M00F0201
Health Systems and Infrastructure Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 13 Actual	FY 14 Working	FY 15 Allowance	FY 14-15 Change	% Change Prior Year
General Fund	$80,133	$86,756	$92,190	$5,434	6.3%
Contingent & Back of Bill Reductions	0	-1,251	-433	819	
Adjusted General Fund	**$80,133**	**$85,505**	**$91,757**	**$6,252**	**7.3%**
Special Fund	5,140	4,469	4,477	8	0.2%
Contingent & Back of Bill Reductions	0	0	-22	-22	
Adjusted Special Fund	**$5,140**	**$4,469**	**$4,456**	**-$13**	**-0.3%**
Federal Fund	5,822	6,681	28,753	22,071	330.3%
Contingent & Back of Bill Reductions	0	0	-3	-3	
Adjusted Federal Fund	**$5,822**	**$6,681**	**$28,749**	**$22,068**	**330.3%**
Reimbursable Fund	720	799	779	-20	-2.5%
Adjusted Reimbursable Fund	**$720**	**$799**	**$779**	**-$20**	**-2.5%**
Adjusted Grand Total	**$91,815**	**$97,454**	**$125,741**	**$28,287**	**29.0%**

- The fiscal 2015 budget increases by $28.3 million (29.0%) over the fiscal 2014 working appropriation, primarily due to new federal grant funding that is, in fact, unlikely to be fully realized in fiscal 2015.

- General funds increase by $6.3 million (7.3%), primarily due to increased Core funding for local health departments and increased personnel expenditures in the State's two chronic disease hospital centers.

- Two deficiency appropriations reduce the fiscal 2014 appropriation by a total of $100,000 to realize savings attributed to favorable average daily population trends at both State chronic disease hospital centers, as well as to realize additional revenue from the Strategic Energy Investment Fund.

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

For further information contact: Jennifer A. Ellick Phone: (410) 946-5530

Personnel Data

	FY 13 Actual	FY 14 Working	FY 15 Allowance	FY 14-15 Change
Regular Positions	532.05	532.05	525.80	-6.25
Contractual FTEs	22.53	20.92	21.32	0.40
Total Personnel	**554.58**	**552.97**	**547.12**	**-5.85**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	31.60	6.01%
Positions and Percentage Vacant as of 12/31/13	57.25	10.76%

- The agency's vacancy rate remains high at 10.76%, primarily due to ongoing recruitment challenges at the two State chronic disease hospital centers.

- Regular full-time-equivalent positions decrease by 6.25 due to the abolition of long-term vacancies at the Western Maryland Hospital Center.

Analysis in Brief

Major Trends

Local Health Departments Are Pursuing National Accreditation: In fiscal 2013, five local health departments submitted prerequisites for public health accreditation.

Local Health Improvement Coalitions Are Making Progress: In fiscal 2012, local health improvement coalitions (LHIC) were formed to set community health goals. In fiscal 2013, 17 LHICs documented progress on at least one LHIC goal.

Number of Providers Accepting a State Loan Repayment Program Obligation Remains Static: In fiscal 2013, the number of health care providers accepting a practice obligation in Maryland under the State Loan Repayment Program remained static.

Average Length of Stay Continues to Decline in State Chronic Disease Hospital Centers: Due to changes in federal reimbursement rates for patient days, the State chronic disease hospital centers are working to efficiently treat patients so that they can be moved to a setting that requires a lower level of care.

Issues

Federal Grant Funding for State Innovation Models Project Unlikely to Be Realized in Fiscal 2015: The agency had anticipated the State Innovation Models (SIM) implementation grant to be awarded in the amount of $60 million over a 42-month period, with an expected start date of late summer or early fall 2014. The fiscal 2015 allowance includes $20 million in federal funds, based on the assumption that one-third of the SIM implementation grant will be spent in fiscal 2015. However, given that federal delays have prevented the agency from yet applying for these funds, the Department of Legislative Services advises that new SIM grant funding is unlikely to be realized in fiscal 2015.

Recommended Actions

		Funds
1.	Reduce the federal fund appropriation for the State Innovation Models Grant unlikely to be attained in the fiscal year.	$ 20,000,000
	Total Reductions	**$ 20,000,000**

Updates

Report on Local Health Outcomes and Funding for Local Public Health Services: The 2013 *Joint Chairmen's Report* (JCR) required the Department of Health and Mental Hygiene (DHMH) to report on local health outcomes as they relate to public health funding reductions. The agency reports that Core services continue to be provided, and Maryland is on track to meet health outcome goals.

Report on Local Health Department Billing Challenges: Committee narrative in the 2013 JCR required DHMH, in conjunction with local health departments, to report on the department's efforts to address the challenges faced by local health departments with regard to billing generally and third-party contracting in particular. The department found that the 24 local health departments are evenly distributed among high-, moderate-, and low-readiness categories. Statutory and regulatory changes are proposed.

M00F0201
Health Systems and Infrastructure Administration
Department of Health and Mental Hygiene

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. The agency improves access to quality health services in Maryland by developing partnerships with agencies, coalitions, and councils; funding and supporting local public health departments through the Core Funding Program; collaborating with the Maryland State Department of Education to assure the physical and psychological health of school-aged children through adequate school health services and a healthy school environment; 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.

HSIA also oversees the State's two chronic disease hospital centers – Western Maryland Hospital Center and Deer's Head Center – which provide specialized services for those in need of complex medical management, comprehensive rehabilitation, long-term care, or dialysis. Specifically, both centers provide:

- chronic care and treatment to patients requiring acute rehabilitation (at a level greater than that available at a nursing home) for management of complex medical issues such as respiratory, coma, traumatic brain injury, spinal cord injury, wound management, dementia, cancer care, and quarantined tuberculosis;

- long-term nursing care for patients who do not need hospital-level care but are unable to function in traditional nursing homes; and

- inpatient and outpatient renal dialysis services.

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. 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 on the aforementioned standards. In order to be eligible for accreditation, a local 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. These three documents are prerequisites in the application process.

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

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

In fiscal 2013, 5 of Maryland's 24 local health departments had submitted prerequisites for public health accreditation. Local health departments have been encouraged by the Department of Health and Mental Hygiene (DHMH) to pursue accreditation – and most have indicated that they are either considering or actively pursuing accreditation. However, approximately half of local health departments have noted lack of funding as a primary barrier to accreditation. Competing priorities

[1] The cost of accreditation varies based on the size of the jurisdictional population served by the health department. Fees range from approximately $13,000 for populations less than 50,000 to approximately $100,000 for populations greater than 15 million.

and lack of staff time were also cited as barriers. The agency estimates that 8 local health departments will have submitted prerequisites for accreditation by fiscal 2015.

2. Local Health Improvement Coalitions Are Making Progress

The Maryland Health Care Reform Coordinating Council (HCRCC), established by executive order in March 2010, has advised that Maryland's public health infrastructure – including local health departments 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 recommendations, 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 highlighted a need for public and private sector partners to work with local health departments and the State to monitor a number of performance metrics. HCRCC has further recommended that local implementation processes be developed which involve local health department-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, 29 can be stratified by race and ethnicity. 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.[2] To date, each coalition has met, assessed the health of its community, and developed health priorities and goals.

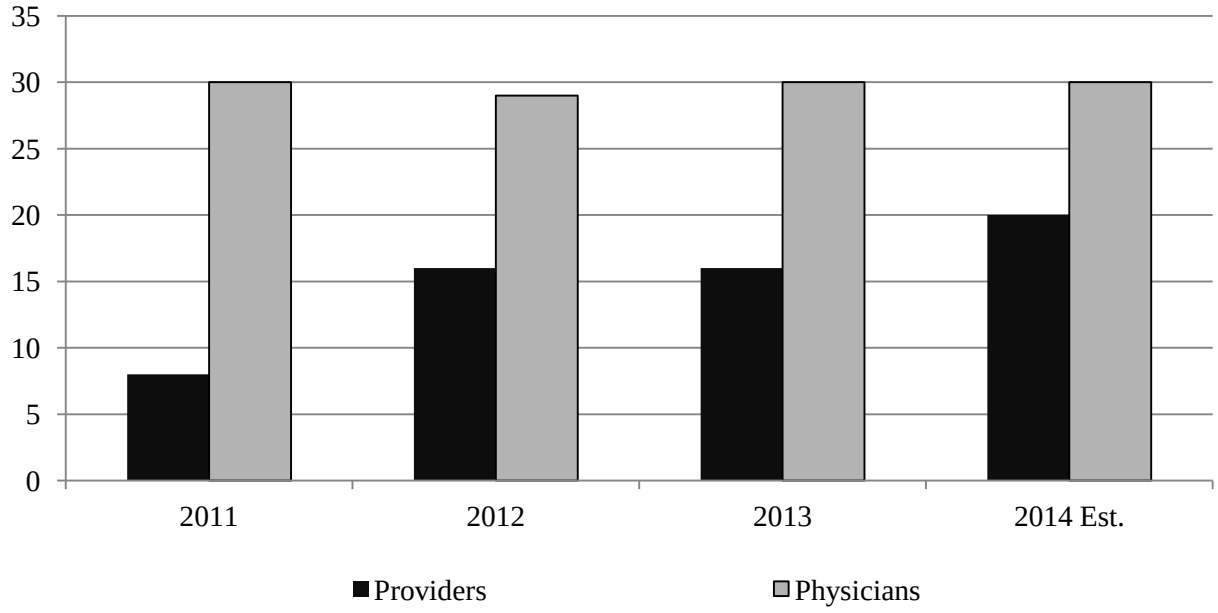
In fiscal 2013, 17 local health departments had made documented progress on at least one LHIC goal. HSIA estimates that 22 local health departments will have made documented progress on at least one LHIC goal by fiscal 2015. It is important to note that there is no baseline for this Managing for Results measure as goals were set in fiscal 2012.

[2] 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.

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

HSIA aims to maximize the number of health care providers accepting a practice obligation in Maryland under the State Loan Repayment Program (SLRP) and the number of physicians accepting a practice obligation under the J-1 Visa Waiver Program. SLRP offers providers 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 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. Similarly, physicians can accept a practice obligation under the J-1 Visa Waiver Program, which enables foreign physicians to improve access to health care in federally designated shortage areas. As shown in **Exhibit 1**, in fiscal 2013, the number of health care providers and physicians accepting a practice obligation in Maryland remains static. (As of September 2012, providers include nurse practitioners, physician assistants, dentists, and social workers). However, the number of providers accepting a practice obligation is expected to increase slightly in fiscal 2014.

Exhibit 1
Health Care Providers and Physicians Accepting a Practice Obligation
Fiscal 2011-2014 Est.

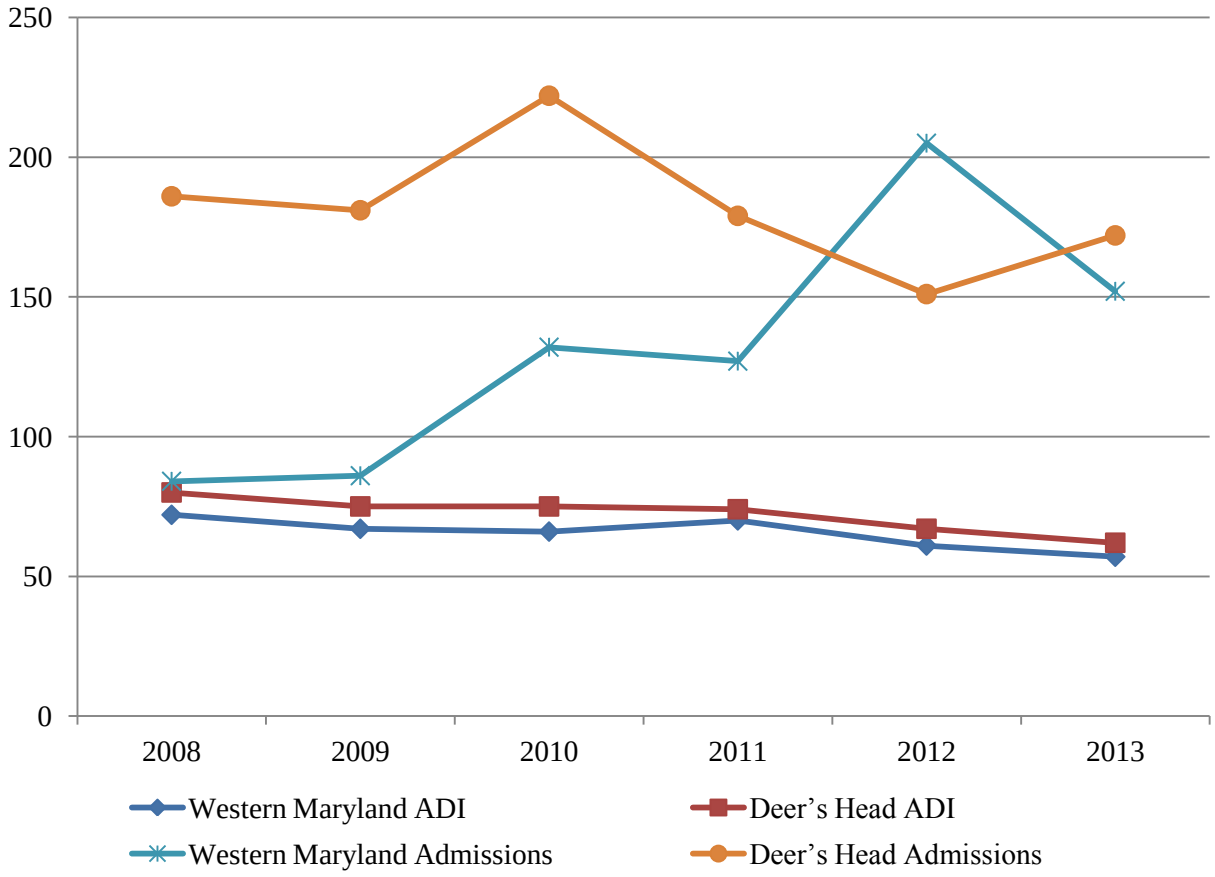


Source: Department of Health and Mental Hygiene

4. Average Length of Stay Continues to Decline in State Chronic Disease Hospital Centers

Due to changes in reimbursements for patient days, the hospitals are working to efficiently treat patients and allow them to move on to a lower level of care as soon as is medically possible. **Exhibit 2** shows that while admissions have fluctuated year to year at both State chronic disease hospitals, the average daily number of patients has declined steadily since fiscal 2008.

Exhibit 2
Average Daily Inpatients and Admissions
Fiscal 2008-2013



ADI: Average Daily Inpatients

Source: Department of Health and Mental Hygiene

Fiscal 2014 Actions

Proposed Deficiency

Two deficiency appropriations reduce the fiscal 2014 appropriation by a total of $100,000 to realize savings attributed to favorable average daily population trends at both State chronic disease hospital centers. In addition, $357,590 in general funds is withdrawn and replaced with revenue from the Strategic Energy Investment Fund for the costs of the energy performance contract at Deer's Head Center.

Cost Containment

There are three across-the-board withdrawn appropriations that offset the increase in deficiency appropriations. These include reductions to employee/retiree health insurance, funding for a new Statewide Personnel information technology system, and retirement reinvestment. These actions are fully explained in the analyses of the Department of Budget Management (DBM) – Personnel, the Department of Information Technology, and the State Retirement Agency (SRA), respectively. The agency's share of the reductions totals $793,534 in general funds.

Proposed Budget

As shown in **Exhibit 3**, the Governor's fiscal 2015 budget increases by $28.3 million (29.0%) over the fiscal 2014 working appropriation, primarily due to federal grant funds. General funds increase by $6.3 million (7.3%), primarily due to Core funding for local health departments and increased personnel expenditures in the State's two chronic disease hospital centers. Finally, special funds decrease by $13,000 (0.3%), and reimbursable funds decrease by $20,000 (2.5%).

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

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2014 Working Appropriation	$85,505	$4,469	$6,681	$799	$97,454
2015 Allowance	91,757	4,456	28,749	779	125,741
Amount Change	$6,252	-$13	$22,068	-$20	$28,287
Percent Change	7.3%	-0.3%	330.3%	-2.5%	29.0%

Where It Goes:

Personnel Expenses	
Annualized salary increase for fiscal 2014 cost-of-living adjustment and increments	$971
Employee retirement	311
Turnover adjustments	149
Increments and other compensation	125
Other fringe benefit adjustments	82
Employee and retiree health insurance	-273
Abolished positions	-400
Other Changes	
State Innovations Models Grant (federal funds)	18,891
Statutory adjustment to the Core funding formula	5,135
Health Care Innovation Challenge Grant (federal funds)	3,000
Student Loan Repayment Program (federal funds)	150
Other adjustments	146
Total	**$28,287**

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

Cost Containment

There is one across-the-board reduction and one contingent reduction reflected in the Governor's spending plan for the fiscal 2015 allowance. This affects funding for employee/retiree health insurance and retirement reinvestment. These actions are fully explained in the analyses of DBM – Personnel and SRA. The agency's share of these reductions totals $457,577 in all funds.

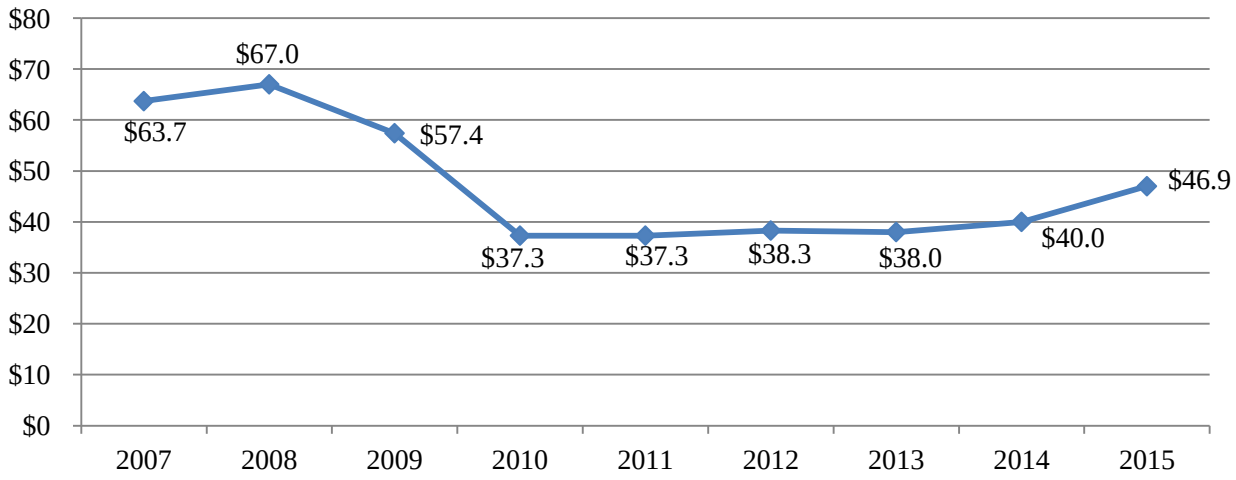
Personnel

Personnel expenditures for HSIA increase by $965,000 over the fiscal 2014 appropriation, primarily due to the annualized salary increase for fiscal 2014 cost-of-living adjustment (COLA) and increments ($971,000). Other increases to the budget include employee retirement contributions ($311,000), turnover adjustments ($149,000), increments and other compensation ($125,000), and other fringe benefit adjustments ($82,000). These increases are offset by a $400,000 decrease due to abolished positions in the Western Maryland Hospital Center as well as a $273,000 decrease in employee and retiree health insurance.

Core Public Health Services

Exhibit 4 shows the funding level for Core Public Health Services from fiscal 2007 to 2015. 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 ($37.3 million) for fiscal 2011 and 2012 with inflationary increases beginning again in fiscal 2013. There was a slight increase ($1.0 million) in funding in fiscal 2012 due to the one-time $750 bonus for State employees. Similarly, the fiscal 2013 budget included funding ($0.8 million) for the 2013 COLA. However, due to budget constraints, there was no statutory formula adjustment factor applied to fiscal 2013 spending levels.

Exhibit 4
Local Health Aid
Fiscal 2007-2015
($ in Millions)



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

Source: Department of Health and Mental Hygiene

The fiscal 2014 budget added to the $37.3 million base $1.2 million to reflect the formula adjustment factor and $1.5 million to account for the annualization for the fiscal 2013 COLA for State employees. Thus, Core funding totaled $40.0 million in fiscal 2014.

Similarly, the fiscal 2015 budget increases due to the formula adjustment factor ($1.1 million) and to account for the annualization of the 2014 COLA and increments ($5.7 million). However, these adjustments were added not to the statutory base ($37.3 million), but rather were added to the prior year allocation ($40.0 million). Thus, Core funding totals $46.9 million in fiscal 2015.

The formula adjustment factor is mandated under Health-General § 2-302 and is calculated by combining an inflation factor with a population growth factor.[3] 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 could decline when compared to the prior year. Moreover, the formula does not account for ongoing expenditures related to the annualization of COLAs.[4] This additional funding is not mandated by statute and is instead budgeted at the discretion of the Administration.

DLS recommends an amendment in the Budget Reconciliation and Financing Act of 2014 that would clarify that, beginning in fiscal 2016, the formula adjustment factor is to be applied to the prior year's allocation.

Other Changes

Federal funds increase by $21.9 million due to two federal grants: the State Innovation Models (SIM) Grant ($18.9 million) and the Health Care Innovation Challenge Grant ($3.0 million). However, SIM grant funds are not likely to be fully realized, as discussed in the Issues section of this document.

If awarded the Health Care Innovation Challenge Grant, Maryland will receive approximately $10.0 million over three years to fund three new Health Enterprise Zones (HEZ) and develop a payment model and continuous quality improvement infrastructure for these as well as five existing HEZs. (HEZs are small geographic areas with some of Maryland's highest rates of poverty, worst health outcomes, highest health care costs, and most significant health disparities.) HSIA applied for the Health Care Innovation Challenge Grant in August. Although award notifications were expected in December 2013, they are still pending.

Federal funding also increases for the Student Loan Repayment Program ($150,000).

[3] 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.

[4] The fiscal 2015 allowance for the Department of Budget and Management includes centrally budgeted funds for the fiscal 2015 cost-of-living adjustment.

Issues

1. Federal Grant Funding for State Innovation Models Project Unlikely to Be Realized in Fiscal 2015

In February 2013, the federal Centers for Medicare and Medicaid Services awarded Maryland a SIM planning grant to fund the development of the new community-integrated medical home (CIMH) initiative. According to the agency, the CIMH model of care is designed to integrate patient-centered medical care with community-based resources while enhancing the capacity of local health entities to monitor and improve the health of individuals and their communities as a whole. CIMHs – consisting of primary care physician-led teams focused on coordinating care – engage with LHICs to offer complementary supports to high-risk patients, identify and respond to hot spots of health needs, and monitor community and population health.

The agency had anticipated the SIM implementation grant to be awarded in the amount of $60 million over a 42-month period, with an expected start date of late summer or early fall 2014. The fiscal 2015 allowance includes $20 million in federal funds, based on the assumption that one-third of the SIM implementation grant will be spent in fiscal 2015. However, the agency advises that, as of February 2014, the relevant request for proposals (RFP) has still not been issued. The agency further advises that, once the RFP has been issued, it will take approximately two months for the agency to submit its grant application. Given that it will take still more months for applications to be reviewed and awards to be made, the Department of Legislative Services (DLS) advises that new SIM grant funding is unlikely to be realized in fiscal 2015. **Accordingly, DLS recommends that the committees add budget bill language (1) reducing the agency's fiscal 2015 federal fund appropriation by $20 million to more accurately reflect the agency's budget; and (2) specifying that, if new SIM grant funding is received in fiscal 2015, the agency is authorized to process a budget amendment to provide for additional spending authority under the grant.**

Recommended Actions

		Amount Reduction	
1.	Reduce the federal fund appropriation for the State Innovation Models (SIM) Grant to more accurately reflect the agency's budget. If new SIM grant funding is received in fiscal 2015, the agency is authorized to process a budget amendment to provide for additional spending authority under the grant.	$ 20,000,000	FF
	Total Federal Fund Reductions	**$ 20,000,000**	

Updates

1. Report on Local Health Outcomes and Funding for Local Public Health Services

The 2013 *Joint Chairmen's Report* (JCR) required DHMH to report on local health outcomes as they relate to public health funding reductions. In its report, the department found that local health departments continue to provide core services to Marylanders despite funding reductions that have affected program delivery and overall administrative functions. Furthermore, data indicates that Maryland is generally on track to meet the Healthy People 2020 goals established by the U.S. Centers for Disease Control and Prevention. However, it is important to note that budget cuts to funding for core services are relatively recent, and quantifiable negative health outcomes stemming from those cuts may not become apparent for some time.

2. Report on Local Health Department Billing Challenges

Committee narrative in the 2013 JCR required DHMH, in conjunction with local health departments, to report on the department's efforts to address the challenges faced by local health departments with regard to billing generally and third-party contracting in particular. The report describes how the department – through a grant agreement with the Maryland Partnership for Prevention (MPP) and MPP's partnership with SHR Associates, Inc. (SHR), a Maryland-based practice management firm – conducted 24 local health department site assessments, and to develop implementation plans for each individual local health department.

SHR assessed the overall readiness level of each local health department based on both current industry standards and onsite observations and discussions with LHD officials during and following each site visit. Local health departments with readiness scores of 14 to 15 (out of 15) were ranked as having a "high readiness" level; those with scores of 11 to 13 were ranked as having a "moderate readiness" level; and those with scores of 10 or below were ranked as having a "low readiness" level. As of May 2013, 8 of Maryland's 24 local health departments were rated at a high readiness level; 9 were rated at moderate readiness level; and 7 were rated at low readiness level.

DHMH reported that both statutory and regulatory changes are needed to help address billing challenges and that the department has developed proposed legislation that would complement its ongoing efforts to improve overall local health departments' readiness to bill for clinical services. According to the department, its proposal would clarify, with certain exceptions established by law, local health departments' authority to expend funds collected from fees or charges, as well as carry over any unspent balances for use in subsequent fiscal years. In addition, DHMH and the local health departments have agreed upon regulatory changes concerning the setting of charges for local health department clinical services. According to the department, proposed changes would simplify the methodology for the setting of charges and eliminate disparities in charges set by local health departments for similar services.

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 2013					
Legislative Appropriation	$78,871	$4,144	$4,493	$667	$88,175
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	1,262	1,148	1,507	63	3,980
Reversions and Cancellations	0	-153	-177	-10	-340
Actual Expenditures	**$80,133**	**$5,140**	**$5,822**	**$720**	**$91,815**
Fiscal 2014					
Legislative Appropriation	$84,508	$4,448	$5,567	$799	$95,323
Budget Amendments	2,248	20	1,114	0	3,383
Working Appropriation	**$86,756**	**$4,469**	**$6,681**	**$799**	**$98,705**

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

Fiscal 2013

In fiscal 2013, the budget for HSIA closed at $91.8 million, $3.6 million over the original legislative appropriation.

Budget amendments over the course of fiscal 2013 increased the budget by approximately $4.0 million. The fiscal 2013 budget included centrally budgeted funds for the 2013 COLA for State employees. This resulted in the transfer of funds to HSIA ($928,532 in special funds and $2,509 in federal funds). General funds also increased due to a transfer of funds from the Prevention and Health Promotion Administration (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. In addition, one amendment increased the special fund appropriation by $87,657 to cover the cost of a contract with the University of Maryland Baltimore County to support the Women, Infants, and Children Quality Improvement Initiative. Another amendment increased the agency's special fund appropriation by $132,283 (available due to decreased Maryland AIDS Drug Assistance Program expenditures) to realign special funds within DHMH.

General funds also increased to realign health insurance and telecommunication appropriations within DHMH ($96,780) and decreased to realign general funds within the department ($160,850). In addition, general funds for the Western Maryland Center decreased by $100,000 to realign the general fund appropriation between State agencies based on estimated health insurance expenditures.

Federal funds also increased to realign federal funds within DHMH ($447,520) and to realign the State Retirement administrative fee and the Department of Information Technology (DoIT) services allocation appropriations within the department ($623).

At the close of the fiscal year, $152,718 in special funds was cancelled, primarily due to lower than budgeted expenses at both hospitals. Lower than budgeted expenditures for HSIA also resulted in the cancellation of $177,167 in federal funds and $10,179 in reimbursable funds.

Fiscal 2014

The fiscal 2014 working appropriation is $98.7 million, an increase of $3.4 million over the original legislative appropriation. The fiscal 2014 budget included centrally budgeted funds for the 2014 COLA and salary increment increase for State employees, which resulted in the transfer of funds to HSIA ($2.2 million in general funds, $20,431 in special funds, and $4,515 in federal funds). In addition, federal funds increased by $1.1 million for the State Innovation Model (SIM) design; these funds were available from a SIM Design and Model Testing Assistance grant. Finally, federal funds increased by $605 to realign the State Retirement administrative fee and DoIT services allocation appropriations within DHMH.

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 measures can be stratified by race and ethnicity.

Source: Department of Health and Mental Hygiene

Object/Fund Difference Report
DHMH – Health Systems and Infrastructure Administration

Object/Fund	FY 13 Actual	FY 14 Working Appropriation	FY 15 Allowance	FY 14 - FY 15 Amount Change	Percent Change
Positions					
01 Regular	532.05	532.05	525.80	-6.25	-1.2%
02 Contractual	22.53	20.92	21.32	0.40	1.9%
Total Positions	**554.58**	**552.97**	**547.12**	**-5.85**	**-1.1%**
Objects					
01 Salaries and Wages	$ 34,262,251	$ 37,359,666	$ 37,988,627	$ 628,961	1.7%
02 Technical and Spec. Fees	1,435,073	1,193,327	1,260,474	67,147	5.6%
03 Communication	90,036	93,469	93,204	-265	-0.3%
04 Travel	43,336	41,560	33,595	-7,965	-19.2%
06 Fuel and Utilities	1,290,774	1,290,986	1,232,891	-58,095	-4.5%
07 Motor Vehicles	79,241	98,816	56,949	-41,867	-42.4%
08 Contractual Services	6,134,179	6,147,222	28,413,559	22,266,337	362.2%
09 Supplies and Materials	5,229,979	6,042,621	5,495,044	-547,577	-9.1%
10 Equipment – Replacement	426,930	30,390	53,000	22,610	74.4%
11 Equipment – Additional	168,450	0	24,997	24,997	N/A
12 Grants, Subsidies, and Contributions	42,546,124	46,261,209	51,396,532	5,135,323	11.1%
13 Fixed Charges	108,515	146,161	149,842	3,681	2.5%
Total Objects	**$ 91,814,888**	**$ 98,705,427**	**$ 126,198,714**	**$ 27,493,287**	**27.9%**
Funds					
01 General Fund	$ 80,132,839	$ 86,756,281	$ 92,189,977	$ 5,433,696	6.3%
03 Special Fund	5,140,044	4,468,747	4,477,170	8,423	0.2%
05 Federal Fund	5,822,383	6,681,448	28,752,738	22,071,290	330.3%
09 Reimbursable Fund	719,622	798,951	778,829	-20,122	-2.5%
Total Funds	**$ 91,814,888**	**$ 98,705,427**	**$ 126,198,714**	**$ 27,493,287**	**27.9%**

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

Fiscal Summary
DHMH – Health Systems and Infrastructure Administration

Program/Unit	FY 13 Actual	FY 14 Wrk Approp	FY 15 Allowance	Change	FY 14 - FY 15 % Change
01 Health Systems and Infrastructure Administration	$ 2,915,612	$ 3,705,104	$ 25,870,098	$ 22,164,994	598.2%
07 Core Public Health Services	42,543,787	46,236,209	51,371,532	5,135,323	11.1%
01 Services and Institutional Operations	24,290,823	25,559,663	25,267,932	-291,731	-1.1%
01 Services and Institutional Operations	22,064,666	23,204,451	23,689,152	484,701	2.1%
Total Expenditures	**$ 91,814,888**	**$ 98,705,427**	**$ 126,198,714**	**$ 27,493,287**	**27.9%**
General Fund	$ 80,132,839	$ 86,756,281	$ 92,189,977	$ 5,433,696	6.3%
Special Fund	5,140,044	4,468,747	4,477,170	8,423	0.2%
Federal Fund	5,822,383	6,681,448	28,752,738	22,071,290	330.3%
Total Appropriations	**$ 91,095,266**	**$ 97,906,476**	**$ 125,419,885**	**$ 27,513,409**	**28.1%**
Reimbursable Fund	$ 719,622	$ 798,951	$ 778,829	-$ 20,122	-2.5%
Total Funds	**$ 91,814,888**	**$ 98,705,427**	**$ 126,198,714**	**$ 27,493,287**	**27.9%**

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