

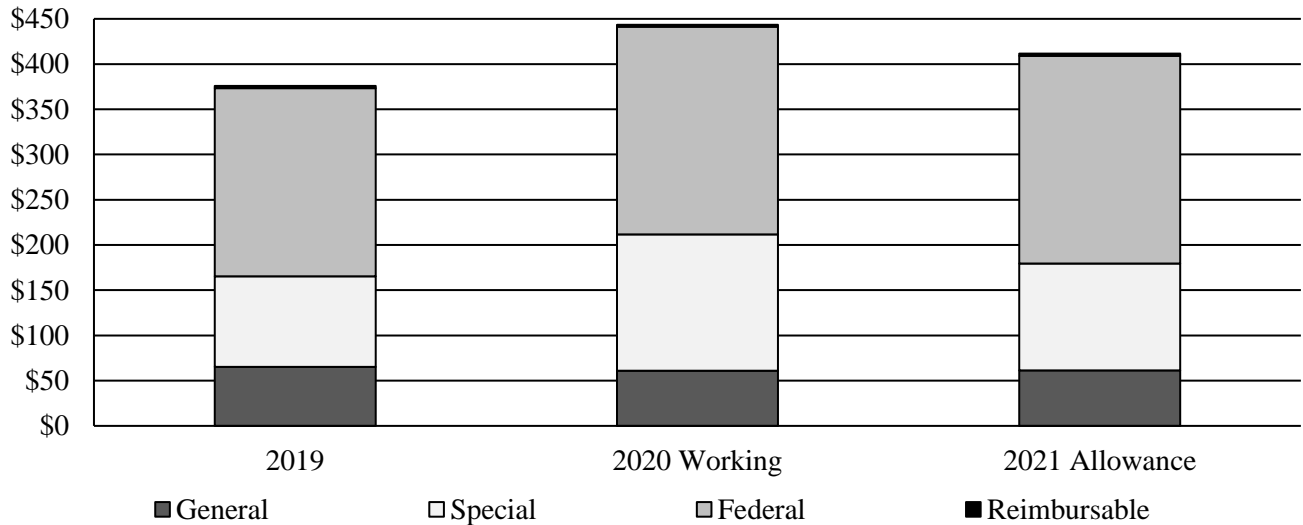
M00F03
Prevention and Health Promotion Administration
Maryland Department of Health

Executive Summary

The mission of the Maryland Department of Health (MDH) 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 health efforts.

Operating Budget Summary

Fiscal 2021 Budget Decreases by \$32.0 Million or 7.2% to \$411.5 Million
(\$ in Millions)



Note: Numbers may not sum due to rounding. The fiscal 2020 appropriation includes deficiencies, planned reversions, and general salary increases. The fiscal 2021 allowance includes contingent reductions and general salary increases.

- Overall, the \$32.0 million net reduction in PHPA’s budget is driven by lower special fund spending of Maryland AIDS Drug Assistance Program rebates.
- Although federal funding for the Special Supplemental Nutrition Program for Women, Infants, and Children reflects a \$14.1 million increase, a large portion of this is double-budgeted funds.
- There are also reductions in federal grants for overdose prevention, family planning services, and other programs.

Key Observations

- ***Title X Final Rule Takes Effect, Impacting Maryland Family Planning Funding:*** Beginning July 15, 2019, a final rule substantially altering the federal Title X Family Planning Program took effect after injunctions through multistate litigation were lifted. Due to 2017 and 2019 legislation, the State is prohibited from accepting Title X funds while the final rule is in effect, and MDH must fund the State Family Planning Program at current levels with general funds only.
- ***Rapidly Increasing Electronic Cigarette Use Among Youth Causes Concern:*** Following continued increases in electronic cigarette (e-cigarette) use among youth and the emergence of severe lung disease associated with e-cigarette use, multiple proposed bills and a task force in 2020 seek to reduce youth vaping, explore bans on the sale of flavored products, and/or consider taxation of e-cigarettes like traditional cigarettes. PHPA indicates that there is no new funding in the fiscal 2021 allowance specifically to address e-cigarette use and that existing tobacco cessation programs will continue to encourage Maryland residents to quit all nicotine addictions (including e-cigarettes).

Operating Budget Recommended Actions

	<u>Funds</u>
1. Delete federal funds due to double-budgeted expenditures under the Special Supplemental Nutrition Program for Women, Infants, and Children.	\$ 9,851,721
Total Reductions	\$ 9,851,721

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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 is organized into five bureaus: the Office of Infectious Disease Prevention and Health Services; the Office of Infectious Disease Epidemiology and Outbreak Response; the Maternal and Child Health Bureau; the Environmental Health Bureau; and the Cancer and Chronic Disease Bureau.

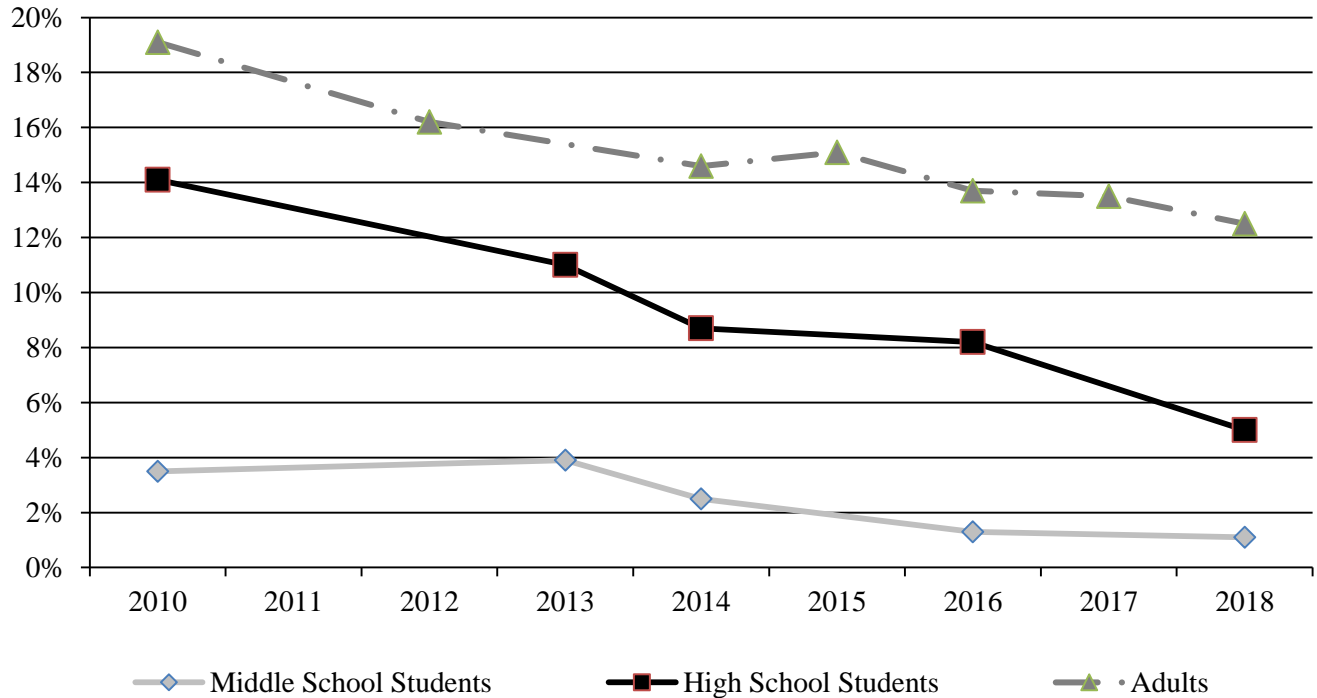
PHPA accomplishes its mission by focusing, in part, on the prevention and control of infectious diseases, investigation of disease outbreaks, protection from food-related and environmental health hazards, and helping impacted persons live longer, healthier lives. Additionally, the administration works 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. Traditional Cigarette Use Continues to Decrease among Youth

The mission of the Tobacco Use Prevention and Cessation Program is to reduce the use of tobacco products and 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. Youth risk behavior surveys and youth tobacco surveys are conducted every other year, while smoking among adults is surveyed annually. As shown in **Exhibit 1**, the prevalence of cigarette smoking has decreased for all ages in 2018, the most recent year with available data. For all years shown, this measure only refers to traditional cigarettes and does not include other tobacco products or electronic cigarettes (e-cigarettes). Further discussion of e-cigarette use in the State can be found in Issue 2.

**Exhibit 1
Tobacco Usage Rates
Calendar 2010-2018**



Source: Maryland Department of Health; Department of Budget and Management

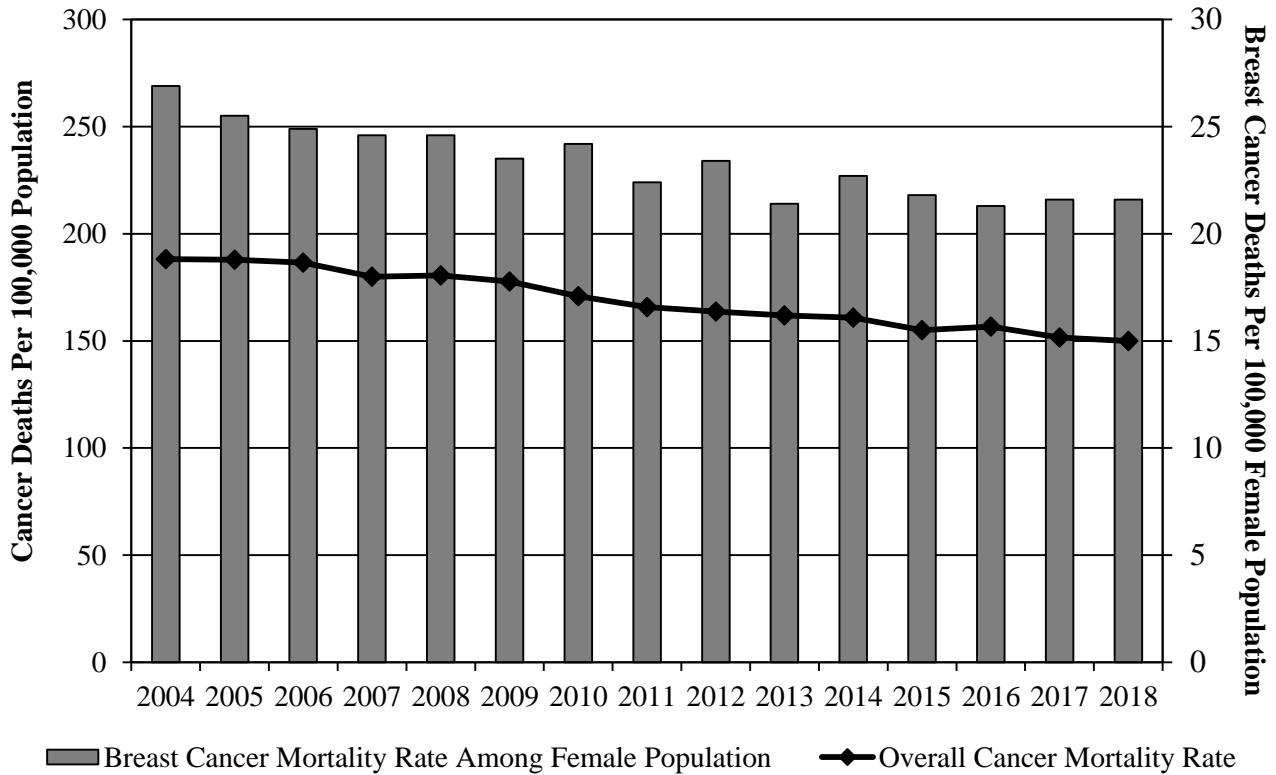
PHPA has a long-term objective to reduce the proportion of underage youth that smoke traditional cigarettes by 87.7% among middle school students and 67.5% among high school students between calendar 2000 and the end of calendar 2020. Fall 2018 surveys found that 1.1% of middle school students and 5.0% of high school students reported currently smoking cigarettes, compared to 7.2% and 23.7% respectively in calendar 2000. This is an 84.9% decrease for middle school students and 78.3% decrease for high school students. To meet the long-term goal, PHPA would need to reduce the rate of smoking among middle school students by 2.8 percentage points more before the end of calendar 2020. However, it has met the high school student objective as of calendar 2018.

Effective October 1, 2019, the minimum age for an individual to purchase or be sold tobacco products rose from 18 to 21 as required by Chapter 369 of 2019, which could aid PHPA in meeting both goals by limiting youth’s access to tobacco. As stated before, this measure only includes self-reported traditional cigarette use among youth, so it is not clear the extent to which the prevalence of e-cigarette smoking explains declines in traditional cigarette smoking. Multiple proposed bills in the 2020 session would ban the sale of all flavored tobacco products, which could also contribute to lower rates of smoking among youth.

2. Cancer Mortality Rates Show Overall Decline, Racial Disparities Worsen

One of the main functions of the Cancer Prevention, Education, Screening, and Treatment Program is to fund community-based programs that prevent, detect, and treat cancer. The mission of the program is to reduce the burden of cancer among Maryland residents by reducing overall cancer mortality in the State. **Exhibit 2** shows that both the overall cancer mortality rate and the breast cancer mortality rate (among females) have declined by approximately 20% between calendar 2004 and 2018. The rate of decline in overall cancer mortality has been sporadic over the period shown, and calendar 2016 actually showed a slight increase. However, calendar 2018 cancer mortality rates decreased for the second successive year, reaching a low for the period shown.

Exhibit 2
Cancer Mortality Rates
Calendar 2004-2018

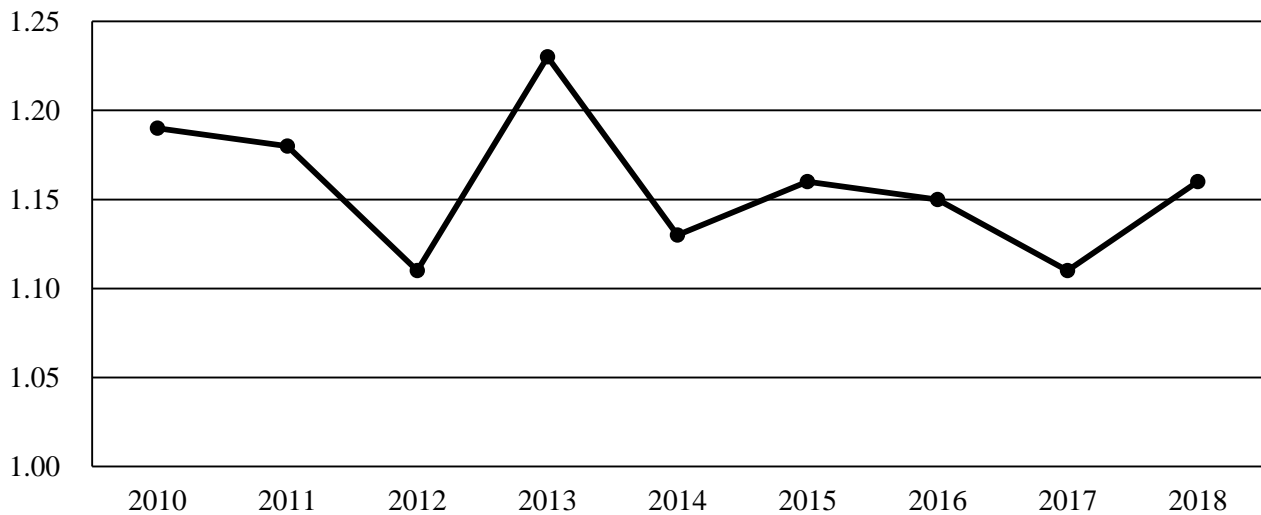


Source: Maryland Department of Health; Department of Budget and Management

Changes in breast cancer mortality rates have also been inconsistent year over year. Most recently, the breast cancer mortality rate showed no change in calendar 2018 compared to 2017. PHPA attributes the overall decline in the breast cancer mortality rate to improved screening, diagnosis, and treatment.

Although cancer mortality rates have generally decreased over time, there remains a disparity between cancer mortality rates among races. **Exhibit 3** shows the ratio of cancer mortality rates among African Americans compared to Whites in Maryland. A ratio of 1.0 would indicate that there is no disparity in cancer mortality, and a ratio greater than 1.0 indicates that African Americans have a higher relative mortality rate. In calendar 2018, the cancer mortality rate among African Americans increased slightly, while the rate among Whites continued to decrease, worsening the disparity. PHPA indicates that the recent increase is a normal fluctuation, but it is seeking to reduce the disparity by focusing screening efforts on underserved, uninsured African American populations, especially in areas of the State where the disparities are most pronounced. Further discussion of overarching disparities in health outcomes based on income, race, and geography can be found in the Maryland Department of Health (MDH) Overview analysis.

Exhibit 3
Cancer Mortality Ratio of African Americans to Whites
Calendar 2010-2018



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; Department of Budget and Management

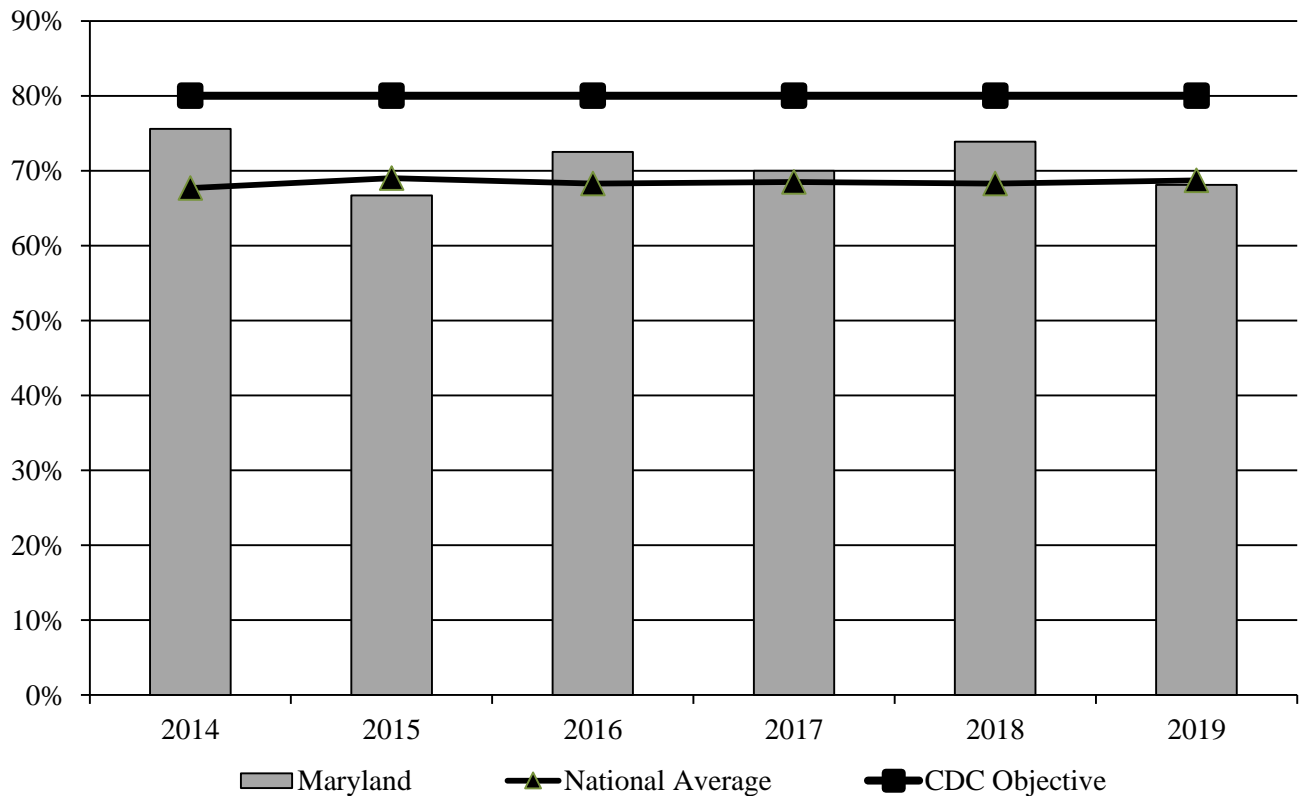
3. Childhood Vaccination Rates Decrease, Falling Below National Average

In the annual Managing for Results submission, PHPA reports its progress in reaching the Centers for Disease Control and Prevention (CDC) goal that 80% of two-year-olds will have up-to-date immunizations. This is measured through the National Immunization Survey, a telephone survey of

parents or guardians of children 19 to 35 months. CDC formerly presented survey results by the year that parents were surveyed. For example, 2019 reporting would have included all survey responses received in calendar 2018. CDC now reports this measure by the birth year of the children included, so the latest data available (published in 2019) displays survey responses for the cohort of children born in 2016.

As shown in **Exhibit 4**, 68.1% of two-year-olds born in 2016 received typical coverage of vaccinations as reported in 2019. This is just below the national average of 68.7% and significantly below the 80% goal. In four of the last six years, Maryland’s childhood immunization rate has surpassed national rates, though it has never reached CDC’s national objective.

Exhibit 4
Two-year-old Children with Up-to-date Immunizations
Reporting Year 2014-2019



CDC: Centers for Disease Control and Prevention

Note: CDC has changed the methodology for this measure and now reports survey results based on the birth year of children included in the National Immunization Survey. Therefore, results published in 2014 depict survey responses for children born in 2011.

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

Although Maryland did not perform better than the national average in the 2019 published survey results, the State 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 providers at 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. PHPA indicates that it continues to educate Marylanders and promote vaccination through the Center for Immunization to improve immunization coverage rates. It should be noted that the Medicaid managed care rate for the same immunization measure shown in Exhibit 4 was 65% in calendar 2018, slightly lower than the statewide average.

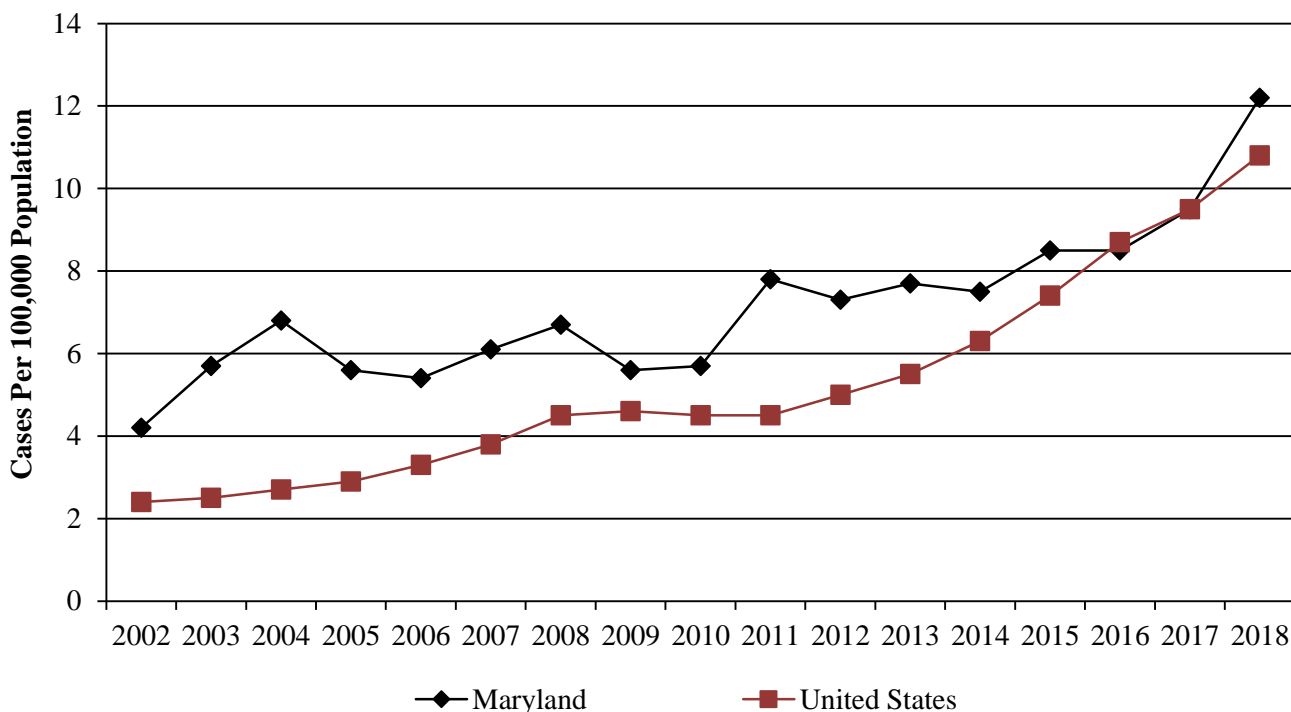
4. Sexually Transmitted Infection Rates Sharply Increase Nationally and in Maryland

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. PHPA reports that Maryland ranked twelfth nationally in primary and secondary syphilis rates in 2018, showing slight improvement over 2017 when it was ranked eleventh. 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 5 shows syphilis rates in Maryland compared with the national average. In calendar 2018, CDC reported a statewide infection rate of primary and secondary syphilis in Maryland of 12.2 cases per 100,000 population, a substantial increase from 8.5 per 100,000 the prior year. This is the third highest growth rate in the statewide primary and secondary syphilis infection rate over the period shown. PHPA attributes the recent rise in syphilis rates to increased drug use, specifically methamphetamines, heroin, and other injection drug use among men with syphilis. Intersecting epidemics of drug use and syphilis have contributed to the rapid growth rate and have made syphilis more difficult to prevent and control.

**Exhibit 5
Rates of Primary and Secondary Syphilis in Maryland
Calendar 2002-2018**



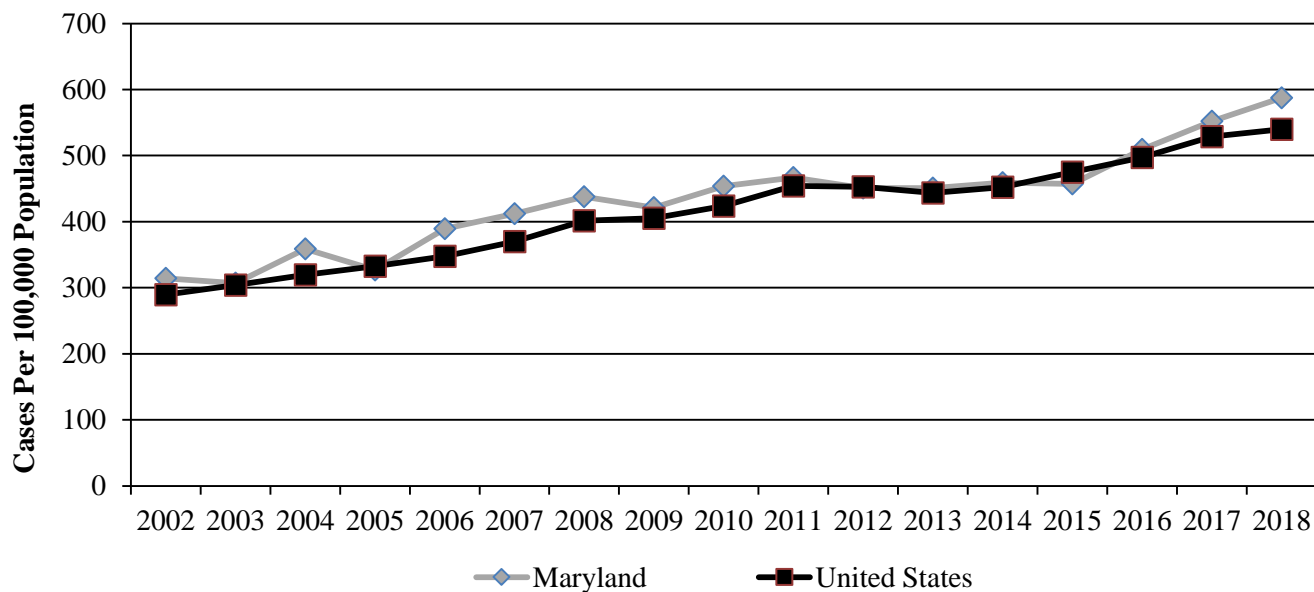
Source: Maryland Department of Health; U.S. Centers for Disease Control and Prevention

Syphilis rates increased from 9.5 to 10.8 nationally, a 13.7% 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.

Chlamydia Infection Rates

As shown in **Exhibit 6**, in calendar 2018, chlamydia rates statewide increased substantially, remaining above the national average. While those aged 15 to 24 represent about 13% of the State’s population, they accounted for 64% 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 6
Rate of Chlamydia in Maryland
Calendar 2002-2018



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

Overall Trends in STI Rates

According to the annual *Sexually Transmitted Disease Surveillance Report* published by CDC, nationwide rates of syphilis, gonorrhea, and chlamydia reached an all-time high in 2018. Maryland's STI rates also increased in the same time period. Compared to other States, however, Maryland improved in its national ranking of reported rates of syphilis and chlamydia. Still, Maryland remains among the highest in the nation for STI rates, ranking twelfth for both syphilis and chlamydia rates in calendar 2018.

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.

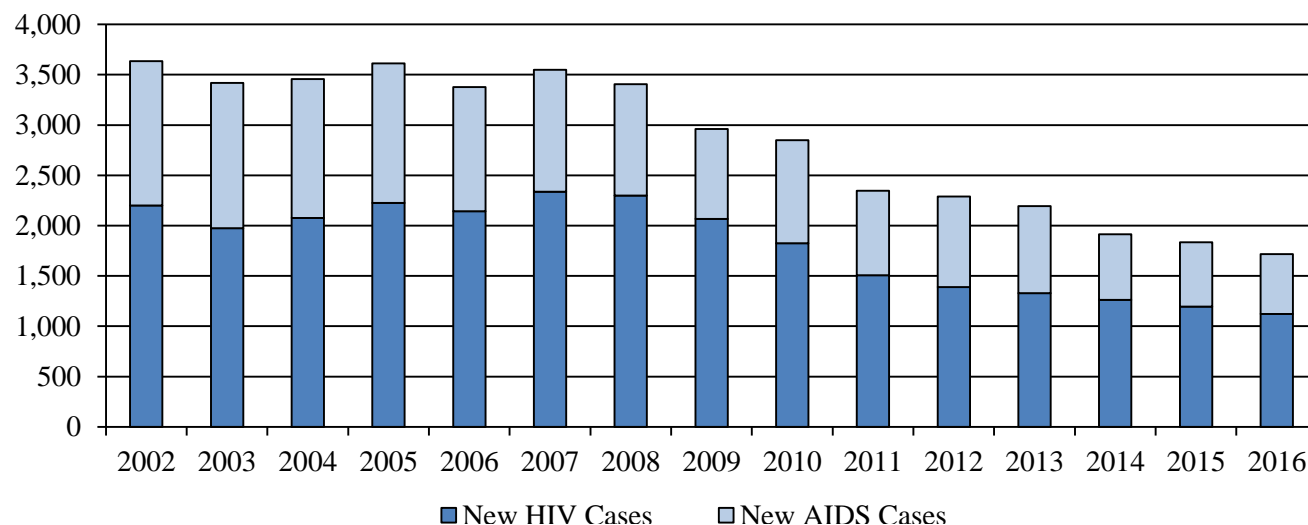
In Baltimore City, where rates for all STIs are the highest in the State, the Baltimore City Health Department receives funding directly from CDC to respond to STIs. Among other activities, Baltimore City has an active outreach program to find and test high-risk individuals, including

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.

5. New HIV and AIDS Cases Continue to Decline

Exhibit 7 details the continued decline in reported cases of HIV and AIDS in Maryland based on the year of diagnosis. As the chart demonstrates, new cases of both HIV and AIDS have declined steadily from a high of 3,548 total cases diagnosed in 2007. PHPA reports this measure is in line with the CDC recommended national convention of assigning HIV/AIDS case information to the year of diagnosis, not the year in which a report was made. Therefore, case numbers are subject to change if a HIV/AIDS diagnosis is reported late, if new information is received that changes the year of diagnosis, if interstate duplicates are identified and a case is reassigned to another state, among other events.

Exhibit 7
Incidence of New HIV and AIDS in Maryland
Calendar 2002-2016



Note: Depicts new HIV/AIDS diagnoses in the year of diagnosis, rather than when a report is made. 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

Due to the way HIV diagnoses are presented, CDC and PHPA advise that the actual number of cases diagnosed may be higher than the numbers presented in recent years and that fluctuations typically subside after two to three years. For this reason, Exhibit 7 only presents HIV and AIDS diagnoses up to calendar 2016. Despite the downward trend over time, the number of diagnosed HIV cases in Maryland remains high compared to other states. According to the calendar 2015 national comparison conducted by CDC, Maryland had the seventh highest diagnoses of HIV infection.

Fiscal 2020

Proposed Deficiency

The allowance proposes a fiscal 2020 deficiency for the Maryland Family Planning Program reducing the appropriation by \$2.9 million in federal funds and providing an additional \$3.6 million in general funds. Further discussion of recent changes to the Maryland Family Planning Program and federal Title X Family Planning Program can be found in Issue 1.

Another proposed deficiency increases the appropriation for the Breast and Cervical Cancer Diagnosis and Treatment Program by \$812,830 in general funds. This program pays for breast and cervical cancer diagnostic treatment services for low-income, uninsured Maryland residents served by participating providers. PHPA reports that a deficiency is needed to cover the increased cost of treatment, primarily due to increases in pharmaceutical costs. The program also received a \$3 million general fund deficiency in fiscal 2019 as outpatient care, physician, and pharmaceutical costs increased. The fiscal 2021 allowance increases \$275,000 over the fiscal 2020 adjusted level, and estimated spending in both fiscal years remains lower than the \$18.4 million actual spending in fiscal 2019. **PHPA should discuss whether it believes that the fiscal 2021 appropriation for the Breast and Cervical Cancer Diagnosis and Treatment Program is adequate to cover the estimated treatment costs.**

There is a third deficiency in the fiscal 2021 budget plan that provides an additional \$100,000 in general funds for tuberculosis grants to local health departments to backfill a planned reversion of funding restricted by the legislature for that purpose but that the Governor chose not to release.

Reorganization of Overdose Prevention and Tobacco Enforcement Efforts

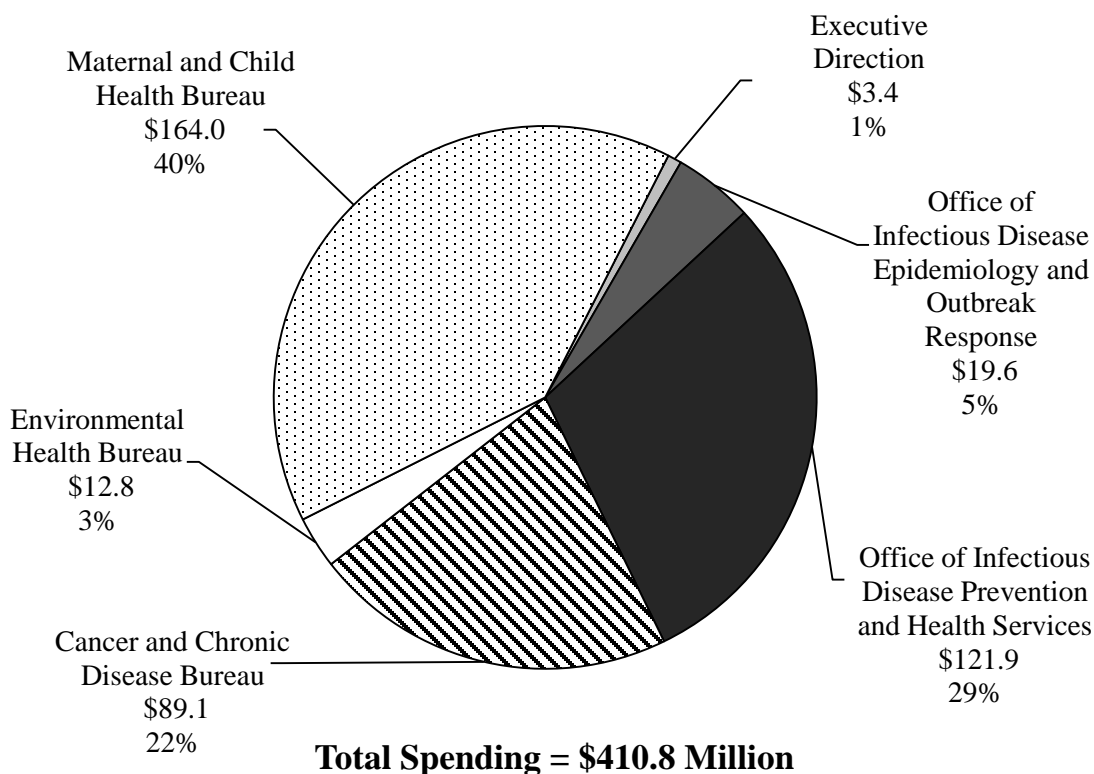
Effective February 4, 2019, MDH realigned its harm reduction, data analysis, and prevention programs related to the opioid crisis from the Behavioral Health Administration (BHA) to Public Health Services. The department's treatment and recovery programs related to the opioid crisis remain under BHA. MDH reports that the reorganization supports the department's goal of driving down overdose deaths by consolidating and strengthening the Public Health Services' prevention, early intervention, harm reduction, and surveillance efforts while allowing BHA to focus on its primary goals of behavioral health treatment and recovery.

A fiscal 2020 amendment reflected this reorganization by transferring \$8.5 million in total funds to PHPA. Of this amount, \$7.2 million were federal funds from the State Opioid Response grant. The amendment also consolidated tobacco enforcement expenditures by transferring \$862,660 in total funds from BHA to the Cancer and Chronic Disease Bureau. Additional funds supporting the Prescription Drug Monitoring Program and other substance use disorder (SUD) prevention programs were transferred to the Public Health Administration through this amendment.

Fiscal 2021 Overview of Agency Spending

Exhibit 8 displays PHPA’s fiscal 2021 allowance broken out by its five main bureaus and executive direction. The Maternal and Child Health Bureau accounts for the largest share of spending at 40%, or \$164.0 million. This is mainly due to \$123.3 million budgeted in federal funds for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Approximately 34% of PHPA’s expenditures are budgeted for programs related to infectious disease prevention, health services, and epidemiology, including HIV/AIDS prevention and treatment programs.

Exhibit 8
Overview of Agency Spending
Fiscal 2021 Allowance
(\$ in Millions)



Note: Does not include statewide general salary increases.

Source: Governor’s Fiscal 2021 Budget Books; Department of Legislative Services

Proposed Budget Change

As shown in **Exhibit 9**, the adjusted fiscal 2021 allowance decreases by \$32.0 million compared to the adjusted fiscal 2020 working appropriation, mainly due to reduced spending of the Maryland AIDS Drug Assistance Program (MADAP) rebate funds.

**Exhibit 9
Proposed Budget
MDH – Prevention and Health Promotion Administration
(\$ in Thousands)**

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2019 Actual	\$65,361	\$99,965	\$207,901	\$2,535	\$375,762
Fiscal 2020 Working Appropriation	60,902	150,696	229,631	2,325	443,554
Fiscal 2021 Allowance	<u>61,275</u>	<u>118,323</u>	<u>229,632</u>	<u>2,306</u>	<u>411,536</u>
Fiscal 2020-2021 Amount Change	\$373	-\$32,373	\$1	-\$19	-\$32,018
Fiscal 2020-2021 Percent Change	0.6%	-21.5%		-0.8%	-7.2%

Where It Goes:

Personnel Expenses	Change
2% general salary increase effective January 1, 2021, and net increase from annualization of 1% general salary increase effective January 1, 2020	\$548
Turnover adjustments.....	522
Retirement contributions.....	62
Social Security contributions	-95
Other fringe benefit adjustments.....	-340
Employee and retiree health insurance.....	-348
Regular earnings primarily due to position transfers within MDH.....	-504
Salaries associated with 14 abolished positions.....	-774
HIV/AIDS Services	
Funding for the HIV Prevention Cooperative Agreement between MDH and the U.S. Centers for Disease Control and Prevention, primarily federal funds	290
Ending the HIV Epidemic grant for Montgomery and Prince George’s counties (federal funds)	250
HIV surveillance and epidemiology activities	-122
Community-based programs to test and cure Hepatitis C (federal fund decline slightly offset by an increase in general funds).....	-807
Maryland AIDS Drug Assistance program rebates generated through general fund expenditures	-1,855

M00F03 – MDH – Prevention and Health Promotion Administration

Where It Goes:

HIV client services (special and federal funds)	-8,380
HIV health services (special and federal funds).....	-25,532
Other Infectious Disease, Epidemiology, and Health Services	
Tuberculosis prevention services (general and federal funds)	502
Emergency Infections program (federal funds)	-82
Net decrease in spending for prevention and treatment of Hepatitis B and C	-466
State Opioid Response Grant funding used for prevention (federal funds)	-5,481
Maternal and Child Health Bureau	
Nonpersonnel spending for the Special Supplemental Nutrition Program for Women, Infants, and Children (federal funds)	14,158
Children’s Medical Services to provide critical specialty care to prevent morbidity and mortality	429
Maternal, Infant, and Early Childhood Home Visiting Grant (federal funds)	410
General fund support for the Maryland Family Planning program as required by Chapters 28 and 810 of 2017 (see Issue 1)	264
Cancer and Chronic Disease Bureau	
Breast and Cervical Cancer Diagnosis and Treatment Program	275
Tobacco retail inspection enforcement services (federal funds)	182
Grants for local fire departments to conduct innovative cancer screening as required by Chapter 219 of 2019.....	100
Cigarette Restitution Fund support for cancer prevention, education, screening, and treatment programs	-211
Healthiest Maryland campaign for chronic disease strategies, including grants to local health departments (Prevention and Public Health federal funds).....	-4,309
Other Program Changes	
Other.....	-705
Total	-\$32,018

MDH: Maryland Department of Health

Note: Numbers may not sum due to rounding. The fiscal 2020 appropriation includes deficiencies, planned reversions, and general salary increases. The fiscal 2021 allowance includes contingent reductions and general salary increases.

HIV/AIDS Programs

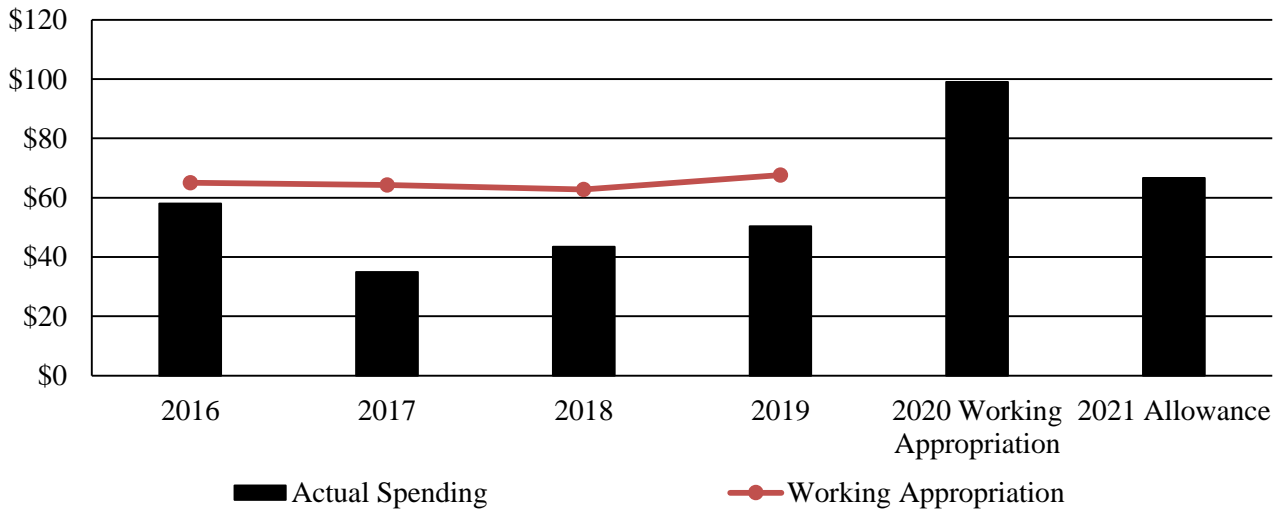
HIV/AIDS program expenditures decrease by approximately \$36.2 million in special and federal funds in the fiscal 2021 allowance, predominantly in reduced MADAP rebate spending. Under federal law, states receive rebates on medications purchased at a price higher than a federally set rate. These rebates can then be used by State AIDS drug assistance programs. HIV/AIDS services provided by programs funded with MADAP rebates include the purchase of pharmaceuticals, insurance premiums or copays, oral health care, housing stability, syringe services, and pre-exposure prophylaxis clinics. PPHA also generates rebate funding from general funds, which do not have the same restrictions as rebates earned from federal grants. MADAP annually generates approximately \$50 million in special

funds for the State via rebates and had accumulated a significant fund balance in prior fiscal years. At the close of fiscal 2018, PHPA reported a fund balance of \$78.2 million in drug rebate funds.

PHPA continued to carry over large fund balances even after Chapter 384 of 2015 expanded the authorized use of pharmaceutical rebates to include all covered services under the federal Ryan White Part B Grant Program, including outreach services and medical transportation. PHPA had also been told by the federal Health Resources and Services Administration to spend its fund balance within five years, leading to the department developing a five-year spending plan and sharply increasing program expenditures. The spending plan focused on infrastructure development, workforce development, and community-identified priorities, and PHPA allocated new spending toward housing, oral health, mental health, SUD treatment, and health care workforce development.

Exhibit 10 displays MADAP rebates budgeted in each fiscal year’s working appropriation at the time that the budget was introduced compared to the actual spending in the first four years of the spending plan and the budgeted spending in fiscal 2020 and 2021. The fiscal 2021 allowance for HIV/AIDS programs is based on PHPA spending only current year rebates and the annual federal grant award. However, PHPA has failed to meet its spending targets in fiscal 2016 through 2019 with budgeted expenditures outpacing actual spending in fiscal 2019 by \$17.3 million. **Considering recent underspending of MADAP rebate funds in the first four years of the spending plan, PHPA should discuss any potential impact this has on future rebate or Ryan White Part B revenues. PHPA should also explain what has caused the persistent underspending and discuss how it would spend additional rebate funding if more is available in fiscal 2021 than is currently budgeted.**

Exhibit 10
Maryland AIDS Drug Assistance Program Drug Rebate Spending
Fiscal 2016-2021 Allowance
(\$ in Millions)



Source: Department of Budget and Management; Governor’s Fiscal 2021 Budget Books

WIC Program

Although federal funding through the WIC program reflects a \$14.2 million increase in fiscal 2021, PHPA indicates that approximately \$9.9 million of this increase was incorrectly double-budgeted across two subobjects in the PHPA allowance. **The Department of Legislative Services recommends deleting the double-budgeted federal funds.**

Fiscal 2021 Federal Grant Reductions

More than half of the PHPA allowance (approximately 55.8%) is made up of federal grants, primarily from CDC and the U.S. Department of Health and Human Services (HHS), to aid PHPA in its mission. From fiscal 2020 to 2021, total federal funds are essentially flat funded. However, this masks some fluctuations in individual federal grant programs. The \$14.2 million increase budgeted for the WIC program offsets the following federal fund reductions.

- \$4.3 million in Prevention and Public Health Fund grants that ended at the close of federal fiscal 2018. These grants were authorized by the Affordable Care Act to provide expanded and sustained national investments in prevention and public health in order to improve health outcomes and to enhance health care quality. PHPA used this funding for management of chronic diseases through health system interventions to improve the delivery and use of clinical services and clinical-community linkages to support cardiovascular disease and diabetes control efforts.
- \$5.5 million under the State Opioid Response (SOR) grant from the Substance Abuse and Mental Health Services Administration for SUD prevention activities transferred to PHPA in fiscal 2020. This SOR funding supported grants to local health departments and community-based organizations for harm reduction activities and Naloxone distribution. The SOR grant ended at the close of federal fiscal 2020.
- \$1.0 million in CDC grant funds for Hepatitis C prevention and control. PHPA received a grant for community-based programs related to Hepatitis C treatments that was not continued after federal fiscal 2019. In fiscal 2020 and 2021, PHPA has continued to fund the program with general funds.
- \$3.4 million from the Ryan White Part B HIV Care Grant Program. This program shows a reduction in fiscal 2021 because PHPA received a supplemental grant totaling approximately \$6.0 million that expires at the close of federal fiscal 2020. The supplemental award is budgeted at \$4.5 million in fiscal 2020 and \$1.5 million in fiscal 2021.

Prince George’s County Hospital Operating Subsidy

The fiscal 2021 allowance provides a \$15 million operating subsidy for the Capital Region Medical Center, showing no change from the fiscal 2020 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.

Personnel Data

	<u>FY 19 Actual</u>	<u>FY 20 Working</u>	<u>FY 21 Allowance</u>	<u>FY 20-21 Change</u>
Regular Positions	401.80	468.60	453.40	-15.20
Contractual FTEs	<u>28.73</u>	<u>52.64</u>	<u>72.19</u>	<u>19.55</u>
Total Personnel	430.53	521.24	525.59	4.35

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	19.86	4.38%
Positions and Percentage Vacant as of 12/31/19	75.00	16.01%
Vacancies Above Turnover	55.14	

- The fiscal 2021 allowance reflects a reduction of 15.2 regular positions due to 1.2 position transfers out of MDH and 14 abolished positions. Of the abolished positions, 8 were new positions in fiscal 2020 related to converted contractual employees of the Maryland Institute for Policy and Research (MIPAR). MDH indicates that these positions were abolished because federal funds backing these positions were no longer available or the MIPAR employee left the State before fiscal 2020, and a new employee was never hired. The remaining 6 positions were abolished because the assigned duties were not statutorily required or because PHPA could address operational needs without the position.

Issues

1. Title X Final Rule Takes Effect, Impacting State Family Planning Program Funding

As part of the federal Title X Family Planning Program, PHPA formerly received funding for projects that offer a broad range of acceptable and effective contraceptive methods and related services on a voluntary and confidential basis. Title X funds may not be used for abortion care under federal law. On March 4, 2019, HHS published a final rule substantially altering the Title X Family Planning Program. Significant provisions include:

- eliminating prior requirements that Title X sites offer a broad range of medically approved family planning methods and services;
- prohibiting Title X grantees from referring patients for abortion services as a method of family planning; and
- requiring that Title X-funded activities have full physical and financial separation from abortion-related activities, among other provisions.

In response to the final rule, 23 states (including Maryland), the District of Columbia, and several provider organizations filed suit against HHS. Preliminary injunctions were initially issued in federal district courts in California, Maryland, Oregon, and Washington, preventing HHS from enforcing the final rule. Baltimore City also filed suit against HHS and was granted a preliminary injunction for the entire State. On July 11, 2019, the Ninth Circuit U.S. Court of Appeals lifted the preliminary injunctions, allowing HHS to begin enforcing the final rule on July 15, 2019, with the exception of the physical separation requirement, which will be enforced March 4, 2020.

PHPA indicates that enforcement of the final rule triggered the conditions of Chapters 28 and 810 of 2017, which established a Family Planning Program under MDH to provide family planning services through providers that lost eligibility for Title X funding as a result of (1) the scope of services offered by the providers or (2) the scope of services for which the providers offer referrals. Maryland providers who received Title X funds through PHPA became ineligible for federal funding because they provide counseling and referral for abortion.

Chapters 733 and 734 of 2019 prohibit MDH from accepting any federal funding under Title X if the program (1) excludes family planning providers and (2) does not require such providers to provide medically approved methods and services. As a result of the final rule taking effect, PHPA notified HHS on September 3, 2019, that it was terminating its federal Title X funds and would not seek any reimbursement for services provided after July 15, 2019. Chapters 733 and 734 also require the Governor to fund the program at the same level of total funds budgeted in the preceding fiscal year. Due to the loss of federal funds, a proposed fiscal 2020 deficiency adds \$3.6 million in general funds

and cuts \$2.9 million in federal funds for the Family Planning Program to maintain the program's appropriation at the fiscal 2019 budgeted level of \$9.9 million total funds.

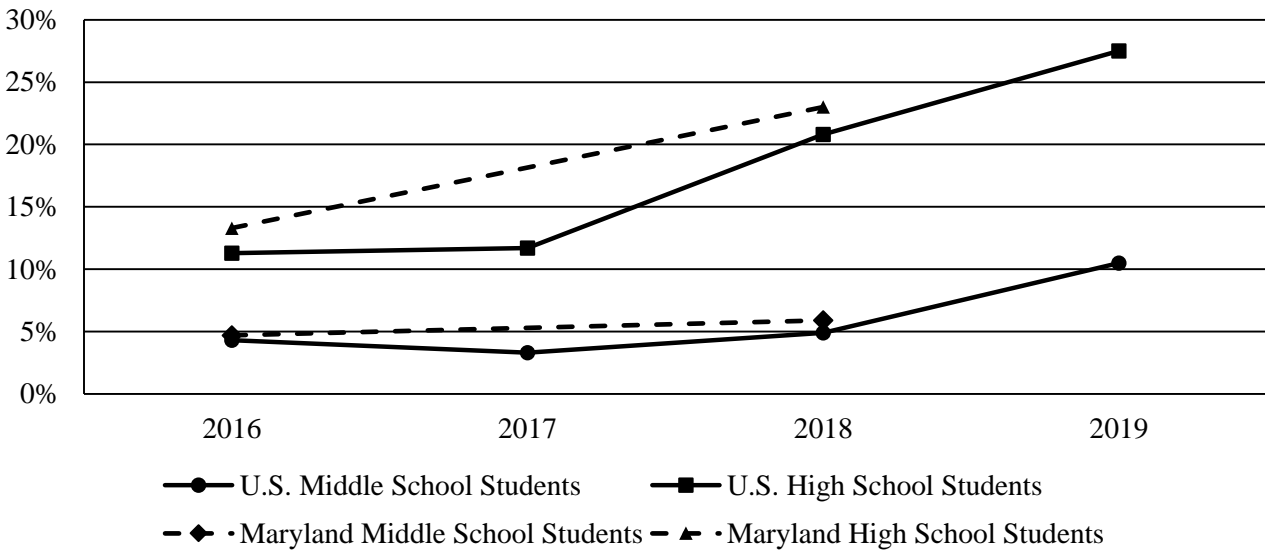
The fiscal 2021 appropriation for the Family Planning Program totals \$10.1 million in general funds only and, other than the shift in fund source, PHPA advises that there have not been any programmatic changes. The additional \$264,417 budgeted in fiscal 2021 is for increased personnel costs. Chapters 733 and 734 do not prohibit local or private entities from applying for Title X grants directly from HHS. In the January 2020 Title X Family Planning Directory, one organization located in Montgomery County was listed as the only Maryland grantee.

2. Rapidly Increasing E-cigarette Use among Youth Causes Growing Concern

As noted in the Performance Analysis section, Maryland has successfully reduced the proportion of youth that smoke traditional cigarettes according to self-reported results from the youth risk behavior survey and youth tobacco survey. However, the use of e-cigarettes among youth nationally and statewide has increased substantially in the past four years, as shown in **Exhibit 11**, and is a growing concern. According to the 2019 National Youth Tobacco Survey released by the U.S. Food and Drug Administration (FDA) and CDC, 1 in 10 middle school students (10.5%) and 1 in 4 high school students (27.5%) in the United States. reported currently using e-cigarettes. In 2018, according to the most recent youth risk behavior survey and youth tobacco survey results, e-cigarette use among middle school students (5.9%) and high school students (23.0%) in Maryland outpaced the rate among U.S. students overall in that year.

The 2019 Monitoring the Future Survey also found significant increases in youth vaping, noting that vaping among grades 8, 10, and 12 more than doubled from 2017 to 2019. According to FDA, increased youth vaping is likely attributable to the popularity of USB-flash-drive-like e-cigarettes that have a high nicotine content, appealing flavors, and the ability to be easily concealed and used discreetly. Of U.S. students reporting current and exclusive e-cigarette use in the 2019 National Youth Tobacco Survey, 59.2% of middle school students and 72.2% of high school students reported that they use flavored e-cigarettes. PHPA also emphasizes that electronic smoking devices (ESD) are not FDA-approved cessation devices and that adult use of e-cigarettes and other ESD are also of concern.

**Exhibit 11
Percentage of U.S. and Maryland Students Reporting E-cigarette Use
Calendar 2016-2019**



Note: Depicts self-reported data from the National Youth Tobacco Survey, Youth Risk Behavior Survey, and Youth Tobacco Survey

Source: U.S. Food and Drug Administration; U.S. Centers for Disease Control and Prevention; Department of Legislative Services

Severe Lung Disease Associated with E-cigarette Use

Further fueling concerns over increases in youth vaping is the emergence of severe lung disease associated with e-cigarette use. As of January 21, 2020, a total of 2,711 hospitalized e-cigarette or vaping associated lung injury (EVALI) cases or deaths had been reported to CDC from all 50 states, the District of Columbia, and two U.S. territories. CDC reports that 60 deaths have been confirmed in 27 states and the District of Columbia. As of January 28, 2019, PHPA reported 49 hospitalized EVALI cases and no deaths. CDC is coordinating a multistate investigation and has found that vitamin E acetate is strongly linked to the EVALI outbreak that increased sharply in August 2019 and peaked in September 2019. Vitamin E acetate is used as an additive, most notably as a thickening agent in vaping products containing tetrahydrocannabinol (THC, a psychoactive component of the marijuana plant).

Regulation of E-cigarettes in Maryland

In a 2016 report, the U.S. Surgeon General outlined actions to reduce e-cigarette use among youth, including preventing youth access to e-cigarettes and price and tax policies. In 2019, the American Academy of Pediatrics called for similar policies to combat the rise in youth vaping,

including (1) bans on the sale of flavored e-cigarettes (including menthol), the sale of e-cigarettes to individuals younger than 21, internet sales of e-cigarettes, and e-cigarette advertising accessible to youth and (2) taxation of e-cigarettes at rates comparable to traditional cigarettes.

The Maryland General Assembly has worked to limit youth access to e-cigarettes, established a licensing framework, and increased penalties for sales to youth through various legislation. 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 ESD (formerly called 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 ESD and does not need a separate license. Three ESD licenses authorize the sale to consumers under specified circumstances: manufacturer; retailer; and vape shop vendor.

Chapter 785 of 2018 established that the distribution of ESD to minors is a misdemeanor subject to existing criminal penalties for the distribution of tobacco products to minors, established that the possession of ESD 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 ESD to minors. Chapter 396 of 2019 revised the definition of tobacco product to include ESD and raised the minimum age for an individual to buy tobacco products from 18 to 21, effective October 1, 2019. Active duty military members 18 years or older who present valid military identification were still able to buy tobacco products under the law. Chapter 396 also authorized MDH to conduct unannounced inspections of a licensed tobacco product retailer to ensure the licensee's compliance with the criminal prohibition against the distribution or sale of tobacco products to individuals younger than 21 years old.

Multiple proposed bills in the current legislative session would prohibit or limit the sale of flavored tobacco products in Maryland. Another proposed bill would limit the in-person sale of certain ESD to age-restricted areas, set a sales and use tax rate for ESD, and restrict 50% of the resulting tax revenue for activities aimed at reducing tobacco use in the State. The Comptroller has also created a task force on ESD, known as e-facts, to examine the public health and safety implications of ESD. PHPA indicates that the fiscal 2021 allowance does not include any new funding to address increased e-cigarette use specifically, but funds for traditional tobacco cessation programs will continue to encourage Maryland residents age 13 and older to quit using ESD along with all other tobacco products causing nicotine addictions.

Recent Federal Actions

In calendar 2016, FDA finalized a rule extending its regulatory authority over tobacco products to include e-cigarettes. Federal regulations prohibited retailers from selling e-cigarettes to minors and required retailers to check the photo identification of any individual younger than age 27 who attempts

to purchase e-cigarettes. On December 20, 2019, President Donald J. Trump signed legislation that amended the Federal Food, Drug, and Cosmetic Act, raising the federal minimum age for sale of tobacco products (including e-cigarettes) from 18 to 21.

Although all e-cigarettes and ENDS have been subject to FDA’s tobacco authorities in the Federal Food, Drug, and Cosmetic Act since August 2016, FDA deferred enforcement of the premarket authorization requirements related to ENDS. As a result, no e-cigarettes or other ENDS currently on the market are authorized by FDA, and all products are considered illegally marketed. In the January 7, 2020 *Federal Register*, FDA issued nonbinding final guidance on its ENDS enforcement priorities, stating that it would prioritize enforcement resources against certain ENDS on February 6, 2020. These products include:

- any flavored, cartridge-based ENDS product (other than a tobacco- or menthol- flavored ENDS product);
- all other ENDS products for which the manufacturer has failed to take (or is failing to take) adequate measures to prevent minors’ access; and
- any ENDS product that is targeted to minors or likely to promote use of ENDS by minors.

FDA also indicated that it would prioritize enforcement where the manufacturer fails to take adequate measures to prevent youth access. The final guidance claims that by not prioritizing enforcement against other flavored products in the same way as flavored cartridge-based ENDS, FDA attempted to balance public health concerns related to youth ENDS use with considerations regarding addicted adult cigarette smokers who may try to use ENDS products to transition from traditional tobacco products.

Actions to Ban or Restrict E-cigarette Products in Other States

In response to the alarming health concerns related to e-cigarette use, several states have taken action through legislation, emergency regulations, or rulemaking. As of January 2020, two states (Massachusetts and New Jersey) have enacted legislation banning the sale of flavored vaping products. The Massachusetts legislation, signed into law in November 2019, restricts the sale and consumption of flavored nicotine vaping products and flavored cigarettes and other tobacco products (as defined in that state), including menthol cigarettes and flavored chewing tobacco, to licensed smoking bars, among other things. This followed a four-month ban on sales of all vaping products in Massachusetts beginning on September 24, 2019, an action that was upheld in federal court in early October 2019. The New Jersey legislation, signed into law in January 2020, bans the sale and distribution of flavored vaping products, including menthol flavored products.

Operating Budget Recommended Actions

	<u>Amount Reduction</u>	
1. Delete federal funds due to double-budgeted expenditures under the Special Supplemental Nutrition Program for Women, Infants, and Children.	\$ 9,851,721	FF
Total Federal Fund Reductions	\$ 9,851,721	

Appendix 1
2019 Joint Chairmen’s Report Responses from Agency

The 2019 *Joint Chairmen’s Report* (JCR) requested that the Maryland Department of Health (MDH) Prevention and Health Promotion Administration prepare one report. An electronic copy of the full JCR response can be found on the Department of Legislative Services Library website.

- ***Training on Integration of Family Planning and Preconception Counseling into Primary Care:***
In its response to the 2019 JCR, MDH included input from interested stakeholders, such as the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians, on training options that encourage health care providers to integrate family planning counseling into routine care. MDH outlined current resources and tools for providing counseling services related to family planning and preconception care training, such as through national training centers and through the Administrative Care Coordination program under Medicaid.

Appendix 2
Object/Fund Difference Report
MDH – Prevention and Health Promotion Administration

<u>Object/Fund</u>	<u>FY 19</u> <u>Actual</u>	<u>FY 20</u> <u>Working</u> <u>Appropriation</u>	<u>FY 21</u> <u>Allowance</u>	<u>FY 20 - FY 21</u> <u>Amount Change</u>	<u>Percent</u> <u>Change</u>
Positions					
01 Regular	401.80	468.60	453.40	-15.20	-3.2%
02 Contractual	28.73	52.64	72.19	19.55	37.1%
Total Positions	430.53	521.24	525.59	4.35	0.8%
Objects					
01 Salaries and Wages	\$ 36,577,245	\$ 46,296,775	\$ 44,820,339	-\$ 1,476,436	-3.2%
02 Technical and Spec. Fees	1,596,760	2,686,758	3,369,993	683,235	25.4%
03 Communication	583,283	225,921	226,071	150	0.1%
04 Travel	632,160	697,980	630,461	-67,519	-9.7%
07 Motor Vehicles	170,485	162,681	187,709	25,028	15.4%
08 Contractual Services	242,272,555	302,469,178	272,948,360	-29,520,818	-9.8%
09 Supplies and Materials	31,553,118	34,691,514	29,624,406	-5,067,108	-14.6%
10 Equipment – Replacement	144,643	150,870	124,147	-26,723	-17.7%
11 Equipment – Additional	760,410	393,981	692,235	298,254	75.7%
12 Grants, Subsidies, and Contributions	61,313,170	54,004,522	58,071,827	4,067,305	7.5%
13 Fixed Charges	158,443	194,471	150,355	-44,116	-22.7%
Total Objects	\$ 375,762,272	\$ 441,974,651	\$ 410,845,903	-\$ 31,128,748	-7.0%
Funds					
01 General Fund	\$ 65,361,353	\$ 56,486,460	\$ 60,995,513	\$ 4,509,053	8.0%
03 Special Fund	99,964,959	150,688,059	118,291,382	-32,396,677	-21.5%
05 Federal Fund	207,900,543	232,475,413	229,253,382	-3,222,031	-1.4%
09 Reimbursable Fund	2,535,417	2,324,719	2,305,626	-19,093	-0.8%
Total Funds	\$ 375,762,272	\$ 441,974,651	\$ 410,845,903	-\$ 31,128,748	-7.0%

Note: The fiscal 2020 appropriation does not include deficiencies, planned reversions, or general salary increases. The fiscal 2021 allowance does not include contingent reductions or general salary increases.

**Appendix 3
Fiscal Summary
MDH – Prevention and Health Promotion Administration**

<u>Program/Unit</u>	<u>FY 19 Actual</u>	<u>FY 20 Wrk Approp</u>	<u>FY 21 Allowance</u>	<u>Change</u>	<u>FY 20 - FY 21 % Change</u>
01 Administrative, Policy, and Management	\$ 142,969,873	\$ 201,391,260	\$ 157,908,865	-\$ 43,482,395	-21.6%
04 Family Health and Chronic Disease Services	232,792,399	240,583,391	252,937,038	12,353,647	5.1%
Total Expenditures	\$ 375,762,272	\$ 441,974,651	\$ 410,845,903	-\$ 31,128,748	-7.0%
General Fund	\$ 65,361,353	\$ 56,486,460	\$ 60,995,513	\$ 4,509,053	8.0%
Special Fund	99,964,959	150,688,059	118,291,382	-32,396,677	-21.5%
Federal Fund	207,900,543	232,475,413	229,253,382	-3,222,031	-1.4%
Total Appropriations	\$ 373,226,855	\$ 439,649,932	\$ 408,540,277	-\$ 31,109,655	-7.1%
Reimbursable Fund	\$ 2,535,417	\$ 2,324,719	\$ 2,305,626	-\$ 19,093	-0.8%
Total Funds	\$ 375,762,272	\$ 441,974,651	\$ 410,845,903	-\$ 31,128,748	-7.0%

Note: The fiscal 2020 appropriation does not include deficiencies, planned reversions, or general salary increases. The fiscal 2021 allowance does not include contingent reductions or general salary increases.