,** reliance on special funds for provider reimbursements in Medicaid and MCHP falls in fiscal 2017 to $917.3 million, a drop of $47.7 million, 4.9%, from fiscal 2016.

Exhibit 17
Medicaid and MCHP Provider Reimbursement Budget
Supported by Special Funds
Fiscal 2014-2017
($ in Millions)



MCHP: Maryland Children's Health Program

Source: Department of Legislative Services

In terms of specific special fund sources, the fiscal 2017 budget includes $25 million less support derived from the Medicaid Deficit Assessment derived from hospitals. This reduction was put in place as a specific dollar reduction of $25 million per year beginning in fiscal 2016 by the Budget Reconciliation and Financing Act (BRFA) of 2014 but was temporarily stayed by the BRFA of 2015. Support from the Cigarette Restitution Fund (CRF) also falls significantly in fiscal 2017, reflecting the one-time revenue adjustment of $40 million included in the fiscal 2016 budget for the realization of funds as a result of the successful appeal of a national arbitration ruling finding that the State had diligently enforced its qualifying statute under the Master Settlement Agreement (MSA). At this time, funding of at least that amount is expected to be received in April 2016.

The loss of revenue from the deficit assessment and the CRF is partly offset by anticipated increases in support from the Health Coverage Fund, the Nursing Home Assessment, and the Rate Stabilization Fund.

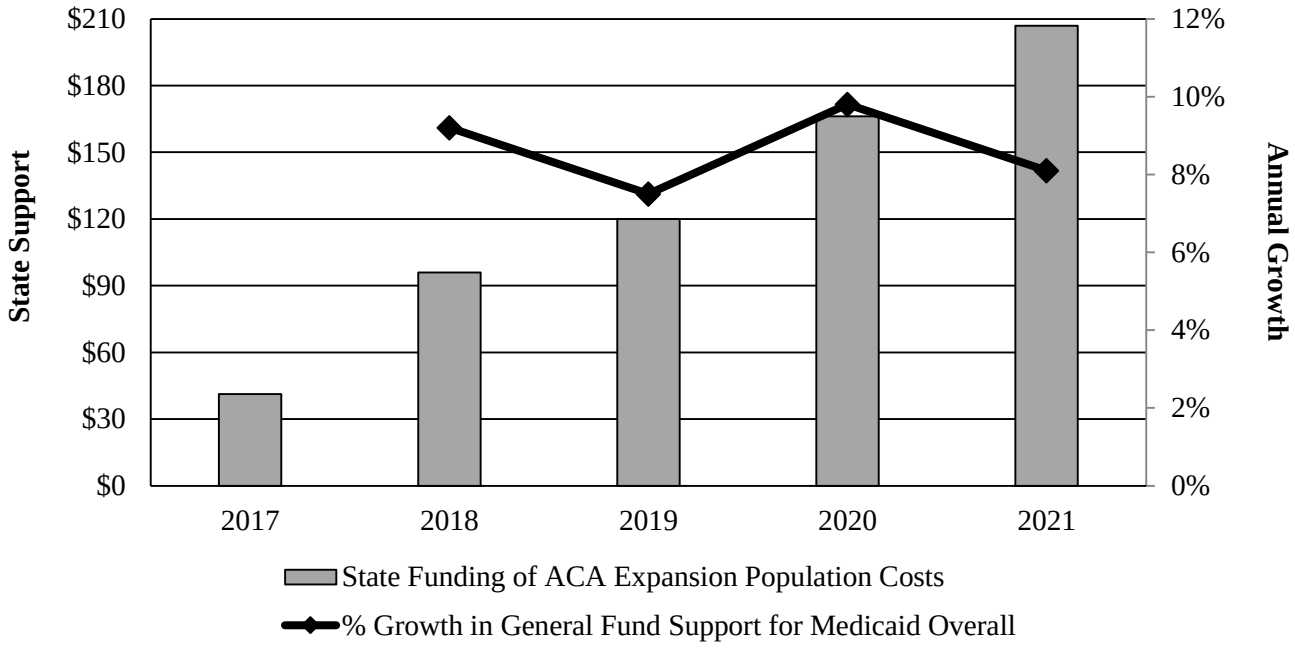
DLS would note that its estimates of special fund revenues for fiscal 2017 are $13.7 million higher than the Administration's, primarily reflecting additional attainment in the Rate Stabilization Fund and Health Care Coverage Fund.

State Support of the ACA Expansion Population

Fiscal 2017 represents the first budget that includes State support for the ACA expansion population: 5% of total expenditures for the six months beginning January 1, 2017. The State's share of expenditures in fiscal 2017 is estimated at $41.2 million. Over the next several years, the State's responsibility for the expenses of this group will gradually increase to 10%, fully phasing in by fiscal 2021. As shown in **Exhibit 18**, DLS currently estimates that State spending on that group in fiscal 2021 will be $207.0 million.

The State's growing fiscal responsibility for the spending on this group, combined with the ending of the current 23.0% enhanced match on MCHP expenditures (beginning in fiscal 2020 and completely phased out in fiscal 2021) and declining special fund support from the Medicaid deficit assessment results in significant out-year growth in the share of Medicaid expenditures that will need to be supported with general funds. For the period fiscal 2018 to 2021, annual general fund growth in Medicaid is estimated at 8.7%. This underscores the notion that while surpluses in the Medicaid program have proven to be beneficial to the fiscal 2017 budget plan, in the out-years, estimates of general fund support for the Medicaid program significantly outpace estimates of general fund revenue growth (3.3%).

Exhibit 18
State Support for the ACA Expansion Population and Annual Growth in General Fund Support for Medicaid Overall
Fiscal 2017-2021
($ in Millions)



ACA: Affordable Care Act

Source: Department of Legislative Services

Other Major Changes

There are a number of other significant cost changes in the fiscal 2017 allowance of note: additional funding for Autism Spectrum Disorder services; additional funding for Hepatitis C kick payments; and long-term care funding changes.

Coverage for Autism Spectrum Disorder

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) issued an informational bulletin offering clarification for Medicaid coverage of services to children with Autism Spectrum Disorder (a term that includes previously separately diagnosed conditions of autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger syndrome). The bulletin specifically referenced one particular therapy, Applied Behavioral Analysis, but also referred to other treatment modalities. Applied Behavioral Analysis is a practice that has been used for several

decades but has recently received national attention as a treatment for Autism Spectrum Disorder. It is typically defined as the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree and demonstrating that the interventions employed are responsible for the improvement in behavior.

The bulletin was intended to provide some clarification about whether intensive Applied Behavioral Analysis should be provided as a Section 1905(a) state plan benefit, a Section 1915(i) state plan benefit, or a Section 1915(c) waiver service. This is important because CMS and some courts have taken the position that the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit (a comprehensive array of preventive, diagnostic, and treatment services for children and adolescents under 21) must include any service coverable under Section 1905(a) that is medically necessary.

Subsequent to its July 2014 bulletin, CMS issued a clarification in September 2014 indicating that the July bulletin should not be considered as mandating coverage of Applied Behavior Analysis. Rather, state Medicaid agencies are responsible for determining what services are medically necessary for eligible children. However, states should be reviewing their benefit design for children with Autism Spectrum Disorder to ensure that programs meet obligations under current Medicaid law and regulations.

Maryland's response to the bulletin is that Applied Behavioral Analysis would be added as a therapy under EPSDT to the Maryland State Plan. The department has outlined a six-step approach to allow for the reimbursement of these services beginning in July 2016, including funding in the allowance, developing clinical criteria, amending the administrative services organization (ASO) contract to include Applied Behavioral Analysis as a covered service, amending existing regulations to reflect the change, amending the State Plan, and developing rates and ensuring provider enrollment.

The allowance includes $13.4 million in costs for fiscal 2017 based on 700 children using applied behavioral analysis. Annual costs are estimated at $38,000 per child, but the allowance assumes a gradual ramp up and reflects only a half year of costs.

Expenditures for New Hepatitis C Therapies Increase Sharply

The allowance also includes $65 million additional funding for new Hepatitis C therapies over that included in the fiscal 2016 working appropriation. Total funding for the new Hepatitis C therapies in fiscal 2017 amounts to $130 million. In the past two years, the emergence of breakthrough drug treatments, for example, Sovaldi and Olysio, offer the promise of high rates of cure with limited side effects. Indeed, taken in combination, it is reported that 94% of individuals infected with the Hepatitis C virus and with advanced liver disease were cured. However, the cost of these therapies is significant. Medicaid has established certain criteria for individuals to be eligible for the new therapies: diagnosis with chronic Hepatitis C; have liver fibrosis corresponding to a Metavir score of 2 or more; have consulted with, and had medication prescribed by, a physician specializing in infectious disease or gastroenterology/hepatology; have a treatment plan developed by a specialist; and if, of childbearing age or having a partner of childbearing age, must utilize two forms of contraception.

Most other states have adopted medical criteria like Maryland Medicaid to determine which recipients receive the new therapies. These include limiting therapies to those with certain Metavir scores (some states requiring a score of 3 or even 4), requiring some period of abstinence from abuse of alcohol or drugs, and requiring a specialist to prescribe. In November 2015, CMS issued somewhat vague guidelines about the criteria that states may impose in order to access the therapies, encouraging "states to exercise sound clinical judgement and utilize available resources to determine their coverage policies." Some medical groups have urged coverage at an earlier stage of the disease, and at least one state Medicaid program, Indiana, is being sued about its medical criteria. At this point, more states (Massachusetts, Minnesota, and Pennsylvania) are being sued for criteria for treatment used in their prison systems. According to the Department of Public Safety and Correctional Services (DPSCS), it has adopted the same medical criteria as Maryland Medicaid.

Medicaid believes that its medical criteria meets the CMS guidelines, although at the time of writing was about to send a clarification about its existing policies.

As shown in **Exhibit 19**, in calendar 2014, the first year of spending on the new therapies, Medicaid expenditures totaled just under $42.0 million. It projects spending will reach $143.0 million in calendar 2015, although through February 2015, only $57.3 million had been paid out. Documentation requirements and denial appeals have resulted in significant delays in reimbursement, a source of some irritation for MCOs, especially given current financial issues.

Exhibit 19
Spending on New Hepatitis C Therapies
Calendar 2014 and 2015

	2014 Approved Payments	2015 Paid	2015 Projections
ACA Expansion	$18,116,240	$24,728,237	$61,670,309
Traditional Medicaid	23,877,353	32,592,019	81,281,973
Total	**$41,993,592**	**$57,320,256**	**$142,952,282**

ACA: Affordable Care Act

Source: Department of Legislative Services

Long-term Care Funding Changes

In the area of long-term care, there are several funding and administrative changes of note:

- CFC funding (excluding a rate increase) increases by $7.8 million. Most of this increase is due to an increase in the estimated number of individuals being served in the waiver, 10,858,164 (1.5%) higher than assumed in the fiscal 2016 working appropriation plus an increase in the estimate of weighted plan costs.

- The budget includes $12.0 million for an additional 200 registry slots under the Community Options waiver, similar to fiscal 2016. However, spending on other activities such as conflict free case management and training and implementation of various assessment instruments included in the fiscal 2016 budget is not included in the fiscal 2017 allowance.

- Funding for Money Follows the Person (MFP) activities decreases by $5.7 million but is actually budgeted significantly higher ($14.8 million) than the most recent actual. Funding in fiscal 2017 generally aligns to expenditure levels from fiscal 2013 and 2014. According to the department, the funding levels in fiscal 2016 and 2017 are higher because of the amount of accumulated savings from prior years that need to be invested in rebalancing activities prior to the end of the MFP demonstration period in fiscal 2019.

Finally, while not a budgetary change, it should also be noted that the department announced that the implementation of its new payment system for nursing homes would be slightly revised as a result of fiscal 2016 budget actions. Under the revised plan, payments based on an approved rate (as opposed to being cost settled) would increase to 50% effective January 1, 2016 (from 25%), increase to 75% on July 1, 2016, and be fully implemented on January 1, 2017. The hold harmless provision, which had been 100% in the first year of implementation, would fall to 50% for the last six months of fiscal 2016, and be 0% in fiscal 2017.

Budget Adequacy

Based on the review of current enrollment, utilization, and cost trends and the availability of special funds not recognized in the 2017 allowance, even after taking into consideration the rate increases and program changes proposed in the fiscal 2017 allowance, DLS estimates the Medicaid budget is overfunded. Specifically, DLS estimates that general funds in the fiscal 2017 allowance are overstated by $58.1 million, of which $13.7 million is based on estimates of special fund availability above that included in the allowance. **Exhibit 20** summarizes the various Medicaid surpluses in fiscal 2015 through 2017. DLS projects the surplus over the three-year period will exceed the Administration's estimate by $91.4 million.

Exhibit 20
Estimated Medicaid General Fund Surpluses
Fiscal 2015-2017
($ in Millions)

	2015	2016	2017
Surplus Assumed in Administration Fiscal 2017 Budget Plan	$34.0	$188.2	$0.0
Department of Legislative Services Estimate of Surplus	38.7	216.8	58.1
Difference	**$4.7**	**$28.6**	**$58.1**

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

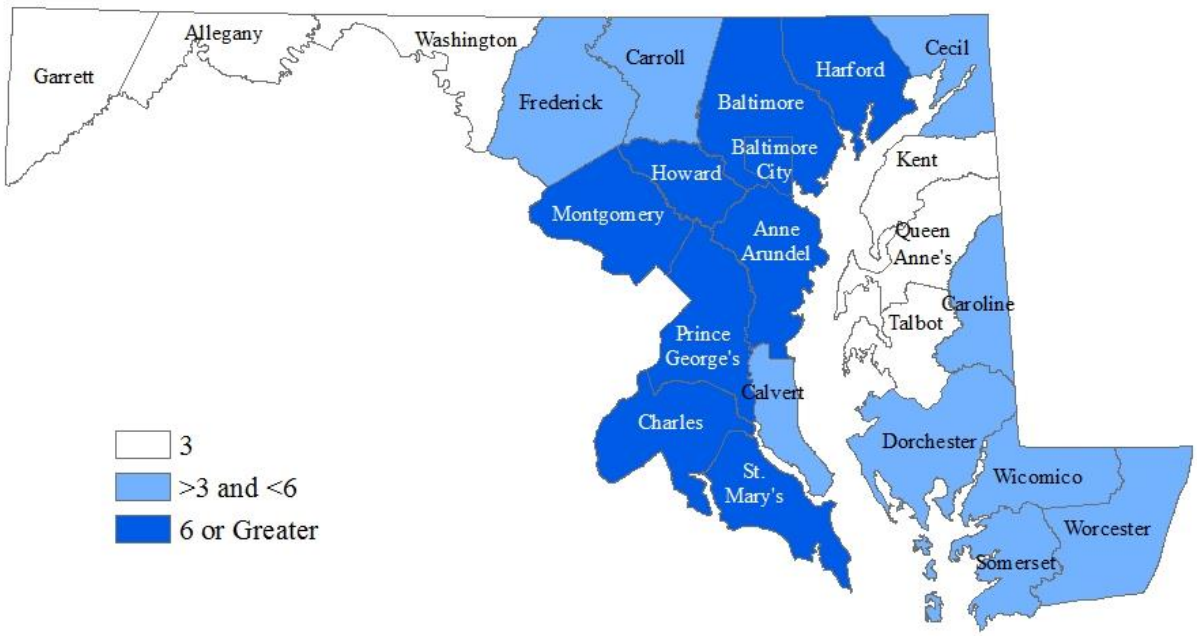
Issues

1. HealthChoice

Access to Care

Under federal rules, the HealthChoice program requires a choice of at least two MCOs in any jurisdiction unless a region has been officially defined as a rural area. MCOs make an annual determination on whether they are open or closed to new enrollees, the department would be required to seek a waiver to federal rules or operate a FFS program in that jurisdiction. As shown in **Exhibit 21**, the federal requirement is met in calendar 2016.

Exhibit 21
MCOs Open for Enrollment by Jurisdiction
Calendar 2016



MCO: managed care organization

Note: Based on January 2016 announced coverage as of December 2015. MCO-specific participation information is provided in **Appendix 3**.

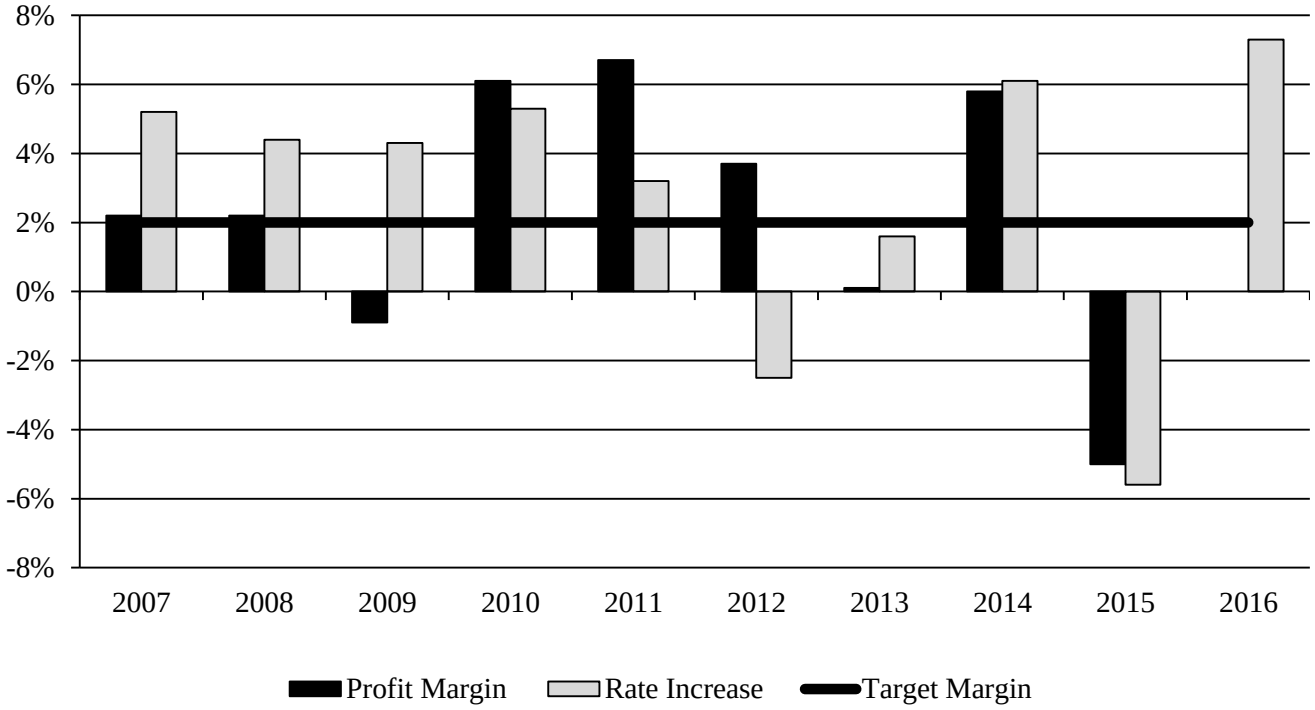
Source: Department of Health and Mental Hygiene; Department of Legislative Services

Compared to the beginning of calendar 2015, the number of MCOs open in each jurisdiction is virtually unchanged: more MCOs are open in Cecil and Frederick counties; fewer in Kent, Queen Anne's, and Talbot counties.

After Enjoying Significant Profits in Calendar 2014, MCOs Will Suffer Significant Losses in Calendar 2015

Despite virtually no change in participation in HealthChoice in calendar 2016, MCOs experienced significant losses in calendar 2015, anticipated at over $200 million, as shown in **Exhibit 22**. This is despite a mid-year rate adjustment that reduced the calendar 2015 rate cut to 5.6% and was intended to add $150 million into rates.

Exhibit 22
Managed Care Organizations
Profit Margins and Rates
Calendar 2007-2016



Note: Rates are final (accounting for mid-year adjustments) except for calendar 2016, which is the current rate prior to any mid-year adjustment. Profit margins are actual through calendar 2013. Calendar 2014 is the managed care organization (MCO) projection. Calendar 2015 is a projection based on incomplete data provided by an actuary hired by the MCOs.

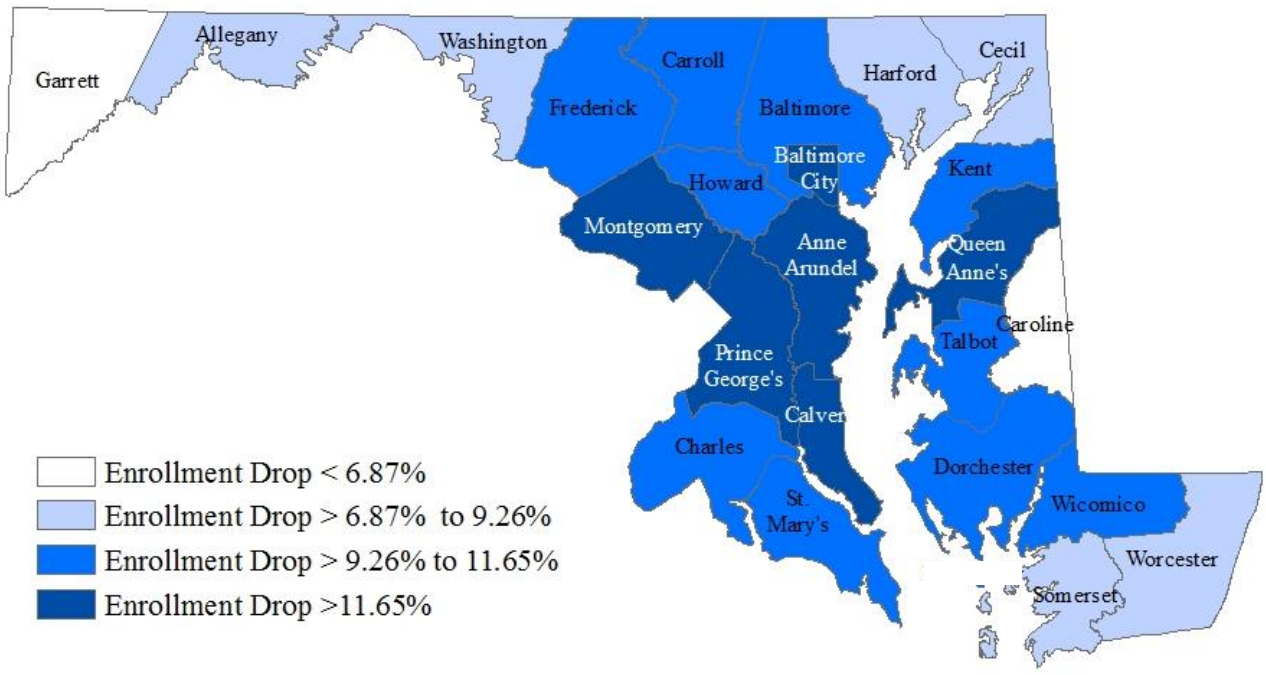
Source: Department of Health and Mental Hygiene

As noted in prior year analyses, in recent years, MCO rate setting has become somewhat of a rollercoaster ride. In particular, it has been difficult to estimate costs for new expansion populations (the Maryland expansion to parents of children in Medicaid and the subsequent ACA expansion to childless adults), with initial rates for those groups being high relative to actual experience, which results in a subsequent rate correction, and in the case of the ACA expansion population, multiple rate corrections. In calendar 2015, the impact of redeterminations has added another element of volatility.

Given that MAGI-eligible enrollees make up most of HealthChoice enrollment, it is not surprising to note that HealthChoice enrollment dropped at a slightly higher rate between March and November 2015, 11.65% (128,000 enrollees), than Medicaid as a whole. However, in the last four months, HealthChoice enrollment has begun to grow again, from just under 980,000 to just over 1.0 million. However, this is still well below the 1.1 million enrolled earlier in 2015.

It is interesting to note that the drop in enrollment has not been uniform, either between MCOs or geographically. As shown in **Exhibit 23**, for example, the drop in HealthChoice enrollment was generally much lower in Western Maryland than in most other parts of the State.

Exhibit 23
Managed Care Organizations
Enrollment Change
March 2015-November 2015



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

Similarly, the enrollment drop between MCOs showed significant variation over the same time period: three MCOs saw enrollment drops significantly above the MCO average, United Healthcare (25.4%), Jai Medical Systems (18.4%), and Riverside Health (17.6%); Priority Partners' enrollment fell much less than the MCO average, 6.5%; and Kaiser Permanente actually saw enrollment grow by 55.0%, a reflection of the fact that Kaiser Permanente is so new to the program that it really did not have as many enrollees who were subject to redetermination.

In theory, while lower enrollment results in lower capitated payments, there should be some corresponding offset of expenditures on medical expenses. However, it is the contention of MCOs that the population that has remained in the program is sicker and, therefore, consumes relatively more health care than those who have left (and on whom the MCOs would have expected to pay much less in medical expenses than received in capitated payments).

Exhibit 24 presents various MCO financial data from calendar 2014 and the first nine months of calendar 2015. In considering the data, a number of important caveats must be considered. First, calendar 2014 revenues and medical expenses include funding for substance abuse services that were carved out of HealthChoice effective January 1, 2015. As part of the calendar 2015 rate process, DHMH reduced rates 4.1% to reflect that switch. Second, MCO financial performance in calendar 2015 has varied considerably from quarter to quarter. MCOs collectively made a modest profit in the first quarter before losing heavily in subsequent quarters. In other words, the losses shown in Exhibit 23 cannot simply be annualized. Indeed, as noted above, an actuary hired by seven of the eight MCOs (all but Jai Medical Systems) is projecting collective losses in calendar 2015 of over $200 million and the MCOs aver that half of the total losses for calendar 2015 came in the last quarter.

Those caveats aside, the exhibit:

- Reiterates the point shown above in Exhibit 23 about MCO profits in calendar 2014 and losses in calendar 2015. However, it also demonstrates that on an individual MCO basis, results were somewhat different. Kaiser Permanente aside, while all MCOs made money in calendar 2014, some MCOs did better than others, Riverside Health and Amerigroup having profit margins of 7.7% and 7.2%, respectively, while United Healthcare only managed a 2.7% profit margin.

- In calendar 2015, at least through three quarters, three MCOs appeared to have been able to just about break even or make a profit: Amerigroup, Maryland Physicians Care (MPC), and Riverside Health. Even though, as noted above, it is likely that at least two (MPC and Riverside Health), if not all three, will end up losing money in calendar 2015, over the two years, they will have made a profit. Other MCOs may not be so fortunate over the two years. United Healthcare will clearly lose a significant amount over the two years, for example. This differing performance among the MCOs is important because it has a material impact on the level of need that different MCOs have for rate relief to build premium reserves and have adequate risk based capital levels.

Exhibit 24
Managed Care Organizations
Various Financial Data
Calendar 2014 and 2015 (through September 2015 only)

	Calendar 2014					Calendar 2015 (through September 2015)				
	Revenue PMPM	Medical Expenses PMPM	MLR	Pre-tax Profit/ Loss $ Millions	Profit Margin	Revenue PMPM	Medical Expenses PMPM	MLR	Pre-tax Profit/ Loss $ Millions	Profit Margin
Priority Partners	$385.77	$309.31	80.2%	$69.7	6.4%	$356.29	$333.86	93.7%	-$46.1	-6.0%
MPC	394.83	329.27	83.4%	40.8	4.6%	377.85	334.30	88.5%	-0.1	0.0%
Medstar	409.64	344.28	84.0%	17.4	5.9%	369.50	346.04	93.7%	-9.5	-4.4%
Jai Medical Systems	604.03	530.17	87.8%	8.1	4.3%	646.71	606.92	93.8%	-2.8	-2.0%
Kaiser Permanente	380.31	377.04	99.1%	-1.8	-13.5%	316.44	325.92	103.0%	-5.2	-8.1%
Riverside Health	475.22	374.98	78.9%	8.7	7.7%	408.15	348.34	85.3%	0.0	0.0%
Amerigroup	359.90	293.06	81.4%	72.7	7.2%	302.79	257.48	85.0%	12.0	1.7%
United Healthcare	416.74	361.06	86.6%	29.9	2.7%	364.28	357.08	98.0%	-68.1	-10.3%
All MCOs	**$397.19**	**$330.21**	**83.1%**	**$246**	**5.2%**	**$356.19**	**$326.4**	**91.6%**	**-$119.8**	**-3.6%**

MCO: managed care organization
MLR: medical loss ratio
MPC: Maryland Physicians Care
PMPM: per member, per month

Source: Maryland Insurance Administration Rate Filings; Department of Legislative Services

- Over the two years, the swing in profit margins for MCOs as a whole was 8.8 percentage points. However, three MCOs had swings significantly higher than the industry average: Medstar (10.3 percentage points), Priority Partners (12.4 percentage points), and United Healthcare (13.0 percentage points).

- The drop in average per member, per month revenues is unsurprising given the rate reduction in calendar 2015 (including the adjustment for substance abuse services). While per member, per month medical expenses also drop, after adjusting for substance abuse medical expenses, per member, per month medical expenses increase. Certainly, medical loss ratios (MLR) increase for MCOs as a group, up to 91.6% in calendar 2015 from 83.1% in calendar 2014, an increase of 8.5 percentage points.

- The increase in MLR from calendar 2014 to 2015 varies among the MCOs, with Priority Partners (13.5 percentage points), United Healthcare (11.4 percentage points) and Medstar (9.6 percentage points), having increases above the MCO average.

What explains the difference in performance between the MCOs? A review of various data does not identify a single answer. There are likely a combination of factors at play: patient acuity (as clearly shown in Exhibit 24 simply looking at relative per member, per month revenues); the extent of ACA expansion enrollment since the rates for this population were lowered the most significantly in calendar 2015; the impact of United Healthcare's decision to voluntarily freeze on the Eastern Shore and what they means for other MCOs, especially Priority Partners, which is the dominant plan in that region plan with just under 60% of all enrollees; the different rates of enrollment decline in certain jurisdictions, especially Western Maryland where MPC is the dominant plan with over 75% of all enrollees; and the general cost structure and efficiency of each plan.

Moving Forward: Battling Actuaries

Given the financial losses being experienced by MCOs, as noted above, MCOs, aside from Jai Medical Systems, hired an actuary to review the calendar 2015 rates. MCOs contend that because of the change in enrollee mix that resulted from the drop in enrollment in calendar 2015, the rates in calendar 2015 did not reflect actual medical costs for the smaller HealthChoice population and the rates for calendar 2016 are similarly inadequate. At the time of writing, the actuary had submitted two different financial analyses for calendar 2015 confirming the widely anticipated MCO losses and projecting similar losses in calendar 2016. The analyses contend that the calendar 2015 rates were in fact not actuarially sound.

Based on the initial financial analysis, the seven MCOs have asked DHMH for fiscal relief as follows:

- Immediate "off-cycle" relief to adjust calendar 2015 and 2016 rates. This would have an impact on both the fiscal 2016 and 2017 budgets and likely on the out-years.

- A mid-year rate adjustment to calendar 2016 rates. Based on the normal timing of this adjustment, July 1, this would only impact the fiscal 2017 budget and the out-years.

In addition, it would be expected that this analysis would also inform the calendar 2017 MCO rate-setting process, which is scheduled to begin in March.

Current Budget Outlook Provides DHMH with Room to Increase Rates

On February 29, 2016, DHMH announced an additional 2.0% rate increase for the traditional Medicaid population, effectively increasing calendar 2016 rates to 7.3%. This increase aligns rates for the traditional Medicaid population and the ACA expansion population within the actuarial rate range. This was something DHMH was going to have to do by calendar 2017. While this action injects some immediate fiscal relief into the HealthChoice program, it does not speak directly to the issue raised by the MCOs that the calendar 2016 rates do not reflect medical trend. Presumably this is something that the department could consider as a mid-year rate adjustment if the data presented by the MCOs' actuaries warrant that adjustment. **The Secretary should comment on the financial health of the HealthChoice program.**

2. Department of Health and Mental Hygiene Formally Terminates the Contract for the Medicaid Enterprise Restructuring Project

In October 2015, DHMH terminated the current contract for the Medicaid Enterprise Restructuring Project (MERP), bringing to a close a lengthy and troubled procurement (see **Exhibit 25** for a timeline). MERP was DHMH's chosen replacement for its legacy Medicaid Management Information System II (MMIS) system, Medicaid's backbone claims processing system. The existing MMIS was originally installed in 1995 and is considered to be outdated technologically, inflexible, costly to maintain, requiring numerous workarounds, and has never been fully integrated into the State's various enrollment systems.

Exhibit 25

Medicaid Enterprise Restructuring Project Timeline: Key Dates

Date	Project Milestone	Comment
July 1, 2008	Project start date	Initial cost estimate of $113.8 million with a December 2013 completion date.
Calendar 2010	Request for Proposals (RFP)	Considerable delay in the development of an acceptable RFP.

Date	Project Milestone	Comment
Calendar 2011	Initial project award rescinded	The department initially made an award of the contract to Computer Sciences Corporation (CSC) but subsequently rescinded that award because CSC would not agree to the liability provisions in the contract. After capping the liability provision, DHMH asks the two vendors who submitted best and final offers to re-bid. Only CSC submits a new offer.
December 2011	Final award made	Contract awarded to CSC.
February 2012	The Board of Public Works (BPW) awards contract	BPW awards contract to CSC. Contract value was for up to $297.1 million to include design, development, and implementation costs plus fiscal agent costs for a five-year base period ($171.0 million) with three two-year options (an additional $126.1 million).
October 2012	Revised schedule	A revised schedule is approved pushing the go-live date to the end of September 2014.
Calendar 2013	Project design issues	Significant concerns about the project emerge and the Department of Health and Mental Hygiene (DHMH) withholds payments and rejects numerous deliverables because of poor quality. Significant disagreement existed between DHMH and CSC on project scope. CSC files a contract claim against DHMH for $62 million.
January 2014	First cure notice issued	DHMH issues a cure notice to CSC related to defects with the Integrated Master Schedule.
March 2014	Second cure notice issued	DHMH issues a cure notice to CSC related to the poor quality of many of its deliverables and the failure to implement a reliable Quality Assurance process.
April/May 2014	CSC contract claim	DHMH rejects revised contract claim filed by CSC for $34 million. CSC lodges an appeal with the Board of Contract Appeals at the end of May. Case still unresolved.
August 2014	Stop work order issued	DHMH orders CSC to suspend all performance on the Medicaid Enterprise Restructuring Project for a 90-day period.
December 2014, February, March, April, May, June, September 2015	Stop work order extended	DHMH extends additional stop work orders through October 30, 2015.
October 15, 2015		DHMH terminates the contract.

Source: Department of Legislative Services

MERP: What Next?

The termination of the MERP contract leaves DHMH with three broad issues to deal with. First, there is the issue of ongoing litigation. In addition to the existing Board of Contract Appeals claim, Computer Sciences Corporation (CSC) has filed two other contract claims. Likewise, DHMH is considering claims that it may bring against CSC. The department is in the process of retaining outside counsel. The cost of that outside counsel is not yet known, although the department has identified just under $3.9 million that is available for legal costs. At this point, the expectation is that any future liabilities that the State might incur or any potential recoveries will be split 90:10 with the federal government based on the funding mix used in the original project, although no agreement is currently in place to that effect.

The second activity for the department consists of two parts: upgrade the legacy MMIS system to meet federal requirements and add enhancements it considers important; and second, extend the current operations and maintenance contract. As shown in **Exhibit 26**, the fiscal 2017 allowance includes almost $17.0 million to upgrade the legacy MMIS system, of which $2.6 million is special funds in the Major Information Technology Project Development Fund (MITPDF). As noted in the exhibit, for the most part, the funding complies with four different federal requirements as well as adding a decision support system/data warehouse capacity and the ability to improve tracking of certain activities such as financial recoveries and high-cost drugs and services. The funding provided in the budget is for planning activities.

In terms of extending the operations and maintenance contract, DHMH has decided to split the contract into two parts: it is currently considering proposals related to the provision of ongoing technical and business support and maintenance services for MMIS II; and, at the time of writing, is actively soliciting proposals to obtain operations, support, maintenance and enhancement resources for the Electronic Data Interchange Transaction Processing System, which receives claims and interfaces with MMIS.

The final issue for the department concerns workforce. MERP was conceived as a fiscal agent contract, with the vendor developing the information technology (IT) system (although still owned by the State) and operating the system. State employees who were doing the work that the vendor was to do were going to be transitioned out of the department. As a consequence, the regular workforce associated with MMIS II activities shrank, backfilled with contractual employees until the transition to the outside vendor occurred. Medicaid estimates that 9 positions in the Office of Operations, Systems, and Pharmacy were abolished during the fiscal 2013 budget cycle and believes that restoration of these positions will be important moving forward as the focus has shifted back to maintenance of the legacy system. DLS would note that Medicaid has a relatively high vacancy rate (11.6%) with more than enough vacancies to meet turnover. Notwithstanding the potential loss of positions as part of the back of the bill cut to positions, some internal reallocation of resources may be appropriate.

The department should comment on the status of hiring outside legal counsel with regard to claims surrounding MERP, the stability of the current MMIS II system, and the adequacy of available staffing.

Exhibit 26
Medical Care Programs Administration
Medicaid Management Information System (MMIS) II

Project Status	Planning.	**New/Ongoing Project:**	New. Enhancements of legacy system.
Project Description:	Implement MMIS legacy system changes to meet federal mandates and add business process improvements.		
Project Business Goals:	Meet federal requirements, reduce incorrect medical coding, improve provider reenrollment process, and add functionality to the existing legacy system.		
Estimated Total Project Cost:	n/a.	**Estimated Planning Project Cost:**	$29,933,339
Project Start Date:	December 2015	**Projected Completion Date:**	August 2017 planning only.
Schedule Status:	n/a.		
Cost Status:	n/a.		
Scope Status:	n/a.		
Project Management Oversight Status:	Normal Department of Information Technology IV&V funding included in budget.		
Identifiable Risks:	High risks identified include staffing availability, interdependence with other systems across business partners, contracted vendors, federal databases, and other State agencies, recent history with the Medicaid Enterprise Restructuring Project (MERP).		
Additional Comments:	Four elements of the project address federal requirements: a Medicaid Information Technology Assessment 3.0 assessment which must be completed before any new substantial improvements to MMIS II; incorporation of more fulsome national correct coding methodologies required by the Affordable Care Act; compliance with a federal rule on the use of a standard health plan identifier; and certification of compliance with certain Health Insurance Portability and Accountability Act requirements. The other two elements of the project are a decision support system and data warehouse (which was also part of the MERP proposal) to allow easy queries of MMIS data, and case management tools to improve areas such as application tracking, financial recoveries, eligibility determination, high-cost drugs and services, and care management for vulnerable populations.		

Fiscal Year Funding ($ in Thousands)	**Prior Years**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**Balance to Complete**	**Total**
Personnel Services	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Professional and Outside Services	5,842.1	16,980.3	7,110.9	0.0	0.0	0.0	0.0	29,933.3
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$5,842.1**	**$16,980.3**	**$7,110.9**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$29,933.3**

3. Medicaid Coverage for Lead Poisoning

In 1989, the U.S. Congress mandated that all children enrolled in Medicaid receive blood lead testing and appropriate follow-up (diagnosis and treatment).

Maryland statute requires testing for blood lead levels of children at 12 and 24 months residing in "at risk" areas of the State. Those areas are defined by zip codes and in some cases encompass an entire county. Additionally, all children living in Baltimore City and children receiving Medicaid services regardless of their place of residence are designated "at risk" and are thus required to be tested. In addition to the blood testing, at the 12 and 24 month wellness visits, a lead exposure risk assessment must be completed. Statute also requires a child under 6 years of age to have evidence of appropriate screening within 30 days of entering a child care center, family child care home, or nonpublic nursery school. Finally, the parent of a child who resides in or previously lived in an "at risk" area must provide documentation of lead testing at first enrollment into pre-kindergarten, kindergarten, or first grade. On December 1, 2015, DHMH promulgated regulations which expanded the definition of "at risk area" to include the entire State.

How Well do MCOs Do in Complying with Requirements?

Screening of children for elevated lead levels forms one of the components of the VBP program in Medicaid (see the Managing for Results section of a more detailed description of the VBP program). Data on MCO performance is presented in **Exhibit 27**. The specific measure is the percentage of children aged 12 to 23 months who are enrolled in an MCO for 90 or more days. Data is derived from MCO encounter data, data from the Lead Registry as well as fee for service data (and is validated by an outside independent entity contracted for by Medicaid). As shown, the actual incentive goal level for this measure varies each year.

Exhibit 27
Managed Care Organizations (MCO)
Value-based Purchasing Lead Screening Outcomes
Calendar 2009-2014

	2009	2010	2011	2012	2013	2014
Incentive Goal (%)	73	67	72	68	72	72
MCO Unweighted Average (%)	56	57	60	59	62	59
High (%)	77	68	75	75	79	78
Low (%)	49	50	54	51	53	43
MCOs Meeting Incentive Goal	1	1	1	1	1	1
MCOs Paying Penalty	2	3	5	3	3	6

Note: The number of MCOs is seven, except in calendar 2013, when the number of MCOs is six and calendar 2014 when the number is eight.

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

Only one MCO has consistently met the goal set, Jai Medical Systems, which is a smaller MCO drawing its membership almost exclusively from Baltimore City. Jai Medical Systems' performance represents the high percentage in each calendar year. In each of the six years of data shown, at least two and as many as six of the MCOs have a percentage of children getting lead screening that resulted in a penalty payment. The low performer for calendar 2009 through 2012 was the Diamond Plan, another smaller MCO whose performance was generally poor on all VBP measures for the period shown. The Diamond Plan left the MCO program in calendar 2013. In that year, United Healthcare was the low performer. In calendar 2014, Riverside Health is the low performer.

It should be noted that during a meeting of the 2013 Task Force on Point of Care Testing for Lead Poisoning, MCOs expressed concern that the VBP measure was different from the nationally recognized and widely used HEDIS quality measures they report on lead poisoning. Specifically, the HEDIS data set includes a measure assessing the percentage of children who had one or more blood tests for lead poisoning by their second birthday, slightly different than the VBP measure. For the first time in calendar 2014, this HEDIS measure is also included in HEDIS measures used by Maryland Medicaid. On the HEDIS measure, six of the eight MCOs have a score above the national HEDIS mean (ranging from 68.6% to 88.6%), Riverside Health is below the HEDIS mean at 53.1%, with Kaiser Permanente not reporting based on insufficient population.

DHMH contends that the VBP measure on lead screening is more tailored to the issue in Maryland where lead poisoning tends to be a bigger problem than in most other states.

Services Beyond Required Lead Screening Offered in Maryland and Other States

Generally, once a child is exposed to lead, an effective response is considered to involve three components:

- environmental investigation (an examination of the child's living environment);
- case management (involving such things as case management, individual assessment and diagnosis, service planning and resource coordination, monitoring of service delivery, and evaluation); and
- control of identified hazards (measures designed to limit exposure to lead-based hazards including interim controls and abatement).

Medicaid reimbursement for the environmental investigation is generally limited to a health professional's time and onsite investigation of a home or primary residence.

A November 2014 report by the National Center for Healthy Housing (*Healthcare Financing of Healthy Home Services: Findings from a 2014 Nationwide Survey of State Reimbursement Policies*) provides recent survey data on Medicaid coverage of follow up services for children with lead exposure. In the survey, follow-up services are defined as services that go beyond screening to include

one or more of the following: service coordination, education, environmental assessments to identify sources of lead exposure in the home, or remediation of the home environment to eliminate lead hazards.

Of the 49 states responding to the survey with regard to lead services, 18 states reported that lead follow-up services were a required service, and 7 states (including Maryland) reported that some services were in place as an optional service. The range of services provided varies from state to state. Remediation services are generally ineligible for Medicaid reimbursement and are funded in other states through complementary funding streams.

In Maryland, Medicaid reimburses for one onsite environmental lead inspection per primary dwelling. Services are limited to Medicaid enrollees under age 21 with confirmed elevated blood lead levels of over 10 micrograms/deciliter and investigations must be performed by Lead Risk Assessors who are accredited by the Maryland Department of the Environment (MDE). This service was added to the State Plan on July 1, 2009. According to Medicaid, these services were added at the request of the Baltimore City Health Department. According to Medicaid, there has been no billing for these inspections.

In addition to DHMH, two other State agencies are involved in lead poisoning prevention programs: the Department of Housing and Community Development (DHCD) and MDE. DHCD operates the Lead Hazard Reduction Grant and Loan Program to assist homeowners and landlords lessen the risk of lead poisoning for properties that are registered with MDE's Lead Poisoning Prevention Program. DHCD's program did receive a modest increase ($800,000) in the fiscal 2017 allowance, to $2 million.

Summary

Although the prevalence of elevated blood levels in children has declined significantly in recent years, exposure to lead poisoning remains a significant issue in Maryland. Medicaid has highlighted the problem of lead poisoning by including a lead screening measure within its VBP, but still a significant number of children in Medicaid aged 12 to 23 months enrolled in an MCO for longer than 90 days have not had a lead screening. Further, the follow-up services that are covered by Medicaid (onsite environmental lead inspections) appear to be significantly underutilized. This data would imply that even more attention needs to be paid to enforcing existing requirements especially with regard to screening. As to the apparent limited utilization of follow-up services, it is not clear why these are not being more heavily utilized. Lack of utilization of these additional follow-up services may explain why greater expansion of services has not been sought by Medicaid.

At the time of writing, in response to the issue of lead poisoning in Flint, Michigan, the state of Michigan has applied to CMS for a waiver to serve the affected population to include lead abatement services in homes including permanent enclosure or encapsulation of lead based paint; the replacement of surfaces and fixtures; the removal or covering of soil lead hazard; and all preparation, cleanup, disposal, and post-abatement clearance testing activities associated with such measures. While the situation in Flint is particularly egregious, it will be interesting to see the extent to which the federal

government accommodates Michigan's request and whether this can be something that other states, in turn, can extend to particular problems in their state.

DLS recommends budget bill language requesting DHMH to develop strategies to improve the extent of lead poisoning testing in the Medicaid population.

4. Senior Prescription Drug Assistance Program: Change in Gap Subsidy and Overcommitment of Fund Balance

The SPDAP provides Medicare Part D premium and coverage gap assistance to moderate-income Maryland residents who are eligible for Medicare and are enrolled in a Medicare Part D prescription drug plan. The SPDAP provides a premium subsidy of up to $40 per month toward members' Medicare Part D premiums. The SPDAP also pays a subsidy to members enrolled in certain Medicare Part D Advantage Plans when those members enter the coverage gap or "donut hole," *i.e.*, the gap between what Medicare Part D funding covers ($3,310 in prescription drug costs in 2016) and where Medicare Part D catastrophic coverage begins). Eligible individuals only have to pay a 5% coinsurance on the total prescription costs incurred in the coverage gap.

Recently, an issue arose with the donut hole coverage offered by the SPDAP. Specifically, while all Medicare advantage plans are required to participate in the general subsidy program, plans always had the option of administering coverage in the donut hole. Over the past two years, more and more plans have dropped donut hole coverage because it is difficult and costly to administer, and the administration fee is small (7%). The only plans currently offering coverage are certain health maintenance organization plans. There is also no longer a Pharmacy Only (Part D) plan (which anybody could use irrespective of their Part A&B coverage) willing to provide coverage.

In response to this problem, in February 2016, the SPDAP board provisionally decided to offer a straight subsidy of $600 to eligible individuals.

Based on the board's decision, the latest SPDAP fund forecast is shown in **Exhibit 28**. As shown, based on estimated fiscal 2016 program expenditures of $15.3 million (which is actually below actual expenditures of $16.5 million in fiscal 2015) and fiscal 2017 program expenditures of $16.8 million (below that actually budgeted of $18.0 million), because of the use of $8.3 million to fund community mental health services, the SPDAP would have a negative fiscal 2017 closing fund balance of $2.1 million. While the SPDAP has historically tended to overestimate projected expenditures, it nevertheless seems that there is insufficient funds to support the full $8.3 million appropriation in the community mental health services budget.

Exhibit 28
SPDAP Fund Balance Projections
Fiscal 2016-2020
($ in Thousands)

	Working 2016	Allowance 2017	2018	2019	2020
Opening Balance	**$1,981**	**$4,838**	**-$2,112**	**-$676**	**$600**
Income	18,125	18,125	18,125	18,125	9,006
Actual/Projected Expenditures	-15,268	-16,815	-16,688	-16,849	-8,491
Transfers to Other Programs		-8,260			
Fund Balance (After Transfers)	4,838	-2,112	-676	600	1,115
Income/Expenditures Difference	**$2,857**	**$1,310**	**$1,437**	**$1,276**	**$515**

SPDAP: Senior Prescription Drug Assistance Program

Note: Fiscal 2017 projected expenditures ($16.8 million) are lower than that assumed in the fiscal 2017 allowance ($18.0 million). HB 489 in the 2016 session extends the SPDAP to December 31, 2019.

Source: Maryland Health Insurance Plan; Department of Legislative Services

5. A Single Point of Entry for State Health and Social Services Programs

One of the goals of the original HIX was that it was to be the platform on which the State could ultimately migrate eligibility determination for all of its health and social services programs. In a perfect world, an applicant for any particular program could be determined eligible for other programs without the need for multiple applications. Somewhat lost in the failure of the HIX was the impact of that failure on this vision.

With the apparently successful replacement of the HIX by the new exchange eligibility system, the HBX, the 2015 *Joint Chairmen's Report* (JCR) requested that MHBE report back on whether the HBX was a platform on which a single point of entry could be built. In its December 2015 response, MHBE noted there is duplication and inefficiency in how health and social programs are accessed in Maryland. The report further noted that this duplication complicates business processes and adds costs throughout the system. Indeed, the report is clear that IT integration is only one part of the challenge. Perhaps the more significant task is integrating and streamlining work processes and consumer assistance services that support enrollment in the various health social services programs. The report concluded with a description of how the HBX could provide the platform for a fully integrated single point of entry over several phases (see the MHBE analysis for additional detail).

Around the same time that this report was released, DHR began circulating plans on developing a shared human services platform that can be used by multiple agencies. It is unclear based on the limited documentation currently available how these two visions complement or compete with one another. There is as yet no approved Information Technology Project Request (ITPR) document for either project, nor any approved funding.

What is clear, given the State's recent dismal history with major IT projects in the health and social services area, is that before any rush to fund any project, a number of key issues need to be resolved:

- The IT platform that is the most appropriate to base a single point of entry on, especially given the State's recent investment in HBX.

- A clear identification of all the potential IT changes that need to be made given the complexity of interactions that is required between systems, notably the legacy MMIS II system.

- Clarification of project governance, especially given DHMH's public reluctance to ally itself to DHR's call for a new shared services platform.

- The level of federal fund participation in any project. It can be expected that any move to a single point of entry system will be expensive (DHR has put forward a $179 million cost for example). Although the federal government has been willing to fund significant system modernization with a 90% Federal Medical Assistance Percentage, there is no formal agreement with the federal government as to federal financial participation on any future project nor has the required Advanced Planning Document been developed.

- The impact on business processes. There are not only multiple State level agencies (*e.g.*, DHMH, DHR, MHBE, and the Maryland State Department of Education) involved in the funding of a variety of services related to enrollment in health and social services programs, those agencies fund other locally based or local government entities (local departments of social services and local health departments) as well as nongovernment entities (*e.g.*, navigators, numerous call centers, enrollment brokers) to perform those services. Some of the players in this arena, for example MHBE, are relatively new and services have been layered over the top of those already provided by other agencies with a longstanding role in this process.

At this point, absent a funding proposal and concomitant ITPR, there is no decision to be made on the way forward technologically. However, the discussion about business processes is of particular interest and could be potentially the most complex and vexing issue because of the desire of vested organizational interests in maintaining the status quo in terms of operations and funding levels. As noted, the current service delivery model crosses state and local lines, as well as public and private. It is unclear if the complexity of this current organizational web fully welcomes people into it or too often keeps them out. **DLS recommends that DHMH solicit an independent review as to how other states organize entry points for health and social services programs in order to determine if significant organizational reform should accompany any proposed major IT development.**

Recommended Actions

1. Add the following language:

   All appropriations provided for program M00Q01.03 Medical Care Provider Reimbursements are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.

   Explanation: The language restricts Medicaid provider reimbursements to that purpose.

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

   Further provided that $100,000 of this appropriation made for provider reimbursements may not be expended until the Department of Health and Mental Hygiene submits a report to the budget committees detailing (1) ways to further incentivize managed care organizations (MCO) to increase the level of lead screening for children enrolled in Medicaid; (2) ways to encourage MCOs to take advantage of existing services available under Medicaid that are not being used; (3) how it can work with other State agencies to maximize access to existing funding for lead remediation activities in the homes of children identified by MCOs as having elevated blood levels; (4) other funding sources for remediation activities; and (5) whether it might be able to pursue a waiver for lead remediation activities like that recently requested by the State of Michigan. The report shall be submitted by November 15, 2016, and the committees shall have 45 days to review and comment. Funds restricted pending the receipt of the report may not be expended or transferred to any other purpose and shall revert to the General Fund if the report is not received.

   Explanation: The language withholds funds pending the receipt of a report from the Department of Health and Mental Hygiene (DHMH) on various elements related to lead screening of children in Medicaid.

Information Request	**Author**	**Due Date**
Lead screening of children in Medicaid	DHMH	November 15, 2016

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

   Further provided that $100,000 of this appropriation made for provider reimbursements may not be made for that purpose and instead may only be expended on an independent review of the organization of entry points for health and social services in other states to serve as a potential model for Maryland in order to (1) maximize access to those services; (2) reduce duplication, inefficiency and costs; and (3) maximize federal fund participation. The review,

together with a joint response to that review from the Department of Health and Mental Hygiene, Department of Human Resources, the Maryland Health Benefit Exchange and any other interested State agencies, shall be submitted to the budget committees by December 15, 2016, and the committees shall have 45 days to review and comment. Funds restricted for the purpose of conducting the review may not be expended or transferred to any other purpose and shall revert to the General Fund if the review is not undertaken.

Explanation: The language restricts funds for the purpose of funding an independent review on how to best organize entry points for health and social services as well as a collective agency response to that report.

Information Request	Authors	Due Date
Independent review on the organization of entry points for health and social services and a response to that review	Department of Health and Mental Hygiene Department of Human Resources Maryland Health Benefit Exchange Any other interested State agency	December 15, 2016

		Amount Reduction	
4.	Reduce funding for provider reimbursements based on current estimates of enrollment, utilization, costs, and special fund availability.	$ 58,100,000 $ 58,100,000	GF FF

5. Adopt the following narrative:

Impact of Federal Managed Care Organization (MCO) Regulatory Changes on HealthChoice: The federal government recently proposed a major overhaul of its regulatory framework governing Medicaid MCOs. Those regulations have yet to be finalized. The committees are interested in the impact on the Maryland HealthChoice program and request the Department of Health and Mental Hygiene (DHMH) to submit a report on the impact of the federal regulations on the program by December 1, 2016. If the regulations have not been finalized, DHMH should indicate that by the same date.

Information Request	Author	Due Date
Impact of federal MCO regulatory changes on HealthChoice	DHMH	December 1, 2016

Total Reductions	**$ 116,200,000**
Total General Fund Reductions	**$ 58,100,000**
Total Federal Fund Reductions	**$ 58,100,000**

Updates

1. Medical Assistance Expenditures on Abortions

Language attached to the Medicaid budget since the late 1970s authorizes the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must certify that, based on his or her professional opinion, the procedure is necessary. Similar language has been attached to the appropriation for MCHP since its advent in fiscal 1999. Women eligible for Medicaid, solely due to a pregnancy, do not currently qualify for a State-funded abortion.

Exhibit 29 provides a summary of the number and cost of abortions by service provider in fiscal 2013 through 2015. **Exhibit 30** indicates the reasons abortions were performed in fiscal 2015 according to the restrictions in the State budget bill.

Exhibit 29
Abortion Funding Under Medical Assistance Program*
Three-year Summary
Fiscal 2013-2015

	Performed under 2013 State and Federal Budget Language	Performed under 2014 State and Federal Budget Language	Performed under 2015 State and Federal Budget Language
Abortions	7,528	7,676	6,866
Total Cost ($ in Millions)	$5.4	$5.5	$5.0
Average Payment Per Abortion	$718	$720	$734
Abortions in Clinics	4,403	4,919	4,464
Average Payment	$374	$385	$392
Abortions in Physicians' Offices	2,488	2,071	1,744
Average Payment	$842	$880	$938
Hospital Abortions – Outpatient	634	680	656
Average Payment	$2,768	$2,552	$2,474
Hospital Abortions – Inpatient	3	6	2
Average Payment	$9,624	$11,680	$16,707
Abortions Eligible for Joint Federal/State Funding	0	0	0

*Data for fiscal 2013 and 2014 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2015 includes all abortions performed during fiscal 2015, for which a Medicaid claim was filed through August 2015. Since providers have 12 months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2015. For example, during fiscal 2015, an additional 967 claims from fiscal 2014 were paid. This claims lag explains differences in the data reported in the fiscal 2016 Medicaid analysis to that provided here.

Source: Department of Health and Mental Hygiene

Exhibit 30
Abortion Services
Fiscal 2015

I. Abortion Services Eligible for Federal Financial Participation
(Based on restrictions contained in federal budget)

Reason		Number
1.	Life of the woman endangered.	0
	Total Received	**0**

II. Abortion Services Eligible for State-only Funding

(Based on restrictions contained in the fiscal 2015 State budget)

Reason		Number
1.	Likely to result in the death of the woman.	0
2.	Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.	2
3.	Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health, and if carried to term, there is a substantial risk of a serious or long-lasting effect on the woman's future mental health.	6,844
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	20
5.	Victim of rape, sexual offense, or incest.	0
Total Fiscal 2015 Claims Received through August 2015		**6,866**

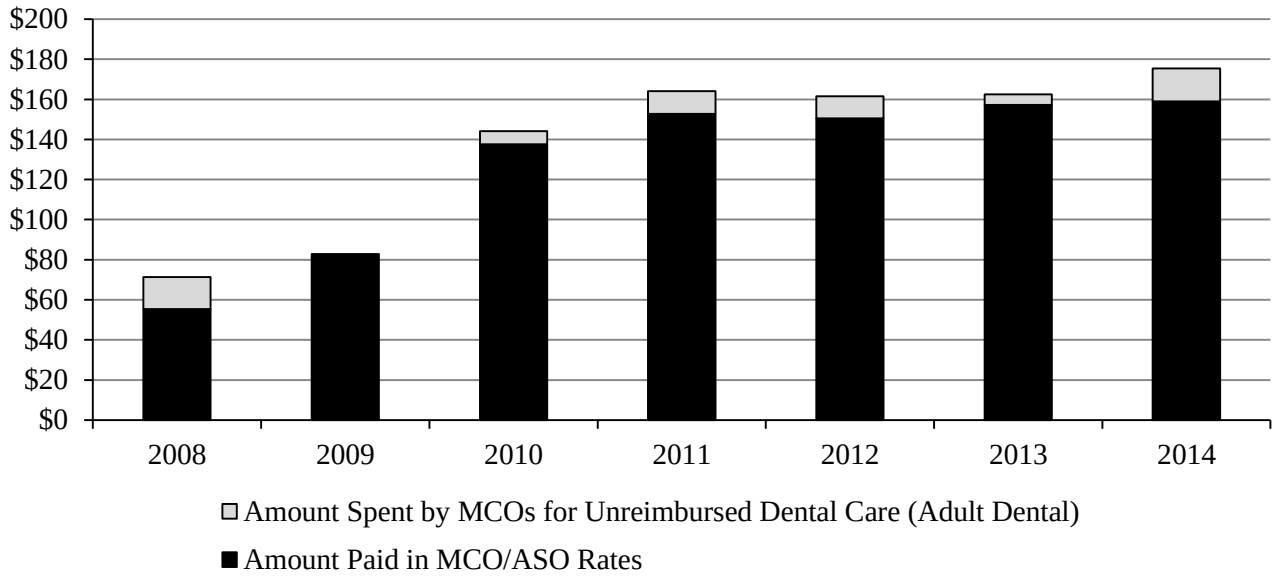
Source: Department of Health and Mental Hygiene

2. Dental Spending

As shown in **Exhibit 31**, total Medicaid spending on dental care has risen sharply in recent years. In calendar 2000, $12.3 million was included in MCO rates for dental care. In calendar 2014, spending through ASOs reached $159.0 million. This growth in expenditures corresponds with a sharp

increase in enrollment due to the recent recession; the carve-out of dental services dental benefits for children, pregnant women, and adults in the Rare and Expensive Case Management (REM) Program from MCOs to an ASO model; and fiscal 2009 ($7.0 million in general funds) and fiscal 2015 ($1.0 million in general funds) targeted rate increases. After slightly falling in calendar 2012, ASO expenditures increased in calendar 2013 and continued to grow in calendar 2014 although at a more modest pace.

Exhibit 31
MCO and ASO Dental Expenditures
Calendar 2008-2014
($ in Millions)



ASO: administrative services organization
MCO: managed care organization

Note: The new dental carve-out under an ASO began in the middle of calendar 2009. In that year, of the $82.8 million in capitated/ASO payments reported, $39.6 million was made to MCOs and $43.2 million to an ASO. In calendar 2014, ASO rates represent ASO administrative fees plus fee-for-service (FFS) claims. The unreimbursed MCO expenditures are for adult dental care. Beginning in calendar 2010, the data for an ASO is for data for all children, including those enrolled in FFS care. Prior to this time, the data reflects only those enrolled in managed care.

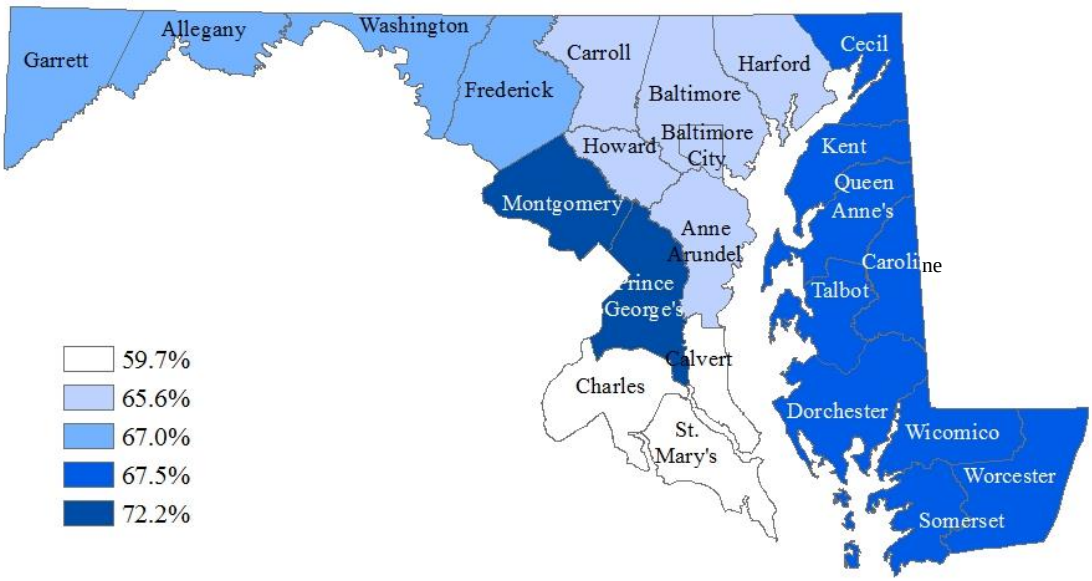
Source: Department of Health and Mental Hygiene; Department of Legislative Services

Progress in access to, and provision of, dental care in the Medicaid program can be measured in different ways. In terms of overall provider participation:

- With the implementation of the new ASO to administer dental benefits for children, pregnant women, and adults in the REM Program, there has been a gradual increase in the number of participating providers, from 649 in August 2009 to 1,385 as of August 2015. This represents a dentist to child enrollee ratio of 1:515. The target is 1:500. It should be noted that the new ASO contract for the dental program includes modest pay-for-performance standards to incentivize the ASO to demonstrate improvement in two measures: general dentist:participant and dental specialists:participant ratios.

- The 1,385 providers enrolled with ASO represented 34.4% of total active dentists as of August 2014, an improvement over the prior year. This varied from 43.7% of active dentists in Western Maryland to 26.1% in the Baltimore metropolitan area (Baltimore City, and Anne Arundel, Baltimore, Carroll, Harford, and Howard counties). Interestingly, as shown in **Exhibit 32**, there is no clear link between dentist participation and utilization. For example, Baltimore City and Baltimore Metropolitan jurisdictions have utilization rates that are just below that in Western Maryland despite the significant difference in relative participation rate by dentists.

Exhibit 32
Medicaid Dental Utilization Rates for Children Age 4 to 20
Calendar 2014



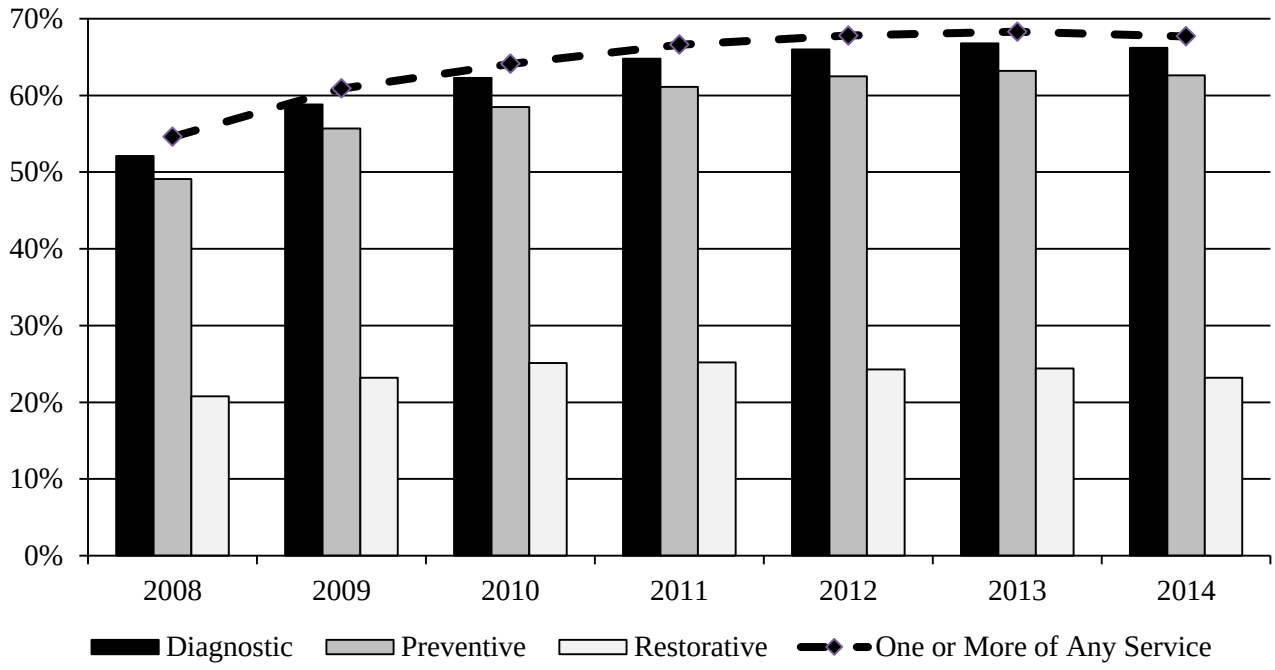
Note: Data is for all children enrolled in the program for more than 320 days.

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

- In calendar 2014, 286,713, or 67.7%, of total enrollees ages 4 to 20 with an enrollment of at least 320 days received at least one dental service. That represents a slight decline from calendar 2013. A similar drop (52.9% from 53.7%) is found for enrollees aged 0 to 20 with any period of Medicaid enrollment.

- Similarly, as shown in **Exhibit 33**, the percentage of children ages 4 to 20 receiving diagnostic, preventive, and restorative treatment all decreased from calendar 2013 to 2014. For restorative treatment, levels are at the lowest rate since calendar 2009. DHMH attributes this drop to the relatively low participation among newer enrollees. However, the percentage of children who were treated at an emergency room with a dental diagnosis held steady from calendar 2013 to 2014 (0.4% or 5,337 visits).

Exhibit 33
Various Medicaid Dental Performance Measures for Children Age 4 to 20
Calendar 2008-2014



Note: Data is for all children enrolled in the program for more than 320 days.

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

In terms of access for adults, dental benefits are only required for pregnant women and REM adults and are otherwise not included in MCO or ASO capitation rates. Nevertheless:

- The percentage of pregnant women over 21 and enrolled for at least 90 days who received dental services fell for the third successive year, calendar 2012, 2013, and 2014, from 32.5% in calendar 2011 to 27.0% in calendar 2014. Similarly, the percent of pregnant women over 14 enrolled in Medicaid for any period and receiving dental services also continues to fall over the same period from 32.7% to 26.8%. DHMH notes that currently, pregnant women are not placed in a dental home. Under the new ASO contract beginning in January 2016, pregnant women will begin to be assigned to a dental home. Also, DHMH just received a new federal grant to improve oral health utilization and outcomes among pregnant women and infants, which will also look to improve utilization rates.

- Adult dental services are not included in MCO capitation rates and, therefore, are not required to be covered under HealthChoice. In calendar 2014, seven of eight MCOs (all but United Healthcare) provided a limited adult dental benefit and spent $16.5 million on these services, up sharply from $5.3 million in calendar 2013. Much of this growth is attributed to the significant enrollment increase from the expansion of Medicaid under the ACA, effective January 1, 2014.

- However, this increase in spending did not translate into a significant increase in the percentage of nonpregnant adults over 21 enrolled for at least 90 days who receive a dental service. In calendar 2014, this number was only 13.5%, up slightly from calendar 2013 but still a long way below the most recent high of 22.8% in calendar 2011.

ASO Contract

During the 2014 interim, Medicaid took a new award to the Board of Public Works (BPW) for the ASO contract, the award being made to the incumbent DentaQuest. However, the contract was a sole-source contract as only the incumbent responded to the Request for Proposals (RFP). The Comptroller in particular raised concerns about the lack of competition and noted the short response time in the RFP. The award was withdrawn, and DentaQuest was awarded a one-year extension to allow DHMH to encourage competition.

After revising the RFP to include some limited performance measures and very limited performance risk, DHMH awarded a new ASO contract to a new vendor, Scion Dental, effective January 1, 2016. It should be noted that the prior vendor filed a contract appeal with the Board of Contract Appeals. However, it subsequently withdrew that appeal.

3. Proposed Overhaul of Medicaid and the Children's Health Insurance Program Managed Care Rules

During the 2015 interim, CMS proposed an overhaul of regulations governing Medicaid and Children's Health Insurance Program (CHIP) managed care, the first significant revision since fiscal 2002. In addition to the fact that the current regulations had not been looked at as a whole in some years, the growth of managed care and the expansion of Medicaid as a source of health care, particularly under the ACA, also prompted the federal government to look at these regulations. Nationwide, it is estimated that 76.0% of all Medicaid and CHIP beneficiaries are enrolled in managed care, the rate is slightly higher in Maryland (81.4% in fiscal 2015).

Key changes include:

- changes to the current system for establishing network adequacy standards;
- requiring states to establish beneficiary support systems to provide services both before and after enrollment in a managed care entity;
- establishing plan information standards;
- aligning the Medicaid/CHIP grievance and appeals process with those in Medicare Advantage and commercial plans;
- clarifying marketing rules;
- requiring a 14-day window and plan information prior to plan enrollment in mandatory managed care systems;
- requiring medical loss ratios and establishing an 85% MLR standard;
- significant revisions to the development and use of actuarially sound capitation rates;
- allowing capitation payments to plans for enrollees who have short-term (15 days or less) stays in an institution for mental disease (IMD) (despite the statutory IMD exclusion);
- requiring managed care quality of care ratings, including requiring accreditation;
- significant updates to program integrity standards;
- authorizing states to require certain payment methodologies to promote delivery system reform and quality initiatives; and

- clarifying that managed care formularies that do not include all drugs required to be covered by states must be covered through a FFS system.

It should be noted that DHMH submitted lengthy written comments on many detailed aspects of the proposed regulations, including for example, in the area of network adequacy. Current regulations largely leave it to the states to set network adequacy standards, and they vary from state to state. The regulations propose to require states to set time and distance standards, differentiating between different provider types, including primary care, obstetrics and gynecology, behavioral health, specialty care, hospital, pharmacy, and pediatric dental. CMS may still allow states to set their own standards, but CMS will assess the reasonableness of those standards. In its submitted comments, DHMH opposed the requirement of time and distance standards because of the difficulty in effectively implementing time standards, preferring distance only measures.

At this time, no final actions have been taken at the federal level with the regulations being sent to the Office of Management and Budget for review at the end of February 2016.

4. Evaluation of Health Homes

Background

Funding for Health Homes (formerly known as Chronic Health Homes) was part of the ACA and involves health services that encompass all the medical, behavioral health, and social supports and services considered appropriate for individuals with chronic conditions. States can choose to provide health home services to individuals based on all or certain chronic conditions. Services provided through Health Homes are eligible for 90% federal medical assistance percentage for a period of eight quarters after a State Plan Amendment for health homes is in effect. There is no time limit by which a state must submit its health home State Plan Amendment to receive the enhanced match. However, the enhanced match is effective only for eight quarters after approval.

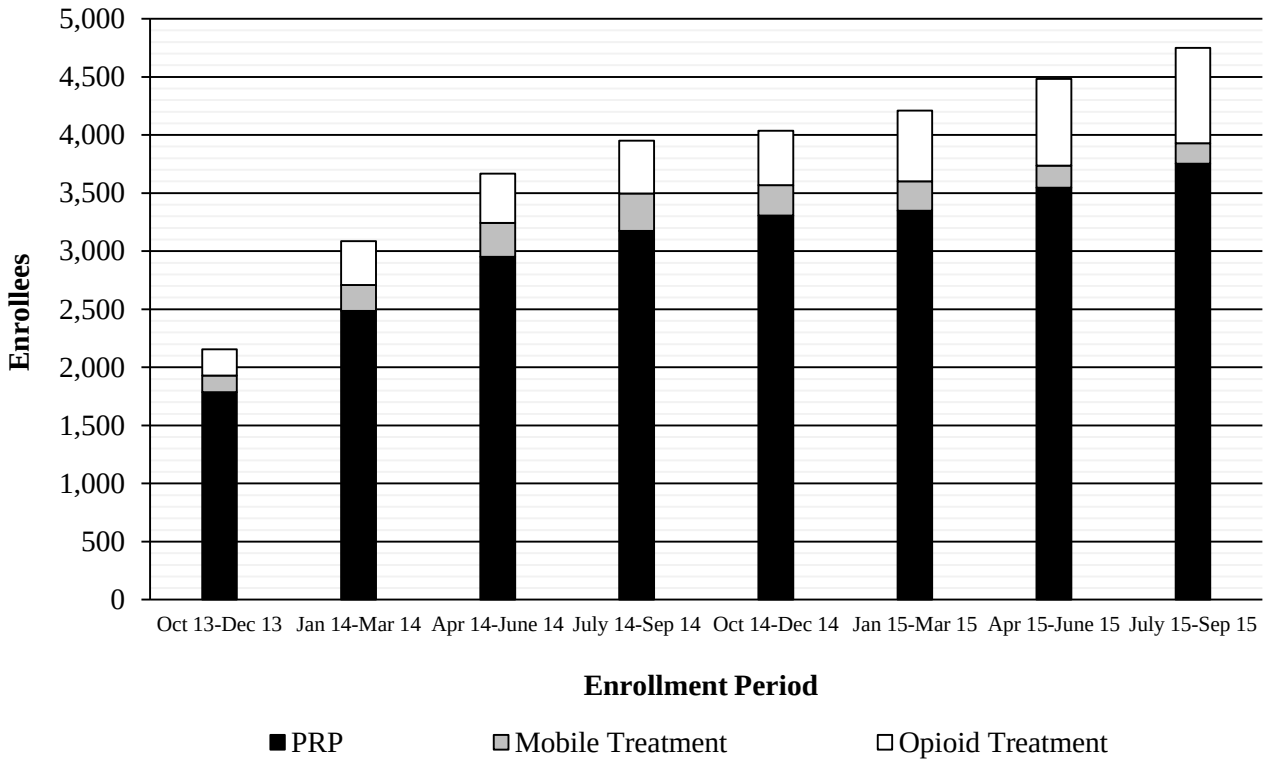
Initial Implementation

After some delay, the State's Health Homes began operation in October 2013, thus the enhanced matching period ended September 2015. The department chose to move forward with health homes aimed at individuals diagnosed with a serious persistent mental illness, serious emotional disturbance, or opioid substance use disorder and who also have one other chronic health condition with risk factors of tobacco use or alcohol abuse. Individuals must also meet certain treatment conditions and may not be receiving other case management services. As of November 2015, there were 32 providers operating 75 health homes. Of the 75 approved health homes listed by DHMH in November 2015, 60 are psychiatric rehabilitation programs (PRP), 10 are mobile treatment programs, and 5 are opioid addiction programs. Every jurisdiction except for Allegany, Calvert, and Garrett counties had at least 1 health home program.

Health home providers receive a care management fee of $98.87 per member for every month a member receives at least two qualified health home services a month plus $98.87 upon enrollment. Qualified services include comprehensive care management, care coordination, health promotion, transitional care, individual and family support services, and referrals to community and social support services.

In the quarter ending September 30, 2015, there were 4,749 enrollees who were enrolled at any point in that quarter (see **Exhibit 34**), and cumulative program expenditures had reached almost $5.9 million, in both cases numbers lower than had been originally forecast and budgeted.

Exhibit 34
Health Homes Enrollment
October 2013-September 2015



PRP: psychiatric rehabilitation program

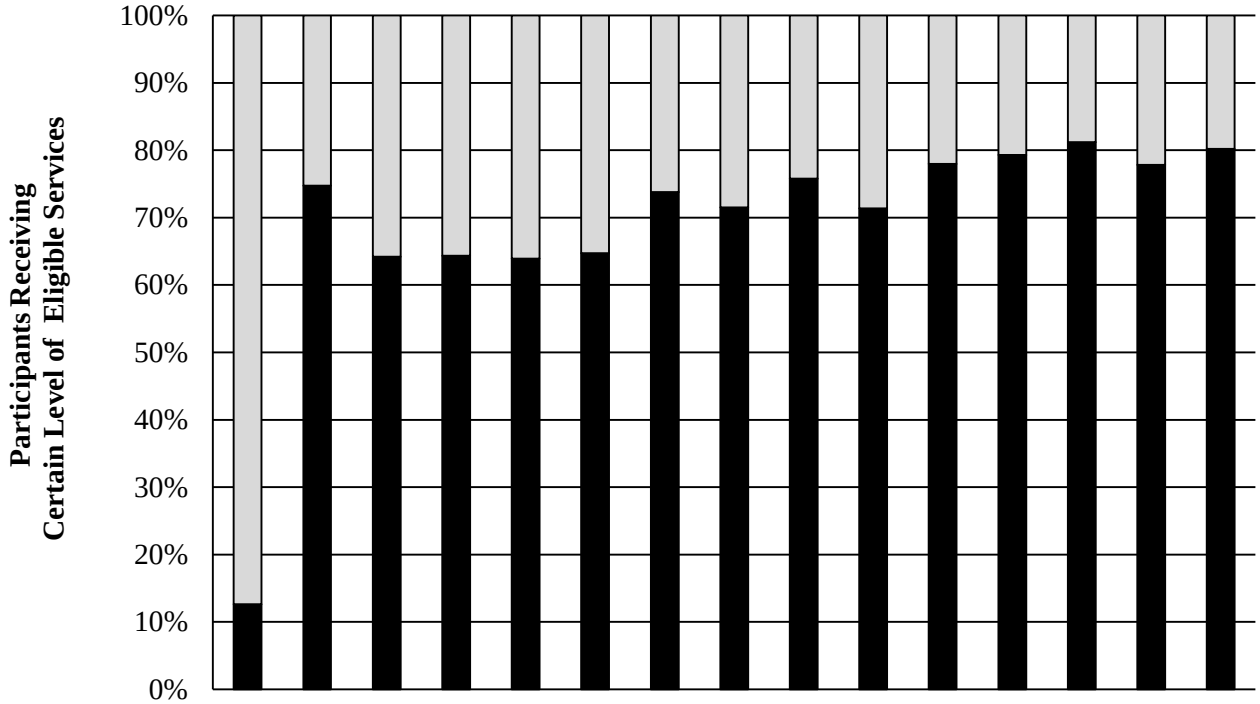
Note: Enrollment is for any participant who was enrolled at any point in that quarter.

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

As also shown in the exhibit, most enrollees are enrolled in a PRP as their health home, broadly reflective of program participation. For the quarter ending September 2015, there were 3,752 enrollees in a PRP, 178 in a mobile treatment program, and 819 in an opioid addiction program. After the initial strong growth in enrollment, enrollment growth has moderated to 6% growth in the last quarter, although this still represents a healthy annual growth rate.

Similarly, the number of enrollees actually receiving two or more eligible services in any month (and thus making the provider eligible for a monthly payment) has increased over time. **Exhibit 35** shows that the percentage of enrollees receiving two or more eligible services in the first five quarters of the program jumped quickly after the initial month and has gradually increased to around 80% by the end of the time period shown.

Exhibit 35
Health Homes Enrollment by Use of Eligible Services
October 2013-December 2014



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
□<2 services	201	196	543	745	846	933	747	876	771	949	758	724	664	800	708
■2+ services	29	580	974	1343	1500	1713	2103	2200	2413	2365	2680	2775	2873	2809	2873

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

Evaluating the Success of Health Homes

The 2015 JCR requested DHMH to submit an evaluation of the health homes program. That evaluation, prepared for DHMH by the Hilltop Institute, was submitted in December 2015. The goal of the health home program is to provide patients with an enhanced level of care management and coordination that results in lower medical costs. The evaluation compared certain health home and other Medicaid participants that met the following criteria: aged 18 to 64, continuously enrolled in Medicaid across calendar 2013 and 2014, and receipt of care from similar providers, and then also applied geographic, gender, race/ethnicity *etc*. criteria.

While the evaluation points to incremental progress, it notes the following limitations:

- insufficient time has passed to detect meaningful and sustained differences in long-term health outcomes;

- any changes that have been noted between the health home study group and comparison groups were small and given the limited data and cohort sizes difficult to specifically attribute to health home participation; and

- much of the data used in terms of Medicaid FFS and MCO encounter data takes 12 months and 6 months, respectively, to be considered final.

These caveats aside, preliminary analysis suggests:

- Health home participants had a slightly higher increase in ambulatory care services compared to the comparison group.

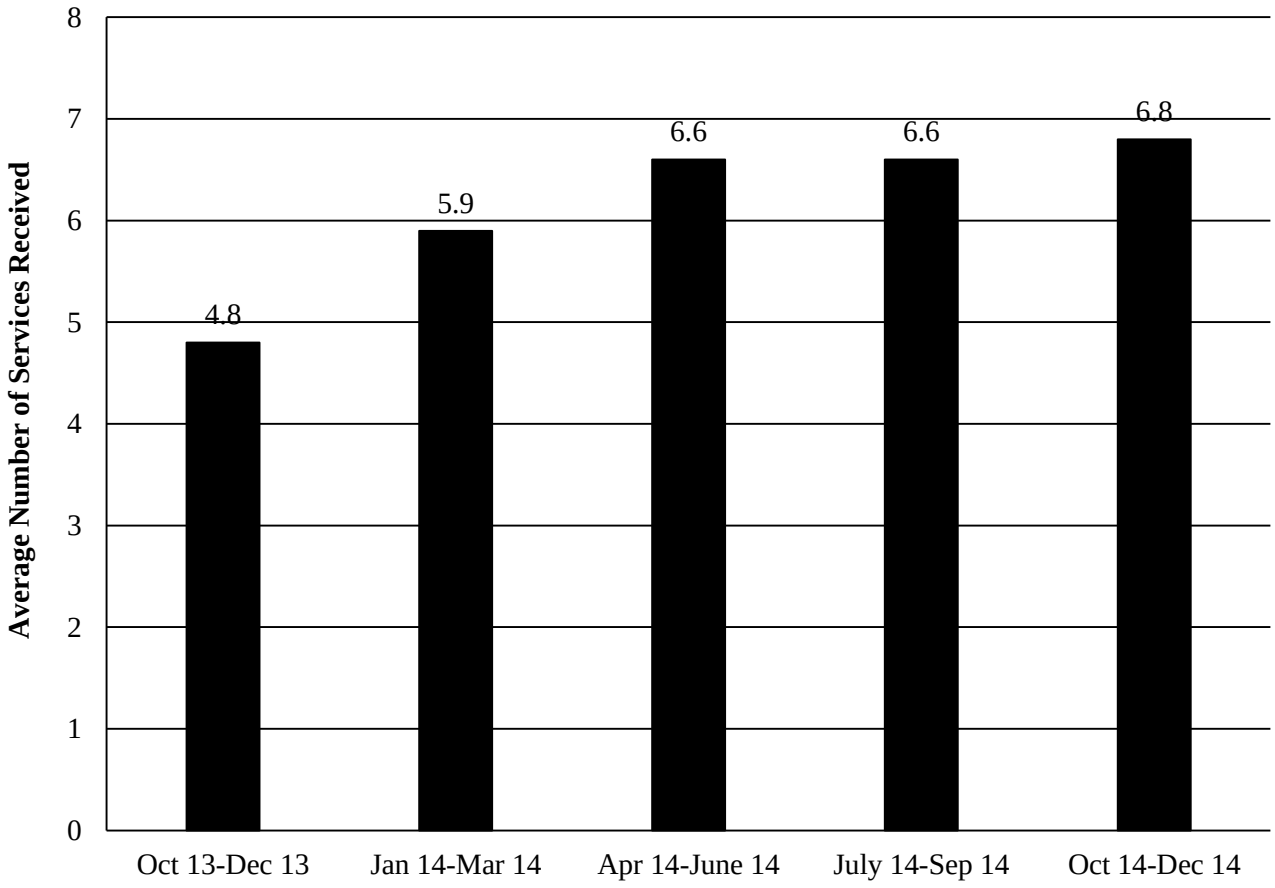
- Although members of the comparison group had higher utilization of health care services generally, their use of inpatient hospitalization, extent of emergency department visits, 30-day all-cause hospital readmissions, and avoidable emergency room visits all fell greater than the participants in health homes.

- Within health homes, participants in health homes operated by a mobile treatment provider had a higher percentage of inpatient hospitalizations, emergency department visits, and 30-day all-cause hospital readmissions when compared to participants in programs operated by opioid treatment providers and PRPs. The report speculated that this could reflect that participants in mobile treatment programs are considered more at risk than other health home participants.

- Health home participants have taken advantage of the health home services made available to them, services which should link them to social and somatic services, which in turn, increase access to preventive care. As shown in **Exhibit 36**, for participants who receive at least one eligible service, participants have increased their use of those services over time. By the last quarter of fiscal 2014, half of these participants were receiving comprehensive care

management and coordination and health promotion services. Far fewer, 10% or less, were receiving transitional care or referral to community and social support.

Exhibit 36
Health Homes Use of Eligible Services by Participants Receiving at Least One Health Home Service
October 2013-December 2014



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

The report also notes that in other states that began health home implementation earlier than Maryland, data is still limited. According to the submitted report, only two states (Missouri and Iowa) had sufficient data to include post-intervention information in available reports. Results were mixed: improvements in such areas as emergency room visits and lower per member per month costs but less or negative impact in areas such as preventive care visits. However, some of the caveats noted above in terms of data limitations also apply to those studies.

Conclusion

The report notes that Maryland intends to continue to evaluate its program and hopes that with additional time, more concrete trends including expenditure data can be included in an evaluation that must be submitted to CMS in 2016. At this time, funding for Health Homes in included in the fiscal 2017 budget.

5. Access to Pharmacy Networks

During the 2015 session, United Healthcare MCO announced a change in its pharmacy network. Although the original proposal met network adequacy standards set by DHMH, Chapter 309 of 2015 required the department to develop a plan, and submit a report detailing that plan, to ensure MCO enrollees have reasonable access to pharmacy services if an MCO makes changes to its pharmacy network that reduces the number of providers or alters the location of pharmacy services.

Although not a required benefit, Maryland (like all other states) includes a pharmacy benefit in its Medicaid benefits package. MCO pharmacy benefits amounted to $448 million in calendar 2014. The current network adequacy standards for MCO pharmacy services are as follows:

- in urban areas, pharmacies shall be within 10 miles of each enrollees residence;
- in rural areas, pharmacies shall be within 30 miles of each enrollees residence; and
- in suburban areas, pharmacies shall be within 20 miles of each enrollees residence.

The department may waive these requirements under special circumstances provided that the overall strength of the MCO network serves to enhance the quality of care in any given area. The department does not give a waiver to any of the MCOs currently participating in HealthChoice. It should be noted that the current network adequacy standards represent a change from those in place prior to calendar 2014 when there was also a time-based standard. This standard was removed because it was considered unreliable and difficult to implement.

Monitoring Compliance with Network Adequacy Standards

In its submitted report on how it monitors MCO compliance with pharmacy service network adequacy standards, the department points to a number of efforts including: (1) prior to an MCO joining the HealthChoice program, there is an extensive review process; (2) once in the program, changes in provider networks are reviewed by the department; and (3) MCOs must participate in a System Performance Review (SPR) process. The SPR process is conducted by an external quality review organization (the cornerstone of DHMH efforts to ensure compliance of the HealthChoice program with federal regulations requiring states to hold MCOs accountable for the adequacy of

provider networks) and includes specific provider network requirements that relate to access to pharmacy services.

Opportunities for Additional Savings

In the report, the department notes that it opposes so-called "any willing provider" laws that require MCOs to contract with any willing pharmacy provider. It continues to believe that permitting MCOs to utilize pharmacy benefit managers (PBM) to limit pharmacy networks can achieve program savings without limiting access to medications and services. Currently, all MCOs use a PBM, although only four limit pharmacy networks (and even in those limited networks there are both chain and independent pharmacies). The department estimates additional savings could be made in the HealthChoice program if all MCOs used a PBM.

Additionally, the department looked at the issue of mail-order pharmacies and the interplay of these pharmacies in assessing network adequacy (currently the availability of a mail order option is not considered). The department believes that for enrollees with limited mobility due to health conditions or limited access to transportation, mail-order pharmacies can offer another option. DHMH points to studies that indicate that the use of mail-order pharmacies could increase medication compliance rates, improve health outcomes, increase the identification of potential drug interactions, lower costs, and improve efficiency.

Under current regulation, MCOs can encourage recipients to use mail-order pharmacies only for specialty drugs. Any other use of mail-order pharmacies must be expressly requested by an enrollee. Currently, six of eight MCOs have a mail-order option. Of these six, four allow mail-order pharmacies to fill all prescription types, while the other two limit use to specialty drugs. Again, the department notes that additional savings could be realized through the wider use of mail-order pharmacies.

6. Community First Choice Program and Community Options Waiver

Narrative in the 2015 JCR requested DHMH to report on various aspects of the CFC program and consolidated Community Options waiver. This report was requested given the numerous changes made by DHMH to the various home- and community-based services programs offered as an alternative to nursing home placement. Specifically, the Living at Home waiver and Waiver for Older Adults were merged into a single Home and Community-Based Options waiver, and services offered under that waiver together with State Plan personal care option services are done so through the CFC. The intent of the changes was to:

- streamline the administration of existing programs;
- standardize waiver services, rates, and provider enrollment;
- expand services to eligible individuals by eliminating the historical discrepancy in services provided through the waiver programs and the State plan personal care program; and

- maximize available federal funding opportunities.

All participants in CFC are assessed for need using an interRAI-Home Care assessment instrument and subsequently grouped into 1 of 23 resource utilization groups (RUG), which have been consolidated into 7 recommended flexible budget groupings. Budgets range from an annual recommended amount of $8,544 for the lowest level of need to $78,269 for the highest. The budgets are intended to provide individuals with similar assessed levels of need an appropriate starting point to request services but are not a budget cap or absolute limitation. All plans of service are reviewed and approved by DHMH, and any plan of service submitted with a budget higher than the target funding level requires an exceptions process.

The report notes that there was no collection of data on the number of exceptions approved or denied in calendar 2014. However, what data that was provided clearly indicates that the relationship between the RUG budget targets and average CFC budgets are somewhat tenuous (see **Exhibit 37**). Furthermore, as also shown in the exhibit, the traditional waiver group has much higher levels of spending that those in the CFC-only group (which includes the traditionally lower-spending State plan personal care group as well as individuals who are new to services).

Exhibit 37
Comparison of RUG Budget Guidelines and Actual Provided CFC Flexible Budgets
Various Groups
Calendar 2014

		Combined CFC Only and Waiver			CFC Only (n=4042)		Waiver (n=3,823)	
RUG Group	People	RUG Budget	Average CFC Budget	Difference (CFC to RUG)	Average CFC Budget	Difference (CFC to RUG)	Average CFC Budget	Difference (CFC to RUG)
1	2,055	$8,544	$16,285	$7,741	$11,733	$3,189	$27,176	$18,632
2	1,764	16,571	25,001	8,430	18,257	1,686	$34,566	17,995
3	1,734	23,066	31,945	8,879	23,462	396	40,996	17,930
4	1,675	31,072	44,915	13,843	31,196	124	52,436	21,364
5	695	35,409	46,345	10,936	31,616	-3,793	55,255	19,846
6	177	44,647	48,095	3,448	35,818	-8,829	55,922	11,275
7	8	78,269	49,147	-29,122	31,442	-46,827	66,851	-11,418

CFC: Community First Choice
RUG: Resource Utilization Group

Source: Department of Health and Mental Hygiene

The data presented in Exhibit 37 raises the following issues:

- How appropriate is the level of the budget target for RUG group 1, where even for recipients in the State Plan category and new CFC recipients, the discrepancy between the budget target and average spent is $3,189 (37%)? The department response is that the budget targets were set based on available funding with some portion set aside for exception requests. Allocations were based on a work measurement study, but the actual experience can drive revisions. Indeed, the department is evaluating budgets in RUG groups 1 and 7.

- The budget targets for the highest level RUG groups appear more than generous (although impact relatively few individuals).

- Why is the level of spending on waiver recipients as high as it is based on RUG groupings? Further, if one aim of CFC is to provide individuals with similar needs (as determined by the standard assessment tool) access to similar levels of services, how will the department achieve that? Again, the department notes that it can reevaluate budgets and plans on an annual basis. It expects that as new waiver participants are enrolled, the discrepancies will narrow.

- Given the discrepancy in spending between the RUG budget target and the average CFC budget, why does the department not track data on exceptions since the exceptions process appears to be driving expenditures broadly higher? Alternatively, RUG budget target levels need to be revised to better reflect actual budgets being allowed. The department notes that it is not collecting data on exceptions because in a single plan there are multiple services that can push total cost over the recommended budget. Plans are approved or denied based on the plan, not the individual services within the plan, so individual exceptions within a plan (approvals and denials) are not captured.

7. Medicaid Inpatient and Outpatient Savings Required in Chapter 489 of 2015 (Budget Reconciliation and Financing Act of 2015)

Chapter 489 of 2015 (the BRFA of 2015) required HSCRC to adopt policies to achieve general fund savings in the Medicaid program of at least $16.7 million in fiscal 2016. These savings were assumed based on an anticipated decrease in hospital inpatient and outpatient uncompensated care as a result of the impact of ACA, including Medicaid expansion, on levels of uncompensated care. If savings from policies related to uncompensated care failed to produce the required savings, HSCRC was required to produce an alternative plan.

Normally, the rate of uncompensated care at each hospital is based on combining historical uncompensated care rates with predictions from a regression model. However, because of the expected savings resulting from ACA expansion, HSCRC tried to incorporate some level of expected savings into its uncompensated care analysis. In fiscal 2015, an adjustment was made to estimate the impact of the PAC population gaining full Medicaid coverage. For fiscal 2016, HSCRC expanded its analysis

to capture the actual calendar 2014 impact on uncompensated care for the entire expansion population, not just the PAC population.

As a result of this analysis, HSCRC recommended that hospital rates include a 5.25% rate adjustment in fiscal 2016 to support uncompensated care. This is a 0.89 percentage point reduction from the rate support provided in fiscal 2015 of 6.14%. HSCRC further estimates that absent ACA expansion, rate support for uncompensated care would likely have been 7.23% in fiscal 2016, or 1.98 percentage points higher than actually proposed. According to HSCRC, this results in savings that almost met the savings level target required in Chapter 489. HSCRC noted that various other smaller additional actions taken resulted in the required savings level being more than met.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Medical Care Programs Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$2,478,264	$979,825	$4,599,533	$65,564	$8,123,187
Deficiency Appropriation	80,300	11,450	0	0	91,750
Cost Containment	-33,515	0	0	0	-33,515
Budget Amendments	-70,858	32,159	1,200,113	5,688	1,167,102
Reversions and Cancellations	-16,797	-2,855	-564,955	-2,973	-587,580
Actual Expenditures	**$2,437,394**	**$1,020,579**	**$5,234,691**	**$68,279**	**$8,760,943**
Fiscal 2016					
Legislative Appropriation	$2,515,611	$962,706	$5,290,324	$59,941	$8,828,582
Budget Amendments	20,308	25,758	37,956	7,384	91,406
Working Appropriation	**$2,535,919**	**$988,464**	**$5,328,281**	**$67,325**	**$8,919,989**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

The fiscal 2015 legislative appropriation for MCPA was increased by $637.8 million. This increase was derived as follows:

- Deficiency appropriations added $91.75 million ($80.3 million in general funds and $11.45 million in special funds). Specifically:
  - $18.0 million in general funds to cover fiscal 2014 deficits rolled into fiscal 2015 (although $11.0 million of this funding was subsequently transferred as authorized in the budget bill to DPSCS and the Maryland State Police to cover fiscal 2015 expenses in those agencies).
  - $17.3 million in general funds to cover the cost of kick payments to MCOs for new Hepatitis C drug treatment.
  - $53.0 million in general funds to more than offset a drop in available CRF special funds of $45.55 million. The loss of special funds was derived as follows: $40.0 million that was not forthcoming in fiscal 2015 from a successful appeal of an adverse national arbitration ruling concerning the State's implementation of certain provisions of the MSA; a reduction of $13.0 million as a result of an accounting error made in fiscal 2014 by the company that calculates State allocations under the MSA that resulted in the need for a repayment in fiscal 2015; and slightly offsetting the overall drop in CRF special fund support in fiscal 2015 is the addition of $7.45 million in the CRF that had been allocated to the academic health centers but was used to backfill a general fund cost containment action in the same amount.
  - The net addition of $65.5 million ($8.5 million in general funds and $57.0 million in special funds) to cover higher than anticipated provider reimbursements. The additional special funds were available from higher than projected Rate Stabilization Fund revenues generated from premiums from higher MCO enrollment ($12.0 million) and MHIP fund balance ($45.0 million). The BRFA of 2015 subsequently authorized the transfer of $55.0 million in MHIP fund balance, the additional $10.0 million transferred in a subsequent budget amendment.
  - The withdrawal of $16.5 million in general funds based on reducing the calendar 2015 MCO rates by an additional 1.9%, to -9.5%. This is intended to represent the bottom of the actuarial range.
- Cost containment actions reduced the general fund appropriation by just over $33.5 million. Specifically:
  - Actions taken by BPW on July 2, 2014, reduced the Medicaid general fund appropriation by $6.4 million as follows: $3.4 million by reducing calendar 2014 MCO

rates for the non-ACA expansion eligibility group to the bottom of the actuarial rate range; $2.5 million to limit the increase in nursing home rates to 1.7% effective January 1, 2015; and $500,000 in general funds to be backfilled by CRF dollars reduced from the Tobacco Transition Program in the Maryland Department of Agriculture.

- Actions taken by BPW on January 7, 2015, further reduced the Medicaid general fund appropriation by $19.7 million: $9.0 million to reduce rates for primary care and specialty care physician evaluation and management codes to 87.0% of the Medicare rate effective April 1, 2015; $7.45 million in general funds backfilled by the CRF available as a result of funding cancer research grants supported by those funds at fiscal 2013 levels; $2.0 million to further reduce the nursing home rate increase to 1.0% effective January 1, 2015; $650,000 by reducing mid-year rate increases for medical day care and private duty nursing services from 2.5% to 1.25%; $524,000 in personnel savings; and $102,000 from reducing pharmacy dispensing fees as part of a transition to a new pharmacy reimbursement methodology.

- Additionally, in implementing the fiscal 2015 across-the-board reduction that was also imposed by BPW in January 2015, DHMH ultimately allocated $7.4 million of that reduction to Medicaid. At the time of that allocation, it was clear that the funding was surplus to requirements in fiscal 2015.

- Budget amendments added almost $1.2 billion to the fiscal 2015 appropriation. This figure is derived as follows:

  - General fund amendments reduced the appropriation by $70.9 million. The major adjustment was a $60.7 million reduction to provider reimbursements. Of these funds, $33.1 million were funds transferred to the Medicaid Behavioral Health program to support substance abuse services that were carved out of the HealthChoice program on January 1, 2015, and that had been originally budgeted in program 03 in MCPA. The remaining funding was available based on lower than expected expenditure trends and was transferred throughout DHMH to programs experiencing budget shortfalls or other issues. For example, $4.0 million was transferred to BHA to fund State-fund-only services to eligible Medicaid recipients, $7.4 million was transferred to the Developmental Disabilities Administration to cover payments to the federal government based on a prior year federal audit disallowance, with the remainder concentrated across the State-operated facilities. The other substantial reduction was $11.0 million transferred as directed in the fiscal 2016 budget bill to offset deficiencies in DPSCS and the Maryland State Police. These reductions were slightly offset by a variety of smaller amendments adding funding for the fiscal 2015 cost-of-living adjustment, health insurance, and various operating expenses.

  - Special fund amendments increased the appropriation by $32.2 million. The most significant changes were the addition of $14.5 million in Rate Stabilization Fund support based on higher than budgeted premium tax collection into that fund, $10.0 million in

funds from MHIP as provided for in the BRFA of 2015, $7.0 million in additional third-party recoveries, and $630,000 transferred from the HSCRC to Medicaid for contract costs with the State's Health Information Exchange (the Chesapeake Regional Information System for our Patients (CRISP)).

- Federal fund budget amendments added $1.2 billion to the appropriation. Virtually all of this funding ($1.18 billion) related to the new ACA expansion eligibility category which in fiscal 2015 was 100% federally funded. The additional funding supported expectations of higher than budgeted enrollment as well as higher than budgeted expenditures based on the MCO capitation rate used to initially develop the budget versus that ultimately paid. Other major federal fund adjustments included $12.8 million in higher federal fund attainment in MCHP based on higher enrollment, and $3.9 million to match the special funds transferred from the HSCRC related to a contract with CRISP.

- Reimbursable fund budget amendments added a further $5.7 million to the appropriation. Most of this funding related to various MITPDF projects being undertaken by Medicaid.

- Reversions and cancellations subsequently reduced the appropriation by $587.6 million. General fund reversions totaled $16.8 million. A fuller discussion of the availability of fiscal 2015 funds is provided above. Special fund cancellations totaled just under $2.9 million, almost all of which was in the SPDAP. Federal fund cancellations totaled $565.0 million, driven by significant MCO rate cuts, especially in the ACA expansion population, in calendar 2015. Reimbursable fund cancellations totaled $3.0 million, primarily related to actual expenditures on various MITPDF projects.

Fiscal 2016

To date, the fiscal 2016 legislative appropriation has been increased by $91.4 million. Of this amount:

- General fund budget amendments have added $20.3 million. Specifically, $31.5 million in general funds was added as a result of the implementation of Section 48 of the fiscal 2016 budget bill establishing legislative priorities that had not been included in the Governor's budget, and $11.2 million in general funds was withdrawn from the Medicaid program as part of the overall reallocation of the across-the-board 2% reduction within DHMH that was part of the fiscal 2016 budget. This reduction included $11.6 million from MCHP that was subsequently backfilled with special funds.

- Special fund budget amendments have added $25.8 million. In addition to the backfilling of the MCHP general fund reduction noted above, an additional $0.6 million was added to MCHP for a total of $12.2 million ($12.0 from anticipated higher attainment in Rate Stabilization Fund

revenues, and $0.2 million in higher than budgeted user fees). An additional $13.6 million was added to the provider reimbursement budget based on higher than anticipated hospital assessment revenues.

- Federal fund budget amendments add $38.0 million, based on the expectation of higher federal Medicaid attainment in provider reimbursements as a result of the additional general funds added to the budget noted above.

- Reimbursable fund budget amendments increase the appropriation by an additional $7.4 million, all related to various MITDPF projects in Medicaid.

Major Information Technology Projects

Medical Care Programs Administration
Long Term Supports and Services Tracking System

Project Status	Implementation.	**New/Ongoing Project:**	Ongoing.
Project Description:	The Long Term Supports and Services Tracking System (LTSS) is an integrated care management tracking system housing real-time medical and service information of Medicaid recipients receiving long-term care services. The elements involved in the system are considered necessary for the State to properly implement the Balancing Incentive Payments Program and Community First Choice options available under the federal Affordable Care Act (ACA). Additional components have now been added to support the Developmental Disabilities Administration (DDA), fulfil requirements under a federal Testing Experience and Functional Tools (TEFT) federal grant, responding to a federal Department of Labor ruling on independent providers which will require the department to move to an agency-only model at least for the time being, and adding a module to support the medical daycare (MDC) program.		
Project Business Goals:	The LTSS will include information generated by a new standardized assessment tool (interRAI-HC) that is one of the requirements to take advantage of enhanced federal funding for long-term care services authorized under the federal ACA. The system will also integrate data from a new in-home services verification system intended to enhance accountability in billing for in-home services.		
Estimated Total Project Cost:	$90,839,793		
Project Start Date:	December 2011.	**Projected Completion Date:**	Original LTSS System is complete. Currently adding enhancements.
Schedule Status:	The LTSS system operations and maintenance contract is transitioning to a new vendor and was expected January 2016. The DDA enhancement is expected to continue into fiscal 2017, but cannot be completed until the completion of a study proposing a revision of the DDA rate-setting methodology. The MDC enhancement is on hold while TEFT grant requirements are implemented.		
Cost Status:	Project cost has expanded to accommodate the DDA and other components that were not part of the original project scope.		
Scope Status:	Project scope has been expanded to accommodate functionality for DDA, TEFT and MDC.		
Project Management Oversight Status:	Normal Department of Information Technology oversight. Independent Verification and Validation assessment initiated in November 2013.		
Identifiable Risks:	Incorporation of the DDA component remains a risk until the requirements are completed (which requires the rate-setting methodology to be completed). A delay in the project schedule for the DDA component of the system could negatively impact other LTSS planned activities.		

Fiscal Year Funding ($ in Thousands)	**Prior Years**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**Balance to Complete**	**Total**
Personnel Services	$0	$0	$0	$0	$0	$0	$0	$0
Professional and Outside Services	27,481	16,100	15,459	10,600	10,600	10,600	0	90,840
Other Expenditures	0	0	0	0	0	0	0	0
Total Funding	**$27,481**	**$16,100**	**$15,459**	**$10,600**	**$10,600**	**$10,600**	**$0**	**$90,840**

HealthChoice Managed Care Organization Open Service Area by County
January 2016

County	Amerigroup	Jai Medical Systems	Kaiser Permanente	Maryland Physicians Care	MedStar	Priority Partners	Riverside Health	United Healthcare
Allegany	X			X		X		Voluntarily frozen
Anne Arundel	X		X	X	X	X	X	X
Baltimore City	X	X	X	X	X	X	X	X
Baltimore County	X	X	X	X	X	X	X	X
Calvert	X		X	X		X	X	Voluntarily frozen
Caroline	X			X		X	X	Voluntarily frozen
Carroll	X			X		X	X	Voluntarily frozen
Cecil	X			X		X	X	Voluntarily frozen
Charles	X		X	X	X	X	X	X
Dorchester	X			X		X	X	Voluntarily frozen
Frederick	X			X		X	X	Voluntarily frozen
Garrett	X			X		X		Voluntarily frozen
Harford	X		X	X	X	X	X	X
Howard	X		X	X		X	X	X
Kent	Frozen			X		X	X	Voluntarily frozen
Montgomery	X		X	X	X	X	X	X
Prince George's	X		X	X	X	X	X	X
Queen Anne's	Frozen			X		X	X	Voluntarily frozen
Somerset	X			X		X	X	Voluntarily frozen
St. Mary's	X		X	X	X	X	X	X
Talbot	Frozen			X		X	X	Voluntarily frozen
Washington	X			X		X		Voluntarily frozen
Wicomico	X			X		X	X	Voluntarily frozen
Worcester	X			X		X	X	Voluntarily frozen

X = Managed care organization participation based on October 2015 commitment letters

Source: Department of Health and Mental Hygiene

Appendix 4

U.S. Department of Health and Human Services
2016 Federal Poverty Guidelines

	Family Size				
% of FPG	**1**	**2**	**3**	**4**	**5**
50%	$5,940	$8,010	$10,080	$12,150	$14,220
100%	11,880	16,020	20,160	24,300	28,440
116%	13,781	18,583	23,386	28,188	32,990
138%	16,394	22,108	27,821	33,534	39,247
185%	21,978	29,637	37,296	44,955	52,614
200%	23,760	32,040	40,320	48,600	56,880
225%	26,730	36,045	45,360	54,675	63,990
250%	29,700	40,050	50,400	60,750	71,100
300%	35,640	48,060	60,480	72,900	85,320
350%	41,580	56,070	70,560	85,050	99,540
400%	47,520	64,080	80,640	97,200	113,760
500%	59,400	80,100	100,800	121,500	142,200
600%	71,280	96,120	120,960	145,800	170,640

FPG: federal poverty guideline

Source: Federal Register Vol. 81, No. 15, January 25, 2016 https://www.gpo.gov/fdsys/pkg/FR-2016-01-25/pdf/2016-01450.pdf

Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	611.00	620.00	620.00	0.00	0%
02 Contractual	82.85	125.92	125.21	-0.71	-0.6%
Total Positions	**693.85**	**745.92**	**745.21**	**-0.71**	**-0.1%**
Objects					
01 Salaries and Wages	$ 49,243,390	$ 51,225,738	$ 52,399,528	$ 1,173,790	2.3%
02 Technical and Spec. Fees	3,594,248	5,002,022	5,299,114	297,092	5.9%
03 Communication	1,467,892	1,710,084	1,551,713	-158,371	-9.3%
04 Travel	88,113	130,021	119,478	-10,543	-8.1%
06 Fuel and Utilities	7,537	15,758	12,674	-3,084	-19.6%
07 Motor Vehicles	7,532	9,638	4,539	-5,099	-52.9%
08 Contractual Services	8,705,837,063	8,861,241,498	9,097,208,179	235,966,681	2.7%
09 Supplies and Materials	377,402	451,999	348,762	-103,237	-22.8%
10 Equipment – Replacement	53,234	0	0	0	0.0%
11 Equipment – Additional	86,252	992	13,147	12,155	1225.3%
13 Fixed Charges	180,619	200,792	210,173	9,381	4.7%
Total Objects	**$ 8,760,943,282**	**$ 8,919,988,542**	**$ 9,157,167,307**	**$ 237,178,765**	**2.7%**
Funds					
01 General Fund	$ 2,437,394,056	$ 2,535,919,142	$ 2,640,261,501	$ 104,342,359	4.1%
03 Special Fund	1,020,578,802	988,463,521	938,486,641	-49,976,880	-5.1%
05 Federal Fund	5,234,691,297	5,328,280,578	5,520,717,360	192,436,782	3.6%
09 Reimbursable Fund	68,279,127	67,325,301	57,701,805	-9,623,496	-14.3%
Total Funds	**$ 8,760,943,282**	**$ 8,919,988,542**	**$ 9,157,167,307**	**$ 237,178,765**	**2.7%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Deputy Secretary for Health Care Financing	2,730,493	6,002,692	3,314,622	-2,688,070	-44.8%
02 Office of Systems, Operations and Pharmacy	22,806,118	24,240,514	24,071,412	-169,102	-0.7%
03 Medical Care Provider Reimbursements	8,401,709,418	8,546,924,185	8,727,660,317	180,736,132	2.1%
04 Office of Health Services	27,732,778	35,377,335	49,397,206	14,019,871	39.6%
05 Office of Finance	3,072,140	3,120,547	3,163,333	42,786	1.4%
06 Kidney Disease Treatment Services	23,901,258	23,382,867	24,773,086	1,390,219	5.9%
07 Maryland Children's Health Program	243,669,332	245,648,414	283,862,703	38,214,289	15.6%
08 Major Information Technology Development Projects	22,829,713	21,442,078	26,911,168	5,469,090	25.5%
09 Office of Eligibility Services	12,492,032	13,849,910	14,013,460	163,550	1.2%
Total Expenditures	**$ 8,760,943,282**	**$ 8,919,988,542**	**$ 9,157,167,307**	**$ 237,178,765**	**2.7%**
General Fund	$ 2,437,394,056	$ 2,535,919,142	$ 2,640,261,501	$ 104,342,359	4.1%
Special Fund	1,020,578,802	988,463,521	938,486,641	-49,976,880	-5.1%
Federal Fund	5,234,691,297	5,328,280,578	5,520,717,360	192,436,782	3.6%
Total Appropriations	**$ 8,692,664,155**	**$ 8,852,663,241**	**$ 9,099,465,502**	**$ 246,802,261**	**2.8%**
Reimbursable Fund	$ 68,279,127	$ 67,325,301	$ 57,701,805	-$ 9,623,496	-14.3%
Total Funds	**$ 8,760,943,282**	**$ 8,919,988,542**	**$ 9,157,167,307**	**$ 237,178,765**	**2.7%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions. Kidney Disease Treatment Services includes all funding for the Senior Prescription Drug Assistance Program

M00R01
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
Special Fund	$176,322	$233,814	$230,337	-$3,477	-1.5%
Deficiencies and Reductions	0	0	-30	-30	
Adjusted Special Fund	**$176,322**	**$233,814**	**$230,307**	**-$3,507**	**-1.5%**
Federal Fund	1,449	2,492	0	-2,492	-100.0%
Adjusted Federal Fund	**$1,449**	**$2,492**	**$0**	**-$2,492**	**-100.0%**
Reimbursable Fund	0	173	173	0	
Adjusted Reimbursable Fund	**$0**	**$173**	**$173**	**$0**	**0.0%**
Adjusted Grand Total	**$177,770**	**$236,479**	**$230,480**	**-$5,999**	**-2.5%**

- The fiscal 2017 allowance for the Health Regulatory Commissions decreases by $6 million, 2.5%, net of back of the bill reductions. This is mainly due to funding added through budget amendments in fiscal 2016 not being carried over into fiscal 2017.

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

For further information contact: Jordan D. More Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	102.70	103.70	103.70	0.00
Contractual FTEs	0.00	0.00	0.00	0.00
Total Personnel	**102.70**	**103.70**	**103.70**	**0.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	4.67	4.50%
Positions and Percentage Vacant as of 12/31/15	11.80	11.38%

- There are no new positions in the allowance for the Health Regulatory Commissions.

- Turnover expectancy within the allowance is 4.50%, which requires the agency to maintain 5.0 vacant positions throughout the year. As of December 31, 2015, there were 11.8 vacant positions, or 11.38%.

Analysis in Brief

Major Trends

Use of Electronic Data Exchange Continues to Grow: Use of the State-designated Health Information Exchange (HIE) is increasing. The HIE is intended to make electronic health records and health information available in a secure environment to providers and patients.

Maryland All-payer Model Contract Metrics Continue to Show Progress: The new Maryland All-payer Model Contract contains numerous tests that the State must meet to maintain the waiver agreement. In 2014, which was year one of the demonstration, the State either met or exceeded all of the goals. In 2015, the State appears to be on pace with these metrics.

Issues

Moving through Phase I and Looking to Phase II – Implementing the All-payer Model Contract: On January 1, 2014, Maryland entered into a new all-payer contract with the federal government, which established new goals that the State must meet in order to maintain its Medicare all-payer waiver. These goals included placing most hospital revenues under global budgets in order to cap cost growth, as well as improvements in certain health outcomes. So far, the Health Services Cost Review Commission (HSCRC) has been focusing on expanding care coordination and seeking waivers to allow for gain sharing, or Pay for Outcomes (P4O) arrangements between hospitals and physicians. **HSCRC should comment on the status of the internal physician and P4O waivers, and what progress has been made on the movement toward Phase II of the All-payer Model Contract, including possibly more aggressive outreach to the nonhospital provider community.**

The Beginning of Integrated Care Networks: In order to improve care coordination, HSCRC, along with the Maryland Health Care Commission (MHCC), have begun to establish Integrated Care Networks (ICN). The main vehicle through which the commissions are establishing these networks is through the State-designated HIE, the Chesapeake Regional Information System for our Patients. **HSCRC should comment on the current status of the ICN projects, where the infrastructure build out is so far, and what steps they plan to take to get more small, nonhospital-based providers into the ICNs.**

Preliminary Sunset Evaluations for MHCC and HSCRC: During the 2015 interim, the Department of Legislative Services (DLS) conducted a preliminary sunset evaluation on both MHCC and HSCRC. Beyond the main recommendation, which is for DLS to conduct a review of the missions and responsibilities of all three health care regulatory commissions and make recommendations regarding how the responsibilities and roles of the commissions could be better aligned, DLS also noted some other policy recommendations for the current legislative session. **Both commissions should comment on their progress toward addressing the DLS recommendations, including the ability of each commission to function under the current user fee assessment caps.**

Recommended Actions

1. Concur with Governor's allowance.

M00R01
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Health Regulatory Commissions are independent agencies that operate within the Department of Health and Mental Hygiene. The agencies variously regulate the health care delivery system, monitor the price and affordability of services offered in the industry, and improve access to care for Marylanders. The three commissions are the Maryland Health Care Commission (MHCC), the Health Services Cost Review Commission (HSCRC), and the Maryland Community Health Resources Commission (MCHRC).

MHCC has the charge of improving access to affordable health care, as well as reporting information relevant to availability, cost, and quality of health care statewide. The commission's goals include:

- improving the quality of care in the health care industry;
- improving access to and affordability of health insurance, especially for small employers;
- reducing the rate of growth in health care spending; and
- providing a framework for guiding the future development of services and facilities regulated under the Certificate of Need program.

HSCRC was established in 1971 to contain hospital costs, maintain fairness in hospital payment, and provide financial access to hospital care. The commission maintains responsibility for ensuring that the cost of health care is reasonable relative to the cost of services and that rates are set without discrimination. The commission's goals include:

- maintaining affordable hospital care for all Maryland citizens;
- expanding the current system for financing hospital care for those without health insurance; and
- eliminating preferential charging activity through monitoring of hospital pricing and contracting activity.

MCHRC was established in 2005 to strengthen the safety net for uninsured and underinsured Marylanders. The safety net consists of community health resource centers (CHRC), which range from

federally qualified health centers to smaller community-based clinics. MCHRC's responsibilities include:

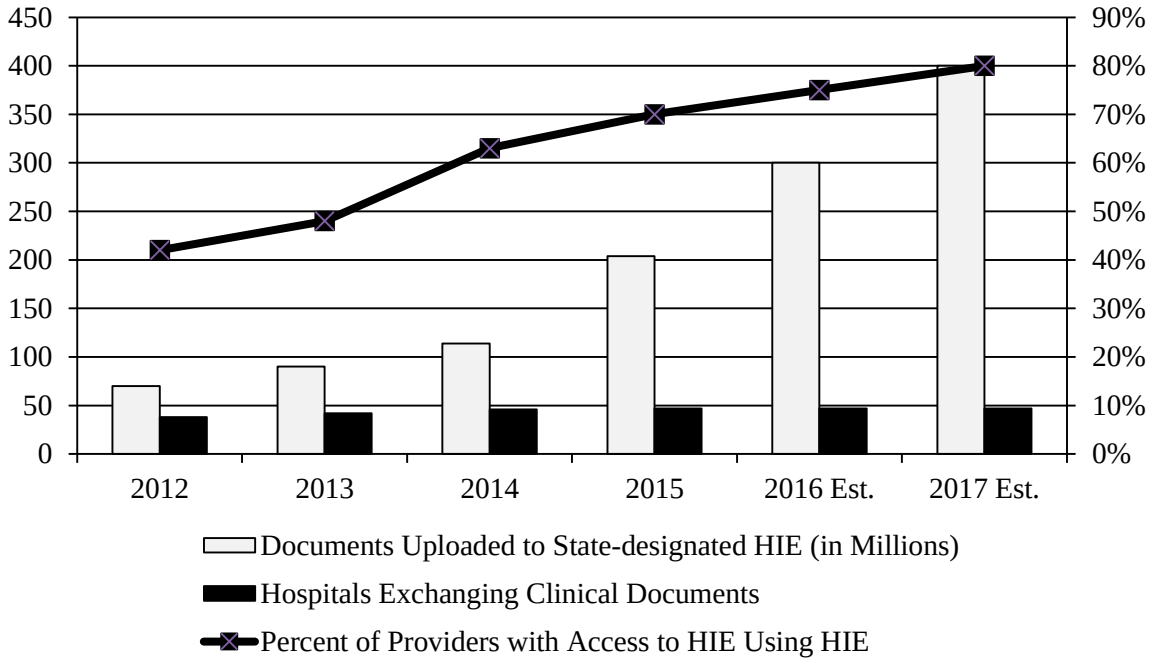
- identifying and seeking federal and State funding for the expansion of CHRCs;
- developing outreach programs to educate and inform individuals of the availability of CHRCs;
- assisting uninsured individuals under 200% of the federal poverty level to access health care services through CHRCs; and
- overseeing the implementation of the Health Enterprise Zones (HEZ) established in Chapter 3 of 2012, which ends at the completion of fiscal 2016.

Performance Analysis: Managing for Results

1. Use of Electronic Data Exchange Continues to Grow

One of the goals of MHCC is to reduce the rate of growth in health care spending in Maryland. One strategy to lower costs is eliminating unnecessary administrative expenses through the adoption of an electronic data exchange, specifically through the utilization of the State Health Information Exchange (HIE). Maryland's designated HIE is the Chesapeake Regional Information System for our Patients (CRISP), which is charged with making electronic health records and health information available in a secure environment to providers and patients. **Exhibit 1** shows the number of documents uploaded to the HIE, the number of hospitals exchanging clinical documents, and the percentage of those providers who have access to and utilize the HIE. As displayed in the exhibit, the use of the HIE continues to grow as a higher proportion of providers with access to the HIE use the system. There was also an especially pronounced jump in the number of documents uploaded between fiscal 2014 and 2015, from 114 million to 204 million. That number is projected to double by fiscal 2017.

Exhibit 1
Utilization of State-designated HIE
Fiscal 2012-2017 Est.



HIE: Health Information Exchange

Source: Department of Health and Mental Hygiene

2. Maryland All-payer Model Contract Metrics Continue to Show Progress

The new All-payer Model Contract requires the State to meet certain metrics throughout the five-year waiver demonstration period in order for the State to maintain the waiver. **Exhibit 2** provides some detail on certain metrics that HSCRC monitors to ensure compliance with the tests that the Center for Medicare and Medicaid Innovation (CMMI) has required of Maryland. So far, the State has been meeting most of the metrics that are tested as part of the model contract. Some early signs of success include keeping per capita all-payer revenue growth below 3.58% in both calendar 2014 and 2015, although growth in calendar 2015 has increased from 1.47% to 2.62%. Further progress has also been exhibited with the savings that Maryland needs to achieve for Medicare fee-for-service (FFS) per beneficiary growth. In calendar 2014, Medicare FFS per beneficiary growth in Maryland shrank by 1.07%, as measured by the federal government, while growth in the nation increased by 1.06%. This resulted in a first year savings to Medicare of approximately $116 million, which is 35.0% of the savings that Maryland needs to achieve under this measure over the course of the five-year

demonstration. However, it is worth noting that the FFS per beneficiary Medicare growth, as measured by the State, increased in calendar 2015 by 1.64%. HSCRC will have to wait until CMMI examines its metrics to determine if the State has regressed in 2015.

Exhibit 2
Maryland All-payer Model Contract Metrics
Calendar 2014-2015

	Goal	Year 1 (2014)	Year 2 (2015)
Per Capita All-payer Revenue Growth	**< or = 3.58%**	**1.47%**	**2.62%**
Maryland Per Beneficiary Medicare FFS Hospital Revenue Growth[1]		-1.12%	1.64%
Medicare FFS Hospital Per Beneficiary Growth Comparison[2]			
Maryland		-1.07%	TBD
National		1.06%	TBD
Cumulative Medicare Savings Over Five Years	**$330m**	**$116m**	**TBD**
Reduction in Hospital Readmissions	Year 1: -6.76%; Year 2: -9.30%	-3.66%	-7.19%
Cumulative Reduction in Hospital Acquired Conditions	**-30.0% Over 5 Years**	**-26.26%**	**-33.91%**

FFS: fee-for-service

[1] This data is specific to Maryland and is used for real time monitoring.
[2] This data is based on Center for Medicare and Medicaid Innovation reporting.

Note: Calendar 2015 is through November with two exceptions. Readmissions data is through October of each year compared to the same timeframe in 2013. Hospital Acquired Conditions is through September of each year.

Note: Bold denotes one of the waiver test metrics.

Source: Health Services Cost Review Commission

Beyond financial measures, the waiver tests also require hospitals in the State to bring the readmission rate below the national readmission rate, as well as to reduce the number of hospital-acquired conditions by 30.0% over the five-year demonstration. For readmissions, HSCRC sets a yearly goal for all hospitals to meet. In neither calendar 2014 nor 2015 did the hospitals achieve this goal, although the reduction in the readmission rate did improve from -3.66% to -7.19%. Further, the State did close the gap with the national readmission rate by 0.21 percentage points. For

hospital-acquired conditions, the State has already exceeded the cumulative goal of 30.0%, having reduced hospital acquired conditions by 33.91% through the end of 2015.

Proposed Budget

As seen in **Exhibit 3**, the total appropriation for the Health Regulatory Commissions decreases by $6 million below the working appropriation net of back of the bill reductions.

Exhibit 3
Proposed Budget
DHMH – Health Regulatory Commissions
($ in Thousands)

How Much It Grows:	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$176,322	$1,449	$0	$177,770
Fiscal 2016 Working Appropriation	233,814	2,492	173	236,479
Fiscal 2017 Allowance	230,307	0	173	230,480
Fiscal 2016-2017 Amount Change	-$3,507	-$2,492	$0	-$5,999
Fiscal 2016-2017 Percent Change	-1.5%	-100.0%		-2.5%

Where It Goes:

Personnel Expenses	
Retirement contributions	$154
Employee and retiree health insurance	101
Other fringe benefit adjustments	-9
Social Security contributions	-53
Workers' compensation premium assessment	-139
Regular earnings and other compensation	-618
Maryland Health Care Commission	
All-payer Claims Database contract increase	834
Expiring Network for Regional Health Care Improvements grant	-100

Where It Goes:

Trauma equipment grant	-300
Various data contracts	-422
Federal grants	-2,264
CRISP Grants	-10,750
Health Services Cost Review Commission	
Integrated Care Networks project	6,528
All-payer Model contracts	1,186
Other Changes	
Other operating expenses (all commissions)	-146
Total	**-$5,999**

DHMH: Department of Health and Mental Hygiene
CRISP: Chesapeake Regional Information System for our Patients

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

Personnel

Personnel costs for the commissions decrease by approximately $565,000 net of the back of the bill reduction for health insurance costs. The largest increases are for retirement contributions ($154,000) and health insurance contributions ($101,000). However, these are more than offset by a decrease of approximately $618,000 in regular earnings and other compensation. This is mainly due to the high number of vacancies within the various commissions, which is leading to lower budgeted salary levels for these vacant positions as positions are reset back to base salaries. However, it should be noted that in fiscal 2016, HSCRC had a budget amendment which increased salaries mid-year due to personnel being hired at larger than base salaries.

MHCC

The largest changes are contained in the MHCC budget. Most of the large decreases are due to expiring programming, including $10.8 million to CRISP for work related to the HIE as well as the initial infrastructure build-out of the Integrated Care Networks (ICN), which are further discussed in Issue 2. There is also a decrease of $2.3 million in federal funds due to the expiration of a federal grant related to insurance rate premium review. One major increase, however, in the MHCC budget is approximately $834,000 for an increase in the contract for the All-payer Claims Database. This

contract is currently being rebid, and these costs are required to cover the costs of a new contractor taking over the project as well as increased reporting deliverables.

HSCRC

Several large increases are contained within the HSCRC budget. The largest increase, $6.5 million, is for increases in the ICN project, particularly for greater connectivity to community-based providers and for care management software. The costs for contracts concerning data and performance measurement for the All-payer Model Contract project also increase by $1.2 million.

Issues

1. Moving through Phase I and Looking to Phase II – Implementing the All-payer Model Contract

Effective January 1, 2014, Maryland entered into a contract with the federal government to replace the State's 36-year-old Medicare waiver with the new Maryland All-payer Model Contract. Whereas under the old waiver test, Maryland's success was based solely on the cumulative rate of growth in Medicare inpatient per admission costs, the new model contract contains completely different benchmarks and components that the State must meet throughout the 5-year demonstration model to continue to have a waiver and be able to set Medicare hospital rates.

The Maryland All-payer Model Contract

After a process that included a draft proposal, stakeholder input, and changes to the original draft proposal, Maryland and the federal government agreed to a new five-year demonstration model, which began on January 1, 2014. The model includes the following major components:

- **All-payer Total Hospital Cost Growth Ceiling:** Maryland will limit inpatient and outpatient hospital cost growth for all payers to a trend based on the State's average 10-year compound annual gross State product per capita between 2003 and 2012 (3.58% for the first 3 years of the demonstration). After year 3, the State may adjust the overall cap based on updated data.

- **Medicare Hospital Savings:** Maryland has agreed to produce $330 million in cumulative Medicare hospital savings over 5 years by holding the growth in Maryland Medicare FFS hospital spending below the national Medicare growth rate.

- **Population-based Revenue:** Initially, HSCRC had agreed under the contract to have 80.0% of all hospital-based revenue into population-based models by year 5 of the contract, *i.e.*, hospital reimbursement tied to the projected services of a specified population of residents, or a fixed global budget for hospitals for services unconnected to the assignment of a specific population. However, all hospitals agreed to global budgets, which began on July 1, 2014, and these global budgets already include approximately 95.0% of all hospital revenue.

- **Reduction of Hospital Readmissions:** Maryland must reduce its Medicare readmission rate over 5 years. Specifically, the aggregate Medicare 30-day readmission rate must be equal to or less than the national readmission rate for Medicare FFS beneficiaries by year 5.

- **Reduction of Hospital Acquired Conditions:** Maryland will achieve an annual aggregate reduction of 6.89% across all potentially preventable conditions measures that comprise Maryland's Hospital Acquired Condition program. This represents a cumulative reduction of 30.0% over 5 years.

- **Medical Education Innovation:** Maryland must develop a 5-year plan for medical and health professional schools to serve as a nationwide model for transformation initiatives.

- **Regulated Revenue at Risk:** Maryland must ensure that the aggregate percentage of regulated revenue at risk for quality programs administered by the State is equal to or greater than the aggregate percentage of revenue at risk under national Medicare quality programs. Quality programs include readmissions, hospital acquired conditions, and value-based purchasing programs.

During the course of the model contract, a so-called triggering event could lead CMMI to send the State a warning notice and potentially require a corrective action plan (see **Exhibit 4**). Unsurprisingly, as noted in the exhibit, while the new all-payer model seeks to generate savings for all payers, the focus of the CMMI concerns is very much on trends related to Medicare. As noted in the performance analysis earlier in this document, HSCRC is currently meeting or exceeding all of the model contract goals.

Exhibit 4
Maryland's All-payer Model Contract: Triggering Events

Triggering Event
The State has not produced aggregate savings in Medicare per beneficiary hospital expenditures for Maryland resident fee-for-service beneficiaries for two consecutive years.
The State has failed to meet the cumulative Medicare savings targets by more than $100 million.
The annual growth rate in Medicare per beneficiary total cost of care for Maryland residents is greater than 1.0 percentage point above the annual national Medicare per beneficiary total cost of care during a single year.
Beginning in year two of the model, the annual growth rate in Medicare per beneficiary total cost of care for Maryland residents (regardless of state of service) is greater than the annual national Medicare per beneficiary total cost of care growth rate for two consecutive years.
The percentage of hospital revenue attributable to nonresident Medicare beneficiaries is 1.5 percentage points above the percentage level of calendar 2013.
A determination by the CMMI that the quality of care to Medicare, Medicaid, and MCHP recipients has deteriorated.

CMMI: Center for Medicare and Medicaid Innovation
MCHP: Maryland Children's Health Program

Source: Maryland All-payer Model Agreement, February 2014

Extending the Model

As previously stated, over 95% of hospital revenue is now included within the global budgets. However, for the model to be a long-term success, better care coordination both inside and outside of the hospital is going to be required. For example, hospital readmissions is the one measure where the State is not currently meeting or exceeding its own goals or expectations. This is arguably because hospitals within the State are not progressing on care coordination as quickly as would otherwise be desired. In order to better address this current deficit, HSCRC is seeking additional waivers from the federal government in order to begin implementing gain sharing programs between physicians in the State and hospitals.

In particular, there are three waivers which HSCRC and hospitals would like to have in order to implement accountable care organization style arrangements. The first waiver would be for physicians that work inside of the hospitals. These physicians are currently still reimbursed on an FFS-basis, and thus do not have the same incentives to reduce hospital utilization as the hospitals themselves have under the new waiver. The second waiver would be for providers who specialize in either primary or post-acute care, including nursing homes, hospice, and other services. This waiver would allow hospitals to set up a Pay for Outcomes (P4O) program where these providers share in the risk and reward structure that is part of the global budgets. The third waiver would allow hospitals and physicians to share data across settings to help hospitals and physicians conduct risk stratification to address high-needs patients.

If these waivers for physicians are granted, HSCRC would then like to move to an ICN structure where both certain physicians as well as the hospitals are all under a unified governance structure where they all share in savings and incentives that align with the goals and tests of the waiver. However, as discussed in the following issue, these ICNs could take a significant amount of time to set up.

Beyond these waivers and gain sharing arrangements, HSCRC is also preparing to move into Phase II of the model contract, which requires a more total cost of care model. A proposal is due to CMMI from HSCRC at the end of calendar 2016 that would cover all health spending in the State from calendar 2019, which is the first year after the current five-year demonstration, and beyond. However, progressing to this new model could be difficult, especially given the difficulties that hospitals and HSCRC have already experienced with care coordination and outreach beyond the hospitals themselves. **HSCRC should comment on the status of the internal physician and P4O waivers, and what progress has been made on the movement toward Phase II of the All-payer Model Contract, including possibly more aggressive outreach to the nonhospital provider community.**

2. The Beginning of Integrated Care Networks

Beginning in fiscal 2016, both MHCC and HSCRC have engaged CRISP to begin the buildout of the software and other information technology infrastructure for an ICN. The purpose of an ICN is to create a system where multiple providers can coordinate care and integrate their efforts in order to better meet the needs of patients, as well as the goals and purposes of the all-payer waiver. Beginning in fiscal 2016, CRISP has developed a new Steering Committee, within its governing structure, to

provide targeted oversight of the effort and to direct the project as it moves forward. Early work has focused on seven workstreams:

- ***Ambulatory Connectivity:*** The project aims to achieve bi-directional connectivity with ambulatory practices, long-term care, and other health providers through multiple methods of connectivity.

- ***Data Router:*** The data router will receive and normalize health records, determine a patient-provider relationship, verify patient consent, and forward the records to where they should go in near real time.

- ***Clinical Portal Enhancements:*** The existing clinical query portal will be enhanced with new elements, including a care profile, a link to a provider directory, information on other known patient-provider relationships, and risk scores.

- ***Notifications and Alerting:*** New alerts will be built such that notification happens within the context of a providers existing workflow.

- ***Reporting and Analytics:*** Existing reporting capabilities will be expanded and made available to many more care managers.

- ***Basic Care Management Software:*** The current scope is for planning only.

- ***Practice Transformation:*** The current scope is for planning only.

CRISP has already made some early progress in the first six months of the project, including with ambulatory connectivity and care management software pilots. Ambulatory connectivity is picking up momentum, but deeper clinical integration is mostly occurring with larger hospital-owned practices. Smaller practices continue to be challenging. The care management software pilots will be in operation by March 2016.

Funding Sources

Funding for this project has been derived from two main sources. The first is through hospital rates as authorized by the Budget Reconciliation and Financing Act (BRFA) of 2014. The Act authorized HSCRC to include within hospital rates up to $15 million for care coordination activities. To date, this funding has gone to the various activities displayed in **Exhibit 5**. Much of the funding ended up in the MHCC budget, as MHCC is the principle State agency that contracts with CRISP. As seen in Exhibit 5, the primary funding priority for these dollars has been to build-out ICN infrastructure, particularly for the better management of Medicare patients. This focus makes sense in the context of the targets in the new All-payer Model Contract.

Second, the BRFA of 2015 authorized HSCRC in fiscal 2016 through 2019 to utilize a portion of the remaining fund balance from the Maryland Health Insurance Plan to support ICNs designed to reduce health care expenditures and improve outcomes for specified Medicare and dual-eligible (Medicaid and Medicare) patients, consistent with the goals of Maryland's All-payer Model Contract. There is more than $18 million included in the current working appropriation and $25 million in the fiscal 2017 allowance for this purpose. **HSCRC should comment on the current status of the ICN projects, where the infrastructure build-out is so far, and what steps they plan to take to get more small, nonhospital-based providers into the ICNs.**

Exhibit 5
2014 BRFA Coordination Funds Uses

Regional Partnerships	
Grants	$2,500,000
Technical assistance	1,000,000
CRISP	
CRS	1,539,000
ICN Initial	229,850
ICN Infrastructure	8,201,000
Total	**$13,469,850**

BRFA: Budget Reconciliation and Financing Act
CRISP: Chesapeake Regional Information System for our Patients
CRS: CRISP Reporting Service
ICN: Integrated Care Network

Source: Health Services Cost Review Commission

3. Preliminary Sunset Evaluations for MHCC and HSCRC

During the 2015 interim, both MHCC and HSCRC underwent preliminary sunset evaluations by the Department of Legislative Services (DLS). The main DLS recommendation was the same for both commissions, which was that the Legislative Policy Committee (LPC) waive both commissions from full evaluation at this time while requiring DLS to conduct a review, by December 1, 2016, of the missions and responsibilities of all three health care regulatory commissions and make recommendations regarding how the responsibilities and roles of the commissions could be better aligned. This recommendation was approved by LPC on December 15, 2015.

Report Summary

In the preliminary evaluations, DLS notes that both commissions continue to fulfill their statutory obligations, which have increased significantly since their most recent evaluations, meet their

respective performance metrics successfully, and provide important policy guidance to the State. However, the implementation of the new All-payer Model Contract, which was previously discussed, along with the changes brought forth by the federal Patient Protection and Affordable Care Act, are drastically changing the landscape of health policy in the State. Further, the change to a population-based approach within the waiver model now impacts not only hospitals but community providers as well. As such, MHCC, HSCRC, and MCHRC which currently each have varying policy and funding roles may now have overlapping responsibilities. The recommendation proposed by DLS, and approved by LPC, will seek to determine the extent to which the roles and responsibilities of the commissions overlap and possibly how these roles and responsibilities may be better aligned in moving forward.

Beyond this main recommendation, both preliminary sunset reviews also identified other policy considerations for the current legislative session. For HSCRC, DLS noted that should HSCRC, in conjunction with CMMI, attempt to expand the scope of the model contract, the current user fee cap of $12 million may need to be raised. DLS also noted that staffing concerns continue to be an issue within HSCRC and recommended that the commission continue to explore innovative ways to meet its staffing needs, including a reevaluation of its current salary schedule. For MHCC, DLS found that the current assessment fee cap of $12 million continues to be inadequate for funding all of the activities of the commission, and subsequently recommended that the cap be raised to $15 million. DLS also recommended that MHCC explore how the workload distribution calculation, which is used to determine what proportion of the user fee assessment each of the four users of MHCC contributes to the assessment, might consider future workload requirements as opposed to the current practice of only considering past workload. **Both commissions should comment on their progress toward addressing the DLS recommendations, including the ability of each commission to function under the current user fee assessment caps.**

Recommended Actions

1. Concur with Governor's allowance.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Health Regulatory Commissions
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$0	$198,616	$0	$0	$198,616
Deficiency Appropriation	0	0	0	0	0
Cost Containment	0	0	0	0	0
Budget Amendments	0	-10,687	3,132	0	-7,555
Reversions and Cancellations	0	-11,607	-1,684	0	-13,291
Actual Expenditures	**$0**	**$176,322**	**$1,449**	**$0**	**$177,770**
Fiscal 2016					
Legislative Appropriation	$0	$198,360	$228	$173	$198,760
Budget Amendments	0	35,454	2,264	0	37,718
Working Appropriation	**$0**	**$233,814**	**$2,492**	**$173**	**$236,479**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

Actual expenditures for the Health Regulatory Commissions were $20,845,270 below the legislative appropriation. Budget amendments removed $10,687,033 in special funds, primarily due to underutilization of the Uncompensated Care Fund ($14,786,156). Large increases in special funds through budget amendments included $4,500,000 to cover the cost of a contract with CRISP to perform work related to the HIE for hospitals in the State (of which subsequently $629,249 was transferred to Medicaid), $123,199 to hire an administrator position as well as fund a contract with Johns Hopkins to evaluate the HEZ program, and $105,173 for the 2015 cost-of-living adjustment. Special fund cancellations totaled $11,606,821, which were mainly related to higher than expected turnover and further underutilization of the Uncompensated Care Fund.

Federal fund expenditures increased by $1,448,584. This is due to a budget amendment that added $3,132,418 to cover the cost for the Health Insurance Premium Review grants, of which $1,683,834 was subsequently canceled.

Fiscal 2016

To date, the working appropriation for the commissions had increased by a total of $37,718,311, including $35,454,477 in special funds and $2,263,834 in federal funds. The largest increase is $18,472,102 in special funds for the ICNs within HSCRC. Other special fund increases include:

- $14,750,000 for CRISP to be paid out of hospital rates per the BRFA of 2014;
- $1,718,206 for HSCRC to cover deficits in salaries and contractual services;
- $214,169 to restore a 2% pay reduction;
- $200,000 to increase the allotment for the University of Maryland Medical System Shock Trauma Center grant; and
- $100,000 for a grant from the Network for Regional Health Care Improvements.

The increase in federal funds is entirely due to a grant to MHCC to conduct Cycle IV of the Health Insurance Premium Rate Review under the federal Affordable Care Act.

Appendix 2

Audit Findings

Audit Period for Last Audit:	May 16, 2011 – June 30, 2014
Issue Date:	February 5, 2015
Number of Findings:	2
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: One individual at MHCC had excessive control over the Maryland Trauma Physician Services Fund.

Finding 2: Grant agreements made by MCHRC were not always executed prior to disbursing funds and certain health care grants were not adequately monitored.

Object/Fund Difference Report
DHMH – Health Regulatory Commissions

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	102.70	103.70	103.70	0.00	0%
Total Positions	**102.70**	**103.70**	**103.70**	**0.00**	**0%**
Objects					
01 Salaries and Wages	$ 11,854,382	$ 13,794,227	$ 13,258,907	-$ 535,320	-3.9%
02 Technical and Spec. Fees	22,558	36,158	37,633	1,475	4.1%
03 Communication	72,613	94,365	75,762	-18,603	-19.7%
04 Travel	89,772	211,781	237,177	25,396	12.0%
08 Contractual Services	154,684,547	194,810,323	205,563,601	10,753,278	5.5%
09 Supplies and Materials	64,661	81,894	79,670	-2,224	-2.7%
10 Equipment – Replacement	30,600	50,495	21,300	-29,195	-57.8%
11 Equipment – Additional	322,907	168,800	168,800	0	0%
12 Grants, Subsidies, and Contributions	10,142,122	26,722,208	10,560,345	-16,161,863	-60.5%
13 Fixed Charges	486,163	508,425	506,431	-1,994	-0.4%
Total Objects	**$ 177,770,325**	**$ 236,478,676**	**$ 230,509,626**	**-$ 5,969,050**	**-2.5%**
Funds					
03 Special Fund	$ 176,321,741	$ 233,814,224	$ 230,337,126	-$ 3,477,098	-1.5%
05 Federal Fund	1,448,584	2,491,952	0	-2,491,952	-100.0%
09 Reimbursable Fund	0	172,500	172,500	0	0%
Total Funds	**$ 177,770,325**	**$ 236,478,676**	**$ 230,509,626**	**-$ 5,969,050**	**-2.5%**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Health Regulatory Commissions

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Maryland Health Care Commission	$ 32,624,993	$ 47,597,714	$ 34,319,369	-$ 13,278,345	-27.9%
02 Health Services Cost Review Commission	137,589,364	180,577,371	188,098,489	7,521,118	4.2%
03 Maryland Community Health Resources Commission	7,555,968	8,303,591	8,091,768	-211,823	-2.6%
Total Expenditures	**$ 177,770,325**	**$ 236,478,676**	**$ 230,509,626**	**-$ 5,969,050**	**-2.5%**
Special Fund	$ 176,321,741	$ 233,814,224	$ 230,337,126	-$ 3,477,098	-1.5%
Federal Fund	1,448,584	2,491,952	0	-2,491,952	-100.0%
Total Appropriations	**$ 177,770,325**	**$ 236,306,176**	**$ 230,337,126**	**-$ 5,969,050**	**-2.5%**
Reimbursable Fund	$ 0	$ 172,500	$ 172,500	$ 0	0%
Total Funds	**$ 177,770,325**	**$ 236,478,676**	**$ 230,509,626**	**-$ 5,969,050**	**-2.5%**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies. The fiscal 2017 allowance does not include contingent reductions.

Department of Human Resources
Fiscal 2017 Budget Overview

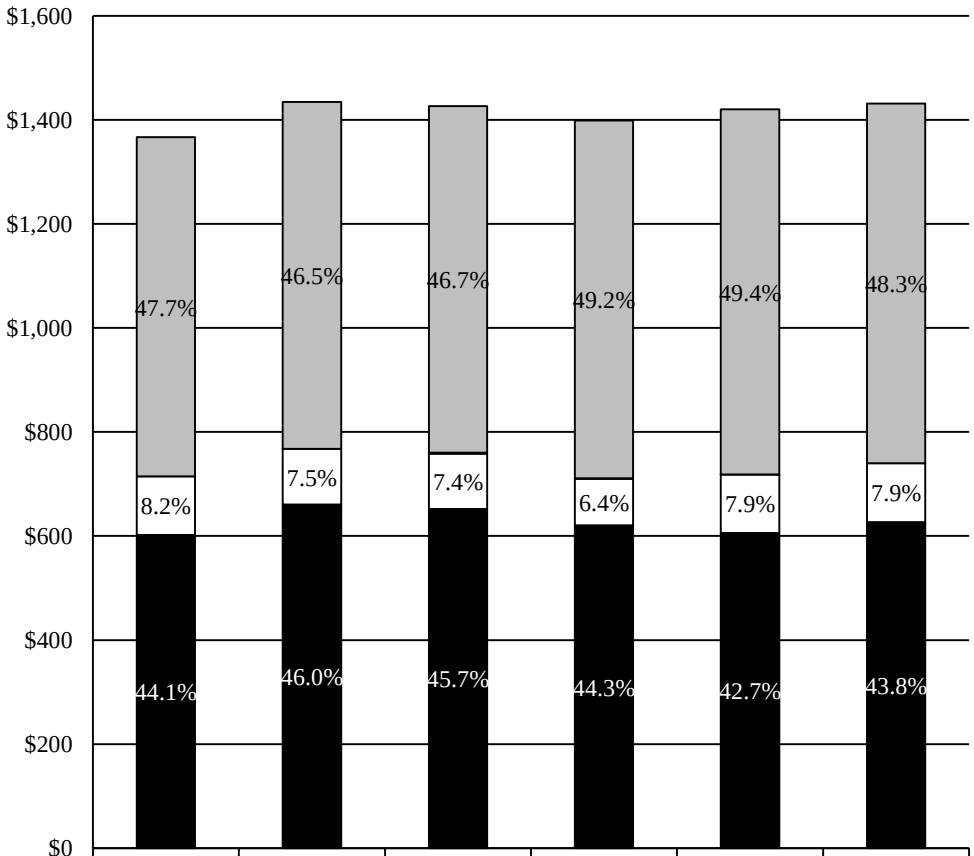
Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

January 2016

For further information contact: Tonya D. Zimmerman Phone: (410) 946-5530

N00
Department of Human Resources
Fiscal 2017 Budget Overview

Department of Human Resources – Funding by Source
Fiscal 2012-2017
($ in Millions)



	2012 Actual	2013 Actual	2014 Actual	2015 Actual	2016 Working	2017 Allowance
Federal Funds (Excluding SNAP)	$652.0	$667.2	$666.3	$688.0	$701.5	$691.5
Reimbursable Funds	0.0	0.0	2.1	0.4	0.6	0.0
Special Funds	112.6	107.1	106.0	90.0	112.0	113.5
General Funds	602.0	660.3	652.1	620.3	606.1	626.5
Total (Excluding SNAP)	$1,366.6	$1,434.6	$1,426.5	$1,398.8	$1,420.2	$1,431.5

SNAP: Supplemental Nutrition Assistance Program

Note: Figures exclude Supplemental Nutrition Assistance Program benefit payments. Fiscal 2016 figures reflect planned reversions assumed in the Governor's fiscal 2017 budget plan. Fiscal 2017 figures include the back of the bill reduction for health insurance. Numbers may not sum to total due to rounding.

Source: Maryland State Budget

The fiscal 2017 allowance for the Department of Human Resources (DHR) increases by $7.4 million, or 0.3%, compared to the fiscal 2016 working appropriation, after accounting for planned reversions in fiscal 2016 and the back of the bill reduction for health insurance in fiscal 2017. When excluding benefit payments for the Supplemental Nutrition Assistance Program (SNAP), a large low-income nutrition program funded 100.0% by the federal government, spending increases by $11.4 million, or 0.8%. Despite the limited change overall, the fiscal 2017 allowance includes a more substantial change in the fund sources. Specifically:

- General funds increase by $20.4 million, or 3.4%, in the fiscal 2017 allowance after accounting for planned reversions and the back of the bill reduction included in the Governor's budget plan. With this increase, general funds comprise 43.8% of the DHR budget (excluding SNAP), an increase from 42.7% in the fiscal 2016 working appropriation. Major general fund changes occur in:
  - administrative areas (for example, the Family Investment Administration (FIA), increases $11.8 million, or 23.1%, largely in the area of personnel);
  - support for the Temporary Cash Assistance (TCA) program, which increases by $6.0 million (or 31.3%) in the fiscal 2017 allowance; and
  - foster care maintenance payments, which decrease by $7.4 million, or 4.0%.
- Special funds increase by a net of $1.5 million, or 1.3%, in the fiscal 2017 allowance largely in:
  - Strategic Energy Investment Funds available for energy assistance, which increase by $7.2 million, or 20.7%, due to anticipated revenue from the Regional Greenhouse Gas Initiative carbon dioxide emission allowance auctions;
  - Child Support Offset Funds (for TCA-related cases), which decreases by $3.1 million, and Child Support Foster Care Offset Funds, which decrease by $0.7 million; and
  - Foster Care Education Funds, which decrease by $1.9 million.
- Federal funds decrease by a net of $13.9 million in the fiscal 2017 allowance when including SNAP, or $10.0 million when excluding SNAP. With this reduction, excluding SNAP, federal funds comprise 48.3% of the DHR fiscal 2017 allowance, a decrease from 49.4% in the fiscal 2016 working appropriation. Despite this decrease, some federal fund revenue assumptions appear optimistic based on recent history. This issue will be discussed further in other DHR analyses. Major federal fund changes include:
  - a decrease of $7.8 million in child care-related federal funds due to the transition of the eligibility determination function to the Maryland State Department of Education (MSDE), providing $6.1 million of this funding for remaining activities;

- a decrease of approximately $4.0 million in Low-Income Home Energy Assistance Program funds, providing $64.6 million, slightly less than has been received in recent years;

- a decrease of $3.9 million in SNAP to align with the fiscal 2015 expenditures;

- a decrease of $3.1 million in Medical Assistance Program funding resulting from the inability to bill Medicaid for rehabilitative services in Foster Care ($16.4 million) partially offset by increases elsewhere in the budget;

- a decrease of $1.9 million in Foster Care Title IV-E funding, which is more than offset by an increase of $3.9 million in Title IV-E Waiver funding;

- an increase of $1.4 million in administrative funding for SNAP; and

- an increase of $1.8 million in Temporary Assistance for Needy Families (TANF).

Department of Human Resources
Budget Overview: All Funds
Fiscal 2015-2017
($ in Thousands)

	2015 Actual	2016 Working	2017 Allowance	2016-17 $ Change	2016-17 % Change
Family Investment	**$461,963**	**$436,775**	**$451,052**	**$14,278**	**3.3%**
TCA Payments	141,580	130,728	133,306	2,579	2.0%
TDAP	40,600	40,104	40,104	0	0.0%
Other Public Assistance	17,839	15,616	16,039	423	2.7%
Work Opportunities	34,680	33,288	33,311	23	0.1%
Office of Grants Management	18,973	13,129	13,181	52	0.4%
Administration	208,291	203,910	215,111	11,201	5.5%
Office of Home Energy Programs	**$123,471**	**$137,572**	**$140,800**	**$3,228**	**2.3%**
Social Services	**$548,252**	**$580,317**	**$571,880**	**-$8,437**	**-1.5%**
Foster Care/Adoption	269,292	288,730	262,320	-26,410	-9.1%
Programs/Administration	278,960	291,587	309,560	17,973	6.2%
Child Support Enforcement	**$88,368**	**$90,781**	**$91,870**	**$1,089**	**1.2%**
Administration	**$176,750**	**$174,734**	**$175,947**	**$1,213**	**0.7%**
Office of the Secretary	27,751	29,292	29,470	178	0.6%
Operations	33,986	30,857	30,658	-200	-0.6%
Information Management	72,119	71,320	70,792	-529	-0.7%
Local Department Operations	42,894	43,264	45,028	1,764	4.1%
Total	**$1,398,804**	**$1,420,179**	**$1,431,550**	**$11,371**	**0.8%**
General Funds	$620,343	$606,097	$626,536	$20,439	3.4%
Special Funds	90,047	112,026	113,490	1,464	1.3%
Federal Funds (Excluding SNAP)	687,999	701,486	691,524	-9,962	-1.4%
Reimbursable Funds	414	569	0	-569	-100.0%
Total Funds (Excluding SNAP)	**$1,398,804**	**$1,420,179**	**$1,431,550**	**$11,371**	**0.8%**
SNAP	**$1,147,618**	**$1,151,553**	**$1,147,618**	**-$3,935**	**-0.3%**
Total (Including SNAP)	**$2,546,422**	**$2,571,732**	**$2,579,167**	**$7,436**	**0.3%**

SNAP: Supplemental Nutrition Assistance Program
TCA: Temporary Cash Assistance
TDAP: Temporary Disability Assistance Program

Note: Fiscal 2016 figures include planned reversions assumed in the Governor's fiscal 2017 budget plan. Fiscal 2017 figures include the back of the bill reductions for health insurance. Health insurance reductions assumed in the Governor's 2017 budget plan are applied to administrative units; in Administration, the amount is fully applied to the Local Department Operations row of that unit. Numbers may not sum to total due to rounding.

Source: Maryland State Budget; Department of Human Resources

Department of Human Resources
Budget Overview: General Funds
Fiscal 2015-2017
($ in Thousands)

	2015 Actual	2016 Working	2017 Allowance	2016-17 $ Change	2016-17 % Change
Family Investment	**$145,024**	**$125,046**	**$143,274**	**$18,228**	**14.6%**
TCA Payments	26,962	19,266	25,305	6,039	31.3%
TDAP	35,467	34,065	34,065	0	0.0%
SNAP	0	0	0	0	0.0%
Other Public Assistance	10,644	8,524	8,826	301	3.5%
Work Opportunities	0	0	0	0	0.0%
Office of Grants Management	11,915	11,963	12,007	43	0.4%
Administration	60,036	51,227	63,071	11,845	23.1%
Office of Home Energy Programs	**$0**	**$0**	**$0**	**$0**	**0.0%**
Social Services	**$363,737**	**$368,080**	**$365,823**	**-$2,258**	**-0.6%**
Foster Care/Adoption	186,069	185,234	177,800	-7,434	-4.0%
Programs/Administration	177,668	182,847	188,023	5,176	2.8%
Child Support Enforcement	**$17,942**	**$18,800**	**$19,025**	**$225**	**1.2%**
Administration	**$93,640**	**$94,172**	**$98,415**	**$4,243**	**4.5%**
Office of the Secretary	18,629	20,342	20,717	375	1.8%
Operations	17,333	17,244	18,254	1,009	5.9%
Information Management	32,425	30,988	31,574	586	1.9%
Local Department Operations	25,254	25,597	27,870	2,273	8.9%
Total	**$620,343**	**$606,097**	**$626,536**	**$20,439**	**3.4%**

SNAP: Supplemental Nutrition Assistance Program
TCA: Temporary Cash Assistance
TDAP: Temporary Disability Assistance Program

Note: Fiscal 2016 figures include planned reversions assumed in the Governor's fiscal 2017 budget plan. Fiscal 2017 figures include the back of the bill reductions for health insurance. Health insurance reductions assumed in the Governor's 2017 budget plan are applied to administrative units; in Administration, the amount is fully applied to the Local Department Operations row of that unit. Numbers may not sum to total due to rounding.

Source: Maryland State Budget; Department of Human Resources

Fiscal 2016 Actions

DHR's fiscal 2016 appropriation was reduced by $10.7 million in total funds as part of the 2% across-the-board reductions ($6.9 million in general funds and $3.8 million in federal funds). **Exhibit 1** provides information on the reductions made by the department.

Exhibit 1
Fiscal 2016 Across-the-board Reductions

	General Fund	Federal Fund	Total
82 vacant position abolitions	$2,956,262	$2,769,438	$5,725,700
Caseload Changes			
Public Assistance to Adults due to declining caseloads resulting from changes in regulations requiring stronger medical justification for placement in assisted living facilities	1,557,885	0	1,557,885
Foster care maintenance payments due to declining caseloads	1,316,011	0	1,316,011
Operational Expenses			
Office of Technology for Human Services including reductions for information technology contracts due to lower utilitization and actual costs, reductions in equipment replacement, reductions in maintenance contracts	$767,494	$678,181	$1,445,675
Montgomery County grant in Local Family Investment, Local Child Welfare Services, and Local General Administration programs	152,285	147,207	299,492
Division of Administrative Services for reductions to building projects, equipment replacement, printing, copying, and emergency shelter supplies	113,809	136,087	249,896
Social Services Administration and Local Child Welfare Services program for facility rentals for meetings and training events and interpreter services	24,254	37,301	61,555
Total Reductions	**$6,888,000**	**$3,768,214**	**$10,656,214**

Source: Department of Budget and Management; Department of Human Resources

Planned Reversions

- Section 48 of the fiscal 2016 budget bill restricted $13.0 million from the TCA program as part of a larger group of restrictions to restore legislative priorities. The Governor's fiscal 2017 budget plan assumes some of the restrictions included in Section 48 will revert to the General Fund, including the $13.0 million restricted from TCA.

- The Governor's fiscal 2017 budget plan also assumes a reversion of $6.4 million in general funds from the Foster Care Maintenance Payments program due to anticipated savings from caseload declines.

Back of the Bill Sections

- Section 19 of the fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. The DHR share of these reductions is $1.8 million in total funds ($871,985 in general funds, $25,722 in special funds, and $873,521 in federal funds).

- There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency. During fiscal 2016, DHR abolished 82.0 vacant positions in addition to the 23.0 vacant positions abolished in the fiscal 2016 budget as introduced. The fiscal 2017 allowance abolishes an additional 21.0 positions. Combined, these actions eliminated 126.0 vacant positions. DHR had a total of 496.5 vacant positions on January 1, 2016, some of which are those abolished in the fiscal 2017 allowance. DHR needs to maintain 445.4 vacant positions to meet fiscal 2017 turnover expectancy.

Department of Human Resources
Major Changes in the Fiscal 2017 Allowance
($ in Millions)

Where It Goes:	
Personnel Expenses	
Employee and retiree health insurance	$8,916
Employee retirement	8,228
Overtime	5,021
Turnover adjustments	2,148
General fund support provided to Local Family Investment Program to account for shortfall from transition of Child Care Subsidy eligibility determination function to the Maryland State Department of Education	2,000
Accrued Leave Payout	775
Unemployment and Workers Compensation	-527
Social Security Contributions	-747
Regular earnings	-1,681
Abolition of 21 regular positions and transfer of 2 positions to another State agency	-1,885
Administration	
Contract for maintenance of the Enterprise Content Management System	1,469
Contract for Technical Operations Support Services	-1,334
Social Services Administration	
Title IV-E Waiver Intervention Services and Evidence-based practice assessments	-678
Foster care maintenance payments accounting for a planned reversion and the transfer of waiver intervention services to another area of the administration	-17,732
Child Support Enforcement Administration	
Cooperative Reimbursement Agreements	1,327
Family Investment Administration	
Temporary Cash Assistance after accounting for a planned reversion of restricted funds	2,579
Supplemental Nutrition Assistance Program benefits to align with recent experience	-3,935
Office of Home Energy Programs	
Energy assistance based on anticipated availability of funding	2,277
Local Administering Agency contracts	900
Other Adjustments	315
Total	**$7,436**

Note: Fiscal 2016 figures include planned reversions assumed in the Governor's fiscal 2016 budget plan. Fiscal 2017 figures include the back of the bill reductions for health insurance. Numbers may not sum to total due to rounding.

The average TCA benefit is projected to decrease slightly from the budgeted amount of $192.60 in fiscal 2016 to $192.30 in the fiscal 2017 allowance. However, through November 2015 (the most recent data available), the average monthly benefit in fiscal 2016 was $191.73. Based on that benefit level, the fiscal 2017 average monthly benefit estimate would be a slight increase compared to fiscal 2016. Overall, the fiscal 2017 allowance increases funding for TCA despite a lower estimated caseload and benefit. It appears that TCA may be over-budgeted in the fiscal 2017 allowance.

Foster care maintenance payments decrease in the fiscal 2017 allowance by $17.7 million compared to the fiscal 2016 working appropriation to better align with the fiscal 2015 actual caseloads and expenditures, after accounting for the planned reversion and a transfer of funding for waiver intervention services. The fiscal 2017 allowance is approximately $7.0 million, or 2.6%, lower than fiscal 2015 expenditures. Although other areas of the State budget that include rates set by the Interagency Rates Committee (such as nonpublic placements in MSDE) assume an inflationary increase for providers in fiscal 2017, the institutional foster care payments do not. In fact, the average estimated payments generally reflect a slight decrease.

The fiscal 2017 allowance includes funding for employee increments within the Department of Budget and Management (DBM). The funding will be distributed to agencies by budget amendment at the beginning of the fiscal year. The DHR share of the employee increments totals $7.9 million in total funds ($4.1 million in general funds, $119,110 in special funds, and $3.7 million in federal funds).

Department of Human Resources
Caseload Estimates Assumed in the Budget
Fiscal 2014-2017

Program	2014 Actual	2015 Actual	2016 Estimated	2017 Estimated	2016-2017 % Change
Cash Assistance					
TCA	63,746	61,739	62,191	57,768	-7.1%
TDAP	18,477	18,500	18,281	18,281	0.0%
Child Welfare					
Foster Care	4,987	3,908	4,250	3,849	-9.4%
Subsidized Adoption\Guardianship	9,576	9,569	9,750	9,546	-2.1%
Child Support Enforcement					
TCA Collections	$20,391,666	$19,928,688	$19,530,114	$19,139,512	-2.0%
Non-TCA Collections	538,170,746	543,836,476	549,872,701	555,957,331	1.1%

TCA: Temporary Cash Assistance
TDAP: Temporary Disability Assistance Program

Note: The fiscal 2016 estimates for both TCA and foster care/subsidized adoptions/guardianships are higher than what the budget could support based on planned reversions and other fiscal 2016 cost containment actions.

Source: Maryland State Budget; Department of Human Resources

- The fiscal 2017 allowance projects a decrease in the average monthly recipients for TCA of 7.1% compared to fiscal 2016. However, the fiscal 2016 estimate has not been updated since the budget introduction in the 2015 session and is higher than could be supported with the budget as a result of the restriction of funding for legislative priorities in Section 48 of the fiscal 2016 budget bill. Through November 2015 (the most recent data available), the fiscal 2016 average monthly recipients was 58,869, and in November 2015, the number of recipients was 57,734.

- The average monthly recipients in the Temporary Disability Assistance Program are expected to remain level between fiscal 2016 and 2017 at 18,281. Through November 2015, the average monthly recipients in fiscal 2016 is higher than the estimate (18,486); however, in November 2015, the number of recipients was 18,257.

- The fiscal 2017 allowance projects a decrease of 9.4% in the foster care caseload and 2.1% in the subsidized adoption and guardianship caseload compared to fiscal 2016. The fiscal 2016

estimate of foster care cases is substantially higher than the fiscal 2015 actual caseload. The fiscal 2017 allowance projects a foster care caseload that is 1.5% lower and a subsidized adoption and guardianship caseload that is 0.2% lower than the fiscal 2015 actual average monthly caseload.

- TCA-related child support collections are projected to decrease by 2.0% in fiscal 2017 compared to fiscal 2016 estimates, while non-TCA-related collections are expected to increase by 1.1%, which reflects recent experience. The combined change would result in a 1.0% increase in child support collections in fiscal 2017.

Department of Human Resources
Employment: Full-time Equivalent Regular Positions and Contractual Positions
Fiscal 2015-2017

	2015 Actual	2016 Legislative	2016 Working	2016 Change	2017 Allowance	2016-17 Change
Regular Positions						
Social Services	2,807.9	2,786.9	2,738.9	-48.0	2,737.9	-1.0
Family Investment	2,113.4	2,113.4	2,093.4	-20.0	2,089.4	-4.0
Administration	861.0	859.0	846.0	-13.0	831.0	-15.0
Child Support Enforcement	665.9	665.9	664.9	-1.0	661.9	-3.0
Office of Home Energy Programs	16.9	16.9	16.9	0.0	16.9	0.0
Total Positions	**6,465.1**	**6,442.1**	**6,360.1**	**-82.0**	**6,337.1**	**-23.0**
Contractual Positions						
Social Services	2.56	2.50	2.50	0.00	2.50	0.00
Family Investment	88.42	68.00	68.00	0.00	68.00	0.00
Administration	28.61	2.90	2.90	0.00	2.90	0.00
Child Support Enforcement	12.71	1.00	1.00	0.00	1.00	0.00
Office of Home Energy Programs	3.95	0.00	0.00	0.00	0.00	0.00
Total Positions	**136.25**	**74.40**	**74.40**	**0.00**	**74.40**	**0.00**

Source: Maryland State Budget

- As part of the agency's actions to meet the 2% across-the-board reduction in fiscal 2016, DHR abolished 82 positions. This action accounts for the decrease in positions between the fiscal 2016 legislative appropriation and working appropriation. DHR abolished 47 positions in the Social Services Administration (SSA), 23 positions in FIA, and 12 positions in DHR Administration.

- DHR also transferred some positions internally within fiscal 2016, resulting in a net increase in 3 positions in FIA, and a 1 position decrease in each of SSA, Child Support Enforcement Administration, and DHR Administration.

- The fiscal 2017 allowance abolishes 21 regular positions and transfers 2 regular positions to another State agency. The majority of these abolished positions occur in DHR Administration primarily in the Office of Technology for Human Services.

- There are no changes in the number of contractual full-time equivalent positions in the fiscal 2017 allowance.

Department of Human Resources
Filled Regular Positions
Fiscal 2014-2016
January 1 Data

	2014	2015	2016	Change 2015-16	% Change 2015-16
Administration	816.0	820.5	776.0	-44.5	-5.4%
Social Services	2,582.4	2,560.7	2,528.4	-32.3	-1.3%
Child Support Enforcement	630.4	636.1	608.9	-27.2	-4.3%
Family Investment	1,958.0	1,926.0	1,951.3	25.3	1.3%
Total	**5,986.8**	**5,943.3**	**5,864.6**	**-78.7**	**-1.3%**

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

Source: Department of Budget and Management

- The number of filled regular positions decreased by 78.7 positions, or 1.3%, between January 1, 2015, and January 1, 2016. The only increase in filled positions occurred in FIA, which had 25.3 more filled positions (1.3%), in fiscal 2016 than in fiscal 2015, despite having 33.0 fewer positions. DHR Administration had the largest decrease in filled regular positions, 44.5 positions (or 5.4%), largely because it had 42.0 fewer positions.

- In total, as of January 1, 2016, DHR had 496.5 vacant regular positions. The budgeted turnover rate for DHR in fiscal 2016 is 7.65%, which would require 486.8 positions to be vacant through fiscal 2016. DHR could fill 9.7 positions and still meet its turnover rate. Agencywide, the turnover rate decreases in the fiscal 2017 allowance to approximately 7.0%.

Issues

1. DHR Continues to Rely on Temporary Assistance for Needy Families Contingency Funds

Maryland receives $229.1 million annually from the federal government for the State's TANF block grant, and since fiscal 2009, Maryland has also received contingency funds that are available to states meeting certain criteria in SNAP participation or unemployment. In order to receive TANF contingency funds, a state must meet one of two conditions:

- an unemployment rate of at least 6.5% that is 110.0% higher in a three-month period compared to the same three-month period in either of the two prior years; or

- a food stamp caseload that is 110.0% higher than in a three-month period than in a corresponding three-month period in 1994 or 1995.

Maryland continues to qualify for these funds because of the increase in SNAP cases. For example, in January 1996 (the earliest date for which data is readily available), households in Maryland certified for SNAP totaled 160,593, while in November 2015, SNAP cases totaled 405,131, 252.3% of the January 1996 cases. The amount of contingency funds received by Maryland has varied but since fiscal 2012, has been near or higher than $20.0 million.

Despite the contingency funds, Maryland began to run a deficit in TANF funding following the recession. DHR took steps to reduce the deficit, and by fiscal 2014, the deficit fell to $6.8 million. However, as is shown in **Exhibit 2**, in fiscal 2015, the deficit began to grow again after decreasing in the prior two years, reaching approximately $16.0 million. The growth in the deficit occurred as DHR spent $263.8 million of TANF in fiscal 2015 despite having received only $254.6 million. The spending in that year was the highest since fiscal 2011, the year that DHR began to run a TANF deficit. To fund these deficits, DHR primarily uses the following year's appropriation to cover expenditures.

DHR projects the TANF deficit will continue to grow in fiscal 2016 and 2017, reaching $30.4 million by the end of fiscal 2017, as DHR continues to budget more TANF than it anticipates receiving. DHR projections are conservative and do not account for any additional contingency funds beyond the amount DHR had in hand as of January 2016 ($7.6 million). Given that Maryland is likely to remain eligible for contingency funds in fiscal 2016 and 2017, and contingency funds have been funded at the same level nationwide in federal fiscal 2016 as in federal fiscal 2015, Maryland should receive additional contingency funds. If DHR were to receive the same level of contingency funds in fiscal 2016 and 2017 as it did in fiscal 2015 ($25.5 million), the deficit would be virtually eliminated in fiscal 2016, and there would be a balance in TANF of approximately $13.1 million in fiscal 2017.

Exhibit 2
Availability of TANF Funding
Fiscal 2014-2017
($ in Millions)

	2014 Actual	2015 Actual	2016 Working	2017 Allowance
Beginning Balance	**-$13.086**	**-$6.754**	**-$15.965**	**-$18.429**
TANF Grant	$229.098	$229.098	$229.098	$229.098
Contingency TANF	22.749	25.522	7.636	0.000
Total Income	**$251.848**	**$254.620**	**$236.734**	**$229.098**
Available Funding (Balance + Income)	**$238.761**	**$247.866**	**$220.769**	**$210.669**
DHR Appropriation	-$245.515	-$263.831	-$239.198	-$241.026
Total Expenditures	**-$245.515**	**-$263.831**	**-$239.198**	**-$241.026**
Ending Balance	**-$6.754**	**-$15.965**	**-$18.429**	**-$30.357**

DHR: Department of Human Resources
TANF: Temporary Assistance for Needy Families

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

Source: Department of Human Resources

Exhibit 3 provides information on the spending of TANF between fiscal 2014 and 2017. Total TANF spending in the fiscal 2017 allowance is $241.0 million, an increase of $1.8 million compared to fiscal 2016. This level of spending is $11.9 million higher than Maryland's base TANF grant.

As shown in this exhibit, the amount of funding used for cash assistance decreased by $15.8 million from fiscal 2014 to 2015 and $12.5 million between fiscal 2015 and 2016. In fiscal 2016 and 2017, $107.9 million of TANF is expected to be spent on cash assistance. Spending in other areas of the budget, particularly Child and Adult Social Services and Family Investment Services, increased between fiscal 2014 and 2015. While this increase appears to be one-time for Child and Adult Social Services, the TANF spending on FIA Services increases by $11.5 million in fiscal 2016 to $55.7 million and is expected to remain at that level in fiscal 2017.

Exhibit 3
Changes in TANF Spending in the DHR Budget
Fiscal 2014-2017 Allowance
($ in Millions)

Activity	2014 Actual	2015 Actual	2016 Working	2017 Allowance	2016-17 Change
Cash assistance	$136.3	$120.5	$107.9	$107.9	$0.0
Work opportunities	34.6	34.7	33.3	33.3	0.0
Family Investment Services	29.7	44.2	55.7	55.7	0.0
Foster Care Maintenance Payments	6.9	6.9	6.9	6.9	0.0
Child and Adult Social Services	22.5	39.3	22.2	24.3	2.1
General Administration	15.6	18.3	13.2	13.0	-0.3
Total DHR Expenditures	**$245.5**	**$263.8**	**$239.2**	**$241.0**	**$1.8**

DHR: Department of Human Resources
TANF: Temporary Assistance for Needy Families

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

Source: Maryland State Budget; Department of Human Resources

State's Maintenance of Effort Requirement Met

In return for the annual TANF block grant, the State must spend $177.7 million of its own money to meet a federal Maintenance of Effort (MOE) requirement, which is 75% of its spending on TANF's predecessor programs in fiscal 1994. Additional MOE funds are required when a state receives contingency funds, specifically, a state must spend 100% of what it spent on the predecessor programs, and then contingency funds must be matched by MOE spending.

Exhibit 4 provides a summary of MOE funding from fiscal 2015 through 2017. Although Maryland has received only a limited amount of contingency funds through January 2016 and is not currently reflecting any additional contingency funds through fiscal 2017, Exhibit 4 shows that the State has accounted for MOE spending to accommodate approximately $22.8 million of contingency funds. Even with the additional MOE required for contingency funds, the State would have $114.5 million of excess MOE spending in fiscal 2016 and 2017.

Exhibit 4
TANF Maintenance of Effort
Fiscal 2015-2017 Allowance
($ in Thousands)

	2015 Actual	2016 Working	2017 Allowance	2016-17 Change
Cash Assistance	$15,322	$17,822	$17,822	$0
Employment Services/Caseworkers	7,197	7,197	7,197	0
Administration	4,112	4,112	4,112	0
Kinship Care/Foster Care Payments	3,363	3,363	3,363	0
Social Services Administration	15,527	15,527	15,527	0
Community Services – Emergency Food, Shelter, Child 1st	2,758	2,758	2,758	0
Refundable State Earned Income Tax Credit	141,369	141,369	141,369	0
Montgomery County Earned Income Tax Credit	17,118	17,118	17,118	0
MSDE Pre-K	86,193	86,193	86,193	0
Electric Universal Service Program	54,699	54,699	54,699	0
Subtotal	***$347,658***	***$350,158***	***$350,158***	***$0***
Required Maintenance of Effort				
Base	$176,965	$176,965	$176,965	$0
Contingency Fund Add-on	35,941	35,941	35,941	0
Contingency Fund Match	25,522	22,749	22,749	0
Total Required	**$238,428**	**$235,655**	**$235,655**	**$0**
Excess Maintenance of Effort	**$109,230**	**$114,503**	**$114,503**	**$0**

MSDE: Maryland State Department of Education
TANF: Temporary Assistance for Needy Families

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

Source: Department of Human Resources; Department of Legislative Services

2. Child Care Subsidy Eligibility Determination Transition

On July 1, 2006, the administration of the Child Care Subsidy program was transferred to MSDE from DHR. However, DHR, through the local departments of social services (LDSS), continued to conduct certain child care subsidy tasks (mailing, invoice processing, and case management including eligibility determination) through a Memorandum of Agreement with MSDE. In early 2010, MSDE assumed the role of mailing and invoice processing and contracted these services to a private vendor.

DHR Funding and the Child Care Subsidy Program

DHR received federal funds (Child Care Mandatory and Matching Funds and Child Care and Development Block Grant funds) from MSDE for performing the mailing, invoicing, case management, and eligibility determination activities. **Exhibit 5** presents information on the fiscal 2014 and 2015 actual expenditures in DHR of these funds and the funds budgeted in fiscal 2016 and 2017 for this purpose.

Exhibit 5
Child Care Federal Funds in the Department of Human Resources
Fiscal 2014-2017

		2014 Actual	2015 Actual	2016 Working	2017 Allowance
N00A01.01	Office of the Secretary	$298,302	$327,813	$302,928	$0
N00B00.04	Social Services Administration		$195		0
N00E01.01	Division of Budget, Finance, and Personnel	273,544	316,373	403,736	0
N00E01.02	Division of Administrative Services	104,998	90,557	147,240	0
N00F00.02	Major Information Technology Development Project	46,794	2,370	0	0
N00F00.04	Office of Technology for Human Services	178,609	147,612	1,176,846	0
N00G00.02	Local Family Investment Administration	7,270,510	8,842,997	10,644,641	6,127,094
N00G00.03	Local Child Welfare Services	25,105	19,891	20,317	0
N00G00.04	Local Adult Services	7,196	6,242	0	0
N00G00.05	Local General Administration	682,049	690,692	1,079,594	0
N00I00.04	Director's Office – Family Investment Administration	141,236	163,959	187,481	0
	Total	**$9,028,343**	**$10,608,701**	**$13,962,783**	**6,127,094**

Source: Governor's Budget Books

DHR uses these funds primarily to support the LDSS work in determining eligibility and for case management. Other funds are used to support the information technology (IT) system used for these purposes and other administrative support in the department. The funds that are used in LDSS contribute to the funding for the caseworker positions.

Transition of Eligibility Determination and Case Management Functions

During the 2014 session, the Department of Legislative Services (DLS) learned that MSDE intended to transfer the eligibility and case management services from DHR. The transfer allows the administration of the program to be fully consolidated.

Fiscal 2015 budget bill language withheld $100,000 of general funds in DHR and MSDE until a report was jointly submitted by the agencies on:

- how the shift in eligibility determinations improves the Child Care Subsidy program both for individuals receiving the subsidy and MSDE;
- how MSDE's vendor will implement the child care subsidy eligibility determinations;
- the impact on services provided to individuals wishing to apply for multiple social services programs including the child care subsidy;
- the impact on DHR's eligibility determination function with respect to quality of performance, positions required, budgetary needs, and how DHR can reduce spending on eligibility determinations by $13.1 million;
- how and when funding will shift from DHR to MSDE and how much DHR will need as a replacement; and
- an accounting of costs and savings for MSDE and the vendor contract.

The report was due on July 1, 2014, with a follow-up report including budget costs and savings and other substantive changes to the program to be submitted December 1, 2014. MSDE requested an extension to submit the reports due to procurement delays. An extension was granted to allow the initial report to be due the same month as the contract was approved by the Board of Public Works, and the follow-up report due six months later.

The contract for the centralized case management services, including eligibility determinations, case management, and payment processing was awarded in May 2015 to Xerox with the transition from DHR completed in August 2015. On June 30, 2015, DHR and MSDE submitted the initial report. Due to the timing of the initial report and the contract award, the agencies could not submit the follow-up report six months after the contract award and still submit the report during the fiscal year; however, the restricted funds were released.

Following the submission of the report, DLS learned that DHR will continue to conduct eligibility determinations for the Child Care Subsidy cases that involve TCA recipients. **DHR should explain to the committees the reason for retaining this portion of the Child Care Subsidy program activities. DHR should also explain how it is working with MSDE on these cases.**

Impact of the Transition on DHR Funding and Agency Operations

Due to delays in the procurement and the timing of the contract award, DHR had already budgeted federal funds related to child care in fiscal 2016 to support the case management and eligibility determination functions within the agency.

LDSS staff that provided Child Care Subsidy eligibility determination services also provide services for a variety of other benefits including SNAP, TCA, and Medical Assistance. DHR attributes staff time for funding purposes by time studies using a federally approved Random Moment Sample. These studies and the time attributed to various work and, therefore, federal funding will be impacted by the change in eligibility determination from the date of the transition including the loss of federal funds associated with the program.

Between fiscal 2007 and 2015, the agencies reported receiving federal funds ranging from a low of approximately $9.0 million in fiscal 2014 to a high of $13.7 million in fiscal 2010. As shown previously in Exhibit 5, DHR budgeted nearly $14.0 million in fiscal 2016 for this purpose but can only expect to receive reimbursements for time spent before the transition (July and August) and time spent to determine eligibility for the TCA-related cases.

To the extent that LDSS staff, post Child Care Subsidy transition, spend more of their time on other benefit programs, DHR may be able to claim a higher share of federal funds from those programs to support caseworker positions. At the time of the report, the agencies reported that DHR and DBM were working together to recover lost revenue through maximizing other federal fund sources. However, there is expected to be a loss to DHR from the transition. Initially, DHR estimated a shortfall between $6 million and $8 million from the transition. This shortfall would be expected to be lower than this amount, to the extent that DHR continues to perform work related to TCA cases.

The budget does not include a fiscal 2016 deficiency appropriation to account for this anticipated shortfall. The fiscal 2017 allowance includes a $2 million increase in general funds in the Local Family Investment Program to address the shortfall from the transition in that year and $6.1 million of federal funds remain in the program to account for the services still provided. It is not clear that the full $6.1 million will be available to DHR, given that in fiscal 2014 and 2015, the agency received less than $11.0 million for work on all cases, and in September 2015, children in TCA cases were only 30% of children in the program. Although these additional funds should assist in reducing the shortfall, it is not clear whether this fully resolves any shortfall that may occur.

DHR should comment on the budget shortfall that resulted from the transition in fiscal 2016 and whether any shortfall is expected for fiscal 2017. DHR should also comment on the plans of the department to address this shortfall in fiscal 2016 and 2017.

3. Local Department Operations Audit

In July 2015, the Office of Legislative Audits (OLA) released a fiscal compliance audit for the DHR Local Department Operations Unit covering the period July 1, 2011, through December 14, 2014. The Local Department Operations audit is handled differently than a standard fiscal compliance audit conducted by OLA. The Office of Inspector General (OIG) in DHR audits the individual LDSS. OLA determines whether it can rely on the work of the OIG to meet OLA's audit objectives. If OLA determines it can rely on the work of the OIG, the audit findings are generally based on the OIG's work. For the fiscal compliance audit released in July 2015, OLA determined it could rely on the OIG's audits of LDSS as a basis for its work.

The audit contained eight findings, of which five were repeated from the prior audit, as shown in **Exhibit 6**. Some of the findings included in the audit were also included in audits of the individual DHR administrations. The five repeat findings are discussed in this issue.

Exhibit 6
Audit Findings

Audit Period for Last Audit:	July 1, 2011 to December 14, 2014
Issue Date:	July 2015
Number of Findings:	8
Number of Repeat Findings:	5
% of Repeat Findings:	62.5%
Rating: (if applicable)	n/a

Finding 1: **The most recent Office of Inspector General (OIG) audits of the Local Departments of Social Services (LDSS) contained a significant number of reportable conditions and repeat findings.**

Finding 2: OIG corrective action monitoring process for LDSS audits was not effectively followed.

Finding 3: OIG audit reports of LDSS were not distributed to all appropriate parties.

Finding 4: **Controls were insufficient over bank accounts, procurements, and gift cards.**

Finding 5: **Numerous LDSS deficiencies existed related to critical Family Investment Administration policies.**

Finding 6: Numerous LDSS deficiencies existed related to critical Social Services Administration policies.

Finding 7: **Users' access to certain key computer systems was not properly restricted and monitored.**

Finding 8: **Medicaid eligibility determinations for long-term care recipients were not always proper.**

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

Source: Office of Legislative Audits

Monitoring of Corrective Actions

Finding 1 stated that the OIG audits of LDSS contained a significant number of reportable conditions, including many repeat findings and that DHR executive management had not established a formal process to provide oversight and monitoring of corrective actions. OLA noted that while OIG did have a corrective action monitoring process, the department's executive management did not. A separate (nonrepeat) finding, however, noted that OIG was not effectively following its corrective action monitoring process.

Specifically, OLA noted that in the audit reports for LDSS issued as of December 2014, there were a total of 299 findings, of which 89 were repeated from the prior OIG audit of LDSS. OLA noted that five of these audit reports contained at least 20 findings, one of which had 30 findings. **Exhibit 7** provides the number of findings and repeat findings by jurisdiction.

Exhibit 7
Number of Findings by Jurisdiction

	Total Findings	Repeat Findings	% of Findings That Are Repeat
Allegany	9	1	11.1%
Anne Arundel	16	5	31.3%
Baltimore City	28	14	50.0%
Baltimore County	14	8	57.1%
Calvert	12	4	33.3%
Caroline	9	1	11.1%
Carroll	7	1	14.3%
Cecil	9	2	22.2%
Charles	20	6	30.0%
Dorchester	6	2	33.3%
Frederick	7	1	14.3%
Garrett	7	2	28.6%
Harford	9	1	11.1%
Howard	26	8	30.8%
Kent	5	0	0.0%
Montgomery	30	13	43.3%
Prince George's	26	14	53.8%
Queen Anne's	5	1	20.0%
St. Mary's	10	4	40.0%
Somerset	11	0	0.0%
Talbot	6	0	0.0%
Washington	7	0	0.0%
Wicomico	11	0	0.0%
Worcester	9	1	11.1%
Total	**299**	**89**	**29.8%**

Source: Office of Legislative Audits

OLA noted that the total count of findings was lower than the prior audit report (a decrease of 74 findings), but the number of repeat findings had increased (an increase of 12 findings). In addition, the percent of total findings that were repeat findings had also increased from 21% in the prior audit report to 30% in the current report. OLA recommended that DHR (the Office of the Secretary and management of the administrations in DHR) establish a process to actively monitor corrective actions taken to address repeat audit findings.

Financial Management Findings

Finding 4 stated that controls were insufficient over bank accounts, procurements, and gift cards. Specifically, OLA noted that there were 97 findings from audit reports for 23 of LDSS related to these fiscal areas. Findings included that:

- bank accounts maintained by LDSS were not reconciled in a timely manner;
- bank accounts had checks outstanding for long periods;
- bank accounts had former employees that continued as authorized check signers;
- LDSS had inadequate physical security over blank check inventories;
- State procurement regulations were not always followed including making payments without written contracts; and
- LDSS had not established accountability of prepaid gift cards including failure to document physical inventories of these gift cards.

OLA recommended that DHR establish appropriate accountability and control over fiscal operations and specifically ensure LDSS establish adequate control over bank accounts and blank check inventories including the timely preparation of account reconciliations and resolution of outstanding checks, comply with State procurement regulations, and establish proper accountability over prepaid gift cards.

FIA-related Findings

Finding 5 stated that numerous LDSS deficiencies existed related to critical FIA policies, such as ensuring eligibility for public assistance and food benefits. Specifically, OLA noted that there were 70 findings from audit reports for 22 of the LDSS related to FIA policies. Findings in this area included that:

- critical duties over Electronic Benefits Transfer System (EBT) cards were not properly segregated and, therefore, LDSS could not ensure that benefits were issued to the intended recipients;

- physical inventory counts of EBT cards found differences between the number of EBT cards on hand and records of these cards;

- the required number of public assistance case files were not subject to supervisory review; and

- potential payment or client eligibility errors noted in periodic OIG computer matches were not pursued timely.

OLA recommended that DHR ensure that FIA program requirements are complied with by LDSS and that DHR ensure that the LDSS establish appropriate controls over the EBT card inventories, perform supervisory reviews on the required number of case files, and perform timely follow-up on all potential payment or eligibility errors identified by the OIG.

OIG conducted a separate review of the DHR Bureau of Long-Term Care, which is included in OLA's review of the Local Department Operations Unit audits. This bureau performs eligibility determinations for Medicaid long-term care recipients for Anne Arundel, Baltimore, and Prince George's counties, and Baltimore City. Finding 8 stated that Medicaid eligibility determinations for long-term care recipients were not always adequately documented. Specifically, OLA noted that:

- certain case records could not be located;

- certain eligibility documentation was missing;

- real property searches to assist in determining if financial resources were within the limit established by State regulations were not conducted.

OLA recommended that DHR ensure that the Bureau of Long-Term Care properly performs Medicaid eligibility determinations.

Information Technology Security

Finding 7 stated that users' access to certain key computer systems was not properly restricted and monitored. Specifically, OLA noted that 40 findings from 21 LDSS related to IT security, including inadequate controls over the granting of user access to critical systems and employees' assigned access capabilities were not properly monitored. OLA recommended that DHR establish appropriate accountability and control over information system access and ensure that LDSS maintain a properly completed and approved authorization form for all user accesses granted, assign access capabilities appropriate to each employee's job duties, and perform formal and periodic monitoring of employee system access and delete the access of former employees.

Corrective Actions

DHR stated in its response to the audit that it agreed with most of the recommendations made by OLA. DHR explained that it had taken action in response to many of the findings and recommendations for those recommendations with which it agreed. In instances where the agency disagreed, actions to respond to the finding were not generally provided. One of the actions taken by DHR in response to the OLA recommendations was that the department established a Corrective Action Monitoring and Resolution team that meets on a regular basis, identifies root causes of findings, provides solutions for resolving findings, and keeps parties accountable.

The Joint Audit Committee (JAC) continues to be concerned with the number and frequency of repeat audit findings across State agencies as cited by OLA. In an effort to satisfactorily resolve these findings, JAC has asked the budget committees to consider action in the agency budgets where such findings occur. As noted this audit contained five repeat audit findings. **Recognizing the challenges in resolving all of the repeat findings, DLS instead recommends that a portion of the Office of the Secretary's appropriation be withheld until OLA has assessed the status of the repeat findings.** This language does not require all of the repeat findings to be resolved.

Recommended Actions

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

, provided that since the Department of Human Resources (DHR) Local Department Operations Unit has had four or more repeat audit findings in the most recent fiscal compliance audit issued by the Office of Legislative Audits (OLA), $100,000 of this agency's administrative appropriation may not be expended unless:

(1) DHR has reported the corrective action taken with respect to all repeat findings on or before January 1, 2017; and

(2) a report is submitted to the budget committees by OLA listing each repeat finding along with an assessment of the corrective action taken by DHR for each repeat finding. The budget committees shall have 45 days to review and comment to allow funds to be released prior to the end of fiscal 2017.

Explanation: The Joint Audit Committee has requested that budget bill language be added for each unit of State government that has four or more repeat audit findings in its most recent fiscal compliance audit. Each such agency is to have a portion of its administrative budget withheld pending the adoption of corrective action by the agency and a determination by OLA that each finding was corrected. Due to the nature of the Local Department Operation Unit audit and the volume of findings to be corrected by the Local Departments of Social Services an alteration to the standard language is prudent. This language requires DHR to report on corrective actions and have OLA assess the corrective actions taken by DHR rather than having the findings resolved.

Information Request	Author	Due Date
Assessment of corrective actions related to the most recent fiscal compliance audit	OLA	45 days before the release of funds

N00A01
Administration
Department of Human Resources

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$93,640	$94,172	$98,556	$4,384	4.7%
Deficiencies and Reductions	0	0	-141	-141	
Adjusted General Fund	**$93,640**	**$94,172**	**$98,415**	**$4,243**	**4.5%**
Special Fund	4,057	4,007	4,126	119	3.0%
Deficiencies and Reductions	0	0	-2	-2	
Adjusted Special Fund	**$4,057**	**$4,007**	**$4,124**	**$116**	**2.9%**
Federal Fund	78,958	75,986	73,496	-2,490	-3.3%
Deficiencies and Reductions	0	0	-87	-87	
Adjusted Federal Fund	**$78,958**	**$75,986**	**$73,409**	**-$2,577**	**-3.4%**
Reimbursable Fund	95	569	0	-569	-100.0%
Adjusted Reimbursable Fund	**$95**	**$569**	**$0**	**-$569**	**-100.0%**
Adjusted Grand Total	**$176,750**	**$174,734**	**$175,947**	**$1,213**	**0.7%**

- The fiscal 2017 allowance of the Department of Human Resources (DHR) Administration increases by $1.2 million, or 0.7%, compared to the fiscal 2016 working appropriation. Increases of $4.2 million in general funds and $116,445 in special funds were partially offset by a decrease of $2.6 million in federal funds and $569,486 in reimbursable funds.

- A large increase ($1.5 million) in general funds in the Office of Technology for Human Services (OTHS) is due to a contract for operations and maintenance of the Enterprise Content Management System.

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

For further information contact: Jared S. Sussman Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	861.00	846.00	831.00	-15.00
Contractual FTEs	28.61	2.90	2.90	0.00
Total Personnel	**889.61**	**848.90**	**833.90**	**-15.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	58.09	6.99%
Positions and Percentage Vacant as of 12/31/15	70.00	8.27%

- The fiscal 2017 allowance abolishes 15.0 vacant regular positions in DHR Administration. The large majority (13.0) of the positions are located in OTHS. Of the remaining 2.0 abolished positions, 1.0 is located in the Division of Budget Finance and Personnel and 1.0 is located in the Carroll County Department of Social Services.

- Turnover expectancy in DHR Administration decreases from 8.02% to 6.99% in fiscal 2017.

- As of December 31, 2015, DHR Administration has a vacancy rate of 8.27%, or 70.0 positions. After accounting for the 15.0 abolished positions, the vacancy rate would be 6.6%. To meet the turnover expectancy of 6.99%, DHR Administration needs to maintain 58.09 vacant positions, which is 3.09 positions more than the current vacancies after adjusting for the abolitions.

Analysis in Brief

Major Trends

DHR Continues to Struggle with Procurement Goals: DHR failed to meet goals related to the percent of procurement contract dollars with minority business enterprises and the percent of contracts for which the date received by the Procurement Division is within the established guidelines for the number of days required to process the contract.

Out-of-home Placement Reviews Increase: Out-of-home placement case reviews increased in fiscal 2015.

DHR Fails to Meet Goals in Two of Three Areas of Services Provided to Children in Out-of-home Placement Reviews: In its Managing for Results (MFR) submission for the Citizen's Review Board for Children (CRBC), DHR reports on several measures of outcomes that are captured in the out-of-home placement reviews. While these measures do not reflect the work of CRBC, the measures reflect the services provided by the local departments of social services. In fiscal 2015, the department did not meet its goals for the percent of children receiving appropriate physical and mental health services and the percent of children with a permanent connection identified.

DHR Fails to Include Earned Income Tax Credit Performance Measures in Managing for Results Submission: Narrative in the 2015 *Joint Chairmen's Report* requested DHR to include goals, objectives, and performance measures related to the State Earned Income Tax Credit (EITC) in its fiscal 2017 MFR. The fiscal 2017 MFR submissions do not include measures related to EITC.

Recommended Actions

1. Add budget language restricting general funds until corrective actions related to repeat audit findings are completed.

2. Add budget bill language restricting general funds in the Maryland Legal Services Program to that purpose.

Updates

Status of Corrective Actions for Audit Findings: In June 2014, the Office of Legislative Audits (OLA) released a fiscal compliance audit for the Office of the Secretary in DHR covering most of the administrative operations of the agency. The audit covered the period from November 17, 2009, to August 12, 2012. Of the nine findings contained in the audit, four were repeated from the previous audit. As of this writing, OLA has not submitted certification regarding the Office of the Secretary's

correction of its repeat audit findings in response to this language. As a result, the funds continue to be withheld.

N00A01
Administration
Department of Human Resources

Operating Budget Analysis

Program Description

The Department of Human Resources (DHR) administers programs through a State-supervised and locally administered system. DHR Administration provides direction through four major units:

- Office of the Secretary;
- Operations Office;
- Office of Technology for Human Services (OTHS); and
- Local General Administration.

The key goal of DHR Administration is to be recognized as a national leader among human service agencies.

Office of the Secretary

The Office of the Secretary provides overall direction and coordination for all programs and activities of DHR. The Office of the Secretary includes the offices of the Attorney General, chief of staff, and deputy secretaries; communications; employment and program equity; inspector general; planning and performance; and government, corporate, and community affairs. Other programs contained within the Office of the Secretary are:

- the Citizen's Review Board for Children (CRBC);
- the Maryland Commission for Women; and
- the Maryland Legal Services Program.

Operations Office

The Operations Office consists of two divisions. The Division of Budget, Finance, and Personnel (DBFP) supports the programs of other units in the department through the management and control of fiscal and personnel systems. The Division of Administrative Services provides key administrative services including fleet management, records management, and risk management to DHR, as well as disaster relief and emergency response throughout the State.

Office of Technology and Human Services

OTHS is responsible for the overall management and direction of DHR information systems. This includes responsibility for computer applications and systems; computer and communication equipment; computer peripheral equipment; ancillary facility and support equipment; and consumables and supplies. OTHS is responsible for the development and administration of DHR information technology (IT) systems including:

- the Child Support Enforcement System;
- the Client Automated Resource and Eligibility System (CARES);
- the Maryland Children's Electronic Social Services Information Exchange (known as MD CHESSIE);
- the Office of Home Energy Programs data system; and
- WORKS, the computer system for the Work Opportunities Program.

Local General Administration

Local departments of social services (LDSS) are situated in each county and Baltimore City; the administrative budgets of each LDSS are combined into the Local General Administrative (LGA) unit for the purposes of the State budget. LGA provides essential support services and staff to operate the 24 LDSS, including the management of staff, finance, statistical reporting, general services, central records, fleet operations, buildings and grounds, equipment, supplies, procurement, and inventory.

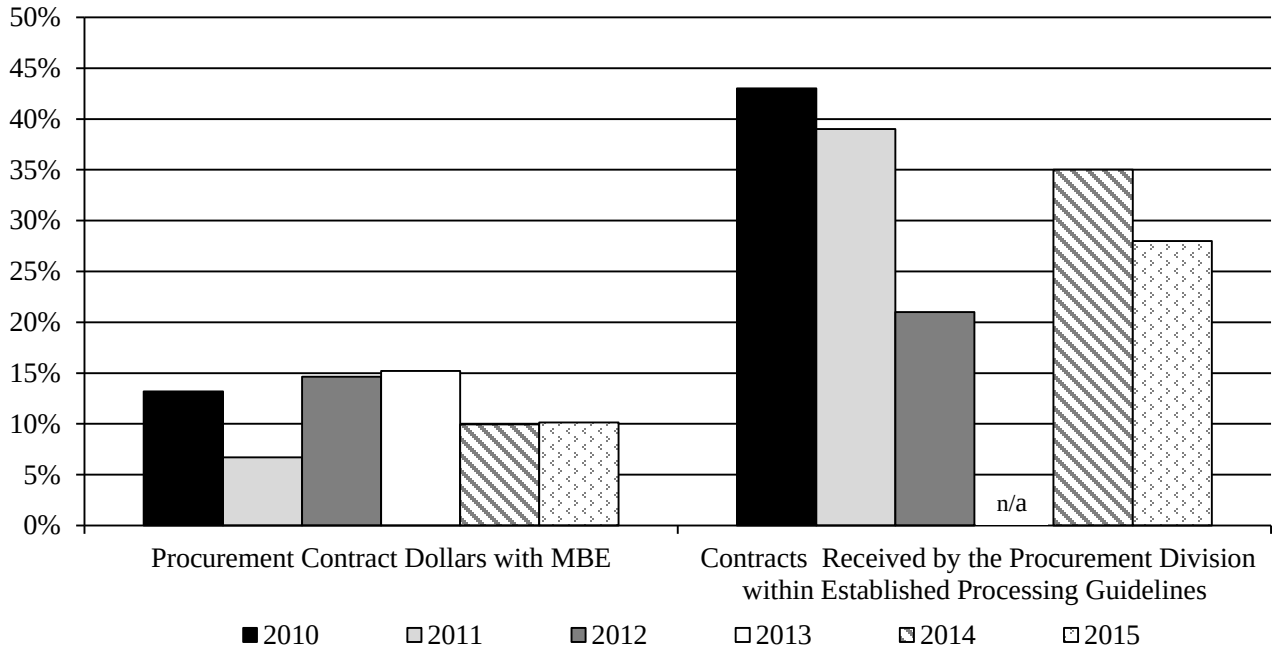
Performance Analysis: Managing for Results

1. DHR Continues to Struggle with Procurement Goals

The DHR goal for the Office of the Secretary is to comply with statewide requirements for agency performance. One of the measures for this goal is the percentage of procurement dollars with Minority Business Enterprises (MBE). Chapter 154 of 2012 eliminated the statewide 25% MBE goal instead requiring the Special Secretary of Minority Affairs, in consultation with the Office of the Attorney General and the Secretary of Transportation, to establish a percentage goal on a biennial basis and apply the previous year's goal for any year that a percentage goal is not established. The 25% goal remained in effect through fiscal 2013. The goal in fiscal 2014 and 2015, however, is 29%.

As shown in **Exhibit 1**, DHR failed to meet either the new 29.0% goal or the old 25.0% MBE goal in all recent years. After performance improved slightly in fiscal 2013 (increasing from 14.7% to 15.2%), the percentage of procurement dollars with MBEs decreased to 10.0% in fiscal 2014 and increased slightly in fiscal 2015 to 10.15%. In an effort to increase the percentage of procurement contract dollars awarded to MBEs, the DHR Office of Performance Management held a strategic planning session focused on better planning for MBE subcontracting opportunities; coordinating resources, training, and information; and filling a key position that will build stronger relationships with MBEs and the small business community.

Exhibit 1
Procurement – Various Data
Fiscal 2010-2015



MBE: Minority Business Enterprise
n/a: not applicable

Note: The Department of Human Resources did not include the percent of contracts received within established guidelines in the 2014 Managing for Results submissions.

Source: Department of Human Resources; Governor's Budget Books

DHR has set a goal of having 50% of contracts received by the Procurement Division from other divisions of DHR within established processing guidelines, which is a key step in the achievement of a timely contract award. DHR performance for this measure increased significantly in fiscal 2014.

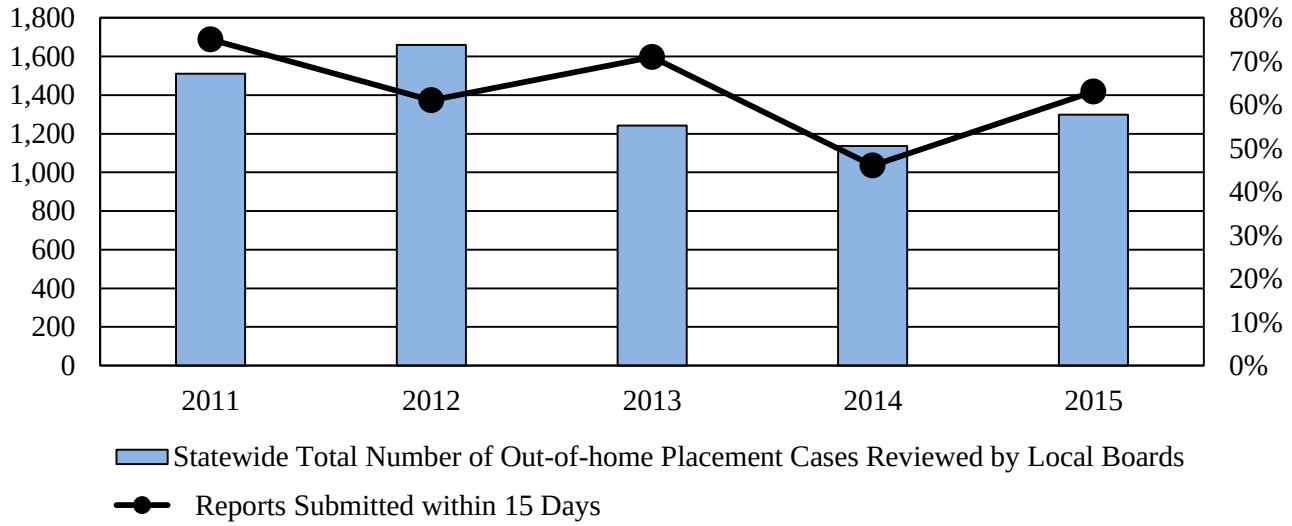
However, as shown in Exhibit 1, in fiscal 2015, performance for this measure decreased from 35% to 28%.

2. Out-of-home Placement Reviews Increase

CRBC trains local volunteer boards to aid in child protection efforts. The local boards have a goal to submit 75% of reports on case reviews within 15 days of the review. In fiscal 2015, the number of out-of-home placement review cases reviewed by local boards increased after large decreases in the previous two years. The percent of reports on case reviews submitted within 15 days of the review rose substantially, but still fell short of the 75% goal.

Exhibit 2 presents data on the number of out-of-home placement cases reviewed by local boards. The number of out-of-home placement cases reviewed increased by 14.3% in fiscal 2015 after large decreases in the two previous years. The decreases in previous years were largely due to staff vacancies in positions that impact the scheduling of reviews and other functions, and a decrease in volunteers. In the previous year, DHR indicated that CRBC planned to hire a volunteer recruitment coordinator to increase volunteers statewide. The volunteer recruitment coordinator position was posted and a suitable candidate was not found. **DHR should comment on its progress in filling the volunteer recruitment coordinator position and on the number of volunteers necessary.**

Exhibit 2
Citizen's Review Board for Children
Out-of-home Placement Reviews
Fiscal 2011-2015



Source: Department of Human Resources; Governor's Budget Books

CRBC has a goal of submitting 75% of reports on the out-of-home placement case reviews within 15 days of the review. As also shown in Exhibit 2, after meeting the goal in fiscal 2011, the CRBC performance has been below the goal in each subsequent year. In fiscal 2015, performance in this measure rose from 46% to 63% of reports submitted within 15 days of the review, which is still below the 75% goal. DHR indicates that the substantial increase over the previous year was due to training and communication regarding the *Code of Maryland Regulations*. DHR intends to improve performance in this measure by tracking, monitoring, and reviewing processes that may impede performance.

3. DHR Fails to Meet Goals in Two of Three Areas of Services Provided to Children in Out-of-home Placement Reviews

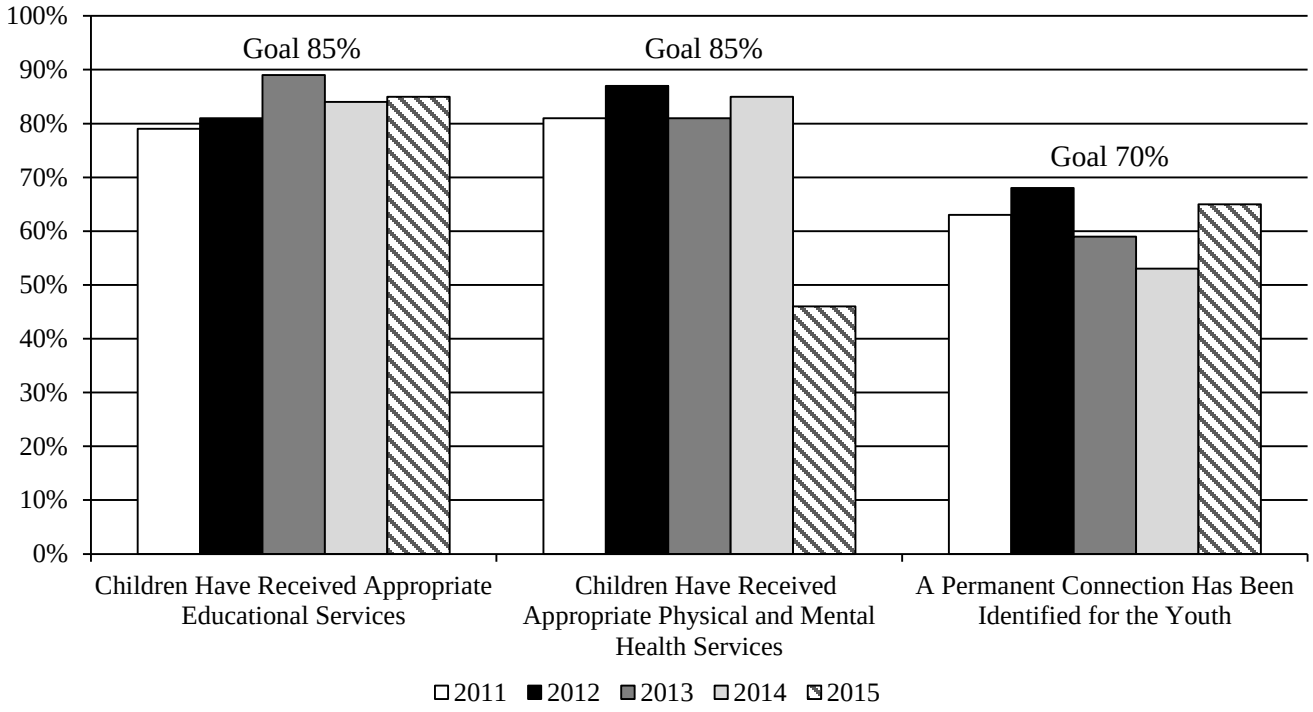
Exhibit 3 contains information on three outcome measures as determined by CRBC. While these outcome measures are not directly impacted by activities of CRBC, the measures provide a means of evaluating LDSS child welfare activities. Based on cases reviewed by CRBC, in fiscal 2015, the percent of children receiving appropriate educational services increased from 84% to 85%, meeting the performance goal. However, LDSS failed to meet the goal of 85% of children receiving appropriate physical and mental health services. The performance declined substantially from hitting the goal of 85% in fiscal 2014 to 46% in fiscal 2015. **The Secretary should comment on the decrease in children receiving appropriate physical and mental health services.**

Based on cases reviewed by CRBC, the percent of cases in which a permanent connection had been identified for the youth increased. In fiscal 2014, 53% of cases had a permanent connection identified. In fiscal 2015, 65% of cases had a permanent connection identified, 5 percentage points from the goal.

4. DHR Fails to Include Earned Income Tax Credit Performance Measures in Managing for Results Submission

Narrative in the 2015 *Joint Chairmen's Report* requested DHR to include goals, objectives, and performance measures related to the State Earned Income Tax Credit (EITC) in its fiscal 2017 Managing for Results (MFR) submission. In its budget response, DHR indicated that it would work with the Department of Budget and Management to integrate goals, objectives, and performance measures related to the program into its performance measures and would submit it with its fiscal 2017 MFR submissions. The fiscal 2017 MFR submissions did not include measures related to EITC. **The Secretary should comment on the absence of EITC goals, objectives, and performance measures in its MFR submission.**

Exhibit 3
Citizen's Review Board for Children
Outcomes of Reviews
Fiscal 2011-2015



Source: Department of Human Resources; Governor's Budget Books

Fiscal 2016 Actions

Cost Containment

DHR Administration's general fund was reduced by $1,392,698 with an additional reduction of $1,165,563 in federal funds, totaling $2,558,261. DHR realized $839,003 of the reduction by abolishing 12 vacant positions ($496,197 in general funds and $342,806 in federal funds). Reductions in operating expenditures amounted to $352,280 ($172,809 in general funds and $179,471 in federal funds). Reductions in the Technical Operations Support Services (TOSS) contract and the Enterprise Project Management Office contract amounted to $1,343,291 ($708,494 in general funds and $634,797 in federal funds). A reduction in the Montgomery County grant amounted to $23,683 ($15,198 in general funds and $8,485 in federal funds).

Proposed Budget

As shown in **Exhibit 4**, the fiscal 2017 allowance of DHR Administration increases by $1.2 million, or 0.7% compared to the fiscal 2016 working appropriation. An increase in general funds ($4.2 million) and special funds ($116,445) is partially offset by a decrease in federal funds ($2.6 million).

Exhibit 4
Proposed Budget
DHR – Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$93,640	$4,057	$78,958	$95	$176,750
Fiscal 2016 Working Appropriation	94,172	4,007	75,986	569	174,734
Fiscal 2017 Allowance	98,415	4,124	73,409	0	175,947
Fiscal 2016-2017 Amout Change	$4,243	$116	-$2,577	-$569	$1,213
Fiscal 2016-2017 Percent Change	4.5%	2.9%	-3.4%	-100.0%	0.7%

Where It Goes:	
Personnel Expenses	
Employee retirement	$1,152
Employee and retiree health insurance	992
Turnover adjustment	704
Accrued leave payout	271
Other fringe benefit adjustments	9
Workers' compensation	-95
Social Security contributions	-150
Salaries	-289
Abolition of 15 positions	-1,301
Information Technology	
Contract for Enterprise Content Management System Operations and Maintenance	1,469
Software licenses	712
Automated Financial System Major Information Technology Development Project Fund	337
Microsoft Office Professional software	315
Enterprise Project Management	-279
Electronic Benefits Transfers due to implementation of a new methodology for the cost per case	-284

Where It Goes:	
Laptop and computer replacement	-612
Decrease in Technical Operations Support Services	-1,334
Cost Allocation	
Statewide Personnel System allocation	280
Department of Information Technology services allocation	143
Insurance coverage	143
Statewide Budget System allocation	136
Office of Attorney General administrative fees and Retirement administrative fees	74
Department of Budget and Management paid telecommunications	-184
Administrative Expenses	
Contractual employment not related to Medicaid Rehabilitation Unit abatement	152
Family Food Day Care Program	51
Attorney fees	37
Motor vehicle purchase	-59
Baltimore County office supplies	-147
Local office rent	-237
Decrease in contractual employee expenses because DHR is no longer allowed to bill Medicaid for Medicaid Rehabilitative Services	-783
Other	-10
Total	**$1,213**

DHR: Department of Human Resources

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

Personnel

Personnel costs in DHR Administration's allowance increase by $1,292,459. This increase is primarily driven by employee retirement and health insurance costs. This increase is despite a decrease of $1,301,105 due to the elimination of 15 vacant positions. Most are IT positions that were abolished following recommendation by the Department of Information Technology (DoIT). One position was transferred to another agency. However, after accounting for the abolished positions, the vacancy rate decreases from 8.27% to 6.60%. While the fiscal 2017 allowance offers some turnover relief ($704,000), the new vacancy rate is still below budgeted turnover expectancy (6.99%) **The Secretary should comment on how DHR Administration intends to meet budgeted turnover expectancy.**

Office of Technology for Human Services

Enterprise Content Management System

The Enterprise Content Management System (ECMS) will be in the third year of operations and maintenance in fiscal 2017. ECMS is a web-based Enterprise Content Management Solution application that is used statewide to capture content of documents used to determine benefits for DHR customers. The fiscal 2017 allowance increases by $1,469,480 for the operations and maintenance contract. DHR indicates that the increase in the contract costs is largely due to an increase in the scope of work. The new contract includes updates to software and technology, as well as the ability to integrate future ECMS expansion features. **The Secretary should explain the need to increase the scope of the contract.**

Technical Operations Support Services

Contract costs for TOSS decrease by $1.3 million in the fiscal 2017 allowance. The contract provides staff that support DHR-wide systems. The contract began in June 2015 and ends in May 2018 with two one-year renewal options. Decreases in the contract cost in the allowance are due to structural reductions in fiscal 2016 to reflect actual costs that were carried over into fiscal 2017.

Major IT Development Projects

The Automated Financial System Replacement project will create a system used in LDSS to maintain the financial transaction history and generate checks for vendor payments, including child care and foster care providers. The existing system is written in an outdated language and, as a result, DHR indicates that it is difficult to find maintenance and support for the application. Additional information on the project goals and schedule is shown in **Appendix 2**.

In the 2015 legislative session, DHR indicated that it would complete the planning phase in November 2015. DHR completed the planning phase in mid-December 2015. The implementation phase is set to begin in March 2016, as planned in the fiscal 2017 Information Technology Project Request (ITPR).

The total estimated project cost is $5.5 million. The ITPR submitted for fiscal 2016 calculated the total estimated project cost as $2.2 million. DHR indicates that the $3.3 million increase is due to now having an accurate estimate of the implementation phase costs. The fiscal 2017 allowance includes $2.49 million for the project (half from the Major Information Technology Development Project Fund (MITDF) and half in federal funds in DHR Administration). The fiscal 2016 appropriation was $676,500 ($338,250 in both the MITDF and in federal funds in DHR Administration). Despite an appropriation of $338,250 in the MITDF, DoIT transferred DHR $569,496 in reimbursable funds for the project in fiscal 2016. The two departments state that the additional reimbursable funds are due to funds from fiscal 2014 and 2015 appropriations which were unspent. DHR indicates that it intends to increase the fiscal 2016 federal fund appropriation through a closeout amendment to uphold a 50/50 general fund and federal fund match.

Recommended Actions

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

, provided that since the Department of Human Resources (DHR) Local Department Operations Unit has had four or more repeat audit findings in the most recent fiscal compliance audit issued by the Office of Legislative Audits (OLA), $100,000 of this agency's administrative appropriation may not be expended unless:

(1) DHR has reported the corrective action taken with respect to all repeat findings on or before January 1, 2017; and

(2) a report is submitted to the budget committees by OLA listing each repeat finding along with an assessment of the corrective action taken by DHR for each repeat finding. The budget committees shall have 45 days to review and comment to allow funds to be released prior to the end of fiscal 2017.

Explanation: The Joint Audit Committee has requested that budget bill language be added for each unit of State government that has four or more repeat audit findings in its most recent fiscal compliance audit. Each such agency is to have a portion of its administrative budget withheld pending the adoption of corrective action by the agency and a determination by OLA that each finding was corrected. Due to the nature of the Local Department Operation Unit audit and the volume of findings to be corrected by the Local Departments of Social Services, an alteration to the standard language is prudent. This language requires DHR to report on corrective actions and have OLA assess the corrective actions taken by DHR rather than having the actions resolved.

Information Request	**Author**	**Due Date**
Assessment of corrective actions related to the most recent fiscal compliance audit	OLA	45 days before the release of funds

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

Provided that $12,170,861 of this appropriation made for the purpose of the Maryland Legal Services Program may be expended only for that purpose. Funds not used for this restricted purpose may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund.

Explanation: The language restricts the general fund appropriation of the Maryland Legal Services Program (MSLP) to that purpose and if it is not needed for that purpose requires that the funds revert to the general fund. During the fiscal 2013 closeout process, the Department of Human Resources recorded an unprovided-for payable in the MSLP. This was the second consecutive year an unprovided-for payable was recorded and the fourth since fiscal 2007. Given the important function of the MSLP, it remains necessary to ensure the program is adequately funded. Similar language has been adopted in the last three fiscal years.

Updates

1. Status of Corrective Actions for Audit Findings

In June 2014, the Office of Legislative Audits (OLA) released a fiscal compliance audit for the Office of the Secretary in DHR covering most of the administrative operations of the agency. The audit covered the period from November 17, 2009, to August 12, 2012. Of the nine findings contained in the audit, four were repeated from the previous audit. The repeated audit findings were:

- DHR did not ensure the propriety of the payments to certain legal firms;
- DHR lacked sufficient procedures and accountability over certain grants;
- DHR had not established sufficient monitoring controls over certain users' access; and
- certain DHR networks were not adequately secured.

The General Assembly adopted language withholding $100,000 of DHR Administration's fiscal 2016 appropriation pending the correction of the repeat audit findings. To have the funds released, OLA must certify that the repeat audit findings have been corrected. OLA has until May 15, 2016, to certify the corrective actions. As of this writing, OLA has not submitted certification regarding the Office of the Secretary's correction of its repeat audit findings in response to this language. As a result, the funds continue to be withheld.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
Department of Human Resources – Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$86,522	$4,025	$82,174	$0	$172,721
Deficiency Appropriation	0	0	0	0	0
Cost Containment	-2,200	0	0	0	-2,200
Budget Amendments	9,388	541	3,496	1,320	14,745
Reversions and Cancellations	-70	-509	-6,713	-1,225	-8,517
Actual Expenditures	**$93,640**	**$4,057**	**$78,958**	**$95**	**$176,750**
Fiscal 2016					
Legislative Appropriation	$93,171	$3,997	$76,664	$0	$173,832
Budget Amendments	1,001	10	-679	569	902
Working Appropriation	**$94,172**	**$4,007**	**$75,986**	**$569**	**$174,734**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversion. Numbers may not sum to total due to rounding.

Fiscal 2015

The fiscal 2015 legislative appropriation for DHR Administration increased by $3.029 million. The appropriation decreased by $2.2 million in general funds through two Board of Public Works cost containment actions. DHR achieved the July 2014 cost containment reduction of $472,600 by holding positions vacant. The second cost containment action was achieved by holding positions vacant, reducing service contracts for copier equipment, reductions in OTHS contracts, and a reduction to the LDSS equipment replacement budget.

The budget increased by $14.75 million through budget amendments. An employee cost-of-living (COLA) increase added $574,031 ($305,266 in general funds, $4,922 in special funds, and $263,843 in federal funds). The budget was decreased by $202,222 in general funds to account for savings from the State Employee Voluntary Separation Program. An additional decrease of $125,631 in general funds resulted from the realignment of telecommunication expenditures across State agencies.

There were also a number of amendments that added appropriations in reimbursable funds:

- $360,000 for improvements to the automated financial system;
- $23,111 for the purchase of radios for disaster preparedness; and
- $937,188 for improvements to ECMS.

Two closeout amendments added funds throughout the DHR budget. These amendments increased the DHR Administration budget by just under $13.2 million including:

- an increase of $1,916,881 in general funds and $29,043 in special funds in the Office of the Secretary for salaries, wages, and fringe benefits; as well as technical and special fees for contractual support staff;
- a reduction of $45,765 in general funds in the CRBC for salaries, wages, and fringe benefits;
- a reduction of $11,495 in general funds in the Commission for Women for salaries, wages, and fringe benefits;
- an increase of $226,790 in general funds and $148,482 in federal funds for critical contractual support staff in DBFP;
- an additional increase in DBFP of $387,067 in general funds for contractual staff support and $58,842 in special funds was for salaries, wages, and fringe benefits;

- an increase of $1,552,249 in federal funds and $17,200 in special funds in the Division of Administrative Services for salaries, wages, and fringe benefits; contractual staff support; communications materials; and office improvements;

- an increase of $3,469,134 in general funds and $1,531,307 in federal funds in OTHS for contractual services due to increased enhancements to meet regulatory requirements; and

- an increase of $3,444,450 in general funds and $430,969 in special funds in LGA for salaries, wages, and fringe benefits.

DHR Administration reverted $69,947 to the general fund, originally intended for a contract to evaluate rate-setting methodology. DHR Administration canceled $6.71 million in federal funds: $5.41 million due to less than anticipated expenditures on salaries and wages for various programs; $1.2 million due to less than anticipated expenditures for the Automated Financial System and the ECMS; and $104,324 due to less than anticipated expenditures on the Medicaid Rehabilitation Program. A $509,000 special fund cancellation resulted from less than anticipated task order deliverables for the Electric Universal Service Program. DHR Administration also canceled $1.225 million in reimbursable funds that were intended for a Major IT Development Project due to less than anticipated expenditures.

Fiscal 2016

To date, DHR Administration's fiscal 2016 budget has increased by $901,545. This includes an increase of $1,081,164 ($584,429 in general funds, $9,925 in special funds, and $486,810 in federal funds) through an amendment which restored a fiscal 2016 2% cut to employee salaries. The realignment of the 2% across-the-board cost containment across all DHR programs, reduced the DHR Administration appropriation by $749,105 (a $416,454 increase in general funds and $1,165,559 decrease in federal funds). DHR Administration established a reimbursable fund appropriation of $569,486 through an amendment for the Automated Financial System Major IT project.

Major Information Technology Projects

DHR-Administration
Automated Financial System

Project Status[1]	Planning completed on December 17, 2015. Implementation expected to begin on March 1, 2016.	**New/Ongoing Project:**	Ongoing.
Project Description:	Replace the Department of Human Resources' (DHR) existing Automated Financial System (AFS), which is used by the local departments of social services (LDSS) to record financial transactions of LDSS; set up, print, and track vendor payments (including those for child care and foster care providers); and generate various financial reports. The project will lower costs of system support and maintenance because the existing system uses an outdated language. The project will also improve security and performance, as well as improve ease of use.		
Project Business Goals:	The new AFS is expected to improve ease of use, eliminate workarounds necessitated by the difficulty of updating the current system, and reduce the cost of maintenance and support of the system. The new system is also expected to consolidate financial information and reduce the time it takes to generate vendor payments. DHR indicates the new system will also allow for the system to be easier to modify and enhance as State and federal requirements change. This project also supports the goal of the agency to standardize the development environment and allow the agency to centralize hardware, functionality, and data.		
Estimated Total Project Cost[1]**:**	$5,474,646	**Estimated Planning Project Cost**[1]**:**	$527,819
Project Start Date:	November 3, 2014.	**Projected Completion Date:**	June 30, 2019 (contingent on planned implementation start date).
Schedule Status:	DHR completed the planning phase of the project on December 17, 2015. Implementation is expected to begin on March 1, 2016.		
Cost Status:	Project costs have increased from the previous year estimates to better account for the addition of estimates for the implementation phase.		
Scope Status:	The Office of Technology for Human Services has requested that the project team add to its existing scope the consolidation of legacy data systems/data repositories. The executive team is aware that consolidation of systems beyond the migration of the current AFS application may significantly increase the project's scope, cost, and time for implementation.		
Project Management Oversight Status:	The fiscal 2017 allowance includes $117,468 for project oversight.		
Identifiable Risks:	The only high risk identified by DHR was implementation, which results from data conversion and application integration concerns. Medium risks identified by DHR were technical, organizational culture, supportability, and that consolidating existing legacy applications may introduce additional complications. If the scope increases as DHR intends in the Information Technology Project Request, this can also pose a significant risk.		

Fiscal Year Funding ($ in Thousands)	Prior Years	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	Balance to Complete	Total
Personnel Services	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Professional and Outside Services	1,052.7	2,490.0	1,273.7	658.3	0.0	0.0	0.0	0.0
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$1,052.7**	**$2,490.0**	**$1,273.7**	**$658.3**	**$0.0**	**$0.0**	**$0.0**	**$5,474.6**

[1] Initially, an agency submits a Project Planning Request. After the requirements analysis has been completed and a project has completed all of the planning required through Phase Four of the Systems Development Lifecycle (Requirements Analysis), including a baseline budget and schedule, the agency may submit a Project Implementation Request and begin designing and developing the project when the request is approved. For planning projects, costs are estimated through planning phases. Implementation projects are required to have total development costs.

Object/Fund Difference Report
DHR – Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	861.00	846.00	831.00	-15.00	-1.8%
02 Contractual	28.61	2.90	2.90	0.00	0%
Total Positions	**889.61**	**848.90**	**833.90**	**-15.00**	**-1.8%**
Objects					
01 Salaries and Wages	$ 71,464,433	$ 70,724,692	$ 72,247,860	$ 1,523,168	2.2%
02 Technical and Spec. Fees	1,352,219	617,870	369,679	-248,191	-40.2%
03 Communication	8,066,186	7,782,527	7,570,267	-212,260	-2.7%
04 Travel	294,654	221,835	230,321	8,486	3.8%
06 Fuel and Utilities	455,105	528,271	474,493	-53,778	-10.2%
07 Motor Vehicles	335,088	572,139	476,564	-95,575	-16.7%
08 Contractual Services	81,911,419	78,528,542	79,643,837	1,115,295	1.4%
09 Supplies and Materials	896,236	1,325,713	1,079,756	-245,957	-18.6%
10 Equipment – Replacement	528,079	2,220,649	1,520,238	-700,411	-31.5%
11 Equipment – Additional	637,279	225,337	534,341	309,004	137.1%
12 Grants, Subsidies, and Contributions	443,774	2,065,864	2,269,649	203,785	9.9%
13 Fixed Charges	10,365,039	9,920,463	9,760,791	-159,672	-1.6%
Total Objects	**$ 176,749,511**	**$ 174,733,902**	**$ 176,177,796**	**$ 1,443,894**	**0.8%**
Funds					
01 General Fund	$ 93,640,353	$ 94,171,570	$ 98,555,601	$ 4,384,031	4.7%
03 Special Fund	4,056,681	4,007,334	4,126,270	118,936	3.0%
05 Federal Fund	78,957,548	75,985,502	73,495,925	-2,489,577	-3.3%
09 Reimbursable Fund	94,929	569,496	0	-569,496	-100.0%
Total Funds	**$ 176,749,511**	**$ 174,733,902**	**$ 176,177,796**	**$ 1,443,894**	**0.8%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHR – Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Office of the Secretary	$ 13,624,922	$ 14,187,407	$ 14,394,934	$ 207,527	1.5%
02 Citizen's Review Board for Children	795,856	898,902	846,695	-52,207	-5.8%
03 Commissions	186,136	138,744	134,361	-4,383	-3.2%
04 Legal Services Program Management	13,143,596	14,067,028	14,093,626	26,598	0.2%
01 Division of Budget, Finance and Personnel	21,862,853	20,420,909	20,001,176	-419,733	-2.1%
02 Division of Administrative Services	12,122,675	10,436,367	10,656,439	220,072	2.1%
02 Major Information Technology Development Projects	148,165	907,746	1,245,000	337,254	37.2%
04 General Administration	71,970,879	70,412,546	69,546,546	-866,000	-1.2%
05 General Administration	42,894,429	43,264,253	45,259,019	1,994,766	4.6%
Total Expenditures	**$ 176,749,511**	**$ 174,733,902**	**$ 176,177,796**	**$ 1,443,894**	**0.8%**
General Fund	$ 93,640,353	$ 94,171,570	$ 98,555,601	$ 4,384,031	4.7%
Special Fund	4,056,681	4,007,334	4,126,270	118,936	3.0%
Federal Fund	78,957,548	75,985,502	73,495,925	-2,489,577	-3.3%
Total Appropriations	**$ 176,654,582**	**$ 174,164,406**	**$ 176,177,796**	**$ 2,013,390**	**1.2%**
Reimbursable Fund	$ 94,929	$ 569,496	$ 0	-$ 569,496	-100.0%
Total Funds	**$ 176,749,511**	**$ 174,733,902**	**$ 176,177,796**	**$ 1,443,894**	**0.8%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

N00B
Social Services Administration
Department of Human Resources

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$363,737	$374,491	$366,314	-$8,177	-2.2%
Deficiencies and Reductions	0	-6,410	-491	5,919	
Adjusted General Fund	**$363,737**	**$368,080**	**$365,823**	**-$2,258**	**-0.6%**
Special Fund	5,343	8,047	5,322	-2,726	-33.9%
Deficiencies and Reductions	0	0	-5	-5	
Adjusted Special Fund	**$5,343**	**$8,047**	**$5,317**	**-$2,730**	**-33.9%**
Federal Fund	179,172	204,190	201,012	-3,178	-1.6%
Deficiencies and Reductions	0	0	-271	-271	
Adjusted Federal Fund	**$179,172**	**$204,190**	**$200,741**	**-$3,449**	**-1.7%**
Adjusted Grand Total	**$548,252**	**$580,317**	**$571,880**	**-$8,437**	**-1.5%**

- The Governor's fiscal 2017 budget plan includes a planned reversion for fiscal 2016 of $6.4 million in Foster Care Maintenance Payments due to anticipated caseload declines.

- The fiscal 2017 allowance of the Department of Human Resources (DHR) Social Services Administration (SSA) decreases by $8.4 million, 1.5%, compared to the fiscal 2016 working appropriation after accounting for the planned reversion and back of the bill reduction in health insurance. General funds decrease by $2.3 million in the fiscal 2017 allowance after accounting for the planned reversion.

- Special funds in SSA decrease by a net of $2.7 million, 33.9%, in the fiscal 2017 allowance, primarily in funds for foster care educational expenses collected from Local Education Agencies ($1.9 million) and in Child Support Foster Care Offset funds ($0.7 million).

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

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- Federal funds decrease by a net of $3.4 million, or 1.7%, in SSA in the fiscal 2017 allowance. The largest decrease occurs in the Medical Assistance funds, a net decrease of $8.2 million, which results from the inability to bill for rehabilitative services (a decrease of $16.4 million) partially offset by increases in other areas of SSA including the Local Child Welfare program ($7.9 million).

- Major changes in the allowance occur primarily in personnel and Foster Care Maintenance Payments.

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	2,807.91	2,738.86	2,737.86	-1.00
Contractual FTEs	2.56	2.50	2.50	0.00
Total Personnel	**2,810.47**	**2,741.36**	**2,740.36**	**-1.00**
Vacancy Data: Regular Positions				
Turnover and Necessary Vacancies, Excluding New Positions		195.76	7.15%	
Positions and Percentage Vacant as of 12/31/15		210.50	7.69%	

- As part of the 2.0% across-the-board reductions in fiscal 2016, DHR abolished 47.0 positions in SSA (41.0 positions in the Local Child Welfare Services program, 5.0 positions in the Local Adult Services program, and 1.0 position in the State offices of SSA).

- One regular position, in Local Child Welfare Services in Anne Arundel County, is abolished in the fiscal 2017 allowance.

- Turnover expectancy decreases from 7.97% to 7.15% in the fiscal 2017 allowance.

- As of January 1, 2016, SSA had 210.5 vacant positions, a vacancy rate of 7.7%. To meet its fiscal 2017 turnover expectancy, SSA needs to maintain 195.8 vacancies. After accounting for the 1.0 abolished position, SSA could fill 13.7 vacant positions and meet its fiscal 2017 turnover expectancy.

Analysis in Brief

Major Trends

Children in Out-of-home Care: In its fiscal 2017 Managing for Results submission, DHR reported on two new measures related to placement stability (rate of placement moves per 1,000 foster care days) and foster care placements (rate of removals per 1,000 children under age 18). Because these are new measures, limited historical data is available. However, DHR met the goal for the rate of placement moves and was near the goal for the rate of removals in fiscal 2015. DHR has a goal of no more than 30.0% of children under 18 remaining in care 24 or more continuous months; however, for the fifth consecutive year, in fiscal 2015, DHR failed to meet this goal. In fiscal 2015, 39.5% of children exited care to permanency within 12 months of entry, slightly below the goal of 40.5%.

Safety: Despite improvements in the percent of children who did not experience a recurrence of maltreatment within 12 months of a first occurrence since fiscal 2013 (an improvement of 0.9 percentage points), SSA failed to meet the goal, with only 90.1% of children not experiencing a recurrence. DHR also failed to meet the goal for the rate of victimization per 100,000 days of foster care. In fiscal 2015, the rate of victimization was 10.1 compared to a goal of 8.5.

Adult Services: The number of investigations of adult abuse decreased in fiscal 2015 for the first time since fiscal 2011. The number of adult cases in which abuse was indicated or confirmed has declined each year since fiscal 2012.

Issues

Title IV-E Waiver: DHR received approval to implement a demonstration project in September 2014. This project included three waivers to provide services that would not otherwise be eligible for funding, to allow for funding of children who would not otherwise be eligible, and expand claiming of federal funds to allow the State to reinvest savings in the program. Expanded services are expected to include additional in-home services and post permanency services to reduce children placed in out-of-home, reduce reentry, and reduce the length of stay in out-of-home care. The implementation of the waiver began with a new assessment of statewide in-home service cases in July 2015. The phase-in of evidence based practices in certain jurisdictions is expected to begin the first quarter of calendar 2016.

Unsuccessful Reunifications of Children Leaving the Foster Care System: Fiscal 2015 budget bill language restricted funds in SSA to be used for a study of unsuccessful reunifications of children with their parents including information on the reasons for reentry into the foster care system and the frequency of reentry. The final report was submitted in April 2015. The study resulted in five recommendations including formalizing a trial home visit process prior to reunification, formalizing post reunification transition and services, and focusing on risk factors for unsuccessful reunifications (for example, child behavior problems, prior child welfare experience, and having siblings in care).

Child Welfare Caseworkers: The 2015 *Joint Chairmen's Report* included committee narrative requesting a report on filled child welfare caseworker positions and child welfare caseloads. On a statewide basis, the Child Welfare League (CWLA) caseworker to case ratios were met, and only 1 jurisdiction (Harford County) did not meet these guidelines. If vacant positions were filled, Harford County would have enough caseworkers to meet the standard. Although statewide, the CWLA supervisor to case ratio was met, 11 jurisdictions did not meet the guidelines, with a shortfall among these jurisdictions totaling 13.4 supervisors.

Recommended Actions

1. Add budget bill language restricting general funds in N00G00.01 Foster Care Maintenance Payments to that purpose.

2. Adopt committee narrative requesting caseload and expenditure forecasts.

3. Add budget bill language restricting the N00G00.03 Child Welfare Services general fund appropriation to that purpose or for transfer only to the Foster Care Maintenance Payments program.

4. Adopt committee narrative requesting child welfare caseload data.

Updates

Alternative Response Final Report: Chapter 397 of 2012 authorized the Secretary of Human Resources to implement an alternative response program for certain reports of abuse or neglect. DHR was to submit a final report on the implementation of the alternative response program. The report stated that, in general, caseworkers and supervisors believed that children were equally safe under the alternative response or investigative response. In general, the study found that, although family engagement was rated positively among both types of cases, there was a higher level of engagement measured for alternative response cases.

Substance Exposed Newborns Final Report: Chapter 90 of 2013 (Substance-Exposed Newborns) required DHR to submit a final report on October 1, 2015, on the implementation of the legislation. The final report noted that DHR received 1,729 reports of substance-exposed newborns for 1,776 newborns between July 1, 2014, and June 30, 2015. The majority (97%) of these reports did not result in a Child Protective Services response. According to the report, during that time, 13 of these cases resulted in terminations of parental rights.

Child Fatalities Involving Abuse or Neglect: Annually, DHR reports the number of child fatalities in which child abuse or neglect was a factor. In calendar 2014, there were 21 such fatalities, 3 fewer than in calendar 2013.

N00B
Social Services Administration
Department of Human Resources

Operating Budget Analysis

Program Description

The Department of Human Resources (DHR) Social Services Administration (SSA) supervises child welfare programs provided through the local departments of social services (LDSS) that are intended to prevent or remedy neglect, abuse, or exploitation of children; preserve, rehabilitate, or reunite families; help children to begin or continue to improve their well-being; and prevent children from having to enter out-of-home care, provide appropriate placement and permanency services. SSA is responsible for policy development, training and staff development, monitoring and evaluation of LDSS programs, and oversight of development and maintenance of the child welfare information system (Maryland Children's Electronic Social Services Information Exchange (MD CHESSIE)).

SSA also supervises adult social services programs for vulnerable adults and individuals with disabilities. These programs protect vulnerable adults, promote self-sufficiency, and avoid unnecessary institutional care.

DHR has an overall goal to be recognized as a national leader among human service agencies. In addition, DHR has two key goals related to SSA, which are that:

- Maryland residents are safe from abuse, neglect, and exploitation; and
- Maryland children live in permanent homes, and vulnerable adults live in the least restrictive environments.

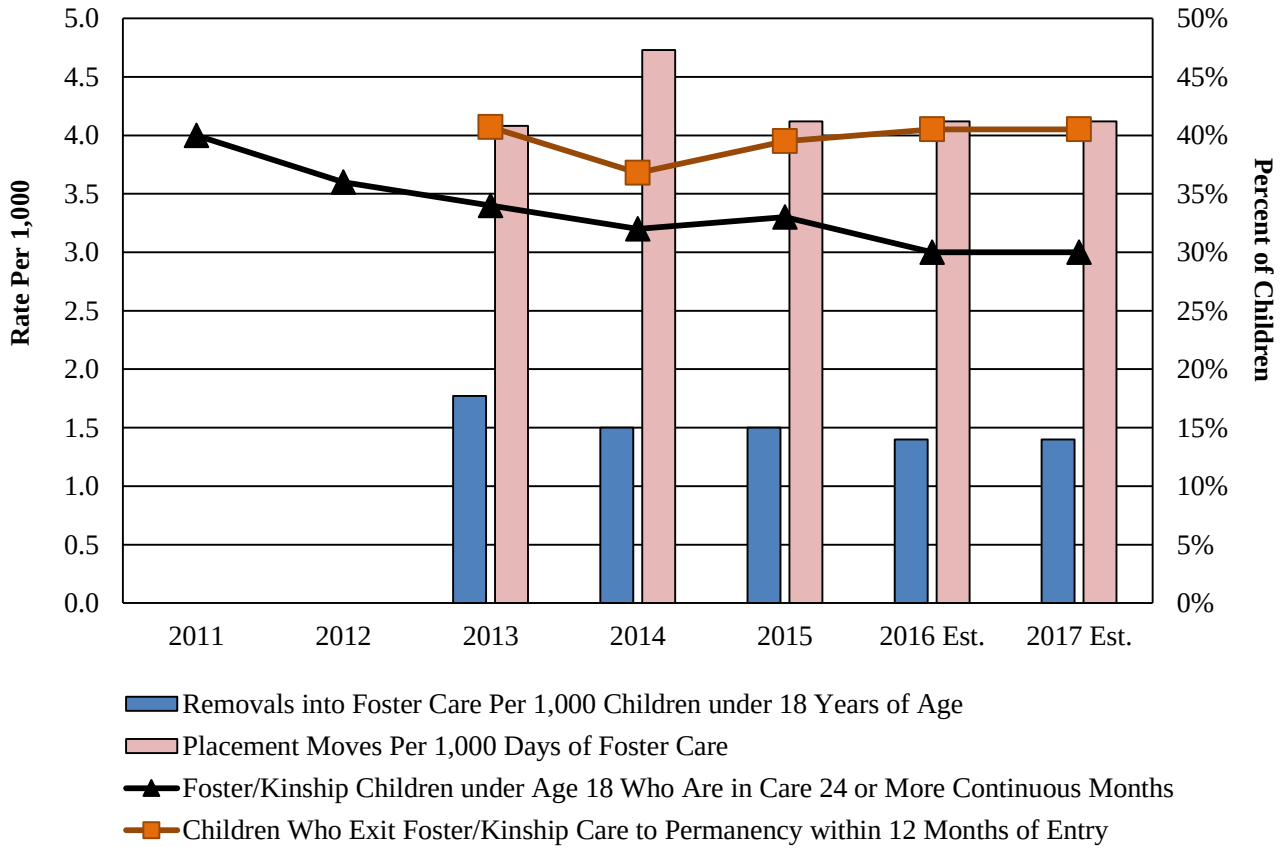
Performance Analysis: Managing for Results

DHR revised a number of its Managing for Results measures with the fiscal 2017 submission. DHR explained that the performance measures were introduced, revised, or eliminated to align with the indicators that will be used in the upcoming round of the Child and Family Services Review (CFSR) and to focus on the goals of the new Title IV-E Waiver. CFSRs are federal reviews of state child welfare systems to ensure states are complying with federal rules and are intended to assist states in achieving positive outcomes. As will be discussed in **Issue 1** of this analysis, the three goals of the Title IV-E Waiver are to reduce out-of-home placements, reduce reentries into out-of-home care, and reduce the length of stay in out-of-home care. As a result of these changes, limited historical data is available for comparison for several measures.

1. Children in Out-of-home Care

DHR has set a goal for fiscal 2016 and 2017 of 1.4 removals into foster care per 1,000 children under 18 years of age. This goal would represent a slight improvement over its performance in this area in fiscal 2014 and 2015, 1.5 removals per 1,000 children, as shown in **Exhibit 1**. In terms of placement stability, for the new measure related to placement moves per 1,000 days of foster care, DHR set a goal using the national standard for the third round of the CFSR of 4.12 placement moves per 1,000 days of foster care, which would equate to a move no more than once every 243 days. DHR met this national standard in fiscal 2013, with a rate of 4.08, but failed to meet the standard in fiscal 2014 (4.73). A rate of 4.73 equates to a move approximately every 211 days. DHR met the goal in fiscal 2015 (4.12).

Exhibit 1
Out-of-home Care and Placement Stability
Fiscal 2011-2017 Est.



Source: Department of Human Resources; Department of Budget and Management; Governor's Budget Books

DHR has set a goal for the new measure of the percent of children who exit foster/kinship care to permanency within 12 months of entry using the national standard in the third round of the CFSR for this measure of 40.5%. As shown in Exhibit 1, SSA did not meet the national standard in fiscal 2014 or 2015, with 36.8% and 39.5% of children achieving permanency within 12 months, respectively.

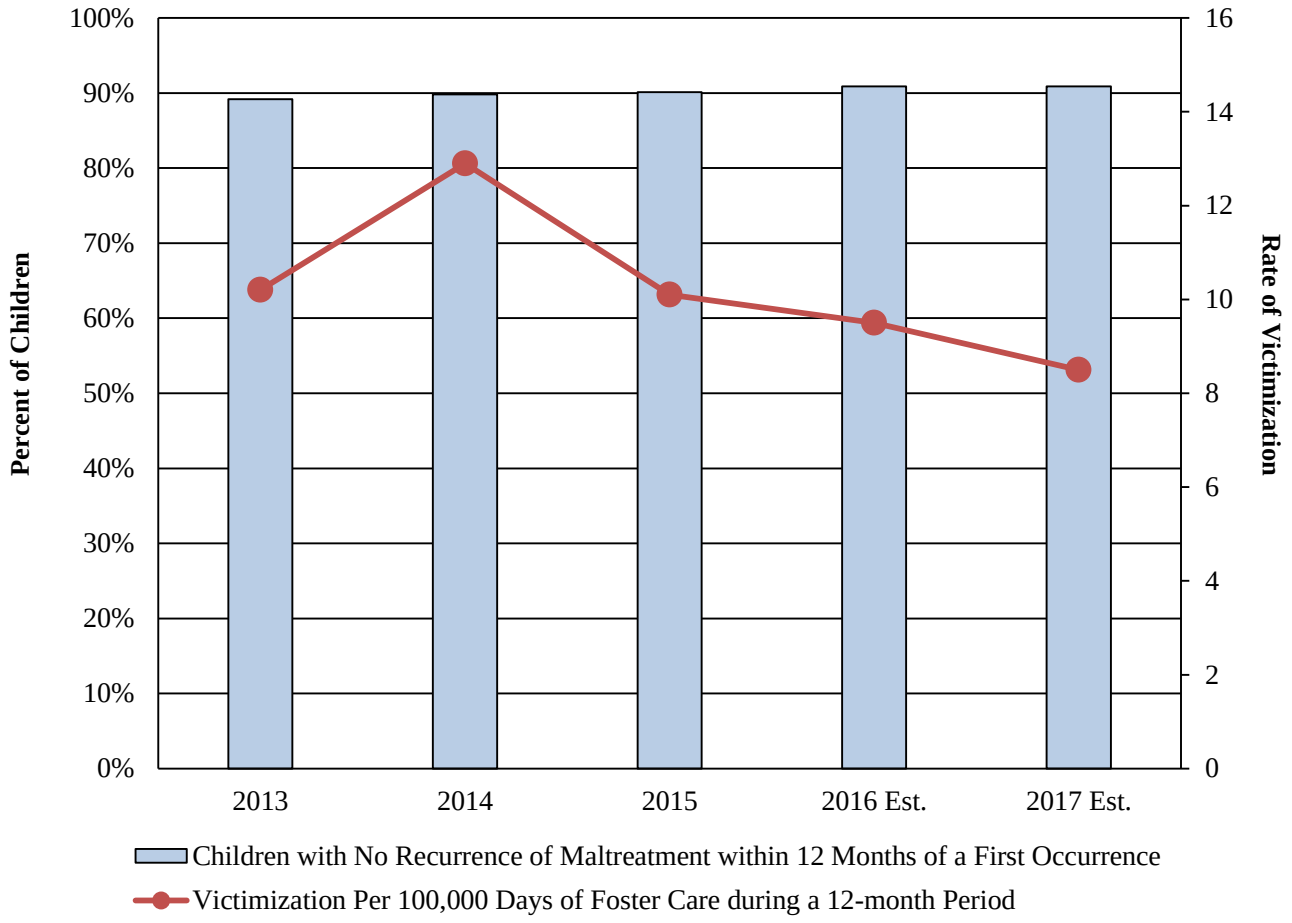
DHR has a goal of no more than 30% of children under age 18 remaining in foster care for 24 or more continuous months. Despite moving closer to this goal in recent years, in fiscal 2015, 33% of children under age 18 remained in foster care for 24 or more continuous months, 1 percentage point higher than in fiscal 2014.

2. Safety

DHR has revised its previous measures of child safety with new measures (percent of children with no recurrence of maltreatment within 12 months of a first occurrence and the rate of victimization per 100,000 days of foster care during a 12-month period). DHR is using national standards as the goal for the measures.

The goal for recurrence of maltreatment is that 90.9% of children would not experience a recurrence within 12 months. As shown in **Exhibit 2**, in fiscal 2015, DHR failed to achieve this goal with 90.1% of children not experiencing a recurrence. However, this represents an improvement over the prior fiscal years, for example, in fiscal 2011, only 86.1% of children had no recurrence of maltreatment within 12 months of a first recurrence. The goal for the rate of victimization per 100,000 days of foster care is 8.5. DHR has fallen short of this goal in each of the last three fiscal years, and in fiscal 2015, had a rate of 10.1. **DHR should comment on its plans to improve performance in these areas to increase safety for children both in and out of foster care.**

Exhibit 2
Safety
Fiscal 2013-2017 Est.

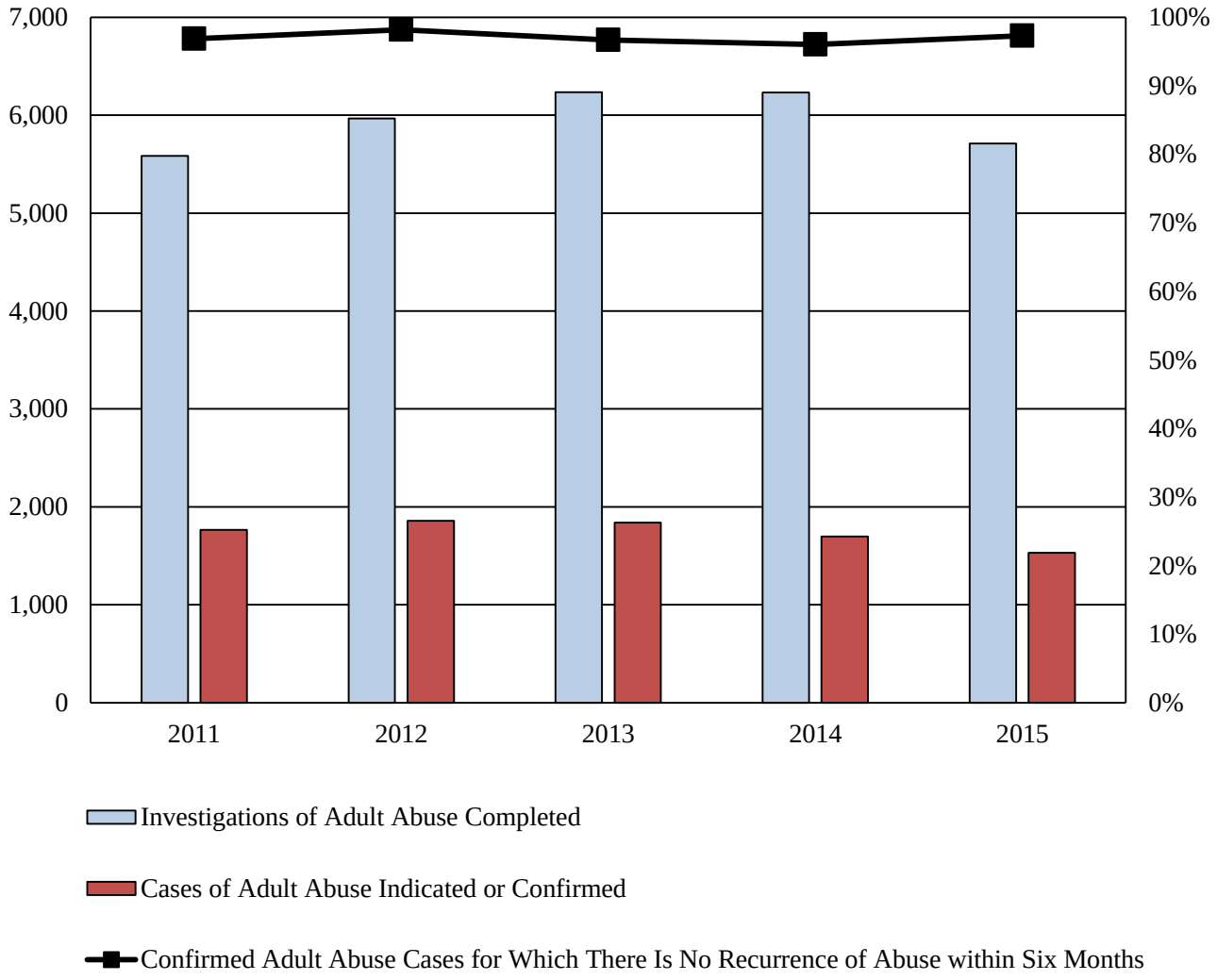


Source: Department of Human Resources; Department of Budget and Management

3. Adult Services

As shown in **Exhibit 3**, the number of investigations of adult abuse decreased by 8.4% in fiscal 2015 compared to the prior year. However, the number of investigations in fiscal 2015 (5,712) was still higher than in fiscal 2011 (5,585). After increasing in fiscal 2012, the number of cases of adult abuse indicated or confirmed has declined in each year, decreasing by 9.7% in fiscal 2015 from fiscal 2014. The number of indicated or confirmed adult abuse cases in fiscal 2015 (1,531) was 17.6% lower than in fiscal 2012, the most recent high.

Exhibit 3
Adult Protective Services
Fiscal 2011-2015



Source: Department of Human Resources; Department of Budget and Management; Governor's Budget Books

DHR has a goal of having no recurrence of maltreatment within six months for 96.5% of adult cases with an indicated or confirmed finding. DHR has met that goal in each year since fiscal 2011, except fiscal 2014. After failing to meet the goal in fiscal 2014, the percent of cases with no recurrence of maltreatment rose to 97.3% in fiscal 2015.

Fiscal 2016 Actions

Planned Reversion

The Governor's Budget plan for fiscal 2017 includes a fiscal 2016 planned reversion of $6.4 million in Foster Care Maintenance Payments as a result of anticipated savings from caseload declines.

Fee Elimination

As part of Governor Lawrence J. Hogan, Jr.'s fee reduction actions, in September 2015 the fee associated with adoption searches is eliminated. This fee was related to an adoption registration and adoption search, contact, and reunion services. The fees were not to exceed $50 for registrations, and a sliding-scale fee from $0 to $725 for search, contact, and reunion services for one person or up to $825 for two people. The funds collected from this fee were used to offset administrative expenses within the agency. In fiscal 2015, DHR received $6,544 from this fee. In fiscal 2016, a total of $61,006 associated with this fee was included in the budget, a similar amount is budgeted in fiscal 2017 despite the fee reduction. DHR indicates that the fiscal 2017 funds were budgeted in error and will not be included in final expenditures.

Cost Containment

The DHR share of the fiscal 2016 2% across-the-board reduction totaled $6.9 million in general funds. The share of the reduction from SSA was $4.9 million in total funds ($3.5 million general funds and $1.4 million federal funds). The majority of the reduction, $3.4 million, ($2.0 million general funds and $1.4 million federal funds), occurred through the abolition of 47 vacant positions (41 positions in the Local Child Welfare Services program, 5 positions in the Local Adult Services program, and 1 position in the State offices of SSA).

A reduction of $1.3 million in general funds occurred in Foster Care Maintenance Payments, funding available as a result of the declining caseload. Other decreases of $192,702 in total funds ($119,288 in general funds and $73,414 in federal funds) represent reductions to the Montgomery County grant, facility rentals for regional meetings and training events, and the use of alternate funds for interpreters in the Local Child Welfare Services program.

Proposed Budget

As shown in **Exhibit 4**, the fiscal 2017 allowance of SSA decreases by $8.4 million, 1.5%, compared to the fiscal 2016 working appropriation after accounting for the fiscal 2016 planned reversion and a fiscal 2017 back of the bill reduction in health insurance. General funds decrease by $2.3 million, 0.6%.

Exhibit 4
Proposed Budget
DHR – Social Services Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Total
Fiscal 2015 Actual	$363,737	$5,343	$179,172	$548,252
Fiscal 2016 Working Appropriation	368,080	8,047	204,190	580,317
Fiscal 2017 Allowance	365,823	5,317	200,741	571,880
Fiscal 2016-2017 Amount Change	-$2,258	-$2,730	-$3,449	-$8,437
Fiscal 2016-2017 Percent Change	-0.6%	-33.9%	-1.7%	-1.5%

Where It Goes:

Personnel Expenses	
Employee and retiree health insurance	$3,783
Employee retirement	3,776
Overtime earnings to better align with recent experience	1,686
Turnover expectancy decreases from 7.97% to 7.15%	1,186
Accrued leave to better align with recent experience	270
Regular earnings	-53
Abolition of 1 vacant position in Anne Arundel County	-65
Social Security contributions	-306
Unemployment and workers' compensation	-341
Out-of-home Placement Costs and Title IV-E Waiver	
Project management support provided by the University of Maryland School of Social Work	65
Title IV-E Waiver Intervention Services	-678
Foster care, subsidized adoption, and subsidized guardianship payments including day care and other flexible funding due to anticipated caseload declines	-17,732
Other Changes	
Rent primarily due to staff and office relocations	475
Office supplies primarily in Baltimore County to align with recent experience	129
Travel primarily in Baltimore City for local child welfare caseworkers	91
Anticipated federal independent living funds	68
Electricity	67

Where It Goes:

Implementation of a screening tool for heroin and opioid use for children, parents, and foster families consistent with the recommendation in the *Heroin and Opioid Emergency Task Force Final Report*	50
Local adult services programs in Prince George's County to align with recent experience	-102
Communications costs to align with recent experience	-112
Gas and oil to align with recent experience	-165
Montgomery County grant in Local Adult Services and Local Child Welfare Services	-370
Other adjustments	-157
Total	**-$8,437**

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

Special funds decrease by $2.7 million, 33.9%, in fiscal 2017 compared to the fiscal 2016 working appropriation after accounting for the back of the bill reduction in health insurance. The decrease occurs primarily among Foster Care Education funds, collected from the Local Education Agencies (LEA) ($1.9 million) and Child Support Foster Care Offset funds ($0.7 million). These decreases align funding with the fiscal 2015 receipts.

Federal funds decrease by $3.4 million, 1.7%, in the fiscal 2017 allowance compared to the fiscal 2016 working appropriation after accounting for a back of the bill reduction in health insurance. The decrease occurs primarily among Medical Assistance funds ($8.2 million). Beginning in fiscal 2016, SSA is no longer able to bill Medicaid for rehabilitative services for children in foster care, due to the nature of the current rate-setting process, which provides one rate for all services offered by a provider, limiting the documentation of the eligible services. A federal audit included findings related to this issue and required the State to improve the documentation of the eligible services before billing again. However, due to timing these funds were included in the fiscal 2016 budget ($16.4 million). The loss of Medical Assistance funds for this purpose are partially offset by an increase in Medicaid funds elsewhere in SSA including in the Local Child Welfare program ($7.9 million). Other substantial federal fund changes include:

- Title IV-E Waiver (an increase of $4.0 million);
- Temporary Assistance for Needy Families (TANF) (an increase of $2.1 million); and
- regular Title IV-E (foster care) funds (a decrease of $1.3 million).

Not included in the agency's budget are anticipated increments, which are included in the budget of the Department of Budget and Management (DBM). These funds will be distributed to agencies early in fiscal 2017. The share of increments expected to be available to SSA is $3.5 million in total funds ($2.0 million in general funds, $42,779 in special funds, and $1.5 million in federal funds).

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. This agency's share of these reductions is $767,128 in total funds ($491,165 in general funds, $4,880 in special funds, and $271,083 in federal funds). There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

Foster Care Maintenance Payments

The fiscal 2017 allowance decreases the funding available in the Foster Care Maintenance Payments program by $17.7 million compared to the fiscal 2016 working appropriation after accounting for a planned reversion and a fund realignment within SSA. These funds include both the funds for placement costs for children in out-of-home placements, subsidized adoptions, and subsidized guardianships as well as other costs for children in out-of-home placements and flexible funds (day care expenses to assist foster parents, medical costs, and educational expenses).

DHR and the Department of Budget and Management (DBM) provided two sets of caseload estimates at different points during January and February 2016 which were stated to have been what the budget was based on. These estimates changed the caseload, average payments, and placement expenditures as well as flexible fund spending. For example, total average monthly caseload was decreased by 679 between these two estimates. Total placement expenditures were decreased by nearly $25 million, while flexible fund expenditures (including day care, education, and emergency services) were increased by the same amount, providing a total flexible fund expenditures of more than double the fiscal 2015 actual expenditures. Neither set of estimates appear to be based on current trends. **The Department of Legislative Services (DLS) recommends committee narrative requesting DHR and DBM present actual fiscal 2016 caseloads by placement type and current forecasted caseloads by placement type for fiscal 2017 and 2018 that will be used in budget development**.

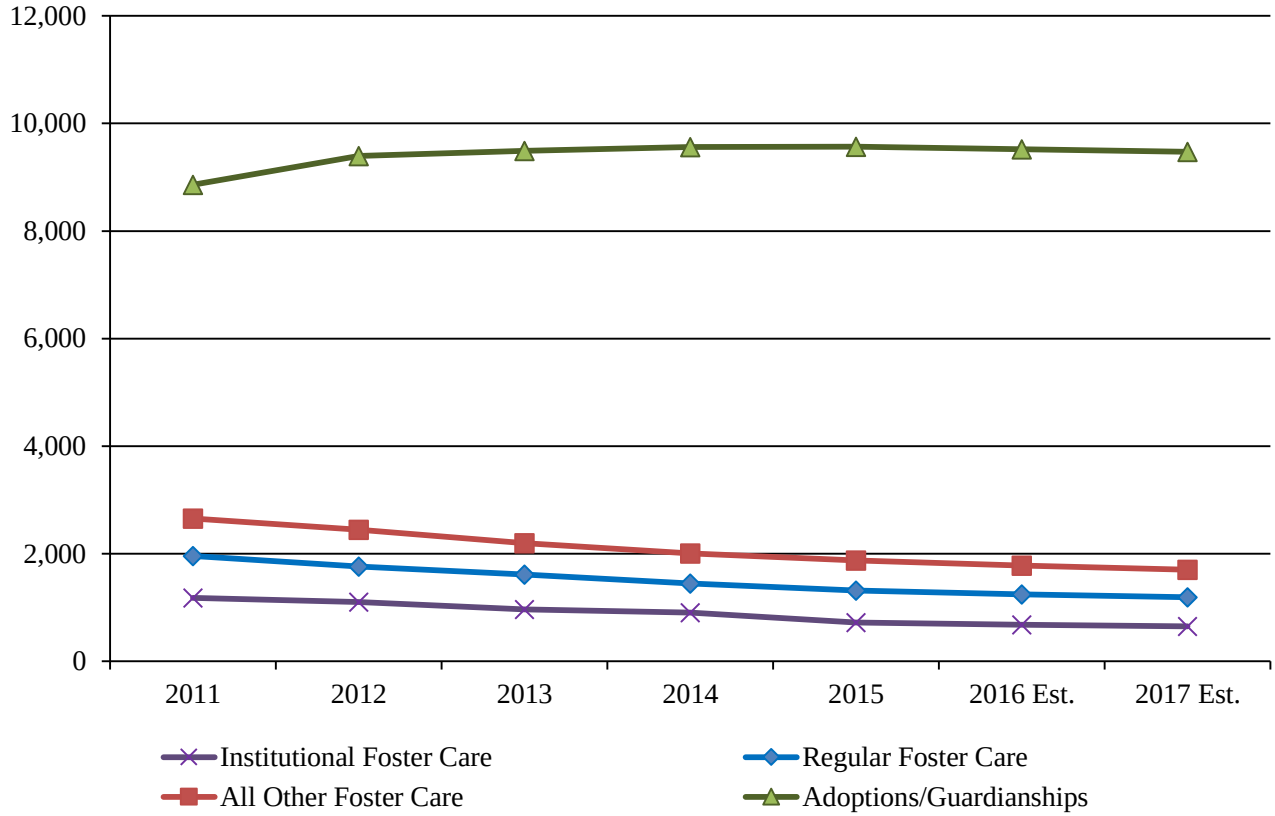
Caseload Estimates

Due to the inconsistencies in the estimating process by DHR and DBM, the discussion of the caseload, payment rates, and expenditures will focus on the DLS estimates. As shown in **Exhibit 5**, the average monthly number of children in foster care placements has decreased in recent years for each type of placement. Figures in Exhibit 5 for fiscal 2016 and 2017 are estimates by DLS. The rates of change vary between placement types and year. In fiscal 2015, children in institutional placements decreased by 20.7% while children in regular foster care decreased by 9.3%. The declines in children in foster care are consistent with the goals of the Place Matters Initiative. Further declines are also consistent with the goals of the Title IV-E Waiver. DLS expects that the number of children in foster care will continue to decrease through fiscal 2017 (5.0% in fiscal 2016 and 4.5% in fiscal 2017), but that the rate of decrease will slow.

The average monthly number of children in subsidized adoption and guardianships has increased in recent years, although the rate of increase has slowed each year. The average monthly number of children in subsidized adoptions and guardianships increased by only 0.1% in fiscal 2015

compared to fiscal 2014. This was the second consecutive year that the rate of growth in these types of placements was less than 1.0%. DLS anticipates that the number of children in subsidized adoptions and guardianships will begin to decrease slowly through fiscal 2017 (0.5% in both fiscal 2016 and 2017).

Exhibit 5
Foster Care and Subsidized Adoptions/Guardianships
Average Monthly Caseloads
Fiscal 2011-2017 Est.



Source: Department of Human Resources; Department of Legislative Services

Exhibit 6 presents the same information by placement type. As shown in this exhibit, in total, DLS projects 243 fewer cases in fiscal 2016 than in fiscal 2015 and 215 fewer cases in fiscal 2017.

Exhibit 6
Foster Care and Subsidized Adoption/Guardianship Caseload Projection
Average Monthly Caseloads
Fiscal 2015-2017

	2015	2016		2017	
	Actual	DLS	2015-2016 Change	DLS	2016-2017 Change
Regular Foster Care	1,314	1,248	-66	1,192	-56
Emergency Foster Care	47	45	-2	43	-2
Treatment Foster Care	21	20	-1	19	-1
Intermediate Foster Care	160	152	-8	145	-7
Purchased Home	1,575	1,496	-79	1,429	-67
Semi-independent Living	13	12	-1	12	-1
Purchased Institution	719	683	-36	652	-31
Voluntary Placements	0	0	0	0	0
Minor Mothers	59	56	-3	54	-3
Subsidized Guard	2,650	2,637	-13	2,624	-13
Subsidized Adoption	6,919	6,884	-35	6,850	-34
Total Combined	**13,477**	**13,234**	**-243**	**13,019**	**-215**

DLS: Department of Legislative Services

Note: Numbers may not sum due to rounding.

Source: Department of Human Resources; Department of Legislative Services

Rate Estimates and the Impact of New Rate-setting Process

In general, in the fiscal 2017 allowance, agencies that have provider rates have generally assumed an inflationary increase, for example, the Department of Juvenile Services provides for an increase of 2.0%. DLS estimates include an assumption of no rate change in fiscal 2016, but an increase of 1.9% in fiscal 2017 for placement types that receive rates set by the Interagency Rates Committee (IRC) to account for inflation.

IRC, continuing work that began with committee narrative from the 2013 *Joint Chairmen's Report* (JCR), is preparing for a change in the rate structure that will go into effect for rates set for fiscal 2017. One of the recommendations that resulted from the request to review the rate-setting process was to develop a new rate structure that (1) allows for flexibility and innovation in order to meet the needs of the child; (2) establishes a link between rates and performance; and (3) maximizes

federal financial participation. The continued work on this issue, through the Rate Reform Workgroup, has led to plans to unbundle clinical and family supports from the room/board/supervision rate. It is believed that the unbundling of the rates will allow for billing of Medicaid rehabilitative services to resume in the future. The rate methodology is expected to be finalized by early April 2016. It is not clear how this new rate structure, when finalized, will impact the fiscal 2017 payments to providers and the budgets of State agencies that pay the rates set by IRC. DHR indicates that the fiscal 2017 allowance of the agency does not specifically account for the planned new rate-setting process.

Forecast and Budget Risk

Exhibit 7 presents a comparison of the DLS estimate of expenditures for foster care and subsidized adoption/guardianship compared to the budgeted funds in fiscal 2016 and 2017. For comparison purposes, in fiscal 2016, the DLS estimate removes from the budgeted funds $16.4 million in Medical Assistance funds originally included in the budget for rehabilitative services. Despite the loss of the Medical Assistance funds and the planned reversion in fiscal 2016, DLS projects a surplus in total funds in fiscal 2016 of approximately $2.1 million, primarily among special funds. However, DLS projects a shortfall of approximately $3.3 million in fiscal 2017.

The fiscal 2017 shortfall, while relatively minor in the total funding for these payments, bears some monitoring. Despite a relatively small shortfall overall, DLS estimates the general fund shortfall is $11.9 million due to the allowance overstating the availability of regular federal Title IV-E funds. A similar issue occurs in fiscal 2016, while DLS projects an overall surplus, DLS projects a general fund shortfall of $9.1 million, as shown in Exhibit 7.

As these estimates show, although the waiver has created stability in the overall availability of federal funds in the foster care program, some uncertainty remains during this early phase of implementation, and this uncertainty could have a large impact on the need for general funds in the program. **DHR should comment on how it estimated the Title IV-E funds that would be available in fiscal 2016 and 2017 and how the department would cover any shortfall that arose from a lower amount of available federal funds.**

Exhibit 7
Foster Care and Subsidized Adoption/Guardianship Caseload and Expenditures
Fiscal 2015, 2016, and 2017 Est.

	2015	DLS Estimate 2016	DLS Estimate 2017	% Change 2016-17
Monthly Caseload				
Foster Care	3,908	3,713	3,546	-4.5%
Adoptions/Guardianships	9,569	9,521	9,474	-0.5%
Total	**13,477**	**13,234**	**13,019**	**-1.6%**
Monthly Cost Per Case	$1,524	$1,500	$1,495	-0.3%
Flex Funds ($ in Millions)	$22.8	$32.1	$22.4	-30.1%
Budgeted Expenditures ($ in Millions)				
General Funds	$186.1	$185.2	$177.8	-4.0%
Total Funds	**$269.3**	**$288.7**	**$262.3**	**-9.1%**
Medical Assistance Program Funds Budgeted but not Available		-$16.4		
Total Funds Available	**$269.3**	**$272.4**	**$262.3**	**-3.7%**
DLS Forecasted Expenditures ($ in Millions)				
General Funds	$186.1	$194.3	$189.7	-2.4%
Total Funds	**$269.3**	**$270.3**	**$265.6**	**-1.7%**
General Fund Surplus/Shortfall		-$9.1	-$11.9	
Surplus/Shortfall (Compared to Budget)		**$2.1**	**-$3.3**	

DLS: Department of Legislative Services

Source: Department of Human Resources; Department of Legislative Services; Governor's Budget Books

Additional Federal Funding Concerns

The fiscal 2017 allowance of SSA includes some budgetary risk related to federal fund spending. One of these was described previously related to the impact of Title IV-E attainment on the general fund need in the Foster Care Maintenance Payments program.

Another significant concern is the extent of Medical Assistance funds included in the fiscal 2017 allowance of the Local Child Welfare Services program. In this program, a total of

$20.9 million of Medical Assistance funds are included in the fiscal 2017 allowance, nearly three times the amount actually received in fiscal 2015 ($5.3 million). It is especially noteworthy, that that Local Child Welfare Services program has nearly as much Medical Assistance funding budgeted in the fiscal 2017 allowance as Local Family Investment (where caseworkers who determine eligibility for Medicaid programs are budgeted), $22.7 million.

DHR explains that there was an error in the fiscal 2017 allowance. Specifically, the funds that should have been shown as regular Title IV-E funds (what the program received in fiscal 2015), are shown as Medical Assistance funds. In addition, the Medical Assistance funds are overstated. **Exhibit 8** presents the fiscal 2015 actual, fiscal 2016 working appropriation, and a revised calculation for fiscal 2017 based on the assumption of DHR for Title IV-E receipts. If the agency received the amount of Medical Assistance and regular Title IV-E funds as in fiscal 2015, fiscal 2017 would have an estimated federal fund shortfall of $6.9 million. A similar, although smaller, issue could occur in fiscal 2016, when Medical Assistance funds are also budgeted at a level more than twice the fiscal 2015 receipts.

Exhibit 8
Local Child Welfare Services Program Shortfall
Fiscal 2015-2017 Est.

	Actual 2015	Working 2016	Revised Allowance 2017	Est. Shortfall 2017
Medical Assistance	$5,282,641	$13,031,910	$12,145,465	$6,862,824
Regular Title IV-E	8,747,034	900,000	8,747,034	?
Total	**$14,029,675**	**$13,931,910**	**$20,892,499**	**$6,862,824**

Source: Governor's Budget Books; Department of Legislative Services

The fiscal 2017 estimated shortfall of $6.9 million assumes DHR receives $8.7 million of regular Title IV-E funds in that year, the amount received in fiscal 2015 (before the Title IV-E Waiver). The Title IV-E Waiver covers a number of the expenditures previously accounted for with regular Title IV-E (foster care and in-home services and related administration costs). Regular Title IV-E can still be claimed for training activities and subsidized adoption and guardianship cases. However, because these activities are only a portion of the activities that the agency received regular Title IV-E funding for in fiscal 2015, the full amount of fiscal 2015 receipts is unlikely to be available to DHR. As a result, the shortfall is potentially significantly higher than $6.9 million in fiscal 2017.

Additional general funds or federal funds from another source would be required to account for these shortfalls since most of these excess federal funds are budgeted in personnel, which are not discretionary expenses. **DHR should explain how the department plans to cover the federal fund shortfall in this program in fiscal 2016 and 2017.**

Heroin and Opioid Screening

The fiscal 2017 allowance includes $50,000 to implement a screening tool for heroin and opioid use. The screening tool is expected to be used to screen children, parents, and foster families. This funding will implement a recommendation in the *Heroin and Opioid Emergency Task Force Final Report*. The task force recommended that an assessment be completed for all customers. If the assessment indicates a risk, a further screening tool would be used to verify the risk. If the risk of abuse is verified, the individual completing the assessment would make referrals to appropriate resources to assist the family recovering from the impact of the heroin or opioid use disorder.

Under Section 5-1202 of the Family Law Article, DHR is required to screen parents for substance abuse in all cases accepted for child abuse and neglect investigation. DHR is also required to have qualified addiction specialists in all local child welfare offices. In addition, DHR has a screening tool that is used for public assistance applicants. DHR currently uses a screening tool for in- and out-of-home cases. The tool can be used to detect heroin/opioid use. If substance use is detected, the client is referred for further testing and treatment. **DHR should explain how the new tool will differ from the existing tool and if the tool will supplement or replace the existing tool.**

Issues

1. Title IV-E Waiver

Waiver Proposal

In February 2014, DHR applied for a Title IV-E Waiver. As stated in the waiver application, DHR intended to expand family preservation and post permanency services, essentially allowing the agency to spend federal funds for more than out-of-home placements. DHR stated in the application that it expected to focus on children transitioning from foster care. DHR identified two priority populations to focus services on (1) children 0 to 8 years old; and (2) children 14 to 17 years old. DHR expected to reduce entries into out-of-home care, reduce reentries into out-of-home care, and reduce the length of stay in out-of-home care. DHR anticipated that the waiver would begin an expansion of evidence-based practices for in-home services and post permanency support and that the services would ultimately be part of the Medicaid State Plan.

The waiver was expected to be rolled out in phases across the State. DHR expected to work with the jurisdictions to identify the specific evidence-based practices that should be implemented or expanded in that jurisdiction. This strategy would ensure that jurisdictions implemented the services that are most effective for the jurisdiction's population.

DHR expected to partner with the University of Maryland School of Social Work (SSW) to assess the effectiveness of the demonstration project. The evaluation was to include a process evaluation (focusing on the implementation, population served, and services provided), an outcome evaluation (focusing on the safety, permanency, and well-being outcomes for the children, youth, and families), and a cost evaluation (focusing on the total cost of care for youth in the treatment and comparison groups).

DHR agreed to continue utilizing funds currently dedicated to child welfare services for that purpose, *i.e.*, savings are to be reinvested. Under the waiver, funds are received based on a capped allocation, with caps identified for maintenance payments and administration separately. The capped allocation that DHR received under the waiver was to cover Foster Care Maintenance Payments and Foster Care Administration, but DHR proposed to exclude:

- information technology costs;
- training;
- subsidized adoption payments; and
- subsidized guardianship payments.

The specific waivers DHR was seeking for this project were related to (1) expanded eligibility (allowing the State to use Title IV-E funds for children and families not otherwise eligible); (2) expanded claiming; and (3) expanded services (to allow the State to use funds for services not normally covered by Title IV-E funds).

Waiver Approval

On September 30, 2014, DHR received approval of the proposed demonstration project and waivers to implement the project. Under the terms and conditions provided to the State for the project, the project was to begin no earlier than July 1, 2015, but no later than October 1, 2015, and to end the twentieth quarter after the project start date or September 30, 2019 (whichever is earlier).

DHR is required under the terms and conditions to, among other items, continue processing Title IV-E eligibility for children (to ensure that the funding for eligible children will continue after the project ends), ensure a program is maintained consistent with the services provided before implementation of the project for children and families not part of the demonstration, and ensure that savings from the project (federal, State, or local) remain in use for child welfare services. Savings are considered to be the funds that would have been expended under the regular Title IV-E program without the demonstration or could have been expended under Title IV-B. **DHR should comment on how it plans to track reinvested savings to ensure compliance with this requirement.**

The base allocation for each federal fiscal year for foster care maintenance costs (which include expanded services under the project) is $77.64 million, and the base allocation for administrative costs is $48.99 million. These costs include both the federal and state share, which is based on the federal Medical Assistance match rate (in Maryland 50%). The federal share of the base allocations are $38.82 million for maintenance payments and $24.50 million for administrative expenses. These allocations are adjusted based on an annual change factor.

DHR is required to submit semi-annual progress reports following the beginning of implementation on project and evaluation activities. An interim evaluation report is due within 60 days of the tenth quarter following the implementation date (two and one-half years after implementation) and a final evaluation within six months after the end of the project.

Waiver Implementation and Status

Activities

DHR began implementation of the project on July 1, 2015, with an assessment for all in-home service cases statewide. In the first quarter of calendar 2016, DHR planned to begin implementation of evidence-based practices. The implementation requires approval from the U.S. Department of Health and Human Services Children's Bureau before it can begin. DHR will begin implementation with Allegany, Anne Arundel, Baltimore, Harford, Howard, Montgomery, and Prince George's counties and Baltimore City. The timing for roll-out in the 16 remaining jurisdictions is still being determined.

As planned in the proposal, evidence-based practices are being tailored to the individual needs of the jurisdictions. For example, Anne Arundel County will be implementing two types of practices related to mental health services and Baltimore County will be implementing a third type of practice related to mental health services. Allegany and Harford counties will be implementing two different parent education practices. Baltimore City will be implementing a substance abuse treatment program (that includes job training and housing) as well as a casework related practice. Howard, Montgomery, and Prince George's counties will also be implementing a practice that is casework related, but it is not the same one as Baltimore City.

Funding

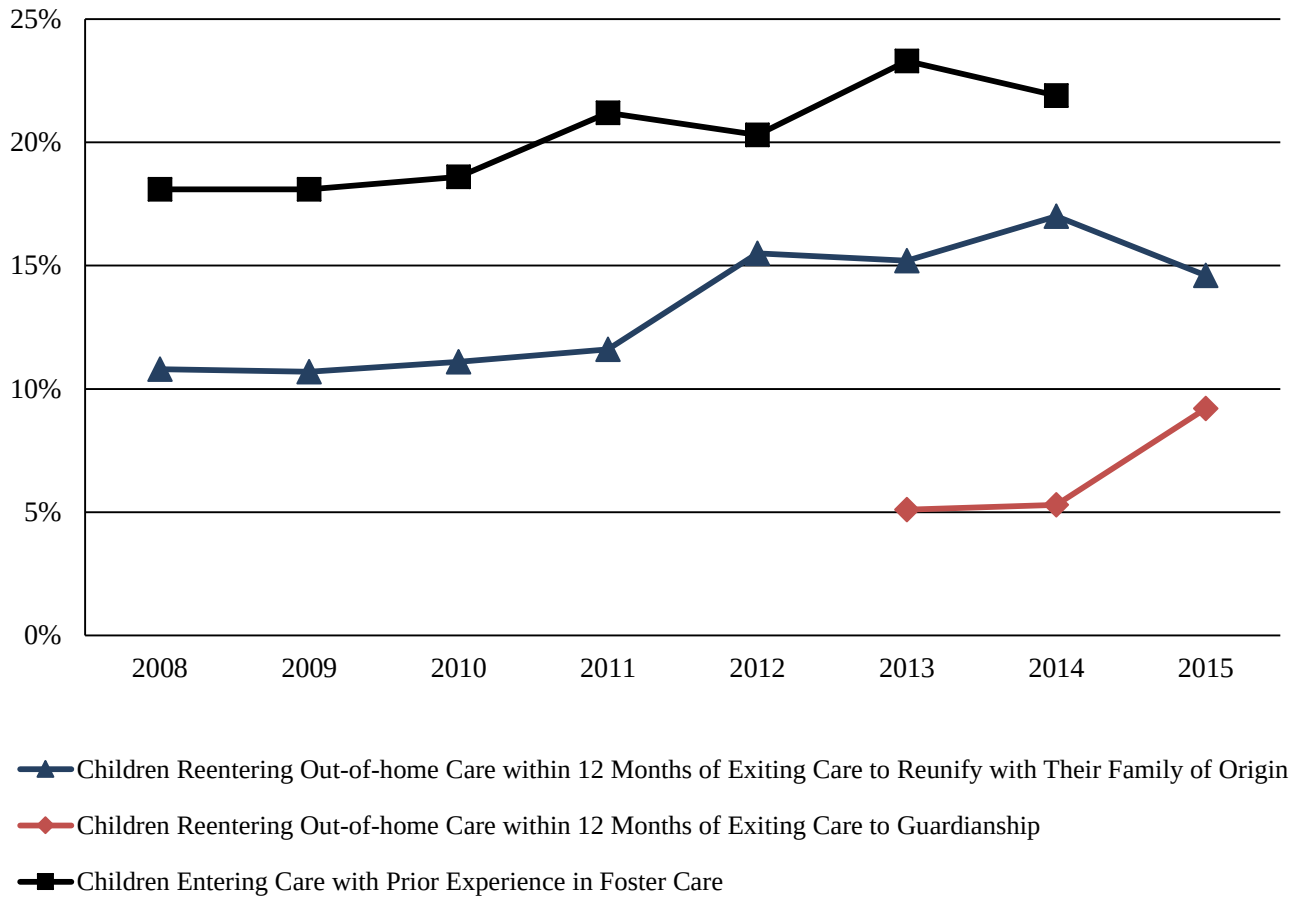
The fiscal 2016 and 2017 budgets contain funding from the waiver for maintenance payments and foster care administration, totaling $70.9 million and $74.8 million respectively. Among the administration expenditures is funding for a contract with the SSW Institute for Innovation and Implementation to provide project management support to DHR for this project ($500,000 in federal funds in fiscal 2016 and $565,000 in total in fiscal 2017). The fiscal 2017 funding is split equally between general and federal funds ($282,500). This support will include working with the department to establish a comprehensive work plan to provide policy analysis, technical support, and document development.

Funding is also provided in these years for Title IV-E waiver intervention services. In fiscal 2016, the waiver intervention services were funded at $8.7 million in federal funds from the Title IV-E Waiver. However, the fiscal 2016 funding is understated because no general funds are specifically budgeted to match these federal funds, as required. DHR advises that general funds will be available to match the federal funds as needed. In fiscal 2017, funding includes $8.0 million ($4.0 million general funds and $4.0 million federal funds) for four statewide evidence-based practices assessments ($500,000 each) and 24 LDSS interventions/promising practices ($250,000 each).

2. Unsuccessful Reunifications of Children Leaving the Foster Care System

Reunifications occur when children in the care of the State are returned to their families. Upon occasion these children subsequently reenter State care. **Exhibit 9** presents information on the rate of reentry within 12 months of reunification with a child's parents. As shown in this exhibit, the rate of reentry within 12 months of reunification, which hovered between 10.7% and 11.6% from fiscal 2008 to 2011, increased in fiscal 2012 to 15.5% and reached 17.0% in fiscal 2014 before falling to 14.6% in fiscal 2015. A similar trend occurs with the re-entries for children with prior experience in foster care.

Exhibit 9
Reentry into Foster Care System within 12 Months of Reunification with Family
Fiscal 2008-2015



Source: Department of Human Resources; Governor's Budget Books; University of Maryland School of Social Work

After the rate of reentry into care had increased for several years, the General Assembly added language in the fiscal 2015 budget bill due to concerns that children were exiting foster care to return to parents who remained unfit to care for their children. This language restricted funding in SSA to be used for a research project at the SSW to study issues related to unsuccessful reunifications of children with their parents after entering the foster care system including (1) the reasons for reentry after reunification; (2) the frequency of reentry after reunification; (3) evaluating the criteria used by caseworkers before reunification; (4) discussing other states management of reunification and the appropriateness for individual cases; (5) describing key aspects of the most successful state programs and a comparison to Maryland; and (6) studying an age-stratified sample of two groups of cases to

better identify factors associated with successful reunifications. An interim report was due on December 1, 2014, with a final report due on April 15, 2015.

SSW used several methods to study this issue including a literature review, interviews with other states that perform better than the national median, caseworker surveys, case reviews, and reviews of administrative data.

Literature Review

A couple of factors were identified as having consistent relationships with reentering care: (1) a short length of stay in foster care (less than six months) increased the likelihood of reentering care; and (2) children placed with relatives during the time in care had a lower likelihood of reentering care. A number of other factors that were studied were found to be a factor in at least one study, but the finding was not consistent among all studies, for example (1) poverty; (2) a high number of placements while in care; and (3) prior involvement with child protective services.

Comparison with Better Performing States

SSW identified 17 states that performed better than Maryland in the rate of reentry in the second round of the CFSR. North Carolina, for example, had a reentry rate of 2.3% compared to the Maryland rate identified in this review of 11.4%. In the CFSR, Maryland performed slightly better than the national median (11.9%). As noted earlier, Maryland's rate has increased even further since that review. SSW determined that 4 of the 17 states had a comparable caseload to Maryland (Louisiana, Kansas, Nevada, and South Carolina). SSW compared Maryland to these states on a number of caseload characteristics. Some of the data reported is shown in **Exhibit 10**. Several key differences were found between Maryland cases and the better performing states, including those related to placement goals, the number of placement settings, the higher rate of multiple removals, and the median length of stay. SSW also explained that several of these states with a lower median time to achieving reunification had a period where the child had returned home but continued to be monitored by the agency before legal custody was transferred.

SSW also attempted to contact the 17 states that performed better than Maryland, but reached only 4 (Alaska, Michigan, New Jersey, and Oklahoma). These states identified the importance of comprehensive assessments of family needs, active family involvement in the decision making processes, intensive post reunification services, and a focus on workforce caseload size as important to the success of reunifications.

Exhibit 10
Comparison of Comparable States on Out-of-home Characteristics
Child and Family Services Review Round Two

	Louisiana	Kansas	Nevada	South Carolina	Maryland
Reentry Rate	6.7%	7.0%	9.7%	9.5%	11.4%
Permanency Goals					
Reunification	75.1%	58.1%	48.3%	46.1%	29.5%
Adoption	16.3%	30.0%	34.8%	32.2%	15.1%
Long-term Foster Care	7.2%	0.0%	3.1%	8.8%	16.1%
Living with Other Relative	0.9%	0.0%	6.0%	2.4%	9.5%
Emancipation	0.4%	8.7%	6.4%	9.8%	11.9%
Placement Settings*					
1	29.5%	28.3%	24.0%	22.0%	23.2%
2	28.1%	21.9%	26.5%	25.2%	21.7%
3 or More	42.1%	49.4%	48.6%	52.9%	55.3%
Removal Episodes					
1	84.1%	87.3%	79.9%	80.2%	74.7%
2	13.2%	11.2%	16.0%	16.0%	19.8%
3 or More	2.7%	1.5%	4.1%	3.8%	5.5%
Median Length of Stay (in Months)	13.1	13.7	14.4	15.5	33.9
Median Length of Time to Achieve Reunification (in Months)	9.0	12.7	5.9	2.6	12.6
Exits to Reunification in Less Than 12 months	65.3%	60.9%	88.0%	77.6%	48.1%

*Placement settings contained missing data for some states: Louisiana 0.3%, Kansas 0.5%, Nevada 0.8%, and Maryland 0.1%.

Source: University of Maryland School of Social Work; Department of Human Resources

Maryland Review

SSW also performed several research activities specific to Maryland cases, including a caseworker survey, a case record review, and a statistical analysis. The caseworker survey was sent to

caseworkers that had a child in their caseload exiting to reunification between January 1, 2013, and August 31, 2014. The survey received a total of 284 responses. The survey revealed the importance caseworkers placed on the child being completely safe prior to reunification, post reunification services being in place before reunification, and trial home visits before reunification. The survey also revealed that caseworkers sought to maintain contact between the child and sibling and the child and parents during the out-of-home stay. Finally, the survey noted that for a successful reunification the child should (1) participate in the reunification process (when developmentally appropriate); (2) feel safe in the home; and (3) be committed to reunification. The survey also found that it was important for parents to acknowledge and work toward alleviating the issues that led to involvement in the child welfare system.

Case Reviews and Case Analysis

As part of the study, SSW conducted a limited number of case reviews. Some of the findings in this review are presented in **Exhibit 11**. SSW found some differences between those cases of successful reunification and those resulting in a reentry to the foster care system, including: no reentry cases had experienced a trial home visit; and the reentry cases were less likely to show progress on case plan goals or a significant reduction in safety/risk concerns. However, the small number of cases reviewed by SSW should be noted before drawing sweeping conclusions.

Exhibit 11
Case Review Comparison

	Reunification (N=42)	Reentry (N=10)
Placements During Removal Episode	2.1	2.6
Biological/Legal Father Was Involved in the Case	51.6%	80.0%
Sibling In Out-of-home Care	47.1%	60.0%
Child's Last Placement		
Relative	19.4%	30.0%
Family Foster Home	36.1%	50.0%
Institution	22.2%	20.0%
Trial Home Visit	22.2%	0.0%
Safety/Risk Assessments Showed a Signifcant Reduction in Concerns at Time of Reunification	92.6%	70.0%
Child and Family Made Progress on Case Plan Goals	90.9%	60.0%
Family Involvement Meetings Held at Points in Accordance with Department Policy	54.5%	40.0%

Source: University of Maryland School of Social Work; Department of Human Resources

SSW also conducted analyses of reunification cases where the child was 16 or younger from fiscal 2009 through 2012 to identify factors associated with the increase and lower likelihood of reentry. Factors identified in this analysis that lowered the likelihood of reentry included:

- ever having a trial visit;
- a final placement of kinship care;
- caseworker visitation; and
- older age at entry compared to infants except for children ages 11 to 13.

Factors that were found to increase the likelihood of reentry in at least some of the statistical analyses were similar to findings in the literature review such as having a sibling in out-of-home care, a short length of stay in care, prior experience with the child welfare system, being placed in a residential treatment center, child behavior problems that were a factor in the removal, and having the presence of one or more of these risk factors. Having a court ordered reunification against the agency recommendation also increased the likelihood of reentry.

Recommendations

SSW made five recommendations in the report, which were to:

- focus on the presence of the identified risk factors;
- formalize a trial home visit process;
- provide post reunification transition and services to families and youth for at least six months after case closure;
- develop collaborative training between SSA and the courts to ensure consistent communication and understanding about the readiness of children and families for reunification and the likelihood of a successful reunification; and
- develop data sharing agreements with other child and family serving agencies.

DHR should discuss whether it has implemented any of these recommendations and describe other steps the agency is taking to address the high reentry rate and the State's progress toward reducing the reentry rate in fiscal 2016.

3. Child Welfare Caseworkers

Child welfare caseload ratios have been of concern to the General Assembly for many years. In 1998, the General Assembly passed the Child Welfare Workforce Initiative requiring that DHR and DBM ensure that Child Welfare League of America (CWLA) recommended caseload to staffing levels are met. The Child Welfare Accountability Act of 2006 reiterated this requirement. For the past decade, the budget committees have either withheld funds until a certain number of caseworker positions were filled or asked DHR to report on caseload ratios for supervisor and caseworker positions.

CWLA recommended caseload to staffing ratios are a series of ratios separated by the type of case or work being undertaken. For example, intake, preservation services, out-of-home placement foster care, and out-of-home placement kinship care each have individual ratios. The number of workers needed are then combined and compared to the number of filled positions. A separate ratio determines the number of supervisors needed. The caseload to staff ratios are of particular concern given that 41 local child welfare services positions were abolished as part of the DHR plan to accommodate the 2% across-the-board reduction in fiscal 2016. The information presented in this issue accounts for these abolitions.

Most Local Departments Meet Caseworker Standards

Exhibit 12 shows the number of positions needed for the caseload by jurisdiction based on the average caseload from September 2014 through August 2015 and the number of filled and vacant positions as of December 1, 2015. The number of caseworker and supervisor positions needed to meet the standard varies based on the number of cases and the mix of cases. These factors may allow the caseload to staffing ratios to improve or decline even without changes in the number of filled positions. For example, the number of caseworker positions needed statewide to meet the CWLA caseworker standards for the September 2014 through August 2015 period is 1,172.9, 38.0 caseworker positions (or 3.1%) lower than for the October 2013 to September 2014 data presented in the fiscal 2016 analysis. This reduction in needed caseworker positions helped ensure that the State continued to meet the caseworker standards even as the number of filled positions declined from 1,343.4 positions on December 1, 2014, to 1,321.9 on December 1, 2015 (a decrease of 1.6%). In fact, the number of surplus positions statewide increased by 4.8 positions between these two periods.

As shown in Exhibit 12, only one jurisdiction did not meet the caseload to staffing ratio guidelines. Harford County had a shortfall of 3.7 caseworker positions to meet the guideline; however, with 6.5 vacant positions, if vacant caseworker positions were filled the guideline would be met.

Exhibit 12

Child Welfare Position Status by Local Department

	Filled Worker Positions Needed to Meet CWLA	Filled Worker Positions	Surplus/ Shortfall	Vacant Caseworker Positions	Filled Supervisor Positions Needed to Meet CWLA	Filled Supervisor Positions	Surplus/ Shortfall	Vacant Supervisors
Allegany	24.3	38.5	14.2	1.0	4.9	5.0	0.1	0.0
Anne Arundel	81.1	84.8	3.7	7.0	16.2	15.0	-1.2	1.0
Baltimore	123.3	123.5	0.2	20.0	24.7	21.0	-3.7	0.0
Baltimore City	442.4	473.5	31.1	31.0	88.5	95.0	6.5	11.0
Calvert	15.9	17.0	1.1	5.0	3.2	3.0	-0.2	0.0
Caroline	11.5	18.5	7.0	0.0	2.3	3.0	0.7	1.0
Carroll	23.7	27.0	3.3	1.0	4.7	3.0	-1.7	1.0
Cecil	39.6	41.0	1.4	1.0	7.9	7.0	-0.9	2.0
Charles	29.0	33.0	4.0	3.0	5.8	6.0	0.2	2.0
Dorchester	15.1	18.0	2.9	1.0	3.0	2.0	-1.0	1.0
Frederick	34.9	39.5	4.6	5.0	7.0	9.0	2.0	0.0
Garrett	9.7	16.0	6.3	0.0	1.9	3.0	1.1	0.0
Harford	55.7	52.0	-3.7	6.5	11.1	11.0	-0.1	0.0
Howard	25.4	33.0	7.6	0.5	5.1	4.0	-1.1	0.0
Kent	4.6	7.0	2.4	0.0	0.9	1.0	0.1	0.0
Prince George's	117.3	124.5	7.2	11.5	23.5	21.0	-2.5	1.0
Queen Anne's	6.1	8.0	1.9	2.0	1.2	2.0	0.8	1.0
Somerset	10.9	15.5	4.6	1.0	2.2	2.0	-0.2	0.0
St. Mary's	19.1	22.6	3.5	4.0	3.8	3.0	-0.8	2.0

	Filled Worker Positions Needed to Meet CWLA	Filled Worker Positions	Surplus/ Shortfall	Vacant Caseworker Positions	Filled Supervisor Positions Needed to Meet CWLA	Filled Supervisor Positions	Surplus/ Shortfall	Vacant Supervisors
Talbot	6.7	12.0	5.3	0.0	1.3	4.0	2.7	0.0
Washington	40.7	64.0	23.3	1.0	8.1	10.0	1.9	0.0
Wicomico	20.0	35.0	15.0	1.0	4.0	6.0	2.0	1.0
Worcester	16.1	18.0	1.9	2.0	3.2	5.0	1.8	0.0
Statewide	**1,172.9**	**1,321.9**	**149.0**	**104.5**	**234.6**	**241.0**	**6.4**	**24.0**
Total Shortfall in Jurisdictions Not Meeting Standards:			**-3.7**				**-13.4**	

CWLA: Child Welfare League of America

Note: Does not account for positions in a frozen status.

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

Local Departments are Less Successful Meeting Supervisor Standards

While only one local department is not meeting the caseworker standards, 11 of 24 jurisdictions failed to meet the CWLA supervisor standards, with a total shortfall among those jurisdictions of 13.4 positions (or 5.7% of the total number of supervisors needed under the guidelines). In all but 3 of those jurisdictions, the number of vacant supervisor positions in that local department would not be enough to resolve the shortfall. However, there are enough vacant supervisor positions statewide to overcome this shortfall. **DHR should comment on any plans to transfer vacant supervisor positions to ensure that all local departments can meet the CWLA guidelines.**

The supervisory shortfall has declined compared to the caseloads from October 2013 to September 2014 and filled positions as of December 1, 2014. At that time, 13 local departments did not meet the required standards, with a total shortfall among those jurisdictions of 28.6 positions. This improvement has come, in part, due to fewer supervisor positions required to meet the standard because of caseload reductions (decreasing from 242.2 to 234.6, or 3.1%) but also because of an increase in the number of filled positions (increasing from 232.5 to 241.0, or 3.7%).

Recommended Actions

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

   Further provided that these funds are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose. Funds not expended or transferred shall revert to the General Fund.

   Explanation: This language restricts general funds appropriated for foster care payments to that use only. This language is similar to language added in recent years except that transfers to N00G00.03 (Local Child Welfare) are not allowed. This restriction prevents a transfer of general funds to other programs that might create or increase a deficit in spending in the Foster Care Maintenance Payments Program (N00G00.01).

2. Adopt the following narrative:

   ***Caseload Estimates for Out-of-home Placements*:** During the 2016 session, the Department of Human Resources (DHR) and Department of Budget and Management (DBM) presented two sets of estimates at two separate times for caseload assumptions and payments estimates for foster care, subsidized adoptions, and subsidized guardianship in fiscal 2017. Neither appear to be based on current trends, but rather based on the funding in the allowance. Given that out-of-home placements costs are entitlements, the forecast of caseloads and payment estimates should be the driving factor in the budget. The committees request that DHR and DBM present by placement type and flexible funding services *(e.g.* daycare, education, child care offset, promoting safe and stable families, ancillary and emergency services, local education agency funding, Title IV-E Waiver intervention services), the caseload estimates, payment estimates, and expenditures for fiscal 2016 actuals, and estimates for fiscal 2017 and 2018 that were used in fiscal 2018 budget development. For flexible funding services, only the total estimated expenditures by type is required. The information should also include the amount of any provider rate change and the share of the charges claimed to regular Title IV-E assumed in the fiscal 2018 allowance.

Information Request	**Authors**	**Due Date**
Caseload and expenditure forecasts	DHR DBM	With submission of the fiscal 2018 allowance

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

, provided that these funds are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose except that funds may be transferred to program N00G00.01 Foster Care Maintenance Payments. Funds not expended or transferred shall revert to the General Fund.

Explanation: This language restricts general funds appropriated for child welfare services to that use only or for transfer to N00G00.01 Foster Care Maintenance Payments.

4. Adopt the following narrative:

Child Welfare Caseload Data: The committees believe that maintaining an adequate child welfare workforce is essential to improving outcomes for children entering the State's care. Therefore, in order to maintain oversight of this important issue, the committees request that the Department of Human Resources (DHR), on November 15, 2016, report to the committees on the actual and annual average number of cases and filled positions assigned, by jurisdiction, for the following caseload types using data current within 70 days:

- Intake Screening;
- Child Protective Investigation;
- Consolidated Home Services;
- Interagency Family Preservation Services;
- Services to Families with Children – Intake;
- Foster Care;
- Kinship Care;
- Family Foster Homes – Recruitment/New Applications;
- Family Foster Home – Ongoing and Licensing;
- Adoption;
- Interstate Compact for the Placement of Children; and

- Caseworker Supervisors.

Information Request	Author	Due Date
Report on caseload data and filled positions assigned by jurisdiction for specified caseload types	DHR	November 15, 2016

Updates

1. Alternative Response Final Report

Chapter 397 of 2012 authorized the Secretary of Human Resources to implement an alternative response program for selected reports of abuse or neglect. Alternative response is a child protective services response that allows caseworkers to comprehensively assess the risk of harm to the child, risk of subsequent abuse or neglect, the family strengths and needs, and the provision of or referral for necessary services without an investigation or formal determination of whether child abuse or neglect has occurred. Chapter 397 required that cases selected for alternative response are only low-risk cases and prohibited certain cases from being considered for alternative response. Cases prohibited from being referred to alternative response include having previously been assigned an alternative response case in a certain timeframe, being a suspect or responsible in a previous abuse or neglect case within a certain timeframe, and sexual abuse.

Cases assigned to alternative response may later be reassigned for investigative response. Similarly, cases assigned for investigation may be reassigned to alternative response. Chapter 397 identifies certain activities that the caseworker and LDSS must undertake including: (1) seeing the child and the child's parent or primary caretaker within 24 hours of receiving a report of physical abuse or within five days of receiving a report of neglect; (2) attempting an on-site interview with the child's parent or primary caretaker; (3) evaluating the child's home environment; (4) deciding on the safety of the child and of other children in the household; and (5) completing an alternative response assessment within 60 days after the receipt of the report. Consistent with the assessment or other safety or service plans, the LDSS is to provide any appropriate services, refer the family or child for additional services, or establish a plan to monitor the safety plan and the provision or completion of appropriate services. Records are to be maintained for three years.

Implementation

Alternative response was implemented in five phases in Maryland:

- Phase 1: Allegany, Frederick, Garrett, Montgomery, and Washington counties (July 1, 2013);
- Phase 2: Baltimore, Carroll, Cecil, Harford, and Howard counties (November 11, 2013);
- Phase 3: Anne Arundel, Calvert, Charles, Prince George's, and St. Mary's counties (January 1, 2014);
- Phase 4: Caroline, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties (April 1, 2014); and
- Phase 5: Baltimore City (July 1, 2014).

Evaluation

Chapter 397 required DHR to contract with an independent agency to conduct an evaluation of the program. An interim report was due October 1, 2014, and a final report due to the General Assembly on October 1, 2015. IAR Associates conducted the evaluation. The evaluation was conducted from April 2013 through September 2015. The evaluation examined a number of questions including those related to (1) the impact on child safety and well-being of children and families; (2) the level of family engagement; (3) case plan effectiveness and family linkages to services; (4) the differences in provision of services; and (5) the responses of families, caseworkers, and stakeholders. The evaluation was conducted using data from MD CHESSIE and surveys with staff, family, and community stakeholders, as well as, interviews during site visits.

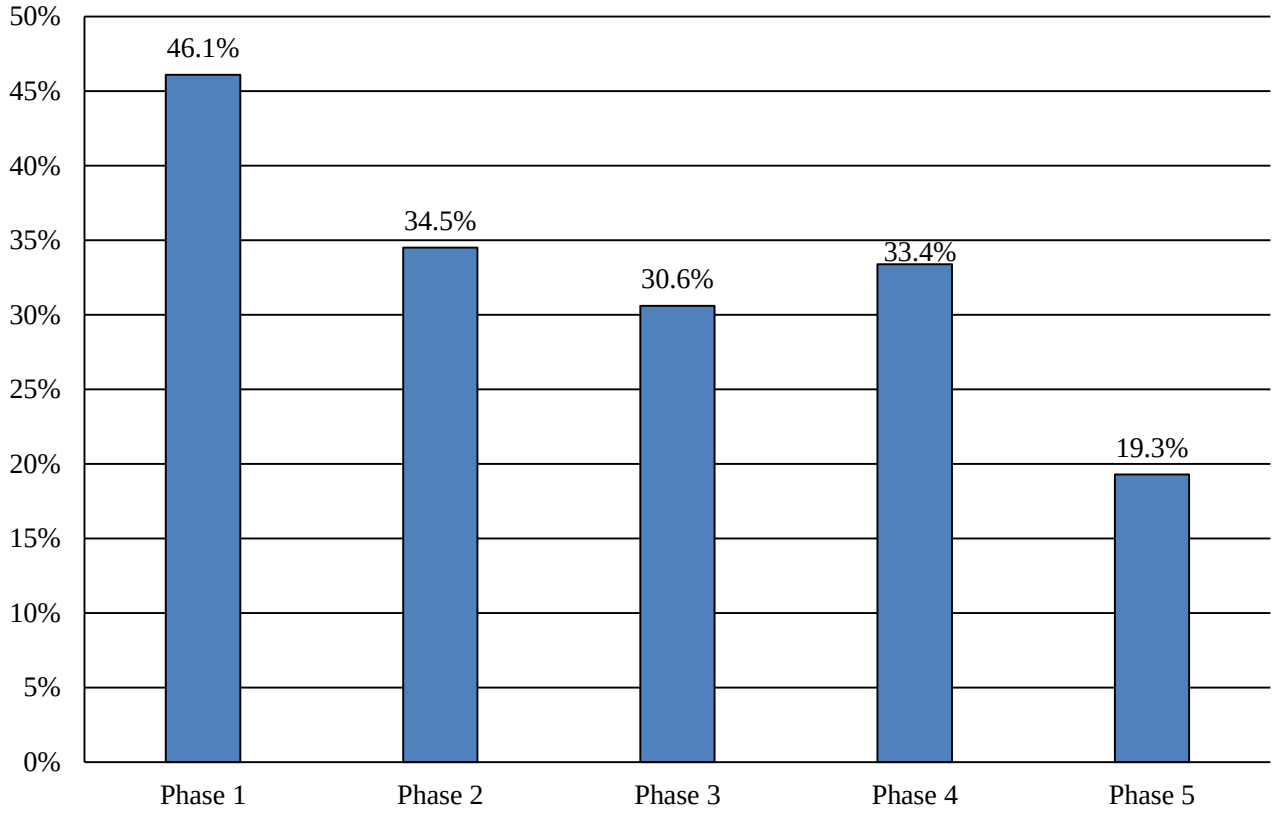
Evaluation Results

The percent of cases assigned to alternative response varied both by phase of implementation and individual county. **Exhibit 13** presents information on the percent of cases assigned to alternative response during the evaluation period by phase of implementation. The earlier phases have had a longer experience with alternative response and more data points. The evaluation notes that, consistent with the implementation in previous states, more cases are assigned to alternative response the longer the jurisdiction had been using the method.

Few of the families initially assigned to alternative response, 3.2% (383) of 12,124 families, were later reassigned to investigative response. The rate of reassignment was consistent with other states (Missouri, Minnesota, and Ohio). The reasons for reassignment varied but included refusal to provide access to the child, refusal to discuss the allegations, and refusal to cooperate and family risk or child safety was a concern.

In case-specific surveys, caseworkers noted that in nearly all cases (91.8%), the case would not have been more appropriately handled with an investigative response. Some of the reasons that were provided for cases where the caseworker thought it might have been more appropriately handled as an investigative response related to ability to rule out a finding and have the record expunged. The caseworkers also estimated that had the alternative response cases been an investigative response, nearly three-quarters (73.9%) would have resulted in a ruled out finding (a finding that abuse or neglect did not occur).

Exhibit 13
Alternative Response Case Assignment
July 2013 – Mid-June 2015



Note: Timeframes for implementation are listed on page 555.

Source: IAR Associates; Department of Human Resources

Risk and Safety

In a general survey, 64.2% of workers and supervisors with experience with alternative response thought children were equally safe with the family assessment (alternative response) or investigations and 24.4% felt they could not judge whether there was a safety difference. A smaller percentage believed either investigative responses (6.9%) or alternative responses (7.5%) were safer.

When assessing safety threats (for example lacking basic needs, unsafe or unclean home, medical/health care neglect, excessive discipline, and emotional maltreatment), in case-specific surveys, caseworkers rated children involved in alternative response cases as no less safe than children in cases involved in an investigative response. In addition, caseworkers noted that the safety threats were addressed at approximately the same rate in the two types of cases.

During site visits, caseworkers, supervisors, and alternative response administrators, generally did not indicate any safety concerns for children with alternative response. The evaluators noted that in the early stages of implementation, some caseworkers preferred the use of investigative response for some cases to provide the leverage to encourage compliance. However, the evaluators noted that this decreased as time passed. The evaluators did note that some experienced caseworkers felt unease that they could not see the child alone (in a site such as school) before speaking with the caregivers.

The evaluators also found a slightly lower rate of recurrence (measured by having an indicated or unsubstantiated finding within six months) for alternative responses cases (5.3%) than both the period right before implementation (6.8%) and investigative response cases during the period of implementation (6.0%). However, the evaluators noted that alternative response cases are not comparable to the investigative response cases included in the analysis. Of note, the evaluators found a significant difference in the recurrence of maltreatment rate for alternative response in jurisdictions in which caseworkers handled both types of cases (6.0%) compared to jurisdictions in which caseworkers were specialized (4.1%).

Family Involvement and Service Provision

In case-specific surveys, caseworker views of changes in well-being and parent/family interaction were very similar between the investigative and alternative responses. The only notable difference between the caseworkers among the two types of responses, in terms of views of changes in individual family member issues, was that caseworkers in alternative response more frequently reported a decrease in the severity of mental health concerns for the child.

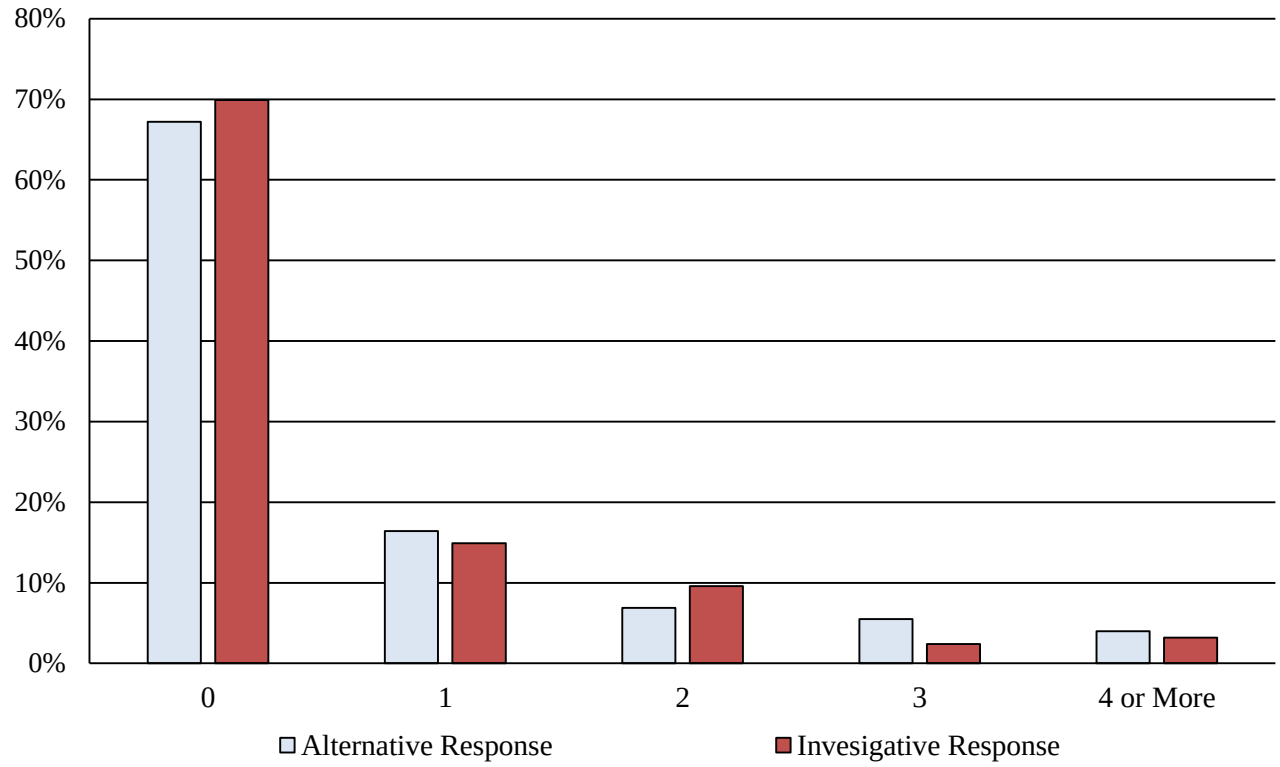
In site visits, caseworkers noted the higher level of cooperation of families involved in alternative response that these workers believed led to an environment that was safer for the child. Similarly, in case-specific surveys, while families in both types of response were rated as cooperative, the families involved in alternative response were rated as more cooperative at both the first and last meetings. Except in Baltimore City, for each phase of implementation, caseworkers noted fewer contacts under alternative response than investigative response.

Families in both types of responses provided positive feedback on the interaction with caseworkers. However, the feedback was more positive for families involved in alternative response. For example, 93.2% of families involved in alternative response stated they were satisfied with the caseworker compared to 85.5% for investigative response. Families involved in alternative response also noted more involvement in decision (64.6% said a great deal of involvement) compared to investigative response (50.7%).

Maryland did not allocate additional funding for services in implementing alternative response, unlike some other states. This resulted in a difference in Maryland in service provision compared to other states. In addition, services are provided in Maryland based on the needs of families rather than the type of response. The majority of caseworkers (69.7%) believed that there was definitely no difference in the types of services a family received under alternative response than the family would have under investigative response. As shown in **Exhibit 14**, caseworkers reported little difference in the number of information or referral services reported. However, the evaluators noted some

differences among the types of services information or referrals were provided to address, for example, a higher rate of child care and mental health/psychiatric services for alternative response cases and a higher rate of drug abuse treatment and public benefits and medical care for investigative response. Services provided, however, were noted at a higher rate for investigative response cases.

Exhibit 14
Information and Referral Services by Response Type



Source: IAR Associates; Department of Human Resources

General Observations

The evaluators also found that at the beginning of the implementation, caseworkers and administrators did not see alternative response as a large change in approach because they felt the approach was similar to what was already occurring. However, the evaluators found that the percentage of workers that reported that the approach impacted the way they approached families or performed work a great deal increased from the first to the final survey (18.9% to 30.8%). Responses varied by phase of implementation.

There was some evidence that job stress and job satisfaction were negatively impacted among workers implementing alternative response. This was believed to be in part due to the need to meet with families together which results in longer evening hours.

Also, several times evaluators noted concerns and issues related to the limited retention of files for ruled out cases.

2. Substance Exposed Newborns Final Report

Chapter 90 of 2013 established a requirement for health care practitioners involved in the delivery or care of a substance-exposed newborn to make a report to the LDSS. A substance-exposed newborn is defined as a newborn that displays (1) a positive toxicology screen for a controlled drug in a test after birth; (2) effects of controlled drug use or symptoms of withdrawal from prenatal controlled drug exposure as determined by medical personnel; or (3) the effects of a fetal alcohol spectrum disorder. Alternatively, a newborn is considered substance-exposed if the newborn's mother had a positive toxicology screen for a controlled drug at the time of the delivery.

An oral report is required as soon as possible and a written report no later than 48 hours after the contact, examination, attention, treatment, or testing that prompted the report. The report does not create a presumption that the child has been or will be abused or neglected. LDSS is required within 48 hours of receiving the report to (1) see the newborn in person; (2) consult with a health care practitioner with knowledge of the newborn's condition and the effects of any prenatal alcohol or drug exposure; and (3) attempt to interview the newborn's mother and any other individual responsible for the care of the newborn. LDSS is also expected to promptly assess the risk of harm and safety of the newborn to determine the necessity of further intervention. If additional intervention is determined necessary, LDSS is to develop a plan of safe care, assess and refer the family for appropriate services, and develop a plan to monitor the safety of the newborn and the family's participation in appropriate services.

The legislation also required an interim report on October 1, 2014, and a final report on the implementation of the legislation on October 1, 2015.

Regulations to implement the legislation were effective December 23, 2013.

Impacts of the Legislation

Information in the final report covered the period July 1, 2014, through June 30, 2015. During that period, 1,729 reports on substance-exposed newborns were made by hospital staff to LDSS, which encompassed 1,776 newborns. The vast majority of these reports (97.0%) did not result in Child Protective Services (CPS) response. An investigative response occurred in 1.8% of these reports and alternative response occurred in 1.2% of reports. The number of reports that led to a CPS response were lower in the final report than in the interim report (which covered the period October 1, 2013, through July 31, 2014), in which a total of 8.1% of reports resulted in either an alternative or investigative response.

LDSS staff conducted an assessment using the Safety Assessment for Every Child (SAFE-C) to determine whether a child is safe, conditionally safe (circumstances in which a family signs an agreement to accept and participate in services and is determined safe at the next assessment if the plan is successful), or unsafe. Of the 4,151 assessments the outcome of these assessments were:

- 2,801 newborns determined safe (67.5%);
- 1,170 newborns determined conditionally safe (28.2%);
- 180 newborns determined unsafe (4.3%); and
- 101 newborns determined unsafe were placed in an out-of-home placement within 90 days of birth.

These results are slightly different than the interim report, which resulted in a higher rate of determination of safe newborns (71.2%) and a higher rate of determination of unsafe newborns (5.1%). LDSS staff also conducted 1,373 family risk assessments within 60 days of birth to identify factors that are most highly associated with future risk of harm for use in guiding decisions about service plans.

Other outcomes described in the final report are:

- 1,502 documented separate in-home services provided or paid for by LDSS;
- 347 individuals who received 703 documented services including assessments, urinalyses, or substance abuse treatment paid for by LDSS; and
- 13 cases of termination of parental rights (1 case of termination of parental rights was reported in the interim report).

DHR notes that some of the documentation on substance abuse treatment was provided in a way that limits counting and therefore figures are undercounted. SSA is working with the Department of Health and Mental Hygiene to improve tracking related to substance abuse treatment.

3. Child Fatalities Involving Abuse or Neglect

Committee narrative included in the 2005 JCR requested that DHR provide a listing by jurisdiction of the number of child fatalities that involved child abuse and/or neglect. The narrative requested the report to be updated annually. **Exhibit 15** displays the data provided by the department for calendar 2010 through 2014. In calendar 2014, there were 21 such fatalities, 3 fewer than in calendar 2013. In calendar 2014, the highest number of these fatalities occurred in Baltimore County.

Exhibit 15

Child Deaths Reports to DHR Where Child Abuse or Neglect Are Determined by DHR Staff to be a Contributing Factor

Calendar 2010-2014

	2010	2011	2012	2013	2014	Total
Allegany	0	1	0	0	0	**1**
Anne Arundel	1	3	4	1	1	**10**
Baltimore City	2	3	2	4	1	**12**
Baltimore	3	5	8	2	4	**22**
Calvert	0	0	1	0	1	**2**
Caroline	0	1	4	0	0	**5**
Carroll	0	0	1	1	0	**2**
Cecil	1	3	0	1	0	**5**
Charles	0	0	1	1	0	**2**
Dorchester	0	0	1	0	0	**1**
Frederick	3	2	1	2	2	**10**
Garrett	0	0	0	0	0	**0**
Harford	2	0	0	4	1	**7**
Howard	0	1	1	2	0	**4**
Kent	0	0	0	0	0	**0**
Montgomery	0	5	1	3	3	**12**
Prince George's	0	1	2	1	3	**7**
Queen Anne's	1	0	0	1	0	**2**
St. Mary's	1	1	0	0	3	**5**
Somerset	0	0	0	0	0	**0**
Talbot	0	0	0	0	0	**0**
Washington	1	0	0	1	1	**3**
Wicomico	0	1	2	0	1	**4**
Worcester	1	0	0	0	0	**1**
Total	**16**	**27**	**29**	**24**	**21**	**117**

DHR: Department of Human Resources

Source: Department of Human Resources

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHR – Social Services Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$393,210	$8,269	$220,229	$0	$621,708
Deficiency Appropriation	-215	0	0	0	-215
Cost Containment	-13,581	0	0	0	-13,581
Budget Amendments	-15,677	334	9,323	0	-6,021
Reversions and Cancellations	0	-3,261	-50,379	0	-53,640
Actual Expenditures	**$363,737**	**$5,343**	**$179,172**	**$0**	**$548,252**
Fiscal 2016					
Legislative Appropriation	$372,483	$8,027	$204,566	$0	$585,077
Budget Amendments	2,008	20	-376	0	1,651
Working Appropriation	**$374,491**	**$8,047**	**$204,190**	**$0**	**$586,728**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

The fiscal 2015 expenditures of SSA were $73.5 million lower than the legislative appropriation. The fiscal 2015 general fund expenditures of SSA were $29.5 million less than the legislative appropriation. A decrease of $46.3 million was the result of caseload declines, including $9.5 million removed in the cost containment actions approved by the Board of Public Works (BPW) in July 2014. Other general fund decreases occurred as the result of:

- salary and wage adjustments and contractual services costs primarily related to in-home aide services and the adult protective services program in the Local Adult Services Program ($6.6 million);

- changes in budgeting of family preservations services and foster care recruitment and retention ($3.4 million);

- across-the-board reductions approved by BPW in January 2015 as part of cost containment actions including holding positions vacant, reducing the call center contract, reducing the contract with Adoptions Together, reducing the Montgomery County block grant, and reducing Foster Care Maintenance Payments due to declining caseloads ($3.2 million);

- charging the federal funds instead of general funds for in-home aide services and respite care ($1.1 million);

- cost containment actions approved by BPW in July 2014 to hold positions vacant throughout DHR ($900,000);

- reduced expenditures on stipends and tuitions in the Local Adult Services Program ($587,535);

- the impact of the Voluntary Separation Program ($233,333); and

- a deficiency appropriation to reduce provider rates ($215,000).

These decreases are partially offset by salary and wage adjustments primarily in Local Child Welfare Services, including the fiscal 2015 cost-of-living adjustment (COLA), totaling $33.0 million.

The fiscal 2015 of SSA special fund expenditures were $2.9 million lower than the legislative appropriation. Increases totaling $334,560 by budget amendment related primarily to salary and wage adjustments including the fiscal 2015 COLA ($329,560). The remainder of the increase ($4,505) was available from the adoption registry search fee for indirect expenses associated with the contract for this activity. These increases are more than offset by cancellations totaling $3.3 million primarily due to lower than anticipated attainment of the child support foster care offset ($2.4 million), LEA collections ($0.8 million), and local government payments ($9,000) for Foster Care Maintenance Payments.

Federal fund expenditures of SSA in fiscal 2015 were $41.1 million lower than the legislative appropriation. Increases of $9.3 million occurred by budget amendment, the majority of the increase ($7.3 million) was the result of salary and wage adjustment and contractual services for in-home aide services and the adult protective services programs in the Local Adult Services Program. The remainder of the increase ($2.0 million) was the result of salary and wage adjustments including the fiscal 2015 COLA. These increases are more than offset by cancellations totaling $50.4 million due to lower than anticipated attainment of Medical Assistance funding ($18.7 million), Title IV-E funding in Foster Care Maintenance Payments ($11.6 million), TANF funding in Local Child Welfare Services ($9.6 million), and Supplemental Nutrition Assistance Program funds in the Local Child Welfare Services Program ($0.5 million). An additional cancellation of $10.0 million results from a change in budgeting for the Social Services Block Grant.

Fiscal 2016

To date, the fiscal 2016, the appropriation of SSA has increased by approximately $1.7 million compared to the legislative appropriation. An increase of $3.0 million is due to the restoration of the 2% pay reduction ($1.95 million in general funds, $1.06 million in federal funds, and $19,606 in special funds). This increase is partially offset by adjustments in the across-the-board reductions largely due to adding the federal fund share of reductions and correcting the programs based on the location of the reduction resulting in a net decrease of $1.4 million (an increase of $54,096 in general funds and a decrease of $1.4 million in federal funds).

Object/Fund Difference Report
DHR – Social Services Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	2,807.91	2,738.86	2,737.86	-1.00	0%
02 Contractual	2.56	2.50	2.50	0.00	0%
Total Positions	**2,810.47**	**2,741.36**	**2,740.36**	**-1.00**	**0%**
Objects					
01 Salaries and Wages	$ 224,513,690	$ 210,189,005	$ 220,891,526	$ 10,702,521	5.1%
02 Technical and Spec. Fees	1,276,200	1,820,200	1,795,464	-24,736	-1.4%
03 Communication	1,811,245	1,601,749	1,471,052	-130,697	-8.2%
04 Travel	1,544,057	1,211,865	1,302,441	90,576	7.5%
06 Fuel and Utilities	762,984	721,973	788,467	66,494	9.2%
07 Motor Vehicles	2,165,915	2,088,611	1,900,068	-188,543	-9.0%
08 Contractual Services	42,737,401	52,796,414	51,980,157	-816,257	-1.5%
09 Supplies and Materials	1,246,732	780,790	904,888	124,098	15.9%
10 Equipment – Replacement	104,736	351,389	350,000	-1,389	-0.4%
11 Equipment – Additional	85,034	907	0	-907	-100.0%
12 Grants, Subsidies, and Contributions	260,932,344	302,122,909	277,741,421	-24,381,488	-8.1%
13 Fixed Charges	11,071,641	13,041,778	13,521,898	480,120	3.7%
Total Objects	**$ 548,251,979**	**$ 586,727,590**	**$ 572,647,382**	**-$ 14,080,208**	**-2.4%**
Funds					
01 General Fund	$ 363,736,788	$ 374,490,564	$ 366,313,762	-$ 8,176,802	-2.2%
03 Special Fund	5,342,780	8,047,085	5,321,549	-2,725,536	-33.9%
05 Federal Fund	179,172,411	204,189,941	201,012,071	-3,177,870	-1.6%
Total Funds	**$ 548,251,979**	**$ 586,727,590**	**$ 572,647,382**	**-$ 14,080,208**	**-2.4%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHR – Social Services Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
04 General Administration - State	$ 22,768,548	$ 25,850,269	$ 25,739,408	-$ 110,861	-0.4%
01 Foster Care Maintenance Payments	269,292,436	295,140,547	262,320,150	-32,820,397	-11.1%
03 Child Welfare Services	212,532,824	219,375,802	237,072,089	17,696,287	8.1%
04 Adult Services	43,658,171	46,360,972	47,515,735	1,154,763	2.5%
Total Expenditures	**$ 548,251,979**	**$ 586,727,590**	**$ 572,647,382**	**-$ 14,080,208**	**-2.4%**
General Fund	$ 363,736,788	$ 374,490,564	$ 366,313,762	-$ 8,176,802	-2.2%
Special Fund	5,342,780	8,047,085	5,321,549	-2,725,536	-33.9%
Federal Fund	179,172,411	204,189,941	201,012,071	-3,177,870	-1.6%
Total Appropriations	**$ 548,251,979**	**$ 586,727,590**	**$ 572,647,382**	**-$ 14,080,208**	**-2.4%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

N00H00
Child Support Enforcement
Department of Human Resources

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$17,942	$18,800	$19,086	$287	1.5%
Deficiencies and Reductions	0	0	-61	-61	
Adjusted General Fund	**$17,942**	**$18,800**	**$19,025**	**$225**	**1.2%**
Special Fund	9,397	10,186	10,266	81	0.8%
Deficiencies and Reductions	0	0	-3	-3	
Adjusted Special Fund	**$9,397**	**$10,186**	**$10,264**	**$78**	**0.8%**
Federal Fund	61,029	61,795	62,703	908	1.5%
Deficiencies and Reductions	0	0	-122	-122	
Adjusted Federal Fund	**$61,029**	**$61,795**	**$62,581**	**$786**	**1.3%**
Adjusted Grand Total	**$88,368**	**$90,781**	**$91,870**	**$1,089**	**1.2%**

- After accounting for a back of the bill reduction in health insurance, the fiscal 2017 allowance for the Department of Human Resources (DHR) Child Support Enforcement Administration (CSEA) increases by $1.1 million, 1.2%, compared to the fiscal 2016 working appropriation. All three fund sources in CSEA increase in the fiscal 2017 allowance.

- Major increases in the allowance of CSEA are in the area of personnel and costs associated with cooperative reimbursement agreements.

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

For further information contact: Jared S. Sussman Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	665.90	664.90	661.90	-3.00
Contractual FTEs	12.71	1.00	1.00	0.00
Total Personnel	**678.61**	**665.90**	**662.90**	**-3.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	58.25	8.80%
Positions and Percentage Vacant as of 12/31/15	57.00	8.57%

- The fiscal 2017 allowance abolishes 3 vacant positions.
- Turnover expectancy increases from 7.6% to 8.8%.
- As of December 31, 2015, CSEA had a vacancy rate of 8.57%, or 57 positions. If the 3 vacant position abolitions are taken into consideration, CSEA has a vacancy rate of 8.16%, slightly below that needed to meet its fiscal 2017 turnover rate.

Analysis in Brief

Major Trends

Child Support Collections Increase: Child support collections continued to increase in federal fiscal 2015; however, the pace of growth slowed, with an increase of only 0.9%, compared to federal fiscal 2012, which saw an increase of 4.8%.

CSEA Performance Improves in Two of Three Federal Performance Measures and Other Key Activities: The percent of cases with a support order decreased slightly in federal fiscal 2015, but remained above the federal goal. Both the percent of current support paid and the percent of cases with arrears for which a payment is received improved, but performance remains below the federal goal.

Cumulative Arrearages Decrease: After a slight increase in federal fiscal 2014, the cumulative arrearages decreased in federal fiscal 2015. The decrease in federal fiscal 2015 was due to a number of factors, including the right-sizing initiative, which bases obligations on the ability to pay.

Caseload Declines Slowly: Case closure activity resulted in relatively large declines in the child support caseload in recent years (with a decrease of 7.6% in federal fiscal 2012). The child support caseload has continued to decrease since that time, but at a much slower pace.

Issues

Study of the Baltimore City Office of Child Support Enforcement to Compare a Privatized Operation to a State Operation: The Baltimore City Child Support Enforcement Office is currently operated by a private contractor. Committee narrative in the 2015 *Joint Chairmen's Report* requires DHR to conduct a cost benefit analysis to determine whether it would be more beneficial to return this function to the State or to remain with a private contractor.

Elimination of the Federal Income Tax Refund Offset and the State Comptroller Intercept Fees: In September 2015, the Governor announced statewide fee rollbacks. Two of the fees that were eliminated affect the DHR CSEA budget, the Federal Income Tax Intercept Fee, and the State Comptroller Intercept Fee. A portion of the foregone revenue, despite not being collected, must be paid to the federal government.

DHR Child Support Enforcement Audit: In June 2015, the Office of Legislative Audits (OLA) released a fiscal compliance audit for CSEA. The audit covered the period October 21, 2010, to May 4, 2014. The audit included six findings, none of which were repeated from the previous audit. OLA found that some licensing authorities were not suspending licenses referred for suspension by CSEA.

Recommended Actions

1. Add language restricting funds in the Motor Vehicle Administration and the Public Service Commission until corrective action has been taken.

N00H00
Child Support Enforcement
Department of Human Resources

Operating Budget Analysis

Program Description

Child support services involve the establishment of paternity when children are born to unmarried parents, establishment of child support orders, and the collection and distribution of current and arrears child support payments. The Department of Human Resources (DHR) Child Support Enforcement Administration (CSEA) administers and monitors child support services provided by the local departments of social services and other offices, provides technical assistance, formulates policy, develops and implements new programs, and ensures compliance with regulations and policy. CSEA also operates several centralized programs related to:

- locating noncustodial parents;
- collecting and disbursing payments;
- processing interstate cases; and
- enforcing support orders.

The key goal of CSEA is to enable, encourage, and enforce parental responsibility.

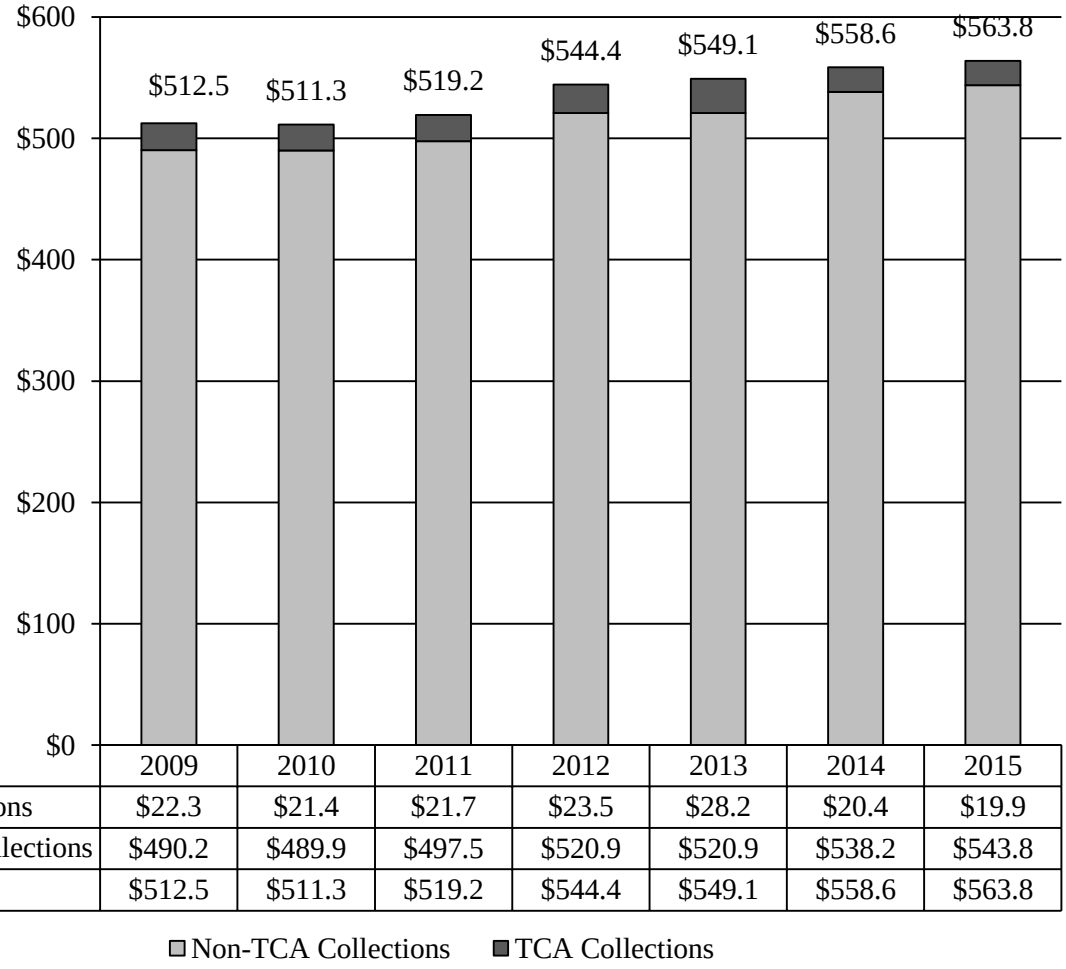
Performance Analysis: Managing for Results

1. Child Support Collections Increase

Total Collections

As shown in **Exhibit 1**, total collections have increased in all recent years except federal fiscal 2010. After a substantial increase in collections in federal fiscal 2012 ($25.2 million, or 4.8%), the rate of growth has slowed. Federal fiscal 2015 collections increased by $5.1 million, or 0.9% compared to federal fiscal 2014. CSEA attributes increased collections in federal fiscal 2015 to improvements in wage attachments and initiating interstate collections. CSEA has improved collections from wage attachments by revising language in letters sent to employers and noncustodial parents, doing outreach to employers failing to report new hires, and using a look-up table to identify the correct address for businesses for mailing wage withholding orders.

Exhibit 1
Total Collections
Federal Fiscal 2009-2015
($ in Millions)



	2009	2010	2011	2012	2013	2014	2015
TCA Collections	$22.3	$21.4	$21.7	$23.5	$28.2	$20.4	$19.9
Non-TCA Collections	$490.2	$489.9	$497.5	$520.9	$520.9	$538.2	$543.8
Total	$512.5	$511.3	$519.2	$544.4	$549.1	$558.6	$563.8

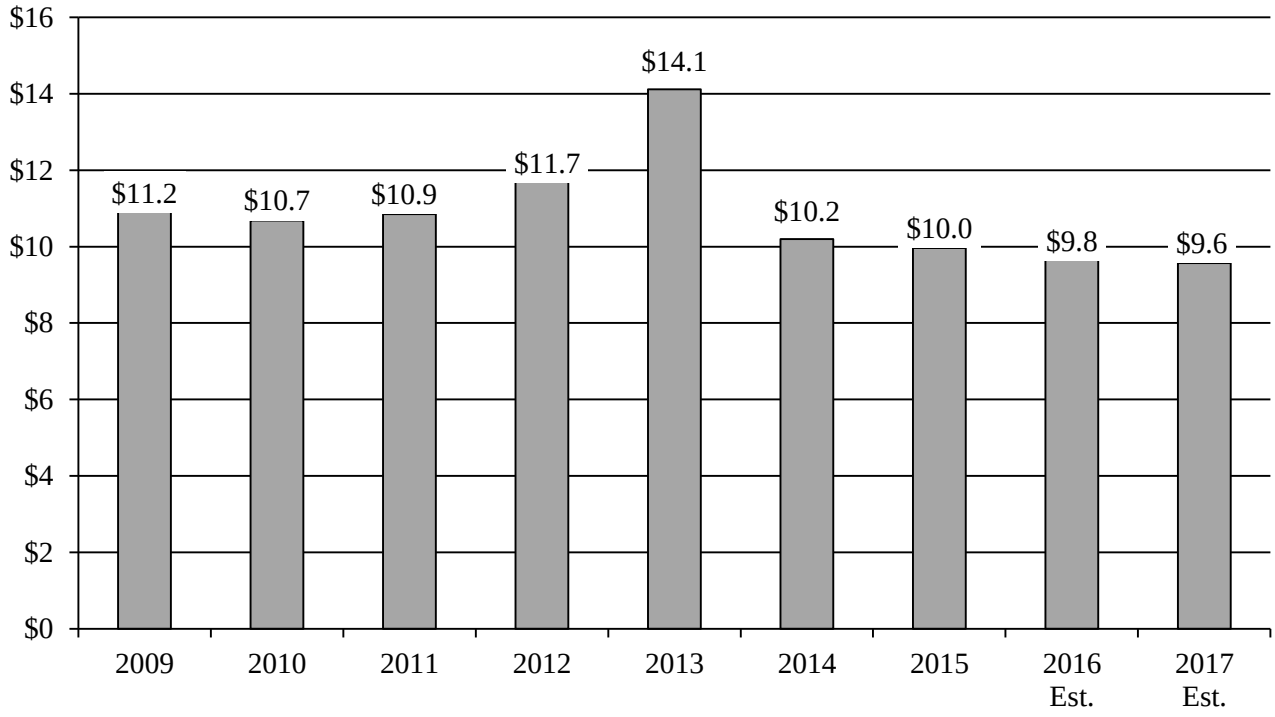
Source: Maryland Department of Human Resources

In federal fiscal 2015, collections increased in 20 of 24 jurisdictions. The jurisdictions that experienced a decrease in collections were Baltimore City and Calvert, Caroline, and Talbot counties. The largest increases in collections in federal fiscal 2015 occurred in Montgomery County ($2.1 million) and Baltimore County ($1 million). The largest percentage increase in collections occurred in Dorchester County (6.5%). The largest dollar and percentage decreases in collections occurred in Baltimore City ($956,834) and Caroline County (1.2%), respectively.

Collections by Source

While total collections increased between federal fiscal 2014 and 2015, the increase occurred among non-Temporary Cash Assistance (TCA) related cases (an increase of $6.0 million, or 1.1%). Collections in TCA-related cases decreased by $0.4 million, or 2.0%, between those years. Collections for TCA-related cases in federal fiscal 2015 of $19.9 million were at the lowest level since federal fiscal 2007. Half of the TCA collections are provided to the federal government, and the State retains the other 50.0%. The State share is used in DHR's budget in the Assistance Payments Program and in CSEA as a special fund (Child Support Offset Fund). As such, lower collections in TCA-related cases have a budgetary impact. As shown in **Exhibit 2**, the State share of collections has decreased slightly in federal fiscal 2015 after a large drop in federal fiscal 2014. DHR anticipates the upward trend in non-TCA collections and the downward trend in TCA collections to continue in federal fiscal 2016 and 2017.

Exhibit 2
State's Share of Temporary Cash Assistance-related Collections
Federal Fiscal 2009-2017 Est.
($ in Millions)

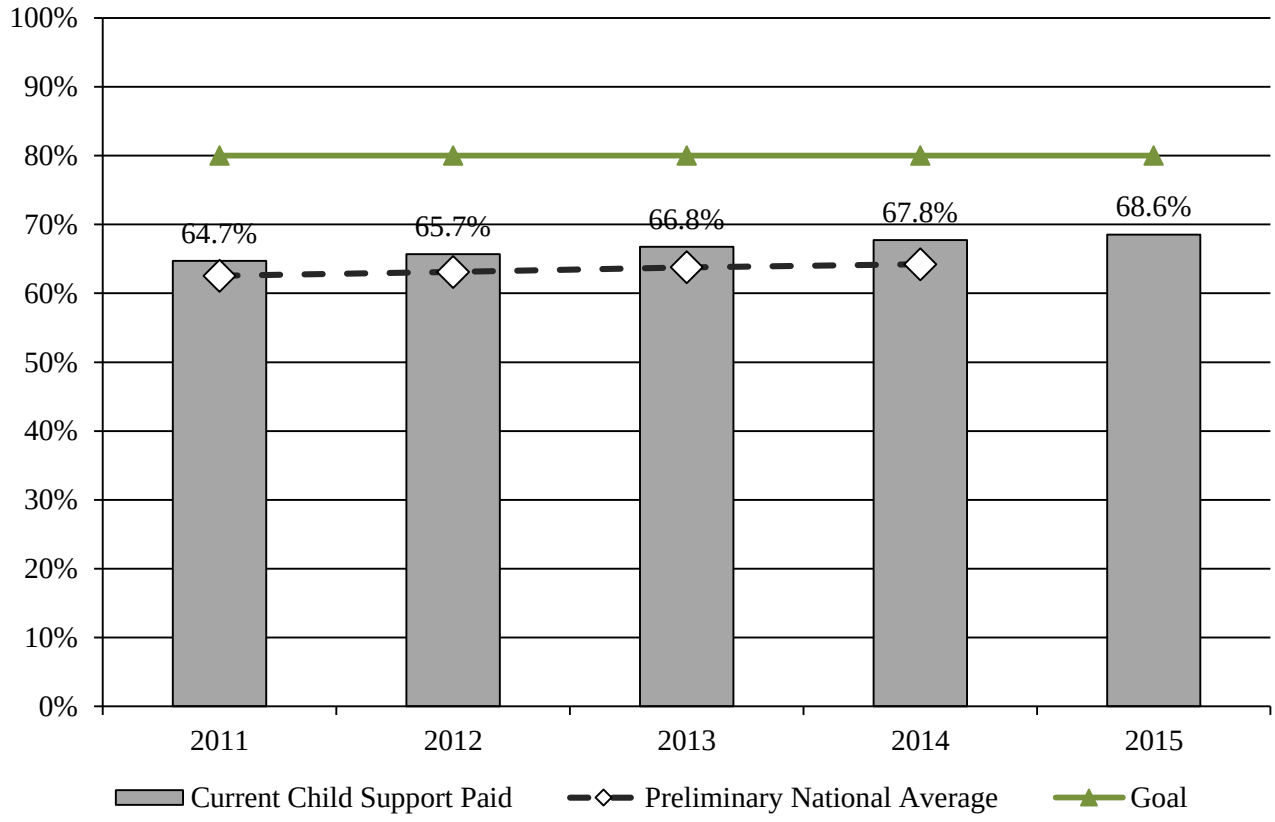


Source: Maryland Department of Human Resources

2. CSEA Performance Improves in Two of Three Federal Performance Measures and Other Key Activities

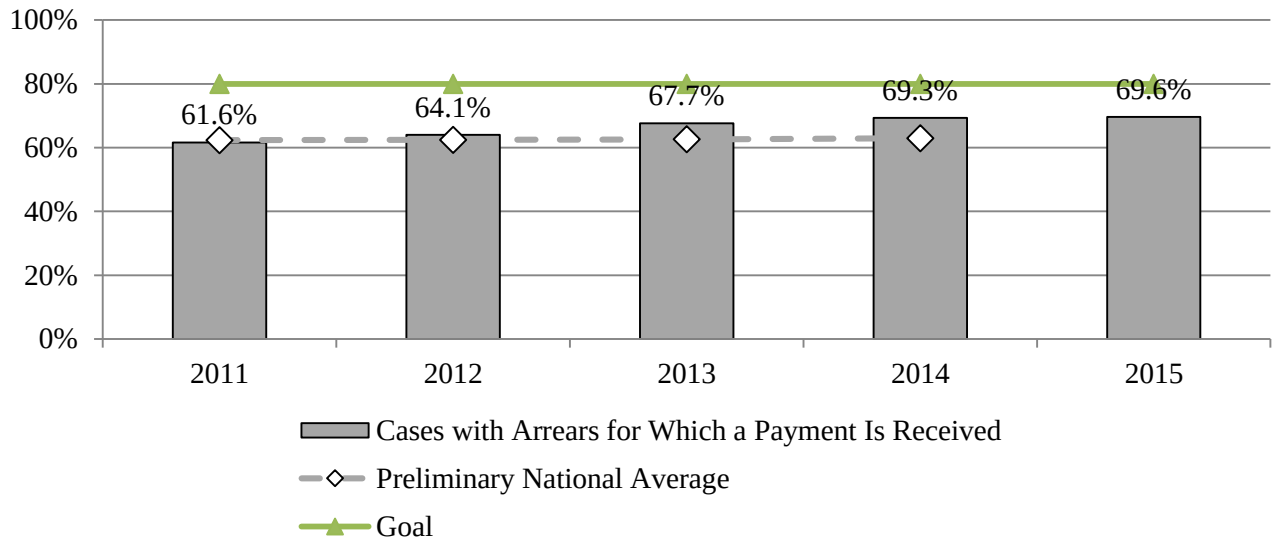
Performance in two measures used by the federal Office of Child Support Enforcement to determine federal incentive payments (percent of current support paid and percent of cases with arrears for which a payment is received) continued to improve in federal fiscal 2015, as shown in **Exhibits 3** and **4.** Despite improving in federal fiscal 2015, the percent of current support paid and percent of cases with arrears for which a payment is received remained below the federal goal of 80.0%. As shown in **Exhibit 5**, the percent of cases with support orders established decreased slightly in federal fiscal 2015 to 84.6%. Despite this decrease in federal fiscal 2015, CSEA remained above the federal goal of 80.0% for this measure.

Exhibit 3
Current Child Support Paid
Federal Fiscal 2011-2015



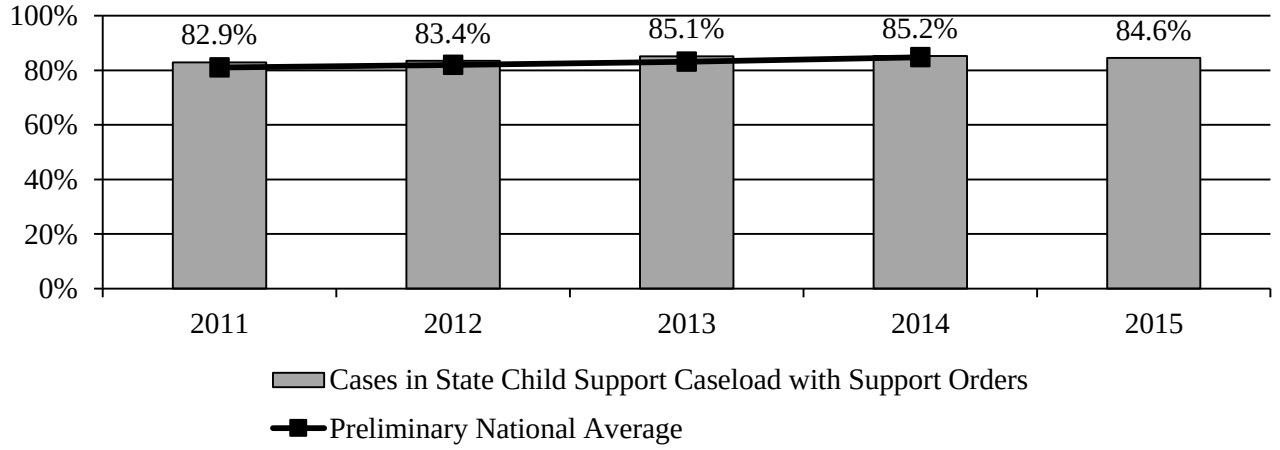
Source: Maryland Department of Human Resources

Exhibit 4
Cases with Arrears for Which a Payment is Received
Federal Fiscal 2011-2015



Source: Maryland Department of Human Resources

Exhibit 5
State Child Support Caseload with Support Orders
Federal Fiscal 2011-2015



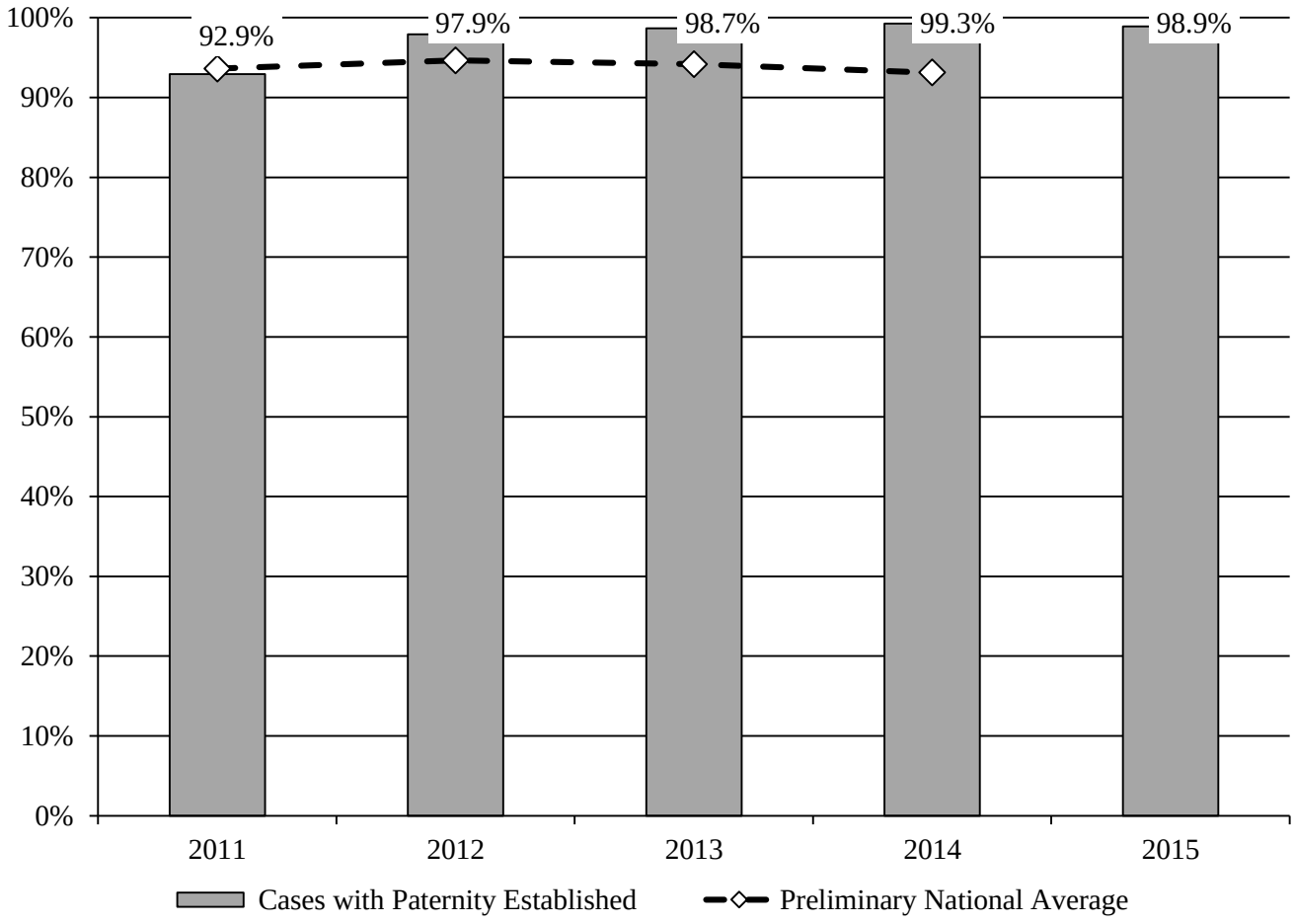
Source: Maryland Department of Human Resources

During the 2015 legislative session, CSEA indicated that it planned to further improve performance in these areas by implementing (1) a case management dashboard; (2) online applications; (3) expedited hearing processes; (4) electronic income withholding orders; (5) outsourcing of return mail processing; and (6) additional payment options for customers. CSEA has worked to implement all of these steps. A case management dashboard has been implemented in Metro and Baltimore City offices and is optional for the smaller offices. Online applications were implemented in November 2014. An expedited hearing process was implemented in the Metro office and is optional in smaller offices. In December 2014, electronic income withholding orders were implemented. CSEA is currently piloting centralized mail options. Finally, the agency is piloting Touchpay kiosks in Prince George's county and installing them in the Baltimore City office. CSEA is also exploring other ways to more conveniently make payments.

DHR has a goal for Maryland to be in the top 10 of state child support performance in each of the federal measures. In federal fiscal 2014, the most recent year with available data, CSEA was ranked eighth in cases with arrears for which payment is received and was nearing the top 10 in the percent of current support paid (ranked thirteenth). In the other two measures, supporter order and paternity establishment, CSEA's performance was ranked thirtieth and twentieth, respectively.

For purposes of the Managing for Results (MFR) submission, DHR reports on the paternity establishment for the State child support caseload. This is different from the measure that DHR reports on for purposes of its federal performance measure (paternity establishment statewide). **Exhibit 6** presents the data using the MFR measure for the State caseload rather than the federal performance measure (the statewide performance). Performance in this measure decreased in federal fiscal 2015. However, CSEA's performance in this measure remains above the federal goal of 90%.

Exhibit 6
Child Support Caseload with Paternity Established
Federal Fiscal 2011-2015



Note: For purposes of measuring federal performance, states also report statewide paternity establishment, which includes all children born out of wedlock.

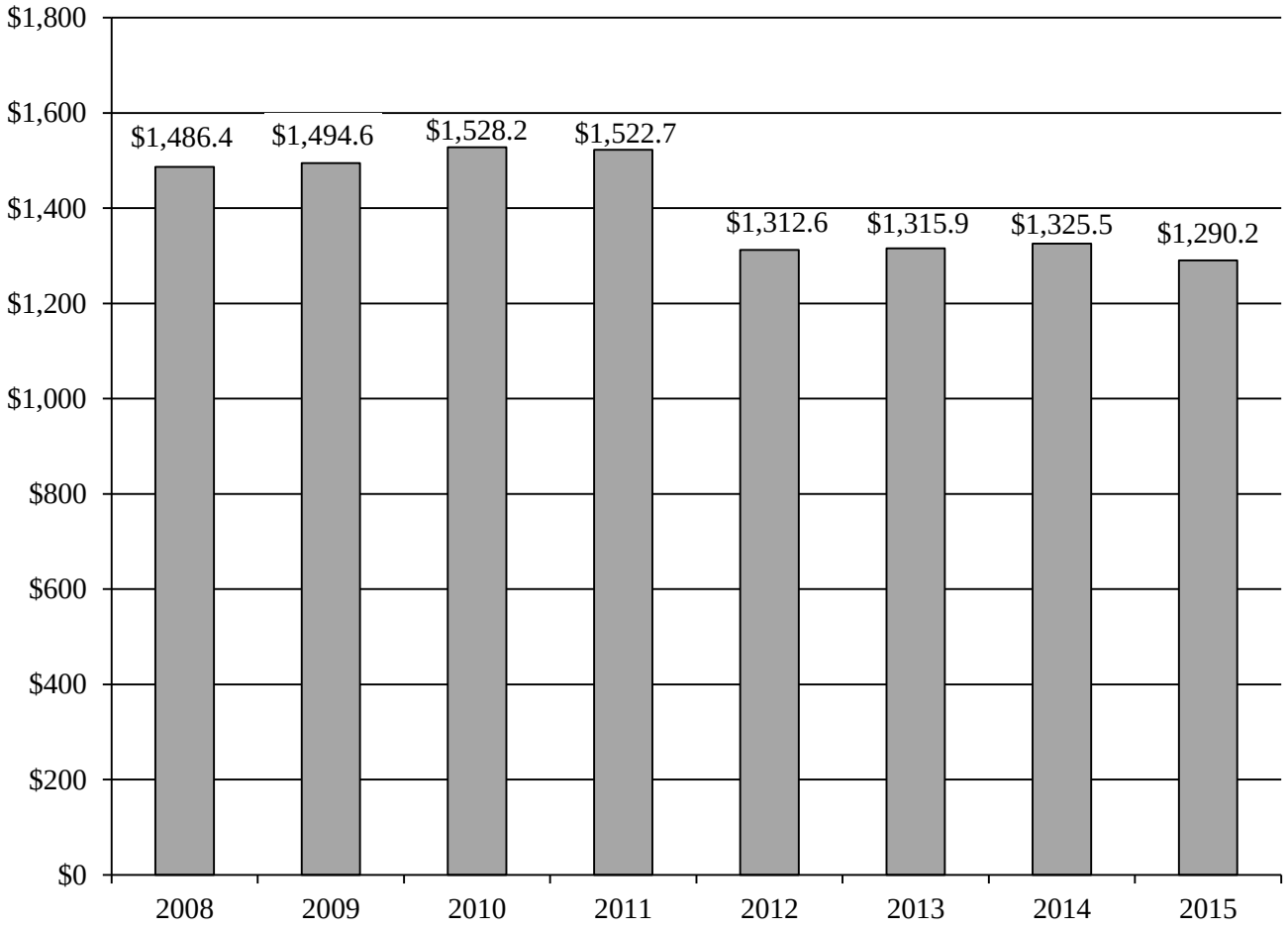
Source: Maryland Department of Human Resources

3. Cumulative Arrearages Decrease

In recent years, CSEA has enhanced its case closure process to make the process more effective while staying in compliance with federal case closure rules. The case closure activity reduced the cumulative arrearages as cases were closed. As shown in **Exhibit 7**, between the last day of federal fiscal 2011 and 2012, cumulative arrearages decreased by $210.1 million, or 13.8%. Historically,

cumulative arrearages have tended to increase over time. Since the decrease in federal fiscal 2012, this tendency continued in fiscal 2013 and 2014. Cumulative arrearages decreased by $35.3 million, or 2.7%, between the last day of federal fiscal 2014 and 2015. CSEA attributes this decrease to increases in current support paid, case closures, and the right-sizing initiative. The right-sizing initiative bases obligations on obligor's ability to pay, which prevents arrears based on unrealistic obligations from accruing.

Exhibit 7
Cumulative Arrearages
Federal Fiscal 2008-2015
($ in Millions)

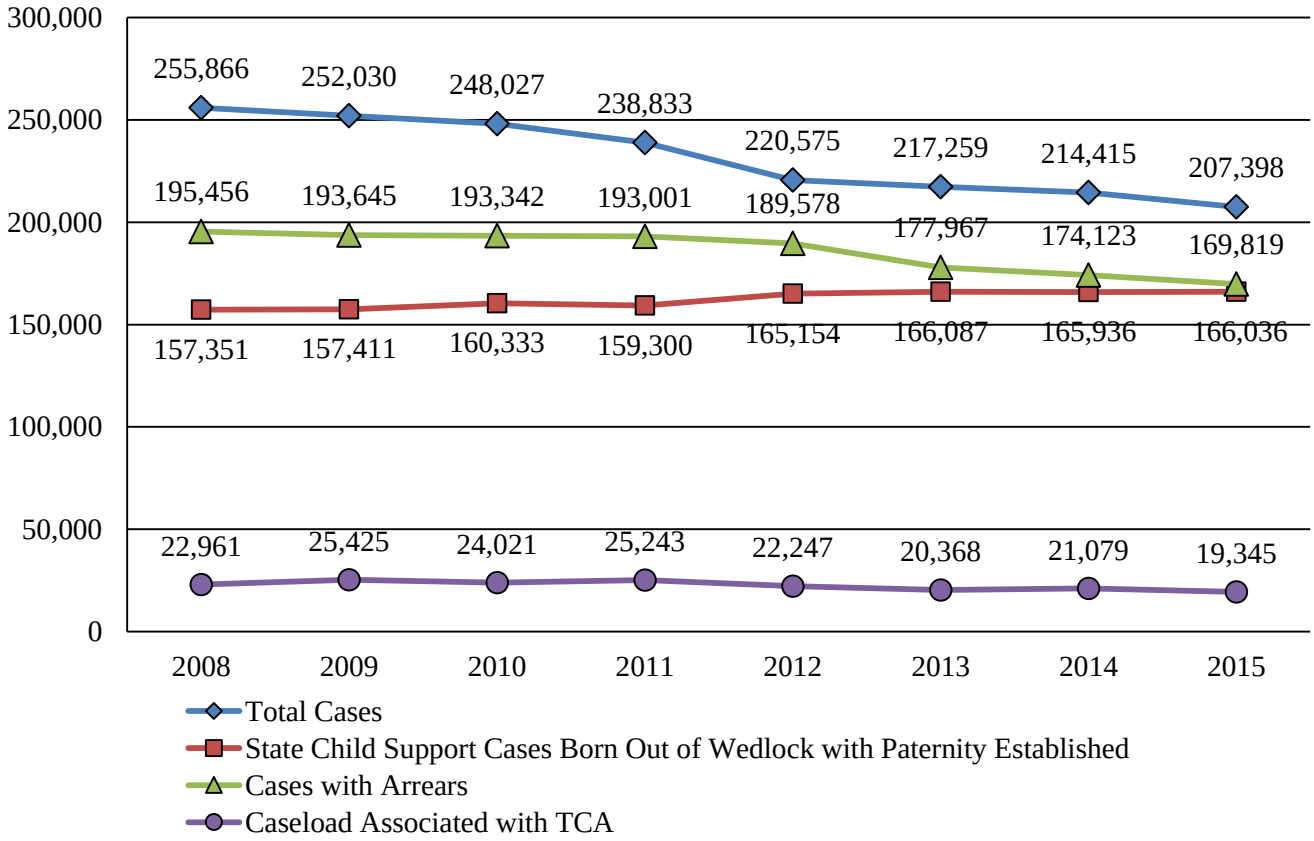


Source: Maryland Department of Human Resources

4. Caseload Declines Slowly

The case closure activity discussed earlier, resulted in a substantial decline in the number of child support cases in federal fiscal 2011 (3.7%) and in federal fiscal 2012 (7.6%). As shown in **Exhibit 8**, the number of child support cases has continued to decline since that time but at a much slower pace. In federal fiscal 2015, the number of child support cases decreased at a faster pace than in recent years (3.3%). Between fiscal 2008 and 2015, the number of child support cases has decreased by 18.9%.

Exhibit 8
Child Support Caseload
Federal Fiscal 2008-2015



TCA: Temporary Cash Assistance

Note: An individual case can belong to more than one category.

Source: Maryland Department of Human Resources

As with the total number of child support cases, the number of cases with arrears has decreased in recent years due to the case closure activity discussed earlier. In federal fiscal 2015, the number of cases with arrears decreased by 2.5%. Although the number of cases with arrears has decreased in most recent years, the share of cases with arrears was higher in federal fiscal 2015 (81.9%) than in federal fiscal 2008 (76.4%). The share of cases with arrears in federal fiscal 2015 was slightly higher than in federal fiscal 2014 (81.2%). **DHR should comment on efforts to reduce the share of cases with arrears.**

The number of cases associated with TCA decreased by 8.22% between federal fiscal 2014 and 2015, after increasing in the previous federal fiscal year and decreasing substantially in federal fiscal 2012 and 2013. Although the number of cases associated with TCA has fluctuated in recent years, the share of cases associated with TCA has fluctuated within a relatively small margin (with a low of 9.0% in federal fiscal 2008 and a high of 10.6% in federal fiscal 2011). In federal fiscal 2015, the share of cases associated with TCA was 9.3%.

Proposed Budget

As shown in **Exhibit 9**, the fiscal 2017 allowance of CSEA increases by $1.1 million, 1.2%, compared to the fiscal 2016 working appropriation after accounting for a back of the bill reduction in health insurance. All three fund sources in CSEA increase.

Federal fund increases are driven by cooperative reimbursement agreements (CRA), up $1.3 million, primarily to reflect recent experience. Under CRAs, the agency undertaking the child support function (including State's Attorney's offices, sheriffs, and the clerk of the courts), pays 34% of the cost and receives the typical federal financial participation (66%) for expenses it incurs for completing the function. The federal funds are budgeted within CSEA as the State child support agency.

Exhibit 9
Proposed Budget
DHR – Child Support Enforcement
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Total
Fiscal 2015 Actual	$17,942	$9,397	$61,029	$88,368
Fiscal 2016 Working Appropriation	18,800	10,186	61,795	90,781
Fiscal 2017 Allowance	19,025	10,264	62,581	91,870
Fiscal 2016-2017 Amount Change	$225	$78	$786	$1,089
Fiscal 2016-2017 Percent Change	1.2%	0.8%	1.3%	1.2%

Where It Goes:

Personnel Expenses	
Employee and retiree health insurance	$945
Retirement	843
Accrued leave payout	68
Overtime, unemployment, and workers' compensation	-43
Social Security contributions	-83
3 abolished positions	-203
Turnover adjustments	-494
Regular earnings	-710
Contractual Services	
Cooperative reimbursement agreements largely due to increased salaries	1,327
Local Area Network contract due to increased personnel costs	292
Banking services contract due to transition period for new contract	220
DHMH Paternity Database	8
New hire data contract	7
Central collections	2
Centralized mailing	-34
Check printing and mailing due to increase in electronic payments	-72
Technical and research contract with UM School of Social Work	-188
Call center contract due to new contract	-331
Administrative Expenses	
Contractual employee health insurance	22
Electricity	17
Temporary contractual staff	7

Where It Goes:

Decrease in supplies due to printed forms.	-51
Postage, telephone, and telecommunications	-113
Rent	-358
Other	11
Total	**$1,089**

DHMH: Department of Health and Mental Hygiene
UM: University of Maryland

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

Personnel

Personnel costs in CSEA's allowance increase by $322,288. This increase is primarily driven by employee retirement and health insurance costs. This increase is despite a decrease of $203,071 due to the elimination of 3 vacant positions. DHR indicates that the 3 positions were long-term vacancies, and it has no impact on CSEA.

Child Support Reinvestment Fund

The Child Support Reinvestment Fund holds the federal incentive payments received by CSEA for performance. These payments are received based on performance in the second preceding year. For example, incentive payments received in federal fiscal 2016 would reflect federal fiscal 2014 performance. DHR anticipates receiving money into this fund each year but recently has had no fund balance. As a result, it would be expected that only the funds received by the department each year could be used to support expenditures. Unlike most fund sources used for child support expenses, DHR cannot use the Child Support Reinvestment Funds to draw down the typical 66% federal participation.

In fiscal 2012, DHR spent $7.2 million more of Child Support Reinvestment Funds than it received by essentially borrowing this amount from the amount it expected to receive in federal fiscal 2013. In fiscal 2013, DHR again borrowed from its anticipated receipts in federal fiscal 2014 and spent more Child Support Reinvestment Funds than it received. After these two years, DHR had overspent its Child Support Reinvestment Fund receipts by $8.7 million.

In fiscal 2014, DHR underspent the amount of Child Support Reinvestment Funds it received by approximately $2.8 to allow the agency to reduce the amount it was borrowing from the next year. DHR continued underspending the amount it received in fiscal 2015 by approximately $3.0 million. The fiscal 2016 and 2017 budget plan should allow the agency to continue to reduce the amount of borrowing. However, at the end of fiscal 2017, DHR would still be borrowing $1.0 million from the next year. In testimony in the 2015 legislative session, DHR indicated that it would need approximately

three years to eliminate borrowed spending. At the current rate of spending, DHR is on track to eliminate borrowed funds in fiscal 2018.

Ending Cooperative Reimbursement Agreement with Carroll County State's Attorney's Office

Under cooperative reimbursement agreements, the agency undertaking the child support function (including State's Attorney's Offices, sheriffs, and the clerk of the court) receives the federal match for expenses it incurs for completing this function. The federal funds are budgeted within CSEA as the State child support agency.

Under State law, State's Attorney's offices involved in a cooperative reimbursement agreement to provide legal support for a local office of CSEA are to complete the written agreement for the following year by September 1 of the year before the agreement. Carroll County's State's Attorney's Office (SAO) will no longer be providing this service in fiscal 2017. SB 195 and HB 194 authorizes the transfer of personnel at Carroll County's SAO to CSEA. DHR indicates that the transfer represents 9 positions and an increase in general fund expenditures of $300,400 in fiscal 2017. The federal fund portion is already budgeted as a CRA. DHR indicates that it received sufficient notice of the transfer of functions to CSEA. However, there are no general funds or positions included in the allowance to support the transfer. **DHR should explain why the allowance does not reflect the transfer and how it intends to handle the additional expenditures.**

Issues

1. Study of the Baltimore City Office of Child Support Enforcement to Compare a Privatized Operation to a State Operation

The Baltimore City Child Support Enforcement Office is currently operated by a private contractor. Committee narrative in the 2015 *Joint Chairmen's Report* (JCR) requires DHR to conduct a cost-benefit analysis (CBA) to determine whether it would be more beneficial to return this function to the State or to remain with a private contractor. The JCR wanted the CBA to examine the following seven factors:

- direct and indirect costs;
- timeframe required to insource the function;
- the number of positions required including positions necessary to improve performance;
- staffing qualifications and types of staffing;
- location;
- projected collections compared to similar jurisdictions and to the extent possible factoring in employment, income, and ability to pay; and
- performance in all federal performance measures.

The Business Economic and Community Outreach Network (BEACON) at Salisbury University prepared a CBA, which was published in December 2015 examining all seven factors. It finds that, when compared to the current arrangement, insourcing would require an additional $10.25 million in direct costs and $3.4 million in indirect costs over 10 years; insourcing can be accomplished in two years; 91 new State positions would need to be created; the staffing mix for the 91 positions would look similar to the current outsourced scenario; three locations would serve Baltimore City better than the current downtown location; collections would rise slightly; and performance measures would rise slightly. **Exhibit 10** presents all of the scenarios analyzed by BEACON in the CBA.

Exhibit 10
Key Findings of Cost Benefit Analysis
December 2015

	Outsourced	Insourced	Outsourced Plus Enhancements	Insourced Plus Enhancements
Aggregate Cost Differential	0	$1,149,769	$164,253	$1,642,527
Performance Impact Range	0	0.25% to 0.5%	1% to 5%	1% to 5%
Transition Timeframe	n/a	1 Year	6 Months	1 Year
State Positions	n/a	91	0	91
Locations	1	1	3	3
Projected Collections	$89,082,737	$89,528,151	$92,646,046	$91,318,714
Paternity Establishment	94.45%	94.69%	95.39%	95.39%
Support Orders	81.69%	81.89%	82.51%	82.51%
Current Support Paid	61.33%	61.48%	61.94%	61.94%
Paying Towards Arrears	62.46%	62.62%	63.08%	63.08%

Note: The findings are not forecasts. Costs do not represent the actual cost of each scenario if implemented.

Source: Maryland Department of Human Resources

Despite the rise in collections and in performance measures, the analysis finds that continuing to outsource the services is more beneficial almost entirely due to the increased labor costs of insourcing. The analysis finds that there is a 12% to 16% cost disadvantage to insourcing the 91 positions.

Proposed Enhancements

The CBA also examines proposed enhancements that can be applied to both outsourcing and insourcing scenarios. The enhancements are as follows:

- enhanced performance metrics;
- workflow changes;

- floor plan changes; and

- location changes.

The CBA found that the performance measures in the current contract are not producing all of the desired outcomes. According to the analysis, enhanced performance metrics can be built into the "pay-for-performance" clauses of the contract, which make them easier to implement in the outsourced scenario than in the insourced scenario. The other three enhancements would be implemented in the same manner regardless of the composition of the office. The analysis identifies issues with the workflow at the Baltimore office, which are exacerbated by the floor plan. The analysis suggests an open floor plan with case management teams. Through an analysis of zip codes for Baltimore City cases, the CBA concludes that three locations running concurrently in shopping centers with public transportation can provide better coverage than the current downtown location and would not cause a significant increase in lease costs. As shown in Exhibit 10, regardless of whether the office is insourced or continues to be outsourced, the enhancements improve the total collections and performance metrics.

Based on the CBA, DHR plans to continue outsourcing the office but with some version of the proposed enhancements. The fiscal 2017 allowance for the privatization contract is $7,958,958, which is the same as in fiscal 2016. DHR indicates that it plans to work within that amount in fiscal 2017. **DHR should provide an update on how it will implement proposed enhancements and what changes it intends to add.**

2. Elimination of the Federal Income Tax Refund Offset and the State Comptroller Intercept Fees

In September 2015, the Governor announced statewide fee rollbacks. Two of the fees that were eliminated affect the CSEA budget, the Federal Income Tax Intercept Fee and the State Comptroller Intercept Fee. Both fees are part of tax refund offset programs for child support obligors with arrears over a certain amount ($500 for the federal offset program and $150 for the State offset program). The fees were deducted from the arrears owed in the past. Eliminating the fees benefits the custodial parent, because the fees are part of the collected arrears. The elimination of the Federal Income Tax Intercept Fee creates a $200,308 general fund shortfall and the elimination of the State Comptroller Intercept Fee creates a $49,354 general fund shortfall.

The impact of the shortfall is exacerbated by a federal requirement that the State send to the federal government 66% of the dollar value of the federal offset fee even when the State elects not to collect the fee. The collections were shared between the State and federal government based on the Title IV-D participation rate of 34% general funds and 66% federal funds. Title IV-D of the Social Security Act authorizes the federal fee when arrears are $500 or more. CSEA will have to provide $388,832 (66% of the expected collections from the federal fee) to the federal government. **Exhibit 11** explains the impact of the fee elimination. **The Secretary should comment on how DHR intends to accommodate the lost revenue.**

Exhibit 11
Impact of Fee Elimination
Fiscal 2017

	Anticipated Collections	Title IV-D Participation, If Collected: State (34%)	Title IV-D Participation, If Collected: Federal (66%)
Revenue Lost			
Federal Income Tax Intercept	$589,140	$200,308	$388,832
State Comptroller Income Tax Intercept	145,160	49,354	95,806
Required Reimbursement to Federal Government			
Federal Income Tax Intercept Revenue		388,832	
Total	**$734,300**	**$638,494**	

Source: Department of Human Resources

3. DHR Child Support Enforcement Audit

In June 2015, the Office of Legislative Audits (OLA) released a fiscal compliance audit for CSEA. The audit covered the period October 21, 2010, to May 4, 2014. As shown in **Exhibit 12**, the audit included six findings, none of which were repeated from the previous audit.

At a Senate Finance Committee hearing in September 2015, discussion of the audit focused on Finding 4. DHR maintains that it is required by statute to refer licenses for suspension to 14 agencies, but it is not required to follow-up and ensure that the licenses have been suspended. The audit found that 2 of the 14 agencies, the Motor Vehicle Administration (MVA) and the Public Service Commission (PSC), were not suspending all of the licenses referred for suspension by CSEA. In 2015, MVA and PSC received 77 and 176 referrals for suspension, respectively. DHR cannot provide the Department of Legislative Services (DLS) with the number of licenses referred for suspension that were suspended. DHR maintains that it is only required to refer the licenses for suspension and has no requirement to determine whether the licensing authorities took action. **DLS recommends withholding a portion of both MVA and PSC appropriations until both submit a plan detailing how they will comply with DHR's Professional License Suspension Program and a subsequent report which provides an update on the compliance plan.**

Exhibit 12
Audit Findings

Audit Period for Last Audit:	October 21, 2010 — May 4,2014
Issue Date:	June 2015
Number of Findings:	6
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: Required follow-up action was not always taken when withholding payments were not received by employers.

Finding 2: Certain obligors were improperly excluded from the driver's license suspension process at a local child support office.

Finding 3: Certain obligors were improperly excluded from occupational license suspension enforcement.

Finding 4: CSEA did not ensure State licensing authorities took action to suspend obligors' occupational licenses when requested.

Finding 5: CSEA needs to enhance monitoring of the vendor responsible for providing child support services at local offices.

Finding 6: CSEA did not adequately monitor the new hire registry contract and did not verify the related invoices.

Source: Office of Legislative Audits

Recommended Actions

1. Add the following section:

   SECTION XX: AND BE IT FURTHER ENACTED, That $100,000 of the special fund appropriation in the Motor Vehicle Administration (MVA) and $100,000 of the special fund appropriation in the Public Service Commission (PSC) may not be expended unless MVA and PSC submit (1) a joint report by October 1, 2016, detailing how each agency plans to comply with the professional license suspension program in the Department of Human Resources – Child Support Enforcement Administration (CSEA), and (2) a follow-up report before December 1, 2016, with the status of implementation of procedures to comply with the professional license suspension program planned in the first report including the number of referrals made to the licensing agencies to date by CSEA in fiscal 2017 and the number of licenses suspended. The budget committees shall have 45 days to review and comment.

   Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall be canceled if the reports are not submitted to the budget committees.

   Explanation: CSEA refers child support obligors who are 120 days or more out of compliance with their most recent court order to licensing authorities for professional license suspension under the professional license suspension program. In CSEA's most recent audit, it was found that the MVA and PSC were not suspending licenses associated with CSEA's referrals for suspension.

   The language restricts $100,000 from the special fund appropriation for both MVA and PSC until reports are submitted detailing how each plans to comply with the professional license suspension program by suspending licenses as appropriate and a follow-up report is submitted on implementation.

Information Request	**Authors**	**Due Date**
Compliance plan with CSEA's professional license suspension program	MVA PSC	October 1, 2016
Status of compliance with professional license suspension program	MVA PSC	December 1, 2016

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHR – Child Support Enforcement
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$18,520	$10,691	$59,035	$0	$88,246
Deficiency Appropriation	0	0	0	0	0
Cost Containment	-373	0	0	0	-373
Budget Amendments	-206	129	2,380	0	2,304
Reversions and Cancellations	0	-1,423	-386	0	-1,809
Actual Expenditures	**$17,942**	**$9,397**	**$61,029**	**$0**	**$88,368**
Fiscal 2016					
Legislative Appropriation	$18,225	$10,175	$61,274	$0	$89,673
Budget Amendments	575	11	522	0	1,107
Working Appropriation	**$18,800**	**$10,186**	**$61,795**	**$0**	**$90,781**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

The fiscal 2015 legislative appropriation for CSEA was increased by $122,000. The appropriation decreased by $372,907 in general funds through a January 2015 Board of Public Works cost containment action. Much of the reductions were achieved through holding positions vacant and modifications to contracts.

The appropriation increased by $2,303,651 through budget amendments. An employee cost-of-living adjustment increase added $382,174 ($125,281 in general funds, $5,428 in special funds, and $251,465 in federal funds). The budget was decreased by $155,556 in general funds to account for savings from the State Employee Voluntary Separation Program.

In addition to those amendments, one closeout amendment affected CSEA's budget across funds. Actions in the budget amendment include:

- an increase of $293,952 in general funds and $123,888 in special funds in Local Child Support Enforcement for salaries, wages and fringe benefits;

- an increase of $2,128,461 in federal funds in the State Child Support Enforcement to cover the costs related to cooperative reimbursement agreements and State disbursement unit services; and

- a reduction of $469,268 in general funds originally appropriated for salaries, wages and fringe benefits in the State Child Support Enforcement. The funds were transferred elsewhere in DHR.

CSEA canceled $386,252 in federal funds due to less than anticipated salaries and wages. Special funds amounting to $1,422,834 intended for Child Support Reinvestment were canceled because they were unattainable.

Fiscal 2016

To date, DHR CSEA's fiscal 2016 budget has increased by $1.107 million. An amendment of $745,465 ($212,764 in general funds, $11,106 in special funds, and $521,595 in federal funds) was added to restore a 2% cut to employee salaries. Additionally, the realignment of the fiscal 2016 across-the-board 2% cost containment resulted in CSEA's appropriation increasing by $361,978 in general funds.

Object/Fund Difference Report
DHR – Child Support Enforcement

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	665.90	664.90	661.90	-3.00	-0.5%
02 Contractual	12.71	1.00	1.00	0.00	0%
Total Positions	**678.61**	**665.90**	**662.90**	**-3.00**	**-0.5%**
Objects					
01 Salaries and Wages	$ 47,513,796	$ 48,194,594	$ 48,702,502	$ 507,908	1.1%
02 Technical and Spec. Fees	632,478	139,230	172,304	33,074	23.8%
03 Communication	427,698	530,835	418,245	-112,590	-21.2%
04 Travel	75,505	97,861	83,897	-13,964	-14.3%
06 Fuel and Utilities	132,894	123,903	141,102	17,199	13.9%
07 Motor Vehicles	44,860	81,389	82,691	1,302	1.6%
08 Contractual Services	34,936,297	36,373,702	37,621,784	1,248,082	3.4%
09 Supplies and Materials	473,486	559,968	511,334	-48,634	-8.7%
10 Equipment – Replacement	10,280	0	0	0	0.0%
11 Equipment – Additional	81,350	0	0	0	0.0%
12 Grants, Subsidies, and Contributions	19,546	209	299	90	43.1%
13 Fixed Charges	4,019,336	4,678,967	4,321,383	-357,584	-7.6%
Total Objects	**$ 88,367,526**	**$ 90,780,658**	**$ 92,055,541**	**$ 1,274,883**	**1.4%**
Funds					
01 General Fund	$ 17,941,554	$ 18,799,585	$ 19,086,168	$ 286,583	1.5%
03 Special Fund	9,397,118	10,185,631	10,266,225	80,594	0.8%
05 Federal Fund	61,028,854	61,795,442	62,703,148	907,706	1.5%
Total Funds	**$ 88,367,526**	**$ 90,780,658**	**$ 92,055,541**	**$ 1,274,883**	**1.4%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions .

Fiscal Summary
DHR – Child Support Enforcement

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
06 Local Child Support Enforcement Administration	$ 47,613,554	$ 49,123,280	$ 49,450,431	$ 327,151	0.7%
08 Support Enforcement – State	40,753,972	41,657,378	42,605,110	947,732	2.3%
Total Expenditures	**$ 88,367,526**	**$ 90,780,658**	**$ 92,055,541**	**$ 1,274,883**	**1.4%**
General Fund	$ 17,941,554	$ 18,799,585	$ 19,086,168	$ 286,583	1.5%
Special Fund	9,397,118	10,185,631	10,266,225	80,594	0.8%
Federal Fund	61,028,854	61,795,442	62,703,148	907,706	1.5%
Total Appropriations	**$ 88,367,526**	**$ 90,780,658**	**$ 92,055,541**	**$ 1,274,883**	**1.4%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

N00I00
Family Investment Administration
Department of Human Resources

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$145,024	$138,046	$143,452	$5,407	3.9%
Deficiencies and Reductions	0	-13,000	-179	12,821	
Adjusted General Fund	**$145,024**	**$125,046**	**$143,274**	**$18,228**	**14.6%**
Special Fund	11,847	19,406	16,213	-3,193	-16.5%
Deficiencies and Reductions	0	0	-13	-13	
Adjusted Special Fund	**$11,847**	**$19,406**	**$16,200**	**-$3,206**	**-16.5%**
Federal Fund	1,452,391	1,443,876	1,439,588	-4,288	-0.3%
Deficiencies and Reductions	0	0	-391	-391	
Adjusted Federal Fund	**$1,452,391**	**$1,443,876**	**$1,439,197**	**-$4,680**	**-0.3%**
Reimbursable Fund	319	0	0	0	
Adjusted Reimbursable Fund	**$319**	**$0**	**$0**	**$0**	
Adjusted Grand Total	**$1,609,581**	**$1,588,328**	**$1,598,670**	**$10,342**	**0.7%**

- The Governor's budget plan assumes a fiscal 2016 reversion of $13.0 million in the Temporary Cash Assistance (TCA) program. These funds were restricted in Section 48 of the fiscal 2016 budget bill for the restoration of legislative priorities.

- In total, the fiscal 2017 allowance of the Department of Human Resources (DHR) Family Investment Administration (FIA) increases by $10.3 million (0.7%) compared to the fiscal 2016 working appropriation, after accounting for the planned reversion and a back of the bill reduction in health insurance.

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

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- General funds in FIA increase by $18.2 million, 14.6%, compared to the fiscal 2016 working appropriation primarily in the area of personnel and the TCA program.

- Special funds in FIA decrease by $3.2 million, or 16.5%, in fiscal 2017 compared to the fiscal 2016 working appropriation. The decrease occurs in Child Support Offset Funds in the TCA program partially mitigated by a small increase in Local Government Payments.

- In the fiscal 2017 allowance, federal funds decrease by $4.7 million, 0.3%, compared to the fiscal 2016 working appropriation. Major changes in federal funds include a decrease of $4.7 million to account for a partial transition of eligibility determination for the Child Care Subsidy program, a decrease of $4.0 million in the Supplemental Nutrition Assistance Program (SNAP) to align with recent experience, and an increase of $3.2 million in Medical Assistance funds.

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	2,113.42	2,093.42	2,089.42	-4.00
Contractual FTEs	88.42	68.00	68.00	0.00
Total Personnel	**2,201.84**	**2,161.42**	**2,157.42**	**-4.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	129.34	6.19%
Positions and Percentage Vacant as of 12/31/15	157.00	7.50%

- As part of the department's actions to address the 2% across-the-board reduction in fiscal 2016, 23 positions were abolished in FIA (20 positions in the Local Family Investment program and 3 positions in the Director's Office).

- The fiscal 2017 allowance abolishes 3 vacant positions in FIA (2 in the Director's Office and 1 in the Work Opportunities Program). The fiscal 2017 allowance also transfers 1 position to another State agency.

- Turnover expectancy decreases from 6.97% to 6.19% in the fiscal 2017 allowance.

- As of January 1, 2016, FIA had 157.0 vacant positions, a vacancy rate of 7.5%. After accounting for the abolished and transferred positions, all of which are vacant, the vacancy rate

of FIA would be 7.3%. To meet the fiscal 2017 turnover expectancy, FIA needs to maintain 129.3 vacant positions. FIA could fill 23.0 vacant positions and still meet its fiscal 2017 turnover.

Analysis in Brief

Major Trends

Job Placement and Retention: As a result of increased job placements and a decrease in the number of TCA cases, the job placement rate has increased in recent years, exceeding 50% in fiscal 2015. In fiscal 2015, more than 13,000 individuals were placed in jobs. The job retention rate remained at 79% in federal fiscal 2015.

Employment and Earnings: According to data presented in the *Life After Welfare* 2015 update, recent leavers (those exiting TCA between January 2012 and March 2015) had a higher rate of employment in the two years after exit than the two years prior to entry, unlike those who left TCA during the mid-2000s recovery or the recession. Each group had higher earnings after leaving TCA than prior to entry. However, recent leavers had the lowest earnings both prior to and after leaving TCA.

Permanency of TCA Exit: The percent of recent and recession era leavers that returned to TCA within 6 months was 23.1% and within 12 months was 32.2%.

Office of Grants Management: In fiscal 2015, funding increases for the Maryland Food Bank and Moveable Feast, Inc. resulted in a higher number of meals provided to hungry Marylanders through programs supported by the Office of Grants Management, an increase of nearly 2.5 million (or 16.9%).

Issues

Budgetary Risks in DHR: The fiscal 2016 working appropriation and fiscal 2017 allowance contain shortfalls throughout DHR primarily due to optimistic federal fund revenue attainment assumptions. Some shortfalls cannot be accurately estimated and, as a result, the shortfalls may be higher. In fiscal 2017, an estimated surplus in TCA and available Temporary Assistance for Needy Families (TANF) balance will assist the agency in resolving the shortfalls in that year. However, the fiscal 2016 shortfalls have no offsetting surpluses.

SNAP Changes: Several changes to Maryland's SNAP impact customers in fiscal 2016. These changes include (1) the end of the statewide waiver for the time limit for able bodied adults without dependents (ABAWD); and (2) phasing in changes to the distribution dates for benefits. Due to local waivers and the ability of the department to exempt individuals from the ABAWD time limit, the end of the statewide waiver only impacts individuals in Anne Arundel, Baltimore, Carroll, Howard, Montgomery, and Prince George's counties.

Family Investment Administration Audit: In April 2015, the Office of Legislative Audits released a fiscal compliance audit for FIA covering the period July 1, 2010, through November 24, 2013. The audit contained five findings, of which four were repeated from the prior audit.

No Wrong Door Report: Committee narrative in the 2010 *Joint Chairmen's Report* (JCR) requested DHR establish a committee related to the No Wrong Door approach to benefit provision. The final report was due in June 2011. In the 2015 JCR, the committees requested DHR provide an update on the implementation of the recommendations of the final report. In its response, DHR described a number of efforts to implement the recommendations. However, the response primarily focused on DHR benefits. DHR did not address some issues, such as areas of gaps in accessing services and improvement in coordination among State agencies requested by the committees.

Recommended Actions

1. Adopt committee narrative requesting a report on the impact of the end of the statewide waiver of the time limit for able bodied adults without dependents for the Food Supplement Program.

2. Add budget bill language restricting general funds until corrective actions related to repeat audit findings are completed.

3. Add budget bill language restricting funds until a report is submitted identifying gaps in accessing services and opportunities for improved coordination.

Updates

Improving SNAP Outreach to Seniors: The 2015 JCR requested that DHR submit a report outlining strategies to assist eligible seniors in receiving SNAP benefits, particularly those strategies outlined in the *Reaching the Underserved Elderly and Working Poor in SNAP* report from Mathematica Policy Research. DHR noted in its response, that it uses some of the outreach strategies highlighted in the evaluation conducted by Mathematica Policy Research. DHR also received a waiver in November 2015 from the U.S. Department of Agriculture demonstration project for an elderly simplified demonstration project.

Refugee Assistance Programs: The United States is expected to increase the number of refugees approved for resettlement in federal fiscal 2016, in part due to the ongoing refugee crisis in Syria. Maryland has recently received approximately 2% of all refugees resettled in the United States. Although controlled at the federal level, Maryland anticipates receiving 2,093 refugees during federal fiscal 2016.

Re-authorization of TANF: TANF continues to operate on temporary extensions included in continuing resolutions. The current extension ends September 30, 2016.

N00I00
Family Investment Administration
Department of Human Resources

Operating Budget Analysis

Program Description

The Department of Human Resources (DHR) Family Investment Administration (FIA), along with the local Family Investment Programs (FIP), administers cash benefits and other grant programs that provided assistance to individuals and families in financing need, as well as employment programs to promote self-sufficiency. Programs administered include:

- **Temporary Cash Assistance (TCA)** – the State's largest cash assistance program provides financial assistance to dependent children and other family members deprived of support due to the death, incapacitation, underemployment or unemployment of one or both parents. Federal welfare reform legislation enacted in August 1996 eliminated an individual entitlement to cash assistance and replaced it with a Temporary Assistance for Needy Families (TANF) block grant. States receive their share of the block grant as long as they comply with a maintenance of effort requirement of 80% (75% if a state is successful in meeting the federal work participation rate) of the amount the state spent under the former Aid to Families with Dependent Children program. Under the legislation, states determine the eligibility criteria for TCA. The federal legislation also requires welfare recipients to work in order to receive assistance for more than two years and establishes a five-year time limit on the receipt of benefits with a hardship exception for as much as 20% of a state's caseload.

- **FIP** – the State's program for serving welfare recipients encompasses the provision of TCA and the efforts to divert potential applicants through employment, move recipients to work, and provide retention services to enhance skills and prevent recidivism. The goal of the FIP is to assist TCA applicants/recipients in becoming self-sufficient. After assessing each family's specific needs and resources, staff focuses on the services required to move clients into work. TCA is provided only as a last resort. Applicants for cash assistance are required to cooperate with child support enforcement staff as a condition of eligibility and must undertake job search activities if asked. Recipients are sanctioned if they fail to comply with any work or training requirements. Screening of TCA recipients for substance abuse is mandatory, with participation in treatment required of individuals offered appropriate treatment.

- **Temporary Disability Assistance Program (TDAP)** – the State's program for disabled adults also provides a limited monthly cash benefit. The State is responsible for clients with a short-term disability (at least 3 months but less than 12 months). If the disability will last longer, the client may be eligible for federal disability payments through Supplemental Security Income (SSI). If so, they are required to pursue an SSI application and may receive help doing so. Those clients receive State cash assistance until their SSI applications are approved. The federal government reimburses the State for cash assistance paid during the processing of approved SSI applications.

- **The Burial Assistance Program** – subsidizes funeral expenses of public assistance recipients, children in foster care, and Medical Assistance recipients. The program is funded by State and local governments.

- **The Supplemental Nutrition Assistance Program (SNAP)** – provides benefits solely for the purchase of food items to individuals and families who meet income and resource requirements. In Maryland, the program is known as the Food Supplement Program (FSP). Benefit costs are 100% federally funded, while the administrative costs are split evenly between the State and federal government.

- **The Emergency Assistance to Families Program** – provides financial assistance to resolve an emergency situation as defined by the local department.

- **Public Assistance to Adults** – provides payments to indigent clients residing in licensed assisted living homes, Project Home clients, and adult foster care clients.

- **Welfare Avoidance Grants** – allow a local department to divert customers from cash assistance when a one-time payment resolves a specific problem and allows the customer to become or remain independent.

The local departments of social services (LDSS) are responsible for making eligibility determinations and redeterminations for the aforementioned programs and for certain populations in the Medical Assistance program, which is administered by the Department of Health and Mental Hygiene (DHMH). Local departments have the flexibility to create their own tailor-made welfare program and determine what training and job search activities will be required of applicants. In addition, the LDSS are responsible for networking with employers and determining the most appropriate use for job training funds.

DHR has one key goal related to the work of FIA, that Maryland residents have access to essential services to support themselves and their families. In addition, DHR has an overall goal to be recognized as a national leader among human service agencies.

Maryland Office for Refugees and Asylees

FIA also includes the Maryland Office for Refugees and Asylees (MORA). MORA oversees a federally funded refugee settlement program that provides various services to refugees and asylees residing in Maryland. Beginning in fiscal 2016, these services are primarily provided by local resettlement agencies through grants from MORA.

Office of Grants Management

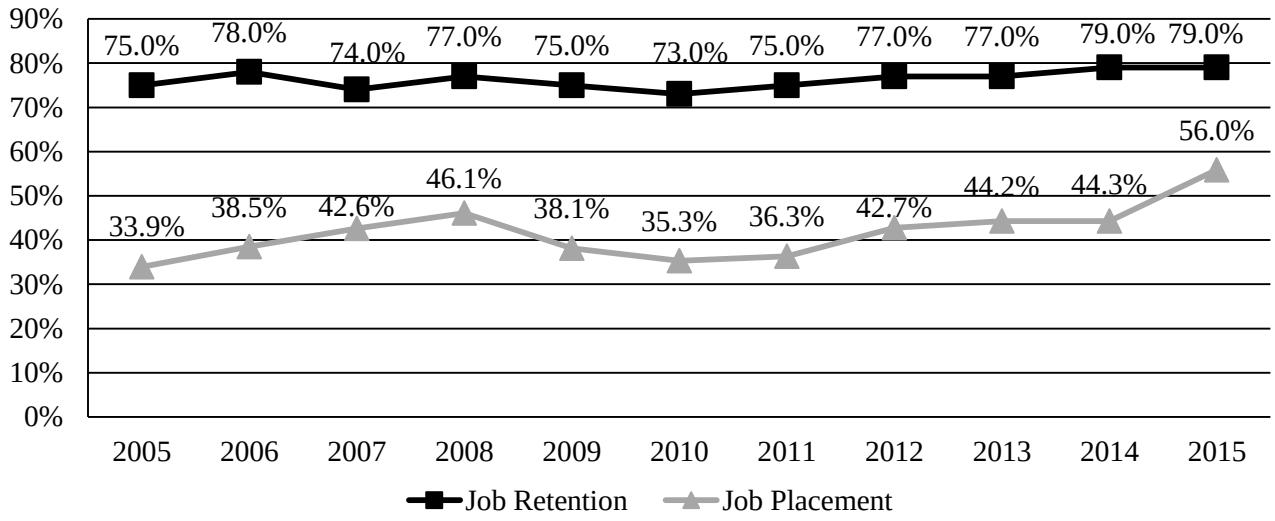
The Office of Grants Management is also administered by FIA. The Office of Grants Management provides funding to government and community-based organizations for homelessness programs, hunger programs, and other community initiatives.

Performance Analysis: Managing for Results

1. Job Placement and Retention

The goal of welfare reform was not only that welfare caseloads would decrease but that parents get jobs and keep them, eliminating the family's need for cash assistance. As shown in **Exhibit 1**, DHR has increased the job placement rate for individuals in the TCA caseload in each year since fiscal 2010. In each of these years except fiscal 2014, the number of job placements also increased. In fiscal 2015, the number of job placements increased by 20.6% (to 13,413) even as the number of TCA cases declined by 4.4%, as a result, the job placement rate of TCA cases reached 56.0%. DHR attributes the increase to factors including improvements in the economy, changes in the minimum wage which encourages individuals to re-enter the workforce, and the State resources to support training and address barriers to employment.

Exhibit 1
Job Placement and Job Retention
Fiscal 2005-2015



Note: Job placement measures the total number of placements as a percent of the total number of Temporary Cash Assistance cases. Job retention measures the percent of individuals who obtained employment in one calendar quarter and remained employed in the following quarter. Job retention is reported on a federal fiscal year basis.

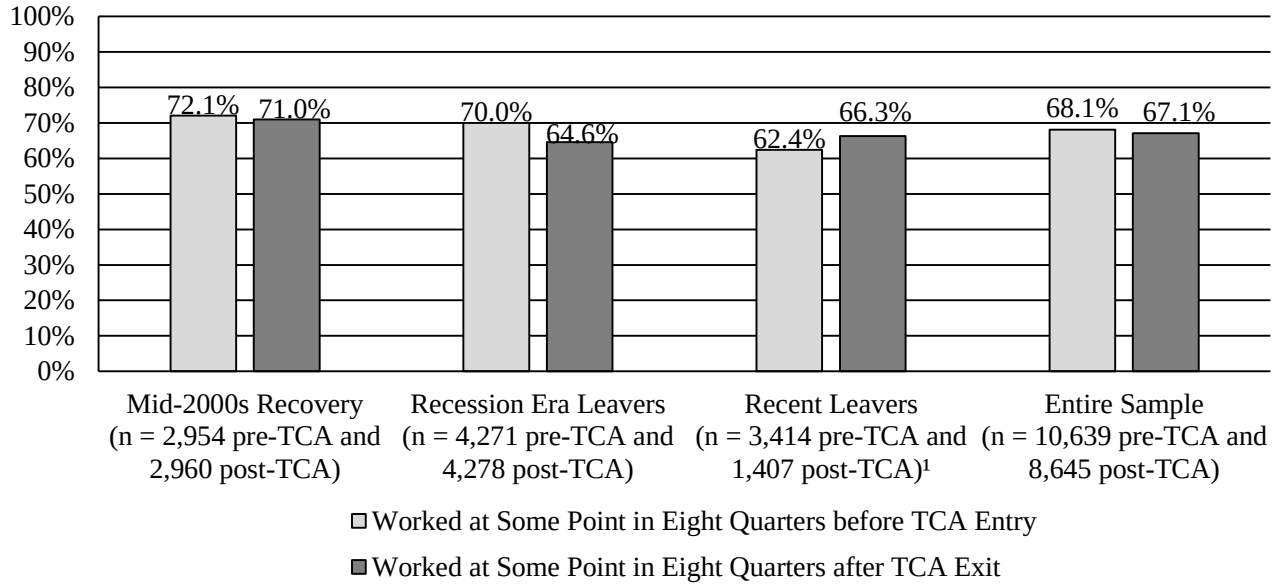
Source: Department of Human Resources; Governor's Budget Books; Department of Budget and Management; Department of Legislative Services

DHR has a goal of achieving a 75% job retention rate. DHR met this goal in fiscal 2011 and has exceeded the goal in each subsequent year. In fiscal 2014 and 2015, DHR achieved a 79% job retention rate.

2. Employment and Earnings

The 2015 *Life After Welfare* annual update reports on individuals leaving TCA between January 2004 and March 2015. The report compares three groups of leavers: (1) mid-2000s recovery (exited between January 2004 and March 2007); (2) recession era (exited between April 2007 and December 2011); and (3) recent leavers (exited between January 2012 and March 2015). **Exhibit 2** presents data from this report on the percent of leavers who worked at some point in the eight quarters before receiving TCA and at some point in the eight quarters after leaving TCA.

Exhibit 2
Employment Prior to and after Leaving TCA



TCA: Temporary Cash Assistance

[1] Due to the timing of the report, two years of employment data for most of the recent TCA leavers is not yet available.

Note: This exhibit is derived from data collected by the University of Maryland School of Social Work and presented in the *Life After Welfare: Annual Update*, December 2015. It follows a sample of TCA leavers from October 1996 (although data is presented only for leavers beginning January 2004) through March 2015, the sample excludes leavers that returned to TCA within 30 days. This data includes TCA leavers employed in jobs in Maryland covered by unemployment insurance.

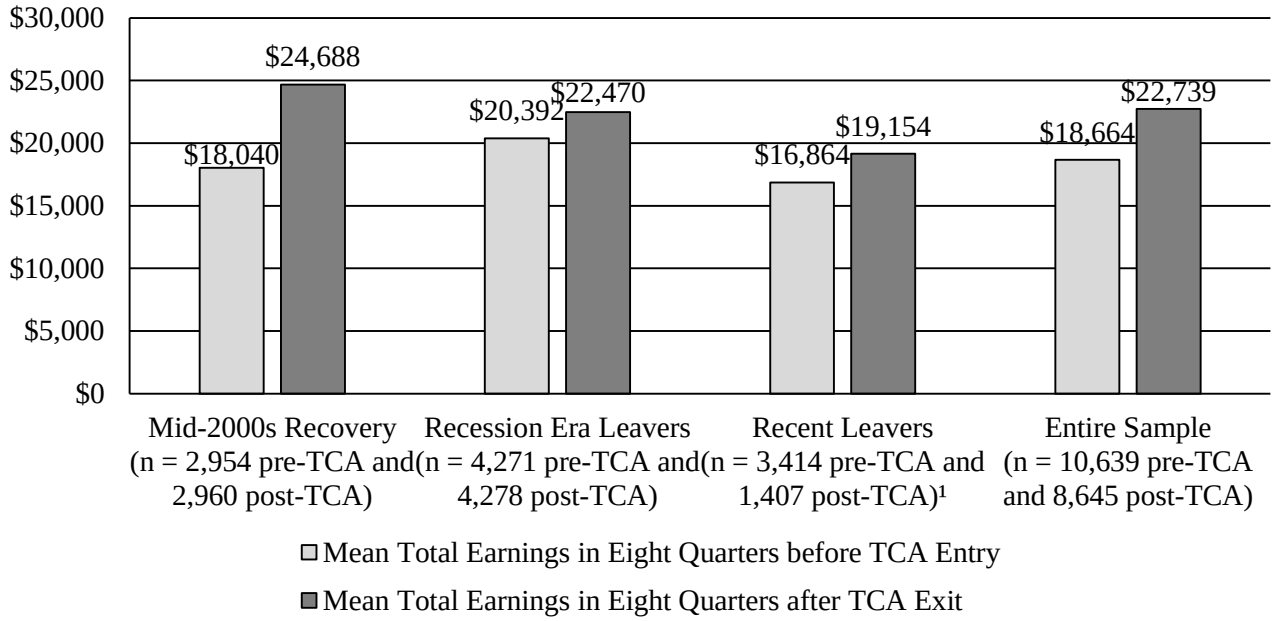
Source: *Life After Welfare: Annual Update*, December 2015, University of Maryland School of Social Work

As shown in Exhibit 2, a substantially lower percent of recent leavers worked at some point in the two years before receiving TCA (62.4%) than leavers in earlier time periods (72.1% for mid-2000s recovery and 70.0% for recession era leavers). However, recent leavers were the only group that had a higher percent of individuals working at some point in the two years after exit (66.3%) than the

two years prior to entry. Limited data is available for the post exit group of recent leavers and, as a result, it is worth following whether this pattern holds as more data becomes available. Despite the increased employment for this group post exit, a lower percent of these individuals worked at some point in the two years after exit than the mid-2000s recovery leavers.

Exhibit 3 presents data on the mean total earnings for individuals in the eight quarters before receiving TCA and in the eight quarters after leaving TCA. Each of the three groups of leavers had higher earnings after leaving TCA than prior to receiving TCA. However, the size of the increase varied, with the mid-2000s recovery leavers experiencing the largest increase ($6,648). Recent leavers had the lowest earnings in the eight quarters prior to entering TCA and the lowest earnings in the eight quarters after exiting TCA.

Exhibit 3
Earnings Prior to and after Leaving TCA



TCA: Temporary Cash Assistance

[1] Due to the timing of the report, two years of earnings data for most of the recent TCA leavers is not yet available.

Note: This exhibit is derived from data collected by the University of Maryland School of Social Work and presented in the *Life After Welfare: Annual Update*, December 2015. It follows a sample of TCA leavers from October 1996 (although data is presented only for leavers beginning January 2004) through March 2015, the sample excludes leavers that returned to TCA within 30 days. This data includes TCA leavers employed in jobs in Maryland covered by unemployment insurance.

Source: *Life After Welfare: Annual Update*, December 2015, University of Maryland School of Social Work

3. Permanency of TCA Exit

Exhibit 4 presents data from the 2015 *Life After Welfare* update on the percent of TCA leavers that were (1) working; (2) working and receiving TCA; (3) receiving TCA only; or (4) disconnected (not receiving either TCA or working) in the first year after exiting TCA. As shown in this exhibit, the mid-2000s recovery leavers had the highest share of those in the work only category (46.0%) and the lowest share receiving TCA only (11.1%). Among recent leavers, 40.5% were in the work only category and 15.2% were receiving welfare only, very similar rates to the recession era leavers. More than one quarter of both the recession era and recent leavers were disconnected from both work and TCA. However, the *Life After Welfare Report* notes that only 7.0% of all disconnected leavers in the first year after exit are disconnected from all benefits, with nearly half receiving both FSP and Medical Assistance.

Exhibit 4
Welfare and Work Status in First Year Post Exit

TCA: Temporary Cash Assistance

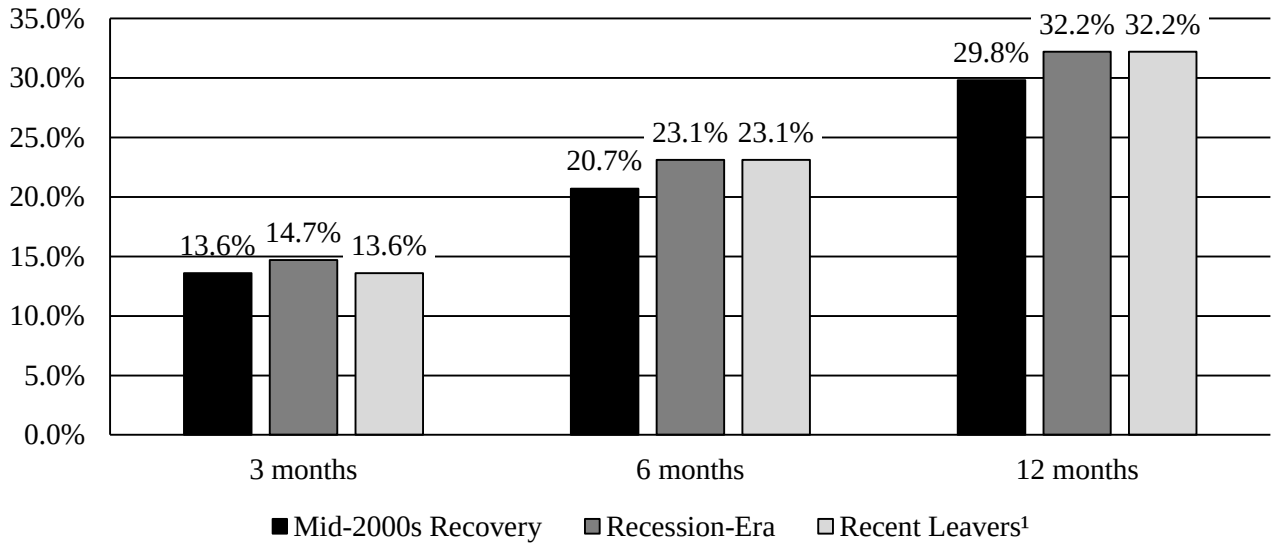
[1] Due to the timing of the report, data at one year after exit is not yet available for all recent TCA leavers.

Note: This exhibit is derived from data collected by the University of Maryland School of Social Work and presented in the *Life After Welfare: Annual Update*, December 2015. It follows a sample of TCA leavers from October 1996 (although data is presented only for leavers beginning January 2004) through March 2015, the sample excludes leavers that returned to TCA within 30 days. This data includes TCA leavers employed in jobs in Maryland covered by unemployment insurance.

Source: *Life After Welfare: Annual Update*, December 2015, University of Maryland School of Social Work

Exhibit 5 presents data on the percent of the leavers in each group that had returned to TCA at 3 months, 6 months, or 12 months after exit. The data show very little variation in the percent of leavers that returned to TCA. More than 20% of leavers returned within 6 months and near or slightly more than 30% returned within 12 months.

Exhibit 5
TCA Recidivism



TCA: Temporary Cash Assistance

[1] Due to the timing of the report, data at one year after exit is not yet available for all recent TCA leavers. Recent leavers group includes data for 3,215 individuals at 3 months after exit, 2,975 individuals at 6 months after exit, and 2,478 individuals at 12 months after exit compared to the total sample of 3,468.

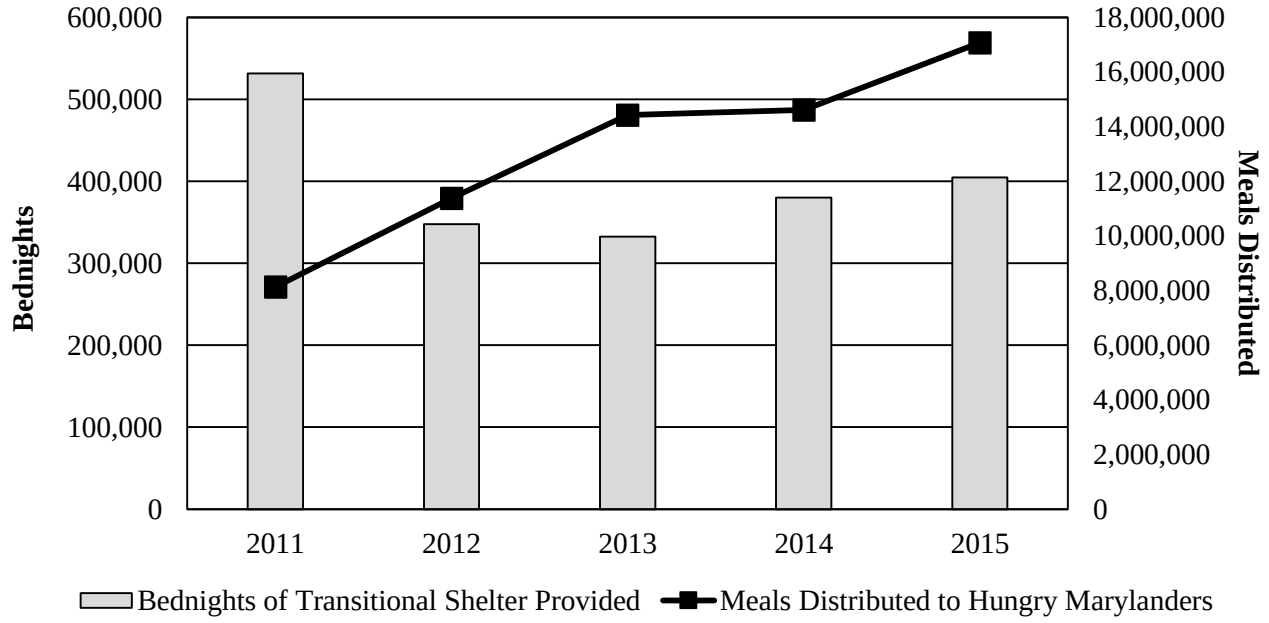
Note: This exhibit is derived from data collected by the University of Maryland School of Social Work and presented in the *Life After Welfare: Annual Update*, December 2015. It follows a sample of TCA leavers from October 1996 (although data is presented only for leavers beginning January 2004) through March 2015, the sample excludes leavers that returned to TCA within 30 days. This data includes TCA leavers employed in jobs in Maryland covered by unemployment insurance.

Source: *Life After Welfare: Annual Update*, December 2015, University of Maryland School of Social Work

4. Office of Grants Management

As shown in **Exhibit 6**, the number of meals provided to hungry Marylanders increased by nearly 2.5 million (16.9%) in fiscal 2015 compared to fiscal 2014. The increase is largely the result of increased grant amounts to the Maryland Food Bank and Moveable Feast, Inc. An increase of 6.5% in the number of bednights of transitional housing was largely the result of the inclusion of data from the Homeless Women's Crisis Shelter Program in fiscal 2015, but not fiscal 2014.

Exhibit 6
Office of Grants Management
Fiscal 2011-2015



Source: Department of Human Resources; Department of Budget and Management; Governor's Budget Books; Department of Legislative Services

DHR has added several new performance measures for the Office of Grants Management including (1) the number of individuals entering emergency shelters; (2) the number of individuals exiting emergency shelters; and (3) the number of grant recipients that have maintained housing up to three months following receipt of a grant. Limited data is available from these new measures. The Secretary of the Department of Housing and Community Development recently indicated some changes are under consideration to the State's homeless services programs, including streamlining the programs and their administration. **DHR should comment on the potential streamlining and the impact on DHR's homeless services programs.**

Fiscal 2016 Actions

Planned Reversion

Section 48 of the fiscal 2016 budget bill restricted funds for a number of programs, including $13 million of general funds in TCA, to restore legislative priorities. The Governor's budget plan assumes the funding restricted in the TCA program will be reverted.

Cost Containment

The DHR share of the fiscal 2016 2% across-the-board reduction was $6.9 million in general funds. The share of the reduction in FIA totaled $3.2 million ($2.0 million general funds and $1.2 million federal funds). The largest reduction ($1.6 million in general funds) occurred in the Public Assistance to Adults program for customers in assisted living facilities, due to declining caseloads in part from changes in regulations requiring stronger medical justification.

The abolition of 23 positions (20 position in the Local Family Investment program and 3 positions in the Director's Office of FIA) resulted in a reduction of $1.5 million in total funds ($0.4 million general funds and $1.1 million federal funds).

The remaining decrease of $144,662 in total funds ($42,053 in general funds and $102,609 in federal funds) is for the Montgomery County grant.

Proposed Budget

As shown in **Exhibit 7**, the fiscal 2017 allowance of FIA increases by $10.3 million, 0.7%, after accounting for the planned reversion in TCA in fiscal 2016 and the back of the bill reduction in health insurance in fiscal 2017. General funds increase by $18.2 million, 14.6%, primarily in TCA and personnel expenditures. Special funds ($3.2 million) and federal funds ($4.7 million) decrease in the fiscal 2017 allowance compared to the fiscal 2016 working appropriation.

Exhibit 7
Proposed Budget
DHR – Family Investment Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$145,024	$11,847	$1,452,391	$319	$1,609,581
Fiscal 2016 Working Appropriation	125,046	19,406	1,443,876	0	1,588,328
Fiscal 2017 Allowance	143,274	16,200	1,439,197	0	1,598,670
Fiscal 2016-2017 Amount Change	$18,228	-$3,206	-$4,680	$0	$10,342
Fiscal 2016-2017 Percent Change	14.6%	-16.5%	-0.3%		0.7%

Where It Goes:

Personnel Expenses	
Overtime to better align with recent experience	$3,316
Employee and retiree health insurance	3,166
Employee retirement	2,435
General funds in Local Family Investment Program to backfill for federal fund loss due to partial transition of eligibility determination for the Child Care Subsidy Program to MSDE	2,000
Turnover expectancy decreases from 6.97% to 6.19%	780
Accrued leave payout to align with recent experience	147
Other fringe benefit adjustments	-37
Social Security contributions	-208
Abolition of 3 positions and transfer of 1 position to another State agency	-315
Regular earnings primarily due to the budgeting of vacant positions at lower salaries	-624
Assistance Payments Program	
Temporary Cash Assistance net of the planned reversion	2,579
Public assistance to adults due to a higher caseload for recipients in assisted living	272

Where It Goes:	
Burial assistance grants to align with recent experience	130
Welfare avoidance grants to align with recent experience	34
Refugee assistance to align with recent experience	-13
Food Supplement Program (FSP) to align with recent experience	-3,935
Director's Office	
FSP nutrition services contract with the University of Maryland Cooperative Extension	595
Share of costs associated with the implementation of the Workforce Innovation and Opportunity Act	110
University of Baltimore research contract	59
End of Couples Advancing Together pilot program in fiscal 2016	-50
Elimination of web hosting contract with the University of Maryland, College Park	-104
Other Changes	
Office and other supplies primarily for Baltimore City and Baltimore County to align with recent experience	236
Rent primarily due to staff relocations	152
Interpreter fees in Baltimore City to align with recent experience	65
Building repairs to more closely align with recent experience primarily in Baltimore City and Baltimore County	51
Other adjustments	15
Electricity	-79
Telephone expenditures to align with recent experience	-82
Montgomery County grant	-124
Medical care related to disability determinations to better align with recent experience and increased cases, primarily in Baltimore City	-227
Total	**$10,342**

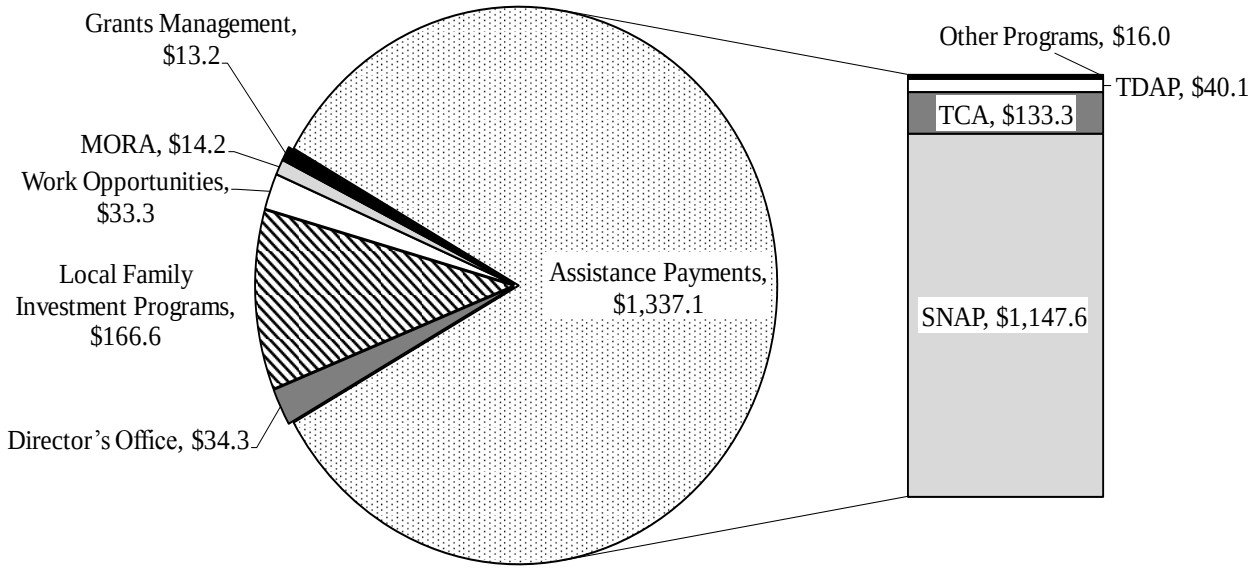
MSDE: Maryland State Department of Education

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

Benefits and Services to Clients

Exhibit 8 presents information on the fiscal 2017 allowance of FIA by program. The Assistance Payments Program continues to be the largest share of the FIA budget, $1.3 billion or 83.6%, primarily due to the size of the FSP.

Exhibit 8
Family Investment Administration
Fiscal 2017 Allowance
($ in Millions)



MORA: Maryland Office of Refugees and Asylees
SNAP: Supplemental Nutrition Assistance Program
TCA: Temporary Cash Assistance
TDAP: Temporary Disability Assistance Program

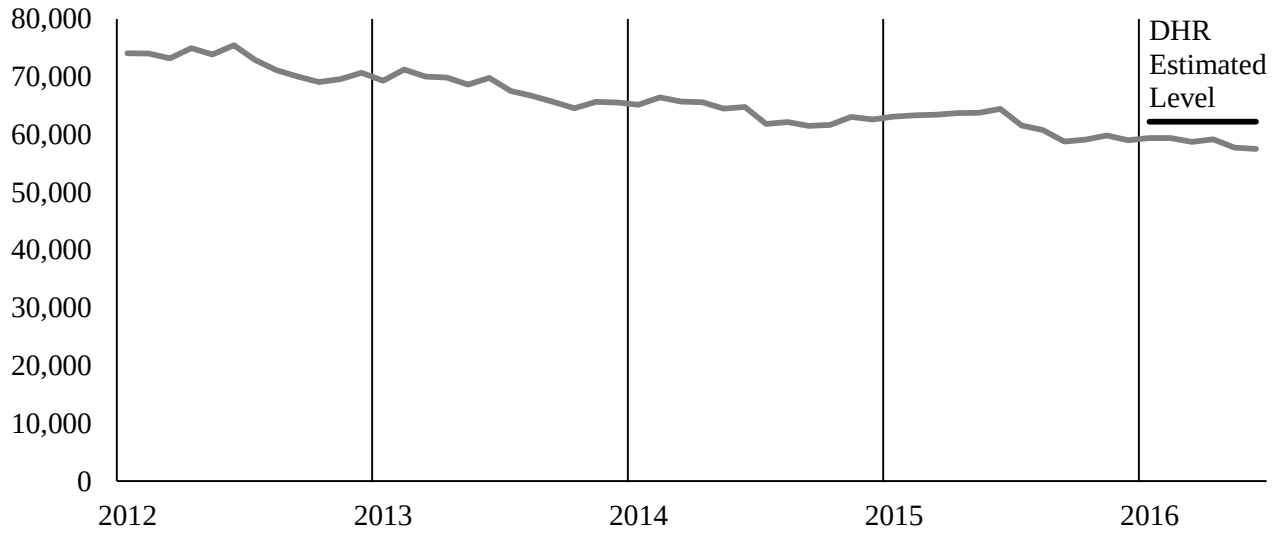
Note: This data accounts for a back of the bill reduction in health insurance.

Source: Governor's Budget Books; Department of Human Resources; Department of Legislative Services

TCA Caseload and Expenditure Trends

Exhibit 9 provides the monthly count of TCA recipients from July 2011 through December 2015. After peaking in December 2011 (75,442), the number of recipients has generally declined. However, some months have seen increased numbers of TCA recipients, for example, the number of TCA recipients increased in each month from July 2014 through December 2014. Despite occasional months of increase, the number of recipients in December 2015 (57,492) was 23.8% lower than the December 2011 peak and 3.2% lower than July 2015. Through December 2015 the average number of recipients in fiscal 2016 is 58,640, 5.7% lower than the DHR fiscal 2016 budget estimate.

Exhibit 9
Temporary Cash Assistance Recipients
July 2011-December 2015



DHR: Department of Human Resources

Source: Department of Human Resources; Department of Legislative Services

Exhibit 10 shows the average monthly caseload, average monthly grant, and total spending for fiscal 2015 and estimated spending for fiscal 2016 and 2017 contained in the budget. This exhibit also presents the Department of Legislative Services (DLS) estimates for fiscal 2016 and 2017.

DHR estimated the average grant would be $192.60 in fiscal 2016, however, DHR later reported that there was no change in the Maryland Minimum Living Level for fiscal 2016. Statute requires that the combined TCA and SNAP benefits equal 61% of the Maryland Minimum Level (and is generally adjusted annually to account for inflation). However, recently, the inflationary adjustment has resulted in no change in the calculation. As a result, through December 2015, the average grant was $191.61, essentially flat compared to fiscal 2015.

Although DLS is projecting average monthly recipients to decline by 6.9% in fiscal 2016 compared to fiscal 2015 and a lower average monthly grant than DHR estimated in budget development, DLS is projecting a shortfall of $1.1 million in fiscal 2016 due to the planned reversion. This shortfall can be attributed to the level of withheld appropriation assumed by the legislature in fiscal 2016. However, the reasoning behind that level of withheld funds is closer aligned to current projections of spending than the fiscal 2016 budget as originally proposed.

Exhibit 10
Temporary Cash Assistance Enrollment and Funding
Fiscal 2015-2017

TCA	2015 Actual	2016 Working	2017 Allowance	2016 DLS Estimate	2017 DLS Estimate
Average Monthly Enrollment	61,739	62,191	57,768	57,468	53,337
Average Monthly Grant	$191.10	$192.60	$192.30	$191.17	$192.61
Total Funding in Millions	**$133.4**	**$143.7**	**$133.3**	**$131.8**	**$123.3**
Planned Reversion		-$13.0			
Available after Reversion		**$130.7**			
Budgeted Funds in Millions					
General Funds				$19.3	$25.3
Total Budgeted Funds				**$130.7**	**$133.3**
DLS Estimated Deficit/Surplus				-$1.1	$10.0

DLS: Department of Legislative Services
TCA: Temporary Cash Assistance

Source: Department of Human Resources; Department of Legislative Services

The DHR estimate for fiscal 2017 assumes the average monthly recipients will decrease to 57,768, which is higher than the number of recipients in November and December of 2015 (57,734 and 57,492, respectively). DLS assumes that the number of recipients will continue to decline through fiscal 2017 at the same rate as in fiscal 2016, resulting in an average monthly number of recipients of 53,337. DHR's estimated average monthly grant of $192.30 is expected to account for an increase in the Maryland Minimum Living Level. DLS projects a slightly higher average monthly grant, but the difference is minimal. Driven by the lower estimate of average monthly recipients, DLS is projecting a surplus of $10.0 million in fiscal 2017 for TCA. However, as will be discussed in Issue 1, to address a variety of budgetary shortfalls in DHR in fiscal 2017, DLS is not recommending this surplus be deleted and is instead noting that this surplus can be used to address budgetary shortfalls elsewhere in the department.

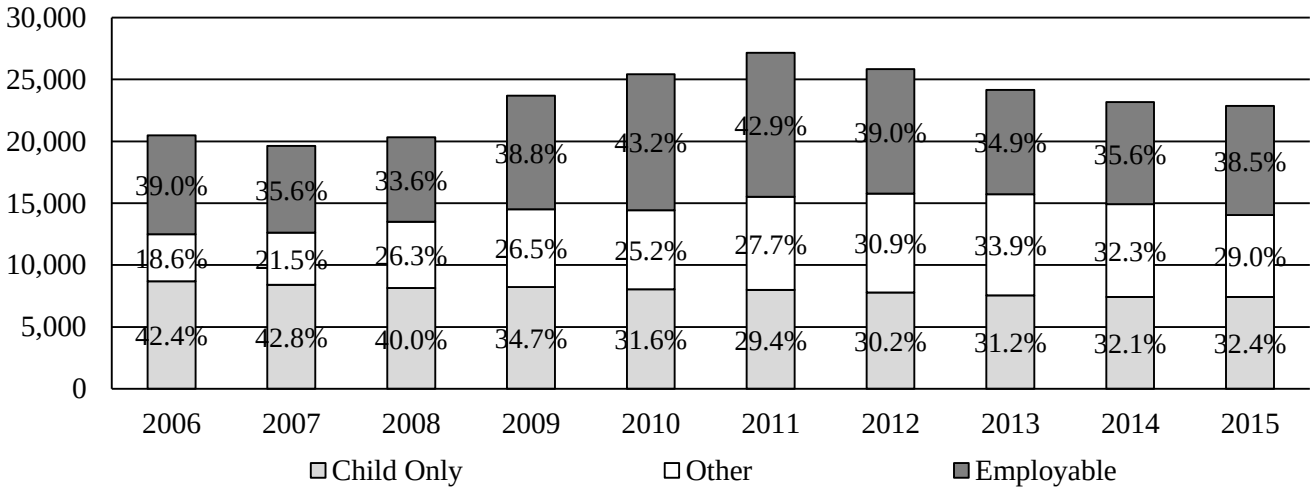
Characteristics of the TCA Core Caseload

The TCA caseload can be divided into two main groups: (1) the core caseload; and (2) cases headed by an employable adult. The core cases include child only cases, women with children under age one, disabled individuals, caretaker relatives, and other cases exempted from work requirements. With the exception of women with children under age one, DHR does not expect the core cases to

transition off of cash assistance by seeking employment. Child only cases, for example, typically leave the TCA rolls after reaching adulthood. As employable adults successfully enter the labor market, the core cases generally represent an increasing percentage of the total TCA caseload.

Exhibit 11 presents information on TCA cases (which may consist of multiple recipients) in July 2015 compared to prior years. These cases are categorized into employable, child only, and other. Other cases represent all other core cases except child only cases. The total number of cases declined by 1.3% (299 cases) between July 2014 and 2015. The decrease occurred primarily in the other category (a decrease of 844 cases or 11.3%), specifically among cases with an individual with a disability and cases with a child under the age of one.

Exhibit 11
TCA Caseload Characteristics
July 2006-2015



TCA: Temporary Cash Assistance

Source: Department of Human Resources

The number of child only cases also decreased slightly between July 2014 and 2015. However, the share of all cases that are child only increased slightly to 32.4%, the highest level since July 2009. These decreases were partially offset by an increase of 566 (6.9%) in employable cases. The share of employable cases increased by nearly 3 percentage points to 38.5%, the highest level since July 2012.

Five-year Lifetime Limit on a Recipient of Cash Assistance

Moving employable adults to self-sufficiency is of particular importance due to the federal limit placed on recipients of cash assistance. Federal law prohibits cases headed by an adult from receiving TANF-funded cash benefits for more than five cumulative years. However, federal law also provides

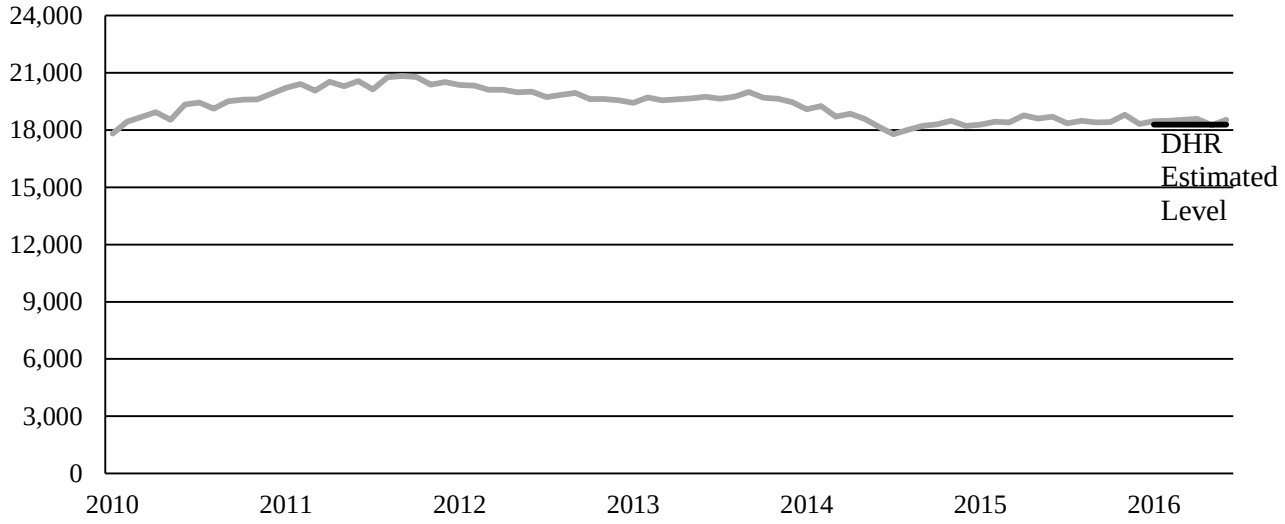
exemptions to the time limit for "hardship." Under this provision, 20% of the caseload receiving TANF-funded cash assistance from the previous fiscal year may continue to receive these benefits beyond five years.

December 2015 was the one hundred and sixty-eighth consecutive month in which some families had reached the five-year benefit limit. The annual average number of families receiving TANF in fiscal 2015 was 23,999, of which the annual average number of cases headed by adults that received assistance for more than 60 months that were subject to the time limit was 1,455. Since this number is below the 20% exemption limit for fiscal 2015 (4,800) no one was removed from the caseload.

TDAP Caseload and Expenditures

Exhibit 12 shows the number of TDAP recipients by month, from July 2009 through December 2015. The number of monthly TDAP recipients peaked in March 2011 (20,841). After reaching its lowest point in January 2014 (17,780), for approximately the last two years the number of TDAP recipients has been fluctuating within a small range.

Exhibit 12
Temporary Disability Assistance Program Recipients
July 2009-December 2015



DHR: Department of Human Resources

Source: Department of Human Resources

As shown in **Exhibit 13**, for fiscal 2016 and 2017, DHR assumes an average monthly number of TDAP recipients of 18,281. However, the number of TDAP recipients has reached that low of a level only twice since July 2014. Through December 2015, in fiscal 2016 the average monthly recipients in TDAP is 18,479 and in that month the number of recipients was 18,536. DLS is projecting

average monthly recipients near the current level of recipients in fiscal 2016 and 2017, which results in a higher average monthly number of recipients than the budget is currently built on. As a result, DLS is currently projecting slight shortfalls in both fiscal 2016 and 2017 ($0.5 million and $0.6 million, respectively).

Exhibit 13
Temporary Disability Assistance Program Enrollment and Funding
Fiscal 2015-2017

	2015 Actual	2016 Working	2017 Allowance	2016 DLS Estimate	2017 DLS Estimate
Average Monthly Enrollment	18,500	18,281	18,281	18,508	18,536
Average Monthly Grant	$182.88	$182.81	$182.81	$182.93	$182.93
Total Funding in Millions	**$40.6**	**$40.1**	**$40.1**	**$40.6**	**$40.7**
Budgeted Funds in Millions					
General Funds				$34.1	$34.1
Total Budgeted Funds				**$40.1**	**$40.1**
DLS Estimated Deficit/Surplus				**-$0.5**	**-$0.6**

DLS: Department of Legislative Services

Source: Department of Human Resources; Department of Legislative Services

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. The FIA share of these reductions is $582,774 in total funds ($178,594 in general funds, $13,029 in special funds, and $391,151 in federal funds). There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

Personnel

The fiscal 2017 allowance increases funding for personnel in FIA by $10.7 million compared to the fiscal 2016 working appropriation after accounting for the back of the bill reduction in health insurance.

The largest increase occurs in the area of overtime, $3.3 million, to better align with experience, providing a total of $3.6 million. Even with this increase, the total funding for overtime is $2.5 million lower than the three-year average of actual expenditures ($6.1 million), primarily among federal funds. However, the general fund share of overtime was higher than the three-year average of expenditures, and as a result any federal fund shortfall could likely be addressed in the closeout process. However, the fiscal 2016 working appropriation for overtime is only $265,587. Based on the three-year average of expenditures, the fiscal 2016 working appropriation would be short by $5.8 million ($2.4 million in general funds). **DHR should comment on steps it is taking to reduce overtime spending and whether filling vacant positions would reduce the need for overtime.**

Other significant increases in personnel occur in the areas of employee and retiree health insurance ($3.2 million) and employee retirement ($2.4 million). These increases are partially offset by the abolition of 3 positions and transfer of 1 position to another agency that results in a decrease of $315,393. In addition, regular earnings decrease by $624,245, primarily due to the budgeting of vacant positions and filling of positions at lower salaries.

The fiscal 2017 budget includes funding for employee increments in the Department of Budget and Management. These funds will be distributed to agencies by budget amendment early in the fiscal year. The share of these increments attributable to FIA is $2.4 million in total funds ($1.1 million in general funds, $55,241 in special funds, and $1.2 million in federal funds).

Child Care Subsidy Transition Impact

As discussed in the DHR Overview budget analysis, the eligibility determination and case management activities for the Child Care Subsidy program were partially transitioned to the Maryland State Department of Education (MSDE) in fiscal 2016. Although DHR transitioned all of these cases in August 2015, in December 2015 the agencies agreed that DHR would continue processing eligibility determinations for TCA-related Child Care Subsidy cases.

As shown in **Exhibit 14**, the fiscal 2016 working appropriation in the Local Family Investment program includes $10.6 million from child care related federal funds. This appropriation is $1.8 million more than was spent in fiscal 2015. While DHR conducted all of the eligibility determination and case management activities in fiscal 2015, in fiscal 2016, DHR only conducted the full eligibility activities for this program for approximately two months and conducted work related to the TCA-related cases for approximately half of the year. As a result, the fiscal 2016 working appropriation overstates the amount of federal funds likely to be available to the program.

Exhibit 14
Child Care Related Funding
Local Family Investment Program
Fiscal 2015-2017

	2015 Actual	2016 Working	DLS Estimate 2016	2016 Estimated Shortfall	2017 Allowance	DLS Estimate 2017	2017 Estimated Shortfall
Local Family Investment Administration	$8,842,997	$10,644,641	$2,733,960	**-$7,910,681**	$6,127,094	$2,520,254	**-$3,606,840**

DLS: Department of Legislative Services

Source: Governor's Budget Books; Department of Legislative Services

The fiscal 2017 allowance includes $6.1 million of child care related federal funds for the portion of the program that remains in DHR in the Local Family Investment program, which is 69.3% of the federal child care related funds that the Local Family Investment program received for all Child Care Subsidy work in fiscal 2015. However, in September 2015 (the most recent data available), TCA involved families represented only 28.5% of Child Care Subsidy program families. As a result, the federal funds available to the program are likely overstated.

While a portion of the work was transferred, caseworker funding needs to remain in DHR because the caseworkers involved in eligibility determination for the child care subsidy also conduct this work for other programs. No positions were transferred from DHR to MSDE during the partial transition. Initially, DHR estimated a shortfall from the full transition of between $6.0 million and $8.0 million. However, the shortfall will be less because of the portion of the program that remains with DHR. Some portion of the shortfall may be addressed by the ability to claim a higher amount of federal funds for work on other activities as caseworkers spend proportionately more of their time on these activities. There is no deficiency appropriation to address the shortfall in fiscal 2016. While the fiscal 2017 allowance includes $2.0 million of general funds in personnel in the Local Family Investment program specifically to address this shortfall, as shown in Exhibit 14, DLS projects shortfalls of $7.9 million in fiscal 2016 and $3.6 million in fiscal 2017 related to the federal fund overstatement.

Contractual Services

Funding in the FIA Director's Office increases by a net of $649,470 (4.6%) in contractual services, the largest of these increases is for FSP Nutrition Services ($595,171) and employment and training related to the implementation of the federal Workforce Innovation and Opportunity Act (WIOA) ($100,000). The increased funding for WIOA may be used for a variety of activities including those related to shared costs for the space at the job centers, shared costs of training, and building shared intake and assessment tools. The specific use of the funds will be determined after the submission of the Maryland WIOA State Plan in March 2016.

Issues

1. Budgetary Risks in DHR

The fiscal 2016 working appropriation and fiscal 2017 allowance present several budgetary risks to the overall DHR budget primarily related to optimistic federal fund revenue attainment assumptions. The details of these risks have been discussed earlier in this analysis and the analysis of the Social Services Administration. These risks relate to:

- regular Title IV-E revenue estimates and caseload assumptions in the Foster Care Maintenance Payments program;
- federal fund budgeting for Medical Assistance and regular Title IV-E in the Local Child Welfare Services program;
- child care related federal funds in the Local Family Investment Program;
- caseload assumptions in TDAP;
- the level of withheld appropriation (and subsequent reversion) for TCA in fiscal 2016 only; and
- overtime expenses in FIA in fiscal 2016 only.

Exhibit 15 quantifies to the extent possible the anticipated general fund shortfalls. However, these shortfalls may be higher than currently projected, as some can only be partially estimated based on available information. In fiscal 2016 the shortfall is projected to be at least $21.6 million.

Exhibit 15
Estimated Surpluses/Shortfalls
Fiscal 2016 and 2017

	2016	2017
Foster Care Maintenance Payments	-$9,083,121	-$11,933,665
Local Child Welfare Services Medical Assistance/IV-E	Unknown	At Least -6,862,824
Local Family Investment Child Care Related Federal Funds	-7,910,681	-3,606,840
Overtime	-2,381,485	932,907
TDAP	-523,957	-586,153
TCA	-1,108,431	10,028,995
TANF Balance[1]	-542,657	13,051,279
Total	**-$21,550,332**	**$1,023,698**

[1] Assumes TANF contingency funds are received at fiscal 2015 level.

TCA: Temporary Cash Assistance
TDAP: Temporary Disability Assistance Program
TANF: Temporary Assistance for Needy Families

Source: Department of Legislative Services

In fiscal 2017 some surpluses are available to offset these shortfalls, including an estimated $10.0 million surplus in TCA and general funds budgeted for overtime ($0.9 million). In addition, as discussed in the DHR Overview, if Maryland continues to receive TANF contingency funds in fiscal 2016 and 2017 at the level it did in fiscal 2015 ($25.5 million) and maintains the current spending plan, the ongoing deficit in TANF will be fully resolved and result in a balance of $13.1 million in fiscal 2017. The availability of the TANF balance is dependent on the current spending plans (*i.e.*, if DHR spends more TANF in fiscal 2016 to assist in the shortfall, a lower balance would be available in fiscal 2017) and the receipt of the TANF contingency funds. In combination, DHR may be able to fully resolve its fiscal 2017 shortfalls, or at least have only a limited shortfall.

In fiscal 2016, there are no surpluses to offset the projected shortfalls. **DHR should explain to the committees how it plans to address the significant shortfalls in the fiscal 2016 budget and its plan to monitor spending in fiscal 2017 to ensure the shortfalls can be fully resolved.**

2. SNAP Changes

Several changes in SNAP, known in Maryland FSP, impact customers in fiscal 2016.

Employment and Training

General Work Requirements

SNAP contains work requirements that recipients (1) register for work; (2) participate in an employment and training program; (3) participate in a workfare program if assigned by the state; (4) accept suitable employment if offered; and (5) not voluntarily quit a job where the individual works more than 30 hours per week or voluntarily reduce work hours below 30 hours per week. Exemptions from these requirements are provided for individuals complying with work requirements of another program, students enrolled at least half-time in school, and individuals who are already working more than 30 hours per week, under the age of 16 or older than age 60, with a disability, participating in a drug or alcohol treatment program, or caring for a child under the age of 6.

Whether the work requirements are mandatory or voluntary and any resulting penalties are subject to State policy. Until fiscal 2016 the work requirements were mandatory in Maryland, the program is now voluntary. Even with this change, participants are still required to complete work registration activities unless the individual qualifies for an exemption. Prior to the change, failure to comply with the requirements resulted in a loss of eligibility for benefits for one month or the date of compliance, whichever is later (first violation); three months or the date of compliance, whichever is later (second violation); or six months or the date of compliance, whichever is later (for the third and any subsequent violation).

Able Bodied Adults without Dependents

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 added a requirement that limited the length of time abled bodied adults without dependents (ABAWD) could receive SNAP benefits (three months in a three-year period) if not working, participating in, or complying with the requirements of a work program for 20 hours or more per week. Exemptions from this requirement are available for individuals (1) under age 18; (2) age 50 or older; (3) caring for a child or incapacitated household member; (4) medically certified as physically unfit for employment or pregnant; or (5) already exempt from SNAP general work requirements. States may also exempt 15% of individuals from this requirement.

States are able to request a waiver for the ABAWD provision for areas with an unemployment rate over 10% or for areas with insufficient jobs. Some of the evidence that can be used to demonstrate this are:

- a recent 12-month unemployment rate over 10%;
- a recent 3-month unemployment rate over 10%;

- a 24-month average unemployment rate 20% higher than the national average;
- a designation as a Labor Surplus Area by the U.S. Department of Labor;
- a qualification for extended unemployment benefits; and
- a low and declining employment to population ratio.

During and since the recession many states have operated with a statewide waiver of the ABAWD time limits for SNAP receipt, including Maryland. As the recovery has continued more states have stopped receiving a waiver. For example, in the first quarter of federal fiscal 2016, 28 states and Washington DC had waivers for the entire state (including Maryland), but in the second quarter of federal fiscal 2016, only 6 states and Washington DC had waivers for the entire state. Maryland's statewide SNAP waiver of the ABAWD time limits expired December 31, 2015. States may continue to receive local waivers.

DHR has received approval for local waivers in 10 counties (Allegany, Caroline, Cecil, Dorchester, Garrett, Harford, Queen Anne's, Somerset, Wicomico, and Worcester) and Baltimore City. In addition, DHR plans to use its 15% exemption on ABAWD individuals living in 7 counties (Calvert, Charles, Frederick, Kent, St. Mary's, Talbot, and Washington counties). As a result of the waivers and exemption plans, only ABAWD individuals living in 6 counties will be impacted by the loss of the statewide waiver:

- Anne Arundel;
- Baltimore;
- Carroll;
- Howard;
- Montgomery; and
- Prince George's.

DHR indicates that the University of Baltimore will, under an existing research contract, be evaluating the ABAWD work programs. **DHR should comment on when the evaluation of these work programs will be completed. DLS recommends committee narrative requesting FIA report on the number of ABAWD removed from the FSP benefits due to failure to comply with work requirements and the number of those who returned to the program after complying.**

Federal Fiscal 2016 SNAP Employment and Training State Plan

Program components include:

- education – includes adult basic education, literacy, English as a second language, the general education diploma, and postsecondary education;
- independent job search;
- job readiness training – includes career and job skill assessments, workplace etiquette, resume and cover letter assistance;
- vocational training – in areas of retail/hospitality, construction, commercial driver's licensing, medical (certified nursing assistant, phlebotomy technician, medical coding and billing, emergency medical technician, and paramedic), veterinary assistance, certified apartment/building maintenance technician, machining, welding, child care, and office skills;
- work experience/community service; and
- workfare (only available for ABAWD participants).

DHR also plans to partner with four third-party vendors to provide services (Humanim in Baltimore City targeting those living in east Baltimore, Lutheran Social Services of the National Capital Areas targeting refugees receiving services from the Suburban Washington Resettlement Area, Garrett College, and the International Rescue Committee serving refugees and asylees in Montgomery and Prince George's counties).

Funding

The SNAP Employment and Training program spent $939,214 in fiscal 2015. A total of $1.17 million is budgeted for the program in fiscal 2016 and 2017.

Benefit Distribution

During the fall of 2015, DHR began a process of expanding the number of days each month that FSP benefits are distributed, from 10 days to 20 days. The expansion was phased in so that no customer would have to wait 5 days beyond when the distribution would have occurred in the past to receive the new benefits. The phase-in schedule was designed to limit the wait of customers beyond their typical distribution date and no change in the schedule occurred during the holiday periods (November and December). DHR notes that retailers previously had problems adequately stocking shelves during the peak distribution dates. The longer distribution schedule is expected to assist the retailers in ensuring adequate stocking of shelves, adequate staffing, and reduce long wait lines at store registers.

During the initial phase, DHR received some calls from customers related to the benefits not being available as expected or noting concerns because of the delays. DHR stated that LDSS and the department's constituent services staff were able to provide information on food pantries and food banks in the caller's area to assist them during the delay. **DHR should comment on whether any additional issues have occurred during the second phase of the transition of benefit distribution dates.**

The department indicated that there was minimal cost to the State to make the transition (slightly less than $50,000 split between general and federal funds for information technology (IT) system modifications).

3. Family Investment Administration Audit

In April 2015, the Office of Legislative Audits (OLA) released a fiscal compliance audit for FIA covering the period of July 1, 2010, through November 24, 2013. The audit included five findings, four of which were repeated from the prior audit, as shown in **Exhibit 16**. The four repeat findings are discussed in this issue.

Exhibit 16
Audit Findings

Audit Period for Last Audit:	July 1, 2010 – November 24, 2013
Issue Date:	April 2015
Number of Findings:	5
Number of Repeat Findings:	4
% of Repeat Findings:	80%
Rating: (if applicable)	n/a

Finding 1: **FIA lacked documentation of required computer matches, and system alerts were not always adequately resolved.**

Finding 2: Certain quality assurance reviews were not always conducted as required.

Finding 3: **Documentation required to support energy assistance recipient eligibility and the validity of payments was not always maintained.**

Finding 4: **Certain contract costs and deliverables were not adequately monitored.**

Finding 5: **FIA lacked procedures and documentation to support the TDAP recipient eligibility for certain cases and federal funds were not always recovered.**

FIA: Family Investment Administration
TDAP: Temporary Disability Assistance Program

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

Source: Office of Legislative Audits

Computer Matches

Finding 1 stated that FIA lacked documentation that required computer matches were performed and adequately resolved. These computer matches compare assistance recipient data in the Client Automated Resources and Eligibility System (CARES) including with data from the Social Security Administration, prison records, a new hire registry, and the Public Assistance Reporting Information System (PARIS). These matches provide data verification to ensure recipients are eligible for assistance and detect potential fraud. For example OLA noted that:

- FIA could not provide documentation of Social Security number matches before September 2013, PARIS matches before December 2012, and some new hire matches prior to October 2012;

- the alerts generated by the matches were not always recorded in CARES, and FIA did not always investigate why the alerts were not recorded; and

- a number of alerts remained unresolved for long period (as of January 2014, approximately 18,000 alerts related to unverified or missing Social Security numbers were unresolved for longer than six months, of which 10,500 were unresolved for longer than one year).

OLA noted that similar issues related to the Social Security number alerts were found in the two prior audits. OLA recommended that FIA ensure documentation is maintained that shows all computer matches are performed as required and results are investigated, determine the reasons and appropriateness of the reason for certain match results not being recorded in CARES as alerts, and ensure that LDSS investigate and resolve unverified or missing recipient Social Security numbers timely.

Energy Assistance Programs

Finding 3, discussed in further detail in the Office of Home Energy Programs budget analysis, stated that FIA did not ensure that adequate documentation was maintained by the Local Administering Agencies (LAA) to support applicant eligibility and the validity of payments for the energy assistance programs. OLA found that of 10 applications, 5 did not include required documentation including driver's licenses or lease agreements, 2 did not include documentation of the utility services, 4 did not include a signature to indicate a supervisory review was completed, and that 2 of the applications were approved more than 50 days beyond the 45-day requirement for processing program applications established in State regulations. OLA recommended that FIA ensure that LAAs obtain and maintain all required documentation to support critical energy assistance application data and approve or deny completed applications within the required timeframes.

Contract Monitoring

Finding 4 stated that the monitoring of contract costs and deliverables for certain contracts by FIA was insufficient, including contracts with State and local government agencies to provide services

such as training. OLA found that FIA did not sufficiently verify billed costs for three contracts, including a contract totaling $13.3 million related to SNAP nutrition education and training for which OLA noted that the reported salary costs did not include detail on the number of hours or dates of work. OLA explained that similar findings were noted in the prior two audits. OLA also noted that for another contract that FIA did not receive contractually required quarterly reports on certain economic benefits. OLA recommended that FIA obtain adequate documentation to verify the accuracy and propriety of contract billings and ensure that required contract deliverables are received.

TDAP

Finding 5 stated that FIA lacked procedures and documentation to ensure that TDAP payments were made only to eligible recipients and that federal funds were recovered. OLA found that out of 22 cases received:

- documentation including the application, medical forms, or Interim Assistance Reimbursement forms (filed with the Social Security Administration to allow FIA to receive federal reimbursement) could not be provided for 12 recipients who had received benefits totaling $76,025 between November 2008 and June 2014;

- cases were not closed for 3 to 19 months after the final decision by the Social Security Administration for 8 cases, despite a policy requiring immediate closure after a final decision (a repeat finding); and

- FIA did not receive reimbursements totaling $6,465 for 3 of 11 cases that the person was approved for SSI benefits because of delays in submitting the Interim Assistance Reimbursement forms.

OLA recommended that FIA establish procedures to ensure that all documentation required to establish eligibility is received and maintained prior to making payments, that TDAP cases are closed timely after a Social Security Administration final decision, and Interim Assistance Reimbursement Forms be appropriately filed and all reimbursements received.

Corrective Actions

In its response to the audit, DHR noted agreement with the findings and recommendations. Although for some, the agency had reservations about the recommendations. DHR explained the steps it would take to follow the recommendations. For example, DHR indicated it would expand its retention of computer match data from three quarters to four years for PARIS matches and that it would address why certain match results are not recorded in CARES as a system alert.

The Joint Audit Committee (JAC) continues to be concerned with the number and frequency of repeat audit findings across State agencies as cited by OLA. In an effort to satisfactorily resolve these findings, JAC has asked the budget committees to consider action in the agency budgets where such findings occur. As noted, this audit contained four repeat audit findings. **Therefore, DLS**

recommends withholding a portion of the administration's appropriation until OLA has determined that the repeat findings have been corrected.

4. No Wrong Door Report

The 2010 *Joint Chairmen's Report* (JCR) requested that DHR, in consultation with the Advisory Board for Maryland Access Point, convene a committee to address several specific topics including (1) a uniform application for all benefits; (2) enhanced or new information and case management technology; (3) customer information sharing; (4) partnerships with community organizations; (5) multiple community-based service access points; and (6) expedited eligibility processing. DHR was to submit a final report by June 30, 2011. In the fiscal 2011 *No Wrong Door Report,* a No Wrong Door approach was defined as an approach that, "…no matter how a person applies for benefits (at an agency or community organization, by phone, paper, or through an automated process), they should receive information about all available benefits and services offered in their community and be able to access all the programs for which they are eligible" (p. 7). Under the approach, there was not a single point of entry to benefit programs, but multiple points of entry that would provide customers with access to the full range of benefit programs.

Committee narrative in the 2015 JCR requested that DHR provide an update on the department's efforts to implement the recommendations contained in the *No Wrong Door Final Report* from fiscal 2011, including an analysis of additional steps that could be taken to ensure that Marylander's are able to access a full range of services from multiple entry points. The department was asked specifically to discuss:

- where gaps in services exist;
- how the department works with other State agencies to ensure individuals have access to and are aware of the full range of benefits and programs for which they are eligible;
- how coordination among agencies could be improved;
- whether expanding the scope of outreach workers' activities could further the goals of No Wrong Door; and
- whether it is feasible to create a grant program to implement innovative No Wrong Door strategies across the State.

Implementation of Recommendations

Applying for Benefits

DHR provided information on activities related to several recommendations related to applying for benefits. It should be noted that while the information provided by DHR highlights steps that have been taken to ease the application process for benefits administered by the agency, these steps show that there is not a common point of entry for individuals to access benefits administered by other agencies.

Uniform Application Including Both DHR and Non-DHR Benefits: DHR explained that FIA introduced a new short application that is available in multiple languages and online. This application is available for applying for cash assistance, child care services, FSP benefits, or medical assistance.

Alternative Service Delivery Mechanisms: DHR indicated that it recently replaced its previous online application portal with a new online application (myDHR) that can be used on mobile devices or computers (available for TCA, FSP, energy assistance, TDAP, and medical assistance including long-term care (LTC)). In addition, through this portal, a separate online application is available for child support services. The portal also provides a screening tool to determine potential eligibility for programs and a standalone application for only FSP benefits. There is also a feature that allows customers to update their account. For non-English speakers, the website provides a link to the application form on DHR's website available in multiple languages.

Streamlining Eligibility and Barriers to Express Lane Eligibility

DHR provided information on a variety of waivers or policies that limit the information or requirements for processing applications:

- postponing the required interview prior to issuing expedited FSP benefits in certain situations (an FSP waiver);

- allowing eligibility determination for LTC medical assistance based on written declaration pending verification after approval (a policy action);

- adjusting application processes and procedures, training and education, work activities, and other items to ensure equal opportunities (a policy action);

- processing applications upon receipt at a local office, even if the customer has an active case elsewhere (a policy action); and

- implementing a SNAP demonstration project to simplify the FSP application for individuals of a certain age who receive SSI benefits and a recently approved waiver (Elderly Simplified Application Project) for individuals of a certain age who do not receive SSI benefits (discussed later in this analysis).

These actions do not necessarily improve the ability of applicants for one benefit to receive other benefits, but improve the ease of applying for particular benefits.

Streamlining Access and Outreach

Co-location of LDSS Workers, Local Health Department Workers, Energy Assistance Workers, and Child Care Workers: DHR explained that Health Care Navigators are located in LDSS offices and community-based organizations administering other DHR programs and these individuals assist customers in applying for Medical Assistance and other health programs. DHR also noted that in most LDSS child support workers are co-located with FIA staff. DHR did not describe any other co-location of staff, but DLS would note that energy assistance is administered in some jurisdictions by LDSS. Outside of Health Care Navigators, these co-locations are not different than those that were occurring prior to the report.

Information and Outreach: The committee conducted a survey that identified the most frequently accessed benefits from respondents, the most useful information resources, and effective outreach strategies. DHR noted the State's most frequently accessed programs are Medicaid, FSP, and energy assistance. DHR identified some information resources, including the various State websites. DHR also noted its SNAP outreach partners and the partnerships of the energy assistance program with community action agencies and local governments.

Administrative, Legal Barriers, and Technology

Data Sharing, Enhancing or Implementing New Case Management Technology, and a Uniform Technology Platform: DHR explained that it is currently undertaking an IT modernization project. The first part of this project is to create a data warehouse that would include data that is shareable under confidentiality rules from various State agencies. The data warehouse would allow for the sharing of information provided on applications for benefits to be used for another application. However, the fiscal 2017 allowance does not include funding for an IT modernization project in DHR or a data warehouse.

DHR also noted that the various IT systems for child support, child welfare, and family investment share certain client information. In addition, DHR implemented an Enterprise Content Management Solutions system which allow for scanning of customer verifications into a secure common statewide database.

DHR also noted that the Maryland Health Connection offers an online application for health programs. This website also has links to other benefit program websites.

DHR also explained that through its partnership with the Benefits Data Trust (BDT) (an organization that focuses on increasing access to public benefits), DHR uses data from energy assistance and medical assistance to conduct outreach to individuals potentially eligible for FSP. In July 2015, BDT also began assisting elderly individuals applying for other programs in addition to FSP with funding from a private grant. DHR notes additional grants or general funds would be required to expand the outreach to other FSP outreach partners.

Consolidated Customer Hotline: DHR noted that the Maryland Health Connection has a toll-free number. DHR also noted that the DHR call center assists applicants and customers and may refer customers to the appropriate source for health questions.

Culture Shift

The committee encouraged a cultural shift for true integration within and across organizations. DHR explained that it collaborates with various organizations including the Department of Labor, Licensing, and Regulation (DLLR) for workforce activities, DHMH and the Health Benefit Exchange for medical assistance, and MSDE for the child care subsidy. DLS notes these collaborations were generally already in place prior to the *No Wrong Door Report* and some are also required by federal law (as in the connections between TANF and workforce activities under WIOA).

In the response, DHR provided updates on the fiscal 2011 *No Wrong Door Report*. In some ways the report makes it clear that there is still limited benefit coordination between agencies as most of the report focused on actions only within the department. The coordination mentioned was generally pre-existing to the report and it is not clear that any new coordination is occurring. The report also left the remainder of issues unaddressed, including the current service gaps, how coordination could be improved, and the feasibility of creating a grant program. **DLS recommends budget bill language withholding funds until the agency submits information on the issues of gaps in accessing services, how coordination among agencies could be improved, whether expanding the scope of outreach workers' activities could further the goals of No Wrong Door, and the feasibility of creating a grant program to implement innovative strategies across the State.**

Recommended Actions

1. Adopt the following narrative:

Able Bodied Adults Without Dependents Time Limit: The Supplemental Nutrition Assistance Program, known in Maryland as the Food Supplement Program (FSP), has a requirement that limits receipt of benefits for able bodied adults without dependents (ABAWD) to 3 months in a 36 month time period, unless the individual complies with certain work requirements. Statewide waivers were available in many states during and after the recent recession. Maryland's statewide waiver ended December 31, 2015. The committees are concerned about the impact of this transition on this vulnerable population. The committees request that the Department of Human Resources (DHR) report on the number of individuals removed from FSP benefits by month and jurisdiction from January 2016 through November 2016 and the number by month and jurisdiction who were able to return to the program after complying with work requirements. The department should include a discussion of the impact of the end of the waiver on ABAWD individuals and the agency.

Information Request	**Author**	**Due Date**
Report on ABAWD individuals removed from FSP due to the program time limit	DHR	December 15, 2016

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

, provided that since the Department of Human Resources (DHR) Family Investment Administration has had four or more repeat findings in the most recent fiscal compliance audit issued by the Office of Legislative Audits (OLA), $100,000 of this agency's administrative appropriation may not be expended unless:

(1) DHR has taken corrective action with respect to all repeat audit findings on or before November 1, 2016; and

(2) a report is submitted to the budget committees by OLA listing each repeat audit finding along with a determination that each repeat finding was corrected. The budget committees shall have 45 days to review and comment to allow for funds to be released prior to the end of fiscal 2017.

Explanation: The Joint Audit Committee has requested that budget bill language be added for each unit of State government that has four or more repeat audit findings in its most recent fiscal compliance audit. Each such agency is to have a portion of its administrative budget withheld pending the adoption of corrective action by the agency and a determination by OLA

that each finding was corrected. OLA shall submit reports to the budget committees on the status of repeat findings.

Information Request	Author	Due Date
Status of corrective actions related to the most recent fiscal compliance audit	OLA	45 days before the release of funds

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

Further provided that $100,000 of this appropriation made for the purpose of administration in the Family Investment Administration may not be expended until the Department of Human Resources submits a report to the budget committees providing information on additional steps that could be taken to ensure Marylanders are able to access a full range of services from multiple entry points, identifying gaps in access to services, explaining how the department works with other State agencies to ensure that individuals have access to and are aware of the full range of benefits and programs for which they are eligible, discussing how coordination among agencies could be improved, discussing whether expanding the scope of outreach workers' activities could further the goal of No Wrong Door, and discussing the feasibility of creating a grant program to implement innovative No Wrong Door strategies across the State.

Explanation: The 2015 Joint Chairmen's Report included committee narrative requesting that the Department of Human Resources (DHR) update the committees on the department's efforts to implement recommendations contained in the 2011 No Wrong Door Report, including an analysis of additional steps that could be taken to ensure that Marylanders are able to access a full range of services from multiple entry points. The committees also requested that the agency specifically address certain items including where gaps in access to services exist and how coordination among the agencies can be improved. In its response, the department updated the committees on actions related to the recommendations in the 2011 No Wrong Door Report, but did not address some of the other requests of the committee. This language restricts funds until the department addresses these issues.

Information Request	Author	Due Date
Report on gaps in access to services and improved coordination	DHR	November 1, 2016

Updates

1. Improving SNAP Outreach to Seniors

In April 2014, Mathematica Policy Research (Mathematica) released *Reaching the Underserved Elderly and Working Poor in SNAP: Evaluation Findings from the Fiscal Year 2009 Pilots* final report. This report was conducted under contract with the U.S. Department of Agriculture (USDA). In the report, Mathematica evaluated six demonstration projects testing models of facilitating SNAP access among the elderly or working poor. Michigan, Pennsylvania, and Ohio tested methods of facilitating access to SNAP for the elderly and Wisconsin, Washington, and Massachusetts tested methods of facilitating access to SNAP for the working poor. This update will focus on those states that sought to increase access for the elderly.

Michigan

Michigan's project attempted to raise awareness of SNAP and reduce the burden of the application process. Michigan eliminated the need to visit a SNAP office to apply for the program and attempted to minimize other problems faced by the elderly while applying for assistance (mobility, application complexity, and lack of understanding). The activities in Michigan were largely conducted through an existing partner and community organizations. Michigan received a waiver that allowed the community organizations to conduct the eligibility interviews mostly done by telephone (although the decision on the application was still made by the state). Community organizations also assisted the applicants in assembling verification documents and submitting the completed applications. The organization running the pilot received lists of individuals already receiving other assistance benefits, used voter registration lists, and sent mailings to individuals that had previously used the project partner's services in the demonstration areas.

Mathematica was not able to test whether there was an increase in the applications as a result of the project because of data availability. However, Mathematica found that there was an increase in the participation in SNAP by the elderly in the demonstration counties after 13 months and 31 months from the submission of the first demonstration-related application, even after controlling for other trends and economic factors.

Pennsylvania

Pennsylvania's project was designed to increase the elderly's comfort with SNAP by increasing understanding and reducing stigma associated with receiving assistance and easing the burden of the application process. The Department of Public Welfare partnered with BDT. Pennsylvania received waivers allowing individuals to self-declare medical expenses and allowed demonstration staff to conduct eligibility interviews (although the local SNAP offices retained responsibility for the eligibility determination). Applicants were also able to self-declare shelter expenses and other data that the state had verified for other programs within six months (income, residency, and citizenship). Applicants could also "sign" the application over the telephone. BDT received information from the Department of Public Welfare on seniors recently approved for other benefits that were not receiving SNAP and

targeted these groups for outreach. BDT also provided application assistance based on the circumstances of the seniors different levels of screening and document verification required.

Mathematica found no effects on applications after controlling for other trends and economic factors. However, Mathematica did find an increase in participation after controlling for other trends and economic factors by 17 months after the beginning of the demonstration.

Ohio

Ohio's demonstration project focused on reducing barriers related to mobility and transportation in applying for SNAP and reducing stigma in receiving benefits. Ohio contracted with an organization to conduct the project with which it had a prior partnership. The organization primarily conducted outreach, provided screening and application assistance at various community sites, and completed public service announcements. Mathematica found fewer applications were received from the project than anticipated, and no increase in applications or participation after controlling for other trends or economic factors.

Mathematica's Conclusions

Mathematica noted that two of the three demonstration projects that targeted the elderly had increased to access to SNAP. Mathematica highlighted that these two states (Michigan and Pennsylvania) were the two pilots that simplified the application process and used strategies that compared lists (largely of other program participants) to target those that were likely eligible for SNAP. Mathematica explained that all of the states (including those that targeted the working poor) used a combination of:

- engagement;
- application assistance; and
- a simplified application process (including receiving waivers in Michigan and Pennsylvania).

JCR Response

Committee narrative in the 2015 JCR requested that DHR submit a report on strategies that can help eligible seniors start to receive SNAP benefits, particularly those outlined in the Mathematica report. DHR noted in its response that it had received performance bonuses in fiscal 2012, 2013, and 2014 for program participation. In addition, DHR explained that between fiscal 2010 and 2015, the percent of the caseload that were seniors increased from 6.6% to 11.2% (an increase from 38,238 to 78,810 seniors).

DHR partners with 14 community-based organizations that provide outreach to certain groups including the elderly, one of which is BDT. According to DHR, in total, in calendar 2013 and 2014, these partners assisted 200,000 households. Between August 2012 and August 2015, BDT assisted

36,915 seniors file applications for SNAP benefits. DHR also noted that it currently conducts strategies discussed in the Mathematica report to increase participation.

DHR also explained that it was working with the USDA to allow the State to participate in a demonstration project (Elderly Simplified Application Project). According to USDA, Elderly Simplified Application demonstration projects are for elderly households that have no earned income and includes waivers that extend the certification period for benefits, allows agencies to use data matches for verification of information rather than documentation unless the information is questionable, and eliminates the need for an interview at recertification. In November 2015, DHR was granted the waiver to conduct this project and has two years to begin to implement it. DHR is evaluating whether to implement the project with the existing IT system or under its planned modernization project.

2. Refugee Assistance Programs

Refugees are individuals granted protective status while abroad based on a credible fear of being persecuted on the grounds of race, religion, nationality, social group, or political stand. Asylees are those granted protective status after entering the United States. The majority of refugees resettled in the United States are referred by the United Nations High Commissioner on Refugees (75%), while the remainder apply directly under special programs such as individuals from Iraq that worked with the military.

Refugee Resettlement Program

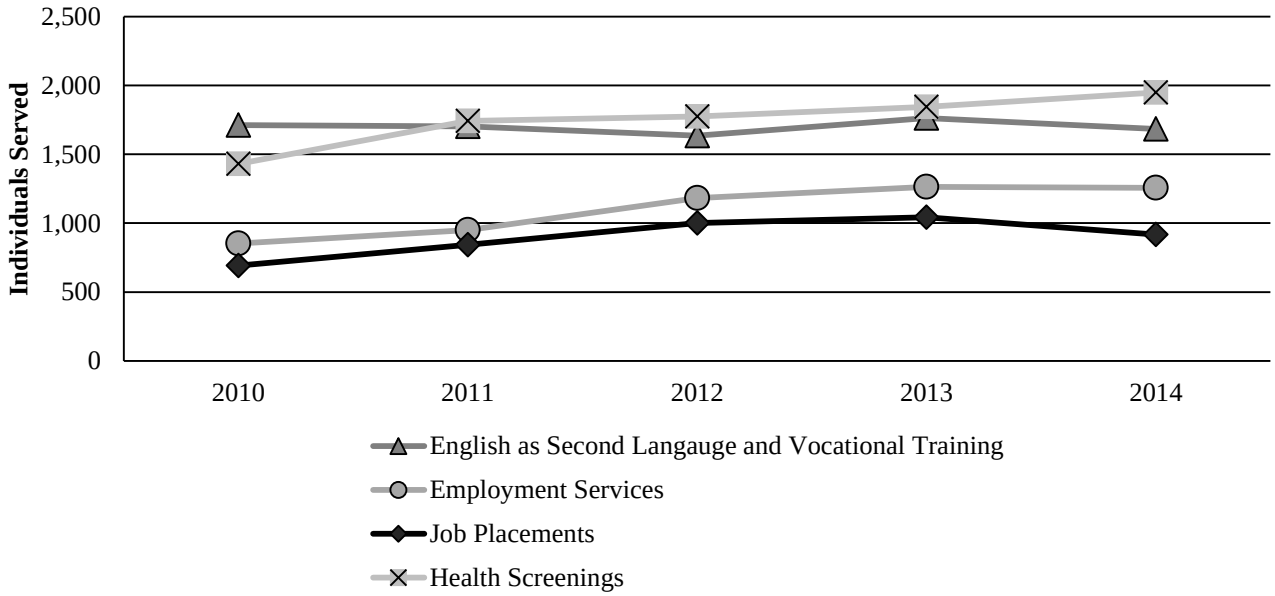
Before being admitted to the United States as a refugee, those seeking this status must be interviewed in person by Department of Homeland Security staff, undergo security checks, and undergo medical exams. Security screening involves the National Counterterrorism Center, the Federal Bureau of Investigation's Terrorist Screening Center, the Department of Homeland Security, the Department of Defense, and others. The process typically takes between 18 and 24 months from the referral.

Refugee Resettlement Services

The U.S. Department of State, in conjunction with nine resettlement programs, work together to place refugees for resettlement. Meetings are held each week, at which the needs of a particular refugee are matched with a community. Refugees with a relative in the United States are often resettled near that family. The resettlement programs have local affiliates, and individuals from the local affiliate (or the local family member) are expected to meet the refugee at the airport. Resettlement agencies and affiliates are responsible for providing (1) basic support for at least 30 days including housing, furnishings, basic necessities, and food allowances; (2) assistance in applying for Social Security cards; (3) assistance in obtaining health and mental health services; (4) assistance in obtaining benefits and enrolling in employment services; (5) assistance in enrolling children in school; (6) two home visits in the first 30 days of placement; (7) case management; and (8) cultural orientation.

Support for refugees during the first three months is provided by the Department of State, after which time the support for refugees is provided by the U.S. Department of Health and Human Services Office of Refugee Resettlement. MORA operates and administers the Office of Refugee Resettlement programs for the State. These programs are entirely federally funded. Programs offered by MORA are cash assistance, medical assistance, health screening, employment services, and English language instruction. Refugee cash assistance and refugee medical assistance are available for the first eight months after arrival, other services are generally available for five years. Beginning in fiscal 2016, most services in Maryland are provided through local resettlement agencies as grantees of MORA. **Exhibit 17** provides information on services provided by MORA from federal fiscal 2010 through 2014.

Exhibit 17
MORA Services
Federal Fiscal 2010-2014



MORA: Maryland Office for Refugees and Asylees

Note: Services are provided to both refugees and asylees.

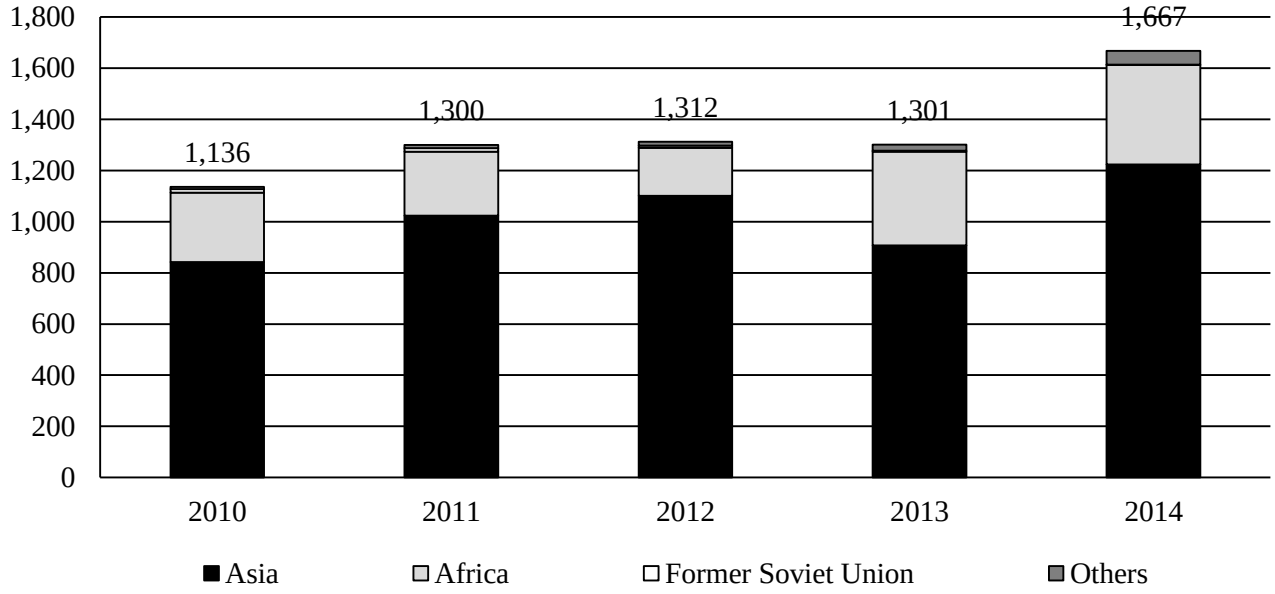
Source: Department of Human Resources, *Refugee and Asylee Resettlement in Maryland 2010 -2014: Statistical Abstract*

Refugees and Asylees

From federal fiscal 2010 to 2014, Maryland received 2.0% of the refugees resettled in the United States. California and Texas received the largest share of refugees during this time, 10.0% each. The number of refugees resettled in Maryland was approximately 1,300 per year between fiscal 2011

and 2013, as shown in **Exhibit 18**. In federal fiscal 2014, the number of refugees resettled in Maryland increased by 28.1%, to 1,667. In federal fiscal 2015, a total of 1,803 refugees were resettled in Maryland.

Exhibit 18
Refugees by Area of Origin
Federal Fiscal 2010-2014

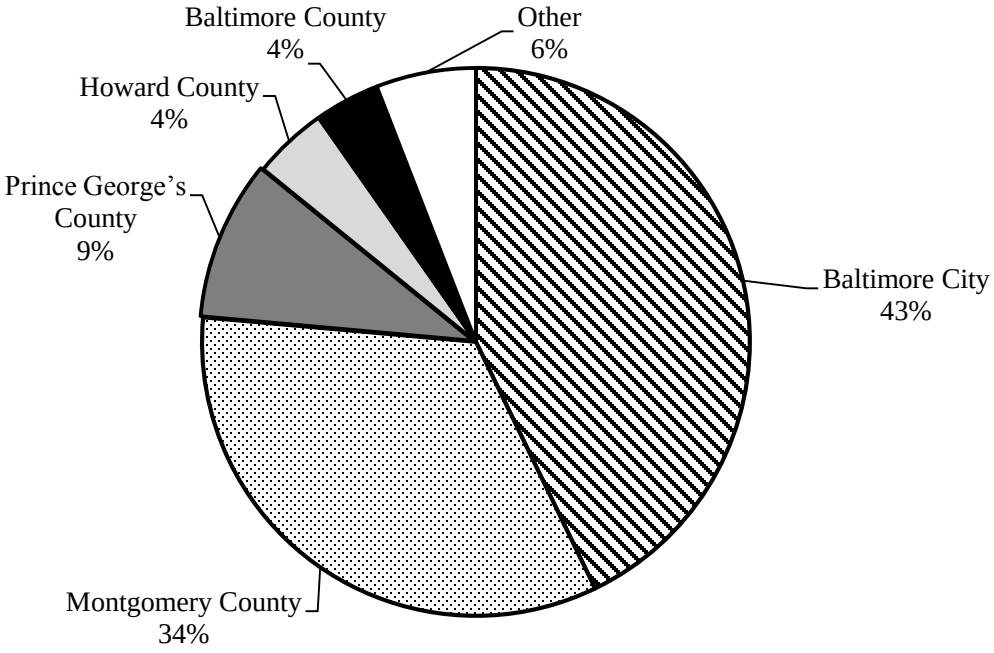


Source: Department of Human Resources, *Refugee and Asylee Resettlement in Maryland 2010 -2014: Statistical Abstract*

From federal fiscal 2010 through 2014 the majority of the resettled refugees were from Asia. In total, during this time 75.9% of resettled refugees from Asia were primarily from Burma, Bhutan, and Iraq. In federal fiscal 2015, the primary countries of origin for resettled refugees were Iraq, Afghanistan, Democratic Republic of Congo, Burma, Eritrea, and Burundi. Between October 1, 2010, and October 30, 2015, 40 refugees from Syria were resettled in Maryland.

The largest share of refugees were settled in Baltimore City and Montgomery County, as shown in **Exhibit 19**. Combined, these jurisdictions received 76.4% (5,133) of the refugees resettled in Maryland between federal fiscal 2010 and 2014.

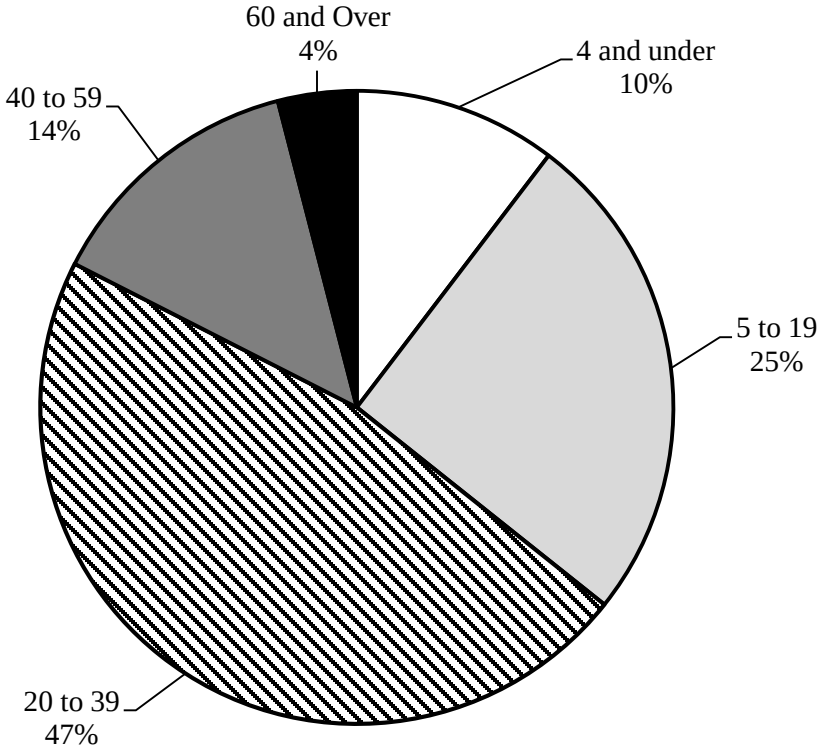
Exhibit 19
Refugees by Area of Resettlement
Federal Fiscal 2010-2014



Source: Department of Human Resources, *Refugee and Asylee Resettlement in Maryland 2010 -2014: Statistical Abstract*

Slightly more than half of the refugees resettled in Maryland between federal fiscal 2010 and 2014 were male (55.4%). Between federal fiscal 2010 and 2014, 46.8% of the refugees resettled in Maryland were between the ages of 20 and 39, as shown in **Exhibit 20**. The median age at arrival was 25. Approximately one quarter (25.3%), were school aged children (5 to 19 years old) with an additional 10.4% younger than school age. The share of children 4 or younger and school age children was highest in federal fiscal 2014.

Exhibit 20
Refugees by Age at Arrival
Federal Fiscal 2010-2014



Source: Department of Human Resources, *Refugee and Asylee Resettlement in Maryland 2010 -2014: Statistical Abstract*

Maryland received 3,955 asylees between federal fiscal 2010 and 2014. The vast majority of the asylees were from Africa (82%), primarily Ethopia and Cameroon. The majority of asylees resettled in Montgomery County (55%). The asylee population was slightly older than the refugee population, with a median age of 30 and 62% of the asylee population between 20 and 39 years of age. As with refugee data, slightly more than half of the asylees were male (52%).

Federal Fiscal 2016 Resettlement Plans

In October 2015, MORA anticipated receiving a total of 2,093 refugees in federal fiscal 2016. Slightly more than half of the anticipated refugees (50.5% or 1,058) were expected to have a relative already in the United States.

In the wake of the terrorist attacks in Paris, there have been calls for slowing down or stopping placement of Syrian refugees at both the State and federal level. On November 25, 2015, the Director of the federal Office of Refugee Resettlement sent a letter to State refugee assistance offices to explain

the federal screening process of refugees, and that under federal law states in the state plan for refugee assistance must include an assurance that the state will provide assistance and services "without regard to race, religion, nationality, sex, or political opinion." In addition, the director noted that states cannot deny refugee services and benefits based on the country of origin or religious affiliation of the refugee. The letter explains, "[a]ccordingly, states may not categorically deny ORR-funded benefits and services to Syrian refugees. Any state with such a policy would not be in compliance with the State Plan requirements, applicable statutes, and their own assurances, and could be subject to enforcement action, including suspension or termination" (Dear Colleague Letter- 16 -02). The letter also explains that the Civil Rights Act of 1964 also prohibits discrimination in programs that receive federal funding on the basis of national origin.

3. Re-authorization of TANF

TANF must be periodically reauthorized by Congress. TANF's most recent reauthorization occurred in the Deficit Reduction Act of 2005. This reauthorization ended in federal fiscal 2010 (September 30, 2010). Since that time, TANF has operated on a series of temporary extensions. TANF is currently operating under a temporary extension approved in the Consolidated Appropriations Act, 2016 that passed in December 2015. This extension expires September 30, 2016. The extension includes funding for TANF contingency funds.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHR – Family Investment Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$138,968	$21,256	$1,528,556	$1,385	$1,690,165
Deficiency Appropriation	500	0	12,155	0	12,655
Cost Containment	-1,748	0	0	0	-1,748
Budget Amendments	7,304	3,272	12,605	0	23,181
Reversions and Cancellations	0	-12,681	-100,925	-1,066	-114,672
Actual Expenditures	**$145,024**	**$11,847**	**$1,452,391**	**$319**	**$1,609,581**
Fiscal 2016					
Legislative Appropriation	$138,351	$19,364	$1,443,543	$0	$1,601,257
Budget Amendments	-305	42	334	0	71
Working Appropriation	**$138,046**	**$19,406**	**$1,443,876**	**$0**	**$1,601,328**

DHR: Department of Human Resources

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

The fiscal 2015 expenditures of FIA were $80.6 million lower than the legislative appropriation. The fiscal 2015 general fund expenditures of FIA were $6.1 million higher than the legislative appropriation. The majority of the increase occurs as the result of salary and wage adjustments, including the fiscal 2015 cost-of-living adjustment (COLA) ($7.9 million). An increase of $500,000 is the general fund share of a deficiency appropriation to provide funds to support 45 new regular positions created by the Board of Public Works (BPW) in the Local Family Investment program to support medical assistance and health benefit application processing. The remaining increase ($366,725) supports technical and special fees for contractual staff related to the Promoting Responsible Fatherhood program. These increases are partially offset by lower expenditures resulting from:

- the administration's share of the across-the-board reduction included in the January 2015 BPW cost containment actions including holding positions vacant, reducing the call center contract, reducing funding for agreements with DLLR and the Governor's Workforce Investment Board, reducing funding for disability determination services contracts, and replacing general funds with federal funds for TCA ($1.3 million);

- a decrease in TCA ($840,072);

- the administration's share of holding positions vacant throughout DHR as part of cost containment actions approved by BPW in July 2014 ($450,000);

- savings under the Voluntary Separation Program ($108,889); and

- a realignment of telecommunications expenses through various executive agencies ($4,629).

The fiscal 2015 special fund expenditures of FIA were $9.4 million lower than the legislative appropriation. Increases totaling $3.3 million occurred by budget amendment for salary and wage adjustments including the fiscal 2015 COLA. These increases were more than offset by cancellations totaling $12.7 million, primarily from the Child Support Offset fund (which offsets TCA expenditures) and Interim Assistance Reimbursement (which offsets TDAP expenditures) ($12.1 million). The remaining cancellations ($541,579) result from lower than anticipated receipt of local government payments.

The fiscal 2015 federal fund expenditures of FIA were $76.2 million lower than the legislative appropriation. Deficiency appropriations resulted in a net increase of $12.2 million, largely due to available TANF contingency funds ($11.5 million). Other deficiency appropriations provided an increase of $1.5 million for the federal fund share of costs associated with 45 new regular positions created by BPW in the Local Family Investment program to support medical assistance and health benefit application processing and a decrease of $800,000 to reduce TANF to address a prior year shortfall. Other increases are the result of:

- the value of commodities in the Temporary Emergency Food Assistance Program (TEFAP) ($5.6 million);

- salary and wage adjustments including the fiscal 2015 COLA ($4.5 million);

- contractual services for the FSP nutrition education program and the substance abuse treatment program ($1.7 million);

- contractual services associated with the subsidized employment program ($561,071); and

- contractual services associated with TEFAP ($236,679).

These increases are more than offset by cancellations totaling $100.9 million, largely due to a lower than anticipated SNAP caseload.

FIA also cancelled $1.1 million of the reimbursable fund appropriation due to the lack of available reimbursable funds for health care related activities.

Fiscal 2016

To date, the fiscal 2016 appropriation of FIA has increased by $70,709. An increase of $2.1 million is the result of the restoration of the 2% pay reduction ($1.5 million federal funds, $527,252 general funds, and $42,184 special funds). This increase is partially offset by a decrease of $2.0 million due to the realignment of the 2% across-the-board reduction and the addition of the federal fund share of the reductions ($832,528 general funds and $1.2 million federal funds).

Object/Fund Difference Report
DHR – Family Investment Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	2,113.42	2,093.42	2,089.42	-4.00	-0.2%
02 Contractual	88.42	68.00	68.00	0.00	0%
Total Positions	**2,201.84**	**2,161.42**	**2,157.42**	**-4.00**	**-0.2%**
Objects					
01 Salaries and Wages	$ 148,150,394	$ 134,884,508	$ 146,126,741	$ 11,242,233	8.3%
02 Technical and Spec. Fees	4,076,088	2,517,319	2,592,524	75,205	3.0%
03 Communication	1,178,986	1,180,611	1,039,570	-141,041	-11.9%
04 Travel	228,651	177,374	178,086	712	0.4%
06 Fuel and Utilities	1,533,142	1,655,985	1,575,769	-80,216	-4.8%
07 Motor Vehicles	54,006	25,038	19,781	-5,257	-21.0%
08 Contractual Services	65,133,307	60,150,994	59,490,036	-660,958	-1.1%
09 Supplies and Materials	1,315,616	786,541	1,037,593	251,052	31.9%
10 Equipment – Replacement	18,399	0	0	0	0.0%
11 Equipment – Additional	115,140	0	0	0	0.0%
12 Grants, Subsidies, and Contributions	1,374,152,365	1,385,419,316	1,372,505,850	-12,913,466	-0.9%
13 Fixed Charges	13,625,197	14,530,277	14,687,132	156,855	1.1%
Total Objects	**$ 1,609,581,291**	**$ 1,601,327,963**	**$ 1,599,253,082**	**-$ 2,074,881**	**-0.1%**
Funds					
01 General Fund	$ 145,024,485	$ 138,045,677	$ 143,452,424	$ 5,406,747	3.9%
03 Special Fund	11,847,260	19,405,906	16,212,775	-3,193,131	-16.5%
05 Federal Fund	1,452,390,836	1,443,876,380	1,439,587,883	-4,288,497	-0.3%
09 Reimbursable Fund	318,710	0	0	0	0.0%
Total Funds	**$ 1,609,581,291**	**$ 1,601,327,963**	**$ 1,599,253,082**	**-$ 2,074,881**	**-0.1%**

DHR: Department of Human Resources

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHR – Family Investment Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
02 Local Family Investment Program	$ 157,905,094	$ 157,994,924	$ 167,128,183	$ 9,133,259	5.8%
08 Assistance Payments	1,347,636,311	1,351,000,863	1,337,067,106	-13,933,757	-1.0%
10 Work Opportunities	34,680,216	33,288,084	33,311,034	22,950	0.1%
04 Director's Office	37,121,490	31,518,321	34,350,084	2,831,763	9.0%
05 Maryland Office for New Americans	13,264,792	14,396,684	14,215,543	-181,141	-1.3%
07 Office of Grants Management	18,973,388	13,129,087	13,181,132	52,045	0.4%
Total Expenditures	**$ 1,609,581,291**	**$ 1,601,327,963**	**$ 1,599,253,082**	**-$ 2,074,881**	**-0.1%**
General Fund	$ 145,024,485	$ 138,045,677	$ 143,452,424	$ 5,406,747	3.9%
Special Fund	11,847,260	19,405,906	16,212,775	-3,193,131	-16.5%
Federal Fund	1,452,390,836	1,443,876,380	1,439,587,883	-4,288,497	-0.3%
Total Appropriations	**$ 1,609,262,581**	**$ 1,601,327,963**	**$ 1,599,253,082**	**-$ 2,074,881**	**-0.1%**
Reimbursable Fund	$ 318,710	$ 0	$ 0	$ 0	0.0%
Total Funds	**$ 1,609,581,291**	**$ 1,601,327,963**	**$ 1,599,253,082**	**-$ 2,074,881**	**-0.1%**

DHR: Department of Human Resources

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

N00I0006
Office of Home Energy Programs
Department of Human Resources

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
Special Fund	$59,404	$70,380	$77,589	$7,209	10.2%
Deficiencies and Reductions	0	0	-3	-3	
Adjusted Special Fund	**$59,404**	**$70,380**	**$77,586**	**$7,206**	**10.2%**
Federal Fund	64,068	67,192	63,216	-3,976	-5.9%
Deficiencies and Reductions	0	0	-2	-2	
Adjusted Federal Fund	**$64,068**	**$67,192**	**$63,214**	**-$3,978**	**-5.9%**
Adjusted Grand Total	**$123,471**	**$137,572**	**$140,800**	**$3,228**	**2.3%**

- The fiscal 2017 allowance of the Department of Human Resources (DHR) Office of Home Energy Program (OHEP) increases by $3.2 million, or 2.3%, compared to the fiscal 2016 working appropriation after accounting for the back of the bill reduction for health insurance.

- Special funds increase by $7.2 million, or 10.2%, in the fiscal 2017 allowance compared to the fiscal 2016 working appropriation, primarily from the Strategic Energy Investment Fund due to estimated revenue. Federal funds decrease by $4.0 million, or 5.9%, in the fiscal 2017 allowance compared to the fiscal 2016 working appropriation.

- Major changes occur among funds available for energy assistance benefits and contracts for local administering agencies.

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

For further information contact: Tonya D. Zimmerman Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	16.87	16.87	16.87	0.00
Contractual FTEs	3.95	0.00	0.00	0.00
Total Personnel	**20.82**	**16.87**	**16.87**	**0.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	1.68	9.98%
Positions and Percentage Vacant as of 12/31/15	2.00	11.86%

- There are no changes in the number of regular positions in the fiscal 2017 allowance for OHEP.
- Turnover expectancy in OHEP increases from 7.21% to 9.98% in the fiscal 2017 allowance.
- As of January 1, 2016, OHEP had a vacancy rate of 11.86%, or 2.0 positions. To meet the turnover expectancy of 9.98%, OHEP needs to maintain 1.68 vacant positions.

Analysis in Brief

Major Trends

Demand for Energy Assistance: In fiscal 2015, energy assistance applications declined for the third time in four years. Households receiving energy assistance also declined, and the two bill assistance programs served the fewest households since fiscal 2008. Through December 2015, fiscal 2016 shows a similar trend. Improvements in the economy and weather play key roles in these declines. Benefit amounts have increased in fiscal 2016, which has led to higher spending ($3.2 million or 4.5%) through December 2015 than in the prior year even with fewer recipients.

Percent of Eligible Households Receiving Benefits Continues to Decline: The percent of eligible households receiving benefits continues to decline, falling to near 30.0% in fiscal 2015 (30.8% for the Electric Universal Service Program bill payment and 30.2% for the Maryland Energy Assistance Program). OHEP sought requests for outreach activities from local aging agencies in fiscal 2016. The OHEP fiscal 2017 allowance includes $100,000 for outreach activities.

Benefits Provided to Targeted Populations: After reaching 46.5% in fiscal 2012, the percent of eligible households with children under the age of 6 receiving energy assistance has fallen in each year. In fiscal 2015, only 33.0% of these households received assistance. The percent of eligible households with an individual over the age of 60, or an individual with disabilities receiving benefits, remained under 30.0% in fiscal 2015.

Issues

Program Enhancements: In a report submitted in fiscal 2015, the Public Service Commission indicated that DHR was considering enhancements to the energy assistance program as a result of higher revenue available to the program. The 2015 *Joint Chairmen's Report* requested that DHR provide information on program enhancements implemented in fiscal 2016 and planned for fiscal 2017. The responses indicated that DHR is still in the planning stages of program changes but that the agency expects to begin implementing some changes in fiscal 2017. The details of these changes are still in discussion by various workgroups and advisory groups.

Energy Assistance Application Processing Times: Statewide, average energy assistance application processing times improved for the period through December 20, 2015, in fiscal 2016, compared to a similar period in fiscal 2015 (through December 16, 2014), from 29 days to 27 days. These processing times are well within the termination protection period of 55 days. In addition, the percent of applications processed in longer than 55 days decreased from 17% to 11% between these two years. Despite the statewide improvement, some jurisdictions application processing timeliness have worsened.

Recommended Actions

1. Adopt committee narrative requesting information on application processing times.
2. Adopt committee narrative requesting information on outreach plans.
3. Adopt committee narrative requesting information on program changes including anticipated legislative changes.

Updates

Audit Findings Related to the Energy Assistance Programs: The fiscal compliance audit of the Family Investment Administration released by the Office of Legislative Audits contained one finding specific to the energy assistance program related to maintaining adequate documentation. The Baltimore City Single Audit for fiscal 2013 contained four findings specific to the management of the Low-Income Home Energy Assistance Program related to missing documentation, questionable payments, weaknesses in internal controls, and discrepancies in the application process. OHEP indicates that in response to these audits, monitoring of local administering agencies has been improved. In addition, DHR notes that the document management system implemented by the agency should address some of the documentation concerns in the audits.

N00I0006
Office of Home Energy Programs
Department of Human Resources

Operating Budget Analysis

Program Description

The Office of Home Energy Programs (OHEP) is a program of the Family Investment Administration (FIA) in the Department of Human Resources (DHR). The services of OHEP include cash benefits, budget counseling, vendor arrangements, referrals, and assistance with heating/cooling equipment repair and replacement.

OHEP administers the following two energy assistance programs for residential customers: (1) the Maryland Energy Assistance Program (MEAP) funded by the federal Low-Income Home Energy Assistance Program (LIHEAP) providing bill payment assistance, crisis assistance, and furnace repair/replacement for a variety of heating sources; and (2) the Electric Universal Service Program (EUSP) funded from a ratepayer surcharge and an allocation of revenue from the Regional Greenhouse Gas Initiative (RGGI) carbon dioxide emission allowance auctions (budgeted through the Strategic Energy Investment Fund (SEIF)) that provides both bill payment and arrearage assistance to electric customers. These programs are administered using local administering agencies (LAA), including local departments of social services, in each county and Baltimore City. Two LAAs serve multiple counties: (1) the Southern Maryland Tri-County Community Action Committee, Inc. serves Calvert, Charles, and St. Mary's counties; and (2) Shore UP! Inc. serves Somerset, Wicomico, and Worcester counties. All other LAAs serve one jurisdiction.

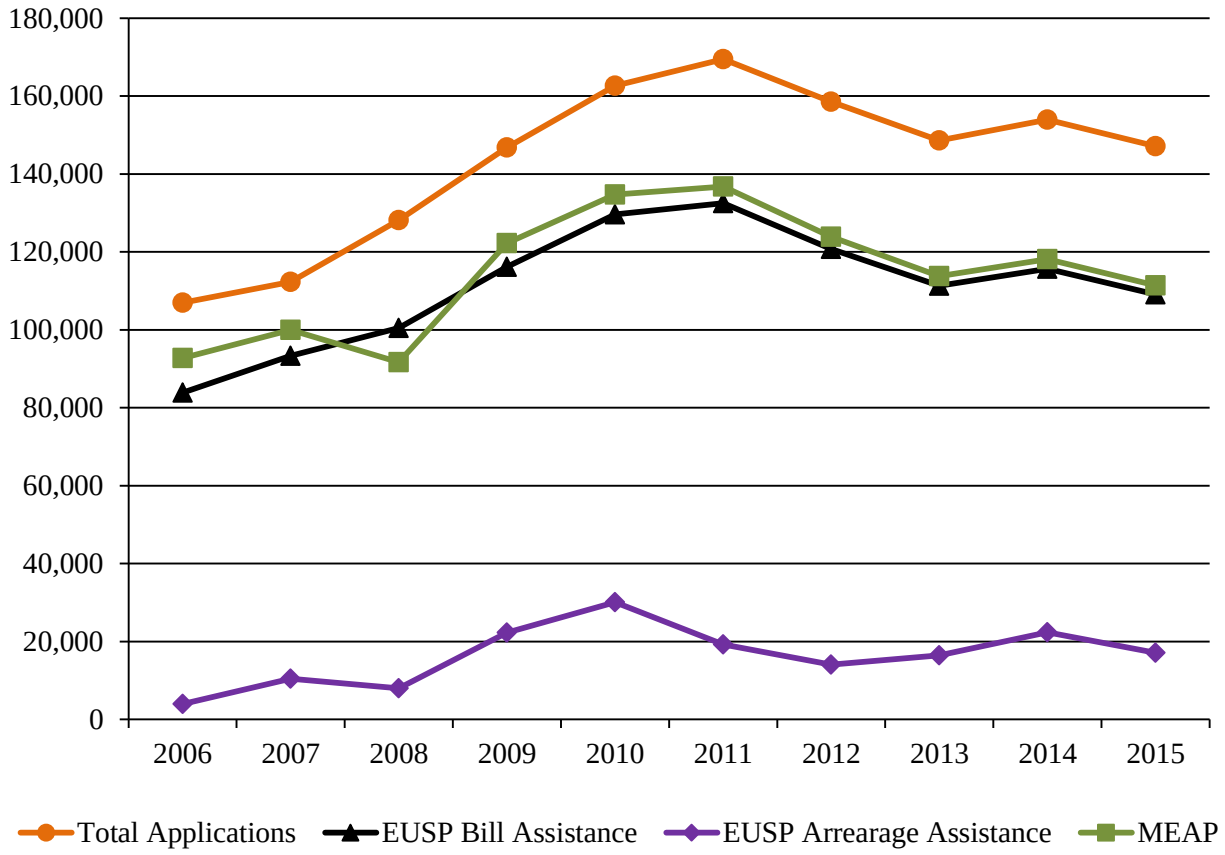
DHR has one key goal related to the work of OHEP, which is that Maryland residents have access to essential services to support themselves and their families. In addition, DHR has an overall goal to be recognized as a national leader among human service agencies.

Performance Analysis: Managing for Results

1. Demand for Energy Assistance

As shown in **Exhibit 1**, total energy assistance applications declined for the third time in four years, a decrease of 4.4%. Energy assistance applications were at the lowest level since fiscal 2009. Similarly, households receiving EUSP bill payment assistance and households receiving MEAP assistance also declined for the third time in four years, with declines of 5.7% for each program, and the programs served the fewest households since fiscal 2008. DHR attributes these declines to improvements in the economy and the winter weather.

Exhibit 1
OHEP Benefits Provision History
Fiscal 2006-2015

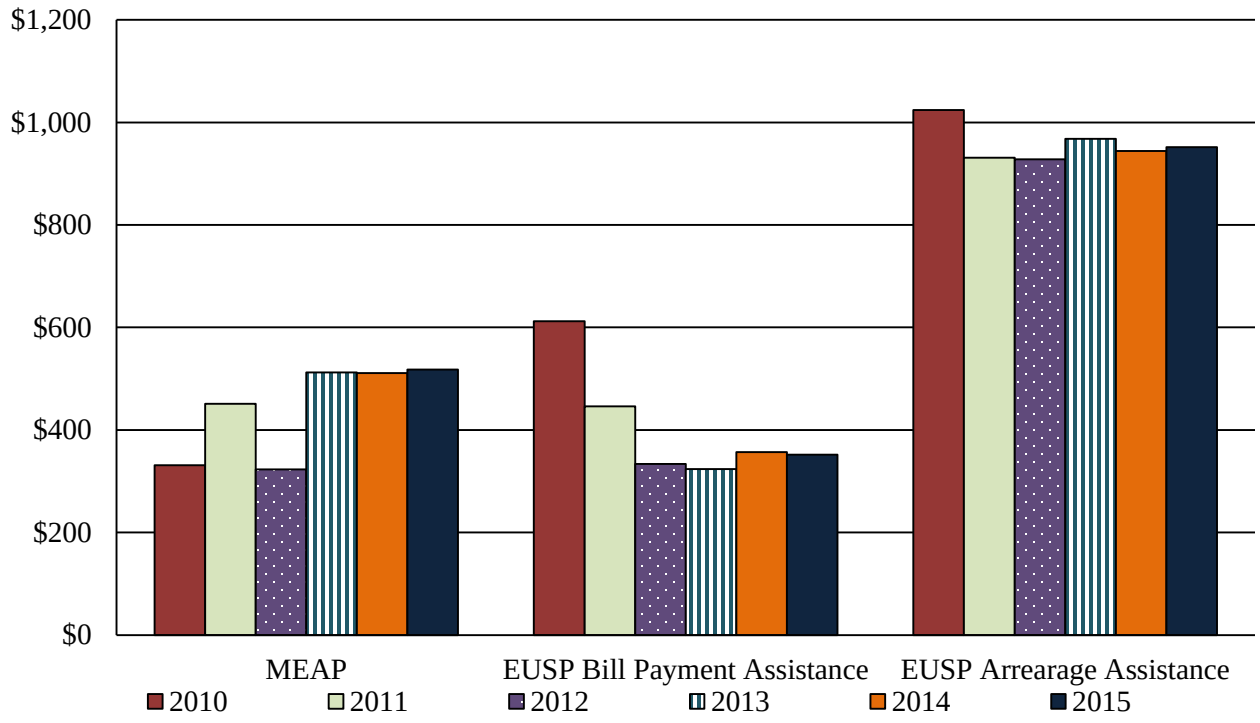


EUSP: Electric Universal Service Program
MEAP: Maryland Energy Assistance Program
OHEP: Office of Home Energy Programs

Source: Department of Human Resources

Households receiving EUSP arrearage assistance declined in fiscal 2011 and 2012 in part due to informal caps on spending in the program due to funding limitations. In fiscal 2013 and 2014, additional funding was available for these benefits, and the number of households receiving EUSP arrearage assistance increased. The number of households receiving EUSP arrearage assistance declined in fiscal 2015, a decrease of 23.8%, due to lower demand. However, as shown in **Exhibit 2**, the average benefit for those receiving EUSP arrearage assistance was slightly higher in fiscal 2015 than the prior year.

Exhibit 2
Average Grant Amounts
Fiscal 2010-2015



EUSP: Electric Universal Service Program
MEAP: Maryland Energy Assistance Program

Note: Average grants do not include supplemental benefits offered for certain MEAP recipients (fiscal 2012, 2013, and 2014) and EUSP bill payment assistance recipients (fiscal 2014).

Source: Department of Human Resources

For EUSP bill assistance and MEAP, an individual's benefit is calculated based on income level, energy usage, energy cost, and utility service territory. Garrett County also receives payments at a higher level for MEAP because of the longer winter heating season. The income portion of the calculation is used to determine a percent of the bill paid. Incomes are grouped into categories (0.0% to 75.0% of federal poverty level (FPL), 75.0% to 110.0% of FPL, 110.0% to 150.0% of FPL, 150.0% to 175.0% of FPL). The percent of the bill paid varies by electricity and heat source for MEAP. Average benefits are largely influenced by the percent of bill paid but are also influenced by changes in electric usage, cost, and customer mix. The average benefit for EUSP bill payment assistance decreased 1.4% in fiscal 2015 despite a slight increase in the percent of bills paid for those at the lowest income levels compared to fiscal 2014. OHEP intends to increase the percent of the bills paid from

EUSP for individuals at the lowest income level in fiscal 2016 (from 40.0% to 50.0%). At that level, OHEP would be paying the highest percent of bills paid since fiscal 2010 when OHEP paid 65.0% of the bills for the lowest income level.

Natural gas customers and bulk fuel customers of OHEP received a substantial increase in the percent of bills paid in fiscal 2013, reaching 95% for the lowest income level, and stayed at that level through fiscal 2015. In fiscal 2016, OHEP is slightly decreasing the percent of bills paid for natural gas and bulk fuel sources, while increasing the percent of bills paid for electric sources.

As shown in **Exhibit 3**, through December in fiscal 2016, applications and households receiving each energy assistance benefit are lower than the same time period in fiscal 2015. As a result of the changes in the percent of bills paid for each benefit type, the average EUSP bill payment benefit is higher than the same time period in fiscal 2015, an increase of $39, or 11.1%, and the average MEAP benefit has increased by $55, or 10.3%. The higher average benefits have led to an increase in overall spending in OHEP in fiscal 2016 compared to the same time period in fiscal 2015 despite fewer households receiving assistance, an increase of $3.2 million, or 4.5%. At the current pace of spending, OHEP would be expected to spend $5.1 million more on benefits than in fiscal 2015 for a total of approximately $117.4 million. However, weather can substantially impact demand for energy assistance benefits. The recent cold weather and snow may result in changes in the current trends in energy assistance applications. The fiscal 2016 budget for OHEP could accommodate an increased pace of spending, as $125.7 million is currently budgeted for these benefits, and more funding is available from the SEIF than is currently budgeted.

Exhibit 3
OHEP Applications and Benefits Data
Fiscal 2015 and 2016
(July through December in Each Year)

	Fiscal 2015	Fiscal 2016	Change	% Change
Applications				
MEAP	98,531	94,559	-3,972	-4.0%
EUSP Bill Payment	96,119	92,467	-3,652	-3.8%
EUSP Arrearage	14,412	13,566	-846	-5.9%
Receiving Benefits				
MEAP	68,254	65,393	-2,861	-4.2%
EUSP Bill Payment	67,984	65,184	-2,800	-4.1%
EUSP Arrearage	9,858	9,146	-712	-7.2%

	Fiscal 2015	Fiscal 2016	Change	% Change
Percent of Bill Paid (Lowest Income Level)				
MEAP Natural Gas and Bulk Fuels	95%	94%	-1%	
MEAP Electric Heat (no EUSP)	40%	55%	15%	
MEAP Electric Heat (if also receive EUSP)	16%	26%	10%	
EUSP Bill Payment Assistance	40%	50%	10%	
Average Benefit				
MEAP	$533	$588	$55	10.3%
EUSP Bill Payment	351	390	39	11.1%
EUSP Arrearage	959	977	18	1.9%
Benefits Paid ($ in Millions)				
MEAP	$36.4	$38.5	$2.1	5.8%
EUSP Bill Payment	23.9	25.4	1.6	6.5%
EUSP Arrearage	9.5	8.9	-0.5	-5.5%
Total Benefits Paid	**$69.7**	**$72.9**	**$3.2**	**4.5%**

EUSP: Electric Universal Service Program
OHEP: Office of Home Energy Programs
MEAP: Maryland Energy Assistance Program

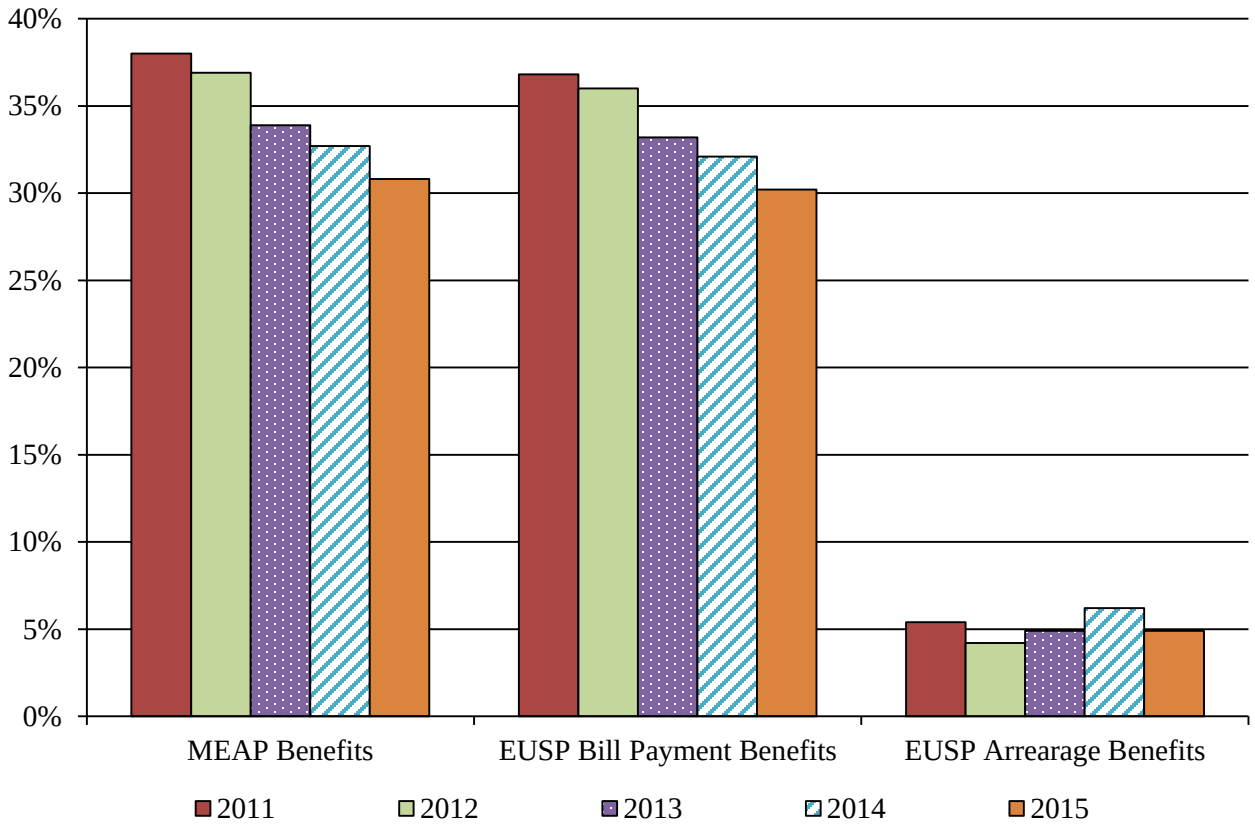
Source: Department of Human Resources

2. Percent of Eligible Households Receiving Benefits Continues to Decline

The percent of eligible households receiving benefits may move in a different direction to the number of households receiving benefits due to adjustments in the estimates of eligible households. As shown in **Exhibit 4**, the percent of eligible households receiving MEAP and EUSP bill payment assistance has decreased in all recent years. In fiscal 2015, 30.8% of eligible households received MEAP benefits, and 30.2% of eligible households received EUSP bill payment benefits (decreases of nearly 2 percentage points from fiscal 2014). OHEP has undertaken a new competitive solicitation that allows LAAs to submit budget requests for outreach measures. OHEP awarded the first funding under this solicitation at the end of October 2015. OHEP also developed a winter preparedness outreach campaign involving social media, direct mailings, and press releases. The fiscal 2017 allowance for OHEP includes $100,000 for outreach activities.

The percent of eligible households receiving EUSP arrearage assistance typically fluctuates within a small range. In fiscal 2015, the percent of eligible households receiving EUSP arrearage assistance was 4.9%, a decrease of 1.3 percentage points from fiscal 2014, the same level as in fiscal 2013.

Exhibit 4
Eligible Households Certified for Energy Assistance Benefits
Fiscal 2011-2015



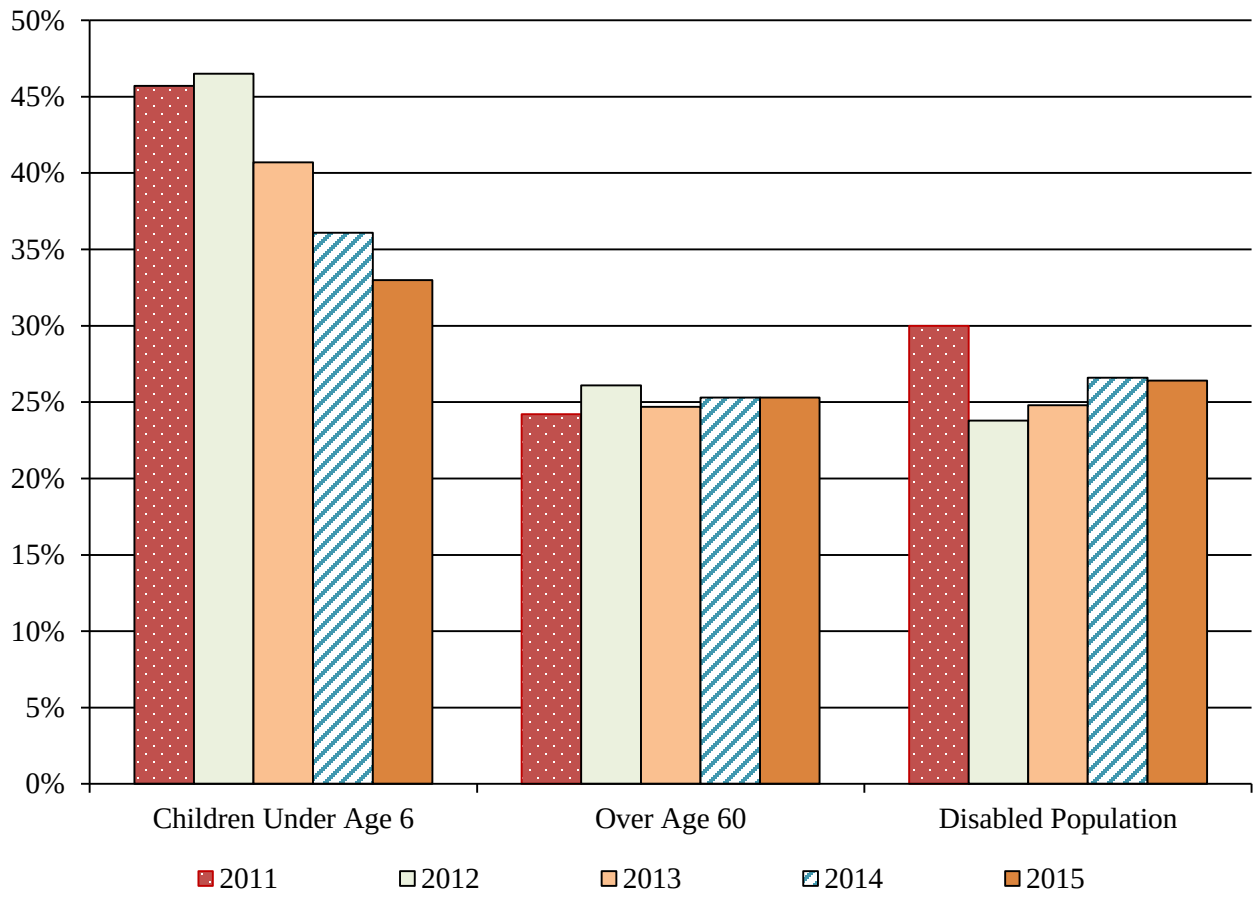
EUSP: Electric Universal Service Program
MEAP: Maryland Energy Assistance Program

Source: Department of Human Resources; Department of Budget and Management

3. Benefits Provided to Targeted Populations

Consistent with the recent trends in the percent of eligible households receiving EUSP bill payment and MEAP benefits, the percent of households with children under the age of six receiving energy assistance benefits has decreased since fiscal 2012, as shown in **Exhibit 5**. During that period, the percent of these households that were certified for benefits fell from 46.5% to 33.0%. DHR is considering undertaking a mass mailing to Food Supplement Program recipients that have not received an OHEP benefit to encourage applications.

Exhibit 5
Targeted Populations Receiving Energy Assistance Benefits
Fiscal 2011-2015



Source: Department of Human Resources; Department of Budget and Management

The percent of eligible households with an individual with a disability receiving benefits decreased slightly in fiscal 2015, 0.2 percentage points to 26.4%, after increasing in the two prior years. The percent of eligible households with an individual over the age of 60 remained even in fiscal 2015 compared to the prior year at 25.3%.

The Department of Legislative Services (DLS) recommends committee narrative requesting that OHEP report on the outreach efforts undertaken by the office and LAAs in fiscal 2016 and plans to further improve outreach in fiscal 2017, including among the targeted populations.

Proposed Budget

As shown in **Exhibit 6**, the fiscal 2017 allowance of OHEP increases by $3.2 million, or 2.3%, compared to the fiscal 2016 working appropriation after accounting for back of the bill reductions in health insurance. Aside from changes in energy assistance benefits, the fiscal 2017 allowance of OHEP increases by $951,030. The non-energy assistance benefit increase occurs nearly entirely among funding for contracts for LAAs, an increase of $900,000. DHR has also initiated a new call center contract; the OHEP share of the increased cost associated with this contract is $25,000.

Personnel expenses increase by $40,429, after accounting for the back of the bill reduction in health insurance. Increases occur primarily among employee and retiree health insurance ($30,895), employee retirement ($22,141), and accrued leave payout ($19,068). These increases are partially offset by reductions due to an increase in turnover expectancy from 7.21% to 9.98% ($28,569) and regular earnings ($3,874).

The fiscal 2017 allowance includes funding for employee increments in the budget of the Department of Budget and Management. These funds will be distributed to agencies at the beginning of the fiscal year. OHEP's share of the employee increments is $23,033 in total funds ($12,183 in special funds and $10,849 in federal funds).

Exhibit 6
Proposed Budget
DHR – Office of Home Energy Programs
($ in Thousands)

How Much It Grows:	Special Fund	Federal Fund	Total
Fiscal 2015 Actual	$59,404	$64,068	$123,471
Fiscal 2016 Working Appropriation	70,380	67,192	137,572
Fiscal 2017 Allowance	77,586	63,214	140,800
Fiscal 2016-2017 Amount Change	$7,206	-$3,978	$3,228
Fiscal 2016-2017 Percent Change	10.2%	-5.9%	2.3%

Where It Goes:

Personnel Expenses

Employee and retiree health insurance	$31
Employee retirement	22
Accrued leave payout to align with recent experience	19
Regular earnings	-4
Turnover expectancy increases from 7.21% to 9.98%	-29
Other fringe benefit adjustments	1

Where It Goes:

Energy Assistance Benefits	
Strategic Energy Investment Fund due to available funding	7,206
Electric Universal Service Program due to increased administrative funding requirements	-480
Low-Income Home Energy Assistance Program due to anticipated funding and increased administrative funding requirements	-4,449
Administrative Expenses	
Contract costs for local administering agencies	900
Office of Home Energy Programs share of the department's call center contract	25
Department of Budget and Management paid telecommunications	-1
Postage and telephone expenses to align with recent experience	-12
Other adjustments	-1
Total	**$3,228**

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

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. OHEP's share of these reductions is $4,977 in total funds ($2,677 in special funds and $2,321 in federal funds). There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

Energy Assistance Benefits

The majority of the increase in the fiscal 2017 allowance for OHEP occurs in the area of energy assistance benefits, an increase of $2.3 million, which is driven by anticipated funding availability.

LIHEAP

In any given year, the State's LIHEAP allocation may vary based on both the federal appropriation level and the State share of the appropriation. Overall, LIHEAP funding is level funded in federal fiscal 2016 compared to federal fiscal 2015 ($3.39 billion). The final allocation for Maryland in federal fiscal 2016 is not yet available; however, to date, Maryland has received $64.8 million. Maryland's share of the allocation is slightly higher than the prior year; as a result, the total LIHEAP received by Maryland in federal fiscal 2016 may be slightly higher than federal fiscal 2015. Maryland's recent allocations were:

- $69.8 million in federal fiscal 2012;

- $70.4 million in federal fiscal 2013;
- $68.5 million in federal fiscal 2014; and
- $68.9 million in federal fiscal 2015.

The fiscal 2016 working appropriation of LIHEAP, including funds budgeted in the Office of Technology for Human Services (OTHS) in DHR Administration for the OHEP data system, of $68.6 million, is very near the LIHEAP allocations in recent years. The fiscal 2017 allowance of LIHEAP decreases by approximately $4.0 million to $64.6 million. The amount budgeted in fiscal 2017 is lower than has been received in recent years but is near the amount received as of this writing in fiscal 2016. The decrease occurs primarily among funds budgeted for energy assistance benefits (a decrease of $4.4 million), while funds budgeted for administrative expenses increase by $473,020.

EUSP

Section 7-512 of the Public Utilities Article sets the level of ratepayer funding for EUSP at $37.0 million. For several years, the collections from the ratepayer surcharge exceeded the statutory level. In February 2014, the Public Service Commission (PSC) reduced the surcharge used to collect EUSP. The fiscal 2017 allowance continues to reflect EUSP collections at the level allowed by statute, with the EUSP total in the DHR budget at $37.0 million.

Although EUSP funds in the fiscal 2017 allowance are essentially level compared to the fiscal 2016 working appropriation, the allowance reflects a slight shift in the use of the funds. To account for increased administrative expenses, EUSP available for energy assistance benefits decreases by $480,349.

SEIF

Funding available to OHEP from the SEIF has increased in recent years following changes in the RGGI program. The fiscal 2017 spending plan for the SEIF assumes $92.8 million in revenue from RGGI auctions in that year, a decrease of $2.6 million compared to current fiscal 2016 estimates, primarily because it does not account for cost containment reserve allowances that have boosted revenue in fiscal 2016. Based on the revenue estimates, including funds available from set-aside allowances, $47.2 million is expected to be distributed to energy assistance from RGGI sources, as shown in **Exhibit 7**. The fiscal 2017 allowance for OHEP, however, includes only $42.0 million of the SEIF for energy assistance.

Exhibit 7

Comparison of RGGI Revenue Distribution and Potential Allocation

	Revenue Available without Transfer	Revenue Available with Transfer
Revenue Estimate	$96,181,852	$96,181,852
RGGI Dues	457,438	457,438
Electric Vehicle Tax Credit	1,287,000	1,287,000
Proposed Transfer to Environmental Trust Fund		10,000,000
Revenue Available for Distribution	**$94,437,414**	**$84,437,414**

	Fiscal 2017 Allowance	Distribution as determined by Statue		Fiscal 2017 Revenue Allocation	Fiscal 2017 Revenue Allocation If Proposed Transfer Occurs	Difference between Allocations with and without Proposed Transfer
Energy Assistance	**$42.0**	**at least**	**50%**	**$47.2**	**$42.2**	**-$5.0**
Department of Human Resources	$42.0					
Other SEIF Allocations from RGGI	**$48.4**		**50%**	**$47.2**	**$42.2**	**-$5.0**
Total	**$90.4**			**$94.4**	**$84.4**	**-$10.0**
Excess Administration Revenue Beyond Cap That Is Redistributed				$4.4	$3.4	

RGGI: Regional Greenhouse Gas Initiative

Note: Exhibit assumes that the excess administration allocation (revenue received above the $5 million cap) is reallocated to only the energy efficiency and renewable energy portions of the program, as is currently the Administration plan identified in Appendix T of the Governor's Budget Books. Allowance figures are the figures identified in the Governor's Budget Books and will not necessarily match the figures presented in Appendix T. The Department of General Services figure corrects an error in the budget. Figures exclude non-RGGI revenue budgeted as the Strategic Energy Investment Fund.

Source: RGGI, Inc.

The amount of revenue available for energy assistance from the SEIF could be reduced in fiscal 2017 and future years depending on the outcome of legislation proposed by Governor Lawrence J. Hogan, Jr. (SB 389/HB 459). As part of a larger fee reduction plan, Governor Hogan has proposed eliminating the Environmental Trust Fund surcharge, which is used for funding a variety of programs (the largest of which is the Department of Natural Resources Power Plant Research Program). The surcharge would be replaced with a diversion of revenue from the SEIF (up to $10 million annually) based on the funding that is required for programs receiving the Environmental Trust Fund monies. If the full diversion of $10 million were to occur in a given year, the energy assistance program revenue would be reduced by $5 million. Exhibit 7 provides a comparison of the revenue distribution with and without this proposed diversion based on the fiscal 2016 revenue estimates. As shown in this exhibit, the OHEP fiscal 2017 allowance is less than the amount of revenue the program would receive, even if the proposed diversion occurs in that year.

Fund Balance: Revenue continues to outpace the estimates used to build the budget and in some years, such as fiscal 2017, OHEP's budget does not include all of the SEIF revenue expected to be available for this purpose. In addition, demand for benefits has decreased in some years. As a result, the SEIF balance attributable to energy assistance has grown. As shown in **Exhibit 8**, the fiscal 2015 closing balance for energy assistance was $45.1 million and is expected to grow in upcoming years, reaching $62.8 million. The balance would remain near the fiscal 2016 level (nearly $58.0 million) if the proposed transfer of funds to the Environmental Trust Fund were to occur. **DHR should comment on the agency's plan to reduce the fund balance in the SEIF available for energy assistance benefits.**

Dominion Cove Point

In April 2013, Dominion Cove Point LNG, LP (DCP) filed an application with PSC for a Certificate of Public Convenience and Necessity (CPCN) to construct a 130-megawatt nameplate capacity electric generating station at the existing liquefied natural gas (LNG) terminal site in Calvert County near Cove Point. The terminal currently receives LNG imports. DCP was also seeking approval from the Federal Energy Regulatory Commission (FERC) to allow for exporting of LNG. The electric generating station is to be used for the needs of the facility and not connected to the State's electric grid.

Exhibit 8
Strategic Energy Investment Fund Balance
Fiscal 2015-2017 Est.
($ in Millions)

	Actual 2015	Est. 2016	Est. 2017	(With Environmental Trust Fund Transfer) 2017 Estimated Balance
Energy Assistance	$45.1	$57.5	$62.8	$57.8
Energy Efficiency and Conservation Programs, Low- and Moderate-income Sector	4.8	3.7	2.0	0.7
Energy Efficiency and Conservation Programs, All Other Sectors	5.3	5.4	1.1	-0.1
Renewable Energy, Clean Energy, Climate Change, Education, and Resiliency	4.9	3.4	3.1	0.6
Administration	3.9	4.1	4.3	4.3
Subtotal RGGI Portion	***$63.9***	***$74.2***	***$73.2***	***$63.2***
Renewable Portfolio Standard	0.0	0.0	33.0	$33.0
Offshore Wind Development	15.3	13.8	11.6	$11.6
Cove Point	8.0	16.0	0.0	$0.0
Total	**$87.2**	**$104.0**	**$117.8**	**$107.8**

CIF: Customer Investment Fund
RGGI: Regional Greenhouse Gas Initiative

Note: Excludes CIF in fiscal 2016 and 2017. Fiscal 2016 balances assume certain program spending not yet appropriated in the Department of Housing and Community Development and the Maryland Department of Agriculture. The fiscal 2017 balance accounts for a transfer of funds to the State Agency Loan Program. Fiscal 2016 and 2017 figures include adjustments to reflect appropriated levels of funding for the Maryland Energy Administration and the Department of Health and Mental Hygiene and to correct an error in the Department of General Services. Due to the adjustment in the Department of Health and Mental Hygiene, figures will not match Appendix T of the Governor's Budget Books. Balances do not account for changes in revenue distribution that would result from the proposed transfer to the Environmental Trust Fund.

Source: Maryland Energy Administration; Governor's Budget Books; Department of Legislative Services

On May 30, 2014, PSC granted (in Order 86372) the CPCN for the new electric generating station to DCP subject to a number of conditions, including FERC approval of the export facility and that all conditions imposed by FERC for the expansion of the facility are met. Two of the conditions imposed in the PSC order provide revenue for State use. PSC ordered a contribution of $40 million ($8 million per year for 5 years) into the SEIF, with the first payment due within 90 days of the commencement of construction of the generating station, for certain activities related to renewable and clean energy, energy efficiency, greenhouse gas reduction/mitigation, or demand response programs. The other condition required contributions totaling $8 million ($400,000 per year for the expected

20 years of plant operations) to MEAP or other Maryland low-income energy assistance programs specified by PSC by January 1, 2016.

In calendar 2015, DCP began contributing the funds to the SEIF because the generating facility is under construction. PSC did not specify any other low-income energy assistance program to receive the energy assistance portion of the contribution by January 1, 2016, so it would be expected that the energy assistance contribution will be available to MEAP. The fiscal 2017 allowance does not include funding from this source. **OHEP should comment on when the funds are expected to be received by MEAP from DCP, given that the plant is under construction. OHEP should also discuss plans for using these funds.**

Issues

1. Program Enhancements

In January 2012, PSC initiated a review of Maryland's energy assistance programs as a result of concerns that arose from the *Fiscal 2011 Electric Universal Service Program Annual Report*, particularly whether the energy assistance programs are currently fulfilling (or could fulfill the intended purposes) and whether the programs were appropriately funded. As part of the review, PSC staff worked with the Office of People's Counsel to develop consensus recommendations that would have drastically changed energy assistance programs in Maryland. The proposal would have converted Maryland's current programs, which determine benefits by income level (through a percent of bill paid), energy use, energy cost, and utility service territory to a percentage of income payment plan (under which a certain percent of a household's income is deemed affordable and is subtracted from a customer's actual or estimated energy bill for a year to determine the benefit amount). In addition, the proposed program would have contained an arrearage forgiveness program for pre-program arrearages, under which the arrearage would be forgiven if the customer paid a certain additional amount per month toward the bill. The current arrearage program provides a benefit at the level of arrearage between $300 and $2,000, no more than once every seven years. Other program components focused on energy conservation and crisis intervention. The cost was estimated at $250 million.

Following the release of the PSC staff proposal, DHR expressed interest in implementing budget neutral enhancements. However, with additional funding and more funding stability from the SEIF, DHR indicated that it was considering additional enhancements. In response to a 2014 *Joint Chairmen's Report* (JCR) request, PSC noted that this new interest was prompted by permanent changes in the share of the RGGI auction proceeds dedicated to energy assistance, and an increase in revenue available from these auctions.

The 2015 JCR requested that DHR provide information on program enhancements implemented in fiscal 2016 and planned enhancements in fiscal 2017. This information was submitted in two reports during fiscal 2016. Much of the work in fiscal 2016, described by DHR, focused on planning and preparing for possible changes.

Planning Activities

In the initial report, DHR explained that it would conduct an analysis of the LAA operations including customer intake and certification, quality assurance procedures, utilization of the online application tool, and utilization of the Enterprise Content Management System (ECMS), fraud prevention strategies, training, and outreach. DHR conducted these reviews in summer and fall 2015. These reviews were used to identify needs, issues, and an agenda to address the needs and issues.

DHR also planned to establish an operations and technology workgroup, involving LAAs and stakeholders to plan and prioritize improvements to increase program efficiency and customer service. Ultimately, OHEP developed three workgroups (policy, technology, and communications) that launched in October 2015. DHR identified the areas under each workgroups purview:

- **policy** – crisis assistance, fraud, arrearage waivers, operations manual, income and other verifications, budget billing, and monitoring;

- **technology** – modifying data system reports, ECMS, fraud tracking, performance tracking, use of electronic applications, developing a dashboard, tracking refunds, and tracking application processing timeliness; and

- **communications** – data system generated notices, call center, outreach data analysis, revising application, analyzing pending/denial rates, developing a document library, use of email notifications, and mass mailing strategies.

OHEP has developed a monthly schedule of operational improvements that are focused on by the workgroups.

Operational Improvements

Electronic Documentation Storage

DHR has identified different usage patterns of the ECMS system among LAAs, with half of the LAAs successfully incorporating the system into operations and the other half not doing so. OHEP noticed that the LAAs with larger caseloads have had the most difficulties incorporating the system. OHEP is meeting with the department's OTHS to identify equipment and system needs, and the technology workgroup will begin efforts to increase use of the system beginning in January 2016.

Communication

OHEP is updating communication materials to allow for electronic communication. OHEP expects to offer email as a way for customers to provide documentation or request information by the close of fiscal 2016. OHEP intends to begin collecting application email addresses with the fiscal 2017 application. OHEP plans to launch electronic notifications by the close of fiscal 2017 (in addition to the regular mail process) and to develop email outreach tools during fiscal 2017. OHEP also plans to improve outreach through targeted mailings to low-income households receiving other benefits (*e.g.*, Food Supplement Program) not already receiving energy assistance.

Customer Service

OHEP is also part of the call center operations for DHR. A new contract for the call center begins in February 2016. The call center will be able to assist with questions about applying for benefits, requesting a status update on the application, and other inquiries. This process will also allow for tracking of the resolution of customer issues.

Application Processing

DHR has worked to resolve confidentiality issues that previously prevented LAAs operated by Community Action Agencies (rather than local departments of social services) from accessing eligibility verification systems used by other FIA programs. In fiscal 2017, OHEP will implement access to the verification tools for wages, Social Security income, and eligibility for other DHR programs. These efforts are expected to improve application processing time and fraud prevention. DHR is also improving its application processing timeliness tracking (these efforts are discussed further in Issue 2).

Program Design Improvements

OHEP plans to use the policy workgroup to develop recommendations for program revisions. OHEP expects to evaluate program proposals, and research best practices. DHR plans to focus its reform efforts on two areas: (1) incentivizing energy conservation, education, and case management to reduce customer dependence on energy assistance; and (2) provide incremental arrearage forgiveness contingent on customer co-payment to increase customer accountability for on-time bill payment. DHR anticipates that these program revisions may require legislative changes. OHEP initially planned to have a Policy Reform Plan developed by January 2016. DHR currently expects the Policy Reform Plan will be developed in early fiscal 2017. **DLS recommends committee narrative requesting information on the planned program changes including anticipated legislative changes required during the 2017 session.**

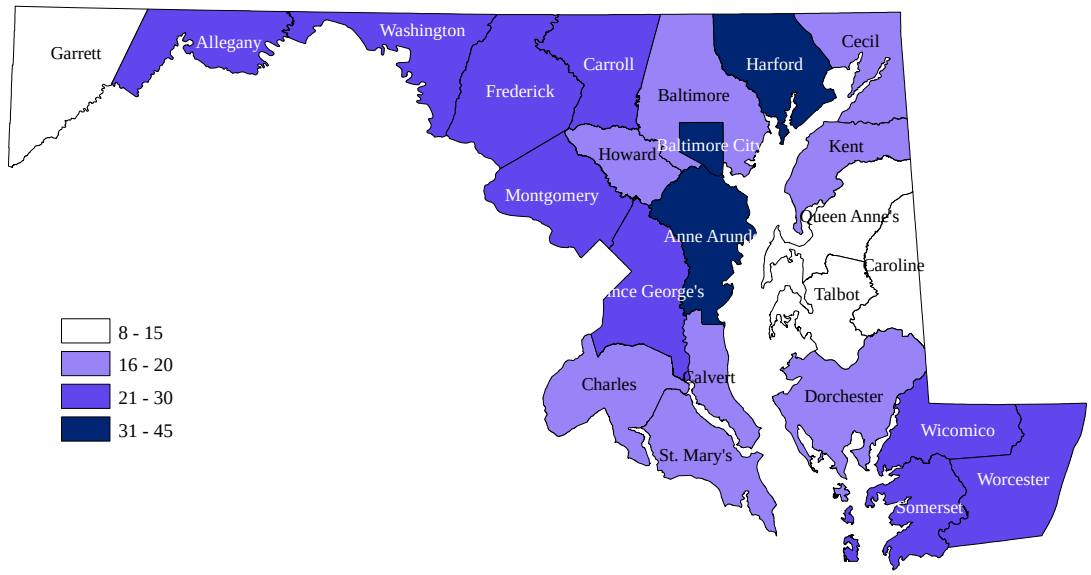
2. Energy Assistance Application Processing Times

Energy assistance applicants have a termination protection during the application period. This protection, known as the 55-day agreement, protects applicants from termination for a period of 55 days while a decision is made on the application. Until recently, DHR was unable to track application processing times in the OHEP data system. Committee narrative in the 2014 and 2015 JCRs requested that DHR provide information on application processing times by LAA to the budget committees.

Average Processing Time

Through December 20, 2015, in fiscal 2016 no jurisdiction had an average application processing time longer than 55 days. In fact, as shown in **Exhibit 9**, through December 20, 2015, of the 20 LAAs only 3 had an average processing time of longer than 30 days (Baltimore City, Anne Arundel County, and Harford County). In addition, the statewide average processing time of 27 days in fiscal 2016 was lower than the average processing time of 33 days during a similar period in fiscal 2015 (through December 16, 2014).

Exhibit 9
Average Days to Process Energy Assistance Applications
Fiscal Year to Date through December 20, 2015



Note: Two local administering agencies serve multiple counties (Shore UP! Inc. serves Somerset, Wicomico, and Worcester counties and the Southern Maryland Tri-County Community Action Council serves Calvert, Charles, and St. Mary's counties). For purposes of the map, each of these counties is shown as having the outcome of the local administering agency as a whole.

Source: Department of Human Resources

The number of jurisdictions with an average processing time of longer than 30 days decreased compared to a similar time period in fiscal 2015 during which 10 jurisdictions had average processing times longer than 30 days, as shown in **Exhibit 10**. To date, in fiscal 2016, the longest average processing time among LAAs was 45 days (Baltimore City), which was 12 days longer than the second highest average processing time (33 days in Anne Arundel County). In a similar period in fiscal 2015, the longest average processing time was 53 days (Howard County), which was 8 days longer than the second highest average processing (45 days in both Garrett County and Southern Maryland). Ten LAAs in the fiscal 2016 period had average processing times of 20 days or fewer compared to only four LAAs in a similar period in fiscal 2015.

Exhibit 10
Comparison of Average Days to Process Energy Assistance Applications

	Dec. 2014 [1]	Jun. 2015 [2]	Dec. 2015 [3]	Change in Average Processing Days Dec. 2014-15
Allegany County Human Resources Development Commission	30	26	24	-6
Anne Arundel County CAC	25	23	33	8
Baltimore City Department of Housing and Community Development	35	37	45	10
Baltimore County DSS	28	22	16	-12
Caroline County DSS	18	16	15	-3
Human Service Programs of Carroll County Inc.	40	37	22	-18
Cecil County DSS	44	42	17	-27
Dorchester County DSS	14	11	19	5
Frederick County DSS	31	25	21	-10
Garrett County CAC	45	34	8	-37
Harford County CAC	30	26	32	2
Howard County CAC	53	37	20	-33
Kent County DSS	22	17	17	-5
Montgomery County Department of Health and Human Services	45	38	29	-16
Prince George's County DSS	31	26	29	-2
Queen Anne's County DSS	17	16	12	-5
Southern Maryland Tri-County Community Action Committee Inc. (Calvert, Charles, and St. Mary's)	45	36	17	-28
Neighborhood Service Center (Talbot County)	16	15	14	-2
Washington County CAC	25	21	25	0
Shore UP! (Somerset, Worcester, and Wicomico)	36	25	26	-10
Total	**33**	**29**	**27**	**-6**

CAC: Community Action Council
DSS: Department of Social Services

[1] December 2014 data – fiscal 2015 through December 16, 2014.
[2] June 2015 data – fiscal 2015 through June 5, 2015.
[3] December 2015 data – fiscal 2016 through December 20, 2016.

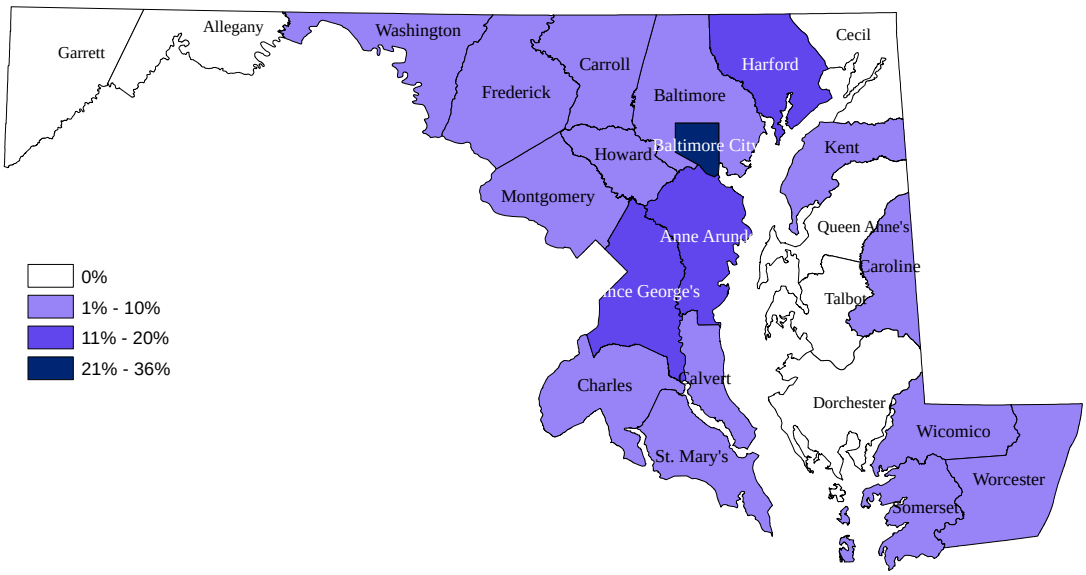
Source: Department of Human Resources

As shown in Exhibit 10, some LAAs have had dramatic improvements in the average processing time between similar periods in fiscal 2015 and 2016 (such as Garrett County with a reduction from 45 days to 8 days and Howard County with a reduction from 53 days to 20 days). However, four LAAs have had performance worsen (Anne Arundel, Dorchester, and Harford counties and Baltimore City,) between these two periods.

Applications Processed Beyond the 55-day Guideline

Through December 20, 2015, in fiscal 2016, 6 of the 20 LAAs had processed all of the applications received by that LAA in 55 days or fewer, as shown in **Exhibit 11**. An additional 5 LAAs processed only 1% of applications that it received in longer than 55 days. In fiscal 2016, the most significant problem in processing applications timely has been concentrated in 1 LAA (Baltimore City), which processed more than one-third of applications (36%) in longer than 55 days. However, three additional jurisdictions (Anne Arundel, Harford, and Prince George's counties) have processed more than 10% of applications in longer than 55 days.

Exhibit 11
Applications Processed Beyond the 55-day Guideline
Fiscal Year to Date through December 20, 2015



Note: Two local administering agencies serve multiple counties (Shore UP! Inc. serves Somerset, Wicomico, and Worcester counties and the Southern Maryland Tri-County Community Action Council serves Calvert, Charles, and St. Mary's counties). For purposes of the map, each of these counties is shown as having the outcome of the local administering agency as a whole.

Source: Department of Human Resources

As shown in **Exhibit 12**, in general, LAAs have made substantial improvements in processing applications timely compared to fiscal 2015 (through December 16, 2014). For example, while in fiscal 2016 (through December 20), four LAAs had more than 10% of applications processed in longer than 55 days, in fiscal 2015 (through December 16, 2014) half of the LAAs processed more than 10% of applications beyond the 55-day guideline, three of the LAAs processed more than one-third of the applications in longer than 55 days, and one LAA processed more than half of applications beyond the 55-day guideline.

Exhibit 12
Comparison of Applications Processed Beyond the 55-day Guideline

	Dec. 2014 (1)	Jun. 2015 (2)	Dec. 2015 (3)	Percentage Point Change Dec. 2014-15
Allegany County Human Resources Development Commission	1%	0%	0%	-1%
Anne Arundel County CAC	4%	7%	18%	14%
Baltimore City Department of Housing and Community Development	17%	24%	36%	19%
Baltimore County DSS	16%	9%	2%	-14%
Caroline County DSS	1%	1%	1%	0%
Human Service Programs of Carroll County Inc.	26%	22%	3%	-23%
Cecil County DSS	28%	32%	0%	-28%
Dorchester County DSS	0%	0%	0%	0%
Frederick County DSS	4%	1%	1%	-3%
Garrett County CAC	42%	31%	0%	-42%
Harford County CAC	7%	5%	14%	7%
Howard County CAC	53%	30%	1%	-52%
Kent County DSS	1%	1%	1%	0%
Montgomery County Department of Health and Human Services	38%	23%	5%	-33%
Prince George's County DSS	14%	11%	11%	-3%
Queen Anne's County DSS	0%	0%	0%	0%
Southern Maryland Tri-County Community Action Committee Inc. (Calvert, Charles, and St. Mary's)	27%	21%	1%	-26%
Neighborhood Service Center (Talbot County)	0%	1%	0%	0%

	Dec. 2014 [1]	Jun. 2015 [2]	Dec. 2015 [3]	Percentage Point Change Dec. 2014-15
Washington County CAC	1%	1%	3%	2%
Shore UP! (Somerset, Worcester, and Wicomico)	17%	8%	3%	-14%
Total	**17%**	**15%**	**11%**	**-6%**

CAC: Community Action Council
DSS: Department of Social Services

[1] December 2014 data – fiscal 2015 through December 16, 2014.
[2] June 2015 data – fiscal 2015 through June 5, 2015.
[3] December 2015 data – fiscal 2016 through December 20, 2016.

Source: Department of Human Resources

OHEP Actions to Improve Application Processing Times

OHEP is currently working with LAAs experiencing the most difficulties in processing applications in a timely manner. OHEP is coordinating with Baltimore City to secure Work Experience interns (Temporary Cash Assistance recipients) to supplement existing staff. In addition, OHEP is working with Baltimore City to review options to improve its intake processes. The Anne Arundel County LAA is filling vacancies that should help reduce the backlog of applications. OHEP is also working with the Harford County LAA to determine trends related to the cases with processing times beyond 55 days to develop a plan of corrective action.

In March 2016, OHEP will implement an enhancement to the OHEP data system that will provide additional monitoring of application processing timeliness. In particular, LAAs and the State office will be able to identify applications that have been in processing for between 25 days and 45 days and longer than 45 days. LAAs and OHEP can also then prioritize those cases for processing and monitor times of individual caseworkers. OHEP also indicates that in the new contract period with LAAs, which began in summer 2015, OHEP worked to address staffing limitations that impacted processing timeliness.

DLS recommends committee narrative requesting that DHR continue to submit information on energy assistance application processing times so that the committees can continue to monitor improvements.

Recommended Actions

1. Adopt the following narrative:

   Energy Assistance Application Processing Times: The committees are interested in continuing to monitor the progress of the local administering agencies (LAA) of the Office of Home Energy Programs in improving energy assistance application processing timeliness. Although progress is evident to date in fiscal 2016, some LAAs have experienced worsening performance. The committees request that the Department of Human Resources (DHR) provide by LAA (1) the number of applications received; (2) the average number of days to process applications; (3) the number and percent of applications processed within 30 days, 55 days, and longer than 60 days; and (4) the date of the data.

Information Request	**Author**	**Due Date**
Application processing times	DHR	December 31, 2016
Application processing times	DHR	June 30, 2016

2. Adopt the following narrative:

   Outreach Plans: The percent of eligible households receiving energy assistance has declined recently and was 30.8% in fiscal 2015. The percent of eligible households with a child under the age of one receiving benefits was 33.0%. The percent of eligible households with an individual over the age of 60 or an individual with disabilities was receiving benefits less than 30.0% in fiscal 2015. The committees are concerned that eligible households are not receiving energy assistance and may be vulnerable to problems associated with lack of heat or electricity. The Office of Home Energy Programs (OHEP) has taken steps during fiscal 2016 to improve outreach by local administering agencies (LAAs). The committees request that OHEP report on the outreach efforts undertaken by the State and LAAs in fiscal 2016 and plans to further improve outreach in fiscal 2017 to increase the percent of eligible households receiving benefits.

Information Request	**Author**	**Due Date**
Report on energy assistance outreach efforts	DHR	August 15, 2016

3. Adopt the following narrative:

Planned Program Changes: In response to committee narrative in the 2015 Joint Chairmen's Report, the Department of Human Resources (DHR) indicated that the Office of Home Energy Programs (OHEP) plans to develop a Policy Reform Plan by early fiscal 2017, following work to develop these plans during fiscal 2016. The plans are expected to focus on incentivizing energy conservation, education, and case management to reduce customer dependency on energy assistance and providing incremental arrearage forgiveness contingent on customer co-payments to increase customer accountability for on-time bill payment. The committees request that DHR submit a plan on the planned program changes, including information on anticipated legislative changes that result from the Policy Reform Plan or generally from the ongoing work in the agency's program review.

Information Request	**Author**	**Due Date**
Report on planned energy assistance program changes and anticipated legislative changes	DHR	December 1, 2016

Updates

1. Audit Findings Related to the Energy Assistance Programs

During calendar 2015, two audits were released that contained findings relevant to OHEP and/or LAAs that administer energy assistance programs.

Family Investment Administration Audit

In April 2015, the Office of Legislative Audits (OLA) released a fiscal compliance audit of FIA. Of the five findings included in the audit, one finding was specific to the energy assistance programs. This finding stated that FIA did not ensure that adequate documentation was maintained to support applicant eligibility and the validity of payments made for the energy assistance programs. OLA found that in a test of 10 applications processed by two LAAs:

- 5 applications did not include required documentation to support the applicant's identity or proof of residency (including a valid driver's license or lease agreement);
- 2 applications did not include required documentation to support utility services;
- 4 applications did not have a signature to indicate supervisory review (a similar finding was included in the prior audit); and
- 2 applications were approved more than 50 days past the 45-day requirement for processing applications established in State regulations.

OLA recommended that FIA ensure that LAAs obtain and maintain all required documentation to support critical energy assistance application data (this recommendation was repeated from the prior audit) and approve or deny completed applications within the required timeframe.

In its response to the audit, DHR explained that it has taken steps to address these recommendations. However, DHR also explained that one of the identified LAAs lost some of the records in flooding of a storage area where applications were filed.

DHR noted that use of a document imaging system (the ECMS) was expanded to LAAs in calendar 2014. DHR explained that this system should resolve the documentation concerns because documents such as Social Security cards would be scanned in to the system and become a permanent part of the case record, and annual documentation can be scanned into the case record at the time of the application. DHR also noted that LAAs identified in the audit have online access to the utility company billing records and dedicated phone numbers for communication.

In addition, DHR explained that the development of the Local Processing Time Report, which is used to provide information on the application processing times requested in the 2014 and 2015 JCRs, is used to monitor processing times and identify LAAs that need technical assistance. DHR also noted that in fiscal 2015, the agency increased staffing during the first six months of the fiscal year for LAAs that received the highest volume of applications.

Baltimore City Single Audit

Baltimore City conducts a single audit for the major federal fund programs that it receives. The fiscal 2013 single audit released in calendar 2015 contained 19 findings, of which 4 were related to LIHEAP, at that time managed by the Baltimore City Department of Housing and Community Development (DHCD). The Baltimore City DHCD served as LAA for Baltimore City.

Missing Documentation and Other Errors

One of the findings stated that missing folders and various errors and omissions were noted during the review of program documentation. In particular, the auditors noted that in a sample of 114 client folders, 24 could not be provided because the folders were lost in water damage from burst water pipes in August 2013, and there were widespread and pervasive errors and omissions in the remaining 90 folders. These errors and omissions included missing information, omitted signatures, and incorrect data entered (data in database did not match the folder). Based on the sample, the auditors projected questionable costs to total $6.2 million.

The auditors recommended that the Baltimore City DHCD resolve both the known and projected questioned costs with the U.S. Department of Health and Human Services (DHHS). In addition, the auditors recommended that Baltimore City DHCD institute internal controls to ensure that future applications are properly processed and completed, benefit awards are accurately calculated, and benefits are provided only to qualified individuals.

Payment Errors

A second finding questioned costs due to duplicate payments and benefits paid for client addresses outside Baltimore City. The auditors found 33 duplicate payments, totaling $13,651. The auditors also found payments for 36 clients with addresses outside of Baltimore City, totaling $20,302. The auditors recommended that the Baltimore City DHCD resolve the questioned costs ($33,953) with the U.S. DHHS and that the program institute internal control procedures to prevent these types of payments.

Internal Control Weaknesses

A third finding stated that weaknesses were noted in several internal control areas (recordkeeping, cash management, and segregation of duties). The auditors found that client files, which include information on income, household size, energy usage, addresses, and Social Security numbers, were not maintained appropriately. The auditors noted that files were stored in cardboard boxes on the floor and on top of cabinets. The files were also not sufficiently organized (for example,

files from one year were in an area labeled with another year). The auditors noted that, had the files been maintained in secure filing cabinets, the situation with a burst water pipe destroying files could have been prevented.

The auditors explained that there was no checkbook ledger maintained for a bank account that is used for client benefits paid to oil vendors. Because no ledger was maintained, no bank reconciliations were performed. The auditors also found that there was not a check log maintained. Finally, the auditors found that a single party drafted and imprinted the check, which could be done without the official check signer viewing the check or supporting documentation.

The normal application process requires intake personnel to receive the application and review it for completeness, accuracy, and ensure that documentation is provided, and a second person certifies whether the client is eligible for a benefit. The auditors also explained that applications were not signed by two persons for intake and approval.

The auditors recommended that the Baltimore City DHCD improve internal controls including (1) improving organization and storage procedures to protect client files and personal information; (2) maintaining a check log for accounts; (3) preparing monthly bank reconciliations; (4) maintaining a balance for bank accounts; (5) reviewing checks and support documentation prior to printing checks by the official signer; and (6) completing applications in accordance with regulations.

Client Application Process

The auditors also found widespread discrepancies in the client application process. This finding included discussion of the earlier findings that questioned costs in the program. The auditors recommended that internal control procedures be instituted to ensure that applications are processed, completed, and maintained properly, benefits are awarded to only eligible individuals, and benefits are calculated accurately.

Baltimore City Response

In its response to the audit, Baltimore City described corrective actions for these findings. Baltimore City explained that as of July 1, 2014, the management of the program was transferred from the Baltimore City DHCD to the Mayor's Office of Human Services. The Baltimore City DHCD was expected to work with the Mayor's Office of Human Services to recreate the missing files and complete information in the other files with missing information. In addition, Baltimore City noted that internal controls are being strengthened as recommended.

Baltimore City also explained that the company returns funds associated with duplicate payments to the State (when the duplicate payment was made to Baltimore Gas and Electric). In addition, Baltimore City noted that clients residing in other counties are still eligible (because Baltimore City only passes through the State funds).

DHR Response

Although this audit was about Baltimore City specifically, DHR is responsible for ensuring the overall integrity of the program. OHEP has also taken steps to improve monitoring of the program, including increasing the sample size of the applications that are reviewed to improve accuracy of the monitoring results. DHR also noted that it will work with LAAs to correct issues identified in the monitoring process. DHR explained that the temporary staff added to assist high-volume LAAs (noted earlier) will also reduce some of the errors noted in the audit by reducing workload burdens. DHR also explained that ECMS will resolve the case filing issues in the future (as noted earlier). Baltimore City has obtained additional filing cabinets for the historical records.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHR – Office of Home Energy Programs
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$0	$76,662	$65,603	$0	$142,265
Deficiency Appropriation	0	0	0	0	0
Cost Containment	0	0	0	0	0
Budget Amendments	0	5	4	0	9
Reversions and Cancellations	0	-17,263	-1,540	0	-18,803
Actual Expenditures	**$0**	**$59,404**	**$64,068**	**$0**	**$123,471**
Fiscal 2016					
Legislative Appropriation	$0	$70,371	$67,183	$0	$137,554
Budget Amendments	0	9	9	0	18
Working Appropriation	**$0**	**$70,380**	**$67,192**	**$0**	**$137,572**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

In total, the OHEP fiscal 2015 expenditures were $18.8 million lower than the legislative appropriation. An increase of $9,264 ($4,867 in special funds and $4,397 in federal funds) occurred by budget amendment to support the fiscal 2015 cost-of-living adjustment. This increase was more than offset by special fund cancellations totaling $17.3 million and federal fund cancellations totaling $1.5 million. These cancellations are the result of a decrease in energy assistance applications and warmer winter weather compared to the prior year.

Fiscal 2016

To date, the OHEP fiscal 2016 appropriation has increased by $17,679 ($9,179 in special funds and $8,500 in federal funds) to restore the 2% pay reduction.

Object/Fund Difference Report
DHR – Office of Home Energy Programs

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	16.87	16.87	16.87	0.00	0%
02 Contractual	3.95	0.00	0.00	0.00	0.0%
Total Positions	**20.82**	**16.87**	**16.87**	**0.00**	**0%**
Objects					
01 Salaries and Wages	$1,578,714	$1,132,347	$1,177,773	$45,426	4.0%
02 Technical and Spec. Fees	433,798	1,150	1,150	0	0%
03 Communication	29,328	50,307	37,253	-13,054	-25.9%
04 Travel	4,426	2,967	2,979	12	0.4%
06 Fuel and Utilities	14,542	0	0	0	0.0%
08 Contractual Services	120,533,860	136,227,009	139,428,870	3,201,861	2.4%
09 Supplies and Materials	160,359	148,602	149,681	1,079	0.7%
10 Equipment – Replacement	2,122	0	0	0	0.0%
11 Equipment – Additional	7,438	0	0	0	0.0%
12 Grants, Subsidies, and Contributions	622,052	0	0	0	0.0%
13 Fixed Charges	84,621	9,450	7,200	-2,250	-23.8%
Total Objects	**$123,471,260**	**$137,571,832**	**$140,804,906**	**$3,233,074**	**2.4%**
Funds					
03 Special Fund	$ 59,403,601	$ 70,380,085	$ 77,588,858	$ 7,208,773	10.2%
05 Federal Fund	64,067,659	67,191,747	63,216,048	-3,975,699	-5.9%
Total Funds	**$ 123,471,260**	**$ 137,571,832**	**$ 140,804,906**	**$ 3,233,074**	**2.4%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.