M00F03
Prevention and Health Promotion Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 13 Actual	FY 14 Working	FY 15 Allowance	FY 14-15 Change	% Change Prior Year
General Fund	$52,842	$53,446	$54,338	$892	1.7%
Contingent & Back of Bill Reductions	0	-249	-152	97	
Adjusted General Fund	**$52,842**	**$53,198**	**$54,187**	**$989**	**1.9%**
Special Fund	72,265	85,986	83,745	-2,241	-2.6%
Contingent & Back of Bill Reductions	0	0	-18	-18	
Adjusted Special Fund	**$72,265**	**$85,986**	**$83,727**	**-$2,259**	**-2.6%**
Federal Fund	209,751	215,401	217,216	1,815	0.8%
Contingent & Back of Bill Reductions	0	-3,090	-206	2,884	
Adjusted Federal Fund	**$209,751**	**$212,311**	**$217,010**	**$4,700**	**2.2%**
Reimbursable Fund	1,931	2,051	2,392	340	16.6%
Adjusted Reimbursable Fund	**$1,931**	**$2,051**	**$2,392**	**$340**	**16.6%**
Adjusted Grand Total	**$336,789**	**$353,545**	**$357,315**	**$3,770**	**1.1%**

- The Governor's proposed allowance for the Prevention and Health Promotion Administration (PHPA) increases by $3.8 million (1.1%) over the fiscal 2014 working appropriation.

- There is one proposed deficiency ($182,059) for fiscal 2014 to provide funds for consultant technical services and support for the immunization registry system. In addition, there is a fiscal 2014 fund swap ($3.1 million) to recognize additional special funds from Human Immunodeficiency Virus (HIV) Care Formula grants for Maryland AIDS Drug Assistance Program drug rebates.

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

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Personnel Data

	FY 13 Actual	FY 14 Working	FY 15 Allowance	FY 14-15 Change
Regular Positions	364.80	362.80	362.80	0.00
Contractual FTEs	5.43	8.93	8.90	-0.03
Total Personnel	**370.23**	**371.73**	**371.70**	**-0.03**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	18.14	5.00%
Positions and Percentage Vacant as of 12/31/13	39.00	10.75%

- As of December 31, 2013, the agency had 39 vacant positions. PHPA had intentionally left positions vacant prior to the reorganization of Public Health Services and is still in the process of filling these positions. Additionally, several positions were intentionally left vacant due to uncertainty as to the continuation of funding for the Ryan White Program; PHPA is now recruiting for these positions.

Analysis in Brief

Major Trends

Infant Mortality Rates Continue to Improve: 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).

Cancer Mortality Rates Continue to Improve: Both the overall cancer mortality rate and the breast cancer mortality rate continue to decline steadily in Maryland. However, the prevalence of cigarette smoking among middle and high school students has remained relatively constant since calendar 2006.

Childhood Vaccinations Rate Drops but Remains Consistent with National Average: In calendar 2012, 67% of children in Maryland received the typical coverage of vaccinations (which approximates the national average of 68%). This represents a 14% decrease from the previous year and marks a return to the calendar 2010 level due, as in calendar 2010, to a nationwide vaccine shortage. Nonetheless, the rate of children enrolled in the Medicaid program receiving the typical coverage of vaccinations remained relatively high at 80%.

Syphilis and Chlamydia Rates Remain High, Particularly in Baltimore City: In calendar 2012, the Centers for Disease Control and Prevention reported statewide infection rates of primary and secondary syphilis in Maryland of 7.3 cases per 100,000 population, representing a slight decrease from the calendar 2011 rate. However, the primary and secondary syphilis rates in Baltimore City continue to increase and – at 40.3 cases per 100,000 population – now exceed the State average by more than five times. Furthermore, while chlamydia rates statewide have dropped to below the national average, infection rates continue to be a concern in Baltimore City, where they far exceed that national average.

AIDS Rate, High Among States, Continues to Decline: In calendar 2013, the State had an estimated 1,689 new HIV diagnoses, representing a 2% decrease over the calendar 2012 level. Moreover, there were an estimated 620 new AIDS diagnoses in calendar 2013, representing a 13% decrease over the previous calendar year.

Varying Enrollment Trends in Health Services Programs: The Maryland AIDS Drug Assistance Program (MADAP) and MADAP-Plus have experienced enrollment growth in recent years – reaching an estimated 7,759 and 3,313 enrollees, respectively, in calendar 2012. However, the fiscal 2015 allowance reflects a decline in MADAP program enrollment due to the implementation of federal health care reform.

Recommended Actions

1. Concur with Governor's allowance.

Updates

Reducing Sexually Transmitted Infection Rates in Baltimore City: The 2013 *Joint Chairmen's Report* (JCR) requested the Department of Health and Mental Hygiene (DHMH) to submit a report on how it plans to achieve a reduction in the rate of sexually transmitted infections (particularly primary and secondary syphilis, chlamydia, and HIV/AIDS) in Baltimore City by 2015.

Breast and Cervical Cancer Diagnosis and Treatment Program: Committee narrative in the 2013 JCR directed DHMH to submit biannual reports on program enrollment and costs for the Breast and Cervical Cancer Diagnosis and Treatment Program.

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.

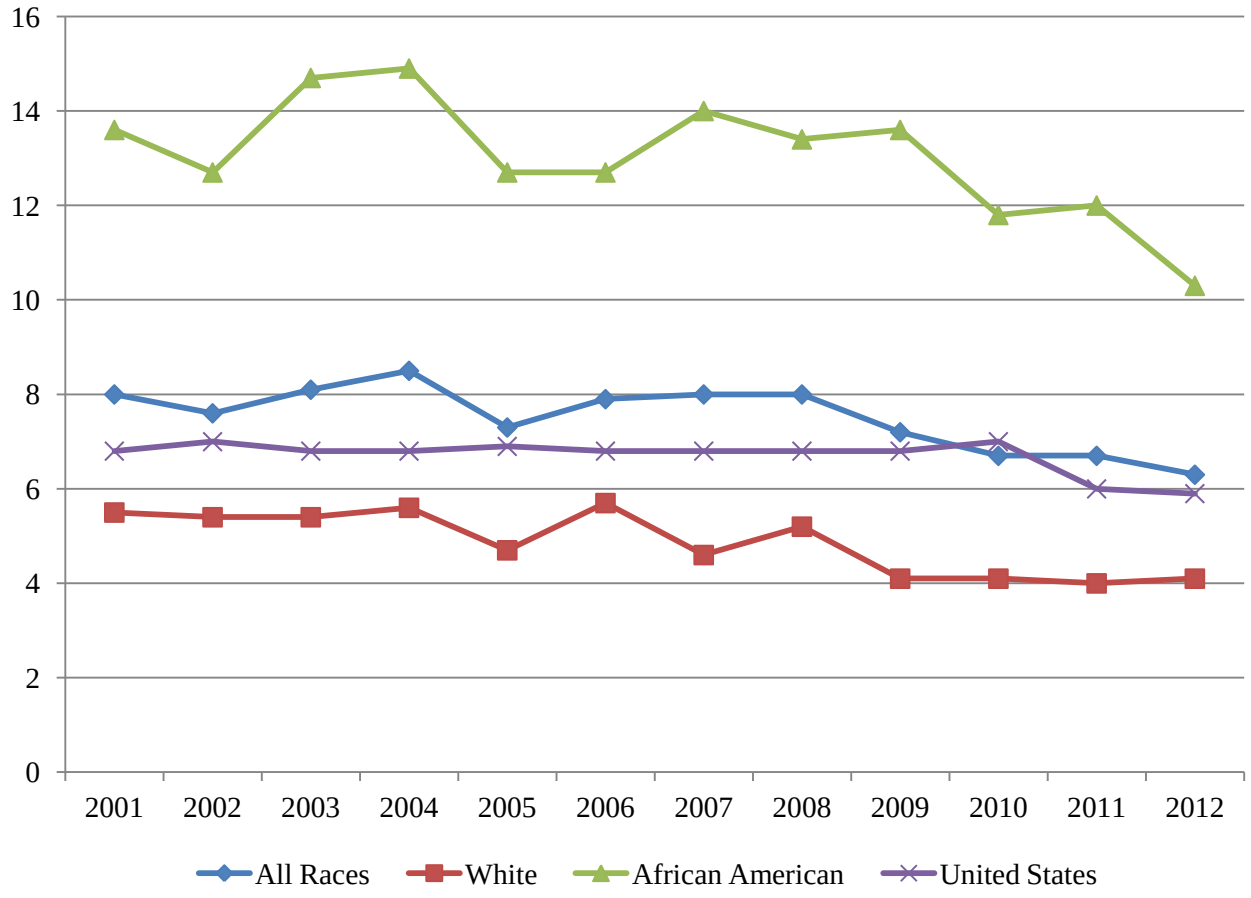
Performance Analysis: Managing for Results

1. Infant Mortality Rates Continue to Improve

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 United States' infant mortality rate increased for the first time since 1958. According to the National Center for Health Statistics, infant mortality rates were the highest among mothers who smoked, had no prenatal care, were teenagers, were unmarried, and had less education. Following the national trend, Maryland's overall infant mortality rate increased from calendar 2002 through 2004 to 8.5 deaths per 1,000 live births. Since that time, Maryland has made steady progress to reduce the infant mortality rate to 6.3 in calendar 2012, as shown in **Exhibit 1**. It is important to note that this reflects the lowest rate ever recorded in Maryland. Following national trends, Maryland's African American infant mortality rate has consistently been higher than other races but has declined in the past several years – driving the overall reduction in the infant mortality rate.

Exhibit 1
Infant Mortality Rates
Calendar 2001-2012

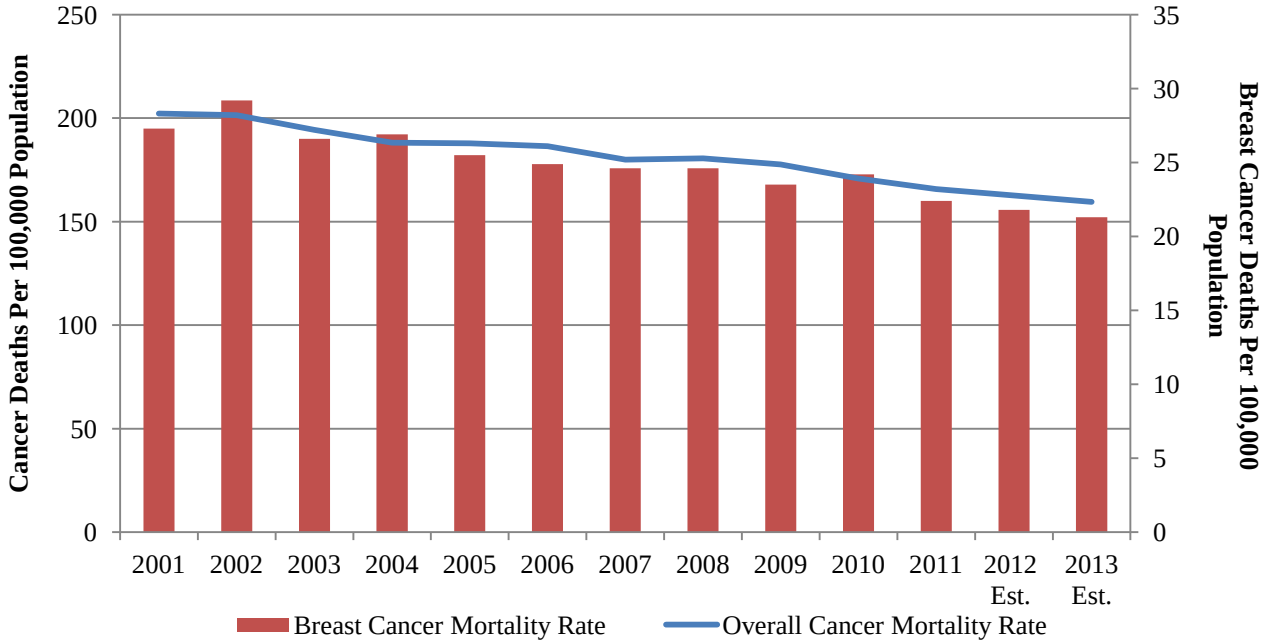


Source: Department of Health and Mental Hygiene

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) program target colorectal cancer, prostate cancer, and cancers associated with tobacco use.

Exhibit 2
Cancer Mortality Rates
Calendar 2001-2013 Est.



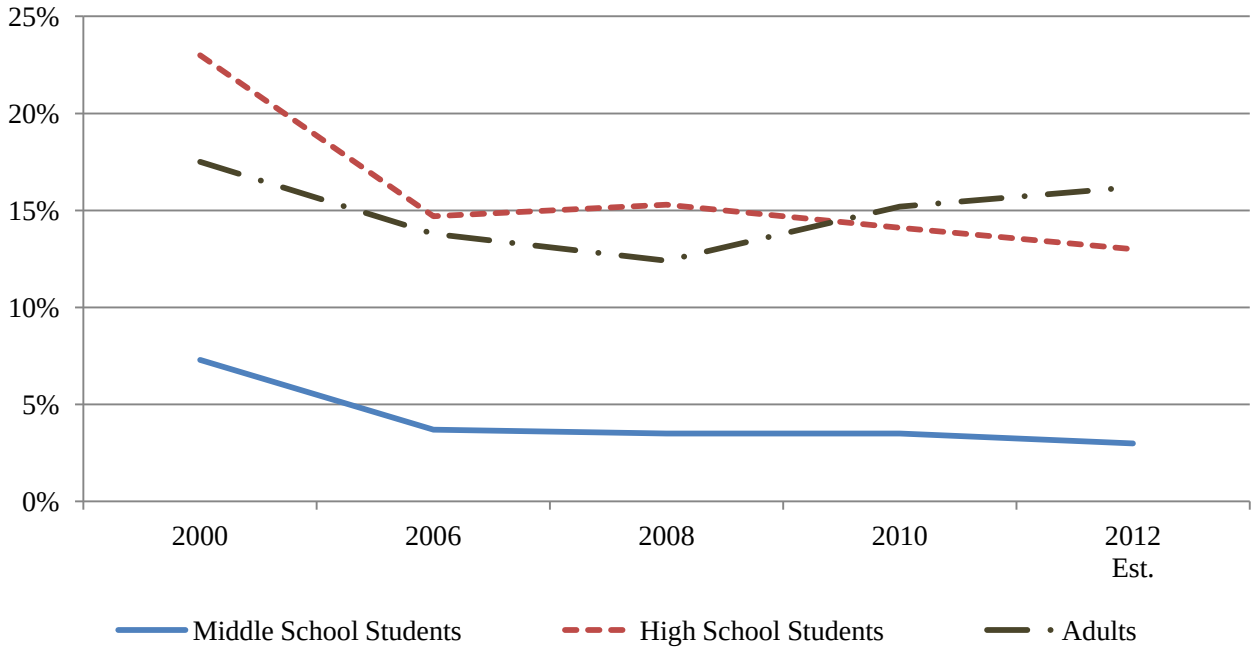
Source: Department of Health and Mental Hygiene

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. Two surveys funded with CRF revenue are the Maryland Youth Tobacco

Survey and the Maryland Adult Tobacco Survey. Surveys such as these are intended to track smoking preferences and usage among Marylanders. As shown in **Exhibit 3**, the prevalence of cigarette smoking has decreased by 58.9% among public middle school students (from 7.3% in calendar 2000 to 3.0% in calendar 2012) and by 43.5% among underage public high school students (from 23.0% in calendar 2000 to 13.0% in calendar 2012). However, as the graph demonstrates, these rates have remained relatively constant since calendar 2006. It is important to note that student data for calendar 2012 is estimated, as youth tobacco-use survey results are still being compiled.

Exhibit 3
Tobacco Usage Rates
Calendar 2000-2012 Est.



Note: See text for discussion of survey methodology.

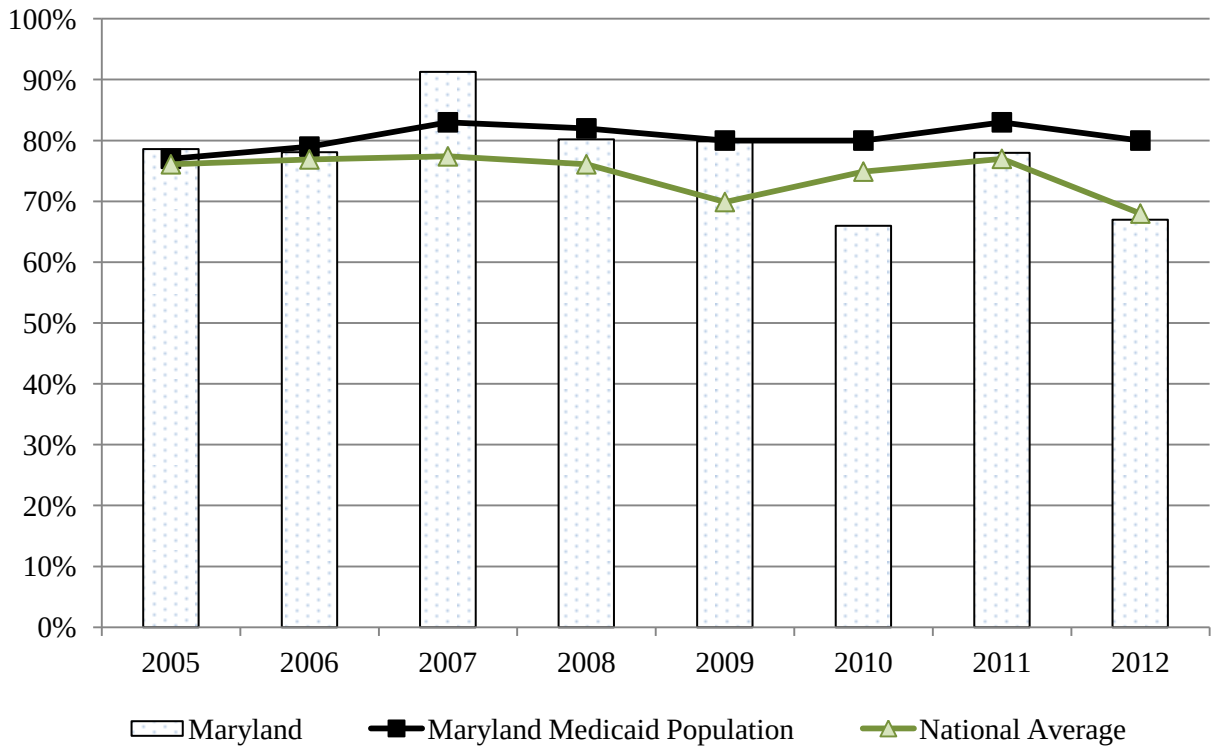
Source: Department of Health and Mental Hygiene

The Department of Legislative Services notes that, although it appears from Exhibit 3 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.

3. Childhood Vaccinations Rate Drops but Remains Consistent with National Average

As shown in **Exhibit 4**, 67% of children in Maryland received the typical coverage of vaccinations in calendar 2012, which approximates the national average of 68%. This represents a 14% decrease from the previous year and marks a return to the calendar 2010 level – due, as in calendar 2010, to a nationwide vaccine shortage. Nonetheless, the rate of children enrolled in the Medicaid program receiving the typical coverage of vaccinations remained relatively high at 80%. Immunization rates among the Medicaid population have been consistently above the statewide average since calendar 2005. Between calendar 2006 and 2007, the rate of immunizations jumped 13 percentage points; however, reasons for this increase were unclear. In calendar 2008, the vaccination rate returned to historic levels.

Exhibit 4
Rates of Children, Ages 19 to 35 Months, with Up-to-date Immunizations
Calendar 2005-2012



Source: Department of Health and Mental Hygiene

Maryland is able to keep the vaccination rates of children 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 (children who have health insurance that does not cover immunization).

4. Syphilis and Chlamydia Rates Remain High, Particularly in Baltimore City

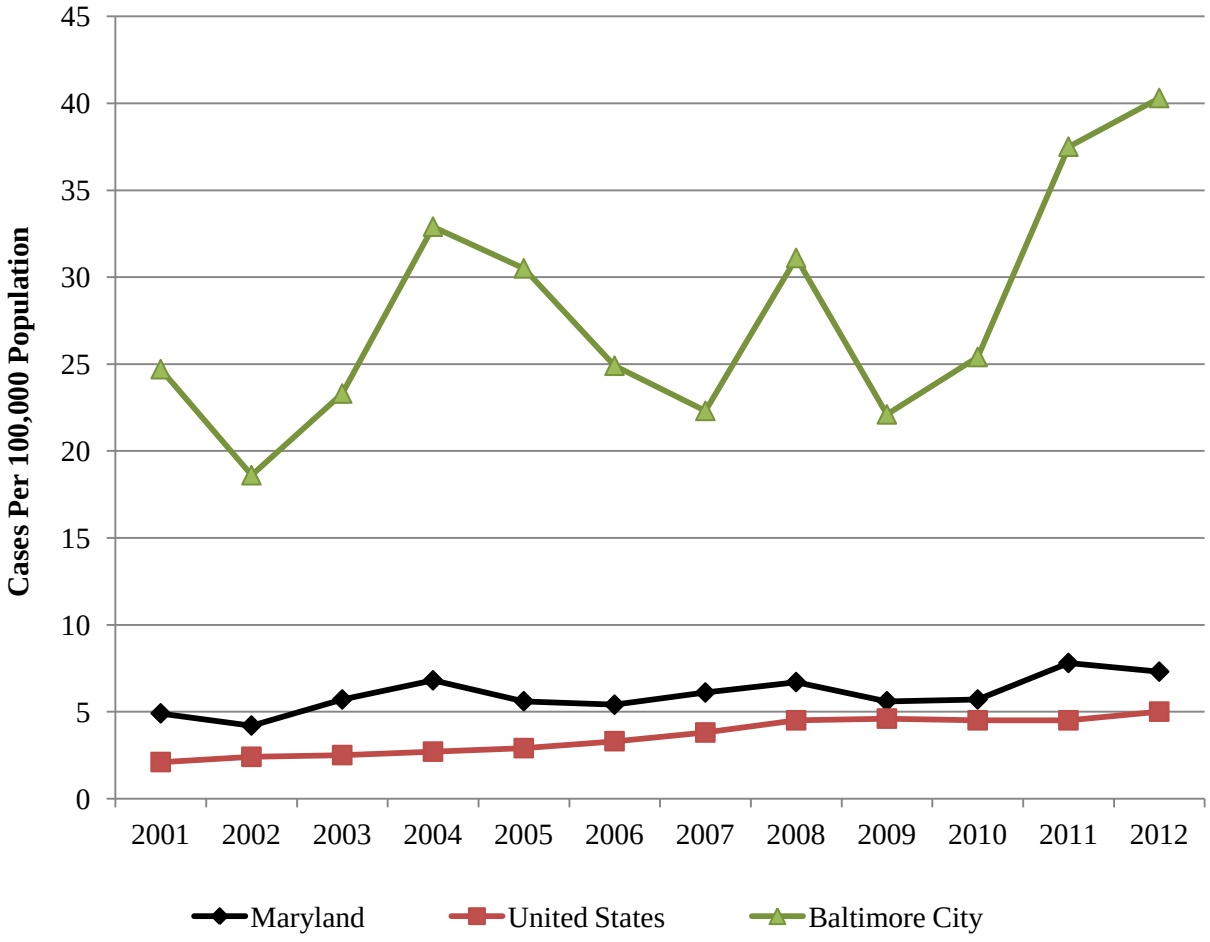
Syphilis Infection Rates

PHPA is charged with preventing and controlling the transmission of infectious diseases, including sexually transmitted diseases (STD). The administration has developed initiatives to reduce the spread of STDs, with an emphasis on populations at risk, such as economically disadvantaged and incarcerated populations. Syphilis continues to be a major concern in the State, with the rate of infection in Maryland the second highest in the nation (as of the most recent national comparison, which was conducted with data from calendar 2011). In addition to its primary effects, syphilis presents public health concerns for its role in facilitating transmission of Human Immunodeficiency Virus (HIV). Untreated syphilis in pregnant women can result in infant death in up to 40% of cases.

Exhibit 5 shows syphilis rates in Baltimore City compared to those statewide as well as the national average. In calendar 2012, CDC reported a statewide infection rate of primary and secondary syphilis in Maryland of 7.3 cases per 100,000 population, representing a slight decrease from the calendar 2011 rate. However, the primary and secondary syphilis rates in Baltimore City continue to increase and are now more than five times the State average at 40.3 cases per 100,000 population.

CDC has indicated that syphilis remains a major health problem, with increases in rates persisting among men who have sex with men. Moreover, cases that involve men who have sex with men have been characterized by high rates of HIV co-infection. In fiscal 2012, men who have sex with men accounted for 75% of all primary and secondary syphilis cases. DHMH advises that this trend is consistent with increased syphilis infection rates seen in Maryland. Accordingly, the Baltimore City Health Department (BCHD) has implemented programs to specifically target this population. Current and proposed interventions to reduce the rate of syphilis in Baltimore City are discussed in the Updates section of this document.

Exhibit 5
Rates of Primary/Secondary Syphilis
Calendar 2001-2012

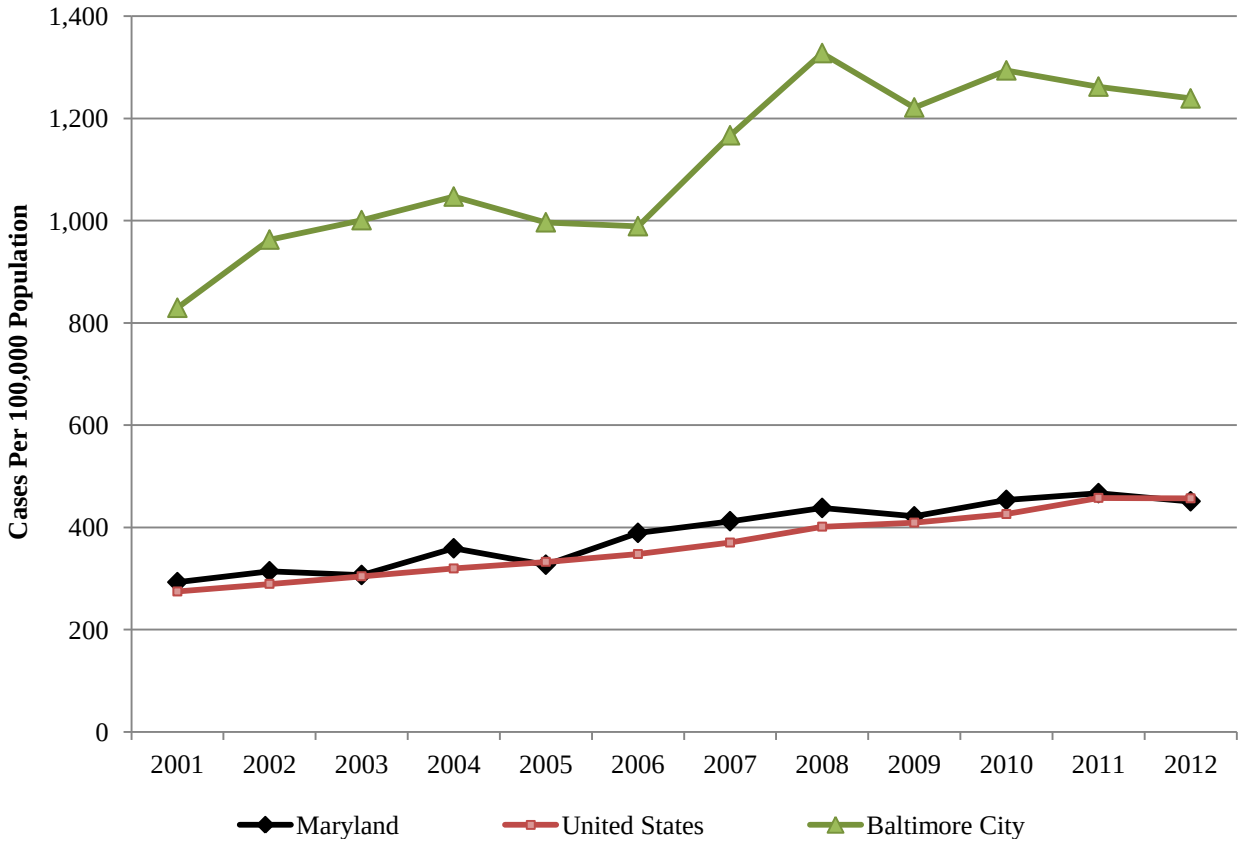


Sources: Department of Health and Mental Hygiene; Center for Disease Control and Prevention

Chlamydia Infection Rates

While chlamydia rates statewide have dropped to below the national average, infection rates continue to be a concern in Baltimore City, where they far exceed that national average. **Exhibit 6** shows the chlamydia rate in Maryland compared to the national average, as well as the chlamydia rate in Baltimore City for all ages from calendar 2001 to 2012. In calendar 2012, the chlamydia rate in Maryland was 450.9 per 100,000 population compared to the national average of 456.7; however, the rate in Baltimore City was 1,239 infections per 100,000.

Exhibit 6
Rate of Chlamydia
Calendar 2001-2012



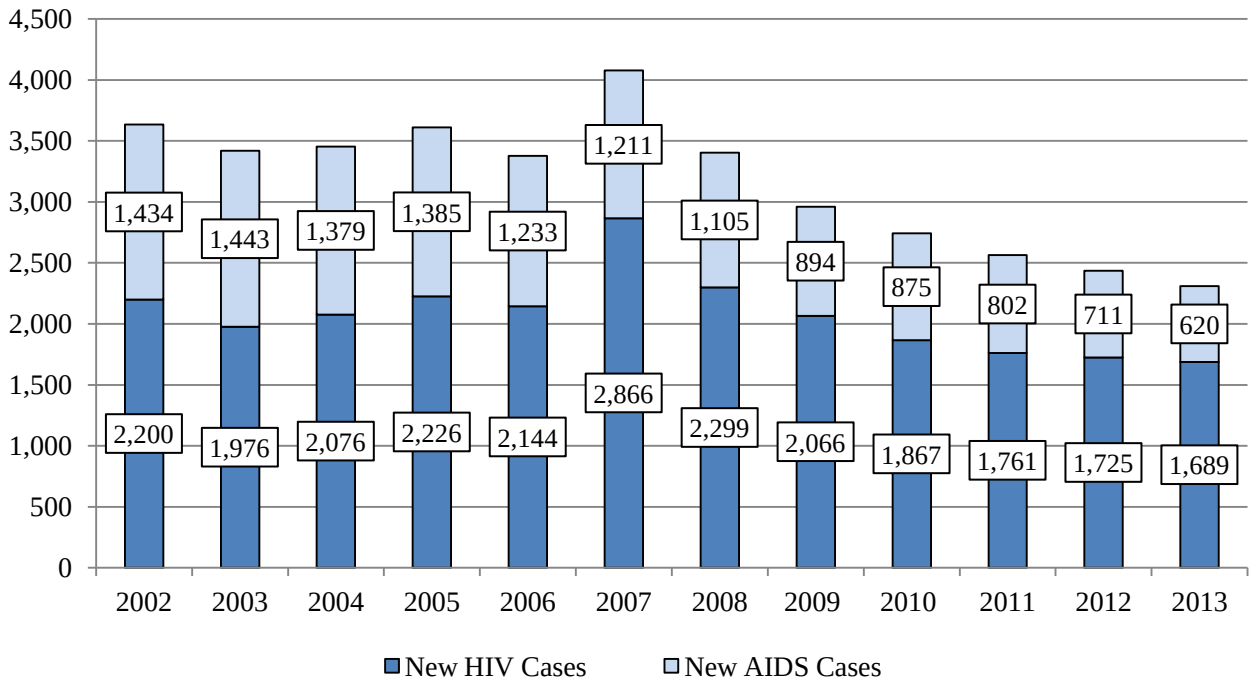
Source: Department of Health and Mental Hygiene; Center for Disease Control and Prevention

BCHD receives funding directly from CDC to respond to sexually transmitted infections. Among other things, the city has an active outreach program to find and test high risk individuals, including commercial sex workers. It also has two sexually transmitted disease clinics that provide free testing and treatment, as well as school-based clinics that test for chlamydia and gonorrhea. The department also 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 STDs to distribute antibiotics to their sexual partners. Patients can deliver antibiotics to up to three of their partners without a prescription for their partners and without the health care provider first examining their partners. By treating individuals and their partners through the EPT program, the department aims to prevent individuals from being reinfected with the disease by their partners.

5. AIDS Rate, High Among States, Continues to Decline

Exhibit 7 details the continued decline in newly reported cases of HIV and AIDS in Maryland. In calendar 2013, the State had an estimated 1,689 new HIV diagnoses, representing a 2% decrease over the calendar 2012 level. Moreover, there were an estimated 620 new AIDS diagnoses in calendar 2013, representing a 13% decrease over the previous calendar year.

Exhibit 7
Incidence of New HIV and AIDS in Maryland
Calendar 2002-2013



AIDS: Acquired Immunodeficiency Syndrome
HIV: Human Immunodeficiency Virus

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

According to the most recent national comparison conducted by CDC (based on calendar 2010 data), Maryland had the ninth highest number of cumulative AIDS cases, the seventh highest number of newly reported AIDS cases, and the second highest AIDS rate, behind only Washington, DC. The CDC analysis reported that in calendar 2010, nationally, the AIDS rate was 10.8 AIDS cases per 100,000 population, compared with the Maryland rate of 22.1 per 100,000 population.

6. Varying Enrollment Trends in Health Services Programs

PHPA provides two major health services programs related to HIV/AIDS: Maryland AIDS Drug Assistance Program (MADAP) and MADAP-Plus. A third program – the Maryland AIDS Insurance Assistance Program (MAIAP) – was eliminated in 2009. These are outlined in **Exhibit 8**.

Exhibit 8
PHPA – Health Services Programs for HIV/AIDS

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

AIDS: Acquired Immunodeficiency Syndrome
FPL: Federal Poverty Level
HIV: Human Immunodeficiency Virus
MADAP: Maryland AIDS Drug Assistance Program
MAIAP: Maryland AIDS Insurance Assistance Program
PHPA: Prevention and Health Promotion Administration

* The MAIAP ended on June 30, 2009.

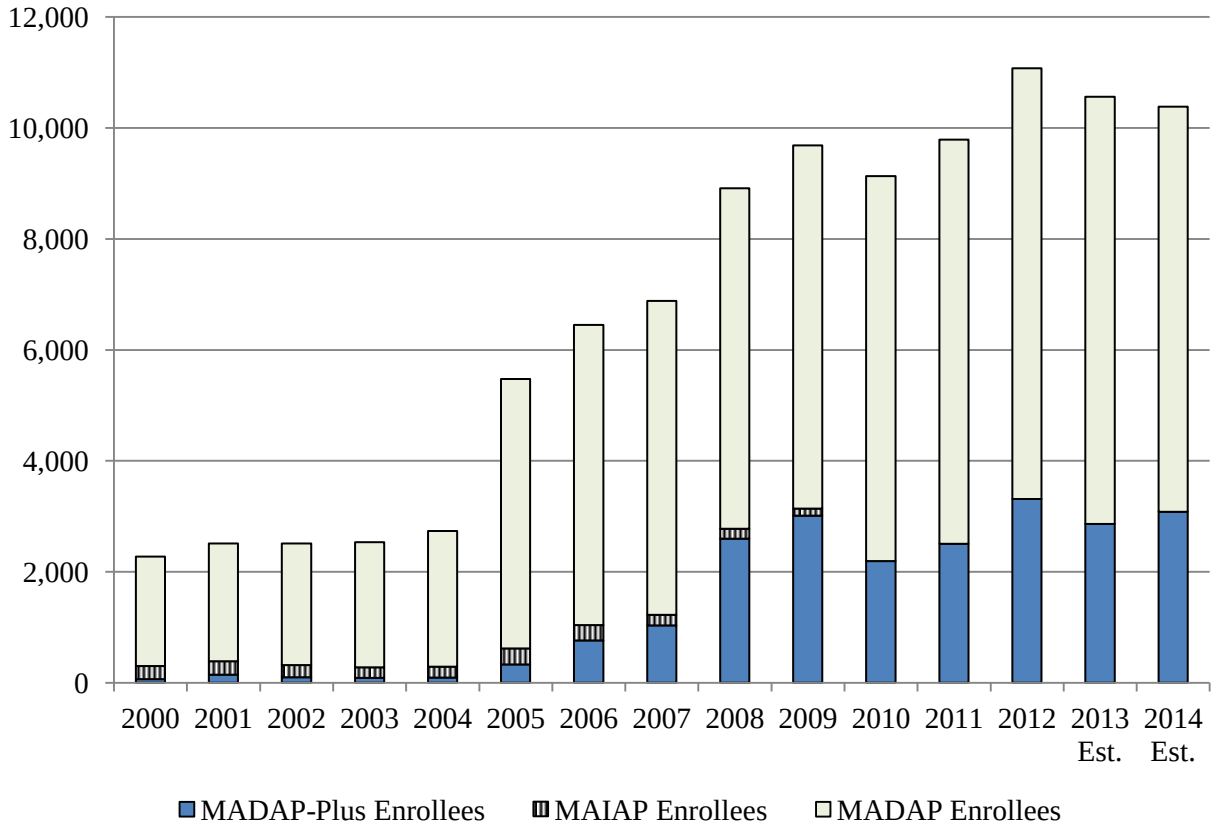
Source: Department of Health and Mental Hygiene

MADAP is the larger of the two programs with an estimated 7,700 enrollees in calendar 2013. MADAP helps low- to moderate-income 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. Following the increase in eligibility limits promulgated by the AIDS Administration in calendar 2004, MADAP has one of the nation's most expansive eligibility requirements along with extremely generous drug coverage.

MADAP-Plus offers health insurance assistance to individuals living with HIV/AIDS. MADAP-Plus experienced significant enrollment increases in calendar 2005, and the program had an estimated 2,861 enrollees in calendar 2013.

As shown in **Exhibit 9**, both MADAP and MADAP-Plus have experienced enrollment growth in recent years. MADAP-Plus enrollment had increased due to the elimination of MAIAP in June 2009 and due to the recession (as a higher number of individuals were in need of health insurance). In calendar 2012, MADAP and MADAP-Plus enrollment reached highs of 7,759 and 3,313 enrollees, respectively. However, the fiscal 2015 allowance reflects a decline in MADAP enrollment due to the implementation of federal health care reform.

Exhibit 9
MADAP, MADAP-Plus, and MAIAP Enrollment
Calendar 2000-2014 Est.



MADAP: Maryland AIDS Drug Assistance Program
MAIAP: Maryland AIDS Insurance 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 2014 Actions

Proposed Deficiency

There is one proposed deficiency ($182,059) for fiscal 2014 to provide funds for consultant technical services and support for the immunization registry system. In addition, there is a fiscal 2014 fund swap ($3.1 million) to recognize additional special funds from HIV Care Formula grants for MADAP drug rebates.

Cost Containment

There are three across-the-board withdrawn appropriations that offset the increase in deficiency appropriations. These include reductions to employee/retiree health insurance, funding for a new Statewide Personnel information system, and retirement reinvestment. These actions are fully explained in the analyses of the Department of Budget Management (DBM) – Personnel, the Department of Information Technology (DoIT), and the State Retirement Agency (SRA), respectively. PHPA's share of the reductions totals $248,856 in general funds.

Proposed Budget

The Governor's fiscal 2015 budget, as shown in **Exhibit 10**, increases by $3.8 million, or 1.1%. General funds increase by $989,000, or 1.9%, from fiscal 2014. Special funds decrease by $2.3 million, or 2.6%, and the federal fund allowance increases by $4.7 million, or 2.2%, from fiscal 2014. Finally, reimbursable funds increase by $340,000, or 16.6%.

It should be noted that the total change of $3.8 million shown in Exhibit 10 accounts for the withdrawn appropriation that is a part of a fiscal 2014 fund swap assumed in the Governor's budget plan but not for the related deficiency appropriation replacing that withdrawal. The fund swap reduces the fiscal 2014 federal fund appropriation by $3.1 million (from HIV Care Formula grants) and its deficiency appropriation adds an equal amount of special funds (for MADAP drug rebates). After accounting these deficiency appropriations, the overall increase in spending slows to $680,000 (0.2%).

Cost Containment

There is one across-the-board reduction and one contingent reduction reflected in the Governor's spending plan for the fiscal 2015 allowance. This affects funding for employee/retiree health insurance and retirement reinvestment. These actions are fully explained in the analyses of DBM – Personnel and SRA. PHPA's share of the reductions totals $273,086 in all funds.

Exhibit 10
Proposed Budget
DHMH – Prevention and Health Promotion Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2014 Working Appropriation	$53,198	$85,986	$212,311	$2,051	$353,545
2015 Allowance	54,187	83,727	217,010	2,392	357,315
Amount Change	$989	-$2,259	$4,700	$340	$3,770
Percent Change	1.9%	-2.6%	2.2%	16.6%	1.1%

Where It Goes:

Personnel Expenses	
Annualized salary increase for fiscal 2104 cost-of-living adjustment and increments	$929
Increments and other compensation	281
Retirement contributions	215
Other fringe benefit adjustments	126
Turnover adjustments	-61
Employee and retiree health insurance	-684
Other Changes	
Maternal, Infant, and Early Childhood Home Visiting Program – competitive funds	3,091
WIC electronic benefit transfer implementation	2,669
Maryland Million Hearts and Institute for a Healthiest Maryland (federal funds)	1,316
WIC Special Supplemental Food and Nutrition Program	1,102
Testing and Linkage to HIV Care	666
Other adjustments	158
Breast and Cervical Cancer Program	-1,470
MADAP and MADAP-Plus Programs	-4,568
Total	**$3,770**

HIV: Human Immunodeficiency Virus
MADAP: Maryland AIDS Drug Assistance Program
WIC: Women, Infants, and Children Program

Note: The fiscal 2014 working appropriation reflects negative deficiencies and contingent reductions. The fiscal 2015 allowance reflects back of the bill and contingent reductions. Numbers may not sum to total due to rounding.

Personnel

Personnel expenditures increase by $806,000 over the fiscal 2014 working appropriation. Annualized salary increases add $929,000 to the budget. Increments and other compensation increase by $281,000, while employee retirement contributions increase by $215,000. Other fringe benefit adjustments increase by $126,000. These increases are offset by decreases in employee and retiree health insurance ($684,000) and turnover adjustments ($61,000).

Women, Infants, and Children Program

The budget increases by $2.7 million for the Women, Infants, and Children (WIC) Program electronic benefit transfer (EBT) implementation (to replace the current system of issuing paper checks to WIC participants). The WIC EBT is expected to begin in January 2015. Additionally, funding for the WIC Special Supplemental Food and Nutrition Program in the fiscal 2015 allowance increases by $1.1 million, which is primarily attributable to increased food expenditures. **Exhibit 11** shows the number of women, infants, and children enrolled in the program, as well as monthly food package costs for fiscal 2011 through 2015. While the number of program enrollees in the WIC Program has remained constant since fiscal 2011, monthly food costs have increased by 17% over the same time period.

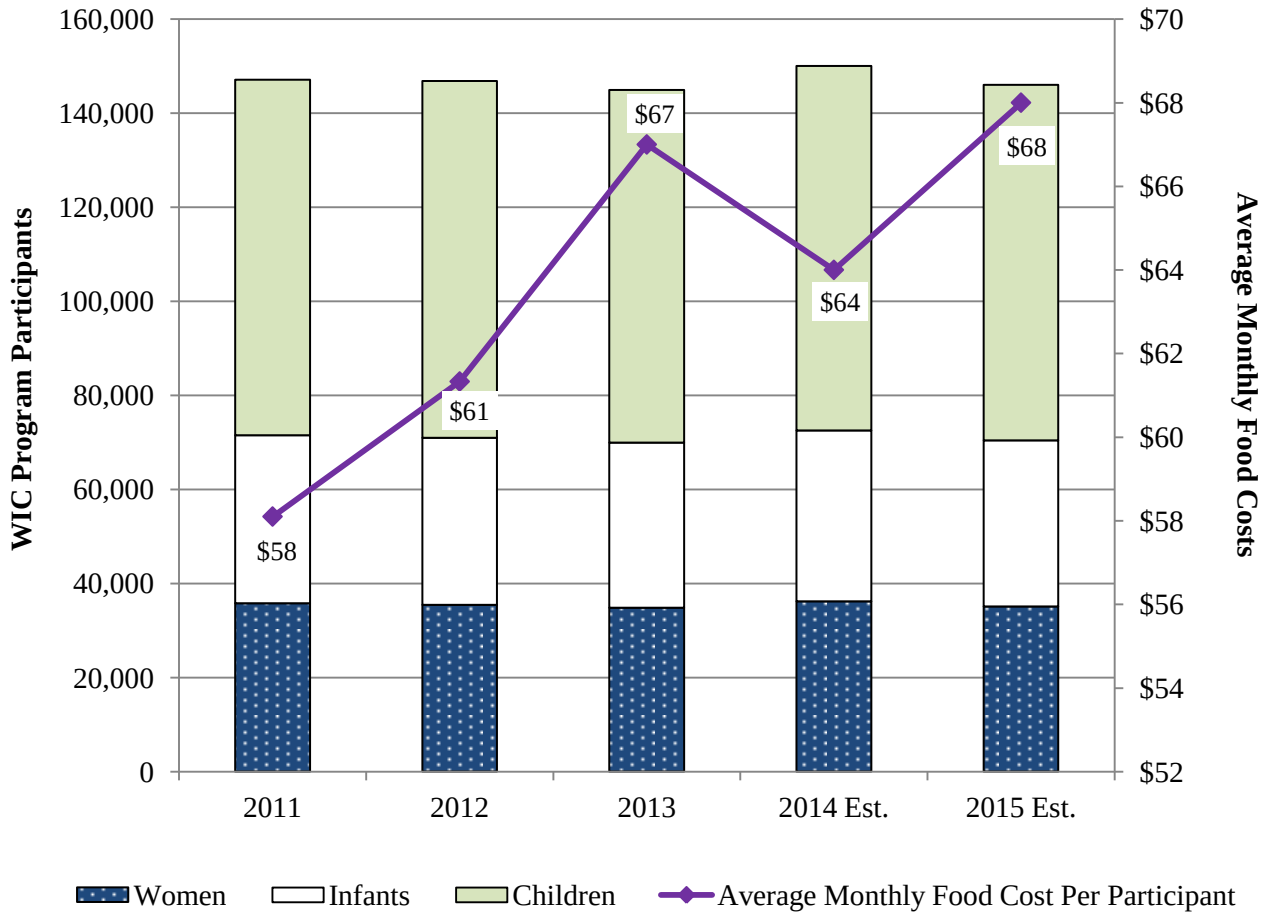
Maternal, Infants, and Early Childhood Home Visiting Program

Beginning in fiscal 2012, DHMH began receiving funding through the Patient Protection and Affordable Care Act for the Maternal, Infant, and Early Childhood Home Visiting Program. The purpose of the program is to provide evidence-based home visitation services to improve outcomes for children and families who reside in at-risk communities. The home visiting program that states choose to implement must also be linked to benchmark areas of improvement at the state level. The fiscal 2015 allowance includes an additional $3.1 million in competitive federal funds to expand evidence-based home visitation services in Maryland. Specifically, the program will continue to build and support its home visiting database, implement a training institute for home visitors, and support evaluation activities.

Breast and Cervical Cancer Diagnosis and Treatment Program

Funds for the Breast and Cervical Cancer Diagnosis and Treatment Program decrease by $1.5 million due to the implementation of health care reform. The program funds breast and cervical cancer diagnostic and treatment services for uninsured, low-income women ages 19 and older. The budget assumes a 10% decrease in the size of the program, as a greater proportion of individuals will be served within the Medicaid program or will obtain private insurance due to the full implementation of federal health care reform.

Exhibit 11
WIC Program Enrollment and Average Monthly Food Costs
Fiscal 2011-2015 Est.



WIC: Women, Infants, and Children Program

Source: Department of Health and Mental Hygiene

MADAP and MADAP-Plus Programs

Funds for the MADAP and MADAP-Plus programs decrease by $4.6 million due to the implementation of health care reform. These programs, which enable income-eligible individuals living with HIV and AIDS to access pharmaceuticals and health insurance coverage, are funded through a combination of federal grant funds and special funds made available through drug rebates. The decrease assumes a decline in program growth and assumes that a greater proportion of

individuals will be served within the Medicaid program or will obtain private insurance due to the full implementation of federal health care reform.

In addition, the budget increases by $666,000 in federal funds to support an initiative for expanded HIV testing and linkage to HIV care.

Other Changes

Two federally funded projects increase the budget by $1.3 million: demonstration projects continue for local health departments through the Maryland Million Hearts Program, while the Institute for a Healthiest Maryland continues to coordinate prevention and clinical quality efforts, provide public health expertise, and enable communication between health care leaders and academic experts. Other changes increase the budget by $158,000.

Recommended Actions

1. Concur with Governor's allowance.

Updates

1. Reducing Sexually Transmitted Infection Rates in Baltimore City

The 2013 *Joint Chairmen's Report* (JCR) requested DHMH, in coordination with BCHD, to submit a report on how it plans to achieve a reduction in the rate of sexually transmitted infections (STI) – particularly primary and secondary syphilis, chlamydia, and HIV/AIDS – in Baltimore City by fiscal 2015.

Included in the department's plan are several technological innovations. Specifically, the department reports that (1) BCHD and the department are coordinating to deploy a new shared web-based data system to ensure coordinated case management in real time, improving coordination and field staff disease intervention effectiveness; (2) BCHD is improving its Laboratory Information Management System and moving away from its current paper-based system used in family planning, outreach, and school-based health center screening; and (3) BCHD is collaborating with a local nonprofit organization to provide web-based STI test results and provider-assisted, web-based partner notification.

The department also outlines a plan for increased case identification through collaboration with the private medical community. Specifically, BCHD will collaborate with the department to develop screening and treatment recommendations to be sent to medical providers in Baltimore City and throughout the State. In addition, BCHD will engage CDC Public Health Associates (PHA) for two-year assignments. The PHAs' primary duties will be to visit health care provider practices and provide information about the incidence of STIs specific to individual practice zip codes. In addition, the PHAs will provide information about STI tests that are required to be reimbursed by insurance companies at no cost to patients. This initiative will prioritize healthcare providers in the highest STI morbidity zip codes.

The department further reports that it will develop an integrated strategy for a selected (but as yet unidentified) Baltimore City neighborhood. Specifically, BCHD will work in a selected community with high rates of STIs to determine the feasibility of conducting STI screening in one local high school, educating health care workers in the community regarding STI rates, and providing mobile outreach screening with partner organizations in that community. BCHD will also provide health education specific to STI prevention in the selected high school. These health education activities will be designed to complement, rather than supplant, existing school-based health education programs related to STI prevention.

2. Breast and Cervical Cancer Diagnosis and Treatment Program

Committee narrative in the 2013 JCR directed DHMH to submit biannual reports on program enrollment and costs for the Breast and Cervical Cancer Diagnosis and Treatment Program. Enrollment and cost data is summarized below.

During the first quarter of fiscal 2014, there were 2,752 clients enrolled in the program, with 1,185 of those clients having paid claims in that time period. During the second quarter of fiscal 2014, there were 2,547 clients enrolled in the program, with 1,152 of those clients having paid claims in that time period. The total cost of paid claims in the first half of fiscal 2014 was $6.9 million – $3.5 million for the first quarter and $3.4 million for the second quarter.

The agency's final report will provide data on the second half of fiscal 2014 as well as advice on program enrollment for fiscal 2015 based on the availability of expanded Medicaid coverage and federally subsidized plans purchased through the Maryland Health Benefits Exchange.

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 2013					
Legislative Appropriation	$44,657	$37,083	$144,520	$0	$226,260
Deficiency Appropriation	0	0	3,736	0	3,736
Budget Amendments	8,185	50,337	62,403	1,931	122,855
Reversions and Cancellations	0	-15,155	-907	0	-16,062
Actual Expenditures	**$52,842**	**$72,265**	**$209,751**	**$1,931**	**$336,789**
Fiscal 2014					
Legislative Appropriation	$53,286	$85,960	$215,070	$2,051	$356,367
Budget Amendments	160	26	331	0	517
Working Appropriation	**$53,446**	**$85,986**	**$215,401**	**$2,051**	**$356,884**

Note: The fiscal 2014 working appropriation does not include deficiencies or contingent reductions. Numbers may not sum to total due to rounding.

Fiscal 2013

The budget for PHPA closed at $336.8 million, $110.8 million over the original legislative appropriation, due primarily to the reorganization of Public health Services.

Deficiency appropriations increased the fiscal 2013 budget by $3.7 million. Additional federal funds were needed for an integrated behavioral health and primary care network ($1,313,643); to develop strategic plans to allow local health departments to bill for immunization services ($594,002); and for the WIC Program ($1,827,885).

Budget amendments over the course of fiscal 2013 increased the budget by $122.9 million due primarily to the reorganization of the Public Health Services Division, which involved merging the Infectious Disease and Environmental Health Administration with the Family Health Administration to create PHPA. In addition, the fiscal 2013 budget included centrally budgeted funds for the fiscal 2013 cost-of-living adjustment (COLA) for State employees; this resulted in the transfer of funds to PHPA ($74,695 in special funds and $135,590 in federal funds). Federal funds also increased to cover the cost of programs associated with food safety and to strengthen Maryland's ability to respond to food-related emergencies ($463,058).

At the end of the year, approximately $15.2 million of the special fund appropriation and $907,000 of the federal fund appropriation were cancelled due to lower-than-expected grant award attainment and expenditures.

Fiscal 2014

The fiscal 2014 working appropriation is $356.9 million, an increase of $0.5 million over the original legislative appropriation. The fiscal 2014 budget included centrally budgeted funds for the fiscal 2014 COLA and salary increment increase for State employees, which resulted in the transfer of funds to PHPA ($222,372 in general funds, $288,091 in federal funds, and $26,361 in special funds). Federal funds also increased by $43,059 to realign the State Retirement Administrative Fee and DoIT Services Allocation appropriations within DHMH. Finally, general funds decreased by $62,462 to transfer a position from PHPA into the Public Health Administration.

Object/Fund Difference Report
DHMH – Prevention and Health Promotion Administration

Object/Fund	FY 13 Actual	FY 14 Working Appropriation	FY 15 Allowance	FY 14 - FY 15 Amount Change	Percent Change
Positions					
01 Regular	364.80	362.80	362.80	0.00	0%
02 Contractual	5.43	8.93	8.90	-0.03	-0.3%
Total Positions	**370.23**	**371.73**	**371.70**	**-0.03**	**0%**
Objects					
01 Salaries and Wages	$ 29,467,281	$ 31,898,333	$ 32,831,011	$ 932,678	2.9%
02 Technical and Spec. Fees	313,049	391,581	415,298	23,717	6.1%
03 Communication	612,433	954,331	754,325	-200,006	-21.0%
04 Travel	405,598	651,632	592,094	-59,538	-9.1%
07 Motor Vehicles	120,852	127,634	124,945	-2,689	-2.1%
08 Contractual Services	228,947,628	237,986,072	236,342,122	-1,643,950	-0.7%
09 Supplies and Materials	43,498,621	43,429,549	44,145,329	715,780	1.6%
10 Equipment – Replacement	137,430	4,399	445	-3,954	-89.9%
11 Equipment – Additional	770,641	625,258	548,749	-76,509	-12.2%
12 Grants, Subsidies, and Contributions	32,017,553	40,418,181	41,439,289	1,021,108	2.5%
13 Fixed Charges	497,461	397,470	497,507	100,037	25.2%
Total Objects	**$ 336,788,547**	**$ 356,884,440**	**$ 357,691,114**	**$ 806,674**	**0.2%**
Funds					
01 General Fund	$ 52,841,534	$ 53,446,371	$ 54,338,215	$ 891,844	1.7%
03 Special Fund	72,264,995	85,985,914	83,744,867	-2,241,047	-2.6%
05 Federal Fund	209,751,456	215,400,986	217,216,424	1,815,438	0.8%
09 Reimbursable Fund	1,930,562	2,051,169	2,391,608	340,439	16.6%
Total Funds	**$ 336,788,547**	**$ 356,884,440**	**$ 357,691,114**	**$ 806,674**	**0.2%**

Note: The fiscal 2014 appropriation does not include deficiencies. The fiscal 2015 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Prevention and Health Promotion Administration

Program/Unit	FY 13 Actual	FY 14 Wrk Approp	FY 15 Allowance	Change	FY 14 - FY 15 % Change
01 Administrative, Policy, and Management Systems	$ 119,691,738	$ 122,366,729	$ 117,726,432	-$ 4,640,297	-3.8%
04 Family Health and Chronic Disease Services	217,096,809	234,517,711	239,964,682	5,446,971	2.3%
Total Expenditures	**$ 336,788,547**	**$ 356,884,440**	**$ 357,691,114**	**$ 806,674**	**0.2%**
General Fund	$ 52,841,534	$ 53,446,371	$ 54,338,215	$ 891,844	1.7%
Special Fund	72,264,995	85,985,914	83,744,867	-2,241,047	-2.6%
Federal Fund	209,751,456	215,400,986	217,216,424	1,815,438	0.8%
Total Appropriations	**$ 334,857,985**	**$ 354,833,271**	**$ 355,299,506**	**$ 466,235**	**0.1%**
Reimbursable Fund	$ 1,930,562	$ 2,051,169	$ 2,391,608	$ 340,439	16.6%
Total Funds	**$ 336,788,547**	**$ 356,884,440**	**$ 357,691,114**	**$ 806,674**	**0.2%**

Note: The fiscal 2014 appropriation does not include deficiencies. The fiscal 2015 allowance does not include contingent reductions.