M00F0201
Health Systems and Infrastructure Administration

Operating Budget Data

($ in Thousands)

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change	% Change Prior Year
General Fund	$39,375	$38,711	$41,526	$2,815	7.3%
Contingent & Back of Bill Reductions	0	0	-1	-1	
Adjusted General Fund	**$39,375**	**$38,711**	**$41,525**	**$2,814**	**7.3%**
Special Fund	0	859	26	-833	-96.9%
Adjusted Special Fund	**$0**	**$859**	**$26**	**-$833**	**-96.9%**
Federal Fund	5,121	5,551	5,568	16	0.3%
Adjusted Federal Fund	**$5,121**	**$5,551**	**$5,567**	**$16**	**0.3%**
Adjusted Grand Total	**$44,496**	**$45,121**	**$47,119**	**$1,998**	**4.4%**

- The fiscal 2014 budget increases by $2.0 million, or 4.4%. General funds are increasing by $2.8 million, or 7.3%.

- Special funds decrease by $0.8 million, or 96.9%, due to the removal of one-time Budget Restoration Funds, and federal funds increase by $16,000, or 0.3%.

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

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Personnel Data

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change
Regular Positions	9.00	10.00	10.00	0.00
Contractual FTEs	0.00	0.00	0.00	0.00
Total Personnel	**9.00**	**10.00**	**10.00**	**0.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	0.40	3.97%
Positions and Percentage Vacant as of 12/31/12	2.00	20.00%

- There is no change in the number of regular or contractual positions at the Health Systems and Infrastructure Administration.

Analysis in Brief

Major Trends

Local Health Departments Are Pursuing National Accreditation: In fiscal 2013, it is estimated that three local health departments will have submitted prerequisites for public health accreditation.

Local Health Improvement Coalitions Are Making Progress: In fiscal 2012, local health improvement coalitions (LHICs) were formed to set community health goals. In fiscal 2013, it is estimated that 12 LHICs will have documented progress on at least 1 LHIC goal.

Number of Providers Accepting a State Loan Repayment Program Obligation Increases: In fiscal 2012, the number of health care providers accepting a practice obligation in Maryland under the State Loan Repayment Program increased to 16. This represents a 100% increase over the fiscal 2011 level. In comparison, the number of physicians accepting a practice obligation remains flat.

Issues

Survey of Local Health Departments in Maryland: During the 2012 interim, the Department of Legislative Services issued a report titled *Survey of Local Health Departments in Maryland* that examined local health department operations, programs, funding, and staffing. Among other research activities, the project included an electronic survey that was sent to, and completed by, each of the local health officers in the State. Responses to the survey significantly informed the analysis in the report. This issue summarizes the findings and recommendations contained in the report.

Recommended Actions

1. Adopt committee narrative requiring the department to report on its efforts to address local health department billing challenges.

M00F0201

Health Systems and Infrastructure Administration

Operating Budget Analysis

Program Description

The Health Systems and Infrastructure Administration (HSIA) contains offices that maintain and improve the health of Marylanders by assuring access to primary care services and school health programs, by assuring the quality of health services, and by supporting local health systems' alignment to improve population health. HSIA offices define and measure Maryland's health status, access, and quality indicators for use in planning and determining public health policy. Among other things, they improve access to quality health services in Maryland by developing partnerships with agencies, coalitions, and councils; funding and supporting local public health departments through the Core Funding Program; collaborating with the Maryland State Department of Education to assure the physical and psychological health of school-aged children through adequate school health services and a healthy school environment; seeking public health accreditation of State and local health departments; identifying areas where there are insufficient numbers of providers (primary care, dental, and mental health) to care for the general, rural, Medical Assistance, low income, and Health Enterprise Zone populations in Maryland; working to recruit and retain health professionals through loan repayment programs and access to J1 Visa waivers; and creating and promoting relevant State and national health policies.

Performance Analysis: Managing for Results

1. Local Health Departments Are Pursuing National Accreditation

The U.S. Centers for Disease Control and Prevention, in partnership with the Robert Wood Johnson Foundation, are supporting the implementation of a national voluntary accreditation program for local, state, territorial, and tribal health departments. The Public Health Accreditation Board (PHAB) is a nonprofit entity which was established to serve as the independent accrediting body.

Among other issues, PHAB accreditation standards address areas related to population health, environmental health, wellness promotion, community outreach, and the enforcement of public health laws. Furthermore, standards also focus on improving access to health care services, maintaining a competent public health workforce, evaluating and improving health department programs, and applying evidenced-based public health practices. This is done through accreditation assessments which provide measureable feedback to local health departments (LHD) on the aforementioned standards. In order to be eligible for accreditation, a health department must have three documents that have been updated in the last five years: (1) a community health assessment; (2) a community health improvement plan; and (3) a strategic plan.

The accreditation process includes seven steps: (1) pre-application, which includes submitting a statement of intent and online orientation; (2) application, which requires a health department to submit application forms and the applicable fee; (3) document selection and submission, which requires a health department to demonstrate its conformity with accreditation measures; (4) site visit by PHAB trained site visitors; (5) accreditation decision by PHAB; (6) reports, which are required on an annual basis if accreditation is received; and (7) reaccreditation.[1]

While accreditation is focused on improving the quality of public health departments, it is important to note that accreditation also highlights the capacity and capability of a health department, which may result in increased opportunities for resources. PHAB advises that potential resources may include funding to support quality and performance improvement; funding to address infrastructure gaps identified through the accreditation process; opportunities for pilot programs; streamlined application processes for grants and programs; and acceptance of accreditation in lieu of other accountability processes.

In fiscal 2013, the agency estimates 3 LHDs will submit prerequisites for public health accreditation. LHDs have been encouraged by the Department of Health and Mental Hygiene (DHMH) to pursue accreditation – and a majority of survey respondents (17) indicated that they are either considering or actively pursuing accreditation. However, lack of funding was noted by 12 LHDs as a primary barrier to accreditation. Competing priorities and lack of staff time were also cited as barriers. Only 1 LHD suggested that LHD accreditation is unnecessary, although another LHD indicated that it lacked any financial incentive to pursue accreditation. In general, however, survey responses revealed that LHDs are interested in becoming accredited but that they have had limited success in obtaining the funds to do so.

According to the National Association of County and City Health Officials' (NACCHO) *2008 Profile on Local Health Departments*, 64% of the nation's LHDs serve populations of fewer than 50,000 individuals. Many of these smaller LHDs do not have the capacity to meet PHAB standards individually. NACCHO, therefore, advises regional arrangements as a strategy to assist smaller LHDs in meeting accreditation standards to ensure that their jurisdictions are receiving all essential public health services required under accreditation.[2] The majority of LHDs in Maryland serve populations greater than 50,000. However, seven health departments, primarily on the Eastern Shore, serve populations ranging from approximately 20,200 to 48,000. In these counties, the regionalization of certain services is already occurring. For instance, Mid-Shore Mental Health Services (a core service agency) oversees Caroline, Dorchester, Kent, and Talbot counties. Furthermore, a number of jurisdicitons operate regional Women, Infants, and Children (WIC) programs. Regional WIC programs have been established in the following jurisdictions: Cecil and Harford couties; Caroline, Dorchester, and Talbot counties; and Somerset, Wicomico, and Worcester counties. **The agency should comment on efforts to encourage voluntary accreditation in**

[1] The cost of accreditation varies based on the size of the jurisdictional population served by the health department. In calendar 2012, fees range from $12,720 for populations less than 50,000 to $95,400 for populations greater than 15 million.

[2] The National Association of County and City Health Officials' *2008 Profile on Local Health Departments* indicated that regional health departments provide a more comprehensive set of services when compared to small local health departments. This was attributed, in part, to the budget constraints faced by small jurisdictions.

jurisdicitons where a lack of funding presents a barrier to obtaining accreditation, including whether regionalization could be beneficial.

2. Local Health Improvement Coalitions Are Making Progress

Among other things, the Maryland Health Care Reform Coordinating Council (HCRCC), established by executive order in March 2010, has advised that Maryland's public health infrastructure – including LHDs as well as population-based programs – serves unique functions that will not be supplanted by the health insurance coverage aspects of federal health care reform. Among other things, HCRCC recommended that Maryland develop State and local strategic plans to improve health outcomes.

DHMH developed a State Health Improvement Process (SHIP) that includes a health needs assessment to identify priorities and set goals for health status, access, provider capacity, consumer concerns, and health equity within the State. Through SHIP, the department has designated public and private sector partners to work with LHDs and the State to monitor a number of performance metrics. HCRCC has further recommended that local implementation processes be developed which involve LHD-led collaborations to identify systemic issues that must be addressed to achieve SHIP goals.

In September 2011, DHMH launched SHIP to improve accountability and reduce health disparities in Maryland by 2014 through implementing local action and engaging the public. As shown in **Appendix 2**, SHIP includes 39 measures of health in six vision areas: healthy babies, healthy social environments, safe physical environments, infectious disease, chronic disease, and healthcare access. Of the 39 SHIP measures, 24 objectives have been identified as critical racial/ethnic health disparities measures; in addition, health disparities exist for all measures related to healthy babies, infectious disease, and chronic diseases. Each measure has a data source and a target and, where possible, can be assessed at the city or county level. SHIP also provides counties with tools to set local priorities and mobilize communities to improve residents' health; one example is the Maryland Tobacco Quitline.

SHIP supports local health improvement coalitions (LHIC) in counties and regions around the State to identify priorities, make plans, and take action by creating a local health improvement process. Maryland has 18 active local or regional health coalitions, with memberships ranging from 10 to 60 individuals.[3] To date, each coalition has met, assessed the health of its community, and developed health priorities. Each jurisdiction or region was required to develop an action plan for 2012 that includes three to five community health priorities that align with SHIP goals. These action plans (which may also include locally identified issues) were expected to serve as each coalition's short-term work schedule for 2012, as local coalitions began to develop their local health improvement process.

[3] The Lower Shore (Somerset, Wicomico, and Worcester counties) and the Upper Shore (Caroline, Dorchester, Queen Anne's, and Talbot counties) are the only two coalitions that include more than one county.

As shown in **Exhibit 1**, 100% of local health improvement coalitions identified one or more measures within the fifth SHIP vision area – chronic diseases – as a community health priority. Among other measures, this vision area includes measures related to heart disease, hypertension related emergency department visits, and the proportion of adults who are at a healthy weight.

Exhibit 1
Local Health Improvement Coalition Community Priorities

SHIP Vision Area	Percentage of Local Health Improvement Coalitions That Have Identified One or More Measures within a Vision Area
Healthy Babies	39%
Healthy Social Environments	33%
Safe Physical Environments	5%
Infectious Disease	28%
Chronic Disease	100%
Health Care Access	56%

SHIP: State Health Improvement Process

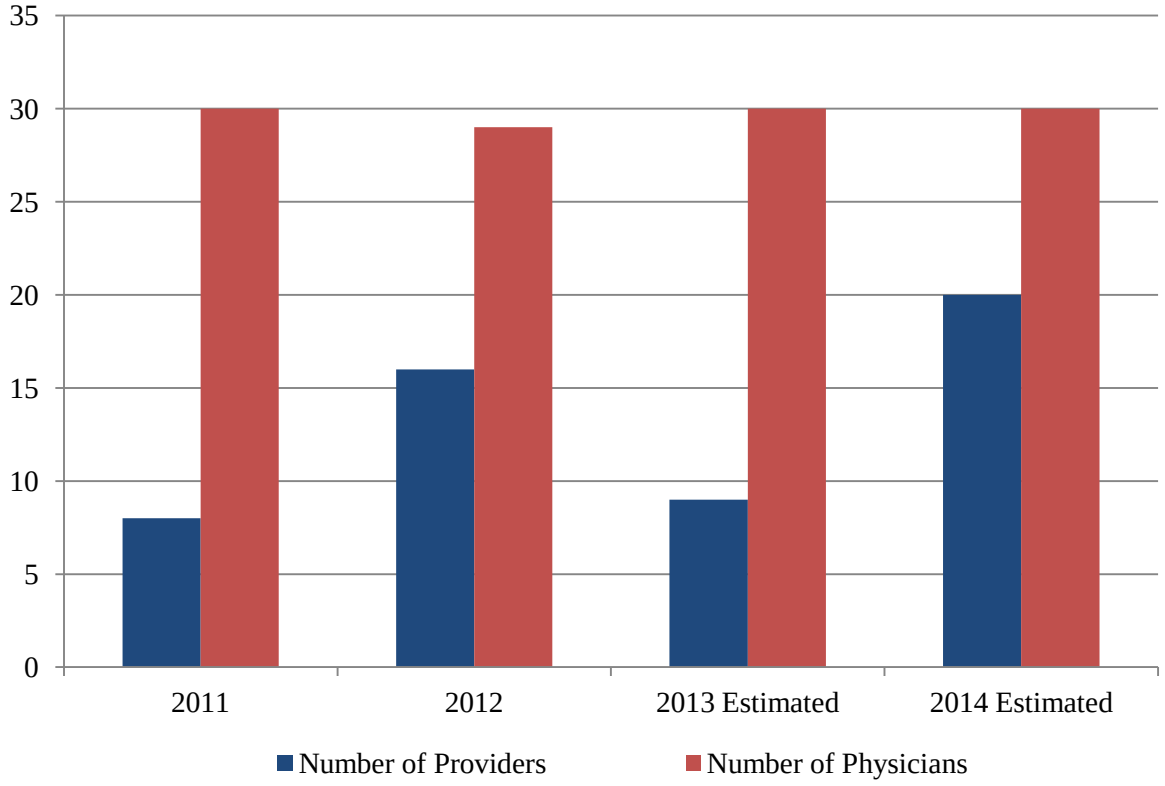
Source: Department of Legislative Services

As stated in its Managing for Results (MFR) submission, by fiscal 2014, the agency's goal is that a minimum of 20 LHDs will have made documented progress on at least one LHIC goal. In fiscal 2013, HSIA estimates 12 LHDs will have documented progress on at least one LHIC goal. It is important to note that there is no baseline for this MFR measure as goals were set in fiscal 2012.

3. Number of Providers Accepting a State Loan Repayment Program Obligation Increases

HSIA aims to maximize the number of health care providers accepting a practice obligation in Maryland under the State Loan Repayment Program (SLRP). SLRP offers physicians an opportunity to practice their profession in a community that lacks adequate primary and/or mental health services while also receiving funds to pay their educational loans. An eligible practice site is a clinic that is public or nonprofit, that treats all persons regardless of their ability to pay, and that is located in a geographic region of Maryland that has been designated as a health professional shortage area. A provider accepting a new SLRP practice obligation is defined as a health care provider who signs the Maryland Higher Education Commission Promissory Note and Obligation Agreement that obligates the provider to serve under SLRP. As shown in **Exhibit 2**, in fiscal 2012, the number of health care providers accepting a practice obligation in Maryland under SLRP increased to 16. This represents a

Exhibit 2
Number of Health Care Providers and Physicians Accepting a Practice Obligation
Fiscal 2011-2014



Source: Department of Health and Mental Hygiene

100% increase over the fiscal 2011 level. Providers include nurse practitioners, physician assistants, dentists, and social workers. In comparison, the number of physicians accepting a practice obligation remains flat.

Proposed Budget

The Governor's fiscal 2014 budget, as shown in **Exhibit 3**, increases by $2.0 million, or 4.4%. General funds increase by $2.8 million, or 7.3%, and the special fund allowance decreases by $0.8 million, or 96.9%, from fiscal 2013. Finally, federal funds increase by $16,000, or 0.3%. The increase in the general fund appropriation is primarily due to the $2.0 million increase for Core Public Health Services.

Exhibit 3
Proposed Budget
Health Systems and Infrastructure Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Total
2013 Working Appropriation	$38,711	$859	$5,551	$45,121
2014 Allowance	41,526	26	5,568	47,120
Amount Change	$2,815	-$833	$16	$1,999
Percent Change	7.3%	-96.9%	0.3%	4.4%
Contingent Reductions	-$1	$0	$0	-$1
Adjusted Change	$2,814	-$833	$16	$1,998
Adjusted Percent Change	7.3%	-96.9%	0.3%	4.4%

Where It Goes:	
Personnel Expenses	
Turnover adjustments	$18
Employee and retiree health insurance	9
Annualized salary increase	9
Employee retirement	5
Other adjustments	3
Regular salaries	-8
Other Changes	
Core funding formula inflationary adjustment	1,998
Primary care organization activities	39
Other adjustments	1
Women, Infants, and Children Quality Improvement Initiative with Maryland Institute for Policy Analysis and Research	-76
Total	**$1,998**

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

Personnel

Overall, personnel expenses for HSIA increase by $36,000 over the fiscal 2013 appropriation. Turnover adjustments increase the budget by $18,000. This reflects decreasing the existing turnover rate from 5.49 to 3.97%. Expenditures for employee and retiree health insurance and the annualization of the fiscal 2013 cost-of-living adjustement (COLA) for State employees each increase the budget by $9,000. Employee retirement contributions increase by $5,000 due to underattainment in investment returns, adjustments in actuarial assumptions, and an increase in reinvestment of savings achieved in the 2011 pension reform. These increases are offset by a decrease in regular salaries (-$8,000).

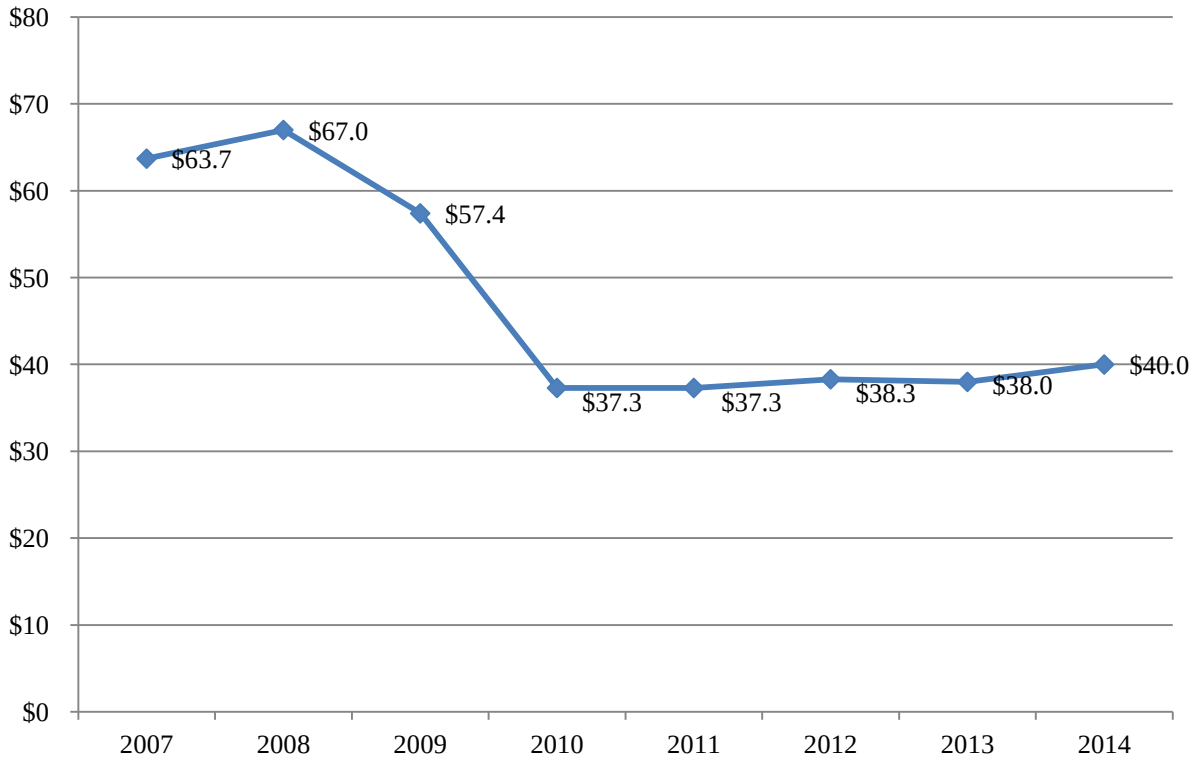
Core Public Health Services

Exhibit 4 shows the funding level for Core Public Health Services from fiscal 2007 to 2014. Funding for this program is established by a statutory formula, referred to as the targeted local health formula, which operates as the sole statutory mechanism for local health services. Due to recent budget constraints and cost-cutting measures, the fiscal 2010 appropriation for local health services was reduced to $37.3 million – which was below even the fiscal 1997 mandated Core funding level. During the 2010 session, the statute underlying the health aid formula was amended to rebase the formula at the fiscal 2010 level for fiscal 2011 and 2012 with inflationary increases beginning again in fiscal 2013. There was a slight increase in funding in fiscal 2012 due to the one-time $750 bonus for State employees. Similarly, the fiscal 2013 working appropriation includes funding for the 2013 COLA. However, due to budget constraints, there was no formula adjustment factor applied to fiscal 2013 spending levels.

The fiscal 2014 budget includes an increase of $2.0 million for Core Public Health Services. This includes adjustments for two factors: (1) the formula adjustment factor and (2) additional funding to account for the annualization of the fiscal 2013 COLA for State employees. The formula adjustment factor is mandated under Health-General § 2-302 accounts for $1.2 million of this increase. This adjustment is calculated by combining an inflation factor with a population growth factor.[4] More specifically, statute mandates that for fiscal 2013 and each subsequent fiscal year, the formula adjustment factor be applied to the $37.3 million base level. As demonstrated by Exhibit 4, prior to cost containment actions that began in fiscal 2009, the inflationary adjustment had been made to the previous year's base allocation. Given that the formula adjustment factor is applied to the base year rather than the prior fiscal year, funding for Core Public Health Services will not grow. Another consequence of applying the adjustment factor to the base level means that the formula does not account for ongoing expenditures related to the annualization of the fiscal 2013 COLA. Therefore, funding in excess of the formula adjustment factor is provided in fiscal 2014 to account for the annualization of the fiscal 2013 salary increase ($0.8 million). DLS advises that similar

[4] Current regulations provide that the annual formula adjustment and any other adjustment for local health services must be allocated to each jurisdiction based on its percentage share of State funds distributed in the previous fiscal year and to address a substantial change in community health need, if any, as determined at the discretion of the Secretary after consultation with local health officers.

Exhibit 4
Local Health Aid
Fiscal 2007-2014
($ in Millions)



Note: Amounts do not include federal pass-through funds administered through the Core Funding Program.

Source: Department of Health and Mental Hygiene

adjustments will have to occur in future fiscal years to account for ongoing costs associated with the fiscal 2013 and 2014 COLAs.[5] This additional funding is not mandated by statute and is budgeted at the discretion of the Administration.

Other Changes

Funding increases by $39,000 for Primary Care Organization program activities. The Primary Care Organization program is a federally funded program that: (1) provides technical assistance and

[5] The fiscal 2014 allowance for the Department of Budget and Management includes centrally budgeted funds for the fiscal 2014 cost-of-living adjustment.

data to primary care practitioners and clinics and to community organizations serving the uninsured, underinsured, and low income populations; (2) coordinates efforts to assess and attract health care professionals to serve in medically underserved areas; and (3) facilitates collaboration among primary care programs for special populations such as the homeless, migrant farm workers, and other underserved groups. This increase is offset by a $76,000 decrease in funding for the Women, Infants, and Children (WIC) Program Quality Improvement Initiative.

Issues

1. Survey of Local Health Departments in Maryland

During the 2012 interim, the Department of Legislative Services (DLS) issued a report titled *Survey of Local Health Departments in Maryland*, which examines the provision of local public health services in the State. More specifically, the report assesses (1) how LHDs finance public health services; (2) the impact of federal health care reform on LHDs; and (3) the regionalization of public health services in the State.

In order to evaluate these three areas, DLS distributed to each of the local health officers in the State an electronic survey containing questions concerning LHD operations, programs, funding and staffing. DLS received a response from every jurisdiction; these responses significantly informed the analysis of the report.

Financing of Public Health Services

A local match is required for LHDs to secure State and federal funds. The match rate varies depending on a jurisdiction's wealth, from a minimum of 20% to a maximum of 80%. No jurisdiction's match rate may exceed its fiscal 1996 rate. In every jurisdiction, local funding for the LHD exceeds the required match. **Exhibit 5** shows LHD funding by jurisdiction for fiscal 2011, as well as the required and actual match provided by each jurisdiction. Not depicted here, however, are fee collections, which offset the cost of services. It is important to note that for fiscal 2011, the actual county match totaled $153.7 million statewide, which represents a 5% decrease from the fiscal 2008 local match of $162.5 million.

As shown in Exhibit 5, total State and local Core funding in fiscal 2011 totaled $195.5 million. This funding supports seven service areas: administration and communications, adult and geriatric health, communicable disease control, environmental health, family planning, maternal and child health, and wellness promotion. In several jurisdictions, additional local funds are directed outside these seven service areas, and this spending is not captured in Exhibit 5. For instance, funding from the Board of Education or a local management board may also support LHD operations.

Data shows that reductions to Core funding have resulted in reductions to all seven service areas, with the most significant reductions occurring in administration and communication, environmental health, and maternal and child health services. To varying extents, some counties increased their contributions to offset State Core funding reductions. Programmatic and budgetary changes as a result of reductions in State Core funding are depicted in **Exhibit 6**.

Exhibit 5
Local Health Grants – Core Funding Program
Fiscal 2011

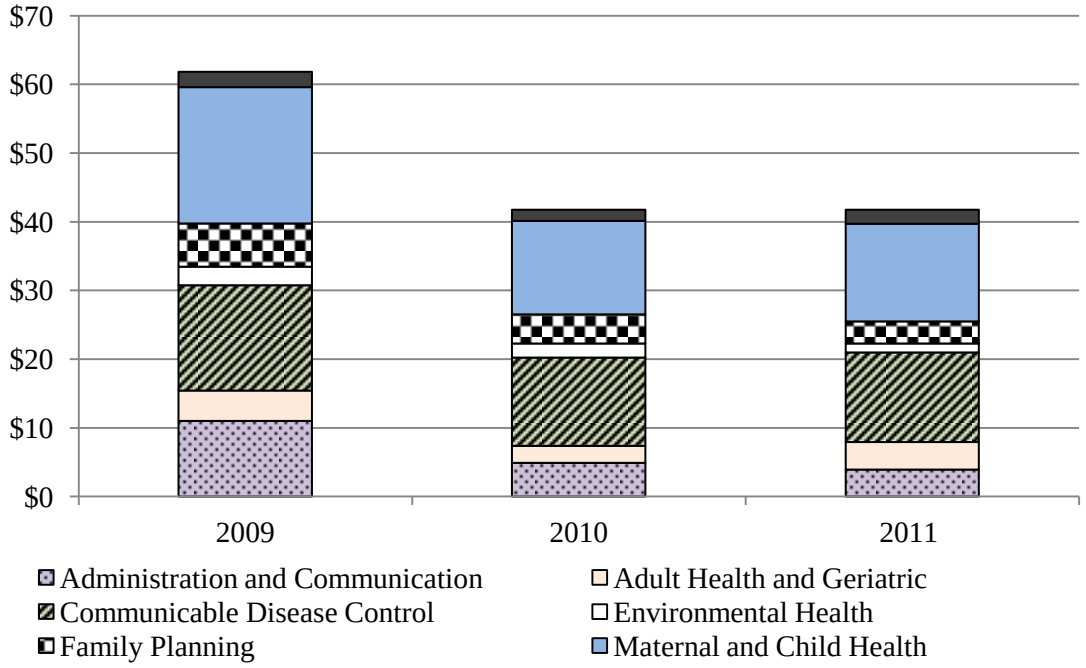
County	State Aid	Required Local Match	Actual County Match	Local Funding Provided Above the Required Match	Total State and Local LHD Funding
Allegany	$967,398	$242,524	$1,153,010	$910,486	$2,120,408
Anne Arundel	3,523,126	3,954,702	20,463,925	16,509,223	23,987,051
Baltimore	4,924,229	4,393,754	21,970,982	17,577,228	26,895,211
Calvert	432,944	738,339	2,041,668	1,303,329	2,474,612
Caroline	565,567	144,847	512,783	367,936	1,078,350
Carroll	1,347,122	898,099	3,373,882	2,475,783	4,721,004
Cecil	885,657	549,303	2,199,732	1,650,429	3,085,389
Charles	1,101,822	886,614	2,211,891	1,325,277	3,313,713
Dorchester	457,055	178,972	507,360	328,388	964,415
Frederick	1,662,354	1,187,889	1,557,258	369,369	3,219,612
Garrett	461,373	224,526	1,076,543	852,017	1,537,916
Harford	1,911,648	1,082,500	2,384,713	1,302,213	4,296,361
Howard	1,388,659	1,870,062	4,616,731	2,746,669	6,005,390
Kent	351,124	148,376	1,842,125	1,693,749	2,193,249
Montgomery	3,601,473	9,123,472	46,476,400	37,352,928	50,077,873
Prince George's	5,713,956	4,157,871	9,879,300	5,721,429	15,593,256
Queen Anne's	451,737	349,826	1,469,437	1,119,611	1,921,174
St. Mary's	879,549	447,861	2,072,485	1,624,624	2,952,034
Somerset	452,446	107,346	617,226	509,880	1,069,672
Talbot	355,694	436,997	2,217,579	1,780,582	2,573,273
Washington	1,491,253	727,697	5,744,414	5,016,717	7,235,667
Wicomico	1,024,070	427,174	2,645,672	2,218,498	3,669,742
Worcester	354,150	857,872	1,054,854	196,982	1,409,004
Baltimore City	7,472,078	2,035,340	15,595,405	13,560,065	23,067,483
Total	**$41,776,484**	**$35,171,964**	**$153,685,375**	**$118,513,411**	**$195,461,859**

LHD: local health departments

Note: Total State aid includes not only general funds but also $4,493,000 in federal pass-through funds administered through the Core Funding Program. Required local match is based on the general fund portion of the State Core Funding award.

Source: Department of Health and Mental Hygiene

Exhibit 6
Core Local Health Services – State Spending by Service Area
Fiscal 2009-2011
($ in Millions)



Source: Department of Health and Mental Hygiene

Local Health Department Expenditures

As a part of the LHD survey, DLS asked respondents to report total LHD expenditures for fiscal 2011.[6] Total spending was reported in the following areas: (1) administration and communications; (2) communicable disease control; (3) family planning; (4) wellness promotion; (5) adult and geriatric health; (6) environmental health; (7) maternal and child health; (8) substance abuse; (9) mental health; (10) emergency preparedness; and (11) other expenditures.[7]

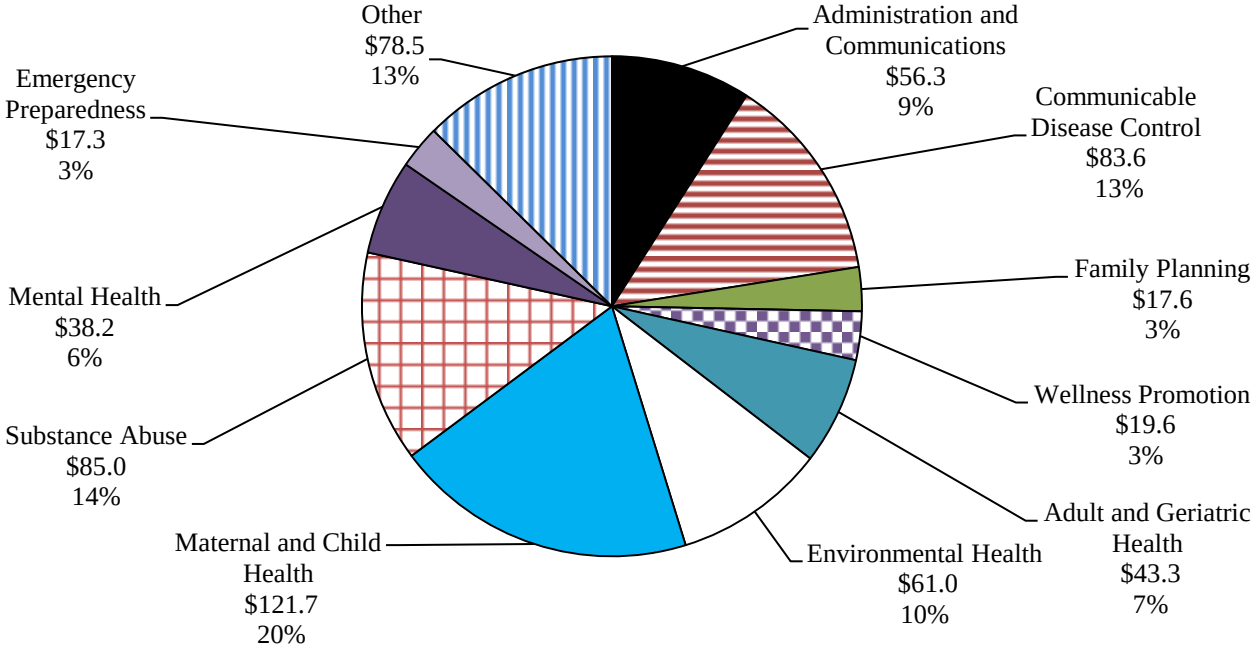
[6] For the purposes of the survey, total expenditures include county, State, and federal sources, as well as funding from private organizations and LHD collections from Medicaid, Medicare, regulatory fees, and other sources (such as self-pay and third-party pay). Furthermore, LHD expenditure and revenue totals for each county do not perfectly align. This is a reflection of revenues from collections.

[7] The initial survey sent to the local health departments did not request information regarding emergency preparedness expenditures. After receiving initial survey responses, the Department of Legislative Services sent follow-up requests for emergency preparedness expenditures for fiscal 2011 and 2012.

As shown in **Exhibit 7**, for fiscal 2011, a total of $622.1 million was spent by LHDs in the State. Of this amount, 20% of total LHD spending was related to maternal and child health programs. In turn, approximately 45% of maternal and child health expenditures are attributable to school health programs. (For the purposes of this survey, spending on school health programs is captured in the maternal and child health category.) "Other" expenditures constituted 13% of LHD spending due to the variation of programs across jurisdictions. Other expenditures include, but are not limited to, transportation, dental, and healthy stores programs, as well as developmental disabilities resource coordination services. Expenditures for communicable disease control and substance abuse each constituted 13% of LHD expenditures.

Administration and communication expenditures and environmental health expenditures represented 9 and 10% of LHD spending, respectively. Finally, emergency preparedness, family planning, and wellness promotion expenditures each represented 3% of LHD spending.

Exhibit 7
Local Health Department Expenditures
Fiscal 2011
($ in Millions)



Note: The percent of local public health expenditure presented in this figure is computed using the total amount of funds for all local health departments (LHD) for each of the expenditure categories as numerator with the total of all LHDs expenditures for all sources as the denominator.

Source: Local Health Departments Survey

Local Health Department Revenues

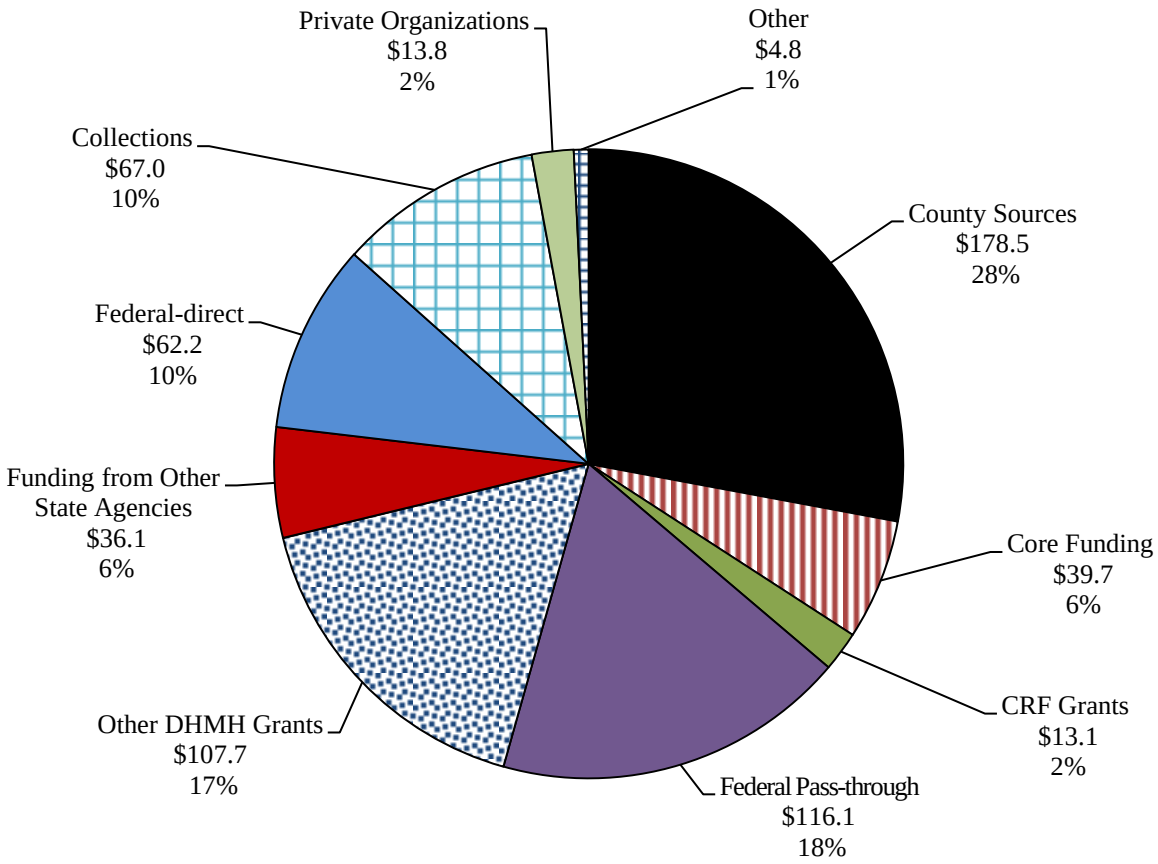
DLS also asked LHDs to report their total revenues for fiscal 2011 and 2012. Specifically, LHDs were requested to report their revenues in the following categories: (1) county sources; (2) Core Funding Program; (3) Cigarette Restitution Fund grants; (4) other grants from DHMH; (5) funding from State agencies other than DHMH; (6) federal pass-through sources; (7) federal-direct sources; (8) Medicaid; (9) Medicare; (10) other collections; (11) regulatory fees; (12) private organizations; and (13) other revenues. Some health departments were unable to distinguish between general funds and federal funds that are administered through the Core Funding Program; therefore, a portion of federal funds are reflected in the Core funding total.

As shown in **Exhibit 8**, LHD revenues for fiscal 2011 totaled $639.0 million. Approximately 49% of LHD revenues are derived from DHMH or other State agencies. Federal pass-through funds and other grants from DHMH represent 18 and 17%, respectively, of LHD revenues. Among other things, federal pass-through funds include emergency preparedness funding, monies related to WIC, and Title X funding. Other grants from DHMH include resource coordination funds through the Developmental Disabilities Administration, block grants administered by the Alcohol and Drug Abuse Administration, funding for core service agencies through the Mental Hygiene Administration, and grants administered by the Maryland Community Health Resources Commission. Furthermore, funding from other State agencies constitutes 8% of LHD revenues. Other State agencies that provide funding to LHDs include, but are not limited to, the Maryland Department of the Environment, the Maryland State Department of Education, the Department of Juvenile Services, the Governor's Office of Crime Control and Prevention, and the State Highway Administration.

The remaining State revenues that support LHDs are derived from Core funding (6%) and Cigarette Restitution (CRF) funds (2%). While Core funding only represents a small portion of local health revenues, it is important to note that State Core funding to local jurisdictions has decreased by 43% since fiscal 2009. Similarly, CRF has also been significantly reduced. Therefore, it is not surprising that county funds constitute a large proportion of overall revenues for LHDs – comprising 28% of total funds. County funds include matching funds required under the Core Funding formula as well as funding from other county entities, such as local boards of education. In comparison, federal-direct and other revenues represent 10 and 1% of LHD revenues, respectively.[8] Finally, funding from private organizations represents only 2% of LHD revenues. DLS' survey indicated that only 13 jurisdictions received private grant funding in fiscal 2011. LHDs that did not seek private funding generally indicated that reductions in staffing levels (combined, in many cases, with a lack of grant writing expertise) made it difficult to apply for private grants. LHDs that did receive private funding reported that they received grants from private organizations including (but not limited to)

[8] A large portion of federal-direct funds are derived from Ryan White Part A grants that are awarded to Eligible Metropolitan Areas (EMA). In order to qualify for EMA designation, an area must have reported at least 2,000 AIDS cases in the most recent five years and have a population of at least 50,000. Funding is used to provide a continuum of care, including medical and support services, for people living with HIV. In Maryland, the Baltimore City Health Department serves as the grantee and overall administrator for the Ryan White Part A funds; however, the EMA consists of Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne's counties, and Baltimore City.

Exhibit 8
Local Health Department Revenues
Fiscal 2011
($ in Millions)



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

Note: The percent of local public health revenues presented in this figure is computed using the total amount of funds for all local health departments (LHD) for each of the sources as numerators with the total of all LHDs revenues from all sources as the denominator.

Source: Local Health Departments Survey

Susan G. Komen, Healthcare for the Homeless, ABC Charities, and the National Association of County and City Health Officials.

Impact of Cost Containment

The 2010 *Joint Chairmen's Report (JCR)* requested DHMH, in conjunction with LHDs, to submit a report on the budgets of the 24 LHDs. Specifically, the department was required to outline how State funds were used programmatically by LHDs in fiscal 2010 and 2011 and to describe programmatic and budgetary changes made in response to State cost containment measures in those years. Specific examples of programmatic changes as a result of Core funding reductions include:

- **Administration and Communication Services** – Cuts in this area have resulted in delayed billing, reduced oversight of leases and purchasing, reductions in website and maintenance support, and reduced emergency response capacity.

- **Adult Health and Geriatric Services** – Queen Anne's County is one of three counties in Maryland that oversee an Adult Day Care Center. Cuts to Core funding have reduced support to the center. In Prince George's County, the LHD eliminated diabetes educational sessions and screening services.

- **Communicable Disease Services** – Funding allocated in this area supports the prevention and control of communicable disease such as influenza and rabies. It also supports foodborne outbreak investigation, child and adult immunization, tuberculosis and sexually transmitted infections (STI) treatment. Reductions in funding have resulted in the elimination of school-based vaccinations in Frederick and Montgomery counties. In addition, Prince George's County reduced the number of clients seen in its STI clinic due to position reductions. Howard County also eliminated its HIV/AIDS case management services and closed its HIV clinic.

- **Environmental Health** – Budget reductions have caused many counties to delay filling vacant sanitarian positions, resulting in longer response times for food service facility inspections. Cecil County no longer conducts water sampling, while Howard County has reduced positions related to pool inspections and food safety.

- **Family Planning** – Reductions in funding have resulted in decreased walk-in family planning services. Cecil County has eliminated pregnancy testing as a stand-alone service, while Wicomico County has reduced its family planning services by 40%.

- **Maternal and Child Health Services** – Multiple counties reported having reduced home visiting services for pregnant women and for mothers and children. Some counties have reduced services by up to 40%.

- **Wellness Promotion Services** – Funding allocated in this service area supports tobacco prevention and cessation, cardiovascular disease prevention, injury prevention, and breast and cervical cancer screening. LHDs generally reported that funding for health education has been either significantly reduced or eliminated completely.

To supplement the findings of the JCR response DLS surveyed LHDs regarding the impact of State budget cuts. All 24 respondents in the LHD survey indicated that State budget cuts have resulted in reductions to programs. Furthermore, 20 LHDs reported that they have had to eliminate programs entirely, and 16 LHDs indicated that they have had to increase their regulatory fees. Only 6 LHDs reported that other funding sources, such as local funding, have increased to offset State funding reductions. DLS also asked LHDs if there were specific areas of priority to which they would direct monies if State funding was to increase; while respondents indicated that they would direct additional funds to all seven Core funding areas, over 60% of LHDs indicated that additional funds are needed specifically to address chronic disease prevention and treatment.

Impact of Health Care Reform on the Provision of Local Public Health Services

On March 23, 2010, President Barack H. Obama signed into law the federal Patient Protection and Affordable Care Act (ACA), as amended by the Health Care and Education Recovery Act of 2010. Among many other provisions of ACA is a requirement for individuals to obtain health insurance. (This has become known as the "individual mandate.") This requirement takes effect January 1, 2014.

The Maryland HCRCC, established by executive order in March 2010, has advised that Maryland's public health infrastructure – including LHDs as well as population-based programs – serves unique functions that will not be supplanted by the health insurance coverage aspects of federal health care reform. However, of the 16 recommendations HCRCC issued in 2012 regarding how Maryland should approach health care reform and implementation, 3 are specifically applicable to LHDs. The recommendations are to:

- develop State and local strategic plans to improve health outcomes;
- encourage active participation of safety net providers in health reform and new insurance options; and
- achieve reduction of health disparities through exploration of financial performance-based incentives and incorporation of other strategies.

The development of State and local strategic plans to improve health outcomes is discussed in the MFR portion of this analysis, and the participation of safety net providers in health reform and new insurance options is discussed below. The reduction of health disparities through performance-based incentives will be discussed in the DHMH budget analysis for the Health Regulatory Commissions as it relates to the establishment of Health Enterprise Zones (Chapter 3 of 2012).

Upon full implementation of the ACA, in January 2014, the role of LHDs in Maryland will likely change. Services related to communicable disease surveillance, as well as environmental health programs, such as those related to food safety, will largely go unaffected; however, the volume

of direct care services provided by LHDs will decrease to the extent that a greater percentage of individuals begin to obtain private insurance. Accordingly, LHDs must determine whether it is advisable for them to continue to provide direct care services within their jurisdictions. (Some LHDs in Maryland have already moved away from providing direct care, either by choice or due to State and local budget cuts.) Furthermore, LHDs that continue to provide direct care under PPACA will need to address barriers to third-party contracting. It is critical that LHDs examine the services that they provide and adjust to the evolving health care system. Similarly, it is important to examine how local public health services are financed in the State.

Barriers to Third-party Contracting Persist Between Local Health Departments and Private Insurers

HCRCC's second recommendation pertaining to LHDs involved the removal of certain statutory and administrative barriers to contracting between LHDs and private entities. This recommendation was addressed legislatively through the passage of Chapters 235 and 236 of 2011, which authorized a county health officer (subject to the written approval of the Secretary of the Department of Health and Mental Hygiene and the consent of the county's governing body) to enter into a contract or written agreement to participate in the financing, coordination, or delivery of health care services with a person that is authorized to provide, finance, coordinate, facilitate, or otherwise deliver health care services in the State. Nonetheless, survey respondents generally reported continued difficulties in contracting with third-party insurers.

Budget constraints have resulted in cutbacks to services provided by LHDs; yet, prior to the passage of Chapters 235 and 236, LHDs did not have clear authority to recoup service costs through agreements with private insurers. Rather, LHDs relied on income-based sliding scales – subsidized through block grants – to bill individuals who are either uninsured or privately insured. According to the Maryland Association of Counties, this practice impeded the delivery of health services in rural parts of the State, in particular. For example, Garrett County had advised that it offers certain services – such as home health care and mental health and substance abuse outpatient services – to many privately insured individuals in the county because it is the county's sole provider of those services. Garrett County had further advised that its ability to continue to provide these and other services (such as family planning services) increasingly depends on its ability to bill in full for its services.

Although Chapters 235 and 236 took effect on October 1, 2011, the Maryland Association of County Health Officers has advised that LHDs remain unable to contract with private insurers as they lack expertise in negotiating contracts with private entities. LHDs' responses to DLS' survey reflect these and other difficulties. For example, many LHDs reported that they have been unable to meet insurers' credentialing requirements. Furthermore, LHDs have had difficulty contracting with insurers due to certain problematic contractual requirements that are at odds with State law, including requirements that the LHD waive or limit defenses; agree to certain confidentiality provisions; interpret a contract according to the laws of a foreign jurisdiction; agree to resolve disputes in a tribunal other than a Maryland court (*i.e.*, in arbitration proceedings or in another state); and purchase

private professional liability insurance (even though the State is self-insured and, thus, has no reason to purchase such insurance). In addition, survey respondents cited a requirement for the provider to unconditionally indemnify the payor (even though statute prohibits State officials from doing so) as the most problematic contractual provision required by insurers.

Insurers' Contractual Requirements at Odds with Statutory Limits on Liability for Employees of State and Local Government

As noted above, survey respondents generally advised that insurers have been unwilling to waive contractual requirements that the LHD unconditionally indemnify the payor. However, local government employees and State personnel alike are statutorily prohibited from doing so by the Local Government Tort Claims Act and the Maryland Tort Claims Act, respectively.[9] DHMH advises that insurers have been unresponsive to LHDs' requests to modify their form contracts in order to accommodate State contracting constraints. Similarly, survey respondents generally reported that negotiations with insurers as to contractual provisions have been unsuccessful. Thus, LHDs' attempts to contract with third-party insurers have stalled.

Efforts at State Level to Address Challenges Related to Contracting and Billing Are Ongoing

DHMH advises that the department, along with the Office of the Attorney General, is attempting to address the contracting hurdles faced by LHDs by negotiating statewide contracts with the various insurance plans. According to DHMH, the department is in the process of reaching out to major health insurers and third-party payors in an attempt to determine how best to negotiate statewide contracts (or other network relationships) with the insurers for the benefit of LHDs. DHMH furthers advises that it is currently still conducting outreach efforts but has been provided with at least one proposed contract from a health insurer. Almost all LHDs reported that they are aware of DHMH's efforts in this area.

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[9] Local Government Tort Claims Act (LGTCA) limits the liability of a local government to $200,000 per individual claim and $500,000 for total claims that arise from the same occurrence for damages from tortious acts or omissions (including intentional and constitutional torts). It further establishes that the local government is liable for tortious acts or omissions of its employees acting within the scope of employment. Thus, LGTCA prevents local governments from asserting a common law claim of governmental immunity from liability for such acts of its employees. LGTCA defines local government to include counties, municipal corporations, Baltimore City, and other specified local agencies and authorities. Under the Maryland Tort Claims Act (MTCA), State personnel are immune from liability for acts or omissions performed in the course of their official duties, so long as the acts or omissions are made without malice or gross negligence. Under MTCA, the State essentially waives its own common law immunity. However, MTCA limits State liability to $200,000 to a single claimant for injuries arising from a single incident. MTCA covers a multitude of personnel, including some local officials and nonprofit organizations. In actions involving malice or gross negligence or actions outside of the scope of the public duties of the State employee, the State employee is not shielded by the State's color of authority or sovereign immunity and may be held personally liable. For causes of action arising during calendar 2012 that are not covered by MTCA, State law limits noneconomic damages to $710,000 for health care malpractice claims. This limit increases annually as specified in statute.

A number of LHDs also reported that they are experiencing challenges with billing generally. In most cases, these challenges were attributed to a lack of staff time and/or billing expertise. DHMH advises that it is currently working to develop and implement a strategy to facilitate LHD billing. Although this project is focused primarily on billing for immunizations, the department anticipates that strategies developed for the project will be fully applicable to billing for other services provided by LHDs.

To the extent that LHDs continue to act as direct service providers after federal health care reform is fully implemented and fewer individuals are uninsured, LHDs' ability to contract with and bill third-party insurers is critical. **Therefore, DLS recommends that committee narrative be adopted requiring DHMH to report on its efforts to address the challenges that LHDs are currently facing with regard to billing generally and third-party contracting in particular. DHMH should also advise whether statutory changes are necessary and/or feasible.**

Recommended Actions

1. Adopt the following narrative:

   The committees direct the Department of Health and Mental Hygiene (DHMH), in conjunction with the local health departments (LHD), to report on its efforts to address the challenges that LHDs are currently facing with regard to billing generally and third-party contracting in particular. DHMH should also advise whether statutory changes are necessary and/or feasible to remedy challenges LHDs are currently facing in regards to billing.

Information Request	**Authors**	**Due Date**
Report on LHD billing challenges	DHMH LHDs	December 1, 2013

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2012					
Legislative Appropriation	$37,283	$0	$4,493	$0	$41,776
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	989	0	0	0	989
Reversions and Cancellations	0	0	0	0	0
Actual Expenditures	**$38,273**	**$0**	**$4,493**	**$0**	**$42,766**
Fiscal 2013					
Legislative Appropriation	$38,575	$0	$5,549	$0	$44,124
Budget Amendments	136	859	3	0	997
Working Appropriation	**$38,711**	**$859**	**$5,551**	**$0**	**$45,121**

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

Fiscal 2012

In fiscal 2012, HSIA spent $42.8 million, an increase of $1.0 million over the original legislative appropriation. Due to the reorganization of public health services, the fiscal 2012 closeout information for HSIA only includes expenditures for Core Funding program. Funding for other programs is captured in the budget analysis for the DHMH's Prevention and Health Promotion Administration (PHPA).

The fiscal 2012 budget for the Department of Budget and Management (DBM) included centrally budgeted funds for the $750 one-time bonus for State employees, including nonbudgeted employees at LHDs. This resulted in the transfer of funds from DBM to HSIA ($989,335).

Fiscal 2013

The fiscal 2013 working appropriation for HSIA is $44.1 million, an increase of $1.0 million over the original legislative appropriation. The fiscal 2013 budget for DBM included centrally budgeted funds for the 2013 COLA for State employees. This resulted in the transfer of funds from DBM to HSIA ($771,181 in special funds and $2,509 in federal funds).

General funds also increased due to a transfer of funds from PHPA to support the Baltimore City School Health Pilot Project ($135,961). Previously this program reported to PHPA; however due to the public health reorganization, the program now reports to the Office of School Health within HSIA. Finally, one amendment increased the special fund appropriation by $87,657. Special funds are required to cover the cost of a contract with the University of Maryland Baltimore County to support the WIC Quality Improvement Initiative.

Appendix 2

Maryland's State Health Improvement Process

	SHIP Measurement	Current Maryland Baseline	Maryland 2014 Target
1.	Increase life expectancy*	78.6 years	82.5 years
Vision Area 1: Healthy Babies			
2.	Reduce infant deaths*	7.2 infant deaths per 1,000 live births.	6.6 infant deaths per 1,000 live births.
3.	Reduce low and very low birth weight*	9.2% of live births were low birth weight; 1.8% were very low birth weight.	8.5% of live births are low birth weight; 1.8% of live births are very low birth weight.
4.	Reduce sudden unexpected infant deaths*	0.95 sudden unexpected infant deaths per 1,000 live births.	0.89 sudden unexpected infant deaths per 1,000 live births.
5.	Increase the proportion of pregnancies that are intended*	55.0% of pregnancies were intended.	58.0% of pregnancies are intended.
6.	Increase the proportion of pregnant women starting prenatal care in the first trimester*	80.2% received prenatal care beginning in the first trimester.	84.2% will receive prenatal care beginning in the first trimester.
Vision Area 2: Healthy Social Environments			
7.	Reduce child maltreatment	5.0 victims of nonfatal child maltreatment per 1,000 children.	4.8 victims of nonfatal child maltreatment per 1,000 children.
8.	Reduce the suicide rate*	9.6 suicides per 100,000 population.	9.1 suicides per 100,000 population.
9.	Decrease the rate of alcohol-impaired driving fatalities	0.28 driving fatalities per 100,000 vehicle miles traveled.	0.27 driving fatalities per 100,000 vehicle miles traveled.
10.	Increase the proportion of students who enter kindergarten ready to learn*	81.0% of students entered kindergarten fully ready to learn.	85.0% of students enter kindergarten fully ready to learn.

	SHIP Measurement	Current Maryland Baseline	Maryland 2014 Target
11.	Increase proportion of students who graduate from high school*	80.7% students graduate from high school in four years after entering grade 9.	84.7% students graduate high school in four years after entering grade 9.
12.	Reduce domestic violence*	69.6 emergency department visits for domestic violence per 100,000 population.	66.0 emergency department visits for domestic violence per 100,000 population.
Vision Area 3: Safe Physical Environments			
13.	Reduce blood lead levels in children	79.1 per 100,000 population.	39.6 per 100,000 population.
14.	Decrease fall-related deaths	7.3 fall-related deaths per 100,000 population.	6.9 fall-related deaths per 100,000 population.
15.	Reduce pedestrian injuries on public roads	39.0 pedestrian injuries per 100,000 population.	29.7 pedestrian injuries per 100,000 population.
16.	Reduce salmonella infections transmitted through food	14.1 salmonella infections per 100,000 population.	12.7 salmonella infections per 100,000 population.
17.	Reduce hospital emergency department visits from asthma*	85.0 emergency department visits for asthma per 100,000 population.	67.1 emergency department visits for asthma per 100,000 population.
18.	Increase access to healthy food	5.8% of census tracts in Maryland are considered food deserts.	5.5% of census tracts in Maryland are considered food deserts.
19.	Reduce the number of days the Air Quality Index exceeds 100	17 days was the maximum number of days in the State that the air quality index exceeded 100.	13 days is the maximum number of days in the State that the air quality index exceeds 100.
Vision Area 4: Infectious Disease			
20.	Reduce HIV infections among adults and adolescents*	32.0 newly diagnosed HIV cases per 100,000 population.	30.4 newly diagnosed HIV cases per 100,000 population.

	SHIP Measurement	Current Maryland Baseline	Maryland 2014 Target
21.	Reduce Chlamydia trachomatis infections among young people*	2,131 Chlamydia cases per 100,000 15-24 year olds.	2,205 Chlamydia cases per 100,000 15-24 year olds.
22.	Increase treatment completion rate among tuberculosis patients*	88.1% of patients complete treatment within 12 months.	90.6% of patients will complete treatment within 12 months.
23.	Increase vaccination coverage for recommended vaccines among young children*	78% of children age 19-35 months received recommended vaccine doses.	80% of children age 19-35 months will receive recommended vaccine doses.
24.	Increase the percentage of people vaccinated annually against seasonal influenza*	45.9% of adults received an influenza shot last year.	65.6% of adults will receive an influenza shot.
Vision Area 5: Chronic Disease			
25.	Reduce deaths from heart disease*	194.0 heart disease deaths per 100,000 population.	173.3 heart disease deaths per 100,000 population.
26.	Reduce the overall cancer death rate*	177.7 cancer deaths per 100,000 population.	169.2 cancer deaths per 100,000 population.
27.	Reduce diabetes-related emergency department visits*	347.2 emergency department visits for diabetes per 100,000 population.	330.0 emergency department visits for diabetes per 100,000 population.
28.	Reduce hypertension-related emergency department visits*	237.9 emergency department visits for hypertension per 100,0000 population.	225.0 emergency department visits for hypertension per 100,000 population.
29.	Reduce drug-induced deaths*	13.4 drug-induced deaths per 100,000 population.	12.4 drug-induced deaths per 100,000 population.
30.	Increase proportion of adults who are at a healthy weight*	34.0% of Maryland adults are at a healthy weight.	35.7% of Maryland adults will be at a healthy weight.
31.	Reduce the proportion of children and adolescents who are considered obese*	11.9% of children ages 12-19 are considered obese.	11.3% of children ages 12-19 will be considered obese.

	SHIP Measurement	Current Maryland Baseline	Maryland 2014 Target
32.	Reduce cigarette smoking among adults*	15.2% of adults reported currently smoking cigarettes.	14.6% of adults report that they are currently smoking cigarettes.
33.	Reduce tobacco use among adolescents*	24.8% of adolescents used tobacco in the last 30 days.	22.3% of adolescents will use tobacco in the last 30 days.
34.	Reduce the number of emergency department visits related to behavioral health conditions*	1,206.3 emergency department visits for behavioral health conditions per 100,000 population.	1,146.0 emergency department visits for behavioral health conditions per 100,000 population.
35.	Reduce the proportion of hospitalizations related to Alzheimer's disease and other dementias*	17.3 hospitalizations for Alzheimer's disease and other dementias per 100,000 population.	16.4 hospitalizations for Alzheimer's disease and other dementias per 100,000 population.
Vision Area 6: Health Care Access			
36.	Increase the proportion of persons with health insurance*	81.7% of nonelderly had health insurance.	92.8% of nonelderly will have health insurance.
37.	Increase the proportion of adolescents who have an annual wellness checkup	46.0% had a wellness checkup in the past year.	60.8% will have a wellness checkup in the next year.
38.	Increase the proportion of low income children and adolescents who receive dental care	53.6% of low income children and adolescents received preventative dental services in the past year.	56.3% of low income children and adolescents will receive preventative dental services in the next year.
39.	Reduce the proportion of individuals who are unable to afford to see a doctor*	12.0% reported that they were unable to afford to see a doctor.	11.4% report that they were unable to afford to see a doctor.

SHIP: State Health Improvement Process

*Indicates a State Health Improvement Process measurement where racial and/or ethnic health disparities exist.

Source: Department of Health and Mental Hygiene

Object/Fund Difference Report
Health Systems and Infrastructure Administration

Object/Fund	FY 12 Actual	FY 13 Working Appropriation	FY 14 Allowance	FY 13 - FY 14 Amount Change	Percent Change
Positions					
01 Regular	9.00	10.00	10.00	0.00	0%
Total Positions	**9.00**	**10.00**	**10.00**	**0.00**	**0%**
Objects					
01 Salaries and Wages	$ 733,324	$ 1,020,794	$ 1,057,641	$ 36,847	3.6%
03 Communication	0	3,968	4,292	324	8.2%
04 Travel	15,556	17,693	24,280	6,587	37.2%
08 Contractual Services	973,088	1,524,170	1,481,148	-43,022	-2.8%
09 Supplies and Materials	613	5,424	5,164	-260	-4.8%
11 Equipment – Additional	2,680	0	0	0	0.0%
12 Grants, Subsidies, and Contributions	42,765,819	42,543,787	44,541,623	1,997,836	4.7%
13 Fixed Charges	4,910	5,072	6,001	929	18.3%
Total Objects	**$ 44,495,990**	**$ 45,120,908**	**$ 47,120,149**	**$ 1,999,241**	**4.4%**
Funds					
01 General Fund	$ 39,374,736	$ 38,710,663	$ 41,525,988	$ 2,815,325	7.3%
03 Special Fund	0	858,838	26,334	-832,504	-96.9%
05 Federal Fund	5,121,254	5,551,407	5,567,827	16,420	0.3%
Total Funds	**$ 44,495,990**	**$ 45,120,908**	**$ 47,120,149**	**$ 1,999,241**	**4.4%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.

Fiscal Summary
Health Systems and Infrastructure Administration

Program/Unit	FY 12 Actual	FY 13 Wrk Approp	FY 14 Allowance	Change	FY 13 - FY 14 % Change
01 Health Systems and Infrastructure Administration	$ 1,730,171	$ 2,577,121	$ 2,578,526	$ 1,405	0.1%
07 Core Public Health Services	42,765,819	42,543,787	44,541,623	1,997,836	4.7%
Total Expenditures	**$ 44,495,990**	**$ 45,120,908**	**$ 47,120,149**	**$ 1,999,241**	**4.4%**
General Fund	$ 39,374,736	$ 38,710,663	$ 41,525,988	$ 2,815,325	7.3%
Special Fund	0	858,838	26,334	-832,504	-96.9%
Federal Fund	5,121,254	5,551,407	5,567,827	16,420	0.3%
Total Appropriations	**$ 44,495,990**	**$ 45,120,908**	**$ 47,120,149**	**$ 1,999,241**	**4.4%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.