Maryland
DEPARTMENT OF HEALTH

*Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary*

Maryland Department of Health
Fiscal Year 2021 Operating Budget
Response to Department of Legislative Services Budget Analysis
of the MDH Administration Budget

Senate Budget and Taxation Committee
Health and Human Services Subcommittee
Chair Melony Griffith
February 7, 2020

House Appropriations Committee
Health and Social Services Subcommittee
Chair Kirill Reznik
February 13, 2020

***MDH should comment on why DDA facilities were not formally moved under the organizational umbrella of the Deputy Secretary of Operations. (pg. 14)***

The Department strongly believes that the reorganization of the Operations Administration to include oversight of the psychiatric and other clinical facilities with the Offices of Procurement and Support Services, Preparedness and Response, Facilities Management and Development, and Safety and Secured Transport allows for a dedicated focus towards building a cohesive State health care system. As part of the continued transition announced by Secretary Neall in 2019, the Department is focused on shifting from siloed, free-standing hospital operations to a system with close communications between facility leadership teams, integrated procurement and other administrative functions, and common facilities policies and procedures.

For the past few months, the Chief Executive Officers (CEOs) from all of the State facilities, including facilities under Operations and the Developmental Disabilities Administration's (DDA) facilities, have been holding weekly conference calls with Operations management and the Office of Human Resources' staff to discuss overtime savings mechanisms and to "share" PINs across the hospital system to help reduce vacancy rates. Operations' vacancy rate is currently at 9.3% and Operations plus DDA is at 10.4%, which are dramatic improvements over vacancy rates at this time last year of 12.5% for Operations and 12.6% for Operations plus DDA. Overtime rates, while still high, have leveled off and the expectation is that with the Governor's proposed salary enhancements for FY 2021 and the potential of nurses moving to three 12-hour shifts, Operations' vacancy rate will continue to fall along with overtime spending.

Residents in DDA facilities have different needs than patients in the behavioral health hospitals and chronic care facilities and therefore have remained outside of the Operations Administration structure. Operations' leadership is in constant communication between the CEOs of all 11 state facilities and the division between Operations and DDA is more theoretical than structural.

***The Department of Legislative Services (DLS) recommends deleting the $1,000,000 general fund appropriation for [Local Health Improvement Coalitions] LHICs and amending the BRFA, delaying the funding restriction for [Community Health Resources Commission] CHRC until fiscal 2022. DLS also recommends restricting $1,000,000 of CHRC special funds for the support of LHICs in fiscal 2021. (pgs. 2, 10-11, 19)***

The Department respectfully disagrees with the recommendation because it would set a precedent for using overly complicated budget maneuvers to support the State's commitment to the Local Health Improvement Coalitions (LHICs).

As proposed in the Governor's budget, the $1 million in new funding for the local health departments is generally funded.

Meanwhile, the DLS recommendation involves reversing Budget Reconciliation and Financing Act language so that the Community Health Resource Commission (CHRC) maintains priority over the Senior Prescription Drug Assistance Program in receiving CareFirst special fund revenue and then restricting $1 million of the CHRC's special funds so that it can be redirected to the Office of the Secretary's budget to replace $1 million in general funds for the LHICs. The net effect is a $1 million savings to the State General Fund while reestablishing priority of the CHRC's local innovation grants over prescription benefits for senior citizens.

In recent years the CareFirst special fund revenue has consistently fallen short of the $22 million in legislative mandates assigned to it. To begin using an under attaining special fund revenue source to replace LHIC general funds sets a precedent whereby DLS will be inclined to question the LHICs' funding source in future budget years and introduce unnecessary uncertainty into local health departments' fiscal planning. State general funds for local health departments, particularly State Core funding, has still not rebounded from reductions.

***DLS recommends amending the BRFA to transfer the [Maryland Board of Physicians] funds to Medicaid to support the expansion of the Primary Care Model to the Chronic Health Home program reducing the need for general fund support in Medicaid. (pgs. 2, 13, 19)***

The Department respectfully disagrees with the recommendation. While DLS asserts there is no "outstanding receivable" for which the Board of Physicians' $199,517 will be used, the Department is actually in the process of hiring new staff—comprised of both high-salary PIN positions and contractual positions that are currently unbudgeted—to support the Department's Diabetes Action Plan. The Diabetes Action Plan is Maryland's framework to prevent and control diabetes, which is a leading cause of preventable death and disability and Maryland's first population health improvement goal aligned with the Total Cost of Care model. These staff will engage key organizations and stakeholders to align with the Plan's action steps and lead statewide implementation and evaluation of the Plan. The Department feels that ensuring the success of the Diabetes Action Plan through a $199,517 one-time transfer from the Board of Physicians is a higher priority and better satisfies the Department's mission than to instead generate $199,517 in savings in Medicaid's $3.1 billion general fund budget.