# 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.

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## *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.

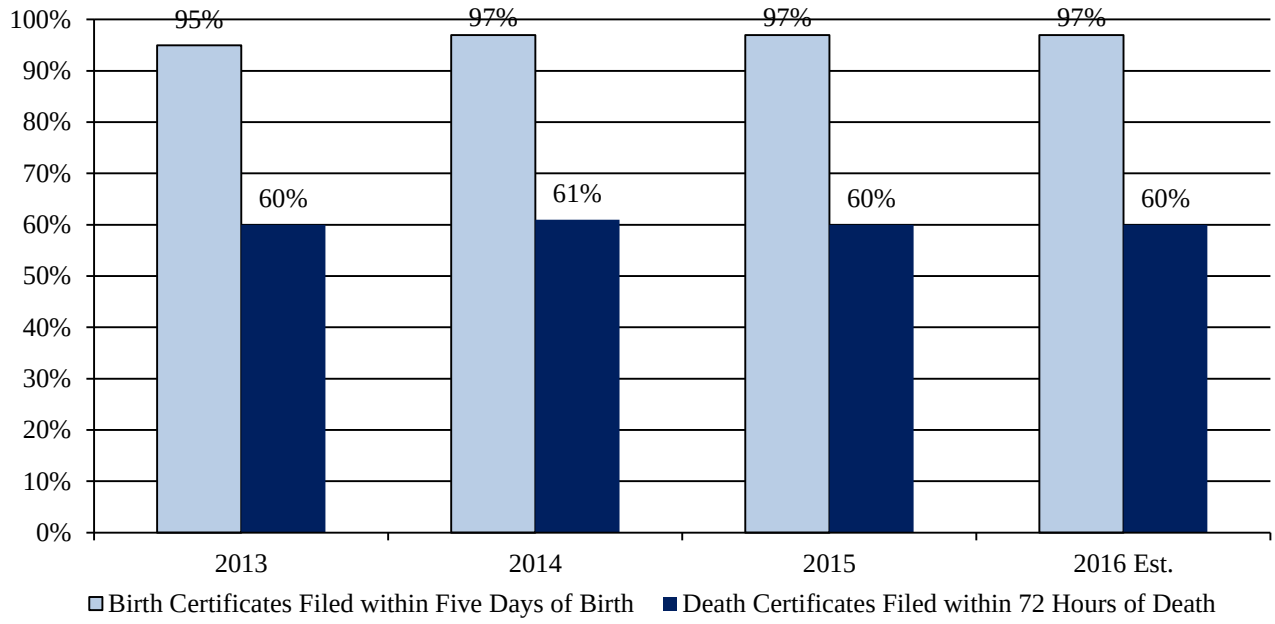
## Performance Analysis: Managing for Results

### 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

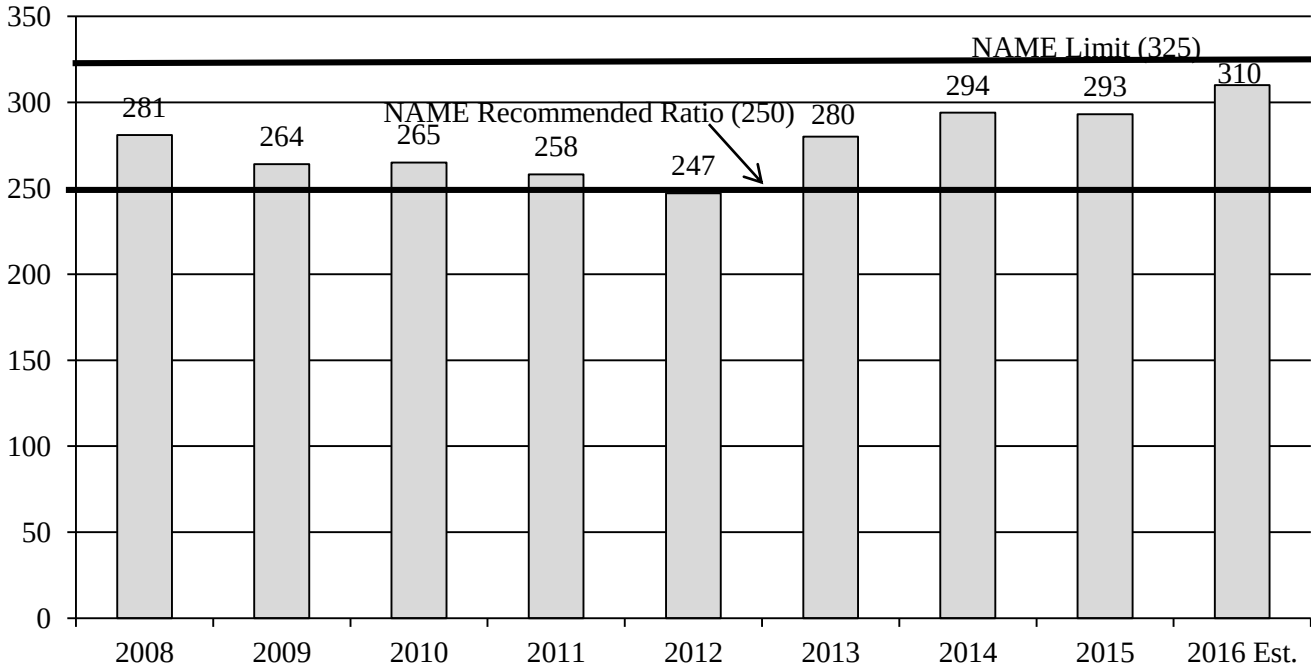
OCME is required to investigate all violent or suspicious deaths, including all deaths unattended by a physician. If the cause of death cannot be established during the initial investigation, a pathologist must perform an autopsy on the deceased.

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

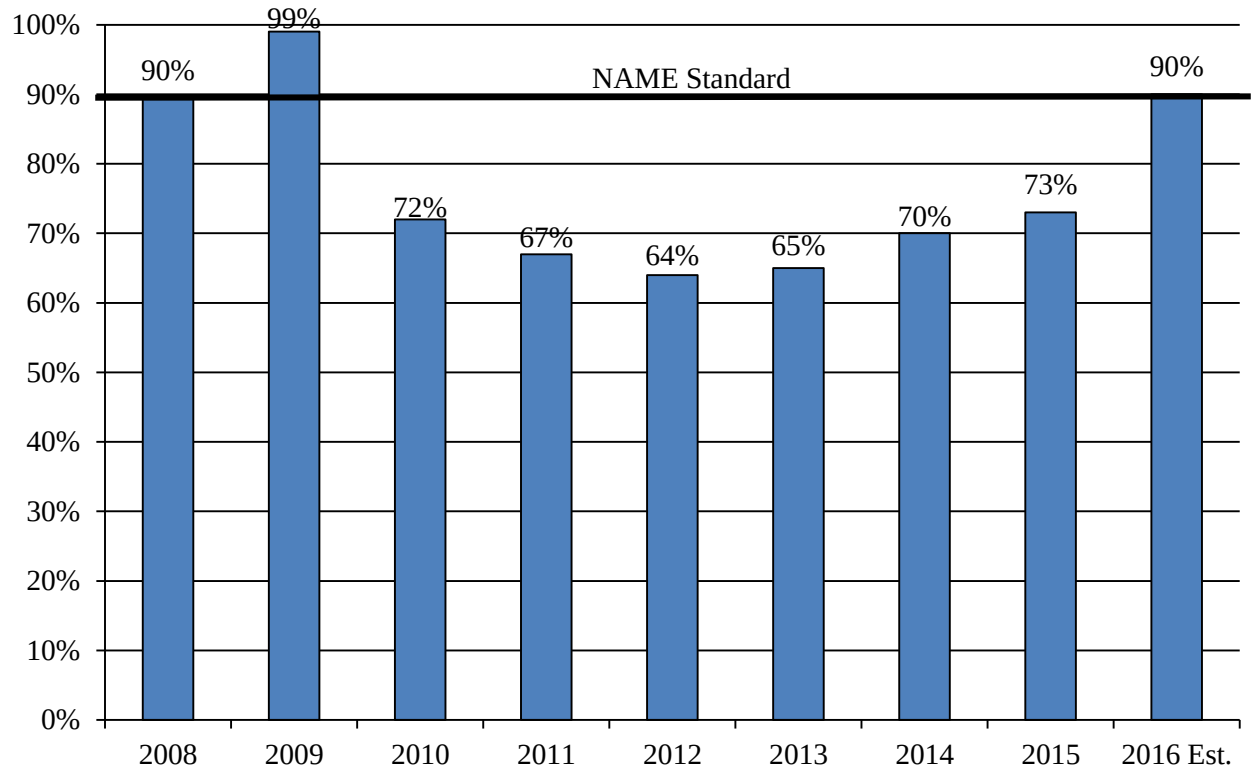
Source: Department of Health and Mental Hygiene

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

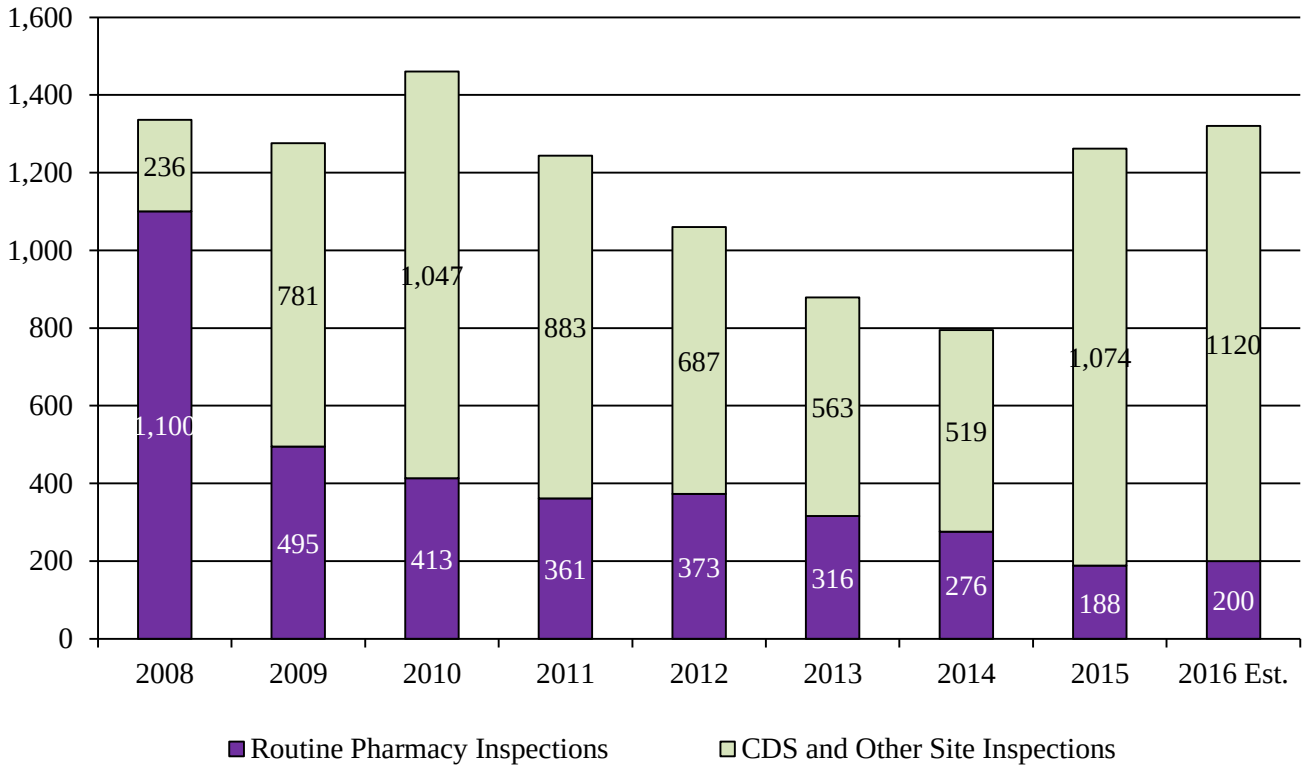
The Division of Drug Control (DDC) registers practitioners and establishments to legally manufacture, distribute, dispense, or otherwise handle controlled dangerous substances (CDS) in Maryland. The federal Controlled Substances Act of 1970 (CSA) authorizes federal regulation of the manufacture, importation, 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.**



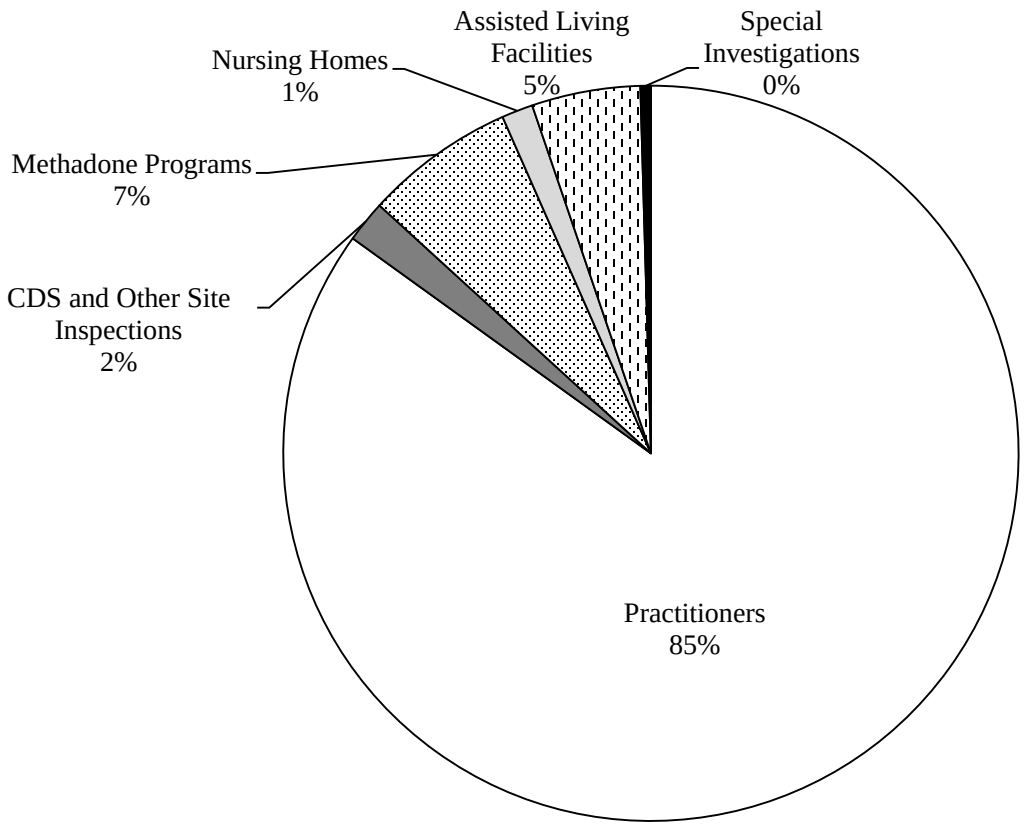

CDS: controlled dangerous substance

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.

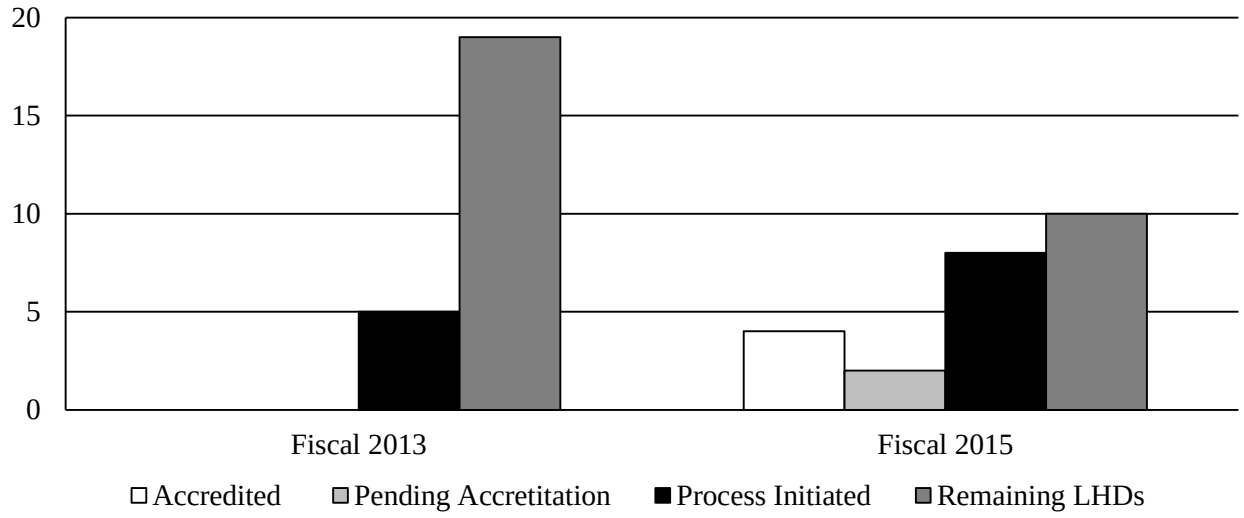
The accreditation process includes seven steps: (1) pre-application, which includes submitting a statement of intent and online orientation; (2) application, which requires a health department to submit application forms and the applicable fee; (3) document selection and submission, which requires a 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.

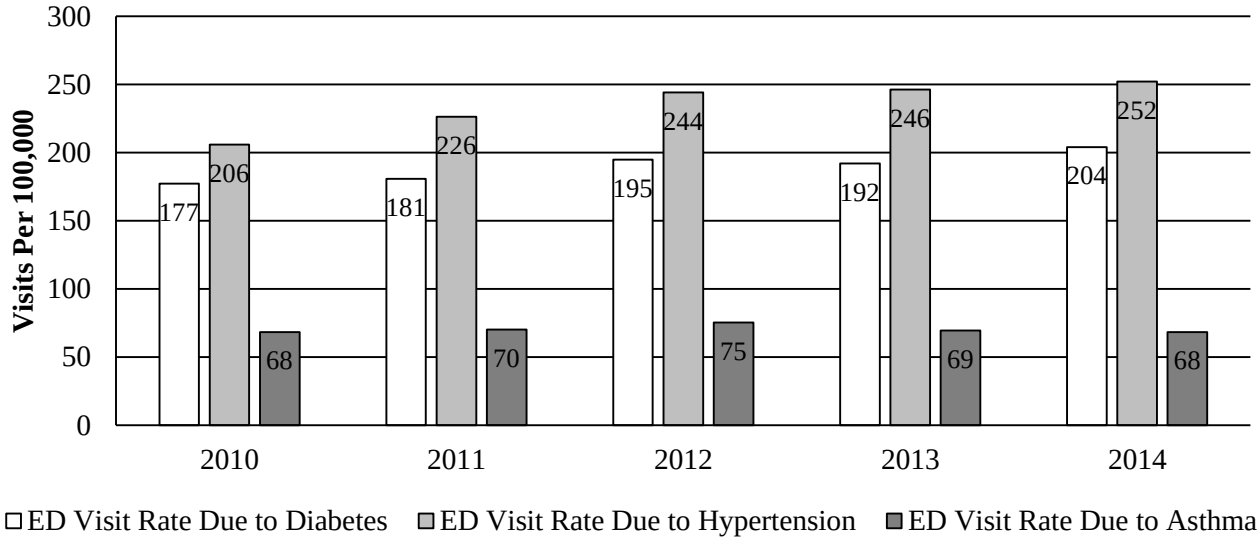
# *Issues*

## 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**

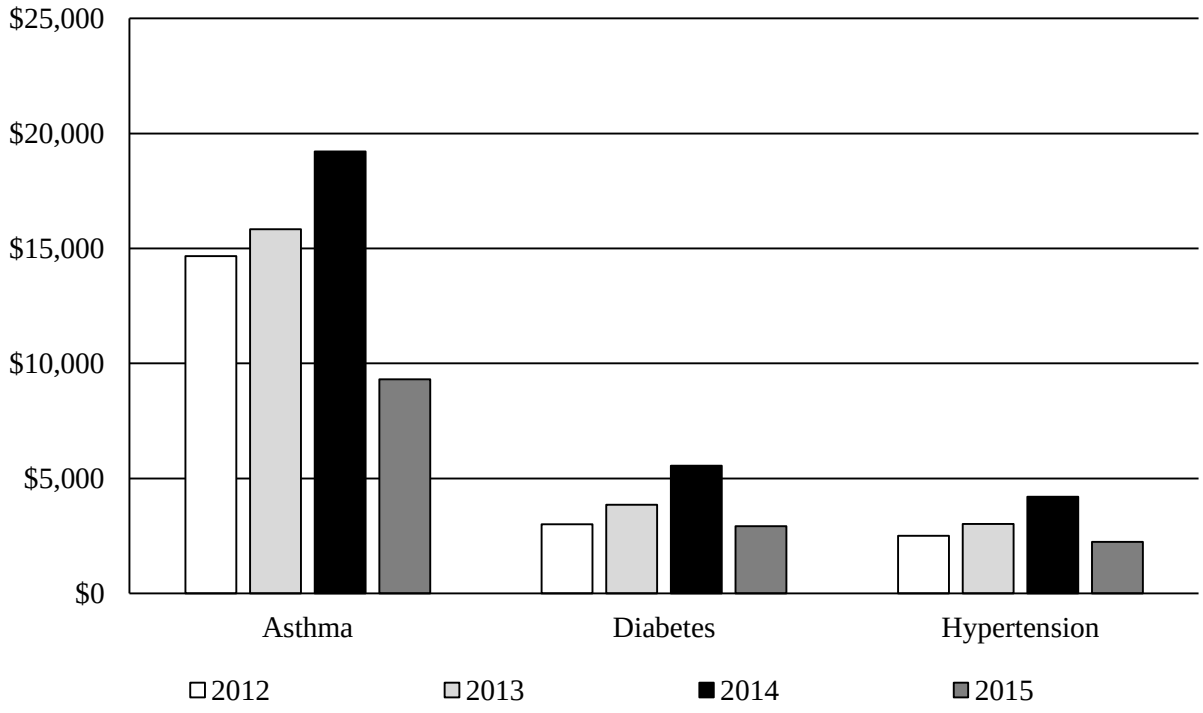



ED: emergency department

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)**

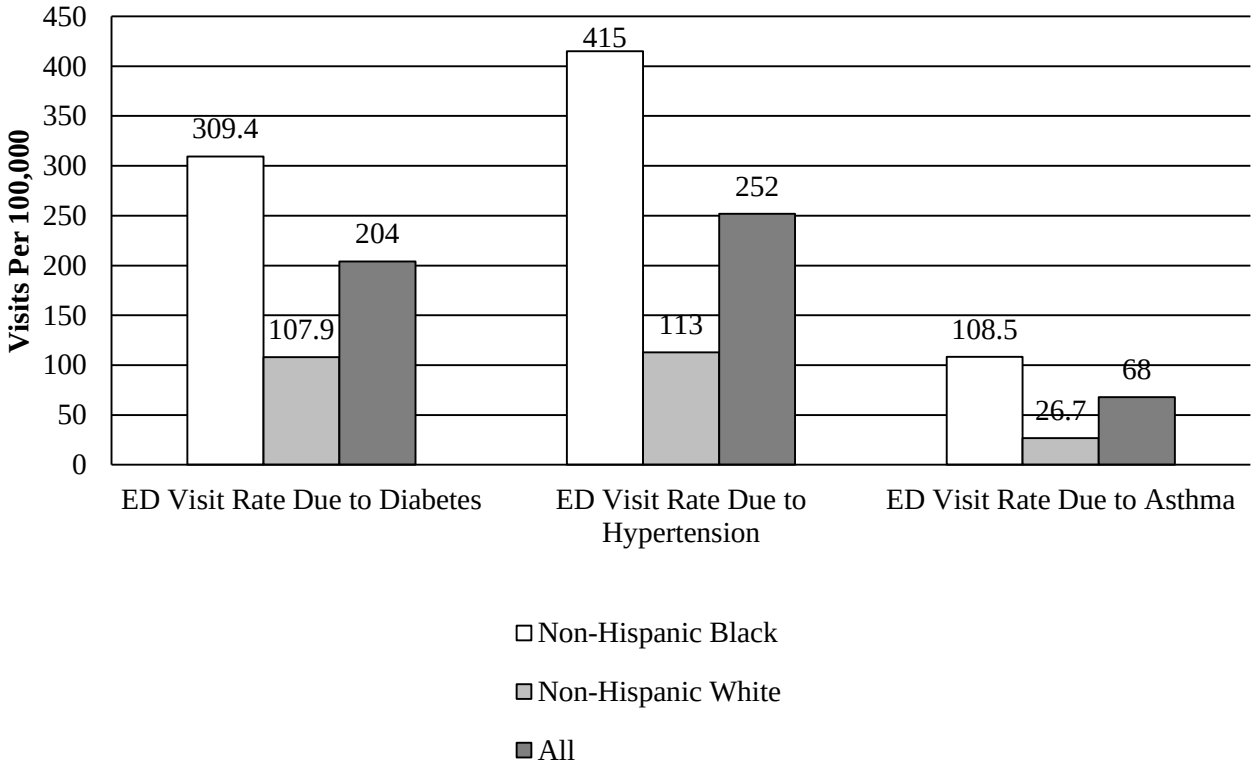



Note: 2015 may not include all charges, actuals as of January 2016.

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.