M00F03
Prevention and Health Promotion Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$53,261	$37,262	$37,510	$247	0.7%
Deficiencies and Reductions	0	1,456	-40	-1,496	
Adjusted General Fund	**$53,261**	**$38,719**	**$37,469**	**-$1,249**	**-3.2%**
Special Fund	92,669	111,779	113,958	2,179	1.9%
Deficiencies and Reductions	0	0	-6	-6	
Adjusted Special Fund	**$92,669**	**$111,779**	**$113,952**	**$2,174**	**1.9%**
Federal Fund	183,087	206,619	206,974	355	0.2%
Deficiencies and Reductions	0	0	-72	-72	
Adjusted Federal Fund	**$183,087**	**$206,619**	**$206,901**	**$283**	**0.1%**
Reimbursable Fund	2,553	6,355	2,476	-3,879	-61.0%
Adjusted Reimbursable Fund	**$2,553**	**$6,355**	**$2,476**	**-$3,879**	**-61.0%**
Adjusted Grand Total	**$331,570**	**$363,471**	**$360,799**	**-$2,672**	**-0.7%**

- There is one proposed deficiency for fiscal 2016 of $1.5 million to provide funds to pay the State share of Certificate of Need expenses for the proposed new regional medical center in Prince George's County.

- After adjusting for a fiscal 2016 deficiency appropriation and a back of the bill reduction in health insurance, the Governor's fiscal 2017 allowance decreases by $2.7 million (0.7%) over the fiscal 2016 working appropriation.

- Supplemental budget number one, not included in the table, adds a $15.0 million operating grant to the University of Maryland Medical System to ease the transition to the new regional medical center in Prince George's County.

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

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Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	362.80	366.80	426.80	60.00
Contractual FTEs	3.96	6.11	6.12	0.01
Total Personnel	**366.76**	**372.91**	**432.92**	**60.01**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	18.78	5.12%
Positions and Percentage Vacant as of 12/31/15	14.80	4.03%

- The fiscal 2017 allowance includes an increase of 60.0 regular full-time equivalents (FTE) over the fiscal 2015 working appropriation but the same number of contractual FTEs. Of the 60.0 new FTEs, 58.0 are federally funded and are contract conversions of individuals currently employed through the Maryland Institute for Policy Analysis and Research. The other additional new FTEs are added for Synar Tobacco enforcement.

- As of December 31, 2015, there were 14.8 vacant positions, less than the number of positions needed to meet turnover.

Analysis in Brief

Major Trends

Infant Mortality Rates Decrease for Whites, Increase for African Americans: Maryland's infant mortality rate for calendar 2012 represents the lowest rate ever recorded in Maryland. Following national trends, Maryland's infant mortality rate among African Americans has consistently been disproportionally high but has declined in the past several years (driving the overall reduction in the infant mortality rate). In calendar 2014, infant mortality increased slightly for African Americans for the second year in a row, while overall infant mortality rates decreased slightly from calendar 2013. Infant mortality rates continue to vary widely by geographic region, likely driven by racial disparities.

Cancer Mortality Rates Continue to Improve: Both the overall cancer mortality rate and the breast cancer mortality rate continue to decline steadily in Maryland. The prevalence of cigarette smoking among all ages has continued to decrease.

Childhood Vaccination Rates Decrease, Remain Above National Average: In calendar 2014, 74% of children in Maryland received the typical coverage of vaccinations – a slight decrease from the previous calendar year. The Maryland rate remains above the national average of 72%.

Syphilis Rates Remain High, While Chlamydia Rates Increase: In calendar 2014, the Centers for Disease Control and Prevention reported a statewide infection rate of primary and secondary syphilis in Maryland of 7.6 cases per 100,000 population. This rate, driven by high primary and secondary syphilis rates in Baltimore City, is the eighth highest in the nation and has remained relatively constant since the calendar 2011 rate. Meanwhile, chlamydia rates statewide have continued to approximate the national average and increased slightly in 2014 from the previous calendar year. Chlamydia continues to be driven by high rates among women, with the highest rates among African American women.

HIV and AIDS Cases, High among States, Continue to Decline: Despite a steady decline in newly reported Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) cases, Maryland's incidence of new cases remains high compared with other states. According to the most recent national data, Maryland had the seventh highest number of newly reported HIV cases among states.

Maryland AIDS Drug Assistance Program Enrollment Continues to Decline: The Maryland AIDS Drug Assistance Program (MADAP) and MADAP-Plus enrollment reached an estimated 7,759 and 3,313 enrollees, respectively, in calendar 2012. However, the fiscal 2017 allowance reflects the decline in MADAP program enrollment in more recent years due to the implementation of federal health care reform.

Issues

Increasing Prevalence of Diabetes and Obesity: The percent of Marylanders considered overweight or obese (a body mass index greater than or equal to 25) reached 65.0% in calendar 2014. Being overweight or obese puts individuals at risk for a number of diseases, including diabetes. The prevalence of diabetic adults in Maryland has also grown from 6.8% in 1999 to 10.0% in 2014. Among the Maryland diabetic population, co-morbidities such as high blood pressure, high cholesterol, obesity, and smoking increase mortality, complications, hospitalization, and cost of treatment.

Underutilization of Providers Accepting Practice Obligations: The State Loan Repayment 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. The Department of Health and Mental Hygiene has identified areas with critical shortages of primary care physicians. However, the number of providers accepting a SLRP obligation has remained underutilized and static since 2012.

Recommended Actions

1. Adopt narrative requesting a report on obesity and diabetes initiatives.

Updates

Fee Reduction Fiscal Impact: On September 15, 2015, the Governor announced a plan to reduce a number of fees across State government. A number of fee reductions in the Prevention and Health Promotion Administration were part of that plan.

M00F03
Prevention and Health Promotion Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The mission of the Prevention and Health Promotion Administration (PHPA) is to protect, promote, and improve the health and well-being of Marylanders and their families through the provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community-based organizations, and public- and private-sector agencies.

PHPA accomplishes this by focusing, in part, on the prevention and control of infectious diseases, investigation of disease outbreaks, protection from food-related and environmental health hazards, and helping impacted persons live longer, healthier lives. Additionally, the administration works to assure the availability of quality primary prevention and specialty care health services with special attention to at-risk and vulnerable populations. Finally, the administration aims to prevent and control chronic diseases, engage in disease surveillance and control, prevent injuries, provide health information, and promote health behaviors. The administration was formed from the integration of the former Infectious Disease and Environmental Health Administration and the Family Health Administration on July 1, 2012.

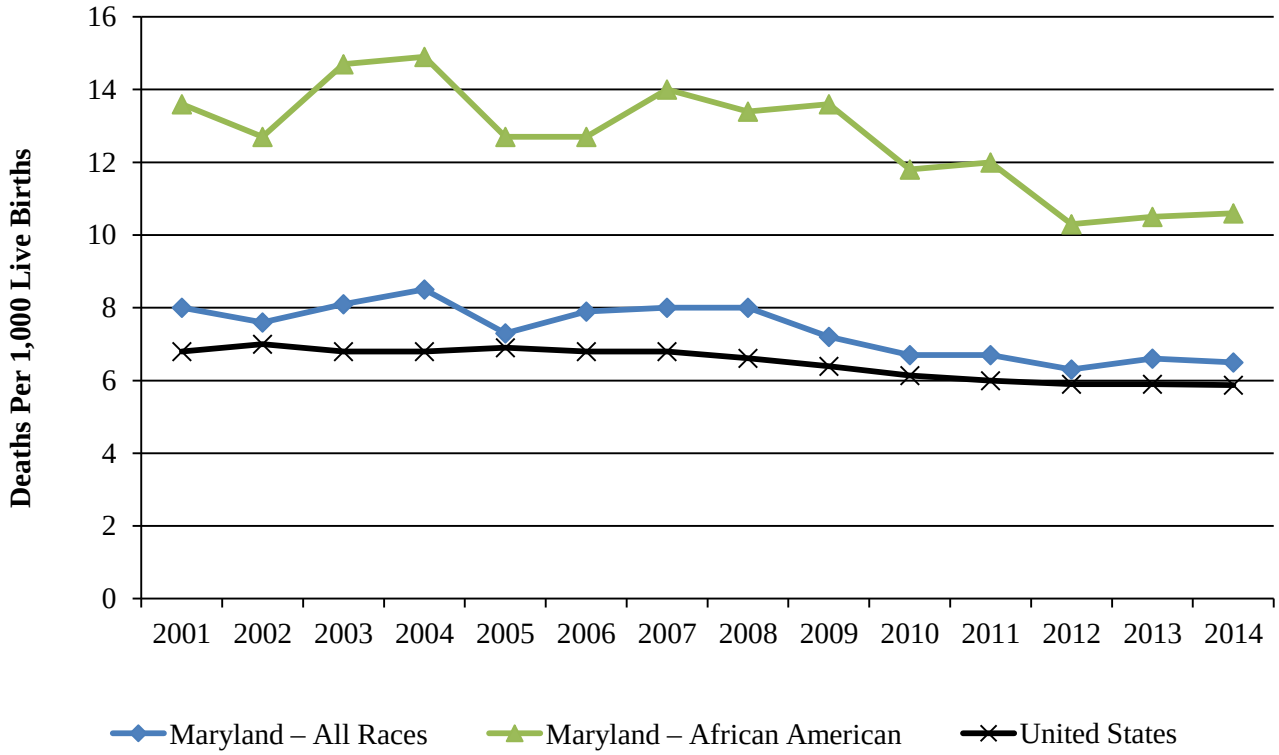
Performance Analysis: Managing for Results

1. Infant Mortality Rates Decrease for Whites, Increase for African Americans

The Maternal and Child Health Bureau within PHPA is charged with reducing infant mortality and promoting the health and well-being of all women and children. Infant mortality rates are used to indicate the total health of populations in the United States and internationally. During the second half of the twentieth century, infant mortality rates in the United States fell from 29.2 to 6.9 per 1,000 live births, a decline of 76%. Mirroring the national trend, Maryland's infant mortality rate decreased 23% during the 1990s due to improved access to preconception, prenatal, and family planning services. Also contributing to the decline was the development of hospital perinatal standards, high-risk consultation, and community-based perinatal health improvements.

In calendar 2002, the U.S. infant mortality rate increased for the first time since 1958. According to the National Center for Health Statistics, infant mortality rates were the highest among mothers who smoked, had no prenatal care, were teenagers, were unmarried, and had less education. Following the national trend, Maryland's overall infant mortality rate increased from calendar 2002 through 2004 to 8.5 deaths per 1,000 live births. Since that time, Maryland has made steady progress to reduce its infant mortality rate, reaching a low of 6.3 in calendar 2012 (the lowest rate ever recorded in Maryland) as shown in **Exhibit 1**. Following national trends, Maryland's African American infant mortality rate has consistently been higher than other races. This rate has generally declined in the past several years – driving the overall reduction in the infant mortality rate – but increased slightly in both calendar 2013 and 2014. Interestingly, in calendar 2014, overall infant mortality rates decreased slightly from calendar 2013 (to 6.5) in spite of the increase in the infant mortality rate among African Americans.

Exhibit 1
Infant Mortality Rates
Calendar 2001-2014

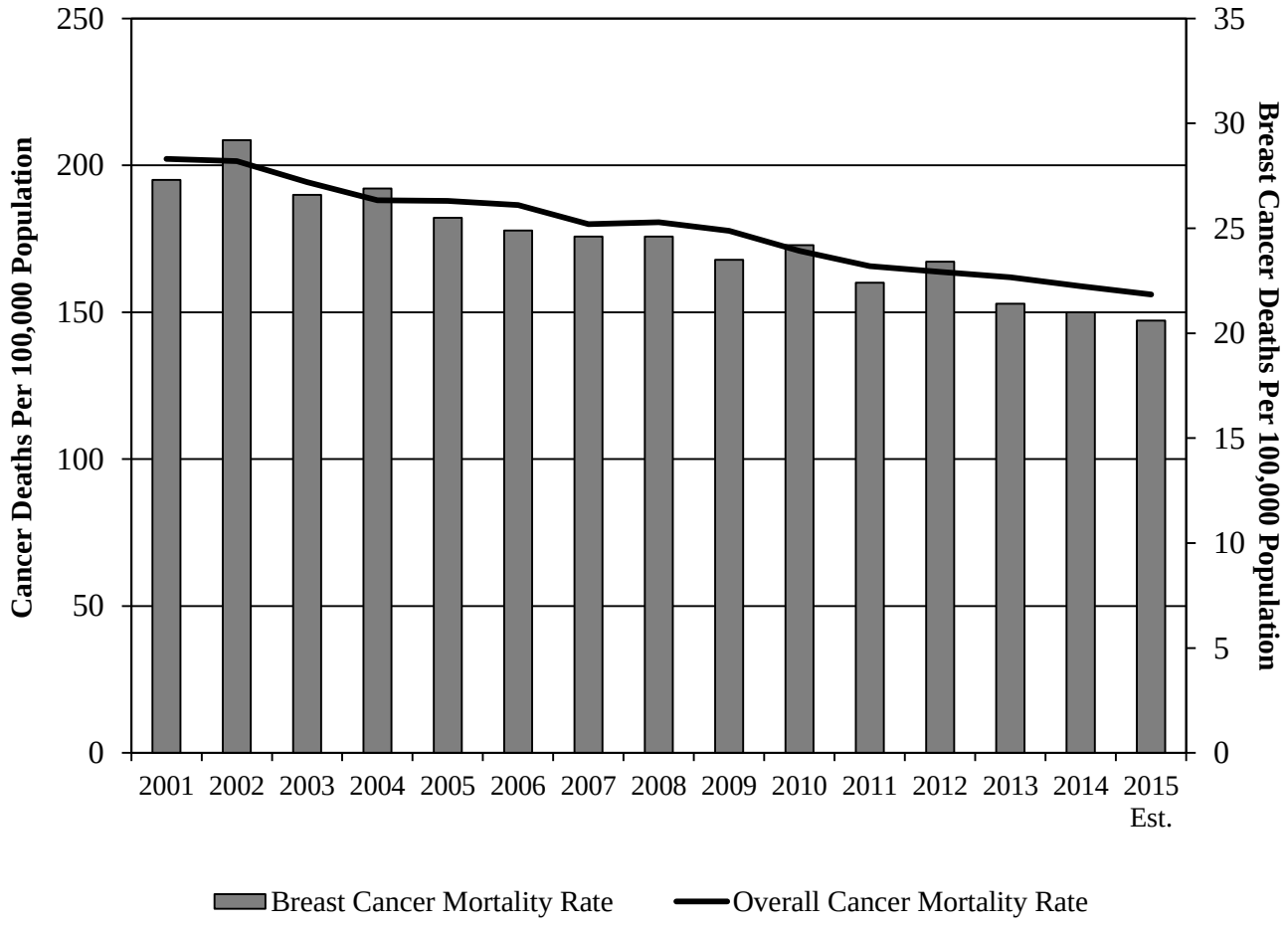


Source: Department of Health and Mental Hygiene

2. Cancer Mortality Rates Continue to Improve

One of the main functions of the Cancer Prevention, Education, Screening, and Treatment Program is to fund community-based programs that prevent, detect, and treat cancer. The mission of the program is to reduce the burden of cancer among Maryland residents by reducing overall cancer mortality in the State. **Exhibit 2** shows that there has been a steady decline in both the overall cancer mortality rate and the breast cancer mortality rate in Maryland. The cancer programs within the Cigarette Restitution Fund (CRF) target colorectal cancer and cancers associated with tobacco use.

Exhibit 2
Cancer Mortality Rates
Calendar 2001-2015 Est.

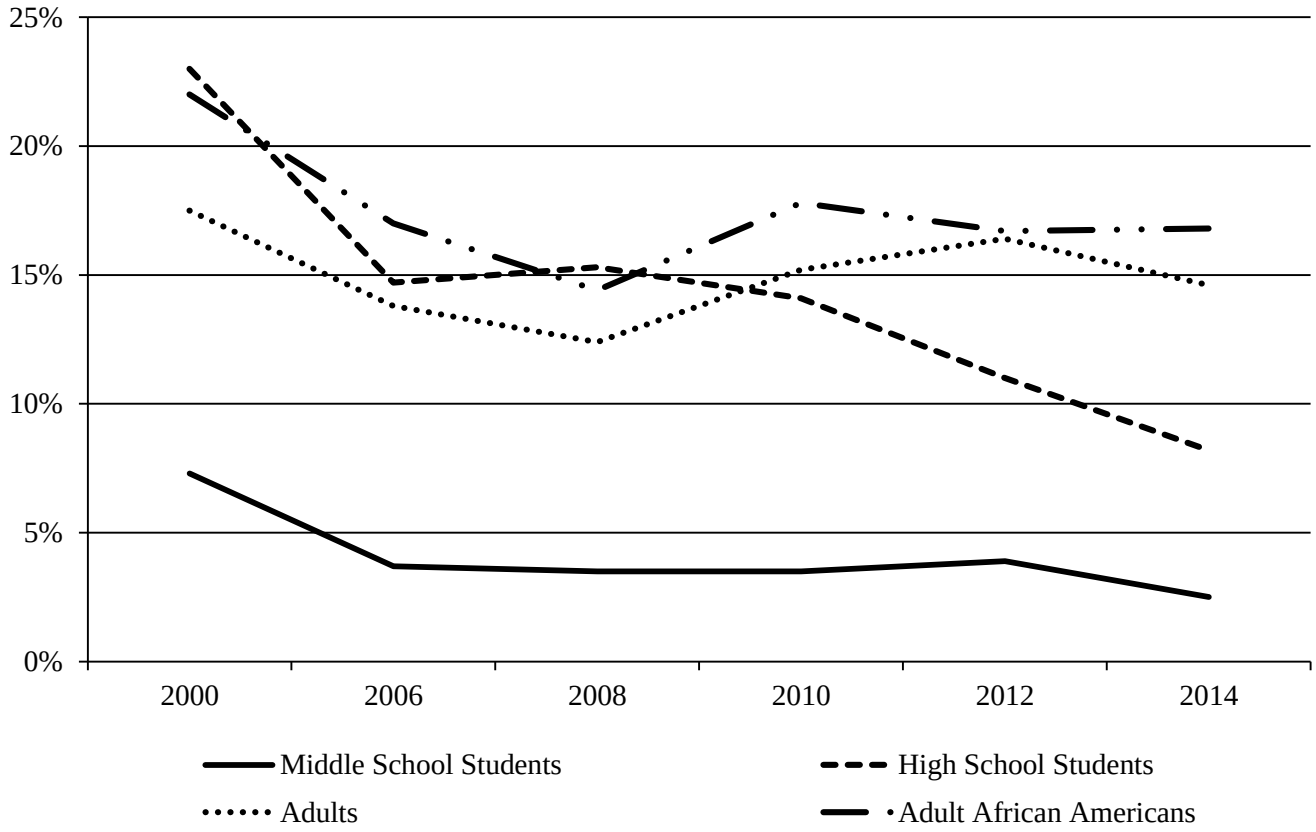


Source: Department of Health and Mental Hygiene

Tobacco Use Prevention and Cessation Program

The mission of the Tobacco Use Prevention and Cessation Program is to reduce the use of tobacco products and to reduce the burden of tobacco-related morbidity and mortality in the State. One of the goals of the program is to reduce the proportion of Maryland youth and adults who currently smoke cigarettes. Surveys funded with CRF revenue are intended to track smoking preferences and usage among Marylanders. As shown in **Exhibit 3**, the prevalence of cigarette smoking has decreased by 66.0% among public middle school students (from 7.3% in calendar 2000 to 2.5% in calendar 2014) and by 64.0% among underage public high school students (from 23.0% in calendar 2000 to 8.2% in calendar 2014).

Exhibit 3
Tobacco Usage Rates
Calendar 2000-2014



Note: See text for discussion of survey methodology.

Source: Department of Health and Mental Hygiene

It should be noted that the Behavioral Health Administration (BHA) and PHPA have traditionally undertaken a variety of activities to ensure compliance with State tobacco laws and federal funding requirements (the Synar amendment) as they pertain to minors, including merchant compliance checks. As a result of an audit revealing that the State was out of compliance with federal Synar inspection outcomes, the State had penalty requirements of $1.4 million and $3.9 million in fiscal 2015 and 2016, respectively. The penalties equated to additional level of State spending on compliance activities. The education and enforcement programs funded reduced the noncompliance rate to 13.8% in federal fiscal 2016. Although the noncompliance rate fell below the threshold that would result in a penalty of 20.0%, the fiscal 2017 allowance includes $2 million and 2 new positions in PHPA to provide retailer education and some local enforcement responsibilities.

The Department of Legislative Services (DLS) notes that although in Exhibit 3 it appears that the percentage of adults who smoke cigarettes increased significantly from calendar 2008 through 2012, this is misleading. Beginning in calendar 2011, the Centers for Disease Control and Prevention (CDC) began using a new, more comprehensive weighting methodology that generates more accurate estimates of adult tobacco use in Maryland. Thus, higher estimates of tobacco use among adults result, at least in part, from changes in survey methodology and not necessarily from any increase in tobacco use. However, since calendar 2012, while tobacco use among all adults has fallen, it has risen among African Americans.

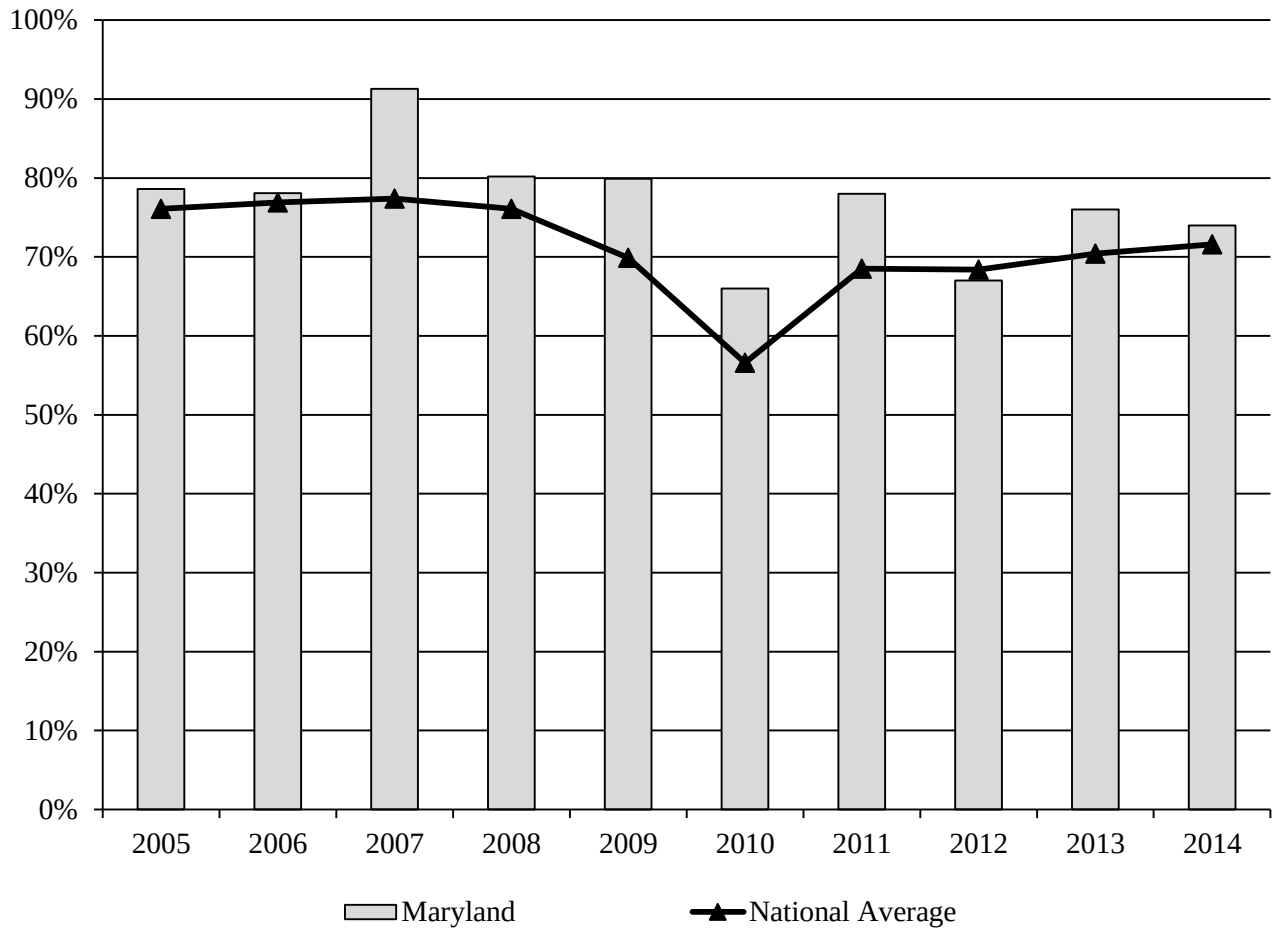
3. Childhood Vaccination Rates Decrease, Remains Above National Average

As shown in **Exhibit 4**, 74% of children in Maryland received the typical coverage of vaccinations in calendar 2014, which is above the national average of 70%. Between calendar 2006 and 2007, the rate of immunizations jumped 13 percentage points, although, reasons for this increase were unclear. In calendar 2008, the vaccination rate returned to historic levels. Low points in calendar 2010 and 2012 resulted, in both cases, from nationwide vaccine shortages. Maryland's childhood vaccination rates have generally remained slightly above national rates.

Maryland is able to keep its vaccination rates relatively high for several reasons. First, the State allows parents to opt out of vaccinating toddlers for medical or religious reasons but not for philosophical reasons. Also, the Department of Health and Mental Hygiene (DHMH) operates the Maryland Vaccines for Children Program, which works with 850 providers at 1,000 public and private practice vaccine delivery sites to provide all routinely recommended vaccines free of cost to children 18 years old or younger who:

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

Exhibit 4
Rates of Children, Ages 19 to 35 Months, with Up-to-date Immunizations
Calendar 2005-2014



Source: Department of Health and Mental Hygiene

4. Syphilis Rates Remain High, While Chlamydia Rates Increase

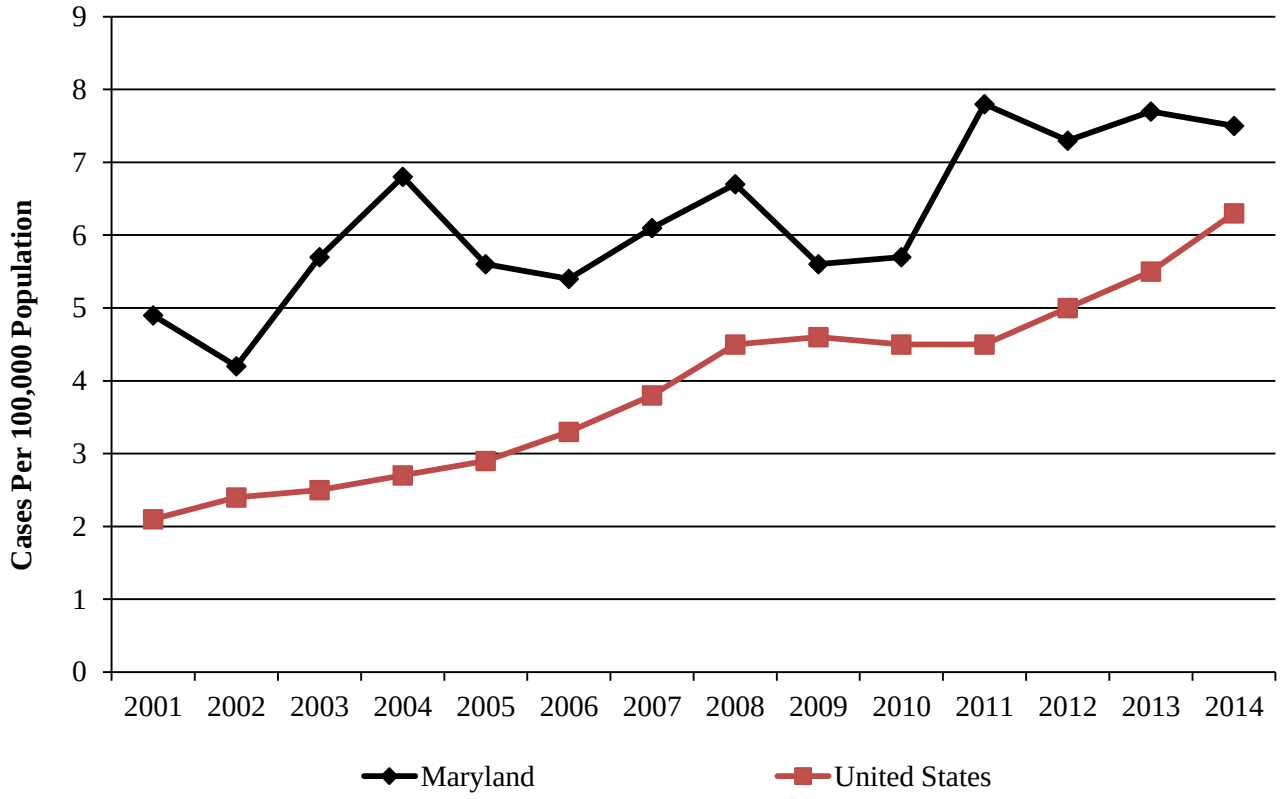
Syphilis Infection Rates

PHPA is charged with preventing and controlling the transmission of infectious diseases, including sexually transmitted infections (STI). The administration has developed initiatives to reduce the spread of STIs, with an emphasis on at-risk populations, such as economically disadvantaged and

incarcerated populations. Syphilis continues to be a major concern in the State, with the rate of infection in Maryland among the highest in the nation. Untreated syphilis in pregnant women can result in infant death in up to 40% of cases. In addition to its primary effects, syphilis presents public health concerns for its role in facilitating transmission of Human Immunodeficiency Virus (HIV).

Exhibit 5 shows syphilis rates in Maryland compared with the national average. In calendar 2014, CDC reported a statewide infection rate of primary and secondary syphilis in Maryland of 7.5 cases per 100,000 population. The primary and secondary stages are curable, yet extremely contagious. If left untreated the disease may progress into the tertiary stage, which may not be curable. This rate, driven by high primary and secondary syphilis rates in Baltimore City (30.9 cases per 100,000 population), is one of the highest in the nation (eighth) and has remained relatively constant since calendar 2011.

Exhibit 5
Rates of Primary/Secondary Syphilis
Calendar 2001-2014



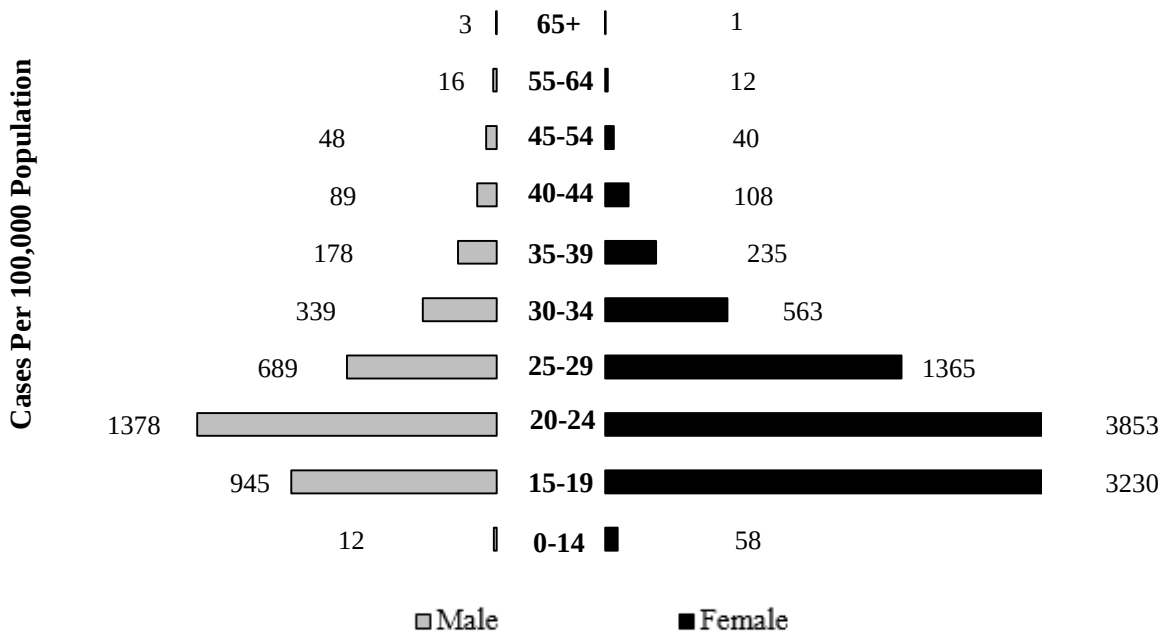
Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

CDC has indicated that syphilis remains a major health problem, with increases in rates persisting among men who have sex with men (who account for a majority of all primary and secondary syphilis cases). Moreover, cases that involve men who have sex with men have been characterized by high rates of HIV co-infection. DHMH advises that these trends are consistent with infection rates seen in Maryland. Accordingly, the Baltimore City Health Department (BCHD) has implemented programs to specifically target this population.

Chlamydia Infection Rates

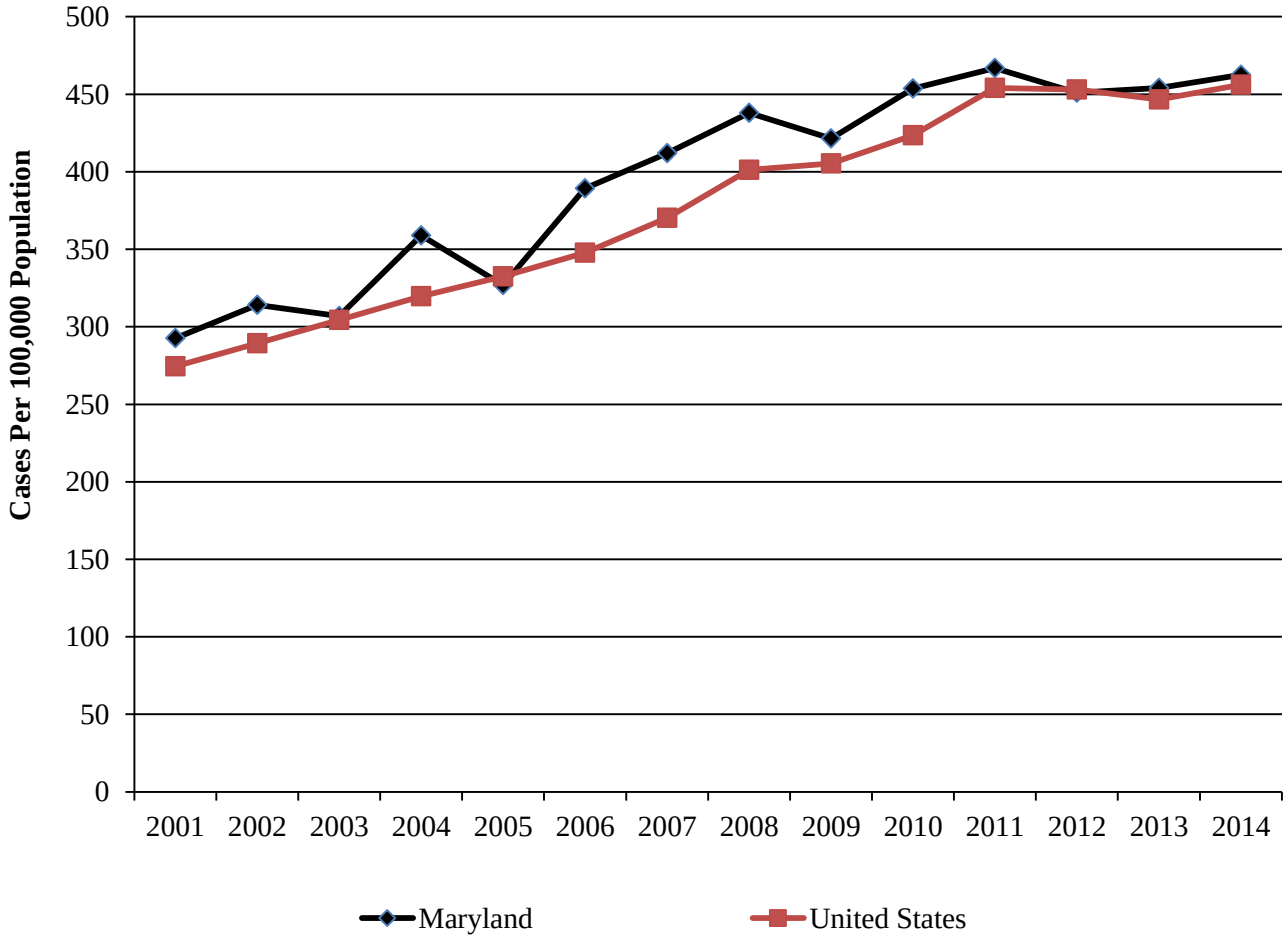
Chlamydia rates statewide have continued to increase and approximate the national average. Consistent with national trends, chlamydia rates for females are two and a half times greater than those for males. **Exhibit 6** shows rates are driven by high rates among 15- to 24-year olds, where rates for females are three times greater than those for males. The rates among both male and female 15- to 24-year olds are driven by high rates among the African American population where rates are nearly six times as high as those for whites. Chlamydia rates increased slightly in 2014 from the previous year, as shown in **Exhibit 7**.

Exhibit 6
Rate of Chlamydia by Age
Calendar 2014



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

Exhibit 7
Rate of Chlamydia
Calendar 2001-2014



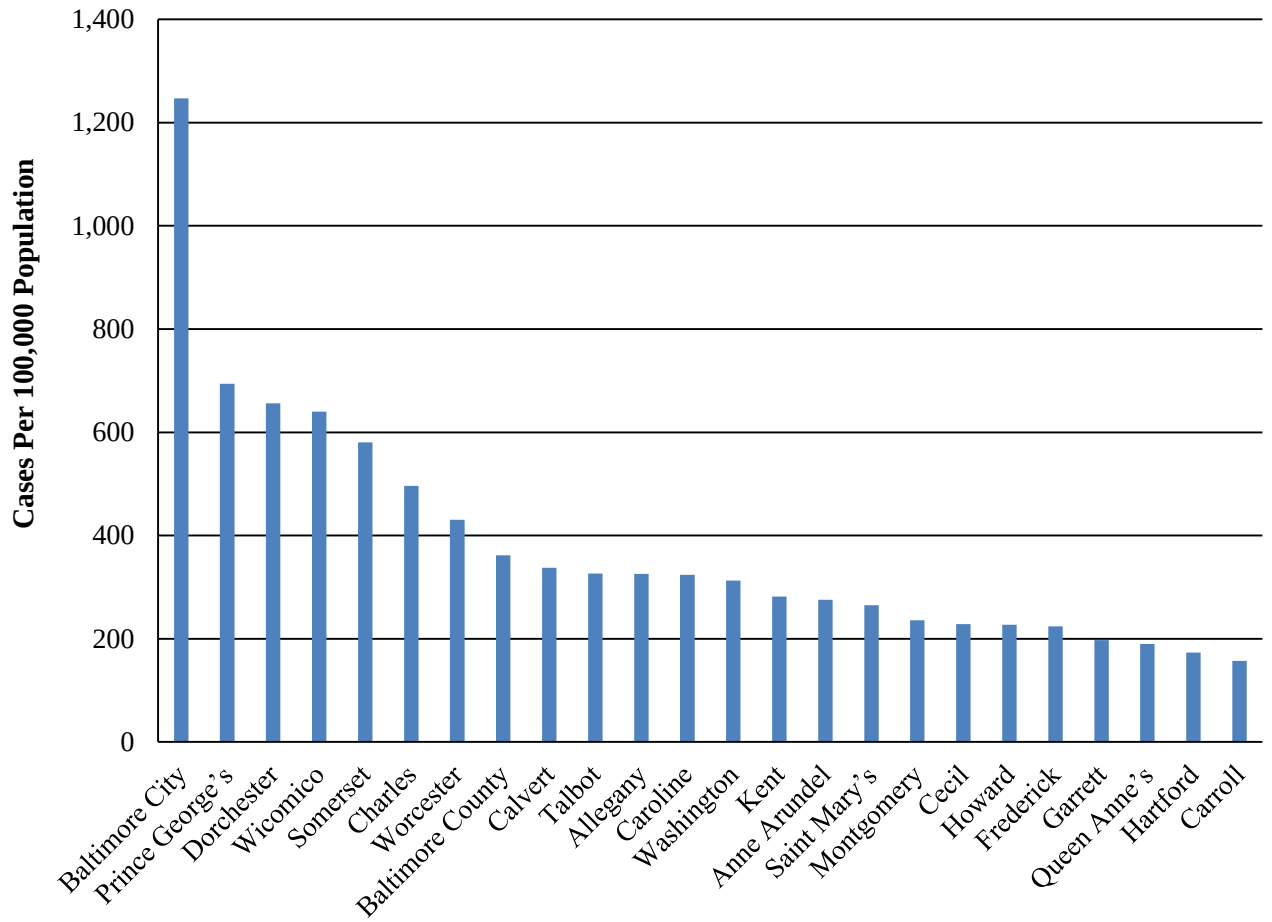
Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

In Baltimore City, where rates for all STIs are the highest in the State, BCHD receives funding directly from CDC to respond to STIs. Among other activities, Baltimore City has an active outreach program to find and test high-risk individuals, including commercial sex workers. It also has a STI clinic that provides free testing and treatment, as well as school-based clinics that test for chlamydia and gonorrhea. In addition, BCHD works with the Baltimore City central booking and intake facility to link inmates who are HIV positive to care prior to their release. Finally, the city has an expedited partner therapy (EPT) pilot project for chlamydia and gonorrhea, which allows individuals with these STIs to distribute antibiotics to their sexual partners. Patients can deliver antibiotics to up to three of their partners without a prescription and without the health care provider first examining their partners.

By treating individuals and their partners, the EPT pilot project aims to prevent individuals from being reinfected with the disease by their partners.

In addition to Baltimore City, other counties also have consistently high rates of chlamydia including (cases per 100,000 population) Prince George's (694.0), Dorchester (656.0), Wicomico (646.0), Somerset (580.0), and Charles counties (496.4), as shown in **Exhibit 8. The agency should comment on initiatives aimed at preventing chlamydia in the other high rate counties.**

Exhibit 8
Rate of Chlamydia by County
Calendar 2013

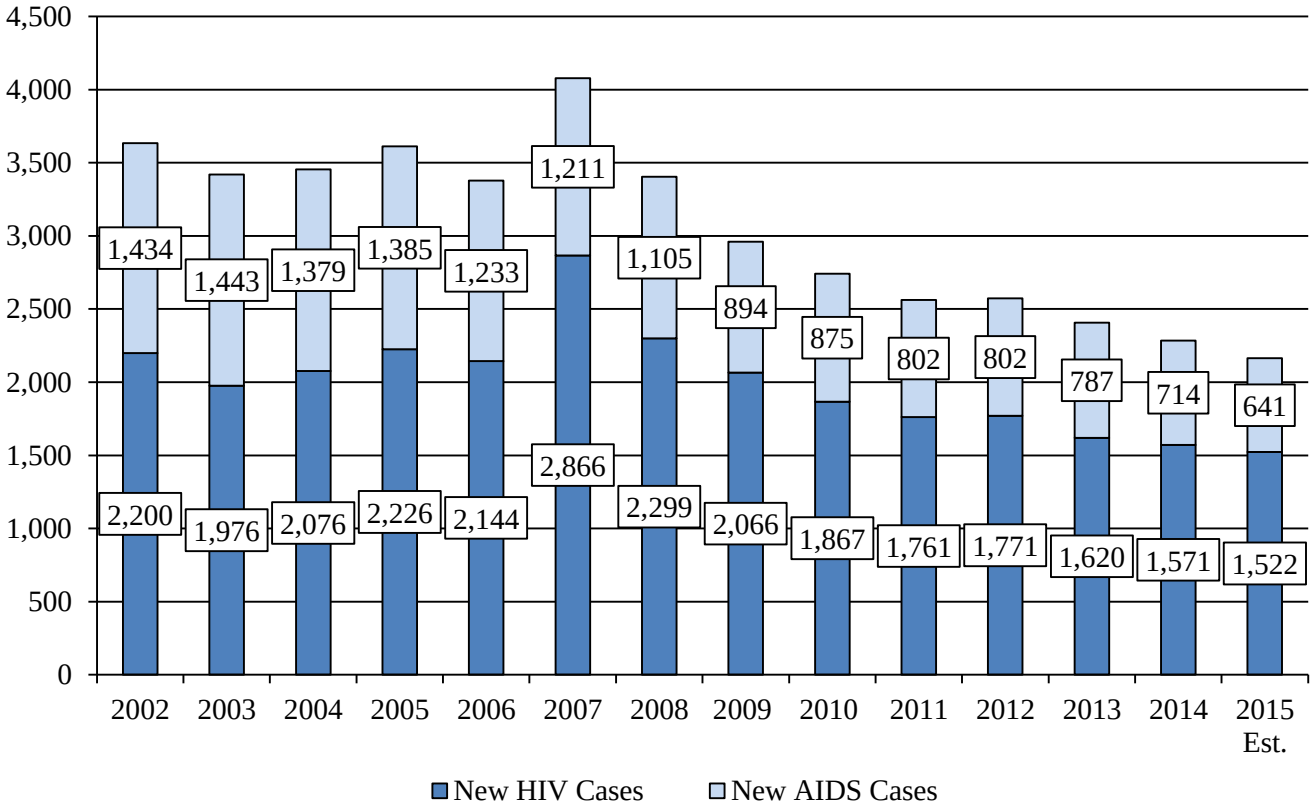


Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

5. HIV and AIDS Cases, High among States, Continue to Decline

Exhibit 9 details the continued decline in newly reported cases of HIV and AIDS in Maryland. As the chart demonstrates, after stalling in calendar 2012, that decline continued in 2013 and 2014.

Exhibit 9
Incidence of New HIV and AIDS in Maryland
Calendar 2002-2015 Est.



AIDS: Acquired Immunodeficiency Syndrome
HIV: Human Immunodeficiency Virus

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

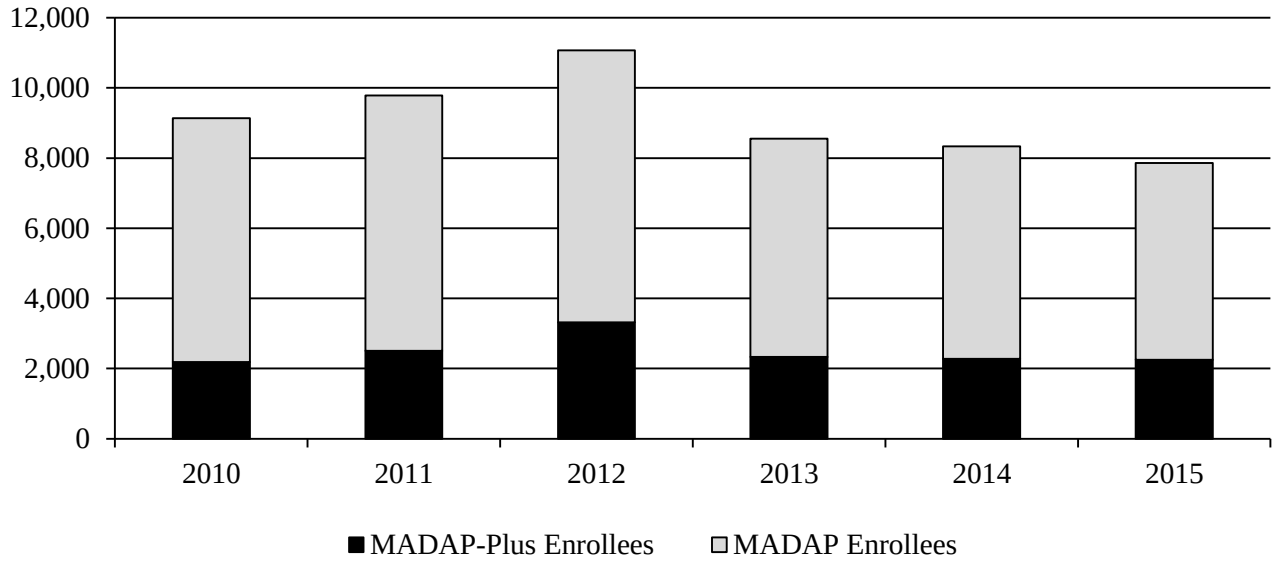
Despite the downward trend, the number of newly reported HIV cases in Maryland remains high compared with other states. According to the most recent national comparison conducted by CDC (based on calendar 2013 data), Maryland had the seventh highest number of newly reported HIV cases among states.

6. Maryland AIDS Drug Assistance Program Enrollment Continues to Decline

PHPA provides two major health services programs related to HIV/AIDS: the Maryland AIDS Drug Assistance Program (MADAP) and MADAP-Plus. MADAP is the larger of the two programs with an estimated 5,611 enrollees in fiscal 2015. MADAP helps Maryland residents pay for certain drugs prescribed to treat HIV/AIDS. Clients are certified eligible for MADAP for a one-year period, after which time they may reapply for certification. MADAP eligibility requirements are up to 500% of the federal poverty level, along with extremely generous drug coverage. MADAP-Plus offers health insurance assistance to individuals living with HIV/AIDS at the same income levels and had 2,252 enrollees in fiscal 2015.

As shown in **Exhibit 10**, both MADAP and MADAP-Plus experienced enrollment growth in fiscal 2010 through 2012. In particular, MADAP-Plus enrollment increased due to the elimination of the Maryland AIDS Insurance Assistance Program in June 2009 and due to the recession (as a higher number of individuals were in need of health insurance). In fiscal 2012, MADAP and MADAP-Plus enrollment reached highs of 7,759 and 3,313 enrollees, respectively. However, MADAP enrollment has since declined, due to the implementation of federal health care reform.

Exhibit 10
MADAP and MADAP-Plus Enrollment
Fiscal 2010-2015



MADAP: Maryland AIDS Drug Assistance Program

Note: An individual must be enrolled in MADAP in order to be enrolled in MADAP-Plus.

Source: Department of Health and Mental Hygiene

Fiscal 2016 Actions

Cost Containment

The fiscal 2016 budget bill contained a 0.6% across-the-board general fund reduction to DHMH totaling $27.2 million. The agency's proportion of the cut amounted to $442,730 due to the elimination of a grant to the University of Maryland Medical System (UMMS) for the Montebello Rehabilitation Center at Kernan Hospital to support 50.0% of annual debt service on bonds issued in fiscal 2004. The grant was also cut as part of the fiscal 2015 cost containment, and the annual agreement was not renewed in anticipation of the fiscal 2016 reduction.

Deficiencies

There is a general fund deficiency for fiscal 2016 of $1.5 million to pay the State share of Certificate of Need (CON) expenses for the proposed new regional medical center in Prince George's County. **The agency should comment on the reason the State is providing funding for the CON and whether the State covers a portion of the costs of other CON applications. The agency should also comment on what entity will receive the funds.**

Proposed Budget

As shown in **Exhibit 11**, after adjusting for a fiscal 2016 deficiency appropriation and a back of the bill reduction in health insurance, the fiscal 2017 allowance decreases by $2.7 million from the fiscal 2016 working appropriation, primarily due to a reduction in HIV health services and a reduction in reimbursable funds for Synar Tobacco enforcement from BHA. General funds and reimbursable funds decrease by $1.4 million (-3.2%) and $3.9 million (61%), respectively. Federal fund support increases by $0.3 million (0.1%) while special funds increase by $2.2 million (1.9%).

Exhibit 11
Proposed Budget
DHMH – Prevention and Health Promotion Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$53,261	$92,669	$183,087	$2,553	$331,570
Fiscal 2016 Working Appropriation	38,719	111,779	206,619	6,355	363,471
Fiscal 2017 Allowance	37,469	113,952	206,901	2,476	360,799
Fiscal 2016-2017 Amount Change	-$1,249	$2,174	$283	-$3,879	-$2,672
Fiscal 2016-2017 Percent Change	-3.2%	1.9%	0.1%	-61.0%	-0.7%

Where It Goes:

Personnel Expenses	
New positions (60 full-time equivalent)	$4,442
Retirement	707
Employee and retiree health insurance	686
Turnover adjustment	74
Overtime	31
Regular earning and adjustment	-115
Workers' compensation premium assessment	-117
Other fringe benefits	-11
HIV/AIDS Programs	
Housing Opportunities for Persons with AIDS	923
Infectious disease prevention and care – HIV	-240
Expiration of HIV Prevention funding (SAMHSA)	-401
HIV Health Services (federal and special funds)	-10,566
Healthiest Maryland Programs	
Healthiest Maryland local health department funding (PPHF)	3,500
Healthiest Maryland Statewide funding (PPHF)	550
Healthiest Maryland non-PPHF Funding	-240
Other Changes	
Affordable Care Act maternal infant and childcare (federal funds)	1,794
Children's medical services	616
Spinal Cord Injury Trust Fund	500
Other	-54
Women, Infants, and Children	-289
Immunization	-301

Where It Goes:	
Breast and cervical cancer early detection	-352
Reversal of deficiency for Certificate of Need for Prince George's Hospital Center System	-1,456
Synar and Tobacco Prevention	-2,354
Total	**-$2,672**

AIDS: Acquired Immunodeficiency Syndrome
HIV: Human Immunodeficiency Virus
PPHF: Prevention and Public Health Funding
SAMHSA: Substance Abuse and Mental Health Services Administration

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

Personnel Expenses

Personnel expenses for the agency increase by $5.7 million over the fiscal 2016 general fund appropriation, primarily due to an increase of 60 positions ($4.4 million). Of the 60 positions, 58 were originally funded through a contract with the Maryland Institute for Policy Analysis and Research (MIPAR). These positions are federally funded, and by insourcing these positions, DHMH can recover indirect costs instead of MIPAR, estimated at $0.8 million in fiscal 2017.

Exhibit 12 shows the fiscal 2016 costs of the employees (contracted through MIPAR) at $3.4 million. The fiscal 2017 cost for the employees' increases to $4.2 million, however, the State now receives $0.8 million of federal indirect cost revenues associated with employing those individuals. In fiscal 2016, overhead costs were included in the contract with University of Maryland. The increase in personnel costs in the PHPA budget are offset by decreases in contract expenses in 26 programs throughout PHPA, the largest of which being HIV-related programs, which received 24 employees who were currently employed through the contract with MIPAR.

Exhibit 12
Cost of Insourcing MIPAR Employees
Fiscal 2016-2017

	Total 2016 Costs	2017 Costs	Difference
MIPAR Employees (FF)	$3,415,475.00	$4,150,211.45	$734,736.45
GF Savings from Indirect Cost Recoveries			-$783,785.22

FF: federal funds
GF: general funds
MIPAR: Maryland Institute for Policy Analysis and Research

Source: Department of Legislative Services

The last time DHMH insourced jobs from MIPAR, 2005 legislation was enacted to ensure MIPAR employees were placed in a comparable classification in the State Personnel Management System without going through the hiring process and received a salary level comparable to the salary under MIPAR. Similar legislation will need to be introduced during the 2016 session to accomplish the same thing.

An additional 2 positions were added for Synar tobacco enforcement to aid in retailer compliance. Outside of the new positions, major personnel changes are increases of $686,000 for employee and retiree health insurance and $707,000 for employee retirement.

HIV Programs

Funds for HIV programs decrease by $11.1 million. Of this amount, $400,000 is due to the expiration of HIV prevention and Substance Abuse and Mental Health Services Administration funding. The remaining $10.7 million reflects a reduction in expenditures for Ryan White Part B covered services. The fiscal 2016 budget reflected additional funding for HIV programs following the enactment of Chapter 384 of 2015, which became effective July 1, 2015. Chapter 384 expanded the authorized use of pharmaceutical rebates to include all Ryan White Part B covered services including outreach services and medical transportations. Ryan White Part B funding is required to be the payer of last resort; if another payer can be identified for services, then that payer must be billed. As a greater proportion of individuals are served within the Medicaid program or private insurance due to the full implementation of federal health care reform, the agency realized that it could not achieve the level of expenditures originally envisioned in fiscal 2016 and, therefore, revised down estimated expenditures for fiscal 2017.

An increase in funding for Housing Opportunities for People with AIDS (HOPWA) partially offsets the decrease by adding $920,000 to the budget in fiscal 2017. The agency is implementing a spending plan to reduce previously unexpended HOPWA funds and to ensure greater access to housing for persons with HIV by providing 3 housing case managers to serve clients in the Western Region and St. Mary's County. This funding will provide:

- tenant-based rental assistance to 39 households;
- short-term rent, mortgage and utility assistance to 102 households; and
- permanent housing placement assistance to 44 households.

Rebate dollars can be used to provide assistance once all of the spend-down funds have been exhausted. Funding for infectious disease prevention, care planning, and quality improvement falls by $240,000 in the fiscal 2017 budget. The decrease reflects a reduction for services related to quality improvement activities that are required for Ryan White funded HIV health services.

Prevention and Public Health Funding

The Affordable Care Act established the Prevention and Public Health Fund (PPHF) to provide national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. The budget increases by $3.5 million in federal funds for Healthiest Maryland local health department funding using the PPHF and $550,000 in federal funds for Healthiest Maryland statewide funding. This funding includes:

- $1.6 million for Heart Disease and Stroke Prevention (HDSP) funding to local health departments and $116,000 for statewide HDSP initiatives;
- $1.6 million for diabetes initiative funding to local health departments and $252,000 for statewide diabetes funding;
- $182,000 for funding statewide Nutrition Physical Activity and Obesity initiatives; and
- $309,000 for school health funding to local health departments.

The grant funding for HDSP and diabetes supports local health departments in nine identified counties – Allegany, Caroline, Dorchester, Garrett, Somerset, Washington, Worcester, Wicomico and Baltimore City – to implement evidence-based chronic disease strategies targeting disparate populations and maintain the infrastructure and partnerships to implement the CDC State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke grant in their community. The grant funding for school health includes initiatives (such as increasing access to healthy foods and beverages) aimed to reduce gaps in health status by focusing efforts on specific population subgroups disproportionately affected by chronic disease. The fiscal allowance included a $240,000 decrease in funding for non-PPHF funded Healthiest Maryland programs.

Synar Enforcement and Tobacco Prevention

Due to noncompliance, the State was required to enhance funding for Synar enforcement and tobacco prevention in fiscal 2015 and 2016 or risk losing additional federal substance abuse prevention and treatment block grant funding. PHPA received $4 million in reimbursable funds from BHA for enforcement activities in fiscal 2016. The noncompliance rate improved, and the State received no penalty in fiscal 2016. The allowance includes $2 million in special funds for the continuation of enforcement activities to reduce the risk of a penalty in the future. However, PHPA is no longer receiving funds from BHA, and overall spending declines by $2 million. Funding for the tobacco use and prevention program falls by $370,000 in federal funds. This reflects a reduction in contract funding for smoking cessation program awareness.

Maternal, Infant, and Early Childhood Home Visiting Programs

Maternal, Infant, and Early Childhood Home Visiting programs increase by $1.8 million in federal funds in the fiscal 2017 allowance. This is primarily due to an increase in funding awarded to

the University of Maryland to evaluate program managers and home visitors to improve coordination practices, $849,000. The funding to the University of Maryland Baltimore County Training Institute also increased by $522,000 to support the development of a Home Visiting Certificate Program. Additional funding is also provided to fund evidenced based home visiting programs in Prince George's County, $430,000.

Other Changes

Funding for children's medical services increases the fiscal 2017 budget by $616,000 due to an increase of children financially eligible for the program and an increase in clinic exams and hospitalizations for this population. Funding for the Special Supplemental Food and Nutrition Program falls in the budget by $300,000, reflecting a reduction in the average monthly food package from $66.42 to $64.10 and an estimated 1,000 fewer participants (to 143,000). The budget decreases $300,000 for the immunization program due to lower costs for the immunization registry maintenance. There is also a $356,000 reduction in grants to local health departments for breast and cervical cancer early detection due to less utilization of the services.

The fiscal 2017 allowance include $500,000 in special funds for the Spinal Cord Injury Trust Fund. Since fiscal 2011, monies have been unavailable to convene the board and to fund grants for spinal cord research. The Budget Reconciliation and Financing Act of 2015 (Chapter 489) authorized the transfer to the General Fund, on or before June 30, 2016, of $500,000 from the Spinal Cord Injury Research Trust Fund. **DLS recommends DHMH comment on plans for spending from the fund.**

Supplemental Funding for Prince George's Regional Medical Center

Not included in Exhibit 6 is $15 million of general funds included by the Governor in supplemental budget number one to provide an operating grant in fiscal 2017 to the Board of Directors of UMMS to assist in the transition to a new Prince George's County Regional Medical System. Intent language also commits the State to an additional $15 million to be provided in 2018 and 2019 and $5 million to be provided in fiscal 2020 and 2021 for a total of $55 million.

In accordance with a Memorandum of Understanding (MOU) between the State, Prince George's County, and Dimensions Health Corporation, in 2008, a financial commitment of $150 million in operating funds was to be provided over five years, split equally between each party and $24 million in State capital funding over three years. The MOU was updated in calendar 2011 to include UMMS and the University of Maryland. This support was on top of other spending provided since fiscal 2013. **Exhibit 13** details the recent financial support. A more detailed discussion on the new regional medical system will be included in the capital budget analysis.

Exhibit 13
Operating and Capital Support Provided to Prince George's Hospital System
Fiscal 2009-2016
($ in Millions)

	2009	2010	2011	2012	2013	2014	2015	2016	Total
State									
Operating Subsidy	$12	$12	$15	$15	$15	$15	$15	-	$99
General Obligation Bonds	-	-	-	4	10	30	15	30	89
Prince George's County									
Operating Subsidy	12	12	15	15	15	15	15	15	114
Total	**$24**	**$24**	**$30**	**$34**	**$40**	**$60**	**$45**	**$45**	**$302**

Note: This exhibit does not capture the operating and capital support provided by the State to the Prince George's Hospital System prior to the 2008 Memorandum of Understanding. Between fiscal 2002 and 2007, $15.8 million and $13.0 million were provided to the hospital system in operating and capital funding, respectively.

Source: Department of Legislative Services

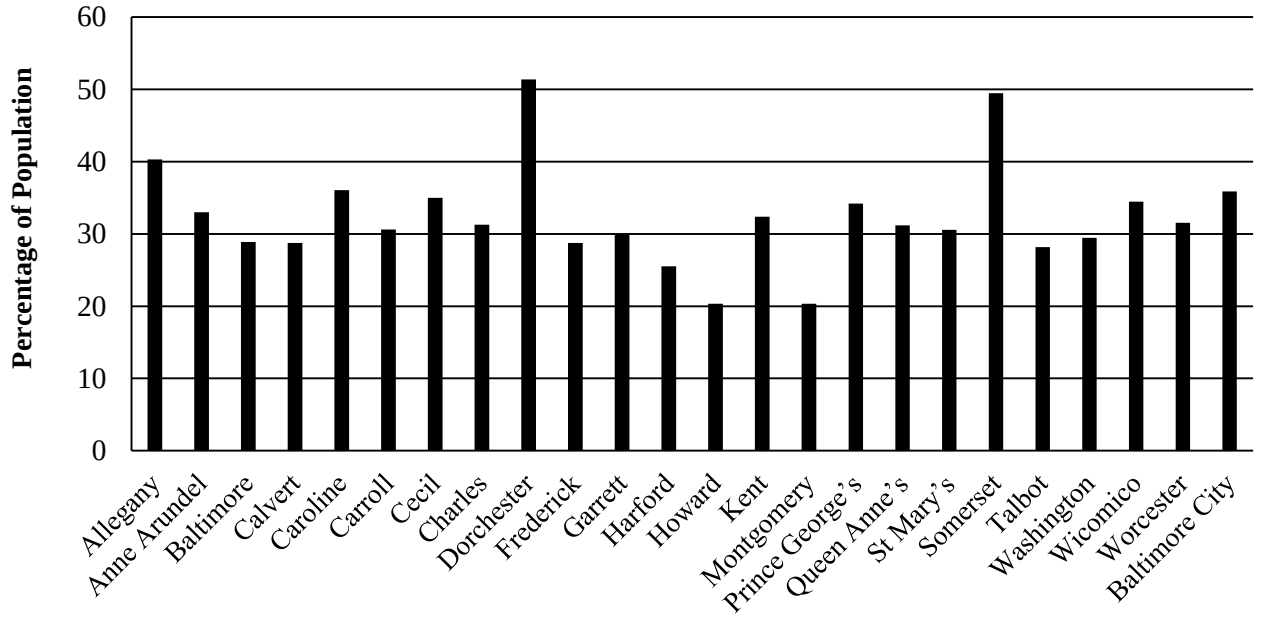
Issues

1. Increasing Prevalence of Diabetes and Obesity

In calendar 2013, 35% of Marylanders were considered to have a healthy weight (a body mass index (BMI) equal or less than 24.9). This percentage has continued to decrease, while the percent of Marylanders considered overweight or obese (a BMI greater than or equal to 25) has increased to 65% of the population. Of the 65% overweight or obese, 35% are considered overweight (BMI 25.0 to 29.9), and 30% are considered obese (BMI 30.00 and above).

Obesity increases risk of chronic diseases such as diabetes, hypertension, high blood cholesterol, coronary heart disease, stroke, arthritis, and some cancers (breast, colorectal, endometrial, and kidney). From calendar 1995 to 1997, only 1 of 24 Maryland jurisdictions had a prevalence of obesity greater than 25.0%, but by calendar 2014, this increased to 22 jurisdictions, shown in **Exhibit 14**. No Maryland jurisdiction has reached the Healthy People 2010 target for adult obesity prevalence less than 15.0%. The prevalence varies largely across jurisdictions with the highest obesity rates of 51.4% and 49.5% in Dorchester and Somerset counties.

Exhibit 14
Percentage of Population with BMI 30 and Above by County
Calendar 2014

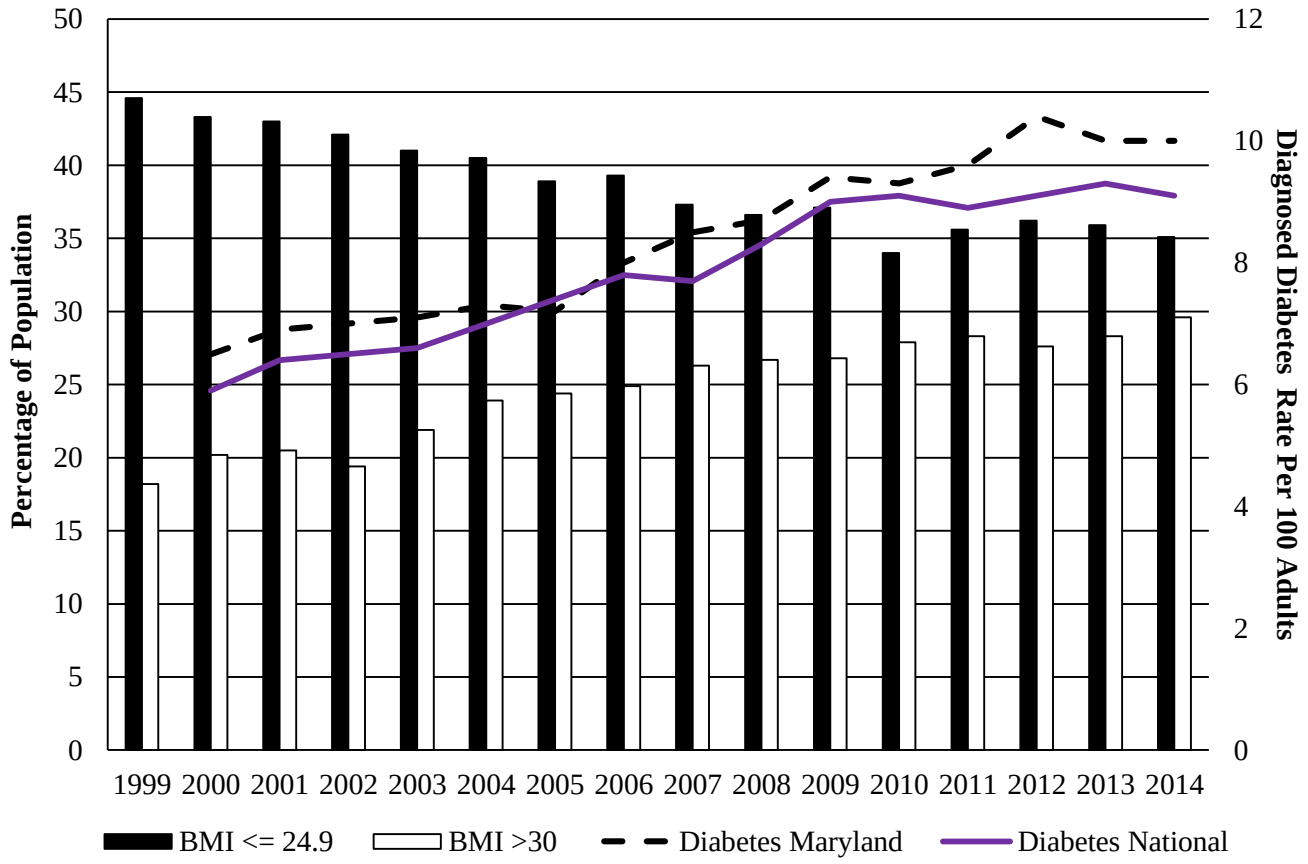


BMI: body mass index

Source: Department of Health and Mental Hygiene

The prevalence of diabetic adults in Maryland has also grown, from 6.8% in calendar 1999 to 10.0% in calendar 2014, and is above the national level, as shown in **Exhibit 15**. As with obesity, the prevalence follows a similar variation across jurisdictions with Dorchester County having the highest prevalence at 19.8%. Among the Maryland diabetic population, comorbidities such as high blood pressure, high cholesterol, obesity, and smoking increase mortality, complications, hospitalization, and cost of treatment. In calendar 2014, individuals with diabetes were more likely to have a stroke (10.3%) or a heart attack (11.0%) compared to individuals without diabetes (2.3 % and 3.0%, respectively).

Exhibit 15
Percentage of Population Considered a Healthy Weight or Obese
Calendar 1999-2014



BMI: body mass index

Source: Department of Health and Mental Hygiene; Center for Disease Control and Prevention

Economic Cost of Diabetes in Maryland

According to a report prepared by DHMH entitled, *Summary: Burden of Diabetes in Maryland*, the annual age-adjusted hospital discharge rates for diabetics between calendar 2004 to 2008 increased from 222.0 per 10,000 to 268.3. The annual total hospital charges for diabetic Marylanders during that same time increased by $45 million. In calendar 2008, the amount of hospital expenses on patients with diabetes as a comorbidity was $1.7 billion, which represents almost a quarter of the total hospital charges ($7.9 billion). The total cost of diabetes in Maryland was estimated to be $5.1 billion in 2012 (medical and indirect).

Although diabetes is widely associated with old age, the older working age population (ages 50 to 64) represents the fastest growing diabetic group in Maryland. Additionally, in calendar 2014, 10.5% of the adult population, excluding those with diabetes, had pre-diabetes, an elevated blood sugar level, which greatly raises their risk of developing Type 2 diabetes. Without proper prevention and management these individuals may add to the State's increasing diabetic population.

Current Funding for Chronic Diseases

The State's current dedicated funding for diabetes includes $100,000 in general funds for diabetes evidenced-based programming, in addition to $500,000 in general funds to fund 3 positions in the Chronic Disease Control program. In addition to the $600,000 in general funds, the agency received PPHF funding as discussed above to aid local health departments in 9 counties. An additional $1.3 million in non-PPHF federal funding is used to control and manage chronic diseases. This funding includes aid to local health departments in all counties, including the 15 that do not receive funding from PPHF. In total, the fiscal 2017 budget includes $5.9 million in federal funds and $600,000 in general funds for diabetes and other chronic illness related programs.

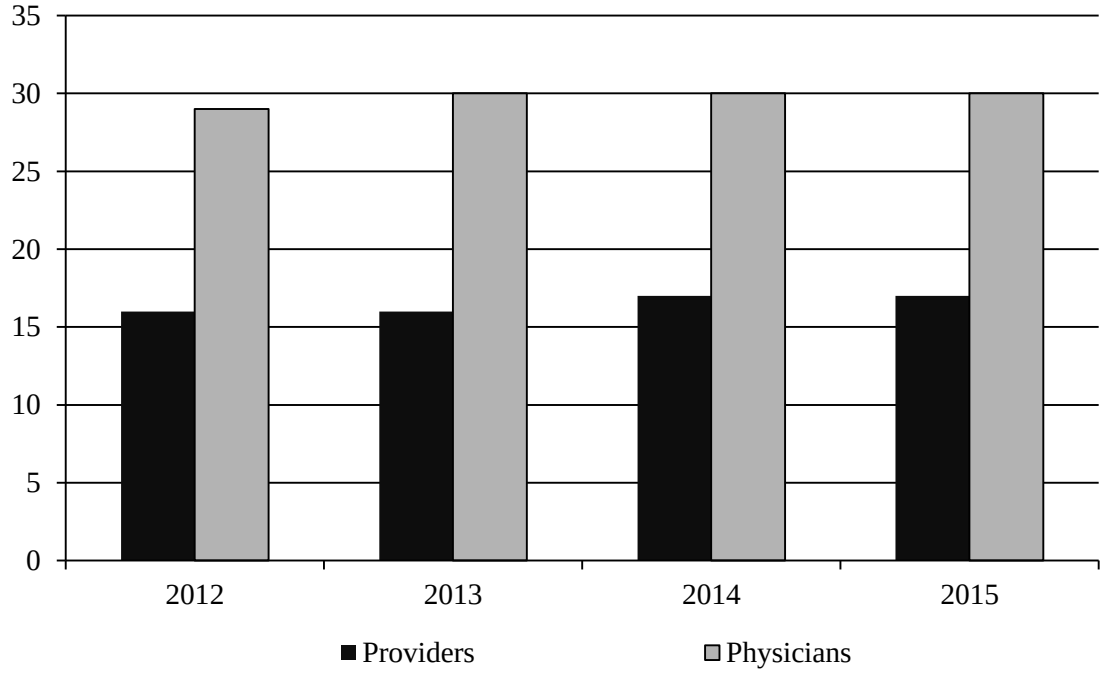
Although the fiscal 2017 allowance includes $5.9 million in federal funds, this may not be a long-term funding source for what is a chronic public health problem. In the long term, the agency may need to identify dedicated sustainable funding streams to address both obesity and diabetes**. DLS recommends narrative to request a response including a detailed analysis of the agency's current initiatives for addressing obesity and diabetes statewide and by county, and identification of potential long-term dedicated funding streams for programs aimed at reducing diabetes and obesity.**

2. Underutilization of Providers Accepting Practice Obligations

The Office of Population Health Improvement 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. The 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 the 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 16**, in fiscal 2015, the number of health care providers and physicians accepting a practice obligation in Maryland remained static, although that number had been predicted to increase slightly. (As of September 2012, providers include nurse practitioners, physician assistants, dentists, and social workers.)

Exhibit 16
Health Care Providers and Physicians Accepting a Practice Obligation
Fiscal 2012-2015



Source: Department of Health and Mental Hygiene

In addition to remaining static, the SLRP is underutilized with more money available than is being used. Demand for loan repayment assistance may be limited due to other outside incentives that might offer more appeal to potential recipients: for example, income driven loan repayment plans, which are pegged to a low percentage of salary, allow loan forgiveness after 10 years of payment while working for government or nonprofit entities.

The SLRP is intended to address the shortage of health professionals in designated areas; however, physicians accepting a practice obligation have to serve only a minimum of two years. The take-up rate is also higher for physicians practicing in urban areas, such as Baltimore City, rather than rural areas which may have a far greater physician shortage. In fiscal 2010, Garrett, Queen Anne's, and Worcester counties had 100% of their populations residing in a primary care health professional shortage area (HPSA). Although Baltimore City had 18 of the State's 47 HSPA designations, these designations encompassed only about 29% of the city's population.

In fiscal 2010, Maryland had 41 dental HPSAs, covering nearly 625,000 people and 44 mental health HPSAs covering more than one million residents, or 18% of the State's population. Jurisdictions with 100% of their populations residing in a mental health HPSA included Calvert, Caroline, Cecil, Charles, Dorchester, Garrett, Kent, Queen Anne's, Somerset, Wicomico, and Worcester counties. The Office of Primary Care within PHPA conducts the Primary Care Needs Assessment. This assessment reports on health care access throughout Maryland in addition to summarizing federal shortage designations, which include HPSA and medically underserved areas. The last assessment was conducted in fiscal 2010 and the next assessment is currently underway. **Given the underutilization of the practice obligations and the percentage of the population living in HPSAs, the agency should comment on workforce programs to recruit and retain physicians in underserved areas, including financial incentives for physicians.**

Recommended Actions

1. Adopt the following narrative:

   Diabetes and Obesity Initiatives and Funding: The committees are interested in efforts to reduce the growing problem of obesity in Maryland. The Department of Health and Mental Hygiene (DHMH) is requested to provide a detailed analysis of the agency's (1) current initiatives for addressing obesity and diabetes statewide and by county; (2) spending by county on initiatives addressing obesity and diabetes; and (3) identification of potential long-term dedicated funding streams for programs aimed at reducing diabetes and obesity.

Information Request	**Author**	**Due Date**
Report on diabetes and obesity initiatives and funding	DHMH	November 1, 2016

Updates

1. Fee Reduction Fiscal Impact

On September 15, 2015, the Governor announced a plan to reduce a number of fees across State government. A number of fee reductions in PHPA were part of that plan, including:

- food manufacturing plants (bakery, cannery, confectionary, crab meat, ice, bottled water, soft drink, frozen food);
- shellfish shipping or reshipping plant (license);
- shellfish shucking, packing, or repacking plant (license);
- food warehouse/distribution center that distributes potentially hazardous food (license); and
- food warehouse/distribution center that distributes only nonpotentially hazardous food (license).

Exhibit 17 shows the current and proposed fees and the estimated general fund revenue loss for each fee. In total, the regulated fee reductions would reduce general fund revenue by $152,500 annually. However, as the legislation will likely be effective for only the second half of fiscal 2016, the general fund revenues decrease by approximately $76,250 in fiscal 2016 and $152,500 in fiscal 2017 and annually thereafter. Costs associated with annual food processing plant licensing are general funded, and the collected fees accrue to the General Fund. Thus, the revenue reductions have no direct programmatic impact.

Exhibit 17

General Fund Revenue Reductions Related to Proposed Changes to Annual License Fees in COMAR 10.01.017.02

Fee Type	Current Fee	Proposed Fee	Revenue Reduction
Food Processing Plants			
Bakery	$400	$150	*
Cannery	400	150	*
Confectionary	400	150	*
Crab Meat	400	150	*
Ice Manufacturing	400	150	*
Food Manufacturing	400	150	*
Bottled Water	400	150	*
Soft Drink Manufacturing	400	150	*
Frozen Food Manufacturing	400	150	*
Subtotal			***$81,000***
Shellfish Plants			
Shucking, Packing, or Repacking	400	150	9,000
Shipping or Reshipping	200	150	3,800
Subtotal			***$12,800***
Food Warehouse/Distribution Centers that			
Distribute Potentially Hazardous Food	400	150	49,000
Distribute Nonpotentially Hazardous Food	200	150	9,700
Subtotal			***$58,700***
Total			**$152,500**

COMAR: *Code of Maryland Regulations*

*unknown.

Source: Department of Legislative Services

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Prevention and Health Promotion Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$53,997	$83,715	$216,886	$2,392	$356,989
Deficiency Appropriation	0	0	0	0	0
Cost Containment	-1,059	-7,450	0	0	-8,509
Budget Amendments	323	19,705	-7,046	162	13,144
Reversions and Cancellations	0	-3,301	-26,753	0	-30,054
Actual Expenditures	**$53,261**	**$92,669**	**$183,087**	**$2,553**	**$331,570**
Fiscal 2016					
Legislative Appropriation	$35,903	$91,017	$205,562	$2,495	$334,977
Budget Amendments	1,359	20,762	1,057	3,860	27,038
Working	**$37,262**	**$111,779**	**$206,619**	**$6,355**	**$362,014**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding

Fiscal 2015

The budget for PHPA closed at $331.6 million, $25.4 million below the original legislative appropriation. Cost containment actions reduced general and special funds by $1,059,000 and $7,450,000, respectively. A Board of Public Work's action taken in January 2015 reduced cancer research grants to academic health centers (funded with CRF dollars) to fiscal 2013 levels and substituted those special funds for general funds in Medicaid. The general fund reduction included an elimination of State support for the Cord Blood Transplant Program ($100,000), elimination of a grant to UMMS for the Montebello Rehabilitation Center at Kernan Hospital for annual debt service on revenue bonds (442,799), $125,000 for savings from level funding medical day care programs to fiscal 2014 levels, hiring freeze savings of $146,978, and administrative efficiency reductions of $244,600.

Budget amendments increased the budget by $13.1 million, primarily in special funds. A budget amendment to reflect the fiscal 2015 cost-of-living adjustment increased general funds by $116,868, federal funds by $146,849, and special funds by $13,772. Federal funds increased by $432,768 and general funds increased by $192,064 to cover the cost of the Behavioral Risk Factor Surveillance System, transferred from Executive Direction under the Public Health Administration. General funds increased $23,700 to cover the cost of Synar activities. Special funds increased $19,691,364 (available from MADAP rebates) to cover the cost of providing HIV formulary pharmaceuticals to eligible individuals.

These increases were offset by reductions of $7.6 million in federal funds to reflect reduced expenditures in the Women, Infants, and Children (WIC) program. General funds were reduced by $9,039 to realign health insurance costs within DHMH.

At the end of fiscal 2015, approximately $27.0 million of the agency's federal fund appropriation was cancelled due to lower than anticipated participation in the WIC ($6.8 million) and MADAP programs ($20.1 million). Special funds of $3.3 million were cancelled made up primarily of MADAP rebates ($2.8 million). In the Maryland Cancer Fund administered by PHPA, $203,802 of the special funds were cancelled. Grants from the fund are given for periods spanning several fiscal years. Since funding is dependent on State income tax check-off participation, which may vary from year to year, it is beneficial for some special funds to be carried over from one year to the next. The additional $282,000 in special funds were cancelled from CRF programs: cancer administration ($101,802), statewide public health ($150,141), and surveillance ($30,352).

Fiscal 2016

To date, the fiscal 2016 legislative appropriation for PHPA has been increased by $27 million through budget amendments. Federal funds increased by $286,538, general funds increased by $235,056, and special funds increased by $24,639 to reflect the restoration of the 2% pay reduction. A full-time equivalents (FTE) transfer from the Office of Population Health Improvement into Infectious Disease and Environmental Health Services (1 FTE) along with the transfer of funds for the Office of Primary Care Services (2 FTEs) and Office of Rural Health (1 FTE) from the Office of Population

Health Improvement into Family Health and Chronic Disease services increased federal funds by $770,040 and general funds by $695,127. Special funds increased by $20.7 million to cover the cost of medicine, drugs, and chemicals for MADAP. General funds increased by $303,908 to realign the 2% cost containment with the agency's cost containment plan and an additional $125,000 to provide support for children's medical day care services to reflect legislative priorities. Reimbursable funds increase by $3.9 million to reflect funds from BHA for Synar Tobacco Enforcement.

Appendix 2

Audit Findings

Audit Period for Last Audit:	July 1, 2012 – October 27, 2013
Issue Date:	March 2015
Number of Findings:	5
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: PHPA did not use available resources to verify applicant income and to identify possible third-party insurance for certain programs.

Finding 2: PHPA did not always consider critical information when redetermining applicant eligibility for one program.

Finding 3: Access to systems used to maintain critical information and process related claims for certain programs was not adequately restricted.

Finding 4: PHPA did not always obtain certain necessary documents to establish provider eligibility and did not conduct periodic eligibility reassessments.

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

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

Object/Fund Difference Report
DHMH – Prevention and Health Promotion Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	362.80	366.80	426.80	60.00	16.4%
02 Contractual	3.96	6.11	6.12	0.01	0.2%
Total Positions	**366.76**	**372.91**	**432.92**	**60.01**	**16.1%**
Objects					
01 Salaries and Wages	$ 31,412,315	$ 33,549,297	$ 39,364,090	$ 5,814,793	17.3%
02 Technical and Spec. Fees	204,110	302,122	303,866	1,744	0.6%
03 Communication	626,183	713,420	787,509	74,089	10.4%
04 Travel	547,590	606,601	631,369	24,768	4.1%
07 Motor Vehicles	129,894	123,203	122,767	-436	-0.4%
08 Contractual Services	221,983,533	254,995,674	240,248,354	-14,747,320	-5.8%
09 Supplies and Materials	40,623,484	41,722,261	45,546,175	3,823,914	9.2%
10 Equipment – Replacement	106,566	0	0	0	0.0%
11 Equipment – Additional	402,420	530,781	358,972	-171,809	-32.4%
12 Grants, Subsidies, and Contributions	35,349,056	29,074,352	33,423,069	4,348,717	15.0%
13 Fixed Charges	184,962	396,675	131,121	-265,554	-66.9%
Total Objects	**$ 331,570,113**	**$ 362,014,386**	**$ 360,917,292**	**-$ 1,097,094**	**-0.3%**
Funds					
01 General Fund	$ 53,260,656	$ 37,262,310	$ 37,509,572	$ 247,262	0.7%
03 Special Fund	92,669,367	111,778,550	113,957,938	2,179,388	1.9%
05 Federal Fund	183,086,902	206,618,535	206,973,579	355,044	0.2%
09 Reimbursable Fund	2,553,188	6,354,991	2,476,203	-3,878,788	-61.0%
Total Funds	**$ 331,570,113**	**$ 362,014,386**	**$ 360,917,292**	**-$ 1,097,094**	**-0.3%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Prevention and Health Promotion Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Administrative, Policy, and Management Systems	$ 113,187,970	$ 141,615,843	$ 134,164,914	-$ 7,450,929	-5.3%
04 Famly Health and Chronic Disease Services	218,382,143	220,398,543	226,752,378	6,353,835	2.9%
Total Expenditures	**$ 331,570,113**	**$ 362,014,386**	**$ 360,917,292**	**-$ 1,097,094**	**-0.3%**
General Fund	$ 53,260,656	$ 37,262,310	$ 37,509,572	$ 247,262	0.7%
Special Fund	92,669,367	111,778,550	113,957,938	2,179,388	1.9%
Federal Fund	183,086,902	206,618,535	206,973,579	355,044	0.2%
Total Appropriations	**$ 329,016,925**	**$ 355,659,395**	**$ 358,441,089**	**$ 2,781,694**	**0.8%**
Reimbursable Fund	$ 2,553,188	$ 6,354,991	$ 2,476,203	-$ 3,878,788	-61.0%
Total Funds	**$ 331,570,113**	**$ 362,014,386**	**$ 360,917,292**	**-$ 1,097,094**	**-0.3%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.