M00F03
Prevention and Health Promotion Administration
Maryland Department of Health

Executive Summary

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 community-based public health efforts.

Operating Budget Data

($ in Thousands)

	FY 18 Actual	FY 19 Working	FY 20 Allowance	FY 19-20 Change	% Change Prior Year
General Fund	$64,593	$61,924	$54,278	-$7,646	-12.3%
Adjustments	0	3,088	426	-2,662	
Adjusted General Fund	**$64,593**	**$65,012**	**$54,705**	**-$10,308**	**-15.9%**
Special Fund	92,265	116,564	148,619	32,055	27.5%
Adjustments	0	12	45	33	
Adjusted Special Fund	**$92,265**	**$116,576**	**$148,664**	**$32,088**	**27.5%**
Federal Fund	192,483	215,163	225,871	10,709	5.0%
Adjustments	0	157	611	454	
Adjusted Federal Fund	**$192,483**	**$215,320**	**$226,483**	**$11,163**	**5.2%**
Reimbursable Fund	1,661	2,389	2,315	-74	-3.1%
Adjustments	0	0	0	0	
Adjusted Reimbursable Fund	**$1,661**	**$2,389**	**$2,315**	**-$74**	**-3.1%**
Adjusted Grand Total	**$351,002**	**$399,297**	**$432,166**	**$32,869**	**8.2%**

Note: The fiscal 2019 appropriation includes deficiencies, a one-time $500 bonus, and general salary increases. The fiscal 2020 allowance includes general salary increases.

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

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- The fiscal 2020 allowance for PHPA increases by $32.9 million, an 8.2% increase over the fiscal 2019 working appropriation. The increase is driven by increased use of an existing fund balance of Ryan White Part B funds that are generated by pharmaceutical rebates. Use of that fund source increases by $31.4 million in fiscal 2020.

Personnel Data

	FY 18 Actual	FY 19 Working	FY 20 Allowance	FY 19-20 Change
Regular Positions	401.80	401.80	458.60	56.80
Contractual FTEs	19.56	27.47	48.87	21.40
Total Personnel	**421.36**	**429.27**	**507.47**	**78.20**
Vacancy Data: Regular Positions				
Turnover and Necessary Vacancies, Excluding New Positions		22.08	5.92%	
Positions and Percentage Vacant as of 12/31/18		48.50	12.07%	

- Regular positions at PHPA increase by 56.8 with 53.8 of these additions due to the conversion of employees of the Maryland Institute for Policy and Research to employees of the Maryland Department of Health (MDH).

- The administration also converted 2.0 contractual positions to regular positions and transferred 1 position to PHPA from another MDH department.

- PHPA is adding 21.4 contractual positions in the fiscal 2020 allowance with most of the positions being added to the Office of Infectious Disease Prevention and Health Services.

Key Observations

- Consistent with national trends, rates of sexually transmitted infections, such as chlamydia, gonorrhea, and syphilis, continue to increase in Maryland.

- A large fund balance of Ryan White Part B drug rebate money allows PHPA to significantly increase spending on HIV/AIDS programs.

- Managing for Results indicators continue to show stark health disparities in the State.

Operating Budget Recommended Actions

		Funds
1.	Delete federal funds due to a double-budgeted federal grant.	$ 1,660,218
	Total Reductions	**$ 1,660,218**

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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.

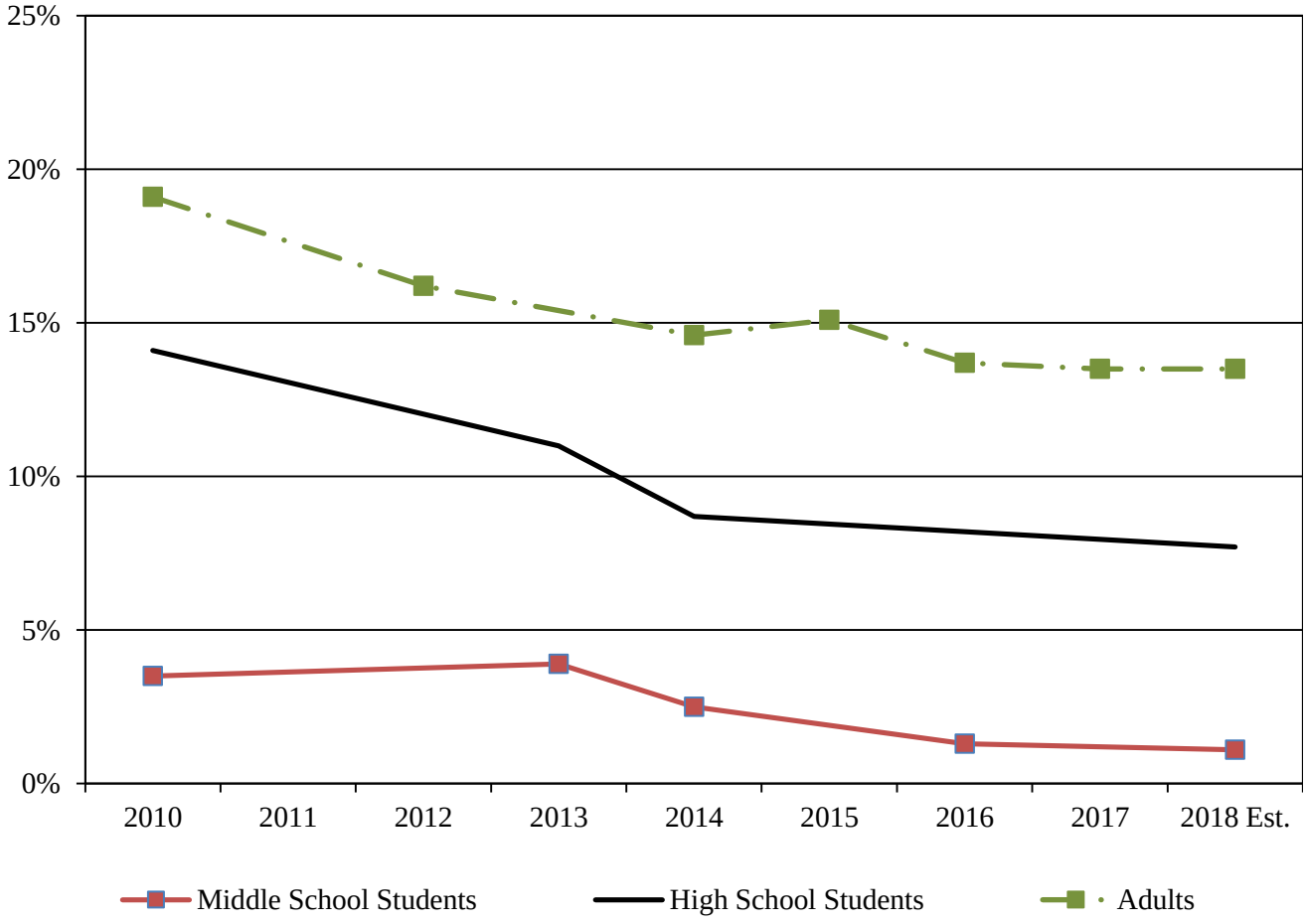
PHPA accomplishes this by focusing, in part, on the prevention and control of infectious diseases, investigation of disease outbreaks, protection from food-related and environmental health hazards, and helping impacted persons live longer, healthier lives. Additionally, the administration works to assure 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 healthy behaviors.

Performance Analysis: Managing for Results

1. Tobacco Use Continues to Decrease

The mission of the Tobacco Use Prevention and Cessation Program is to reduce the use of tobacco products and to reduce the burden of tobacco-related morbidity and mortality in the State. One of the goals of the program is to reduce the proportion of Maryland youth and adults who currently smoke cigarettes. Surveys funded with the Cigarette Restitution Fund revenue are intended to track smoking preferences and usage among Marylanders. As shown in **Exhibit 1**, the prevalence of cigarette smoking has decreased for all ages in 2016, the most recent year with available data. Surveys are conducted every other year, and PHPA estimates continued declines in 2018.

Exhibit 1
Tobacco Usage Rates
Calendar 2010-2018 Est.



Source: Maryland Department of Health

PHPA has a long-term objective to reduce the proportion of underage youth that smoke cigarettes by 79.5% and 67.4% for middle school students and high school students, respectively, between calendar 2000 and the end of calendar 2018. The administration estimates for calendar 2018 that 1.1% of middle school students and 7.7% of high school students smoked cigarettes, compared to 7.2% and 23.7%, respectively, in calendar 2000. This would be an 85% decrease for middle school students and a 67% decrease for high school students. PHPA has met the middle school student objective and would be just shy of the high school student objective.

Maryland has the ninth lowest adult tobacco use rate in the nation, attributed to policies enacted at the local, State, and federal levels that deter tobacco use by reducing exposure to secondhand smoke

indoors, increasing pricing that motivates smokers to quit, and prohibiting youth access to tobacco products in the retail environment. PHPA highlighted recent initiatives at the Maryland Department of Health (MDH) Center for Tobacco Prevention and Control (CPTC) that have also contributed to the decreasing tobacco use rates. In fiscal 2016, CPTC launched a health systems pilot program that allowed for providers to make electronic referrals to cessation programs and developed a mass outreach campaign in conjunction with a national advertising campaign.

As shown in **Exhibit 2**, individuals served by the Tobacco Quitline, one of the referred tobacco cessation programs, increased substantially in fiscal 2016, the year of the campaign. However, individuals served decreased by 5.7% in fiscal 2017 and by a further 19.4% in fiscal 2018. The administration attributes the decline to a shorter and poorly timed U.S. Centers for Disease Control and Prevention (CDC) National Tobacco Education Campaign in 2018. The television campaign ran for four fewer weeks and did not air in January, a popular time for quit attempts.

Exhibit 2
Individuals Served by the Tobacco Quitline
Fiscal 2013-2019 Est.

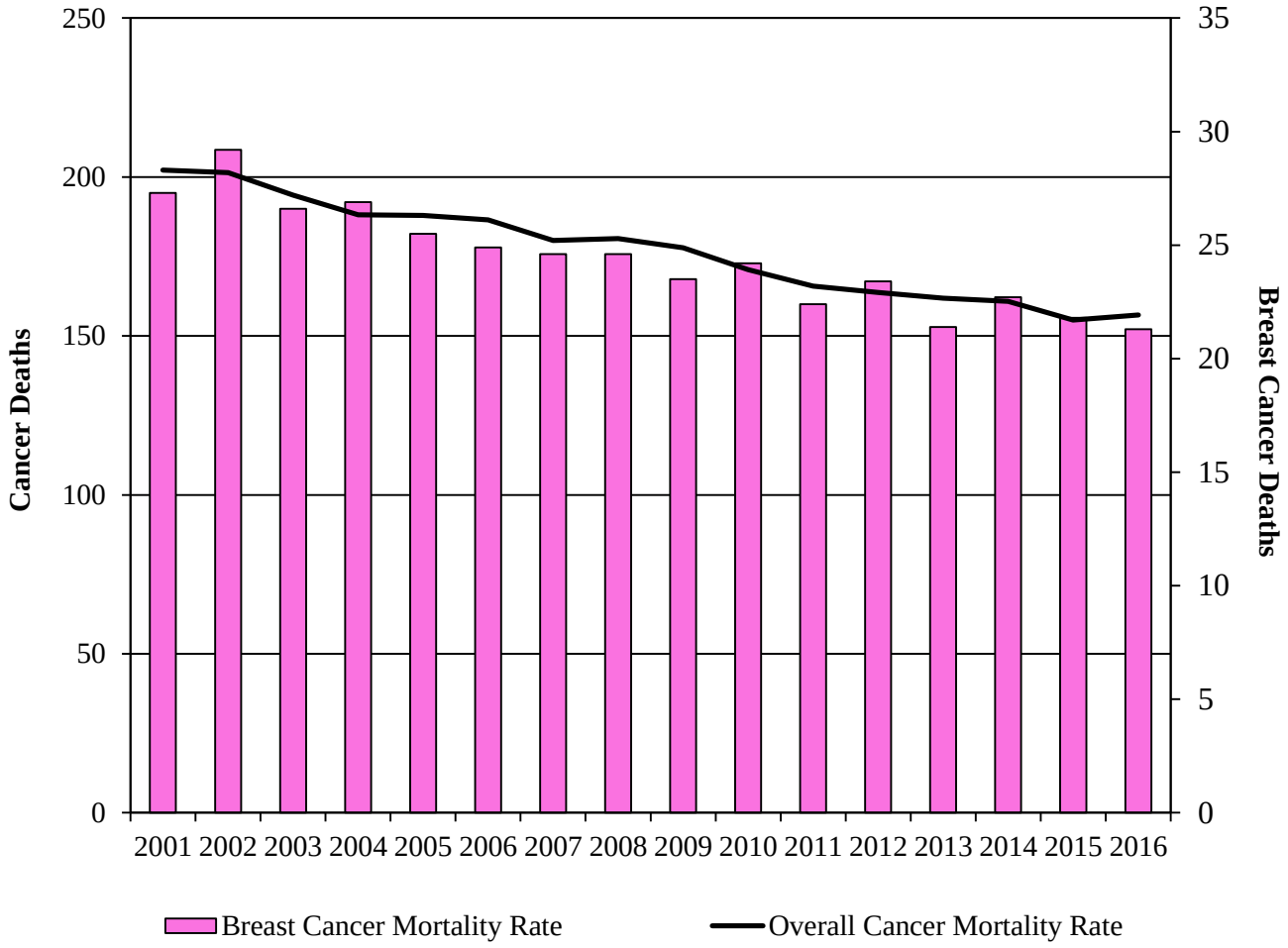
	2013	2014	2015	2016	2017	2018	2019 Est.
Individuals Served	12,180	9,792	9,469	10,324	9,731	7,844	8,753

Source: Maryland Department of Health

2. Cancer Mortality Rates Worsen Slightly

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 3** shows that for the first time since at least 2001, there was a slight increase in the overall cancer mortality rate, from 155 deaths per 100,000 population to 156.6. However, breast cancer mortality rates fell for the second successive year, to a new low for the period shown.

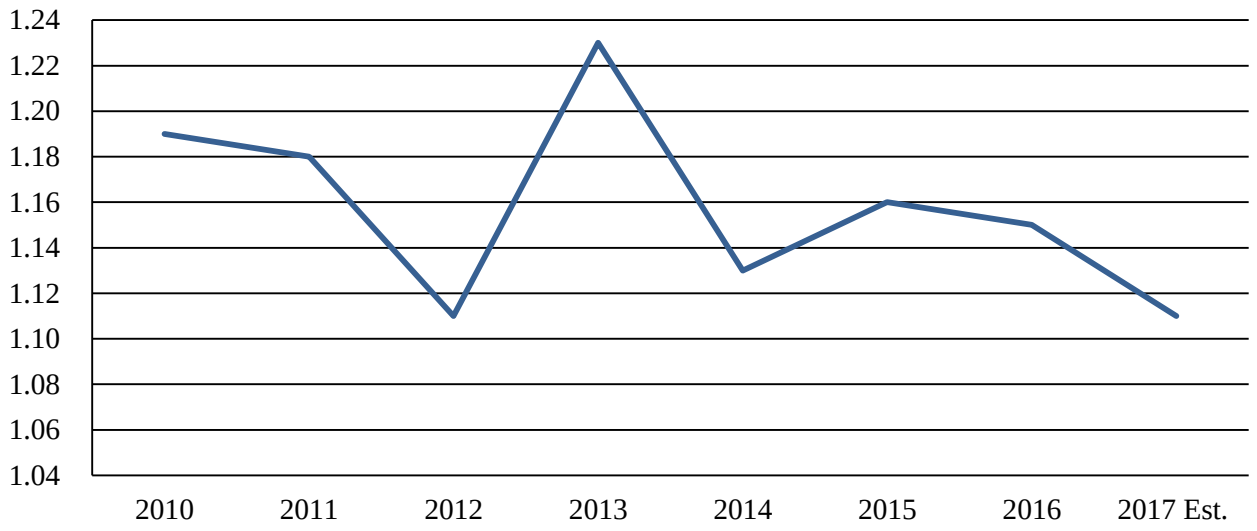
Exhibit 3
Cancer Mortality Rates
Calendar 2001-2016
(Deaths Per 100,000 Population)



Source: Maryland Department of Health

Although cancer mortality rates have generally decreased over time, there remains a disparity between cancer mortality rates among races. **Exhibit 4** shows the ratio of cancer mortality rates among African Americans when compared to Whites in Maryland. A ratio of 1.0 would indicate that there is no disparity in cancer mortality, a ratio greater than 1.0 indicates that African Americans have a higher relative mortality rate. Despite a long-term trend of an overall decrease in cancer mortality, the rate among African American Marylanders has increased in relation to the rate among White Marylanders. In 2017, the ratio fell to 1.11, continuing the recent reduction in the disparity.

Exhibit 4
Cancer Mortality Ratio of African Americans to Whites
Calendar 2010-2017 Est.



Note: A ratio of 1.0 would indicate no disparity. A ratio above 1.0 indicates that the mortality rate is relatively higher for African Americans than for Whites.

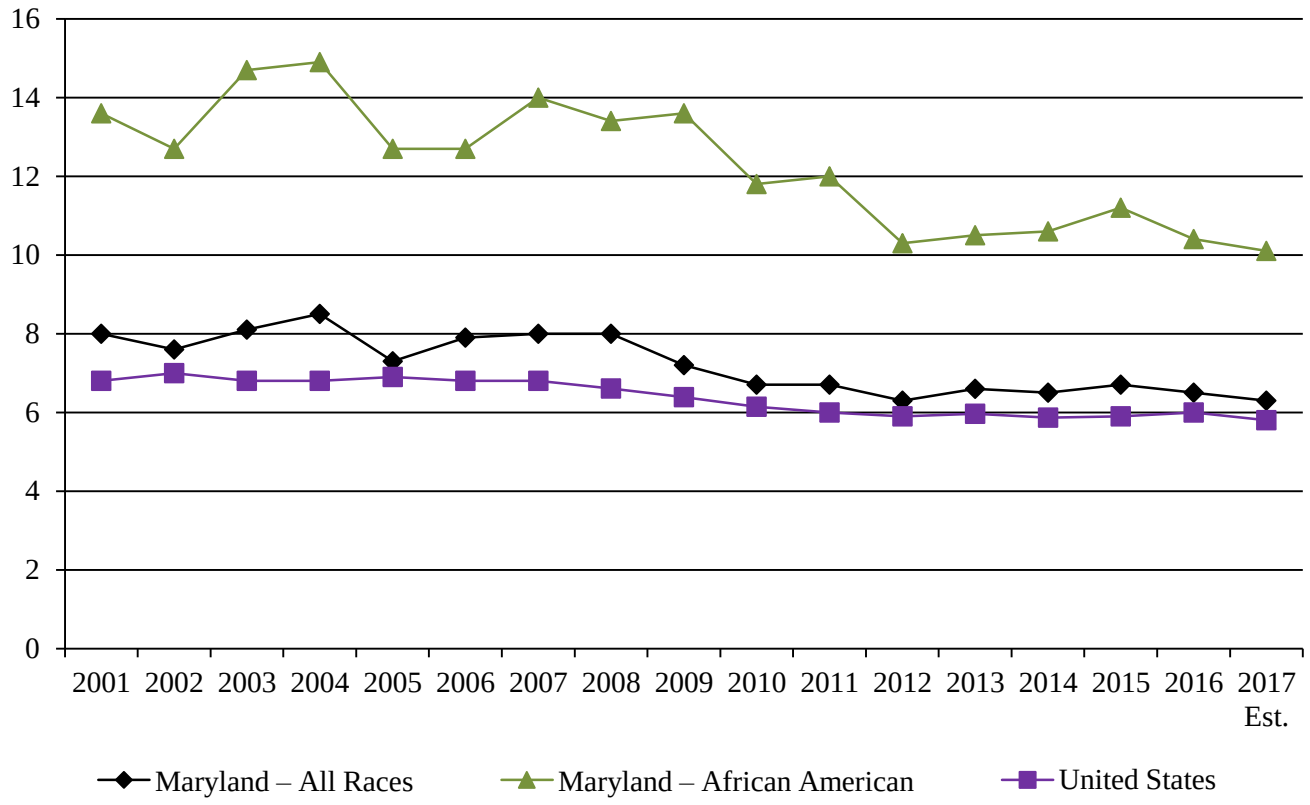
Source: Maryland Department of Health

3. Infant Mortality Rates Decrease Slightly for All Races

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 refer to the number of deaths under age one per 1,000 live births and are used to indicate the total health of populations. 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.

Maryland has made steady progress to reduce its infant mortality rate, reaching a low of 6.3 per 1,000 live births in calendar 2012 (the lowest rate ever recorded in Maryland), as shown in **Exhibit 5**. Following national trends, Maryland's African American infant mortality rate has consistently been higher than other races. In 2017, the overall infant mortality rate decreased to 6.3, matching the previous low. The African American infant mortality rate also fell to a new low for the period shown but is still significantly higher than the overall rate.

Exhibit 5
Infant Mortality Rates
Calendar 2001-2017 Est.

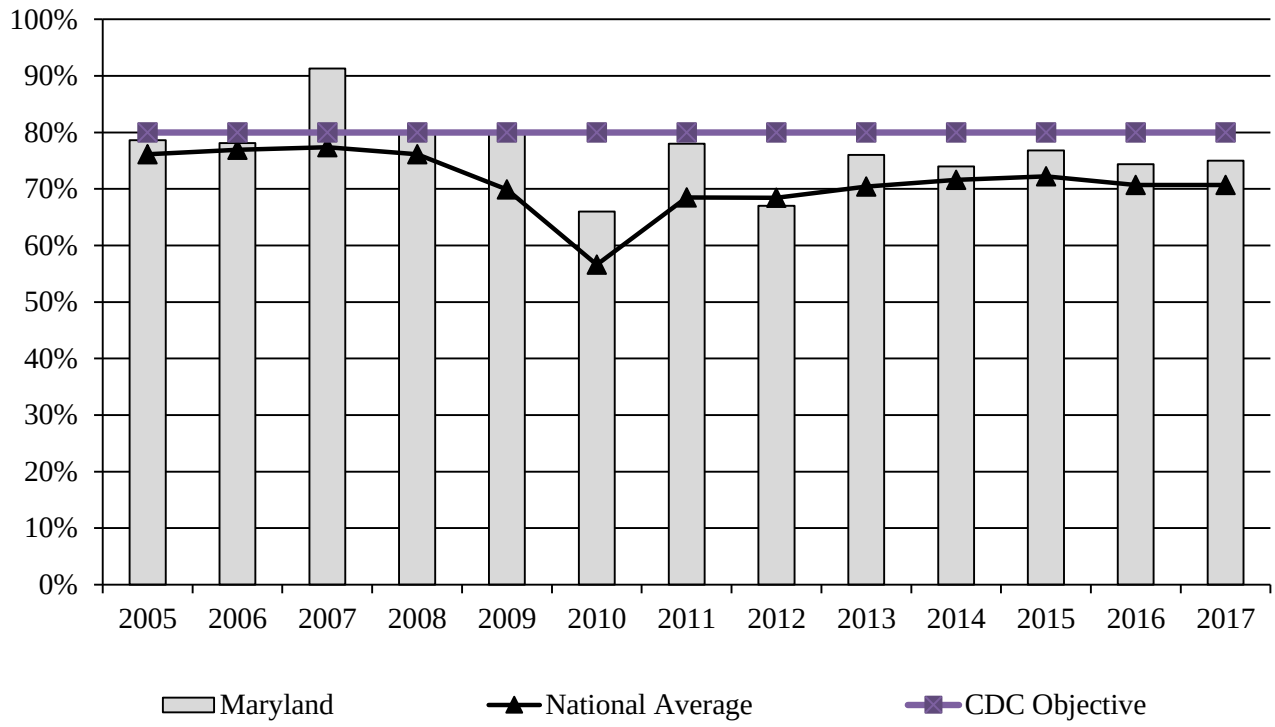


Source: Maryland Department of Health

4. Childhood Vaccination Rates Increase, Remain Above National Average

As shown in **Exhibit 6**, 75% of children in Maryland received the typical coverage of vaccinations in calendar 2017, which is above the national average of 71%, and a 1 percentage point increase over the prior year. Between calendar 2006 and 2007, the rate of immunizations jumped 13 percentage points, although reasons for this increase were unclear. In calendar 2008, the vaccination rate returned to historic levels. Low points in calendar 2010 and 2012 resulted, in both cases, from nationwide vaccine shortages. Maryland's childhood vaccination rates have generally remained slightly above national rates.

Exhibit 6
Children, Ages 19 to 35 Months, with Up-to-date Immunizations
Calendar 2005-2017



CDC: U.S. Centers for Disease Control and Prevention

Source: Maryland Department of Health; U.S. Centers for Disease Control and Prevention

Maryland is able to keep its vaccination rates relatively high for several reasons. First, the State allows parents to opt out of vaccinating toddlers for medical or religious reasons but not for philosophical reasons. Also, MDH operates the Maryland Vaccines for Children Program, which works with 750 providers at 1,000 public and private practice vaccine delivery sites to provide all routinely recommended vaccines free of cost to children 18 years old or younger who are:

- Medicaid eligible;
- uninsured;
- Native American or Alaskan Native; or
- underinsured.

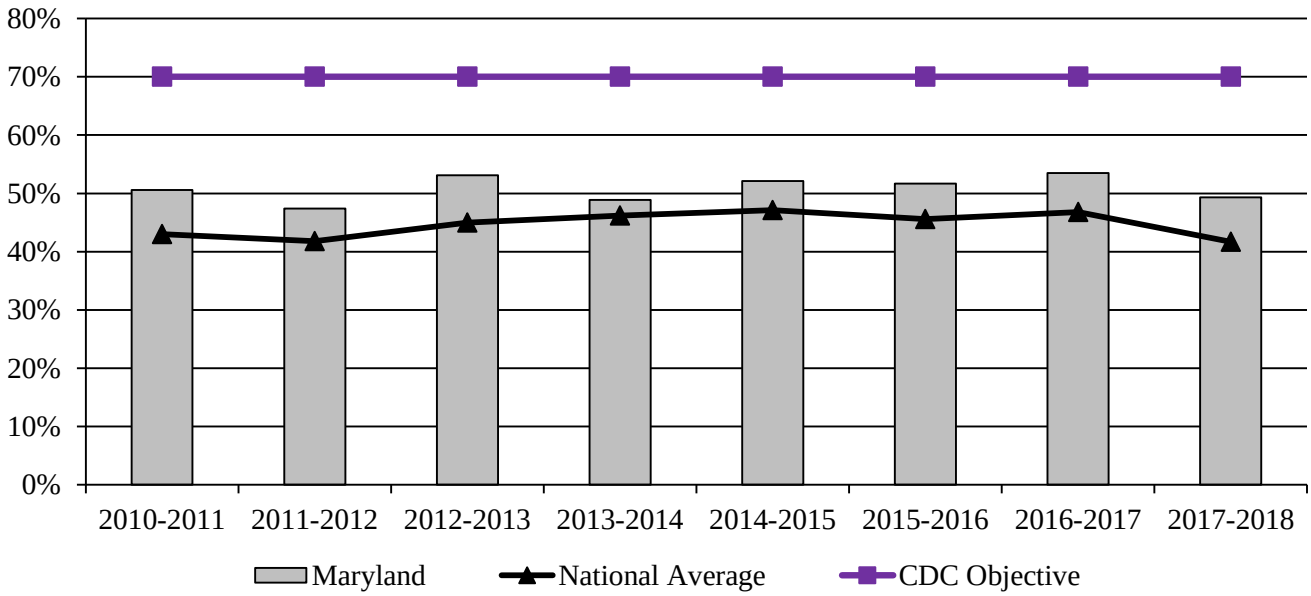
Although childhood vaccination rates in Maryland are above the national average, the State has not yet met the 80% childhood vaccination rate objective set by CDC.

5. Influenza Vaccination Rates Increase, Remain Above National Average

MDH develops an annual *Maryland Influenza Plan* to prepare for, prevent, and mitigate the number and severity of influenza (flu) cases within the State. The plan provides some tips and best practices for Maryland residents and the State and local health departments. Above all other recommendations, MDH emphasizes that the best way to prevent the flu is by getting vaccinated each year.

As shown in **Exhibit 7**, flu vaccination rates among adults ages 18 and over decreased in the 2017 to 2018 flu season to 49.3% – maintaining a level above the national average of 41.7%. Flu vaccination rates are well below the CDC objective of 70%. The decrease in the 2017 to 2018 flu season was potentially due to reports that that year's flu vaccine was not as effective as expected.

Exhibit 7
Influenza Vaccination Rate Age 6 Months+
Flu Seasons 2010-2018



CDC: U.S. Centers for Disease Control and Prevention

Source: U.S. Centers for Disease Control and Prevention

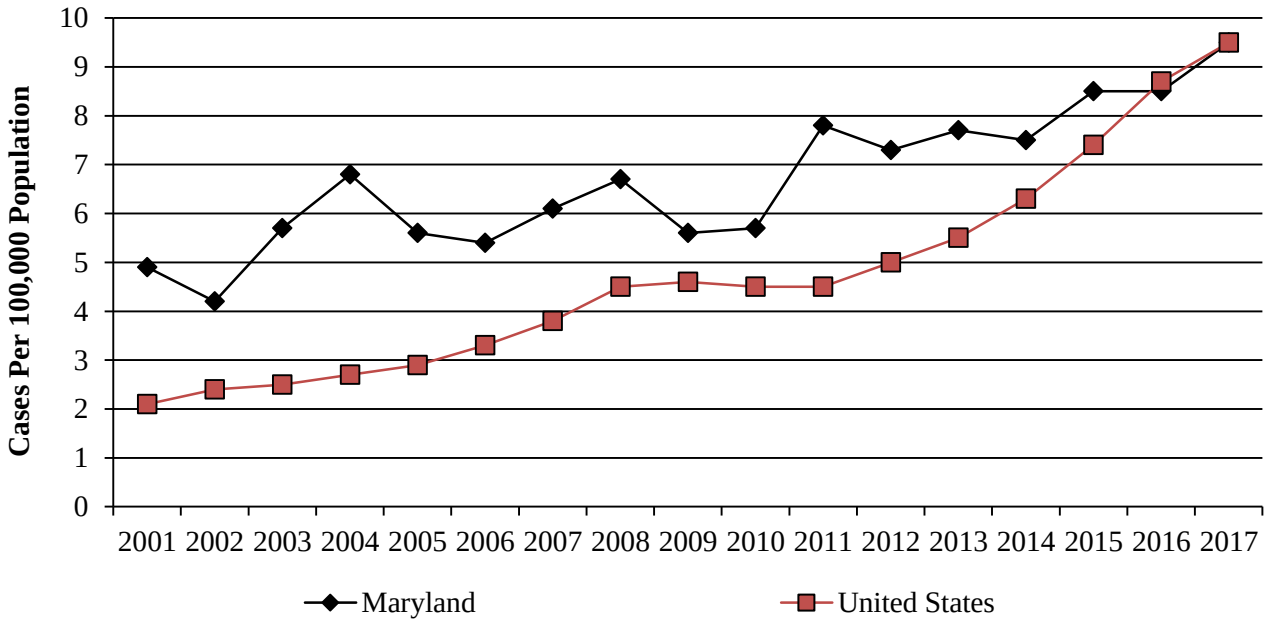
6. Syphilis and Chlamydia Rates Remain High

Syphilis Infection Rates

PHPA is charged with preventing and controlling the transmission of infectious diseases, including sexually transmitted infections (STI). The administration has developed initiatives to reduce the spread of STIs with an emphasis on at-risk populations, such as economically disadvantaged and incarcerated populations. Syphilis continues to be a major concern in the State, with the rate of infection in Maryland among the highest in the nation. Untreated syphilis in pregnant women can result in infant death in up to 40% of cases. In addition to its primary effects, syphilis presents public health concerns for its role in facilitating the transmission of HIV. The primary and secondary stages are curable, yet extremely contagious. If left untreated, the disease may progress into the tertiary stage, which may not be curable.

Exhibit 8 shows syphilis rates in Maryland compared with the national average. In calendar 2017, CDC reported a statewide infection rate of primary and secondary syphilis in Maryland of 9.5 cases per 100,000 population, an increase from 8.5 per 100,000 last year. This rate is driven by high primary and secondary syphilis rates in Baltimore City (34.3 cases per 100,000 population).

Exhibit 8
Rates of Primary and Secondary Syphilis
Calendar 2001-2017



Source: Maryland Department of Health; U.S. Centers for Disease Control and Prevention

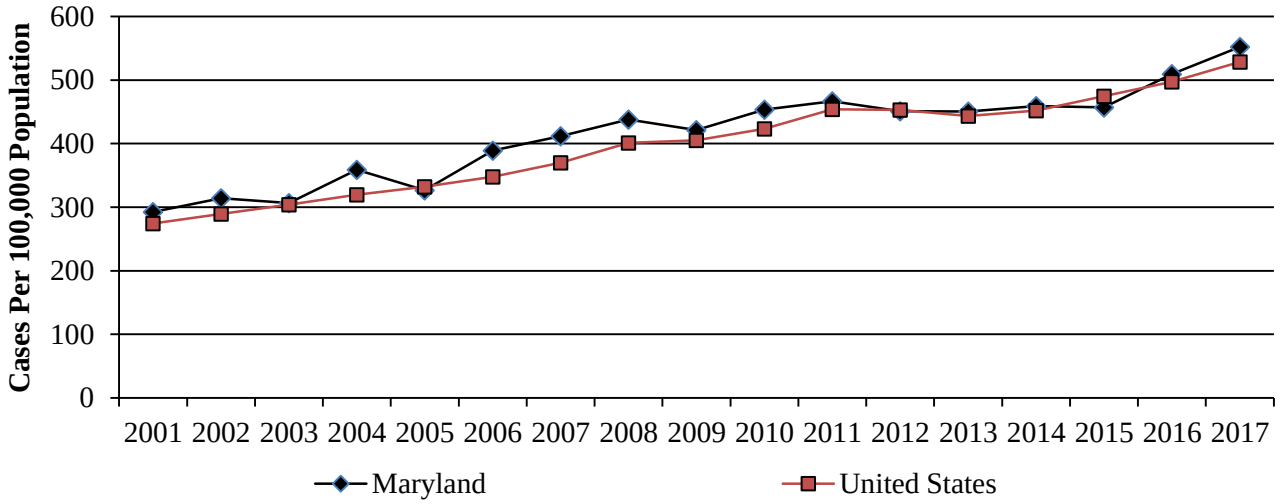
Syphilis rates increased from 8.7 to 9.5 nationally, a 9.2% increase. CDC has indicated that syphilis remains a major health problem with increases in rates persisting among men who have sex with men (who account for a majority of all primary and secondary syphilis cases). Cases that involve men who have sex with men have been characterized by high rates of HIV co-infection. While the rate is high among men who have sex with men, nationally, the rate for women has also increased recently. These increases among women are of particular concern because congenital syphilis cases tend to increase as the rate of primary and secondary syphilis cases among women increase.

Antibiotic resistance also contributed to an increase in sexually transmitted diseases. The World Health Organization has issued new guidelines for the treatment of chlamydia, syphilis, and gonorrhea in response to the growing threat of antibiotic resistance. These STIs are generally curable with antibiotics. However, they often go undiagnosed and are becoming more difficult to treat, with some antibiotics now failing as a result of misuse and overuse. This is particularly true for gonorrhea.

Chlamydia Infection Rates

As shown in **Exhibit 9,** in calendar 2017, chlamydia rates statewide increase substantially, remaining above the national average. While those aged 15 to 24 represent about 13% of the State's population, they accounted for 65% of chlamydia, 48% of gonorrhea, and 23% of syphilis cases in the State. Youth are more at risk for STIs for several reasons including insufficient screening, confidentiality concerns, lack of access to health care, and multiple sex partners.

Exhibit 9
Rate of Chlamydia
Calendar 2001-2017



Source: Maryland Department of Health; U.S. Centers for Disease Control and Prevention

In Baltimore City, where rates for all STIs are the highest in the State, the Baltimore City Health Department receives funding directly from CDC to respond to STIs. Among other activities, Baltimore City has an active outreach program to find and test high-risk individuals, including commercial sex workers. It also has an STI clinic that provides free testing and treatment as well as school-based clinics that test for chlamydia and gonorrhea.

The high rates of STI infection in Maryland are consistent with national trends. Federal investment in STI prevention efforts has been flat, while opioid users shifting to other injection drugs, poverty, and continued stigma around discussions about sex have also increased STI risks.

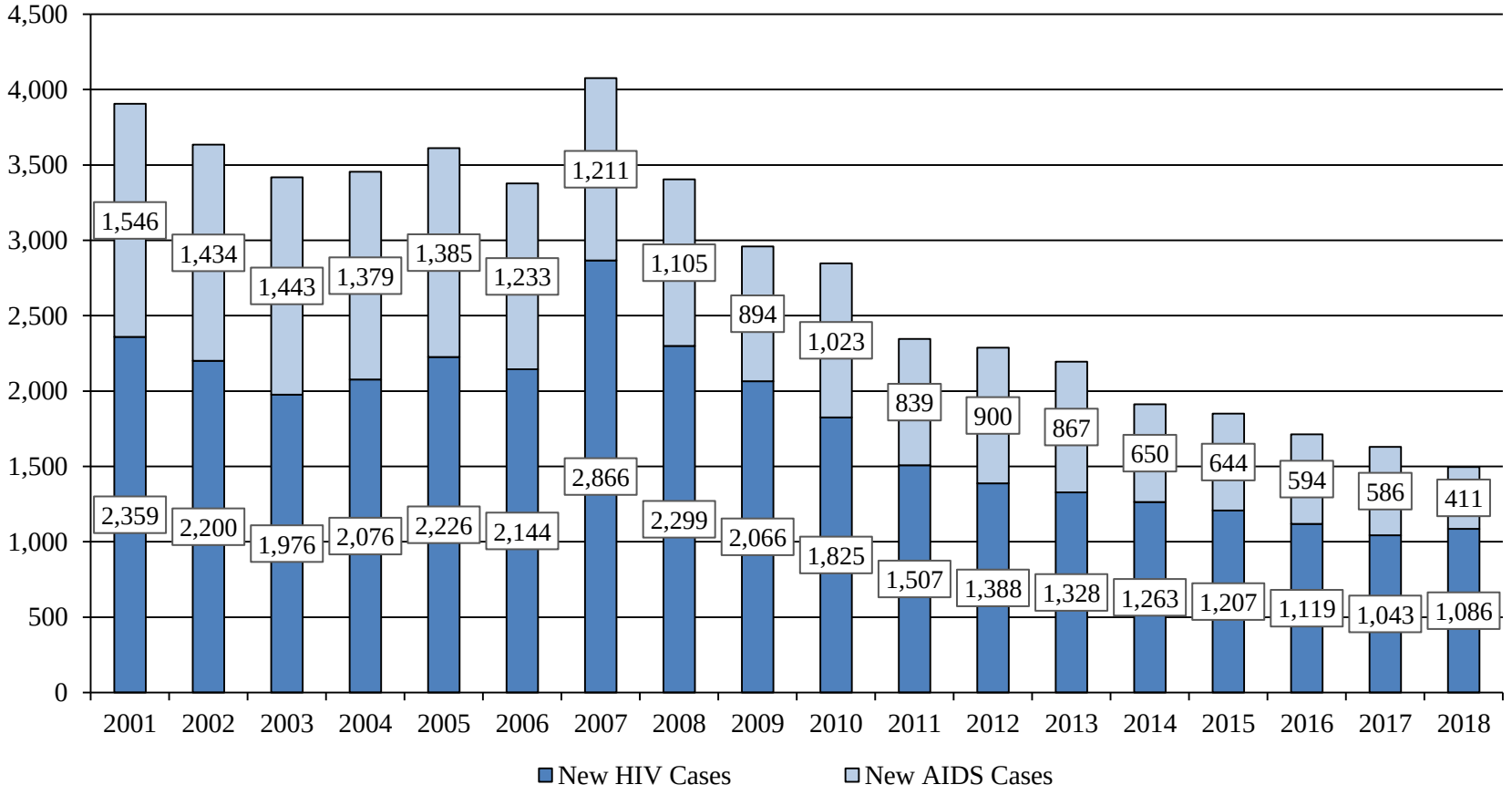
MDH has implemented many new initiatives in recent years to address rising rates of STI infection. In December 2017, MDH implemented electronic laboratory reporting, which will decrease reporting time and allow for quicker follow up, potentially limiting the spread of STIs. MDH is continuing a focus on expedited partner therapy, the practice of treating sex partners of patients diagnosed with STIs, and focusing on partnerships to enhance sexual education/health interventions for youth and schools. The department has also added disease intervention specialists and has supported the expansion of STI and HIV clinical services in Baltimore City.

7. New HIV and AIDS Cases Continue to Decline

Exhibit 10 details the continued decline in newly reported cases of HIV and AIDS in Maryland. As demonstrates in the exhibit, with the exception of calendar 2015, new cases have declined steadily from a high in 2007.

Despite the downward trend, the number of newly reported HIV cases in Maryland remains high compared to other states. According to the most recent national comparison conducted by CDC (based on calendar 2017 data), Maryland had the fifth highest diagnoses of HIV infection. Enrollment in the State's two major programs related to HIV/AIDS, the Maryland AIDS Drug Assistance Program (MADAP) and MADAP-Plus, have each seen increases of 1.8% compared to 2017.

Exhibit 10
Incidence of New HIV and AIDS in Maryland
Calendar 2001-2018



Note: It is possible, although uncommon, that an individual is diagnosed with HIV and AIDS in the same calendar year. In these cases, the individual is reflected in both measures.

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

Fiscal 2019 Actions

Proposed Deficiency

The fiscal 2020 Budget Bill includes a fiscal 2019 deficiency appropriation of $3 million in general funds to supplement the Breast and Cervical Cancer Diagnosis and Treatment Program. The total appropriation for the program in fiscal 2019 would be $3.85 million in general funds and $13.2 million in special funds. The fiscal 2020 allowance increases funding by a further $150,000 in general funds.

This program pays for breast and cervical cancer diagnostic and treatment services for low-income, uninsured Maryland residents served by participating providers. The deficiency appropriation and higher spending level going forward are due to the increased cost of treatment, with the greatest increases in the cost of outpatient care, physician costs, and pharmaceutical costs. New standard prescription drug therapies cost about $11,000 per month, and the program saw a 57% increase in the utilization of the most commonly prescribed treatment in fiscal 2018 compared to the prior year.

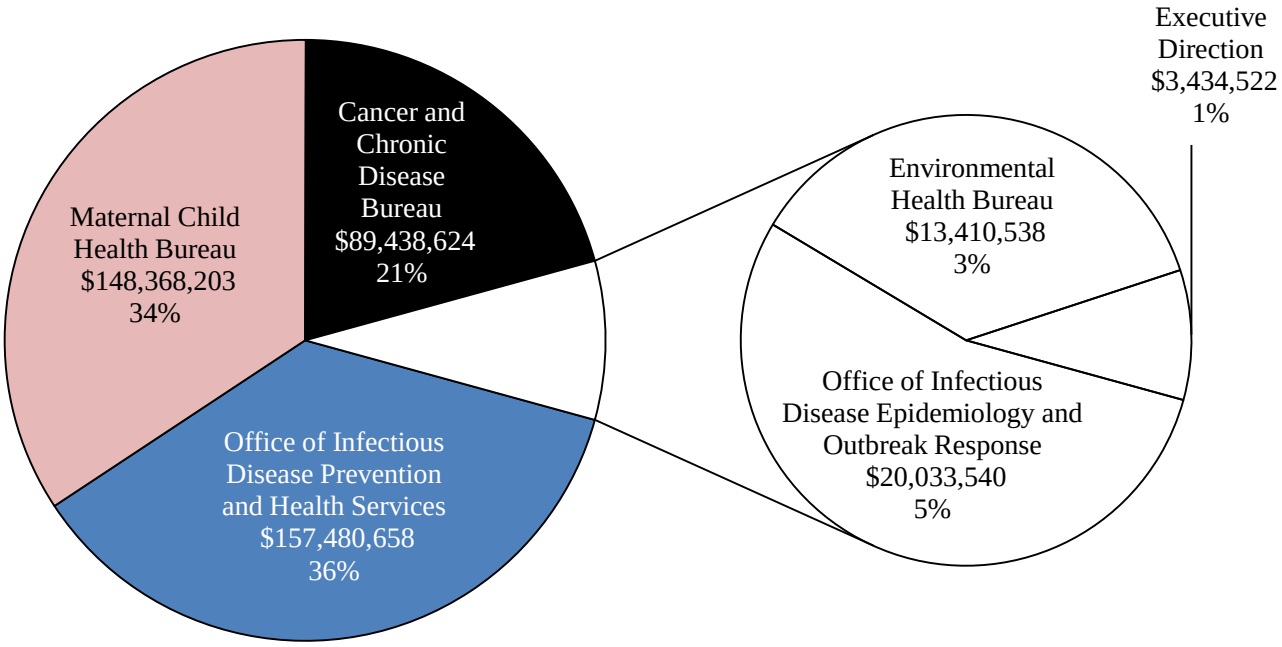
The fiscal 2020 budget also includes fiscal 2019 deficiency appropriations for the 0.5% general salary increase and one-time $500 bonus. The PHPA share of these amounts is $215,338 for the bonus and $41,540 for the salary increase.

Fiscal 2020 Allowance

Overview of Agency Spending

PHPA is arranged into five bureaus that focus on different areas of the agency's mission. As shown in **Exhibit 11**, the vast majority of the administration's funding is in the Office of Infectious Disease – Prevention and Health Services (which houses HIV/AIDS prevention and treatment programs), the Maternal Child Health Bureau, and the Cancer and Chronic Disease Bureau.

Exhibit 11
Fiscal 2020 Allowance by Bureau



Source: Governor's Fiscal 2020 Budget Books, Maryland Department of Health

Proposed Budget Change

The fiscal 2020 allowance increases by $32.9 million, or 8.2%. As shown in **Exhibit 12**, the increase is comprised of significant special fund and federal fund increases, offset by a $10.3 million reduction in general funds.

Exhibit 12
Proposed Budget
MDH – Prevention and Health Promotion Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2018 Actual	$64,593	$92,265	$192,483	$1,661	$351,002
Fiscal 2019 Working Appropriation	65,012	116,576	215,320	2,389	399,297
Fiscal 2020 Allowance	54,705	148,664	226,483	2,315	432,166
Fiscal 2019-2020 Amount Change	-$10,308	$32,088	$11,163	-$74	$32,869
Fiscal 2019-2020 Percent Change	-15.9%	27.5%	5.2%	-3.1%	8.2%

Where It Goes:

Personnel Expenses (Including Contract Savings from MIPAR Insourcing)	
Employee and retiree health insurance	$1,447
Fiscal 2020 general salary increase plus annualization of fiscal 2019 0.5% general salary increase	1,041
Regular earnings including the annualization of the fiscal 2019 2% general salary increase	767
Reduction of turnover rate from 6.8% to 5.92%	451
Retirement system contributions	352
Transferred position (1.0 FTE from Spring Grove to PHPA – Maternal and Child Health)	99
Other contractual conversions (2.0 FTEs)	57
Fiscal 2019 $500 bonus	-215
MIPAR insourcing (53.8 FTEs)	-935
Other fringe benefit adjustments	393
Contractual Personnel Expenses	
Additional contractual personnel (21.4 FTEs)	1,360
HIV/AIDS Programs	
HIV health services (special funds and federal funds)	18,175
HIV client services (special funds and federal funds)	12,112
State restricted rebates (special funds)	4,438
Assessment of transgender communities' experience of HIV risk and related behaviors (special funds)	1,042
Increased award for HIV prevention services (federal funds)	499
Other HIV/AIDS programs	-35

Where It Goes:

Other Infectious Disease, Epidemiology, and Health Services	
Epidemiology and laboratory capacity (federal funds)	2,504
Community-based programs to test and cure Hepatitis C	1,118
Immunizations and vaccines for children (federal funds)	525
Emerging infections program (federal funds)	189
Maternal Child Health Bureau	
New federal grant for Baltimore City youth maternity program (federal funds)	970
Title X family planning grant funds diverted directly to provider (federal funds)	-536
Cancer and Chronic Disease Bureau	
Healthiest Maryland grants (federal funds)	1,382
Reduced grant award for breast and cervical cancer early detection program (federal funds)	-976
Other Changes	
Prince George's County hospital operating subsidy	-12,000
Other changes	-1,355
Total	**$32,869**

FTE: full-time equivalent
MDH: Maryland Department of Health
MIPAR: Maryland Institute for Policy Analysis and Research

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

Personnel

Including new contractual positions, contractual conversions, regular positions, and contractual costs related to adding positions at PHPA from the Maryland Institute for Policy Analysis and Research (MIPAR), personnel costs increase by $4.8 million.

Regular personnel cost increases account for most of this change, with the largest amount ($1.4 million) due to increased employee and retiree health insurance costs.

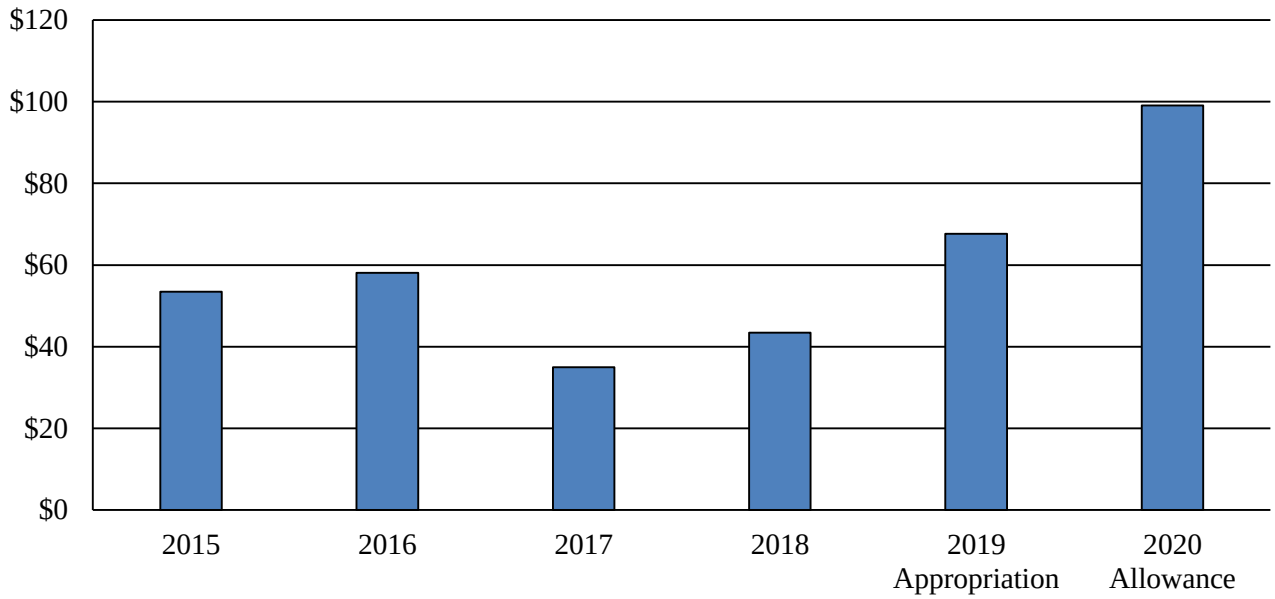
PHPA also added 53.8 new full-time equivalent (FTE) positions as a result of insourcing work previously done under contract with MIPAR. The net impact of this change on PHPA – including the increased personnel costs and the decreased cost of the contract with MIPAR – is to reduce costs at the administration by more than $900,000. As a result of bringing the work in-house, the department will be able to claim more federal indirect cost recoveries on the newly created positions, resulting in general fund savings.

The addition of 21.4 new FTE contractual positions in the fiscal 2020 allowance increases costs by $1.4 million. These new contractual positions are in addition to 7.91 positions added in fiscal 2019. The new positions are primarily in the Office of Infectious Disease Prevention and Health Services, the administration's largest bureau, with many of the positions in HIV/AIDS prevention and treatment programs.

HIV/AIDS Programs

Programmatically, the largest increase in PHPA's fiscal 2020 allowance is in HIV/AIDS programs, increasing by more than $36 million in special and federal funds. The increase is primarily due to the increased use of Ryan White Part B rebate funds. Under the federal law, states are awarded rebates on medications purchased at a price higher than a federally set rate. Those rebate funds can then be used by state AIDS Drug Assistance Programs. The MADAP has generated a significant amount of special funds for the State via rebates and has accumulated a significant fund balance. Chapter 384 of 2015 expanded the authorized use of pharmaceutical rebates to include all Ryan White Part B covered services, including outreach services and medical transportation. That expansion of allowed uses, combined with the increasing capacity of PHPA and local providers, has led to the significant increase in spending in these programs. PHPA has been told by the Health Resources and Services Administration – the federal agency overseeing the rebate program – to spend its balance within five years. The fiscal 2018 closing balance was $78.2 million, and annual revenues to the fund are approximately $53 million. The administration has a five-year plan to spend down the balance after which spending of MADAP funds will return to current year rebates and the annual federal award. The spending plan focuses on infrastructure and workforce development and community-identified priorities. PHPA is focusing on housing, oral health, mental health and substance abuse treatment, and health care workforce development. For example, the Office of Infectious Disease Prevention and Health Services is working with the Office of Oral Health to increase capacity among oral health providers to serve persons with HIV, and the administration is working to develop a five-year housing needs assessment to determine appropriate investments to assist people experiencing homelessness. PHPA is also working with federal partners to expand the capacity of institutions to train providers of HIV-related services. As shown in **Exhibit 13**, the planned use of MADAP funding nearly triples from $34.5 million in fiscal 2017 to the $99.1 million in the fiscal 2020 allowance.

Exhibit 13
Maryland AIDS Drug Assistance Program Drug Rebates Spending
Fiscal 2015-2020
($ in Millions)



Source: Governor's Fiscal 2020 Budget Books

HIV/AIDS services provided by programs funded by MADAP include the purchase of pharmaceuticals, insurance premiums or co-pays, oral health care, housing stability, syringe services, and pre-exposure prophylaxis clinics. The administration is also launching a new program to assess transgender communities' experience of HIV risk and related behaviors at a cost of more than $1 million in special funds. The administration also received a nearly $500,000 increase in a federal grant for HIV prevention services.

Epidemiology and Laboratory Capacity

Funding for epidemiology and laboratory capacity increases by more than $2.5 million in federal funds in the fiscal 2020 allowance. This funding from the CDC's Prevention and Public Health Fund includes additional funds for antibiotic resistance and hospital-acquired infections activities. However, a federal grant award of nearly $1.7 million was incorrectly double budgeted at PHPA and the Laboratories Administration in the Public Health Administration. **The Department of Legislative Services recommends deleting these double-budgeted federal funds.**

Prince George's County Hospital Operating Subsidy

The fiscal 2020 allowance provides a $15 million operating subsidy for the Capital Region Medical Center, a $12 million decrease from the fiscal 2019 amount. Chapter 19 of 2017 mandates an operating subsidy of $15 million in fiscal 2020 and 2021 and $10 million in fiscal 2022 through 2028.

Hepatitis C Programs

Funding for community-based programs to test for and cure Hepatitis C increase by more than $1.1 million in the PHPA fiscal 2020 allowance. The increase is part of a broader initiative to address Hepatitis C infections in the State. Additional funding is included in the Medicaid budget, and the overall plan to address Hepatitis C is discussed further in the Medicaid analysis.

Family Planning

There are two large changes in the fiscal 2020 allowance in the Maternal Child Health Bureau. PHPA, on behalf of the Baltimore City Health Department, was awarded a federal grant of $970,000 to provide services to pregnant youth and young adults, and the administration's Title X family planning funding was reduced by approximately $536,000 in the fiscal 2020 allowance due to CCI Health and Wellness Services in Montgomery County applying for funding directly from the U.S. Department of Health and Human Services and being awarded $800,000.

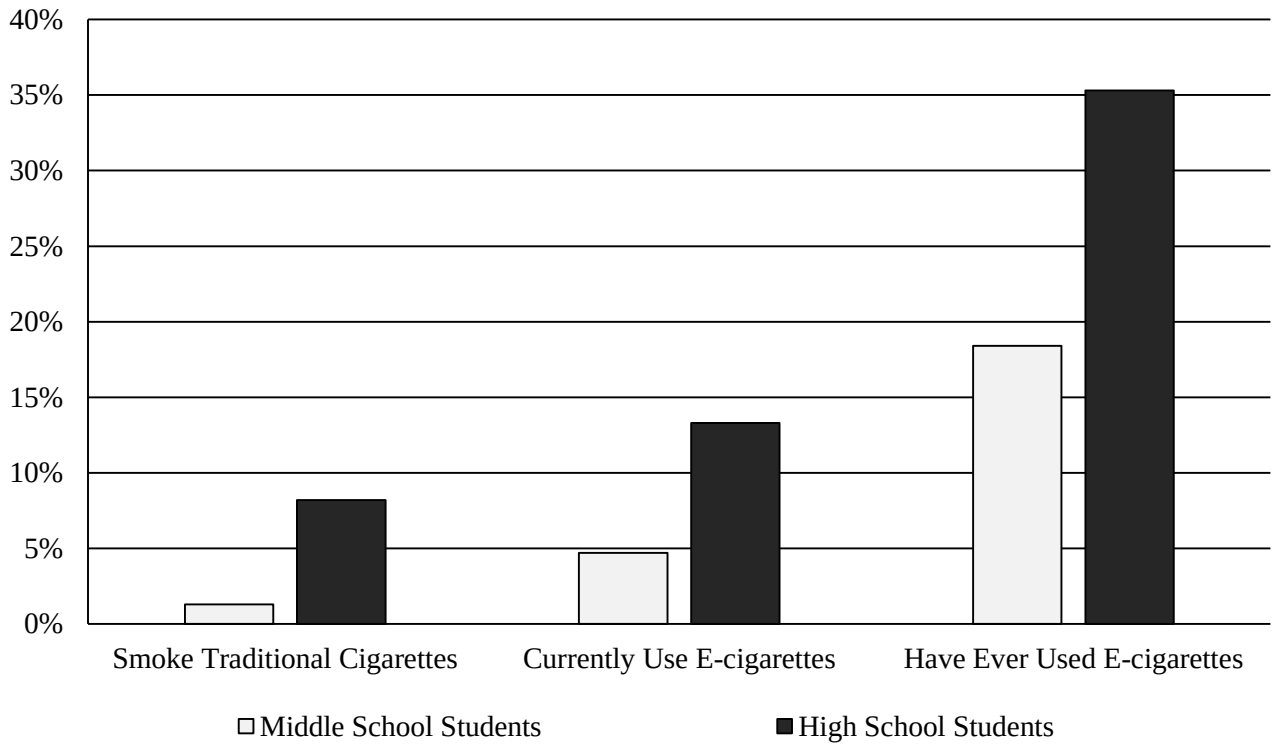
While there has been discussion recently about a change in federal restrictions on the use of Title X funding, Title X grants have been awarded for fiscal 2020 with no further limitations on the use of funding beyond current regulations.

Issues

1. Electronic Cigarette Use among Youth of Growing Concern

As noted earlier in this analysis, Maryland has successfully reduced the proportion of youth that smoke traditional cigarettes. However, the use of electronic cigarettes (e-cigarettes) among youth is a growing concern. According to CDC, between calendar 2011 and 2018, e-cigarette use among high school students increased from 1.5% to 20.8%. Between calendar 2017 and 2018, e-cigarette use among high school students increased by 78%, with youth who use e-cigarettes using them more frequently and using flavored products more often than in calendar 2017. As shown in **Exhibit 14**, in calendar 2016, the most recent available State-level data, 4.7% of Maryland middle school students and 13.3% of Maryland high school students reported currently using e-cigarettes, while 18.4% and 35.3% reported having ever used e-cigarettes.

Exhibit 14
Percentage of Maryland Students Reporting Cigarette Use
Calendar 2016



Source: Department of Legislative Services

E-cigarettes are battery-operated devices that typically contain nicotine cartridges and other chemicals imitating flavors, such as chocolate, mint, or strawberry. According to the U.S. Food and Drug Administration (FDA), several e-cigarette devices resemble a USB flash drive, have high levels of nicotine, and create emissions that are hard to see – characteristics that make the products attractive to youth but make the devices difficult for parents and educators to recognize or detect. In January 2018, the National Academies of Sciences, Engineering, and Medicine published a comprehensive consensus study report that compiled all available evidence on e-cigarettes. The report found substantial evidence that e-cigarette use increases the risk of youth ever using traditional cigarettes and moderate evidence that e-cigarette use increases the frequency of use of traditional cigarettes among youth who already smoke.

Regulation of Electronic Cigarettes in Maryland

Concurrent with the rise in use, the General Assembly has worked to limit youth access to e-cigarettes, established a licensing framework, and increased penalties for sales to youth. Chapter 714 of 2012 established a prohibition on the sale, distribution, or offer for sale to a minor of an electronic device that can be used to deliver nicotine to the individual inhaling from the device, including an e-cigarette. Chapter 425 of 2015 expanded the prohibition to include a component for an electronic device or a product used to refill or resupply an electronic device.

Chapter 814 of 2017 established a licensing and regulatory framework for the manufacturing, wholesale distribution, and retail sale of electronic nicotine delivery systems (ENDS) – e-cigarettes, other similar devices, and its components. A person with a tobacco-related license is authorized to manufacture, distribute, or sell ENDS and does not need a separate ENDS license. Three ENDS licenses authorize the sale of ENDS to consumers under specified circumstances: manufacturer; retailer; and vape shop vendor.

Chapter 785 of 2018 established that the distribution of ENDS to minors is a misdemeanor subject to existing criminal penalties for the distribution of tobacco products to minors, established that the possession of ENDS by minors is a civil offense subject to existing civil procedures and dispositions for the possession of tobacco products by minors, and increased civil penalties for subsequent civil violations of distributing ENDS to minors.

Recent Federal Action Addresses Youth Access and Marketing

In calendar 2016, FDA finalized a rule extending its regulatory authority over tobacco products to include e-cigarettes. Accordingly, federal regulations prohibit retailers from selling e-cigarettes to minors and require retailers to check the photo identification of any individual younger than age 27 who attempts to purchase e-cigarettes. In November 2018, FDA announced that it will require that all flavored ENDS products, other than tobacco, mint, or menthol, be sold in age-restricted, in-person locations or, if sold online, be subject to heightened age verification practices. Furthermore, FDA will pursue removal from the market of ENDS products specifically marketed to and/or appealing to youth.

Strategies to Address Use of Electronic Cigarettes among Minors

In a 2016 report, the U.S. Surgeon General outlined the actions that federal, state, and local governments can take to address e-cigarette use among youth and young adults, including (1) incorporating e-cigarettes into smoke-free policies; (2) preventing youth access to e-cigarettes; (3) price and tax policies; (4) retail licensure; (5) regulation of e-cigarette marketing likely to attract youth; and (6) educational initiatives targeting youth and young adults. The U.S. Surgeon General's recommendations are modeled after evidence-based tobacco control strategies. Maryland has taken action on at least two of these recommendations: (1) preventing youth access to e-cigarettes by establishing the distribution of ENDS to a minor is a misdemeanor; and (2) requiring retail licensure for the sale of ENDS. Some Maryland jurisdictions have incorporated e-cigarettes into smoke-free policies and implemented price and tax policies.

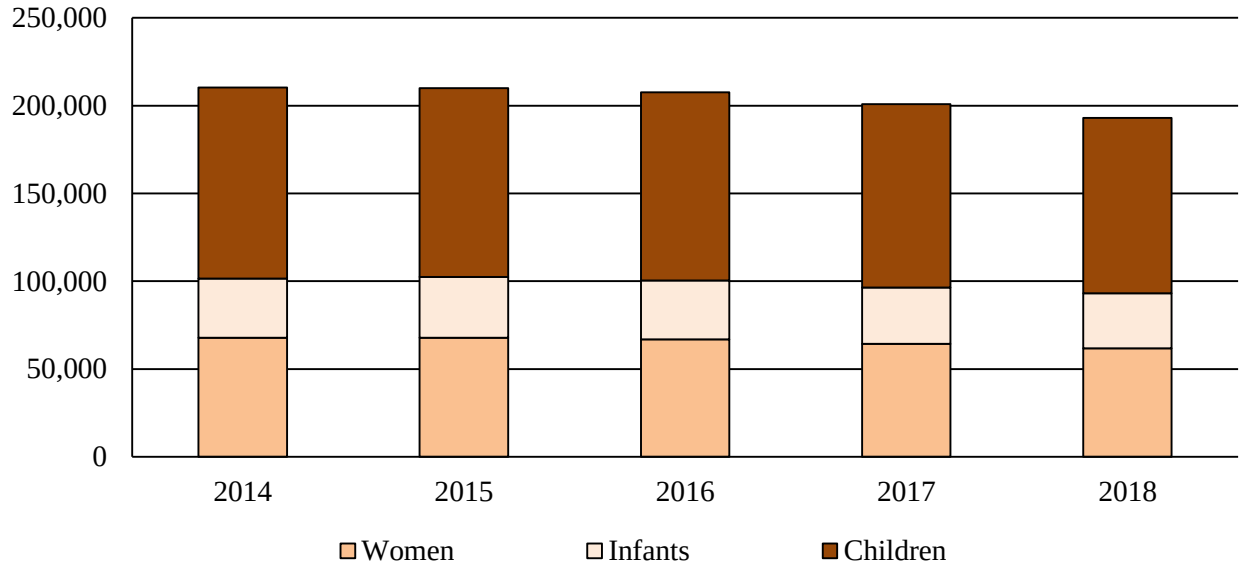
Some states and municipalities as well as one local jurisdiction have implemented price and tax policies by imposing excise taxes on e-cigarettes. In Maryland, e-cigarettes and its components are subject to the sales tax, but statewide, they are not subject to an excise tax as are cigarettes and other tobacco products. In 2015, Montgomery County imposed a 30% excise tax on the wholesale value of e-cigarettes. With the exception of Virginia, all of Maryland's neighboring states and the District of Columbia have imposed excise taxes on e-cigarettes (Delaware, $0.05 per milliliter; District of Columbia, 60% of wholesale value; Pennsylvania, 40% of wholesale value; and West Virginia, $0.075 per milliliter).

2. Many Women, Infants, and Children-eligible Residents Do Not Receive Benefits

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutrition services, including nutrition education and supplemental foods, through local agencies located across the State to low-income (below 185% of federal poverty level) pregnant and post-partum women, infants, and children up to age five. WIC is administered through PHPA. In the 2018 *Joint Chairmen's Report* (JCR), the budget committees requested data on participation, eligible individuals who are not participating, how the benefit is administered, and the expansion of access in other states.

Exhibit 15 shows the number of women, infants, and children receiving the benefit by year since fiscal 2014. In fiscal 2018, most participants were in Baltimore City and Montgomery and Prince George's counties. Total participants have declined from more than 210,000 in fiscal 2014 to just under 193,000 in fiscal 2018.

Exhibit 15
Maryland WIC Participants
Fiscal 2014-2018



WIC: Women, Infants, and Children

Source: Maryland Department of Health

Exhibit 16 shows the estimated number of people in fiscal 2018 not receiving benefits but who are potentially eligible. In Maryland, approximately 28.3 % of all women, infants, and children who are potentially eligible do not receive benefits. Approximately 16% of potentially eligible women do not participate in the WIC program, while 18% of potentially eligible infants and 37% of potentially eligible children do not receive benefits.

Exhibit 16
Eligible for WIC, Not Receiving Benefits
Fiscal 2018

County	Eligibles	Participants	% of Eligibles Not Receiving Benefits
Allegany	3,418	2,504	26.7%
Anne Arundel	18,445	11,938	35.3%
Baltimore City	41,497	31,401	24.3%
Baltimore County	38,172	26,288	31.1%
Calvert	2,271	1,384	39.1%
Caroline	2,198	1,627	26.0%
Carroll	3,812	2,240	41.2%
Cecil	4,674	3,036	35.0%
Charles	6,186	4,300	30.5%
Dorchester	1,966	1,431	27.2%
Frederick	7,981	5,690	28.7%
Garrett	1,416	1,078	23.9%
Harford	7,846	5,099	35.0%
Howard	8,108	5,670	30.1%
Kent	719	522	27.4%
Montgomery	40,133	30,331	24.4%
Prince George's	55,240	41,180	25.5%
Queen Anne's	1,443	841	41.7%
Somerset	1,408	925	34.3%
St. Mary's	3,937	2,817	28.4%
Talbot	1,470	1,018	30.7%
Washington	7,948	5,475	31.1%
Wicomico	6,707	5,061	24.5%
Worcester	1,989	1,059	46.8%
Maryland	**268,983**	**192,915**	**28.3%**

WIC: Women, Infants, and Children

Source: Maryland Department of Health

With regard to increasing access to WIC or increasing the benefit, the U.S. Department of Agriculture informed MDH that the eligibility threshold of 185% of the federal poverty level was the maximum and that increasing the benefit was not allowed.

3. Options for Expanding Prophylactic HIV Therapy for Sex Assault Victims Explored

Preventing the spread of HIV is a high public health priority for the State. One part of the State's strategy of preventing HIV is to provide non-occupational post-exposure prophylaxis (nPEP) HIV therapy to victims of sexual assault. The budget committees in the 2018 JCR requested information regarding this program. Current law requires hospitals providing services to a victim of sexual assault or abuse to do so at no charge to the individual. The medical costs are reimbursed by the Sexual Assault Reimbursement Unit (SARU) in the Governor's Office of Crime Control and Prevention. SARU also provides a 3- to 7-day starter pack of nPEP HIV therapy to patients who are at high risk of HIV infection, such as when the assailant was a known HIV carrier or where there were multiple assailants. However, current CDC guidelines call for a full 28-day course of treatment for patients when the assailant is known to be HIV-positive, or on a case-by-case basis when the assailant's status is unknown. (While the budget committees requested information based on the guidelines of the Clinical Consultation Center of the University of California at San Francisco, MDH used CDC guidelines for their JCR response.)

Under current State practices, approximately 20 claims are approved annually, according to MDH. The total SARU reimbursement in fiscal 2017 was $10,261, or $513 per person. However, hospitals often only billed SARU for 1 day of therapy, indicating that other means of coverage were used. Expanding to a 28-day supply of nPEP HIV therapy would increase the average cost to $3,553, or $71,060, annually. MDH notes that this does not take into consideration the expanded number of patients that would be eligible for nPEP HIV therapy under the expanded CDC guidelines. The department does not have data on the number of sexual assault victims for whom a full course nPEP HIV treatment would be recommended under CDC guidelines and, therefore, is unable to provide an accurate estimate of the number of victims who seek sexual assault forensic exams who would be eligible for a full course of nPEP HIV therapy under CDC guidelines, nor does it have data on the number of victims who are denied a full course of nPeP HIV therapy under the State's current guidelines.

CDC estimates that the average cost of HIV care is $23,000 annually and $379,668 over the course of a patient's lifetime (in 2010 dollars). Approximately 1,100 new HIV diagnoses are made in Maryland annually at an estimated lifetime cost of $514 million. The department does not have the data to determine the costs to the State if an individual did not receive the full course of nPEP HIV therapy and contracts HIV as a result of sexual assault.

MDH notes that there are several barriers to accessing nPEP HIV therapy. A national meta-analysis found the proportion of sexual assault patients who were offered the therapy ranged from 19% to 100%. The study noted that the variation was partially due to the patient's characteristics, such as race or insurance status, hospital policies, or the providers involved. Other barriers include mixed

levels of comfort providing nPEP HIV therapy, a lack of clear protocols, and lack of knowledge of prescribing guidelines. Provider discomfort seemed to be the major barrier to offering nPEP HIV therapy.

The department states that expanding services covered by SARU to include the full course of nPEP HIV therapy would likely result in shifting costs from hospitals, insurance companies, Medicaid, and pharmaceutical companies to the State. While SARU currently only covers the cost of the starter pack, that does not limit the ability of other mechanisms for coverage. For example, Gilead, the manufacturer of one common treatment regimen, offers immediate access once in a patient's lifetime to uninsured patients who are below 500% of the federal poverty level.

MDH recognizes the importance of immediate access to prophylactic HIV treatment but is concerned that expanding coverage guidelines would greatly increase costs and threaten SARU core services. The department recommends other options, such as expanding provider knowledge of nPEP HIV therapy guidelines and coverage options, exploring other State and federal funding sources, working with pharmaceutical companies and pharmacies on pricing, and reducing or eliminating privacy concerns related to use of individual insurance.

Operating Budget Recommended Actions

		Amount Reduction	
1.	Delete federal funds from a grant double budgeted at the Prevention and Health Promotion Administration.	$ 1,660,218	FF
	Total Federal Fund Reductions	**$ 1,660,218**	

Appendix 1
Current and Prior Year Budgets
MDH – Prevention and Health Promotion Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2018					
Legislative Appropriation	$65,208	$112,017	$215,226	$3,337	$395,788
Deficiency/Withdrawn Appropriation	-183	-25	-347	0	-555
Cost Containment	-92	0	0	0	-92
Budget Amendments	-324	2,151	-661	24	1,190
Reversions and Cancellations	-16	-21,877	-21,736	-1,700	-45,330
Actual Expenditures	**$64,593**	**$92,265**	**$192,483**	**$1,661**	**$351,002**
Fiscal 2019					
Legislative Appropriation	$63,169	$116,551	$214,996	$2,389	$397,105
Budget Amendments	-1,245	13	167	0	-1,065
Working Appropriation	**$61,924**	**$116,564**	**$215,163**	**$2,389**	**$396,040**

MDH: Maryland Department of Health

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. Numbers may not sum to total due to rounding.

Fiscal 2018

The fiscal 2018 legislative appropriation for the Prevention and Health Promotion Administration (PHPA) decreased by $44.8 million. The budget decreased by $91,640 in general funds due to a September 2017 Board of Public Works cost containment action. Cost containment was realized primarily by aligning expenditures in the Cord Blood Transplant Program with recent actuals. The budget decreased further from a withdrawn appropriation made by Section 19 of the fiscal 2019 Budget Bill due to a surplus in the health insurance account totaling $346,602 ($182,850 in general funds, $25,265 in special funds, and $346,610 in federal funds).

The PHPA budget increased by $1.2 million through budget amendments. The special fund appropriation increased by $2.2 million to cover additional expenditures for the Maryland AIDS Drug Assistance Program (MADAP). Federal funds were increased by $1.7 million to cover additional expenditures related to HIV programs. However, that increase was offset by a $2.4 million reduction in funds that were intended for the Maternal, Infant, and Early Childhood Home Visiting Expansion grant.

The general fund appropriation decreased by $904,056 due to savings in maternal and child health quality initiative contracts ($518,992), less than anticipated expenditures on local health department contracts ($296,405), vacancies ($59,456), and savings on communications ($29,203). Decreases were offset by an increase of $579,960 in general funds to cover expenses related to PHPA summer camp inspectors.

PHPA reverted $16,484 general funds. PHPA canceled $21.9 million in special funds, which was largely due to the federal guidance to spend down federal funds before spending MADAP Drug Rebate special funds. PHPA canceled $21.7 million in federal funds, primarily due to lower than anticipated participation in the Women, Infants, and Children program ($17.5 million). PHPA canceled $1.7 million in reimbursable funds largely due to a 49% decrease in humanitarian immigrants that drove down expenditures for immigrant health.

Fiscal 2019

To date, PHPA's fiscal 2019 budget has decreased by $1.1 million driven by the transfer of the victim services unit to the Governor's Office of Crime Control and Prevention ($1.4 million). This decrease was partially offset by an increase of $296,596 ($116,551 in general funds, $13,352 in special funds, and $166,693 in federal funds) for a general salary increase effective January 1, 2019, that was centrally budgeted.

Appendix 2
Audit Findings

Audit Period for Last Audit:	October 28, 2013 – August 8, 2016
Issue Date:	April 2018
Number of Findings:	7
Number of Repeat Findings:	2
% of Repeat Findings:	33%
Rating: (if applicable)	n/a

Finding 1: The Prevention and Health Promotion Administration (PHPA) did not ensure that all rebates from drug manufacturers were received and were accurate. Office of Legislative Audit tests disclosed one manufacturer that did not pay rebates for six months and rebates for 20 drugs were underpaid by as much as $2 million for one quarter in 2016.

Finding 2: **PHPA did not use available independent resources to help verify applicant income for certain programs and to identify possible third-party insurance coverage.**

Finding 3: **PHPA did not adequately restrict user access to the Maryland AIDS Drug Assistance Program (MADAP) system. In addition, PHPA did not adequately review overrides of rejected MADAP pharmacy claims and manually processed MADAP-Plus insurance premium payments.**

Finding 4: PHPA did not recover pharmacy claim overpayments totaling $425,000 that were identified during pharmacy audits.

Finding 5: PHPA lacked adequate procedures and controls over MADAP collections.

Finding 6: Numerous PHPA employees had unnecessary access to the confidential demographic and health information of certain patients.

Finding 7: PHPA did not conduct timely inspections to ensure food processing facilities were operating in accordance with State regulations.

*Bold denotes item repeated in full or part from preceding audit report.

Appendix 3
Object/Fund Difference Report
Maryland Department of Health – Prevention and Health Promotion Administration

Object/Fund	FY 18 Actual	FY 19 Working Appropriation	FY 20 Allowance	FY 19 - FY 20 Amount Change	Percent Change
Positions					
01 Regular	401.80	401.80	458.60	56.80	14.1%
02 Contractual	19.56	27.47	48.87	21.40	77.9%
Total Positions	**421.36**	**429.27**	**507.47**	**78.20**	**18.2%**
Objects					
01 Salaries and Wages	$ 36,332,292	$ 36,921,588	$ 44,172,379	$ 7,250,791	19.6%
02 Technical and Special Fees	799,342	1,353,781	2,615,932	1,262,151	93.2%
03 Communication	616,612	603,971	221,591	-382,380	-63.3%
04 Travel	612,543	529,467	665,005	135,538	25.6%
07 Motor Vehicles	246,210	189,145	162,681	-26,464	-14.0%
08 Contractual Services	224,976,861	256,982,636	295,816,003	38,833,367	15.1%
09 Supplies and Materials	27,380,491	36,507,070	34,686,409	-1,820,661	-5.0%
10 Equipment – Replacement	223,679	48,314	150,870	102,556	212.3%
11 Equipment – Additional	1,306,253	352,925	393,981	41,056	11.6%
12 Grants, Subsidies, and Contributions	58,360,262	62,335,371	52,004,522	-10,330,849	-16.6%
13 Fixed Charges	147,060	215,619	194,471	-21,148	-9.8%
Total Objects	**$ 351,001,605**	**$ 396,039,887**	**$ 431,083,844**	**$ 35,043,957**	**8.8%**
Funds					
01 General Fund	$ 64,592,856	$ 61,924,229	$ 54,278,281	-$ 7,645,948	-12.3%
03 Special Fund	92,265,257	116,564,145	148,619,448	32,055,303	27.5%
05 Federal Fund	192,482,786	215,162,912	225,871,457	10,708,545	5.0%
09 Reimbursable Fund	1,660,706	2,388,601	2,314,658	-73,943	-3.1%
Total Funds	**$ 351,001,605**	**$ 396,039,887**	**$ 431,083,844**	**$ 35,043,957**	**8.8%**

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. The fiscal 2020 allowance does not include general salary increases.

Appendix 4
Fiscal Summary
Maryland Department of Health – Prevention and Health Promotion Administration

Program/Unit	FY 18 Actual	FY 19 Wrk Approp	FY 20 Allowance	Change	FY 19 - FY 20 % Change
01 Administrative, Policy, and Management	$ 126,001,666	$ 149,908,064	$ 193,764,345	$ 43,856,281	29.3%
04 Family Health and Chronic Disease Services	224,999,939	246,131,823	237,319,499	-8,812,324	-3.6%
Total Expenditures	**$ 351,001,605**	**$ 396,039,887**	**$ 431,083,844**	**$ 35,043,957**	**8.8%**
General Fund	$ 64,592,856	$ 61,924,229	$ 54,278,281	-$ 7,645,948	-12.3%
Special Fund	92,265,257	116,564,145	148,619,448	32,055,303	27.5%
Federal Fund	192,482,786	215,162,912	225,871,457	10,708,545	5.0%
Total Appropriations	**$ 349,340,899**	**$ 393,651,286**	**$ 428,769,186**	**$ 35,117,900**	**8.9%**
Reimbursable Fund	$ 1,660,706	$ 2,388,601	$ 2,314,658	-$ 73,943	-3.1%
Total Funds	**$ 351,001,605**	**$ 396,039,887**	**$ 431,083,844**	**$ 35,043,957**	**8.8%**

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. The fiscal 2020 allowance does not include general salary increases.