M00F
Public Health Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 16 Actual	FY 17 Working	FY 18 Allowance	FY 17-18 Change	% Change Prior Year
General Fund	$101,399	$105,201	$107,066	$1,865	1.8%
Adjustments	0	402	-847	-1,249	
Adjusted General Fund	**$101,399**	**$105,602**	**$106,219**	**$616**	**0.6%**
Special Fund	6,405	7,475	7,498	23	0.3%
Adjustments	0	0	-9	-9	
Adjusted Special Fund	**$6,405**	**$7,475**	**$7,489**	**$14**	**0.2%**
Federal Fund	31,798	26,576	27,169	593	2.2%
Adjustments	0	0	-18	-18	
Adjusted Federal Fund	**$31,798**	**$26,576**	**$27,151**	**$575**	**2.2%**
Reimbursable Fund	679	811	713	-98	-12.1%
Adjusted Reimbursable Fund	**$679**	**$811**	**$713**	**-$98**	**-12.1%**
Adjusted Grand Total	**$140,281**	**$140,464**	**$141,571**	**$1,107**	**0.8%**

Note: Includes targeted reversions, deficiencies, and contingent reductions.

- There is one deficiency for fiscal 2017 of $401,416 for salaries at the Office of the Chief Medical Examiner.

- The fiscal 2018 allowance is adjusted for a contingent reduction of $747,000 to level fund the core public health funding to local health departments and a $127,000 reduction related to a supplemental pension contribution.

- After adjusting for deficiencies, across-the-board reductions, and contingent reductions the fiscal 2018 allowance increases by $1.1 million (0.8%), primarily due to the transfer of a program from the Prevention and Health Promotion Administration.

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

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Personnel Data

	FY 16 Actual	FY 17 Working	FY 18 Allowance	FY 17-18 Change
Regular Positions	399.90	388.90	391.90	3.00
Contractual FTEs	15.78	17.30	21.30	4.00
Total Personnel	**415.68**	**406.20**	**413.20**	**7.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	25.04	6.68%
Positions and Percentage Vacant as of 12/31/16	37.40	9.62%

- The fiscal 2018 allowance includes an increase of 3.0 regular full-time equivalents (FTE) from the fiscal 2017 working appropriation and 4.0 more contractual FTEs. All regular FTEs were transferred from other agencies within the Department of Health and Mental Hygiene, 2.0 from the Prevention and Health Promotion Administration and 1.0 from the Regulatory Commissions. Of the 4.0 contractual FTEs, 3.0 were added to the Office of Controlled Substances Administration and 1.0 was added to the Vital Statistics Administration related to the electronic death system.

- As of December 31, 2016, there were 37.4 vacant positions, more than enough to meet budgeted turnover.

Analysis in Brief

Major Trends

Division of Vital Records: The Division of Vital Records has a goal to file 97% of birth certificates within five days of the birth date and 65% of death certificates within 72 hours of death. In fiscal 2016, the agency met its goal with respect to birth certificates. The agency estimated it fell short of its goal with respect to death certificates as it transitioned to the new electronic death registration system.

Office of the Chief Medical Examiner – Ratio of Cases Per Examiner: The ratio of autopsies to medical examiners increased in fiscal 2016 and is estimated to increase again in fiscal 2017. The agency completed 76% of autopsy reports within 60 days in 2016, an increase from 2015, yet still fell short of its goal (90%). To assist with recruitment and retention of medical examiners, the agency received a deficiency appropriation of $400,000 in fiscal 2017 to upgrade salaries and funds for reclassifications in fiscal 2018.

Office of Controlled Substances Administration – Increase of Nonpharmacy Inspections: The Office of Controlled Substances has decreased the number of routine pharmacy inspections and has increased the number of total inspections with the growth in controlled dangerous substances inspections of dispensing practitioners.

Office of Population Health Improvement – Number of Local Health Departments with Accreditation Increases: There is currently no required national accreditation for local health departments (LHD). However, LHDs have been encouraged to apply for the voluntary national accreditation. Although the process requires a financial commitment, as of December 2016, 6 LHDs are now accredited with 11 others going through the process.

Issues

Maryland Comprehensive Primary Care Model: In 2014, the Center for Medicare and Medicaid Services approved the new All-payer Model Contract, under which all health care payers pay the same rate for inpatient and outpatient hospital services. While the All-payer Model Contract has achieved savings in hospital care, the total cost of care (TCOC) growth rate for Maryland's Medicare population was higher than the rest of the nation in calendar 2015. In order for hospitals to achieve alignment with nonhospital providers of care so as to accomplish a reduction in TCOC, Maryland has proposed a Comprehensive Primary Care Redesign as part of Phase II of the waiver.

Recommended Actions

1. Concur with Governor's allowance.

M00F
Public Health Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Department of Health and Mental Hygiene's (DHMH) Public Health Administration (PHA) budget analysis includes the following offices within the department:

- Deputy Secretary for Public Health Services;
- Office of Population Health Improvement;
- Office of the Chief Medical Examiner;
- Office of Preparedness and Response; and
- Laboratories Administration.

The **Deputy Secretary for Public Health Services** is responsible for policy formulation and program implementation affecting the health of Maryland's citizens through the actions and interventions of various public health administrations and offices within the department. The Deputy Secretary for Public Health Services' mission is to improve the health status of individuals, families, and communities through prevention, early intervention, surveillance, and treatment.

The **Office of Population Health Improvement** (OPHI) 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. OPHI 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; and seeking public health accreditation of State and local health departments (LHD).

The mission of the **Office of the Chief Medical Examiner** (OCME) is to:

- provide competent, professional, thorough, and objective death investigations in cases mandated in Maryland statute that assist the State's Attorneys, courts, law enforcement agencies, and families;

- strengthen partnerships between federal, State, and local governments through training and education of health, legal, and law enforcement professionals;

- support research programs directed at increasing knowledge of pathology of disease; and

- protect and promote the health of the public by assisting in the development of programs to prevent injury and death.

The **Office of Preparedness and Response** (OPR) oversees programs focused on enhancing the public health preparedness activities for the State and local jurisdictions. The key aspects of the work conducted under the leadership of OPR are interagency collaboration and preparedness for public health emergencies. The projects in OPR are federally funded through (1) the Centers for Disease Control and Prevention (CDC) Public Health Preparedness and Response for Bioterrorism Grant; (2) the CDC Cities Readiness Initiative; and (3) the Department of Health and Human Services' National Bioterrorism Hospital Preparedness Program.

The mission of the **Laboratories Administration** is to promote, protect, and preserve the health of the people of Maryland from the consequences of communicable diseases, environmental factors, and unsafe consumer products through the following measures:

- adopting scientific technology to improve the quality and reliability of laboratory practice in the areas of public health and environmental protection;

- expanding newborn hereditary disorder screening;

- maintaining laboratory emergency preparedness efforts; and

- promoting quality and reliability of laboratory data in support of public health and environmental programs.

DHMH has regional laboratories in Salisbury and Cumberland, in addition to the central laboratory in Baltimore.

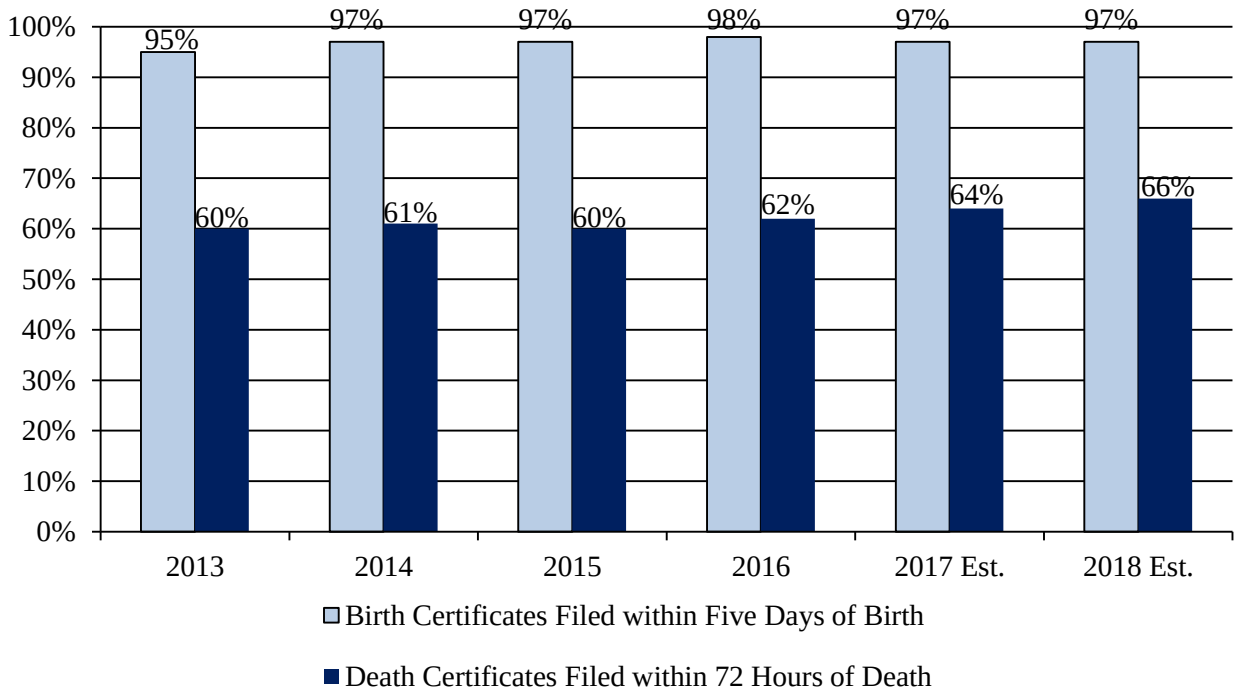
Performance Analysis: Managing for Results

1. Division of Vital Records

The Division of Vital Records has a goal to file 97% of birth certificates within five days of the birth date and 65% of death certificates within 72 hours of death. As shown in **Exhibit 1**, the percentage of birth certificates filed within five days increased to 98% in fiscal 2016, meeting the agency's goal. The percentage of death certificates filed within 72 hours increased slightly, from 60% in fiscal 2015

to 62% in fiscal 2016, but still fell short of the agency's goal (65%). The agency estimates that by fiscal 2018 it will meet the goal of 65%. The agency moved to the Electronic Vital Records System, known as EVRS, for birth records in calendar 2010.

Exhibit 1
Percentage of Birth and Death Certificates Timely Filed with the Division of Vital Records
Fiscal 2013-2018 Est.



Source: Department of Health and Mental Hygiene

2. Office of the Chief Medical Examiner – Ratio of Cases Per Examiner

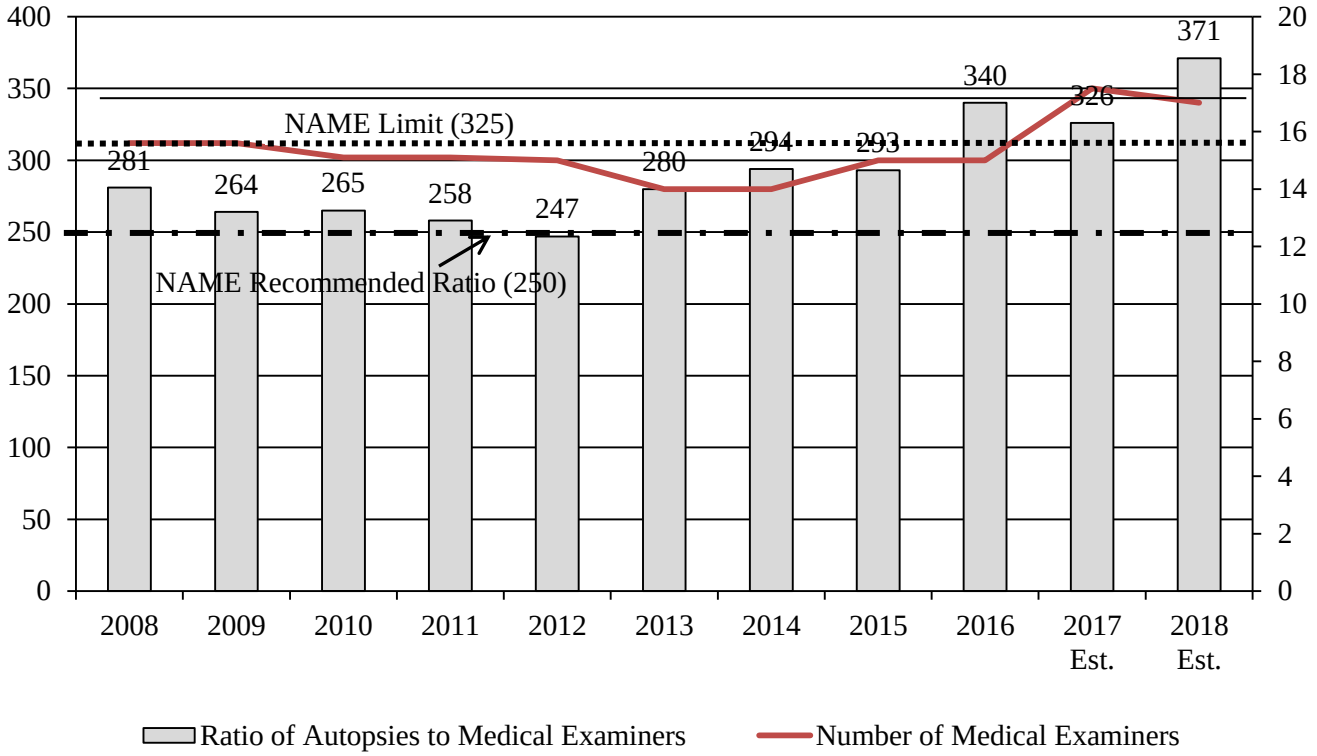
OCME is required to investigate all violent or suspicious deaths, including all deaths unattended by a physician. If the cause of death cannot be established during the initial investigation, a pathologist must perform an autopsy on the deceased.

In fiscal 2007, OCME changed reporting techniques to better reflect the caseload facing pathologists. OCME reports not only the number of autopsies performed but also the total number of cases presented for investigation. Not every death that is presented for investigation will be autopsied, but OCME reports the total number presented for investigation as it adds to the office's caseload. This

change was precipitated by a change in the allowable caseload as identified by the National Association of Medical Examiners (NAME), which now includes external examinations in the total number of allowable autopsies per examiner.

Exhibit 2 shows the caseload per examiner, as well as the NAME limit of 325 and the NAME recommended maximum of 250 cases per examiner. The number of medical examiners allocated to the office increased from 13.5 to 15.6 between fiscal 2006 and 2009, causing the ratio of cases per examiner to drop significantly. Further, the total number of investigations dropped in fiscal 2009, leading to another reduction in the ratio of cases per examiner. The ratio of cases per examiner was relatively stable from fiscal 2009 to 2011 and, due to a decline in the total deaths investigated in fiscal 2012, declined to 247 cases per medical examiner in fiscal 2012. However, the ratio of cases per examiner increased in each of the next two fiscal years, reaching 294 in fiscal 2014 (well above the NAME recommended limit). This ratio was estimated to decrease in 2015 but remained relatively constant at 293.

Exhibit 2
Cases Per Medical Examiner
Fiscal 2008-2018 Est.



NAME: National Association of Medical Examiners

Source: Department of Health and Mental Hygiene

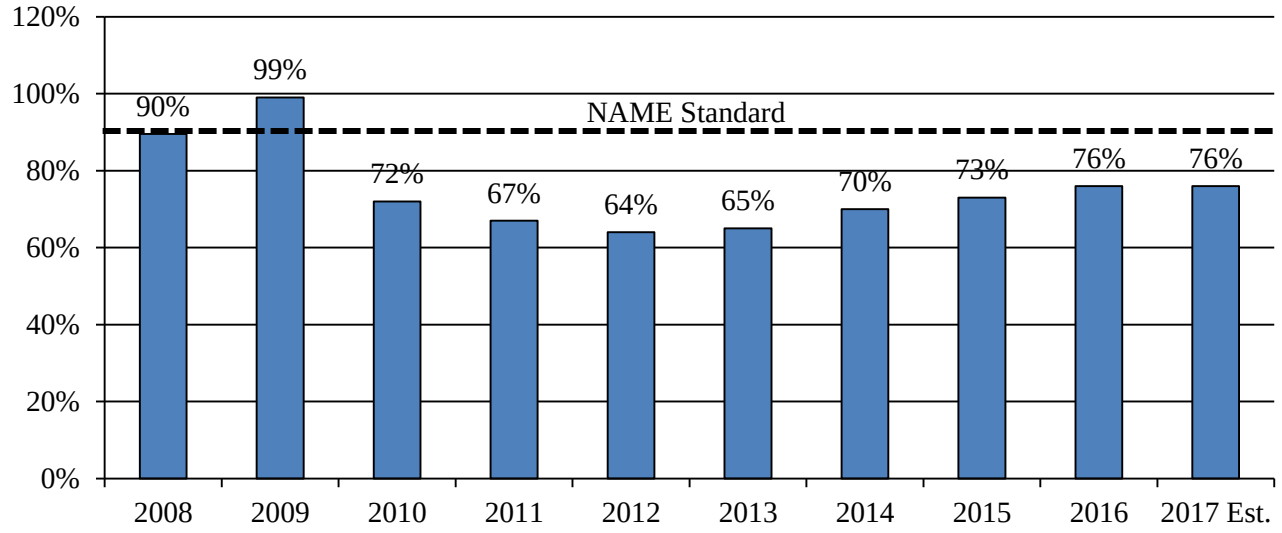
Examinations rose in fiscal 2016, increasing the estimated ratio of cases per examiner to 340. This is above both the NAME recommended ratio and the NAME limit. OCME expects caseload levels to stay above the recommended limit. Additionally, OCME advises the ratio can be misleading as some medical examiners may be examining up to 400 cases while others are focused on more time consuming cases. OCME attributes the current rising autopsy cases to an increase in homicides, drug deaths, and traffic fatalities. Drug deaths alone have accounted for over 1,000 additional deaths in fiscal 2015 and 2016 over those seen in fiscal 2014. Overdose deaths are overwhelming medical examiner offices nationally. However, in Maryland, there is also an increase in homicides, which are thought to be due to drug trafficking associated violence.

The Toxicology Laboratory at OCME has seen the workload increase due to drug deaths, which is complicated by new fentanyl analogs requiring methods of detection. The OCME toxicology laboratory is dedicated to just OCME while other states use the crime lab out of the state police department. This exclusivity has been advantageous for OCME, as the State Police Lab has a slight backlog in blood cases from serious or fatal accidents.

Exhibit 2 also shows the number of medical examiners on staff in each year. For fiscal 2017, OCME notes that it should have 24.0 medical examiners and only has 17.5. Additionally, a fellow that is being trained at OCME for the Armed Forces is being counted as 0.5 full-time equivalent (FTE) but will leave July 1, 2017. In statute, OCME is allowed 4 fellows, and they typically have 3 with 1 guest fellow. OCME may apply for more accredited fellowship slots. OCME has had difficulty recruiting due to the nationwide shortage of trained medical examiners (ME). Due to the high demand for MEs, they may choose to work at an office with a lower workload.

Another goal of OCME is to complete and forward autopsy reports to the State's Attorney's Office within 60 working days following an investigation. NAME accreditation standards specify that 90% of all cases should be completed within 60 working days, and 100% of cases should be completed in 90 working days. **Exhibit 3** shows the percent of autopsy reports completed within 60 days and forwarded to the State's Attorney's Office.

Exhibit 3
Percentage of Autopsies Reported within 60 Days
Fiscal 2008-2017 Est.



NAME: National Association of Medical Examiners

Source: Department of Health and Mental Hygiene

The office has attributed exceeding its goal of 90% of cases completed within 60 days in fiscal 2009 to having adequate secretarial staffing. However, OCME fell short of this goal in fiscal 2010. The office attributed this failure to insufficient transcription support, as OCME lost 2 office secretaries – 1 through the Voluntary Separation Program and 1 to retirement. OCME replaced 1 secretary position in fiscal 2012, but still did not meet its 90% goal. Subsequently, in fiscal 2012, only 64% of autopsy reports were completed within 60 days. In fiscal 2013, 5 new positions (including 2 secretaries) were added, and although OCME reported delays in recruitment and hiring for those positions, OCME's performance has since trended upward. Though still short of its goal, OCME completed 76% of autopsy reports in fiscal 2016 within 60 days. OCME does not estimate meeting its goal in fiscal 2017.

During a NAME inspection, facilities are judged against two standards – Phase I and Phase II. Phase I standards are not considered by NAME to be absolutely essential requirements; violations in these areas will not directly or seriously affect the quality of work or significantly endanger the welfare of the public or staff. Phase II standards are considered by NAME to be essential requirements; violations in these areas may seriously impact the quality of work and adversely affect the health and safety of the public or staff. To maintain full accreditation, an office may have no more than 15 Phase I violations and no Phase II violations. Provisional accreditation may also be awarded for a 12-month period if an office is found to have fewer than 25 Phase I violations and fewer than 5 Phase II violations. If awarded provisional accreditation, an office must address deficiencies that prevented it from achieving full accreditation.

Currently, it is a Phase I violation if 90% of all cases are not completed within 60 days of examination, and it is a Phase II violation if 90% of all cases are not completed within 90 days. OCME may have a Phase II violation as it is currently completing 84% of reports within 90 calendar days. Typically, OCME has 8 Phase I violations. In fiscal 2007, NAME dropped OCME's accreditation to provisional, which is valid for one year, due to facility violations. In fiscal 2010, OCME had a new facility. However, they were short on staff so they were provisionally accredited again until they hired more staff in fiscal 2011. OCME learned in October 2014 that it had successfully attained full NAME accreditation through May 14, 2019. However, if OCME drops to provisional accreditation in May 2017, (its next annual inspection), OCME would need to come up with a plan of action.

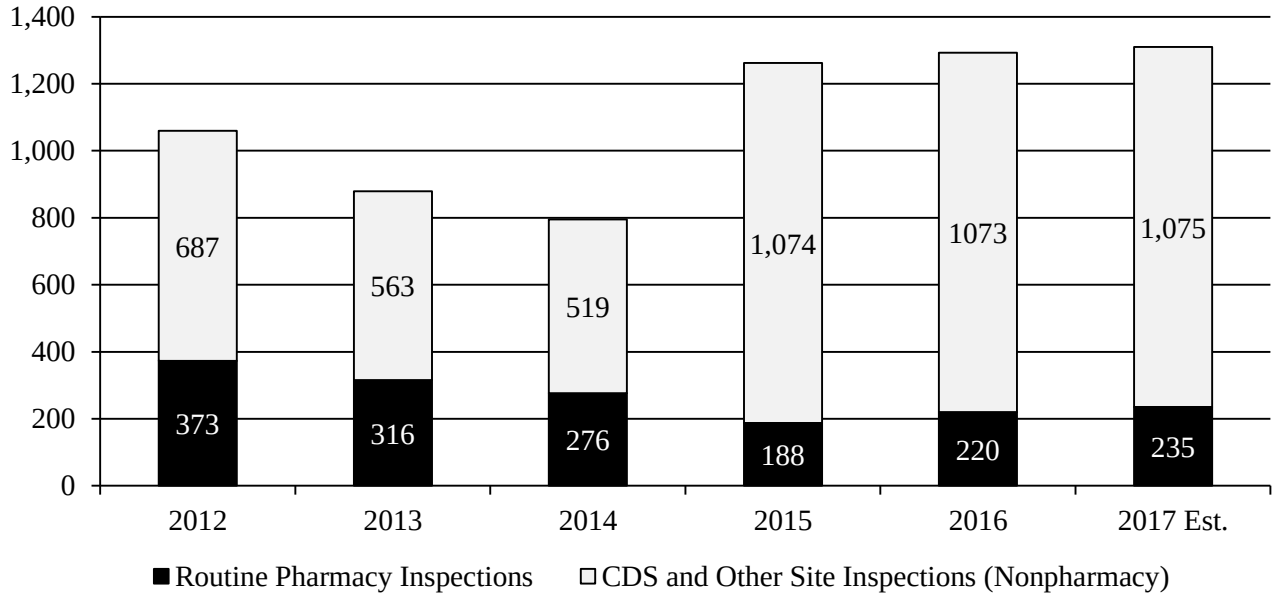
OCME advised that NAME signed a contract with the International Organization for Standardization (ISO) inspectors and will be offering ISO 17011 accreditation in addition to NAME. However, ISO does not distinguish between Phase I and Phase II violations. OCME could continue to maintain NAME accreditation and not attempt to move to ISO accreditation, or attempt both and if they fail ISO they can still maintain NAME accreditation.

3. Office of Controlled Substances Administration – Increase of Nonpharmacy Inspections

The Office of Controlled Substances Administration (OCSA) registers practitioners and establishments to legally manufacture, distribute, dispense, or otherwise handle controlled dangerous substances (CDS) in Maryland. The federal Controlled Substances Act of 1970 (CSA) authorizes federal regulation of the manufacture, importation, possession, and distribution of certain drugs. Under the CSA, various drugs are listed on Schedules I through V and generally involve drugs that have a high potential for abuse. Schedule I drugs have no acceptable medical use in the United States, and prescriptions may not be written for these substances. Morphine and amphetamines (such as Adderall) are examples of Schedule II drugs; anabolic steroids and hydrocodone are examples of Schedule III drugs; and benzodiazepines (such as Valium or Xanax) are Schedule IV drugs. Schedule V drugs include cough suppressants containing small amounts of codeine and the prescription drug Lyrica, an anticonvulsant and pain modulator.

Exhibit 4 shows the number of CDS inspections at pharmacies and nonpharmacy sites. The number of nonpharmacy inspections declined steadily from fiscal 2012 to 2014. OCSA attributes this decline to the retirements of a pharmacist inspector and a decrease in referrals from health occupation boards, the Drug Enforcement Administration, OCME, and other State and federal agencies. OCSA expected to increase the number of inspections once new staff were trained and experienced. In fiscal 2015, CDS inspections for nonpharmacy entities increased and remained stable in fiscal 2016.

Exhibit 4
Office of Controlled Substances Administration Inspections
Fiscal 2012-2017 Est.



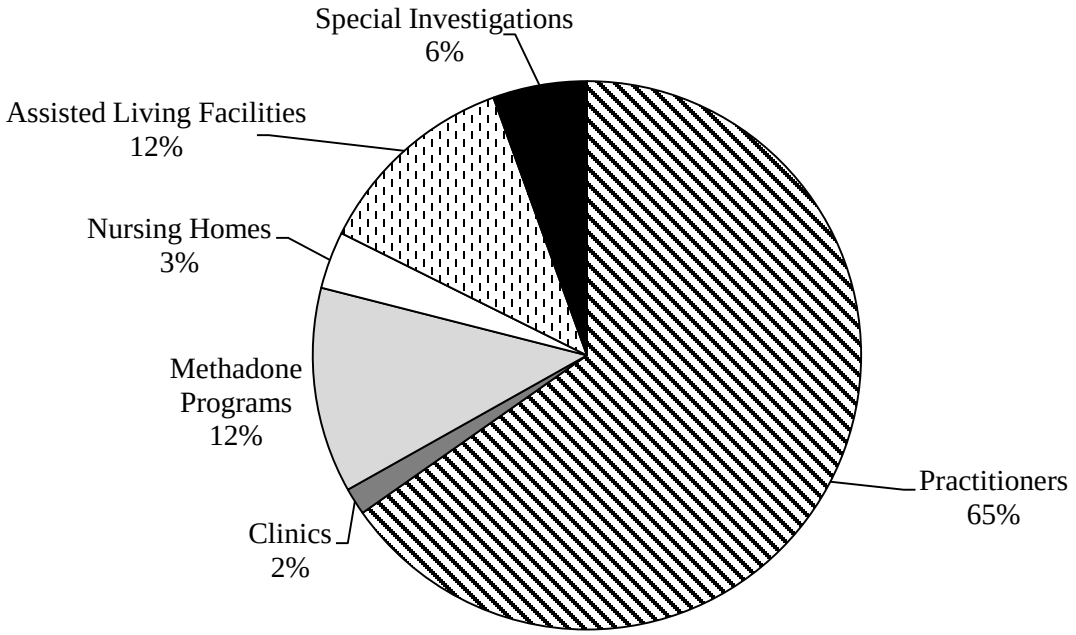
CDS: controlled dangerous substance

Note: CDS and other site inspections include special investigations.

Source: Department of Health and Mental Hygiene

According to the respective health occupations boards, approximately 1,500 CDS dispensing permits are held by nonpharmacist practitioners in Maryland. The fiscal 2014 budget included funds to implement Chapter 267 of 2012, which required OCSA to inspect the office of a dispensing practitioner at least two times within the duration of their five-year CDS permit. To meet this requirement, OCSA must inspect an average of about 500 practitioners annually. OCSA exceeded 500 practitioner inspections in fiscal 2016. **Exhibit 5** shows that practitioners (physicians, podiatrists, and dentists) accounted for almost two-thirds of inspections in fiscal 2016 with 695 inspections. This is a decrease from 925 in fiscal 2015, however it is well above the fiscal 2014 level (278). The agency attributes the slightly lower dispensing practitioner inspections in fiscal 2016 to the two inspectors duties being expanded to include administrative tasks.

Exhibit 5
Nonpharmacy Office of Controlled Substances Administration Inspections
Fiscal 2016



Source: Department of Health and Mental Hygiene

The number of methadone clinic inspections increased in fiscal 2016. Although not mandated, OCSA expects every methadone program to be inspected at least once a year. There were 91 methadone programs in fiscal 2016. Additionally, OCSA witnesses destructions of methadone for the program, where take-home methadone clients bring back methadone for inspection. Inspectors will perform an inspection when they go for the destructions. Some of the larger programs also require two to three visits per year.

Beginning July 1, 2017, licensed pharmacists must be registered with the Prescription Drug Monitoring Program (PDMP) to receive a CDS permit. Practitioners who are authorized to prescribe CDS in Maryland must be registered with PDMP before obtaining a new or renewal registration with DHMH by July 1, 2017. This requirement applies to physicians, physician assistants, nurse practitioners, nurse midwives, dentists, podiatrists, and veterinarians. Additionally, beginning July 1, 2018, prescribers in Maryland must use PDMP prior to prescribing an opioid or benzodiazepine and every 90 days thereafter if the opioids or benzodiazepines continue to be prescribed. Pharmacists must review patient PDMP data prior to dispensing any CDS if they have a reasonable belief that a patient is seeking the drug for any purpose other than the treatment of an existing medical condition.

OCSA is also enforcing violations by removing a violating practitioner's CDS permit. Prior to this action, OCSA would send the violation information to the licensing board, which may or may not suspend the license.

4. Office of Population Health Improvement – Number of Local Health Departments with Accreditation Increases

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. PHAB's scope of accreditation authority does not extend to mental health, substance abuse, primary care, human services, and social services (including domestic violence) that may be provided by some public health departments. 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 LHDs on the aforementioned standards. In order to be eligible for accreditation, a LHD 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.

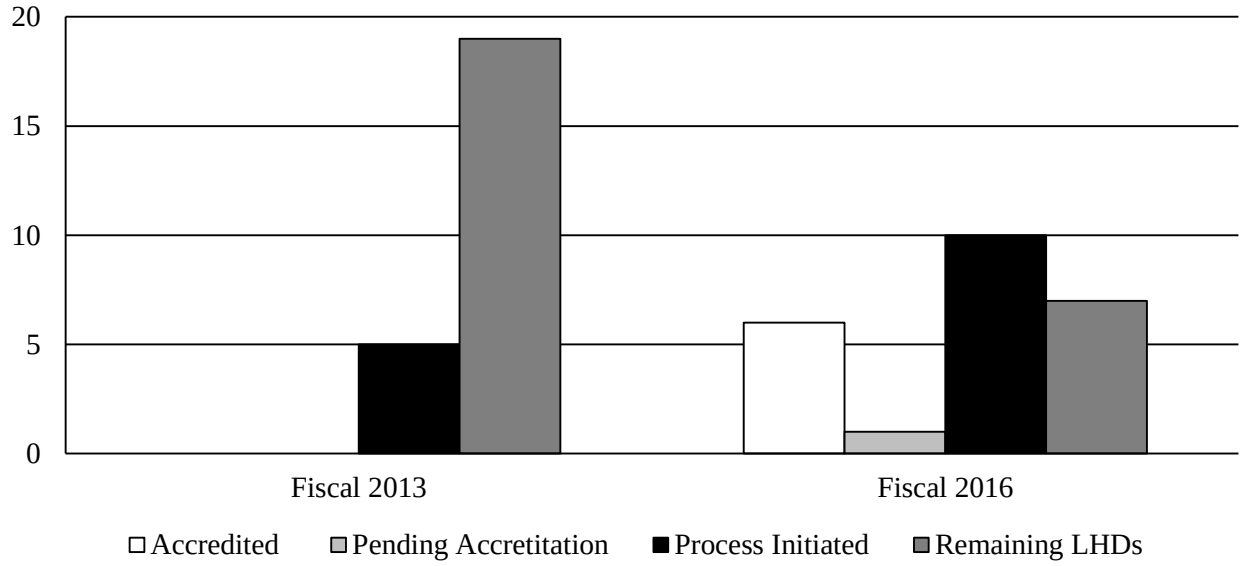
The accreditation process includes seven steps: (1) pre-application, which includes submitting a statement of intent and online orientation; (2) application, which requires a health department to submit application forms and the applicable fee; (3) document selection and submission, which requires a 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.

[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.

In fiscal 2013, 5 of Maryland's 24 LHDs had submitted prerequisites for public health accreditation. As shown in **Exhibit 6**, in fiscal 2016, 6 LHDs are accredited (Allegany, Frederick, Garrett, Harford, Wicomico, and Worcester), 1 is awaiting accreditation decisions, 1 has submitted a letter of intent, and 8 others have initiated the process by working on prerequisites. LHDs have been encouraged by DHMH to pursue accreditation and many have indicated that they are either considering or actively pursuing accreditation. However, some LHDs have noted a lack of funding as a primary barrier to accreditation. The fees are mostly administrative, paying for a specialist and a site visit of peer review experts and support for reaccreditation, which must happen every five years. Competing priorities and lack of staff time were also cited as barriers. According to OPHI, the submission of annual reports and reaccreditation every five years would require a full-time accreditation coordinator for some LHDs.

Exhibit 6
Status of Local Health Department National Accreditation
January 2016



LHD: local health department

Source: Department of Health and Mental Hygiene

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

Revenues derived from collections are beginning to play a more important role in LHD financing with the full implementation of health care reform in 2014. LHDs that continue to provide direct care will need to address barriers to billing private insurers. All LHDs are currently able to bill

Medicaid for services provided. In fiscal 2013 and 2014, there were efforts at the State level to address the challenges related to contracting and billing other third-party insurers. The State entered into a contract with United, allowing all LHDs to bill the insurer for services provided to a client insured by United.

The United contract language allows the insurer to reimburse LHDs at Medicaid rates which tend to be lower than private insurers. Additionally, under the State contract with United, only clinical not behavioral health is included. LHDs have identified difficulty with most private and military insurance for behavioral health. Addiction counseling is only reimbursed if the case is managed by a counselor with a master's degree or higher. Many LHD counselors do not have these advanced degree certifications.

LHDs remain unable to contract with private insurers as they lack expertise in negotiating contracts with private entities. LHDs have noted that they lack the formal training by the State and the staff or time necessary to go through the lengthy process of contracting with third-party payers that have no incentive to contract with the LHDs. The largest insurer by far in Maryland is CareFirst. There is no statewide master contract for CareFirst, as with United. Instead, the State negotiated legal terms such as indemnification and State tort law conformity that would allow LHDs to contract with CareFirst on their own. Although they can negotiate independently, many LHDs expressed that they would like to see a master contract, as with United, instead of spending time individually negotiating with insurers. Additionally, the United contract was negotiated by a CDC special-funded position to increase billing for immunization. This position no longer exists and when the United contract expires, LHDs will have to renegotiate the contract on their own. **The agency should comment on how it intends to reduce the barriers that LHDs still face in contracting with third-party payors and whether it intends to form a centralized process for LHD third-party payor contract negotiation now that funding for that position has been eliminated.**

Fiscal 2017 Actions

Proposed Deficiency

There is one deficiency appropriation that increases the fiscal 2017 appropriation by a total of $402,000 for the OCME to upgrade salaries for State medical examiners in order to meet recruitment, retention, and national accreditation requirements.

Section 20 Position Abolitions

The fiscal 2017 budget bill contained a section which directed the Executive Branch to abolish 657 positions and achieve a savings of $25 million, including $20 million in general funds and $5 million in special funds. This agency's share of the reduction is 13 positions and $432,697 in general funds. Of the 13 positions, 10 were in the Laboratories Administration, 2 were in OCME, and 1 was in the Office of Executive Direction.

The agency advised that some of the abolished positions in the Laboratories Administration were federally funded. A number of the abolished positions were vacant due to a hiring freeze. The agency advised they will work with the Maryland Institute for Policy Analysis and Research (MIPAR) to contract the federally funded abolished positions.

Proposed Budget

As shown in **Exhibit 7**, after adjusting for deficiencies, across-the-board reductions, and contingent reductions, the fiscal 2018 allowance increases by $1.1 million, or 0.8%, over the fiscal 2017 working appropriation. General fund support increases by $616,000, primarily due a transfer of the Rural Health Program from the Prevention and Health Promotion Administration (PHPA) to OPHI. Federal fund support increases by $575,000, primarily due to a transfer of the State Loan Repayment Program (SLRP) from PHPA to OPHI. Special fund support increases by $14,000 and reimbursable fund support decreases by $98,000.

Exhibit 7
Proposed Budget
DHMH – Public Health Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2016 Actual	$101,399	$6,405	$31,798	$679	$140,281
Fiscal 2017 Working Appropriation	105,602	7,475	26,576	811	140,464
Fiscal 2018 Allowance	106,219	7,489	27,151	713	141,571
Fiscal 2017-2018 Amount Change	$616	$14	$575	-$98	$1,107
Fiscal 2017-2018 Percent Change	0.6%	0.2%	2.2%	-12.1%	0.8%

Where It Goes:

Personnel Expenses

Reclassification	$535
Turnover adjustments	363
Other compensation	300

Where It Goes:

Positions transferred from Prevention and Health Promotion	245
Other fringe benefits	-88
Employees' Retirement System	-269
Employee and retiree health insurance	-340
Regular earnings	-478
Office of Population Health Improvement	
Transfer of Rural Health Program from PHPA	589
State Loan Repayment Program transfer from PHPA	400
State Innovation Models	200
Transfer of Primary Care Organization from PHPA	67
Primary Care Model	35
Office of the Chief Medical Examiner	
Resources for increase in cases – ambulance, lab supplies, medical supplies	365
Contractual, housekeeping, and capital lease payments	-64
Gas and electric	-92
Laboratory equipment and service contract	-240
Office of Preparedness and Response	
Strategic National Stockpile program	240
Other preparedness initiatives	-39
Ebola HPP preparedness and response Part A and B	-131
PHEP supplemental for Ebola preparedness and response ended	-552
Bioterrorism hospital preparedness program	-603
Laboratories Administration	
Laboratories supplies and medicine	652
MIPAR contractual	803
Food chemistry and microbiology emergency preparedness ends	-125
One-time STARLIMS upgrade in fiscal 2017	-250
Laboratory building utilities	-416
Total	**$1,107**

DHMH: Department of Health and Mental Hygiene
HPP: Hospital Preparedness Program
MIPAR: Maryland Institute for Policy Analysis and Research
PHEP: Public Health Emergency Preparedness
PHPA: Prevention and Health Promotion Administration
STARLIMS: STAR Laboratory Information Management System (LIMS)

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

Cost Containment

The fiscal allowance assumes level funding for core public health services through the targeted local health formula. Contingent on the Budget Reconciliation and Financing Act (BRFA) of 2017, funding in fiscal 2018 would be limited to the 2017 level of $49.5 million, resulting in a reduction of $747,276 below what the formula under current law would provide.

Across-the-board Reductions

The fiscal 2018 budget bill includes a $54.5 million (all funds) across-the-board contingent reduction for a supplemental pension payment. Annual payments are mandated for fiscal 2017 through 2020 if the Unassigned General Fund balance exceeds a certain amount at the close of the fiscal year. This agency's share of these reductions is $100,000 in general funds, $9,000 in special funds, and $18,000 in federal funds. This action is tied to a provision in the BRFA of 2017.

Personnel Expenses

Personnel expenses for PHA increase by $268,000 over the fiscal 2017 working appropriation. Major changes include increases of $535,486 for reclassifications at OCME and turnover of $363,000, as turnover is expected to be less in fiscal 2018 than 2017. Positions transferred from PHPA increases the budget by $245,000. Significant declines include employee and retiree health insurance (-$340,000), retirement (-$269,000), and regular earnings (-$478,000), which includes the one-time deficiency for reclassifications of $402,000 for OCME.

Operating Expenses

Office of Population Health Improvement

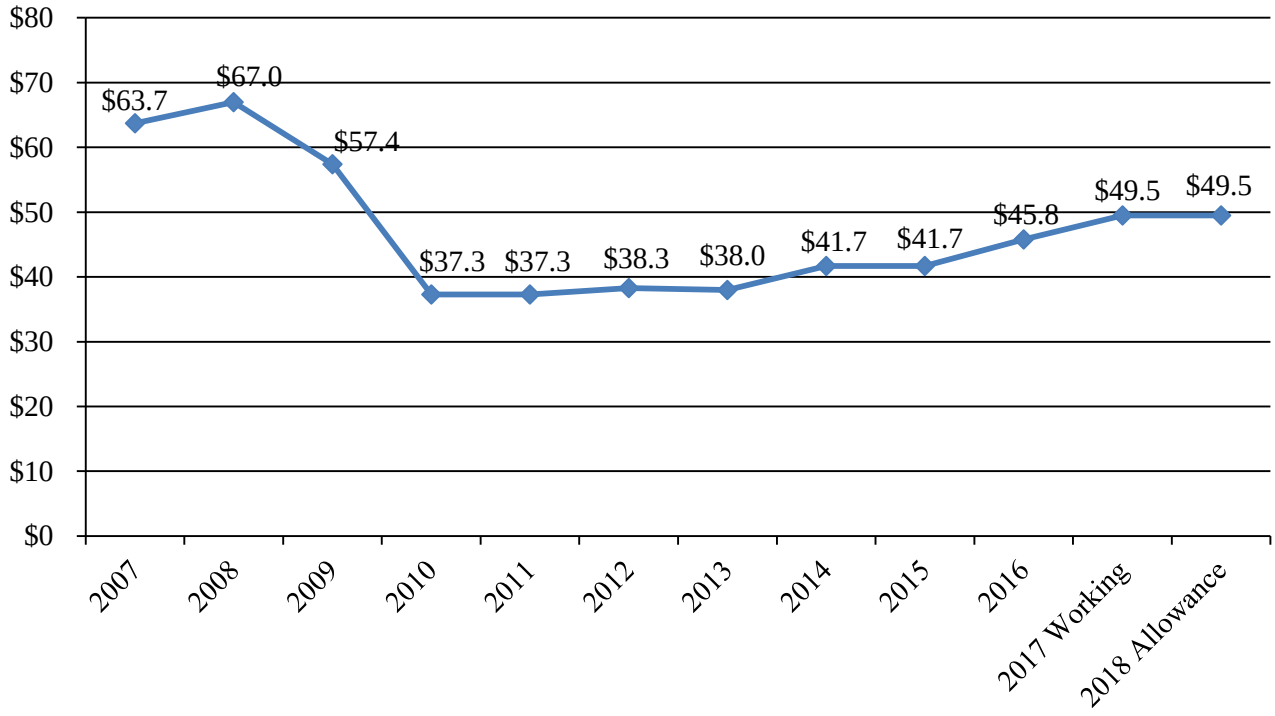
Contingent on the BRFA of 2017, the fiscal 2018 budget for core local public health funding is kept at the fiscal 2017 appropriation of $54.0 million, $49.5 million in general funds. The BRFA also re-bases the local health formula in the out-years to use $49.5 million as the starting point rather than growing off the $50.3 million level required for fiscal 2018 under currents law. The formula adjustment factor is mandated under Health-General § 2-302 and is calculated by combining an inflation factor with a population growth factor.[2] Statute mandates that for fiscal 2015 and each subsequent fiscal year, the formula adjustment factor be applied to the amount of funding for the preceding fiscal year. The formula does not account for ongoing expenditures related to the annual cost-of-living adjustments or salary increments.

Exhibit 8 shows the funding level for core public health services from fiscal 2007 to 2018. This funding has been subject to numerous cost containment actions in recent years. The fiscal 2010 appropriation for local health services for example, was reduced to $37.3 million, which was below

[2] 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 of Health and Mental Hygiene after consultation with local health officers.

even the fiscal 1997 mandated core funding level. During the 2010 session, the statute underpinning 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. However, due to budget constraints, there was no statutory formula adjustment factor applied to fiscal 2013 spending levels.

Exhibit 8
Core Public Health Funding
Fiscal 2007-2018
($ in Millions)



Note: State funds only.

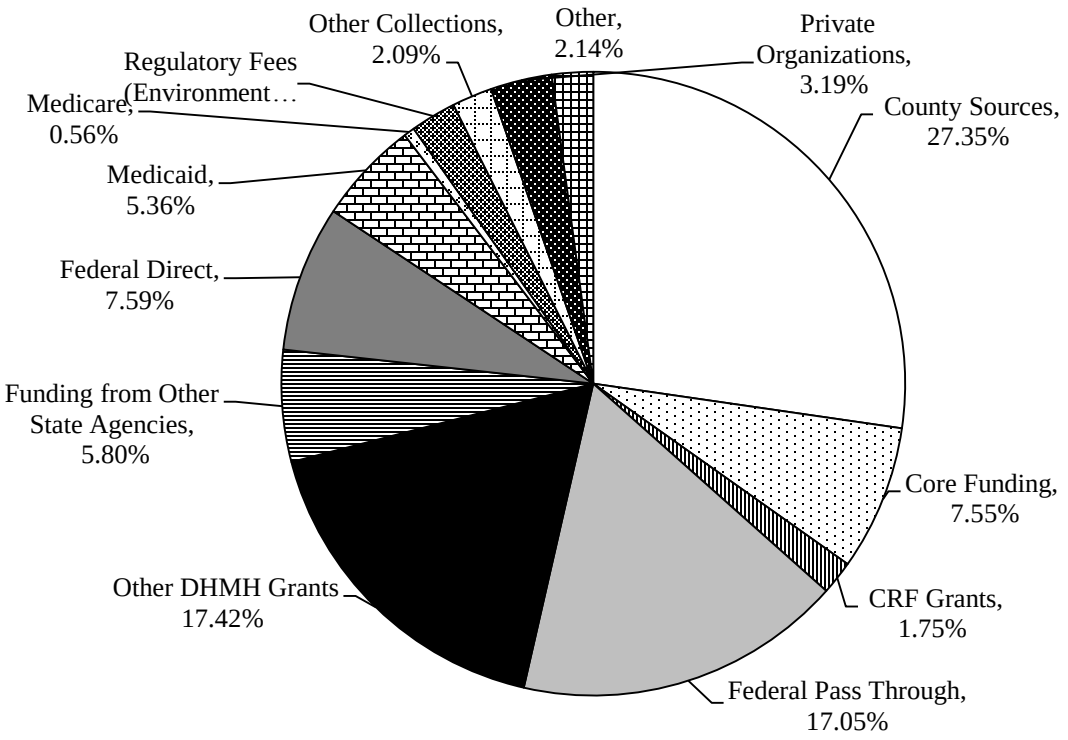
Source: Department of Legislative Services

Contingent budget bill language in fiscal 2016 attempted to limit funding in fiscal 2016 to the 2014 level of $41.7 million, resulting in a reduction of $7,841,378. However, funding was only reduced by half of the $7.8 million, and funding for fiscal 2016 increased to $45.8 million. A county breakdown of funding is included in Appendix 3.

Core funding represented 7.6% of LHD revenue in fiscal 2016, as shown in **Exhibit 9**. When core funding decreases or remains stable, LHDs must make up the revenue from other sources. Even when salaries remain flat, fringe benefits such as health insurance can increase. Some departments have a better relationship with county governments and are able to receive more funding from county

governments. However, not all LHDs are able to do this and find other ways to cover costs, such as holding positions open.

Exhibit 9
LHD Revenue by Source
Fiscal 2016



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

Source: Department of Legislative Services

There is an additional $1.6 million budgeted within the DHMH Administration to provide support to the LHD portion of DHMH's contractual health insurance obligation. This funding is not included in the formula for core funding. According to the agency, many of the contractual FTEs participating in health insurance are at the LHDs.

Other additional changes in OPHI include a transfer of the Office of Rural Health and the Office of Primary Care Services from PHPA to OPHI, an increase of $152,000 in federal funds and $504,000 in general funds. Additionally, the SLRP was transfered to OPHI from PHPA increased federal funds by $400,000 in the fiscal 2018 allowance.

The fiscal 2018 allowance for OPHI increases by $200,000 due to an increase in State Innovation Models (SIM) grant funding. OPHI received a planning grant in fiscal 2016 to design

various delivery reform initiatives, including an Accountable Care Organization for Medicaid/Medicare dual eligible and an Integrated Delivery Network. Two contracts funded by the SIMs Round 2 award from the Centers for Medicare and Medicaid Services (CMS) executed in fiscal 2017 will continue into fiscal 2018. Fiscal 2018 funding will be used to support research and planning on population health finance, development of health measures, and development of patient care plan sharing across Maryland's Health Information Exchange.

The fiscal 2018 allowance includes $35,000 in general funds for the Maryland Comprehensive Primary Care Redesign Proposal (CPC). The CPC Model is discussed in greater detail in Issue 1.

Office of the Chief Medical Examiner

Due to the increase in caseload for OCME, in addition to extra personnel funding, the fiscal 2018 allowance includes an additional $365,000 in general funds over the fiscal 2017 appropriation for lab and medical supplies and ambulance services. This increase is offset by a decrease of $240,000 in general funds for laboratory equipment and service contracts as there was a one-time equipment purchase for $105,000 in fiscal 2017 of a gas chromatograph mass spectrometer used for drug testing procedures. There is an additional decrease of $92,000 in general funds due to lower gas and electric bills and $64,000 in general funds for contractual labor ($19,000) due to a reduction for forensic anthropology services, housekeeping services ($22,000), and capital lease payments for laboratory equipment ($23,000).

Office of Preparedness and Response

The budget for OPR decreases by $1.3 million in fiscal 2018, primarily due to less federal funding for Ebola preparedness and response activities ($0.7 million). Additionally, support for the Maryland Bioterrorism Hospital Program, which provides funds to the State's health care system for emergency preparedness, planning, and response to incidents with a public health impact, falls $603,000. This decrease is primarily due to a decrease in federal grant funding provided to the Maryland Hospital Association.

Funding for the Strategic National Stockpile (SNS) Program, the Board of Pharmacy's program for removing and disposing of expired pharmaceuticals received by the State during H1N1 responses in fiscal 2010, increases by $240,000. This project also allows for the use of funds for other activities to enhance the Baltimore/Washington International Thurgood Marshall Airport Warehouse as it relates to SNS, at the approval of the Board of Pharmacy. These funds are made available through fees collected from Maryland pharmacies.

Laboratories Administration

Increases to the budget for the Laboratories Administration in fiscal 2018 include $652,000, primarily federal funds, to cover the increasing cost of laboratory supplies and medicine and $803,000 in federal funds for contractual positions with MIPAR for 6 contractual FTEs (5 lab scientists and 1 epidemiologist) in emerging infections ($445,000), 2 contractual FTEs in the CDC chemical terrorism program ($175,000), and 2 FTEs in the newborn screening program ($182,000 in special

funds). The 2 positions in the CDC chemical terrorism program were part of the Section 20 abolition. The positions were federally funded, and in order to spend the funds, the agency contracted through MIPAR to hire the positions. The allowance for the laboratory building falls by $416,000, primarily due to lower utilities.

The fiscal 2018 allowance also falls by $250,000 due to a one-time information management system (STARLIMS) upgrade in fiscal 2017 and $125,000 as the Food Chemistry and Microbiology Emergency Preparedness program ends.

Issues

1. Maryland Comprehensive Primary Care Model

Maryland All-payer Waiver – Phase I

Maryland has enacted value-based health care delivery transformation through its statewide All-payer Model Contract. To date, in Phase 1 of the All-payer Model Contract, Maryland has been successful in slowing the growth in hospital costs, reducing hospital acquired conditions, and reducing readmissions. Maryland has a five-year requirement to realize Medicare savings in hospital spending of $330 million. In the first two years, the All-payer Model Contract has generated $251 million in savings, or more than two-thirds of the $330 million in savings promised over the five years of the model agreement.

While the All-payer Model Contract is achieving positive results, the current model is focused on hospital performance. However, reducing readmissions is not just a hospital function. There have been increases in nonhospital costs. As a result, while the All-payer Model Contract has achieved savings in hospital care, the total cost of care (TCOC) growth rate for Maryland's Medicare population is higher than the rest of the nation in calendar 2015.

All-payer Waiver – Phase II

The move to the next phase of the All-payer Model Contract is slated to begin in January 2019. At that time, Maryland will become increasingly accountable for TCOC for Medicare fee-for-service (FFS) beneficiaries. Implementation will first focus on a targeted subset of approximately 800,000 Medicare FFS beneficiaries. Hospitals will need to achieve alignment with nonhospital providers of care to accomplish a reduction in TCOC. Phase II of the waiver is expected to include a voluntary new program for primary care providers serving Medicare recipients.

The primary care program, the Maryland CPC Model, seeks to improve delivery of care to people with chronic conditions and reward providers for quality of care rather than volume. Medicare payments to participating providers would shift from traditional fee-for-service to a hybrid approach that includes fee-for-service payments and up-front payments to support care management and incentivize favorable results.

Maryland's CPC Model, built upon the foundations of CMS's CPC+ Model, includes a State-sponsored coordinated entity (CE) that administers the program. This includes overseeing the budget, informatics and data analytics, model compliance and monitoring, and model evaluation. A governing body will define the rule sets by with the CE administers.

Implementation of the Maryland CPC Model

The Maryland CPC Model is just one of many initiatives proposed for the next phase of the waiver. The Maryland waiver contract required a blueprint for phase two by the end of 2016. The agency advised the Department of Legislative Services that a proposal for the CPC Model was delivered to CMS on December 31, 2016. The Maryland CPC Model concept is currently under CMS review. Implementation of the Model will begin in calendar 2017 with development. During the latter half of calendar 2017 providers may begin participation in the Maryland CPC Model by applying to CE for selection.

DHMH estimates costs for the CE to be $5 million over a five-year period, starting in fiscal 2018. For fiscal 2018, $1 million is budgeted under the Maryland Health Care Commission to fund 2 staff positions ($150,000) and fund the set up and operational costs associated with the CE ($850,000). The funding is derived from surplus Maryland Health Insurance Program funds designated to be used for the Integrated Care Network (ICN). It should be noted that while funds will be used from the ICN in fiscal 2018 and 2019 to fund the CE, funding from this source will not be available in the following years. **The agency should brief the committees on the goals of the Maryland CPC Model, the expected level of provider participation, and how the model will improve on similar programs launched in other states.**

Recommended Actions

1. Concur with Governor's allowance.

Appendix 1
Current and Prior Year Budgets
DHMH – Public Health Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2016					
Legislative Appropriation	$104,973	$965	$25,688	$719	$132,345
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	-3,524	6,543	11,871	3	14,892
Reversions and Cancellations	-49	-1,104	-5,760	-43	-6,956
Actual Expenditures	**$101,399**	**$6,405**	**$31,798**	**$679**	**$140,281**
Fiscal 2017					
Legislative Appropriation	$104,869	$7,429	$26,496	$811	$139,605
Budget Amendments	331	46	80	0	458
Working Appropriation	**$105,201**	**$7,475**	**$26,576**	**$811**	**$140,062**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions. Numbers may not sum to total due to rounding.

Fiscal 2016

The budget for the Public Health Administration closed at $140.3 million, $7.9 million above the original legislative appropriation.

Budget amendments added $14.9 million, including $11.9 million in federal funds, $6.5 million in special funds, and offset by a reduction of $3.5 million in general funds. Of this amount, $12.0 million in federal funds were added to cover Ebola-related and other preparedness and response activities in the Office of Preparedness and Response (OPR). Federal funds increased by $86,844 and general funds increased by $479,847 to restore the 2% pay reduction. Federal funds increased by $163,000 in the Division of Vital Records in Executive Direction due to the electronic death registration system and $412,000 in the Laboratories Administration for a laboratory scientist and laboratory supplies.

General funds increased by $900,000 in the Division of Vital Records in Executive Direction to move vital records to a new office space and increase public awareness around Zika. General funds increased by an additional $222,000 in the Office of the Chief Medical Examiner for overtime pay and to support a higher number of investigations, and $161,000 in the Office of Population Health Improvement (OPHI) for local health department hiring bonuses.

In the Laboratories Administration, $6.5 million in special funds was added for laboratory supplies for newborn screening and Severe Combined Immunodeficiency testing.

These increases were partially offset by a reduction in general funds of $4,602,544 to realign the fiscal 2016 2% cost containment reduction in accordance with agency cost containment plans. An additional reduction in federal funds ($770,040) and general funds ($695,127) was the result of the transfer of 4 positions and other responsibilities from OPHI to the Prevention and Health Promotion Administration.

General fund reversions totaled $49,000. Cancellations totaled $6.9 million. Of the canceled federal funds ($5.8 million), OPR canceled $5.2 million due to a grant extension for Public Health Emergency Preparedness Supplemental for Ebola Preparedness funding ($1.4 million), which allows funds to be redirected to Zika-related activities, issuing fewer grants in the year to hospitals for Ebola preparedness ($2.8 million), and cost savings in public health emergency and hospital preparedness cooperative agreements ($1.0 million). In OPHI, $411,000 of federal funds were canceled due to a grant extension for the State Innovation Models project. In the Division of Vital Records in Executive Direction, $59,000 of federal funds were canceled, primarily due to turnover. In the Laboratory Administration, $57,000 in federal funds were canceled primarily due lower expenditures for the Domestic Ebola Response Grant than were appropriated. The largest special fund cancellation was $1.1 million from the Laboratory Administration due to timing of enacted legislation in 2015 that created a special fund for the newborn screening program.

Fiscal 2017

To date, budget amendments have added $457,000 to the budget. Of this amount, an increase of $434,154 in general funds, $80,320 in federal funds, and $36,881 in special funds is for the centrally budgeted fiscal 2017 salary increment. Special funds increased $9,314 and general funds were reduced by $103,061 to implement Section 20 of the fiscal 2017 budget bill.

Appendix 2
Audit Findings
Vital Statistics Administration

Audit Period for Last Audit:	February 5, 2013 – December 8, 2015
Issue Date:	July 2016
Number of Findings:	2
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	

Finding 1: The Vital Statistics Administration (VSA) did not have comprehensive procedures for conducting local health department site visits, which were performed to assess procedures and controls over the issuance of birth and death certificates and collection of the related fees.

Finding 2: Logging and reviews of database security and audit events were not properly performed or documented, and VSA did not remove inactive domain accounts on a timely basis.

Laboratories Administration

Audit Period for Last Audit:	October 4, 2011 – June 30, 2015
Issue Date:	March 2016
Number of Findings:	2
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	

Finding 1: Controls were not established to ensure the propriety of laboratory services billings, and numerous individuals had unnecessary access to the accounts receivable system.

Finding 2: Controls over issuance of controlled dangerous substance permits and related collections were inadequate.

Appendix 3
Local Health Aid
Fiscal 2017-2018

	2017 Allowance	2018 Allowance	2018 With BRFA	BRFA Difference
Allegany	$1,407,995	$1,614,515	$1,407,995	-$21,261
Anne Arundel	4,107,842	4,170,821	4,107,842	-62,979
Baltimore City	8,094,529	8,218,630	8,094,529	-124,101
Baltimore	5,339,285	5,421,144	5,339,285	-81,859
Calvert	602,595	681,104	602,595	-9,099
Caroline	725,829	749,912	725,829	-10,960
Carroll	1,667,149	1,677,018	1,667,149	-25,174
Cecil	1,123,764	1,141,838	1,123,764	-16,969
Charles	1,453,079	1,466,181	1,453,079	-21,941
Dorchester	620,986	804,347	620,986	-9,377
Frederick	2,033,245	2,107,673	2,033,245	-30,702
Garrett	639,306	787,346	639,306	-9,654
Harford	2,291,265	2,308,603	2,291,265	-34,860
Howard	1,725,028	1,733,685	1,725,028	-26,179
Kent	546,006	607,847	546,006	-8,245
Montgomery	3,907,624	3,967,534	3,907,624	-59,910
Prince George's	6,257,844	6,335,996	6,257,844	-95,674
Queen Anne's	574,849	636,255	574,849	-8,680
St. Mary's	1,048,693	1,064,771	1,048,693	-16,078
Somerset	578,533	587,319	578,533	-8,736
Talbot	485,995	531,221	485,995	-7,339
Washington	1,797,019	1,857,492	1,797,019	-27,135
Wicomico	1,307,152	1,322,457	1,307,152	-19,738
Worcester	703,788	991,028	703,788	-10,627
Total	**$49,488,474**	**$50,335,663**	**$49,488,474**	**-$747,276**

BRFA: Budget Reconciliation and Financing Act

Note: Includes State funds only.

Source: Department of Legislative Services

Appendix 4
Object/Fund Difference Report
DHMH – Public Health Administration

Object/Fund	FY 16 Actual	FY 17 Working Appropriation	FY 18 Allowance	FY 17 - FY 18 Amount Change	Percent Change
Positions					
01 Regular	399.90	388.90	391.90	3.00	0.8%
02 Contractual	15.78	17.30	21.30	4.00	23.1%
Total Positions	**415.68**	**406.20**	**413.20**	**7.00**	**1.7%**
Objects					
01 Salaries and Wages	$ 33,081,524	$ 34,816,071	$ 35,613,124	$ 797,053	2.3%
02 Technical and Spec. Fees	1,056,787	948,950	1,246,450	297,500	31.4%
03 Communication	558,845	589,283	625,496	36,213	6.1%
04 Travel	168,431	128,196	447,509	319,313	249.1%
06 Fuel and Utilities	1,948,179	3,026,725	2,607,168	-419,557	-13.9%
07 Motor Vehicles	23,087	25,578	24,682	-896	-3.5%
08 Contractual Services	17,539,484	15,980,869	16,599,004	618,135	3.9%
09 Supplies and Materials	7,193,345	6,054,168	6,974,299	920,131	15.2%
10 Equipment – Replacement	59,201	202,504	67,261	-135,243	-66.8%
11 Equipment – Additional	189,925	22,000	74,403	52,403	238.2%
12 Grants, Subsidies, and Contributions	58,762,715	58,909,922	58,837,349	-72,573	-0.1%
13 Fixed Charges	19,699,966	19,358,097	19,328,614	-29,483	-0.2%
Total Objects	**$ 140,281,489**	**$ 140,062,363**	**$ 142,445,359**	**$ 2,382,996**	**1.7%**
Funds					
01 General Fund	$ 101,398,906	$ 105,200,589	$ 107,065,680	$ 1,865,091	1.8%
03 Special Fund	6,404,756	7,475,063	7,498,077	23,014	0.3%
05 Federal Fund	31,798,405	26,575,920	27,168,935	593,015	2.2%
09 Reimbursable Fund	679,422	810,791	712,667	-98,124	-12.1%
Total Funds	**$ 140,281,489**	**$ 140,062,363**	**$ 142,445,359**	**$ 2,382,996**	**1.7%**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions.

Appendix 5
Fiscal Summary
DHMH – Public Health Administration

Program/Unit	FY 16 Actual	FY 17 Wrk Approp	FY 18 Allowance	Change	FY 17 - FY 18 % Change
01 Executive Direction	$ 7,524,706	$ 6,893,823	$ 8,467,209	$ 1,573,386	22.8%
01 Health Systems and Infrastructure Administration	1,561,151	1,492,114	2,953,530	1,461,416	97.9%
07 Core Public Health Services	50,318,373	53,981,474	54,728,750	747,276	1.4%
01 Post Mortem Examining Services	11,717,882	12,106,407	12,817,885	711,478	5.9%
01 Office of Preparedness and Response	22,939,087	18,089,198	16,748,696	-1,340,502	-7.4%
01 Laboratory Services	46,220,290	47,499,347	46,729,289	-770,058	-1.6%
Total Expenditures	**$ 140,281,489**	**$ 140,062,363**	**$ 142,445,359**	**$ 2,382,996**	**1.7%**
General Fund	$ 101,398,906	$ 105,200,589	$ 107,065,680	$ 1,865,091	1.8%
Special Fund	6,404,756	7,475,063	7,498,077	23,014	0.3%
Federal Fund	31,798,405	26,575,920	27,168,935	593,015	2.2%
Total Appropriations	**$ 139,602,067**	**$ 139,251,572**	**$ 141,732,692**	**$ 2,481,120**	**1.8%**
Reimbursable Fund	$ 679,422	$ 810,791	$ 712,667	-$ 98,124	-12.1%
Total Funds	**$ 140,281,489**	**$ 140,062,363**	**$ 142,445,359**	**$ 2,382,996**	**1.7%**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions.