M00F
Public Health Administration
Maryland Department of Health

Operating Budget Data

($ in Thousands)

	FY 17 Actual	FY 18 Working	FY 19 Allowance	FY 18-19 Change	% Change Prior Year
General Fund	$106,563	$105,909	$107,479	$1,570	1.5%
Adjustments	0	290	1,127	837	
Adjusted General Fund	**$106,563**	**$106,200**	**$108,607**	**$2,407**	**2.3%**
Special Fund	6,909	7,489	7,509	20	0.3%
Adjustments	0	-41	22	63	
Adjusted Special Fund	**$6,909**	**$7,448**	**$7,531**	**$83**	**1.1%**
Federal Fund	27,435	27,151	22,321	-4,830	-17.8%
Adjustments	0	-74	31	105	
Adjusted Federal Fund	**$27,435**	**$27,077**	**$22,352**	**-$4,725**	**-17.5%**
Reimbursable Fund	708	713	1,212	499	70.0%
Adjustments	0	0	2	2	
Adjusted Reimbursable Fund	**$708**	**$713**	**$1,213**	**$501**	**70.3%**
Adjusted Grand Total	**$141,615**	**$141,438**	**$139,703**	**-$1,735**	**-1.2%**

Note: FY 18 Working includes targeted reversions, deficiencies, and across-the-board reductions. FY 19 Allowance includes contingent reductions and cost-of-living adjustments.

- The proposed budget contains two deficiencies for fiscal 2018 to develop a new Electronic Birth and Death Records System ($486,661) and to digitize microfilm birth and death records ($200,000).

- The fiscal 2019 allowance is adjusted for a contingent reduction of $890,793 to level fund the core public health funding to local health departments.

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

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- The adjusted fiscal 2019 allowance for the Public Health Administration (PHA) decreases by $1.7 million, or 1.2%, compared to the fiscal 2018 working appropriation largely due to the transfer of the federal matching funds for local health departments to the Prevention and Public Health Administration ($4.5 million), partially offset by a general salary increase ($2.1 million).

Personnel Data

	FY 17 Actual	FY 18 Working	FY 19 Allowance	FY 18-19 Change
Regular Positions	395.00	388.00	391.00	3.00
Contractual FTEs	20.09	20.34	24.30	3.96
Total Personnel	**415.09**	**408.34**	**415.30**	**6.96**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	26.81	6.91%
Positions and Percentage Vacant as of 12/31/17	36.00	9.28%

- The fiscal 2019 allowance increases regular positions by 3 regular full-time-equivalents (FTE), compared to the fiscal 2018 working appropriation. All 3 FTEs are pharmacist positions within the Office of Controlled Substances Administration (OCSA).

- Contractual FTEs increase by 3.96 in the Laboratories Administration.

- As of December 31, 2017, there were 36 vacant positons, or 9.28%. Budgeted turnover expectancy in fiscal 2019 is 6.91%. PHA has 9.19 vacancies over 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 2017, the agency met its goal with respect to birth certificates.

Office of the Chief Medical Examiner – Ratio of Cases Per Examiner: The ratio of autopsies to medical examiners decreased in fiscal 2017 to meet accreditation standards, but the outlook is not promising. The agency completed 81% of autopsy reports within 60 days in 2017, an increase from 2016, yet still fell short of its goal (90%).

Office of Controlled Substances Administration – Decrease of Pharmacy and Nonpharmacy Inspections: OCSA has decreased the number of routine pharmacy inspections and the number of total inspections. Turnover contributed to this decrease in inspections, and there is an expectation that inspections will return to a reasonable level in fiscal 2018.

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, 7 LHDs are now accredited, with 10 others going through the process.

Issues

Maryland Primary Care Program: In 2014, the Centers 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. In order for hospitals to achieve alignment with nonhospital providers of care so as to accomplish a reduction in total cost of care, Maryland has proposed a Comprehensive Primary Care Redesign as part of Phase II of the waiver.

Timeline and Funding for a Centralized Revenue Management System for LHDs: The 2017 *Joint Chairmen's Report* requested a report on a timeline and funding for a centralized revenue management system for LHDs. This issue discusses the report.

Interpretation of Section 2-302 of the Health-General Article: Portions of the statute governing mandated spending for Core Public Health Services are subject to interpretation. This issue discusses how to clarify the statute.

Operating Budget Recommended Actions

1. Add language restricting funds pending receipt of a determination of whether a project should be subject to Department of Information Technology oversight.

Budget Reconciliation and Financing Act Recommended Actions

1. Amend Section 2-302 of the Health-General Article to clarify the statute.

M00F
Public Health Administration
Maryland Department of Health

Operating Budget Analysis

Program Description

The Maryland Department of Health (MDH) Public Health Administration (PHA) budget analysis includes the following offices within the department:

- Deputy Secretary for Public Health Services;
- Office of Population Health Improvement (OPHI);
- Office of the Chief Medical Examiner (OCME);
- Office of Preparedness and Response (OPR); 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 PHAs 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.

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 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 the 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.

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 U.S. 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.

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

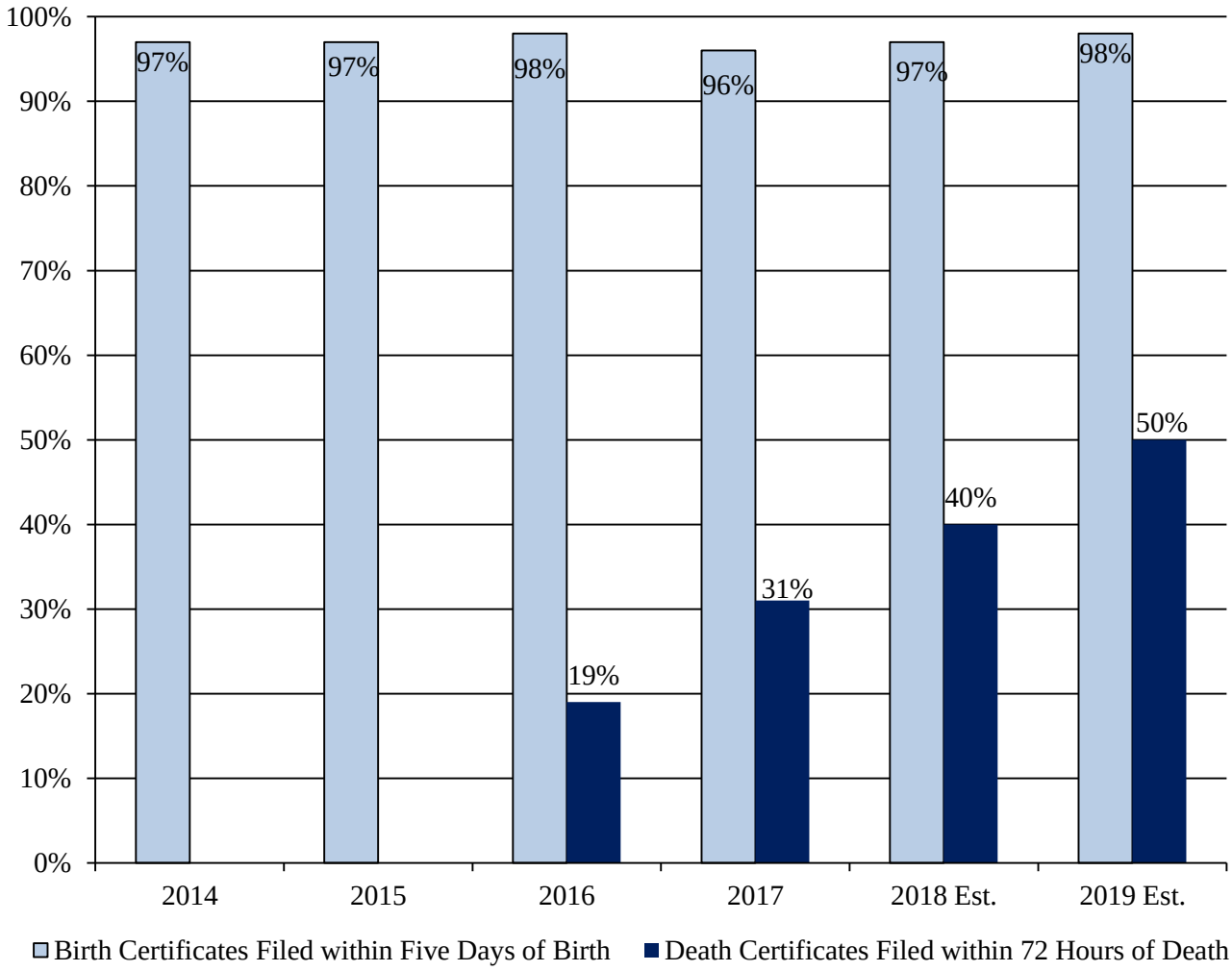
Performance Analysis: Managing for Results

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 decreased to 96% in fiscal 2017, falling just below the agency's goal. The percentage of death certificates filed within 72 hours increased from 19% in

fiscal 2016 to 31% in fiscal 2016 and fell short of the agency's goal (65%). This measure was revised from previous years, and prior year data was removed because MDH was not able to verify the accuracy of reporting before fiscal 2016. MDH used a paper-based system in earlier years and switched to an electronic system in fiscal 2016, which allows for accurate tracking of this measure. The electronic system was phased in across hospitals and funeral facilities, which explains the increase in fiscal 2017 and anticipated increases in fiscal 2018 and 2019.

Exhibit 1
Birth and Death Certificates Timely Filed with the Division of Vital Records
Fiscal 2014-2019 Est.



Source: Maryland Department of Health

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.

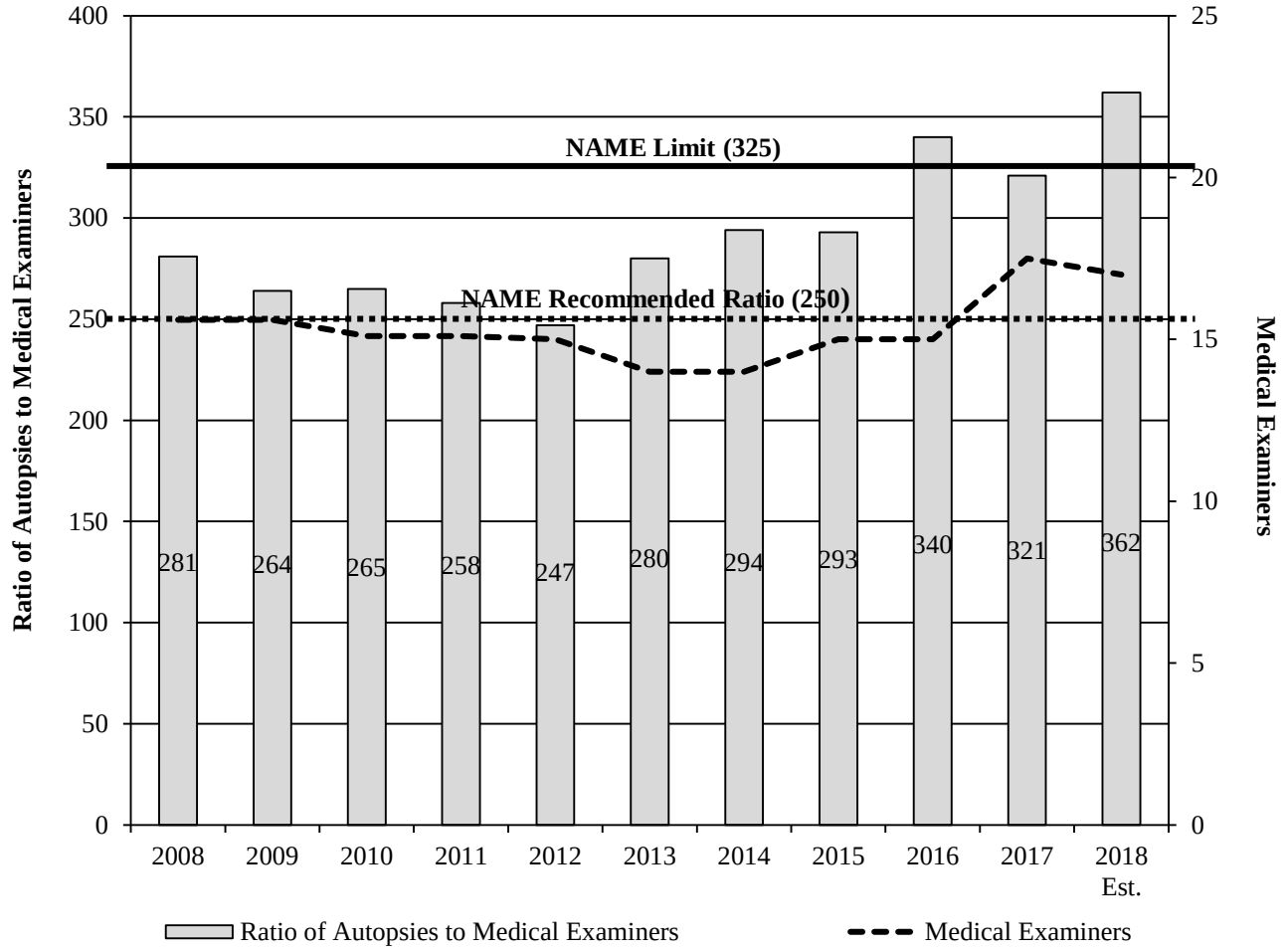
In fiscal 2007, OCME changed reporting techniques to better reflect the caseload facing pathologists. OCME reports not only the number of autopsies performed but also the total number of cases presented for investigation. Not every death that is presented for investigation will be autopsied, but OCME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

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.

Over the past two years, the caseload for OCME has increased dramatically. From fiscal 2014 to 2016, the number of deaths investigated increased by 2,550, or 23%, and the number of cases examined increased by 983, an increase of 24%. In that time, only 1 medical examiner (ME) position was added, leading to an increase in the average caseload to 340 cases per examiner in fiscal 2016.

NAME provides accreditation to coroners and ME offices that meet particular standards. Maryland has managed to maintain accreditation with only one period of provisional status under the old facility for building violations. NAME, as part of the accreditation standard, has set a recommended average caseload of 250 cases a year and a maximum caseload for MEs of 325 cases a year. **Exhibit 2** shows Maryland's compliance with the NAME recommendation and limit. Currently, OCME is in violation of the caseload standard. OCME has indicated that the office will be placed on provisional status on May 14, 2018, and may lose accreditation if caseloads remain high. This would hurt its reputation and the value of its reports and testimony.

Exhibit 2
Medical Examiner Caseloads
Fiscal 2008-2018 Est.

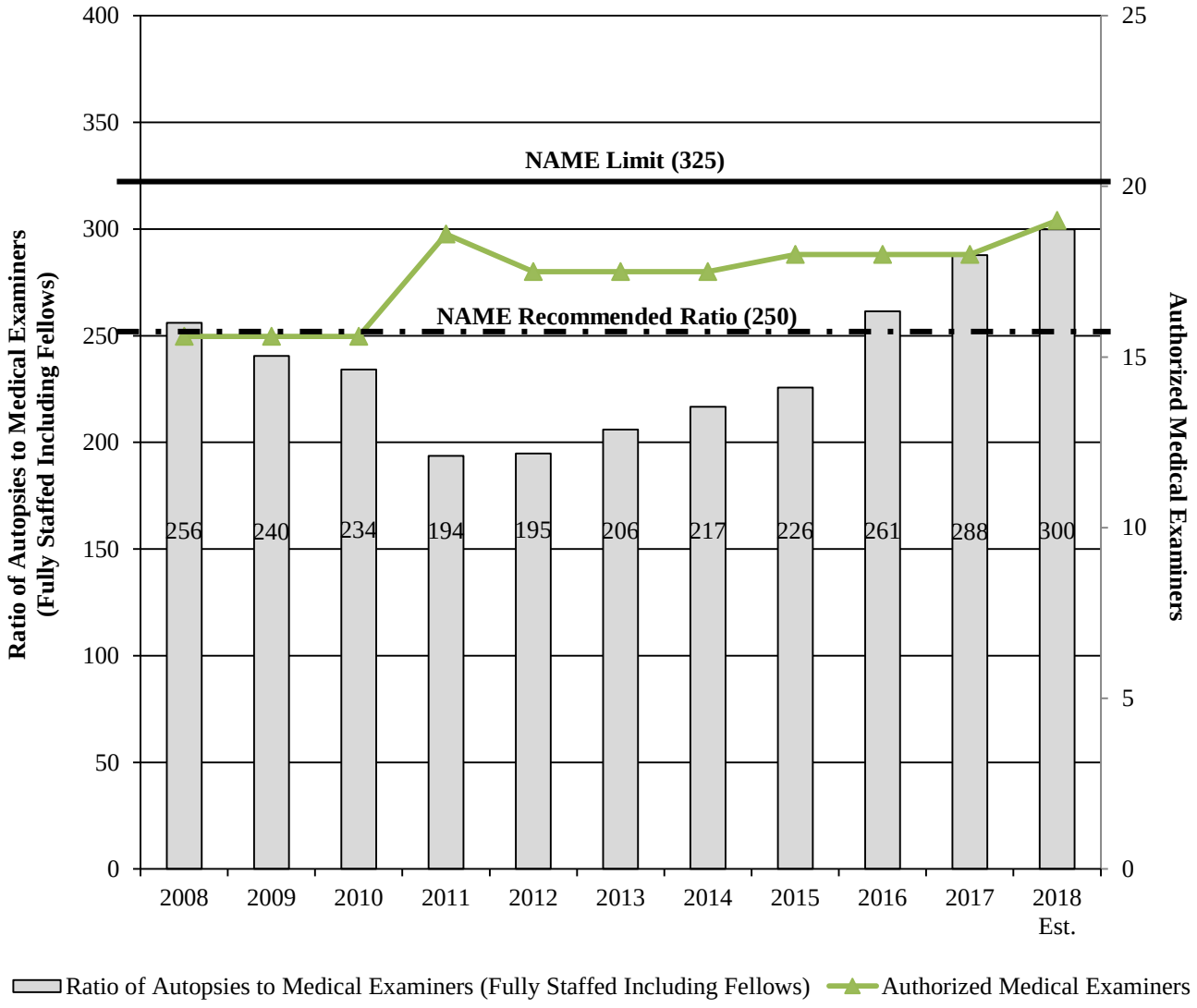


NAME: National Association of Medical Examiners

Source: Maryland Department of Health

OCME has made effective use of its fellowship program to recruit students early and reduce its own workload burden. Each fellow costs the office far less than half of the cost of a full ME, counts for 0.5 a position in the NAME caseload calculations, and, by the end of the fellowship, is as productive as a full-time ME. Currently, the office is accredited for 4 fellows (the equivalent of 2.0 positions). Funding is available for 3.0 of the 4.0 fellowship positions. As shown in **Exhibit 3**, the filling of the current 3.0 vacant ME positions and the full utilization of the fellowship training would bring the office back into a compliant caseload level. These positions have remained vacant long term due to compensation, expanded upon below, and low supply.

Exhibit 3
Medical Examiner Caseloads – All Positions Filled
Fiscal 2008-2018 Est.



NAME: National Association of Medical Examiners

Source: Maryland Department of Health

Additionally, 6.0 out of the 19 MEs, nearly a third, are eligible or will be eligible for retirement within five years, and it is likely that many will leave within that time. This will only exacerbate the current problem unless preemptive actions are taken now not only to fully staff the office but also to fill positions as they become vacant. OCME indicates that 1 ME will retire on July 1, 2018.

Compensation

OCME has difficulty offering competitive compensation for the ME position. In addition to competition with other state ME's offices, the office is in competition with all hospitals for pathologists. Hospital pathologists earn significantly more, often over $100,000 more, and have a lighter and easier caseload. With only 37 accredited forensic pathology training programs in 27 states and 30 to 40 graduates of these programs a year, there is a short supply of MEs. While the office has 3 vacant ME positions, it has difficulty filling them. One of the 3 will be filled in July 2018 by a current fellow at the end of the fellowship. However, this 1 hire is the culmination of 10 one-month recruitment periods. In one case, an offer was made to a prospective hire at the top of the pay scale and it was turned down. Of note, the fiscal 2018 budget included $936,902 to provide additional funding for ME compensation – a fiscal 2017 deficiency appropriation of $401,416 for annual salary reviews (ASR) and $535,486 in fiscal 2018 to annualize the ASRs.

Maryland has managed to stay competitive with other ME programs in the country due, in large part, to its fellowship training program. Many alumni of the program return to work in Maryland when positions open. However, there are some programs across the country that are actively and aggressively recruiting. They offer higher salaries, benefits, and time for research and travel.

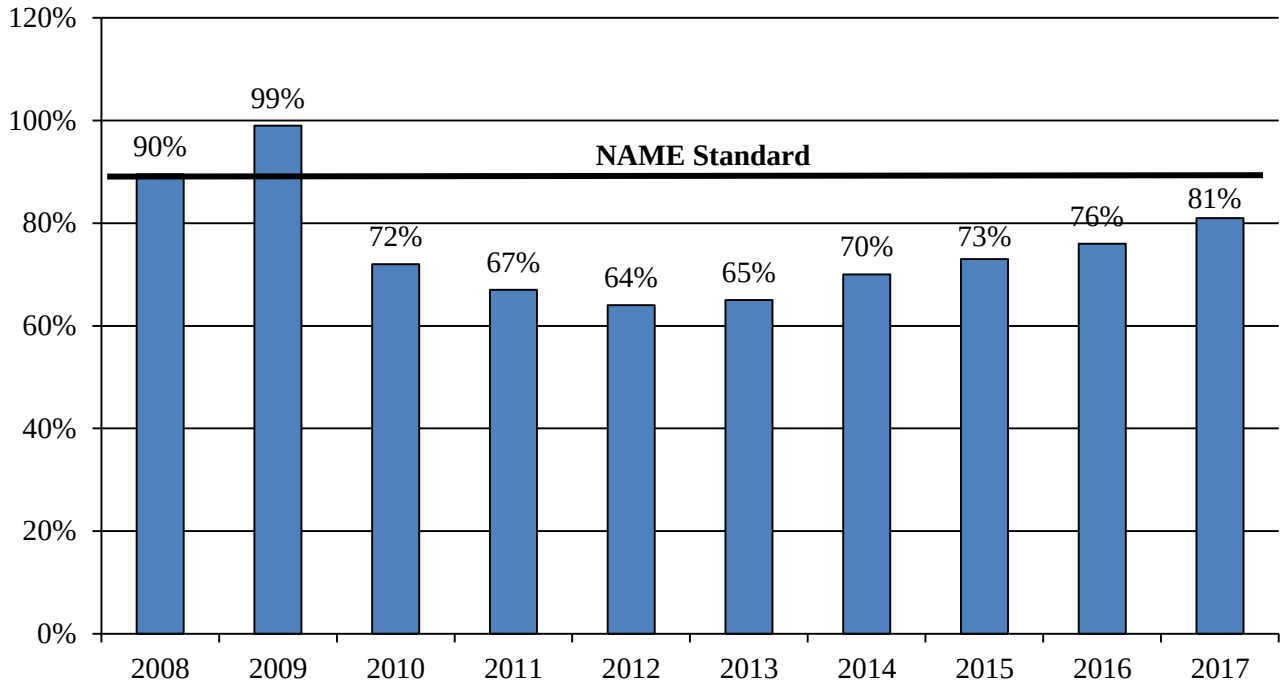
Maryland has the option to increase its successful fellowship program. Currently, the office has 1 unfunded fellowship that it could fill if funding was made available. Furthermore, an additional 1 or 2 more fellowship positions would allow for a reduction in caseload at relatively lower cost without causing damage to the effectiveness of the learning program.

Autopsy Reports

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 4** shows the percent of autopsy reports completed within 60 days and forwarded to the State's Attorney's Office.

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 has since fallen short of this goal. In fiscal 2017, 81% of cases were completed within 60 days. Failure to meet this standard is a Phase I violation of the NAME accreditation standards.

Exhibit 4
Autopsies Reported within 60 Days
Fiscal 2008-2017



NAME: National Association of Medical Examiners

Source: Maryland Department of Health

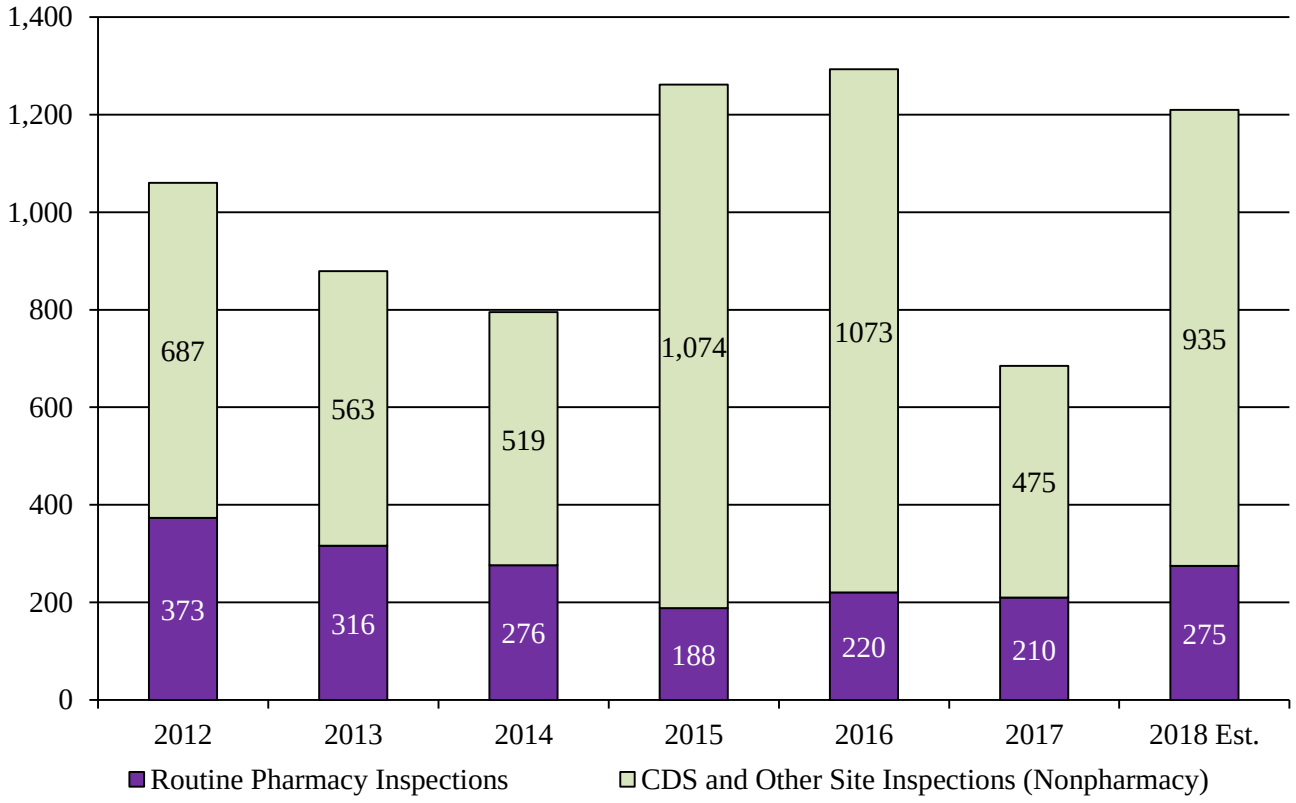
3. Office of Controlled Substances Administration – Decrease of Pharmacy and Nonpharmacy Inspections

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 5 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 retirement of a pharmacist inspector and a decrease in referrals from health occupation boards, the U.S. Drug Enforcement Administration, OCME, and other State and federal agencies. In fiscal 2015, CDS inspections for nonpharmacy entities increased and remained stable in fiscal 2016. In fiscal 2017, nonpharmacy inspections decreased significantly to 475 from 1,073 in the previous year. OCSA attributes this decrease to turnover. In fiscal 2017, only 2 individuals were able to perform inspections. OCSA expects the number of inspections to return to normal levels pending the hiring and training of personnel in fiscal 2018.

Exhibit 5
Office of Controlled Substances Administration Inspections
Fiscal 2012-2018 Est.



CDS: controlled dangerous substances

Source: Maryland Department of Health

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

CDC, in partnership with the Robert Wood Johnson Foundation, is 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 that 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 evidence-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, an 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.

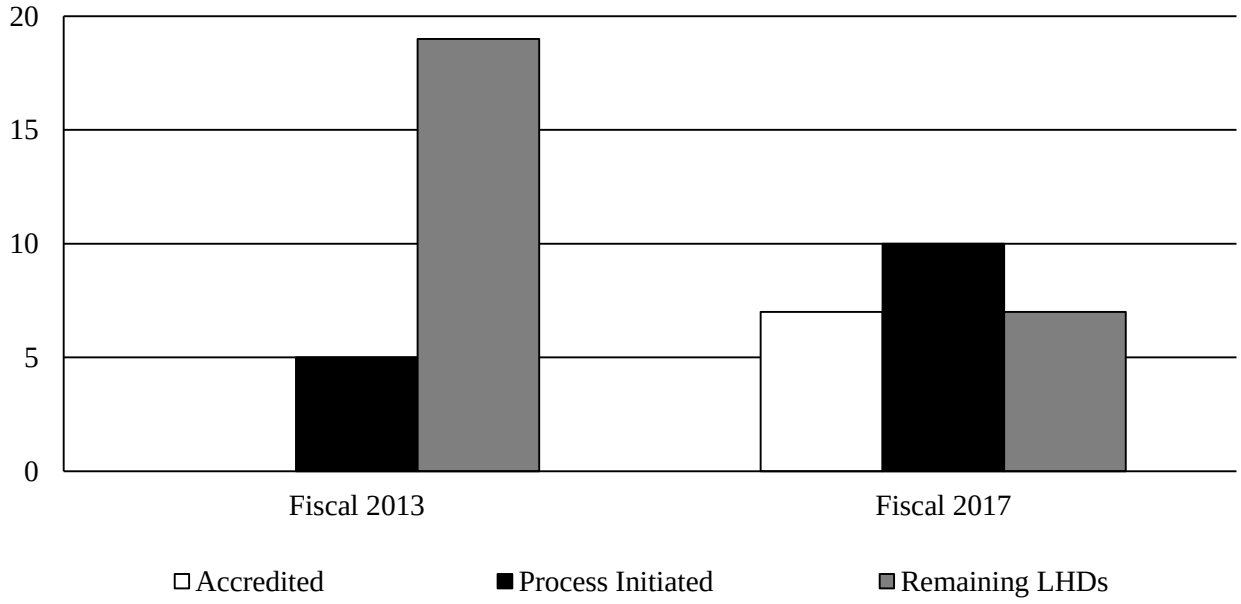
The accreditation process includes seven steps: (1) pre-application, which includes submitting a statement of intent and online orientation; (2) application, which requires a health department to submit application forms and the applicable fee; (3) document selection and submission, which requires a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

In fiscal 2013, 5 of Maryland's 24 LHDs had submitted prerequisites for public health accreditation. As shown in **Exhibit 6**, in fiscal 2017, 7 LHDs are accredited (Allegany, Cecil, Frederick, Garrett, Harford, Wicomico, and Worcester). Cecil County Health Department is the most recent LHD to receive accreditation.

[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 of less than 50,000 to approximately $100,000 for populations greater than 15 million.

Exhibit 6
Status of Local Health Department National Accreditation
Calendar 2017



LHD: local health department

Source: Public Health Accreditation Board

LHDs have been encouraged by MDH 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. MDH received PAHB accreditation as the State health department on June 6, 2017.

Fiscal 2018 Actions

Proposed Deficiency

The proposed budget contains two deficiencies for fiscal 2018 to develop a new Electronic Birth and Death Records System ($486,661) and to digitize microfilm birth and death records ($200,000).

Electronic Birth and Death Records System

The Vital Statistics Administration has been exploring how to best integrate the electronic birth and death registration systems. The vendor no longer supports the old systems, which necessitates this accelerated funding for development of a new system. Major Information Technology (IT) projects are generally developed with oversight from the Department of Information Technology (DoIT) through its Major IT Development Projects (MITDP) program.

For consideration of a project as an MITDP, the project must meet one or more of the following:

- the estimated total cost of development equals or exceeds $1 million;
- the project is undertaken to support a critical business function associated with the public health, education, safety, or financial well-being of the citizens of Maryland; or
- the Secretary of Information Technology determines that the project requires the special attention and consideration given to an MITDP due to:
    - the significance of the project's potential benefits or risks;
    - the impact of the project on the public or local governments;
    - the public visibility of the project; or
    - other reasons as determined by the Secretary.

It is likely that this project meets criteria for inclusion in the DoIT MITDP program. The project meets the second standard and possibly meets the first if there are significant costs in future years. **The Department of Legislative Services (DLS) recommends restricting these funds pending review of the project by DoIT and a determination of whether the project should be subject to inclusion in the MITDP program.**

Digitize Microfilm Birth and Death Records

MDH has approximately 1,000 microfilm tapes of birth and death records. Microfilm readers have been breaking down with increased frequency, and replacement parts are no longer being manufactured. Digitizing records will dramatically improve access time and allow for more secure backup of the information.

Cost Containment

A September 6, 2017 Board of Public Works cost containment action reduced the PHA fiscal 2018 working appropriation by $309,213 in general funds. Cost containment was realized through savings on natural gas.

Across-the-board Employee and Retiree Health Insurance Reduction

The budget bill includes an across-the-board reduction for employee and retiree health insurance in fiscal 2018 to reflect a surplus balance in the fund. This agency's share of this reduction is $396,343 in general funds, $40,624 in special funds, and $73,818 in federal funds.

Proposed Budget

As shown in **Exhibit 7**, the adjusted fiscal 2019 allowance decreases by $1.7 million, or 1.2%, compared to the fiscal 2018 working appropriation largely due to the transfer of the federal matching funds for local health departments to the Prevention and Public Health Administration ($4.5 million), partially offset by a general salary increase ($2.1 million).

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

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2017 Actual	$106,563	$6,909	$27,435	$708	$141,615
Fiscal 2018 Working Appropriation	106,200	7,448	27,077	713	141,438
Fiscal 2019 Allowance	108,607	7,531	22,352	1,213	139,703
Fiscal 2018-2019 Amount Change	$2,407	$83	-$4,725	$501	-$1,735
Fiscal 2018-2019 Percent Change	2.3%	1.1%	-17.5%	70.3%	-1.2%

Where It Goes:	
Personnel Expenses	
General salary increase (including local health department's share)	$2,073
Employee and retiree health insurance, primarily the impact of the fiscal 2018 health insurance deductions holidays	465
Regular salaries (including annualization of salary increases to MEs)	398
3.0 new FTEs (pharmacists)	341
Other adjustments	10
Accrued leave payout	-34
Turnover adjustments	-44
Social Security contributions	-73
Retirement contributions	-74
Reclassifications	-535

Where It Goes:

Office of Population Health Improvement	
Interagency employment agreement with MIPAR	177
Travel	5
State Innovation Models	-500
Transfer of federal matching funds for Core Public Health to PHPA	-4,493
Office of the Chief Medical Examiner	
Laboratory supplies and equipment	212
Reimbursement to DMEs and CFIs for investigations	183
Body transport	123
Fuel and utilities	-29
Office of Preparedness and Response	
Bioterrorism hospital preparedness program	40
Destruction of expired medication	-24
Ebola HPP preparedness and response Part A and B	-472
Laboratories Administration	
Laboratory and Epidemiology capacity	607
Food surveillance and testing	255
CDC-purchased equipment service contracts	248
SCID testing	174
Administrative and support services	136
Zika testing activities	75
New contractual position to perform Chlamydia testing	37
Laboratory supplies and equipment to align with actual expenditures	-119
Operational costs	-213
Executive Direction	
Fiscal 2018 deficiency appropriation for digitization of birth and death records	-200
Fiscal 2018 deficiency appropriation for development of a new Electronic Birth and Death Records System	-487
Other	3
Total	**-$1,735**

CDC: Centers for Disease Control and Prevention
CFI: county forensic investigator
DME: deputy medical examiner
FTE: full-time equivalent
HPP: Hospital Preparedness Program
MDH: Maryland Department of Health
ME: medical examiner
MIPAR: Maryland Institute for Policy Analysis and Research
PHPA: Prevention and Health Promotion Administration
SCID: severe combined immunodeficiency

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

Personnel

Personnel costs in the allowance increase by approximately $2.5 million compared to the fiscal 2018 working appropriation. The fiscal 2019 allowance includes funds for a 2% general salary increase for all State employees, effective January 1, 2019. These funds are budgeted in the Department of Budget and Management's statewide program and will be distributed to agencies during the fiscal year. This agency's share of the general salary increase is $2.1 million in total funds. Approximately $1.7 million is the LHD share of the general salary increase.

The allowance adds 3.0 FTE pharmacist positions for the OCSA. These positions will improve OCSA's ability to conduct regular inspections and investigations. Currently, the office cannot conduct inspections at the levels necessary because only 2 individuals are able to inspect and investigate sites. Of the 3.0 FTEs, 2.0 will primarily conduct regulatory inspections and 1.0 will primarily conduct investigations.

Costs due to reclassification decrease by $535,486, which was for increasing compensation at OCME. However, this is offset by the annualization of compensation increases, which are reflected by an increase of $710,304 in the allowance, offset by decreases in regular earnings across the rest of PHA.

Office of Population Health Improvement

The allowance includes a reduction of $890,794 to align fiscal 2019 formula-based funding to LHDs with fiscal 2018 funding of $49.5 million. The reduction is contingent on the Budget Reconciliation and Financing Act (BRFA) of 2018. Under current law, the amount of funding that would otherwise be provided through the formula, as interpreted by the Administration, is $50.4 million.

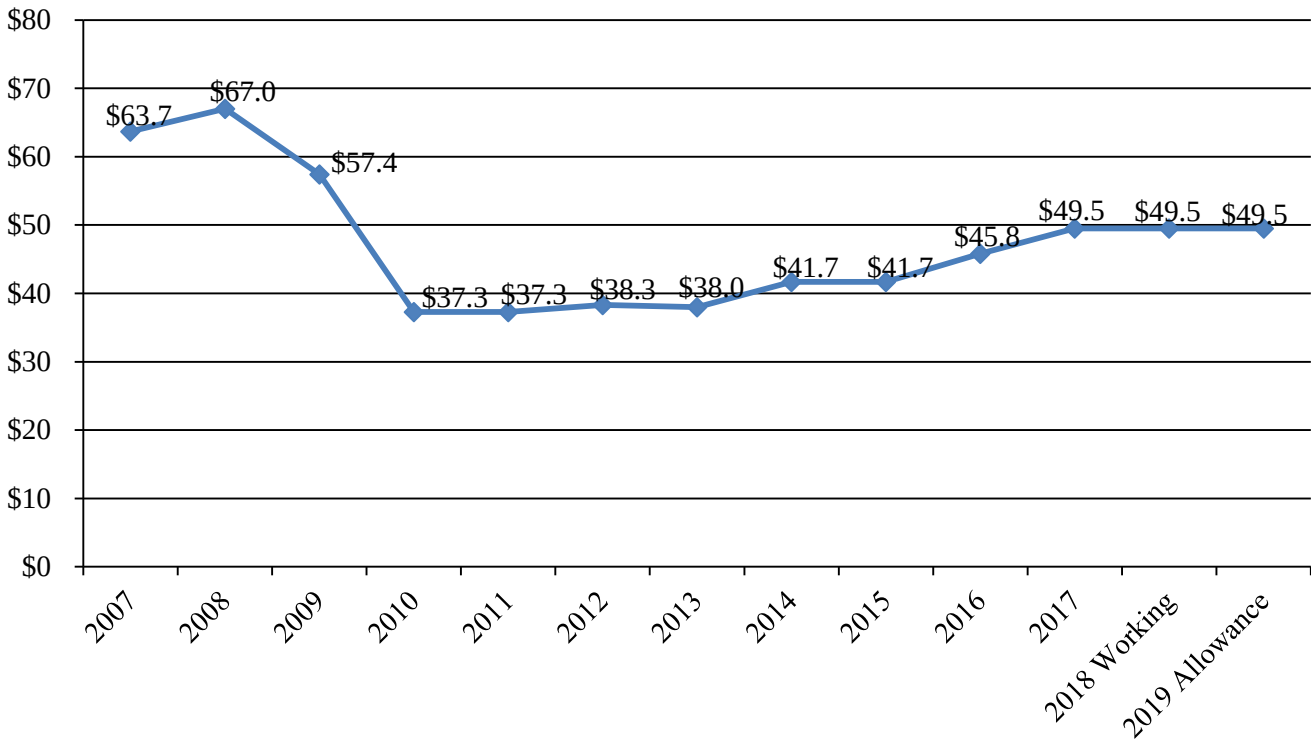
The BRFA also rebases the local health formula in the out-years to use $49.5 million as the starting point rather than growing off the $50.4 million level required for fiscal 2019 under current law. The formula adjustment factor is mandated under Health-General § 2-302 and is calculated by combining 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 2019. 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 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

[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 after consultation with local health officers.

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 2007-2019 Allowance
($ 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 ultimately only reduced by half of the $7.8 million, and funding for fiscal 2016 increased to $45.8 million. A county breakdown of funding in fiscal 2019 is included in **Appendix 2**.

The federal matching funds for the core public health funding transfer to the Prevention and Health Promotion Administration (PHPA) in fiscal 2019, which is shown as a $4.5 million decrease in PHA and a $4.5 million increase in PHPA. The federal office overseeing these funds strengthened the reporting and documentation requirements. PHPA staff needs to interact directly with the grantees to manage these requirements to ensure sufficient documentation is available.

Office of the Chief Medical Examiner

After accounting for changes in personnel costs, the proposed budget for OCME increases by $441,072 compared to the fiscal 2018 working appropriation. The largest increase is in laboratory supplies and equipment which increase by approximately $0.2 million. Of that increase, the largest portion is for the purchase of a new Gas Chromatograph Mass Spectrometer (GCMS), which costs $129,569. The office intends to use the new GCMS to analyze postmortem specimens for Tetrahydrocannabinol (THC). The laboratory currently does not include THC in routine drug testing procedures and does not have an instrument available for THC analysis. OCME indicates that testing of THC levels is necessitated by the legalization of medical marijuana and the potential legalization of recreational marijuana. However, the nature of tests for THC lead to issues when trying to draw a connection between traffic fatalities or even traffic accidents and marijuana impairment.

A July 2017 report to Congress by the National Highway Traffic Safety Administration (NHTSA) concludes that there is a poor correlation of THC levels in the blood or oral fluid with impairment. This is due to the amount of time that THC is present in an individual's system. Unlike alcohol, THC stays in one's system long after impairment. There is a risk that data collected through the use of the GCMS can either be misinterpreted or misused to justify nonevidence-based standards, such as a *per se* limit on THC blood levels that have been established in other states that have legalized marijuana. In those states, the standard is 5ng/ml of blood, a value that NHTSA considers nonevidence-based. Furthermore, research published in the *American Journal of Public Health* found no increased rate of traffic fatalities in states that legalized marijuana three years after legalization.[3] GCMS is a multipurpose machine that can be used to detect opioids, such as fentanyl and carfentanyl in addition to THC.

Office of Preparedness and Response

After accounting for changes in personnel costs, the proposed budget for OPR decreases by $458,774 compared to the fiscal 2018 working appropriation. This is entirely driven by decreases in funding to enhance the State's preparedness and response to Ebola. Fiscal 2019 is the fourth year of a five-year CDC grant to Johns Hopkins University to enhance Ebola preparedness as the Designated Ebola Treatment Center. The fourth and fifth year of the grant have less funding attached than the previous three years.

Laboratories Administration

After accounting for changes in personnel costs, the proposed budget for the Laboratories Administration increases by $1.2 million compared to the fiscal 2018 working appropriation. The largest drivers of this increase are for building epidemiology and laboratory capacity ($607,408) due to an increase in federal funding, food surveillance and testing ($255,265), and service contracts for equipment purchased by CDC ($247,994). Increases are partially offset by decreases in supplies, equipment, and operational costs.

[3] Jayson D. Aydelotte, *et al.* "Crash Fatality Rates After Recreational Marijuana Legalization in Washington and Colorado," American Journal of Public Health 107, no. 8 (August 1, 2017): pp. 1329-1331.

Issues

1. Maryland Primary Care Program

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 four years, the All-payer Model Contract has generated $905 million in savings, well above the $330 million in savings promised over the five years of the model agreement.

All-payer Waiver – Phase II

While the All-payer Model Contract is achieving positive results, the current model is focused on hospital performance. Phase II of the model will focus on savings in Medicare Total Cost of Care (TCOC). The All-payer Model for hospitals (phase I), originally set to expire in 2018, was extended through 2019 to allow for the federal government to approve phase II, which is delayed after transition to a new administration and turnover at the federal level.

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. This program will be called the Maryland Primary Care Program (MDPCP) (formerly referred to as the Maryland Comprehensive Primary Care Model).

The MDPCP 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 FFS payments and up-front payments to support care management and incentivize favorable results.

The MDPCP, built upon the foundations of the Centers for Medicare and Medicaid Services' (CMS) Comprehensive Primary Care Plus Model, includes a State-sponsored coordinating 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 rules that the CE administers. In Maryland's model, the CE will be a program management office within the Executive Director of PHA's office. The program management office was recently established with 4.0 positions in fiscal 2018. A budget amendment was processed on January 9, 2018, to increase the appropriation by $246,280 in funds from the Integrated Care Network special fund through the Maryland Health Care Commission to fund the office. The office was established after the fiscal 2019

budget request process, so funding is not reflected in the fiscal 2019 allowance. MDH will likely process a budget amendment in fiscal 2019 to provide funding for the office.

Implementation of the MDPCP

The MDPCP is just one of many initiatives proposed for the next phase of the waiver. The agency advised DLS that a proposal for the MDPCP model was delivered to CMS on December 31, 2016. The MDPCP concept is currently under CMS review. Implementation of the model was slated to begin in calendar 2017. With the delay in approval of phase II from CMS, it is expected that providers may begin participation in the program by applying to the program management office for selection in the middle of calendar 2018. MDH still expects to initiate the program by the original timeline of January 2019.

Key Elements of the MDPCP

The MDPCP will include two tracks with incrementally advanced care delivery requirements and payment options for practice participation. Both tracks require practices to employ the same five functions, but with varying intensity:

- access to care;
- care management;
- comprehensiveness and coordination;
- patient and caregiver experience; and
- planned care and population health.

Track 1 adds these five functions to visit-based FFS care, while Track 2 includes these services and also offers nonvisit-based care such as phone, email, telehealth, text message, and use of a secure portal. Track 2 is intended to offer more comprehensive health management.

Under the MDPCP, CMS would provide funding directly to practices in several forms:

- care management fees ranging from $6 to $100 per beneficiary per month (pbpm), based on the risk level of the Medicare beneficiary;
- performance-based incentive payments ranging from $2.50 to $4.00 pbpm balanced against measures of quality, patient satisfaction, and utilization;
- a hybrid FFS/partial prepayment system with practices receiving partial quarterly prepayments in advance; and

- the possibility of lump sum payments through Medicare's Quality Payment Program.

The MDPCP will support the establishment of Care Transformation Organizations (CTO) – a key feature of the program. CTOs provide support to practices through personnel, infrastructure, and technical assistance that will generate economies of scale. Additionally, a system will be established that allows for practices to slowly transition into the program with support and as necessary.

The State will support practices through data analysis. Practices will be provided with supports and services through the Chesapeake Regional Information System for our Patients, the statewide health information exchange. Additionally, Medicare data would be provided to practices to assist in risk stratification and provider referrals.

2. Timeline and Funding for a Centralized Revenue Management System for LHDs

The 2017 *Joint Chairmen's Report* (JCR) requested that MDH submit a report on the timeline and funding for a centralized revenue management system for LHDs. This report was requested in response to issues around the ability of LHDs to contract with private insurers for billing purposes.

As the report demonstrates, the public health landscape has changed in recent years. With discretionary funding that had traditionally been provided to LHDs allocated to other health initiatives, many LHDs have reduced or eliminated direct preventive and clinical services. LHDs are increasingly reliant on the ability to negotiate favorable contracts with private contracts in order to provide clinical services.

In 2012, the CDC awarded a $340,000 grant to MDH to assess capabilities and develop and implement a statewide process enabling LHDs to bill insurance companies for immunization services. MDH contracted Roswen, Sapperstein, and Friedlander (RSF) to assist in this effort. In 2014, RSF conducted billing webinars and provided intensive billing support for specific LHDs. RSF also established a billing manual that was tailored to the LHDs needs.

Since the original CDC grant MDH has made efforts to improve the billing capabilities of LHDs. To date, the department has spent approximately $586,000 on these efforts. In the most recent activity, RSF is conducting a pilot billing project across programs with four LHDs – Allegany, Baltimore, St. Mary's, and Wicomico counties. Technical assistance will be provided for front end, back end, and clinical operations as it relates to billing practices.

Although the JCR asked about a timeline of the development of a centralized revenue system, the report indicates that a large number of LHDs are not interested in that approach. MDH is exploring options for maintenance of the billing manual as well as technical assistance for LHDs as they implement their own new billing practices. MDH expects to spend approximately $5,000 on a contract for these services.

If there is a time in the future when LHDs have sufficient interest in a centralized revenue system, it will require the acquisition of new hardware, software, and training. MDH will continue to survey the LHDs on an annual basis to gauge interest levels in pursuing a statewide system.

3. Interpretation of Section 2-302 of the Health-General Article

Section 2-302 of the Health-General article mandates funding for Core Public Health Services. As stated previously, the appropriation is mandated to grow based on population growth and inflation. However, ambiguity in the statute allows for more than one interpretation. The relevant section of statute is as follows:

> "For fiscal year 2018, $49,488,474 to be distributed to each municipality or subdivision in the same amount as the municipality or subdivision received in fiscal year 2017; and
>
> (5) For fiscal year 2019 and each subsequent fiscal year, the amount of funding for the preceding fiscal year adjusted for:
>
> (i) Inflation, as measured by the Consumer Price Index (All Urban Consumers), for the second preceding fiscal year, calculated by the U.S. Department of Commerce; and
>
> (ii) Population growth, as measured by the growth in the total population of the State for the second preceding fiscal year, according to the most recent statistics available through the Maryland Department of Health."

It has recently come to the attention of DLS that the administration is using different data points in interpreting subsection (5)(i) and (5)(ii) despite the language being identical. Both inflation and population growth are meant to be calculated based on the change in the second preceding fiscal year. In the case of inflation, the administration compares the second preceding fiscal year to the third preceding fiscal year. However, in the case of population growth, the administration compares population in the third preceding fiscal year to the fourth preceding fiscal year. This discrepancy can be eliminated by amending the formula to state: "as estimated on July 1 of the second preceding fiscal year" in both relevant subsections.

Additionally, it is unclear what funding should be included in the base number for the formula. Traditionally, funding provided in the formula for one year is the base for the next year. However, LHDs also receive funding for general salary increases and health insurance that could be counted in the formula depending on how it is interpreted. This issue can be eliminated by amending the formula to state: "amount of funding provided through the formula for the preceding fiscal year adjusted for:"

DLS recommends amending provisions of the BRFA of 2018 to clarify statute related to funding for Core Public Health Services.

Operating Budget Recommended Actions

1. Add the following language to the general fund appropriation:

   Provided that this funding may not be expended until the Department of Information Technology reviews the project and makes a determination of whether the project should be included as a Major Information Technology Project and the Maryland Department of Health submits a report that details the Department of Information Technology determination. The budget committees shall have 15 days to review and comment. Funds restricted pending receipt of the report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if a report is not submitted.

   Explanation: The Maryland Department of Health (MDH) Vital Statistics Administration is developing an integrated electronic birth, death, and fetal death registration and cost accounting system. Based on statutory criteria for information technology (IT) projects, it is likely that this project should be considered a Major IT Project in the Department of Information Technology (DoIT) Major IT Project Development program. This language restricts funds for the project pending a determination by DoIT and submission of the determination to the budget committees.

Information Request	**Author**	**Due Date**
Report that details determination made by DoIT	MDH	15 days prior to expenditure

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2017					
Legislative Appropriation	$104,869	$7,429	$26,496	$811	$139,605
Deficiency Appropriation	402	0	0	0	402
Cost Containment	0	0	0	0	0
Budget Amendments	1,409	46	4,423	0	5,879
Reversions and Cancellations	-118	-567	-3,484	-103	-4,272
Actual Expenditures	**$106,563**	**$6,908**	**$27,435**	**$708**	**$141,613**
Fiscal 2018					
Legislative Appropriation	$106,219	$7,489	$27,151	$713	$141,571
Cost Containment	-309		0	0	-309
Budget Amendments	0	0	0	0	0
Working Appropriation	**$105,909**	**$7,489**	**$27,151**	**$713**	**$141,262**

MDH: Maryland Department of Health

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. Numbers may not sum to total due to rounding.

Fiscal 2017

The fiscal 2017 legislative appropriation for the Public Health Administration (PHA) increased by $1.8 million. This includes a deficiency appropriation of $402,000 to upgrade salaries for State medical examiners at the Office of the Chief Medical Examiner.

The PHA budget increased by $5.9 million through budget amendments. The appropriation increased by $551,355 ($434,154 in general funds, $36,881 in special funds, and $80,320 in federal funds) through an amendment that allocates centrally budgeted salary increments across State agencies. Special funds increased by $9,314, and general funds were reduced by $103,061 to implement Section 20 of the fiscal 2017 budget bill. General funds increased by $305,498 to account for unbudgeted positions in executive direction.

In the Office of Populations Health Improvement (OPHI), general and federal funds increased by $638,073 and $729,605, respectively, to account for the transfer of the Office of Primary Care from the Prevention and Health Promotion Administration to OPHI. Federal funds increased by an additional $196,029 to cover additional salary and fringe benefits expenditures. Increases in OPHI were offset by a decrease of $121,652 due to high vacancies.

In the Laboratories Administration, $1.7 million in federal funds was added to reflect the addition of 2 contractual employees to the Emerging Infections program, additional laboratory equipment, and licenses. Increases were offset by a $399,983 decrease in general funds to reflect low electricity expenditures ($99,983) and savings on equipment service contracts ($300,000).

In the Office of Preparedness and Response (OPR), $1.5 million in federal funds was added to reflect federal grant awards related to Zika response ($1.26 million) and Ebola preparedness and response ($251,553).

In the Office of the Chief Medical Examiner, general funds increased by $656,739 for increased salary expenses ($322,503), forensic investigator expenses ($218,895), and body transportation services ($115,341).

PHA reverted $117,784 in general funds due to lower than anticipated utilities costs in the Laboratories Administration. Reimbursable fund cancellations amounted to $103,115 due to a grant that was applied for, but not awarded.

PHA canceled $566,679 in special funds. The largest special fund cancellations were due to utility and rent savings ($230,192), fewer laboratory tests than expected ($171,192), and vacancies in the newborn screening program ($158,416).

PHA canceled $3.5 million in federal funds. OPR canceled $2.0 million due to a grant extension for Public Health Emergency Preparedness Supplemental for Ebola Preparedness funding. The Core Public Health Services canceled $649,094 that will be expended in fiscal 2018. In OPHI, $444,782 was canceled that was intended for the Office of Rural Health and a Primary Care cooperative agreement. In the Laboratories Administration, $349,401 in federal funds were canceled primarily due

to vacancies and lower than expected lab supply expenditures. Lower than expected expenditures for a health statistics contract resulted in a $53,845 cancellation.

Fiscal 2018

To date, PHA's fiscal 2018 budget has increased by $309,213 in general funds due to a September 2017 Board of Public Works cost containment action. Cost containment was realized through savings on natural gas.

Appendix 2
Local Health Aid
Fiscal 2018 and 2019

	2018 Working Appropriation	2019 Allowance	2019 with BRFA	BRFA Difference
Allegany County Health Department	$1,407,995	$1,433,339	$1,407,995	-$25,344
Anne Arundel County Health Department	4,170,821	4,245,896	4,170,821	-75,075
Baltimore County Health Department	5,421,144	5,518,725	5,421,144	-97,581
Calvert County Health Department	602,595	613,442	602,595	-10,847
Caroline County Health Department	725,829	738,894	725,829	-13,065
Carroll County Health Department	1,667,149	1,697,158	1,667,149	-30,009
Cecil County Health Department	1,123,764	1,143,992	1,123,764	-20,228
Charles County Health Department	1,453,079	1,479,234	1,453,079	-26,155
Dorchester County Health Department	620,986	632,164	620,986	-11,178
Frederick County Health Department	2,033,245	2,069,843	2,033,245	-36,598
Garrett County Health Department	639,306	650,814	639,306	-11,508
Harford County Health Department	2,308,603	2,350,158	2,308,603	-41,555
Howard County Health Department	1,733,685	1,764,891	1,733,685	-31,206
Kent County Health Department	546,006	555,834	546,006	-49,828
Montgomery County Health Department	3,967,534	4,038,950	3,967,534	-71,416
Prince George's County Health Department	6,335,996	6,450,044	6,335,996	-114,048
Queen Anne's County Health Department	574,849	585,196	574,849	-10,347
St. Mary's County Health Department	1,064,771	1,083,937	1,064,771	-19,166
Somerset County Health Department	578,533	588,947	578,533	-10,414
Talbot County Health Department	485,995	494,743	485,995	-8,748
Washington County Health Department	1,797,019	1,829,365	1,797,019	-32,346
Wicomico County Health Department	1,307,152	1,330,681	1,307,152	-23,529
Worcester County Health Department	703,788	716,456	703,788	-12,668
Baltimore City Health Department	8,218,630	8,366,564	8,218,630	-147,935
Total	**$49,488,474**	**$50,379,267**	**$49,488,474**	**-$890,794**

BRFA: Budget Reconciliation and Financing Act

Note: Includes State funds only.

Appendix 3
Object/Fund Difference Report
MDH – Public Health Administration

Object/Fund	FY 17 Actual	FY 18 Working Appropriation	FY 19 Allowance	FY 18 - FY 19 Amount Change	Percent Change
Positions					
01 Regular	395.00	388.00	391.00	3.00	0.8%
02 Contractual	20.09	20.34	24.30	3.96	19.5%
Total Positions	**415.09**	**408.34**	**415.30**	**6.96**	**1.7%**
Objects					
01 Salaries and Wages	$ 35,658,057	$ 35,485,934	$ 35,428,933	-$ 57,001	-0.2%
02 Technical and Spec. Fees	1,423,823	1,246,450	1,522,903	276,453	22.2%
03 Communication	479,562	625,496	594,240	-31,256	-5.0%
04 Travel	165,582	438,296	194,501	-243,795	-55.6%
06 Fuel and Utilities	2,081,038	2,307,168	2,264,215	-42,953	-1.9%
07 Motor Vehicles	56,642	24,682	39,067	14,385	58.3%
08 Contractual Services	16,804,153	16,599,004	17,224,718	625,714	3.8%
09 Supplies and Materials	7,542,459	6,974,299	7,574,931	600,632	8.6%
10 Equipment – Replacement	152,109	67,261	222,616	155,355	231.0%
11 Equipment – Additional	697,556	74,403	50,566	-23,837	-32.0%
12 Grants, Subsidies, and Contributions	57,772,204	58,090,073	54,030,735	-4,059,338	-7.0%
13 Fixed Charges	18,781,554	19,328,614	19,373,372	44,758	0.2%
Total Objects	**$ 141,614,739**	**$ 141,261,680**	**$ 138,520,797**	**-$ 2,740,883**	**-1.9%**
Funds					
01 General Fund	$ 106,563,094	$ 105,909,434	$ 107,479,477	$ 1,570,043	1.5%
03 Special Fund	6,909,358	7,488,644	7,508,871	20,227	0.3%
05 Federal Fund	27,434,611	27,150,935	22,320,811	-4,830,124	-17.8%
09 Reimbursable Fund	707,676	712,667	1,211,638	498,971	70.0%
Total Funds	**$ 141,614,739**	**$ 141,261,680**	**$ 138,520,797**	**-$ 2,740,883**	**-1.9%**

MDH: Maryland Department of Health

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. The fiscal 2019 allowance does not include contingent reductions or cost-of-living adjustments.

Appendix 4
Fiscal Summary
MDH – Public Health Administration

Program/Unit	FY 17 Actual	FY 18 Wrk Approp	FY 19 Allowance	Change	FY 18 - FY 19 % Change
01 Executive Direction	$ 7,308,403	$ 8,443,706	$ 8,780,753	$ 337,047	4.0%
01 Office of Population Health Improvement	2,489,387	2,945,097	2,534,313	-410,784	-13.9%
07 Core Public Health Services	53,332,380	53,981,474	50,379,267	-3,602,207	-6.7%
01 Post Mortem Examining Services	13,074,618	12,785,362	13,761,109	975,747	7.6%
01 Office of Preparedness and Response	17,616,596	16,739,688	16,163,144	-576,544	-3.4%
01 Laboratory Services	47,793,355	46,366,353	46,902,211	535,858	1.2%
Total Expenditures	**$ 141,614,739**	**$ 141,261,680**	**$ 138,520,797**	**-$ 2,740,883**	**-1.9%**
General Fund	$ 106,563,094	$ 105,909,434	$ 107,479,477	$ 1,570,043	1.5%
Special Fund	6,909,358	7,488,644	7,508,871	20,227	0.3%
Federal Fund	27,434,611	27,150,935	22,320,811	-4,830,124	-17.8%
Total Appropriations	**$ 140,907,063**	**$ 140,549,013**	**$ 137,309,159**	**-$ 3,239,854**	**-2.3%**
Reimbursable Fund	$ 707,676	$ 712,667	$ 1,211,638	$ 498,971	70.0%
Total Funds	**$ 141,614,739**	**$ 141,261,680**	**$ 138,520,797**	**-$ 2,740,883**	**-1.9%**

MDH: Maryland Department of Health

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. The fiscal 2019 allowance does not include contingent reductions or cost-of-living adjustments.