

**M00F04**  
**AIDS Administration**  
**Department of Health and Mental Hygiene**

***Operating Budget Data***

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(\$ in Thousands)

	<b>FY 02</b>	<b>FY 03</b>	<b>FY 04</b>	<b>FY 03 - 04</b>	<b>FY 03 - 04</b>
	<b><u>Actual</u></b>	<b><u>Approp.</u></b>	<b><u>Allowance</u></b>	<b><u>Change</u></b>	<b><u>% Change</u></b>
General Funds	\$6,073	\$6,342	\$6,109	-\$233	-3.7%
FY 2003 Cost Containment	0	-220	0	220	
Contingent & Back of Bill Reductions	0	-3	-17	-14	
<b>Adjusted General Funds</b>	<b>\$6,073</b>	<b>\$6,119</b>	<b>\$6,092</b>	<b>-\$27</b>	<b>-0.4%</b>
Special Funds	178	286	158	-127	-44.5%
Federal Funds	38,671	42,345	42,074	-272	-0.6%
Contingent & Back of Bill Reductions	0	-2	-21	-19	
<b>Adjusted Federal Funds</b>	<b>\$38,671</b>	<b>\$42,344</b>	<b>\$42,053</b>	<b>-\$290</b>	<b>-0.7%</b>
<b>Adjusted Grand Total</b>	<b>\$44,922</b>	<b>\$48,748</b>	<b>\$48,304</b>	<b>-\$444</b>	<b>-0.9%</b>

- The fiscal 2004 allowance for the AIDS Administration is \$444,000 (0.91%) lower than the adjusted fiscal 2003 appropriation.
- There is relatively little programmatic change in the fiscal 2004 allowance. Most changes reflect the availability of federal funds.

***Personnel Data***

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	<b>FY 02</b>	<b>FY 03</b>	<b>FY 04</b>	
	<b><u>Actual</u></b>	<b><u>Working</u></b>	<b><u>Allowance</u></b>	<b><u>Change</u></b>
Regular Positions	68.00	74.00	64.00	(10.00)
Contractual FTEs	0.00	0.00	0.00	0.00
<b>Total Personnel</b>	<b>68.00</b>	<b>74.00</b>	<b>64.00</b>	<b>(10.00)</b>

***Vacancy Data: Regular Positions***

Budgeted Turnover: FY 04	2.55	3.99%
Positions Vacant as of 12/31/02	15.40	20.81%

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

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- Personnel expenses decline by \$276,000; health insurance and other fringe benefit increases more than offset by savings from ten abolished positions.

## ***Analysis in Brief***

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### **Major Trends**

***New Reported HIV and AIDS Cases Decline:*** Based on a new reporting methodology, new reported HIV cases decline over the five-year period 1998-2002. After a hiccup in 2001, new reported AIDS cases continue their longstanding fall.

***MADAP:*** Enrollment in the Maryland AIDS Drug Assistance Program (MADAP) program continues to show signs of leveling-off, but expenditure growth remains strong. Funding support remains secure.

### **Issues**

***Cost Savings Can Be Realized through Reorganization:*** Reorganization involving the AIDS Administration can produce savings while maintaining program effectiveness.

### **Recommended Actions**

	<b><u>Funds</u></b>
1. Add language transferring the Sexually Transmitted Disease Program from the Community Health Administration to the AIDS Administration.	
2. Reduce general fund operating expenditures by \$19,000.	\$ 19,000
<b>Total Reductions</b>	<b>\$ 19,000</b>

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**AIDS Administration**  
**Department of Health and Mental Hygiene**

## ***Operating Budget Analysis***

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### **Program Description**

The AIDS Administration was established in 1987 to provide the Department of Health and Mental Hygiene (DHMH) and the State with expert scientific and public health leadership to combat the spread of HIV. The mission of the AIDS Administration is to decrease disability and death due to AIDS by reducing transmission of HIV and to help Marylanders already infected live longer and better lives. This is to be accomplished by monitoring the spread of the epidemic and its impact on populations within the State, controlling the spread of HIV infection in Maryland, and reducing morbidity and mortality associated with HIV. The key functions of the AIDS Administration are:

- executive oversight of the mission of the administration;
- planning, developing, and evaluating programs;
- supporting programs statewide for treatment and support services to ensure that people with HIV infection have access to the medical and support services needed to live with their disease;
- supporting programs statewide for prevention and education to reduce the likelihood of transmission by giving people the information they need to adopt behaviors which will prevent them from becoming infected; and
- surveillance to track HIV and AIDS.

The AIDS Administration consults and coordinates its work with the 24 local health departments. Each local health department has counseling and testing sites where free tests and consultations are available. The administration also funds clinical activities for the diagnosis and evaluation of patients with HIV.

### **Performance Analysis: Managing for Results**

Based on data through September 2002, there are currently an estimated 24,200 Marylanders living with HIV or AIDS (13,416 with HIV and 10,784 with AIDS). This number is slightly below the number reported for 2001 and reflects more extensive searching of vital records data to confirm that persons with HIV and AIDS are still alive. Most of the people living with HIV/AIDS are concentrated in two jurisdictions or the prison system: 52% of all Marylanders living with HIV live in Baltimore City, with the correctional population and Prince George's County together accounting for another 26%; 49% of all Marylanders living with AIDS live in Baltimore City, followed by 17% in Prince George's County.

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**Exhibit 1** details performance data on HIV/AIDS in Maryland as well as the State’s compliance with federal Centers for Disease Control (CDC) surveillance standards. The exhibit illustrates:

- New reported HIV cases, as measured over the five-year period 1998 through 2002, shows an average annual decline of 3.7%, although the numbers are fairly flat from 2001 to 2002. This appears to be a significant reverse from prior years when new HIV cases grew relentlessly, albeit slowly. In fact, the reversal reflects a reporting change. In prior years, the administration reported HIV and AIDS cases through an unduplicated count. Thus, if a person’s health status changed from HIV to AIDS, they would be removed from the HIV count and added to the AIDS count. That resulted in an undercounting of prior year HIV cases. The administration has reworked its data so that a person is considered in the HIV data from the year of HIV diagnosis until AIDS diagnosis, and then added to the AIDS data from the year of AIDS diagnosis forward. The result is a larger number of new reported HIV cases compared to numbers previously reported, but a downward trend. It should be noted that the AIDS Administration’s Managing for Results (MFR) goals are still oriented to the old manner of data collection, and need to be revised accordingly.
- New reported AIDS cases fall by an annual average of 3.8% over the same five-year period reflecting the impact of new AIDS drugs and therapies. After spiking somewhat in 2001, new reported AIDS cases seem to be continuing their downward trend and are approaching half the level of new reported AIDS cases found in the mid-1990s.
- In the surveillance area, Maryland is one of 15 states that track HIV cases through the use of a unique identifier rather than name reporting. The CDC allows this method of reporting providing that certain minimum performance guidelines are met. Surveillance funding is contingent on these standards being met. As indicated in exhibit 1, Maryland meets those standards.

**Exhibit 1**

**Performance Data – Selected Indicators  
Calendar 1998 through 2002**

	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>% Change 1998-2002</u>
New Reported HIV Cases*	2,597	2,387	2,406	2,193	2,230	-3.7%
New Reported AIDS Cases*	1,555	1,553	1,430	1,624	1,333	-3.8%
HIV/AIDS reporting within six months of diagnosis. CDC required standard: 66%. (%)		85.1%	83.8%	80.0%	85.1%	
Unduplicated HIV/AIDS reporting. CDC required standard: no more than 5%. (%)		<1%	<1%	<5%	<5%	

\*2002 data for HIV projected from data through September 30,2002; 1999 through 2002 data for AIDS estimated from data through September 30, 2002, based on lags in reporting.

Source: Department of Health and Mental Hygiene

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Compared to national data, Maryland's AIDS rate remains significantly above the national average. CDC data reporting through December 2001 shows Maryland with 35.6 new AIDS cases per 100,000 population compared to the national average of 14.7 per 100,000 population. Only New York and the District of Columbia have higher rates of new AIDS cases. Among metropolitan areas with populations over 500,000, Baltimore City with a new AIDS case rate of 50 per 100,000 population was higher than all but two jurisdictions (Miami and New York). This represents a somewhat dramatic jump for Baltimore from a rate of 37.8 per 100,000 population in 2000, a jump attributed to efforts to improve reporting (and which also contributed in a significant increase in Maryland's AIDS rate in the same period).

Maryland's AIDS population continues to show some striking differences to the nation as a whole in terms of exposure categories:

- Nationally the leading exposure category to AIDS, 46% of all reported AIDS cases, is men having sex with men. In Maryland this category provides only 19% of reported AIDS cases.
- For Maryland, the leading exposure category to AIDS, 49% of all reported AIDS cases, is injection drug use. Nationally, this figure is only 25%.
- Nationally, 34.2% of all AIDS cases are among African Americans, compared to 79.4% in Maryland.

It should be noted that the data collection efforts of the administration do translate into programmatic actions. For example, since injection drug use is the most common exposure category to HIV/AIDS in Maryland, the administration has helped support the Baltimore City needle exchange program, which according to various research studies has had a beneficial impact in the city. Again, the administration observed that the extent of new HIV cases in three zip codes in northwest Baltimore City was increasing at an average annual rate of 36%, significantly above any other area, and so targeted programming (education, prevention, and expanded needle exchange van hours) in those neighborhoods. Results have been positive, with new cases of HIV infection in those zip codes dropping by 24% from 1999 to 2001.

### **Key Program Caseloads**

The major health services programs offered by the AIDS Administration are the Maryland AIDS Drug Assistance Program (MADAP) and two insurance programs MADAP-Plus and the Maryland AIDS Insurance Assistance Program (MAIAP). MADAP and MADAP-Plus are federally-funded programs, while MAIAP is supported through general funds.

MADAP is the largest program run by the AIDS Administration. MADAP assists persons diagnosed with HIV/AIDS who meet certain income eligibility criteria (above 116% and below 400% of the federal poverty guidelines (FPG) or \$10,228 to \$35,440 for a single person under the 2002 FPG) with HIV/AIDS-related drug costs. Clients are certified eligible for MADAP for a one-year period, after which time they may reapply for certification.

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As shown in **Exhibit 2**, MADAP enrollment exceeded 2,000 for the first time in 2002. What is more striking, however, is the sharp drop of persons enrolled in MADAP who are on Highly Active Anti-Retroviral Therapy (HAART), generally considered to be three or more medications including at least one protease inhibitor or non-nucleoside reverse transcriptase inhibitor plus two other anti-retrovirals. HAART is traditionally considered the “gold standard” for HIV/AIDS therapy (reflected in the fact that in 2000, virtually all MADAP enrollees were on HAART), so the decline is potentially alarming. The administration believes that this decline might be attributable to three influences:

- Clients may not be receiving all of the required HAART drugs through MADAP but rather through clinical trials with the result that they are in fact on HAART.
- Clients may be experiencing some resistance to the drugs, some of which have been used for as over seven years (and the allowance contains funds to investigate the issue of antiretroviral resistance).
- Treatment guidelines have recently changed, moving away from taking the full range of HIV/AIDS drugs at first diagnosis.

**Exhibit 2**

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**Program Data Selected Indicators  
Calendar 1998 through 2002**

	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>% Change 1998-2002</u>	<u>% Change 2001-2002</u>
MADAP Enrollees	1,049	1,349	1,650	1,992	2,033	18	0.5
MADAP Enrollees on HAART (% of Clients)	91	95	99	80	76	-4.4	-1.3
MADAP-Plus Enrollees			62	142	100		-8.4
MAIAP Enrollees			237	247	215		-3.4

MADAP enrollment is year-end monthly enrollment (based on three-month average). Beginning July 2000 data includes MADAP-90 enrollment.

MADAP-Plus and MAIAP enrollment is average monthly enrollment in that fiscal year.

Source: Department of Health and Mental Hygiene

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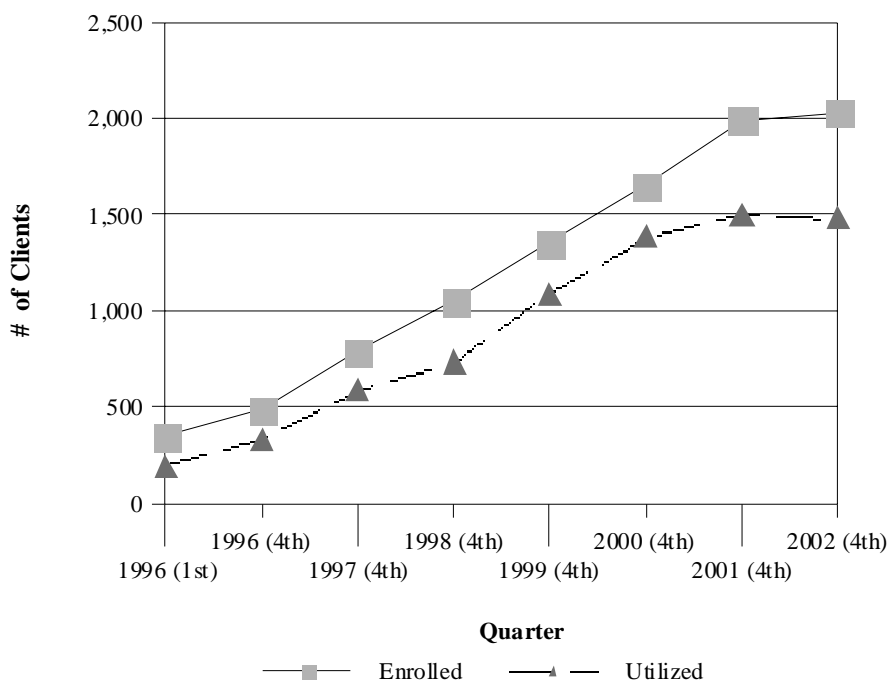
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**Exhibits 3 and 4** detail trends in MADAP enrollment and expenditures from 1996 (when HIV/AIDS therapy became more effective through new drugs) to 2002. Three trends are evident:

- MADAP enrollment appears to be flattening, again perhaps the result of changing treatment guidelines, but also perhaps a sign that the program may be reaching the threshold of those eligible for the program.
- In 2002 utilization by eligible enrollees falls for the first time since 1996, although the percent of eligible enrollees utilizing the program first fell in 2001 (from a high of 83% to 75%) and continues to decline in 2002 (to 73%). Again, the revised treatment guidelines are the suggested explanation.
- Expenditures continue to rise at a healthy rate. Per client average monthly costs rose 10.6% from 2001 to 2002; average monthly expenditures 9.5%. Part of the explanation for this is the well-known inflation in drug costs generally. In addition, the AIDS Administration continues to have plentiful federal funds to spend on HIV/AIDS, and they are able to continue to add new and expensive HIV/AIDS drugs to the MADAP formulary. For example, the administration recently added peginterferon alfa 2b and ribavirin to the formulary at an expected cost of almost \$2 million in fiscal 2003.

**Exhibit 3**

**MADAP Monthly Enrollment and Utilization Trends  
Calendar 1996 through 2002\***

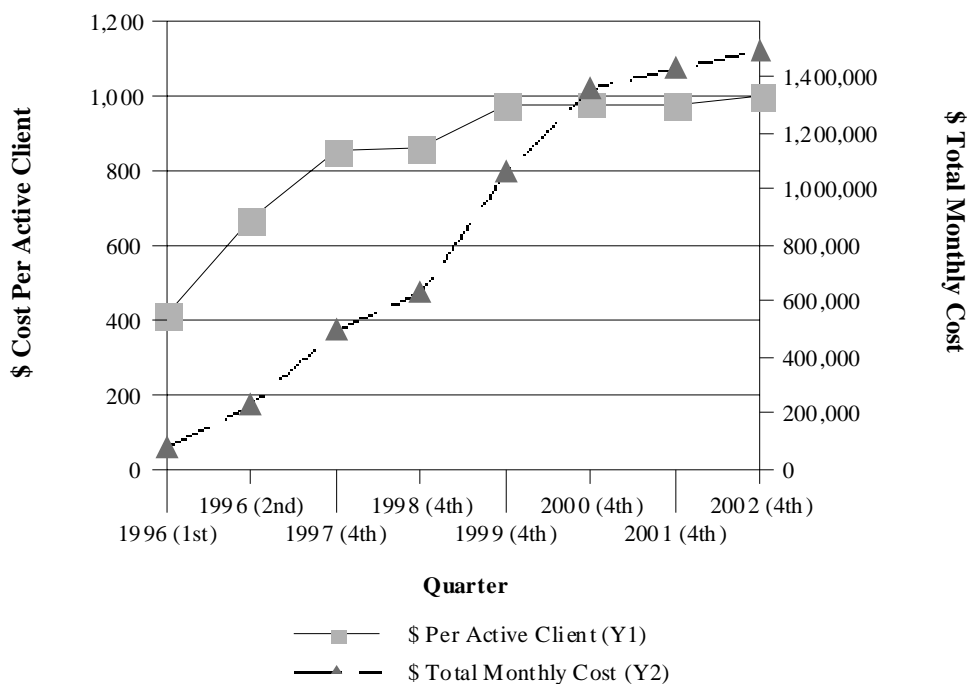


\*Data are three-month averages for the fourth quarter of each year except 1996 when the first and fourth quarters are shown.

Source: Department of Health and Mental Hygiene

Exhibit 4

**MADAP Monthly Spending Trends  
Calendar 1996 through 2002\***



\*Data are three-month averages for the fourth quarter of each year except 1996 when the first and fourth quarters are shown.

Source: Department of Health and Mental Hygiene

Based on a review of the most recent annual report of the National ADAP Monitoring Project (April 2002), the AIDS administration continues to run a program with expansive eligibility requirements and generous drug coverage. They have also avoided the experience of at least nine other states (Alabama, Georgia, Idaho, Kentucky, Maine, North Carolina, South Dakota, Texas, and Wyoming) which as of February 2002 reported having at least one program restriction such as capped enrollment, limited antiretroviral access, and expenditure caps. Indeed, media reports indicate that such restrictions will become more widespread in 2003 as states confront significant budget problems.

Exhibit 2 also details MADAP-Plus and MAIAP enrollment. MAIAP maintains employer-based health insurance for individuals testing positive for HIV who can no longer work due to their illness. Eligibility requirements include a diagnosis of HIV, an inability to work, and incomes below 300% of FPG. Program enrollment is capped at 450, but as shown in Exhibit 2, actual enrollment is much lower. The program was due to sunset in 2002, but Chapter 30, Acts of 2002 extended the program until 2010.

MADAP-Plus complements MAIAP in that it targets persons at risk of losing private health insurance but who are not eligible for MAIAP. The upper income limit is the same as that for MADAP. Enrollment

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in this program has failed to live up to expectations. The 300 average monthly enrollment has never materialized, and as shown in Exhibit 2, enrollment is falling.

### **Fiscal 2003 Actions**

#### **Impact of Cost Containment**

As part of fiscal 2003 cost containment, the AIDS Administration saw general fund reductions of \$220,000. Reductions were in three areas:

- \$87,000 as a result of a 2.8% reduction in human services contracts. These contracts, most of which are awarded to local health departments, support prevention, counseling, and testing programs.
- \$83,000 used to fund an AIDS education program created as part of legislation enacted in 1989 under which persons who plead guilty or nolo contendere to, or who are found guilty of, violating provisions of the Maryland Controlled Dangerous Substances Act are required on the order of a judge to complete an education program on AIDS. The reduction eliminates the program.
- \$50,000 for condom purchases. Funding for condom purchases has been a target for several years, despite condom distribution being an integral part of the administration's HIV prevention efforts. The reduction will force the administration to better prioritize and target requests for condoms from community-based organizations.

#### **Contingent Reductions**

The 2003 Budget Reconciliation and Financing Act (BRFA) deletes fiscal 2003 funding for the employee transit initiative. That results in an additional, albeit small (\$4,503), reduction to the AIDS administration.

After the fiscal 2003 adjustments are made to the AIDS Administration budget, the fiscal 2003 general fund reductions represent 3.5% of the fiscal 2003 legislative appropriation. The total adjusted fiscal 2003 working appropriation is still just over \$3.8 million (8.5%) above actual fiscal 2002 expenditures, although virtually all of this increase (96%) is attributable to the availability of federal funds. The general fund increase is only a little under \$46,000, 0.8%.

### **Governor's Proposed Budget**

As shown in **Exhibit 5**, the fiscal 2004 allowance for the AIDS Administration is some \$444,000 lower than the adjusted fiscal 2003 appropriation (0.91%). The bulk of the reduction, \$290,000 (65.4%), is a reduction in federal funds, \$127,000 (28.6%) is in special funds, and only \$27,000 (or 6%) is in general funds. Specific components of the change from fiscal 2003 to 2004 include:

Exhibit 5

**Governor's Proposed Budget  
AIDS Administration  
(\$ in Thousands)**

<b>How Much It Grows:</b>	<b>FY 02 Actual</b>	<b>FY 03 Approp.</b>	<b>FY 04 Allowance</b>	<b>FY 03-04 Change</b>	<b>FY 03-04 % Change</b>
General Funds	\$6,073	\$6,342	\$6,109	-\$233	-3.7%
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Special Funds	178	286	158	-127	-44.5%
Federal Funds	38,671	42,345	42,074	-272	-0.6%
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<b>Adjusted Federal Funds</b>	<b>\$38,671</b>	<b>\$42,344</b>	<b>\$42,053</b>	<b>-\$290</b>	<b>-0.7%</b>
<b>Adjusted Grant Total</b>	<b>\$44,922</b>	<b>\$48,748</b>	<b>\$48,304</b>	<b>-\$444</b>	<b>-0.9%</b>

**Where It Goes:**

<b>Personnel Expenses</b>	<b>-\$276</b>
Employee and retiree health insurance .....	\$105
Other fringe benefit adjustments .....	56
Abolished positions (10 FTEs) .....	-437
<b>Contractual Program Support</b>	<b>\$718</b>
MIPAR contract (FF) .....	718
<b>Surveillance</b>	<b>-\$364</b>
Antiretroviral resistance project (FF) .....	298
HIV/AIDS Surveillance in Baltimore City (FF) .....	-662
<b>Health Services</b>	<b>\$150</b>
MADAP/MADAP-Plus (FF) .....	1,254
AIDS Youth Initiative (FF) .....	285
Consortia funding for health services (FF) .....	-1,389

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**Where It Goes:**

<b>Prevention</b>	<b>-\$683</b>
Prevention Cooperative Agreement, ending of three-year grant to Blue Waters Coalition (FF)	
.....	-683
<b>Other Changes</b>	11
<b>Total</b>	<b>-\$444</b>

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

- **Personnel expenses** decline by \$276,000. The biggest single change is a reduction of \$437,000 due to abolished positions (10 full-time equivalents (FTEs)). This reduction is offset by an increase in health insurance costs of \$105,000, and other fringe benefit adjustments of \$56,000.

The regular position count at the AIDS administration has fluctuated significantly in the past 12 months. Originally the AIDS Administration’s fiscal 2003 legislative appropriation allowed 62 FTE positions. The Board of Public Works (BPW) allowed the creation of 12 FTE regular positions in the 2002 interim, all supported through federal funds. Essentially, the administration intended to fund these regular positions with dollars that were being use to obtain programmatic support contracted from the University of Maryland, Baltimore County’s Maryland Institute for Policy and Research (MIPAR). However, 10 of those positions are abolished in the fiscal 2004 allowance, hence part of the increase in proposed funding for contract support through MIPAR.

The budgeted turnover rate for the administration is 3.99%, a rate that requires 2.55 FTE vacancies. The current vacancy rate in the administration is 20.81%, or 15.4 vacancies. This rate is artificially high because the BPW-created positions are included in the calculation. However, even when the fiscal 2004 abolished positions are accounted for, the administration has sufficient vacancies to meet turnover.

- **Total MIPAR contract support** increases by \$718,000. In addition to the funding increase explained above, part of the increase for MIPAR is derived from a reduction in funding provided to the Baltimore City Health Department for surveillance activities. MIPAR will instead perform more of that work, a continuation of an effort begun last year to improve surveillance activities in the city (the data from which is the basis for the allocation of a significant amount of federal HIV/AIDS funding).
- **Surveillance** activity funding declines by \$364,000, the reduction noted above to Baltimore City (which is further exaggerated by the fiscal 2003 appropriation being inflated by the existence of prior year carry over funds) offset by a new surveillance activity, \$298,000 for antiretroviral resistance work. Maryland was one of four sites selected by the CDC to participate in research related to drug resistant strains of HIV. As indicated above in the discussion of program trends, drug resistance may be becoming an increasingly important part of the ongoing HIV/AIDS story.
- **Health services** funding increases by \$150,000. Consortia funding for health and support services declines by almost \$1.4 million. These are health and social services provided according to priorities established between the consortia (local health departments, a provider or community-based

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organization, and clients) and the AIDS Administration. This decline is largely artificial as fiscal 2003 funding is again inflated by funding carried over from prior years. The administration expects that fiscal 2003 actual expenditures will be lower and the cancelled funds brought back into the fiscal 2004 budget at a later date via budget amendment, essentially resulting in flat funding.

Offsetting this decline are increases in the form of the AIDS Youth Initiative that appears in the fiscal 2004 allowance as a new program. However, this initiative actually represents more of an enhancement of activities that are currently done in Maryland aimed at youth (under 25) since it is in this age group that a significant amount of new HIV infections are found. MADAP/MADAP-Plus expenditures increase by just under \$1.3 million.

- **Prevention** activities fall by \$683,000. This drop is due to the completion of a three-year federal grant funding the Blue Waters Coalition in Baltimore City.

**Federal Dollars Are Still King in the AIDS Administration**

Federal dollars continue to drive the AIDS Administration budget. Most of these funds comes from HIV Care Formula Grants (better known as the Ryan White Funds) and funds for HIV Prevention Activities. Increases in the HIV Care Formula Grants are formula-driven while funds for HIV Prevention Activities are awarded competitively. **Exhibit 6** shows how the increase in federal funds underpins the historical growth in the administration’s budget. Federal funds comprise 87% of the proposed fiscal 2004 allowance.

**Exhibit 6**

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**AIDS Administration  
Funding by Fund Source  
Fiscal 2000 through 2004**

	<b>Actual FY 2000</b>	<b>Actual FY 2001</b>	<b>Actual FY 2002</b>	<b>Working FY 2003</b>	<b>Allowance FY 2004</b>	<b>% Change FY 00-04</b>
General Funds	\$5,245,537	\$5,171,430	\$6,073,069	\$6,118,756	\$6,092,087	3.8%
Special Funds	124,802	285,074	177,883	285,741	158,490	6.2%
Federal Funds	26,410,242	38,135,611	38,670,900	42,343,586	42,053,088	12.3%
<b>Total</b>	<b>\$31,780,581</b>	<b>\$43,592,115</b>	<b>\$44,921,852</b>	<b>\$48,748,083</b>	<b>\$48,303,665</b>	<b>11.0%</b>
<i>Federal Funds as a % of Total Funds</i>	83%	87%	86%	87%	87%	

Source: Department of Health and Mental Hygiene; Department of Legislative Services

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Federal funds do come with strings. Specifically, the HIV Care Formula Grants funds, which make up

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over two-thirds of the administration's federal funds, have three broad financial requirements:

- ***Maintenance of Effort:*** The State must maintain spending on HIV-related activities at a level at least equal to spending by the State for the one-year period preceding the fiscal year for which the State is applying to receive a grant. For the purposes of this requirement, the administration uses general fund expenditures made by the AIDS Administration.
- ***Matching Funds:*** For states such as Maryland, based on the number of AIDS cases and history of funding, state spending of \$1 is required for every \$2 federal dollars claimed. For the purpose of the match, DHMH utilizes both spending by the AIDS Administration as well as appropriate spending in Medicaid (which is permissible).
- ***Supplantation:*** Formula funds are intended to supplement and not supplant State funds.

The fiscal 2004 allowance potentially falls afoul of the federal maintenance of effort requirements. As noted above, general fund support in the fiscal 2004 allowance actually falls below anticipated fiscal 2003 general fund support for the administration. In reality, the dollar difference is small and DHMH has the flexibility to move dollars around in such a manner as to alleviate potential problems without expanding the base for maintenance of effort.

Given these restrictions, the potential for fiscal 2004 reductions is limited. The only reduction possible is to reduce the fiscal 2003 general fund appropriation down to the level of actual fiscal 2002 general fund expenditures (the current basis for maintenance of effort) through the BRFA and reduce the fiscal 2004 allowance to the same level. **Thus, the Department of Legislative Services (DLS) recommends reducing the fiscal 2003 appropriation by \$45,000 through the 2003 BRFA and the fiscal 2004 allowance by \$19,000.** Federal funds are available and can be substituted for these general funds.

## ***Issues***

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### **1. Cost Savings Can Be Realized through Reorganization**

During the 2002 interim, the council on Management and Productivity spent time looking at the potential for organizational changes at DHMH. The thrust of that work was around the effectiveness of the department rather than potential cost savings. The council did not issue a final report, but structural change around the AIDS Administration was not considered as part of the discussion.

The effectiveness of the AIDS Administration has not been a subject of debate. As noted above, the administration utilizes the research tools at its disposal to effectively target funding, administers a generous MADAP program, and has utilized federal funds to develop a supplemental insurance program (MADAP-Plus) that expands coverage beyond that originally developed by the State (MAIAP).

Nevertheless, given the State's continuing structural deficit, reorganization as the basis for cost savings needs to be considered. As noted above, direct reductions to the AIDS Administration budget are limited by federal constraints. However, reorganization involving the Administration could still yield cost savings. Two avenues of reorganization are readily identifiable:

- merging the AIDS Administration with the Community Health Administration; and
- transferring the Sexually Transmitted Disease (STD) Program from within the Community Health Administration (CHA) into the AIDS Administration.

#### **Merging the AIDS and Community Health Administrations**

The principal rationale behind merging these two administrations is the argument that there is necessarily overlap between the functions of the two organizations. Certainly, the mission of CHA, which includes the prevention of communicable diseases and the performance of epidemiological and consumer awareness work meshes closely with that of the AIDS Administration. Cost savings would come from duplicative administrative functions: executive direction, fiscal, and administrative support staff for example. General fund savings should amount to \$500,000.

Arguments against the merging of the administrations involve the belief that the AIDS Administrations' single-minded focus on AIDS produces results. Further, being organized as a separate administration allows the ability to retain senior staff (the concern here being that a merger could result over time in a downward reclassification of positions). Interestingly, the ten states with the largest AIDS populations (in addition to Maryland, New York, Florida, California, Texas, Pennsylvania, New Jersey, Georgia, Illinois, and Virginia) have an organizational structure similar to Maryland's, distinct HIV/AIDS administrations that report to a level equivalent to a Deputy Secretary or similar official as in Maryland.

Additionally, it could also be argued that the nature of the HIV/AIDS epidemic in Maryland, with exposure to the virus through injection drug use, does not make the fit with communicable disease programs as neat as it might appear at first glance. Similarly, CHA does include other programs, such as

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food inspections, which bear little relation to the work of the AIDS Administration. Finally affecting such a merger would have to be done carefully to avoid federal fund issues, although those should be surmountable.

### **Transferring the STD Program into the AIDS Administration**

Transferring the STD program into the AIDS Administration makes sense given the linkage between the work carried out by the programs. Indeed, the linkage is stronger and currently, for example, the AIDS Administration provides condom supplies for STD programs. General fund savings should amount to \$300,000.

The transfer of the STD program into the AIDS Administration would alleviate concerns about keeping senior staff in the AIDS Administration. However, while the AIDS Administration could accommodate most of the 7 FTE staff currently operating the STD program (through use of their vacancies and also by retaining federally-funded positions currently in the STD program), some might have to find other positions within the department or other State agencies as the principal savings derived from the transfer come from eliminating positions as well as other operating expenses (excluding purchase of care services) in the STD program. Finding such positions within the department can be readily done.

What about the issue of loss of focus? Here again the argument is not as strong. Of the nine other states with the largest AIDS populations, four (Georgia, New York, Virginia, and Texas) have STD responsibility combined into the HIV/AIDS organization. A fifth, California, is looking to do the same thing. It is unclear why the AIDS Administration should lose focus by adding a relatively small (\$1.525 million total budget, \$675,000 general funds, \$850,000 federal funds) and related program.

Finally, again, federal fund issues will have to be considered in such a transfer. However, it would seem that it should be easier to manage those issues.

### **Recommendation**

Added to the options considered above is the option of doing nothing based on the notion that the results provided under the current organizational structure in CHA and the AIDS Administration are worth the price of not doing some form of consolidation. **However, DLS recommends transferring the STD program into the AIDS Administration for a general fund savings of \$300,000 and a reduction of three FTE positions.** DLS believes that this option provides a balance of significant costs savings with minimum dislocation and distraction to either organization. The specific reduction will be found in the recommended actions section of the Community and Family Health analysis. Budget bill language implementing the transfer is recommended in both analyses.

## ***Recommended Actions***

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1. Add the following language:

All positions and funds appropriated to the Sexually Transmitted Disease Program within the Community Health Administration (Subprogram E321) shall be transferred to the AIDS Administration.

**Explanation:** The language transfers positions and funds appropriated to the Sexually Transmitted Disease Program within the Community Health Administration (Subprogram E321) to the AIDS Administration. The consolidation provides administrative savings (which are shown in the Community Health Administration appropriation) with minimum distraction or dislocation to either organization.

	<b><u>Amount Reduction</u></b>	<b><u>Position Reduction</u></b>
2. Reduce general fund operating expenditures by \$19,000. This reduces proposed general fund expenditures in the AIDS Administration to actual fiscal 2002 levels, while still allowing the administration to meet federal maintenance of effort requirements. Federal funds are available and can be substituted for these general funds.	\$ 19,000	GF
<b>Total General Fund Reductions</b>	<b>\$ 19,000</b>	

## *Current and Prior Year Budgets*

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### Current and Prior Year Budgets AIDS Administration (\$ in Thousands)

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
<b>Fiscal 2002</b>					
Legislative Appropriation	\$6,338	\$418	\$42,085	\$0	\$48,841
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	-92	0	0	0	-92
Reversions and Cancellations	-173	-240	-3,414	0	-3,827
<b>Actual Expenditures</b>	<b>\$6,073</b>	<b>\$ 178</b>	<b>\$38,671</b>	<b>\$ 0</b>	<b>\$44,922</b>
<b>Fiscal 2003</b>					
Legislative Appropriation	\$6,342	\$286	\$42,345	0	\$48,973
Budget Amendments	0	0	0	0	0
Cost Containment	-220	0	0	0	-220
Contingent Reductions	-3	0	-2	0	-5
<b>Working Appropriation</b>	<b>\$6,119</b>	<b>\$ 286</b>	<b>\$42,343</b>	<b>\$0</b>	<b>\$48,748</b>

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

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*M00F04 – DHMH - AIDS Administration*

**Fiscal 2002**

The fiscal 2002 legislative appropriation of the AIDS Administration was reduced by \$3.92 million. Budget amendments reduced the appropriation by \$92,000, all in general funds. This reduction is comprised of \$88,000 due to higher than anticipated turnover and \$11,000 due to lower expenditures on health care insurance. This decrease is offset by an increase of \$7,000 to fund the Annual Salary Review for nurses.

Reversions and cancellations further reduced the appropriation by \$3.83 million. This figure includes \$173,000 in general fund cost containment reductions (see the fiscal 2003 operating budget analysis for further details), \$240,000 in special fund cancellations, and just over \$3.4 million in federal fund cancellations (primarily in HIV Care Formula Grants and HIV Prevention Activities Grants).

M00F04 - DHMH - AIDS Administration

Object/Fund Difference Report  
DHMH - AIDS Administration

Object/Fund	FY03			FY04 Allowance	FY03 - FY04 Amount Change	Percent Change
	FY02 Actual	Working Appropriation				
<b>Positions</b>						
01 Regular	68.00	74.00	64.00	- 10.00	- 13.5%	
<b>Total Positions</b>	<b>68.00</b>	<b>74.00</b>	<b>64.00</b>	<b>- 10.00</b>	<b>- 13.5%</b>	
<b>Objects</b>						
01 Salaries and Wages	\$ 3,797,710	\$ 4,345,366	\$ 4,064,969	- \$ 280,397	- 6.5%	
03 Communication	84,964	78,511	79,459	948	1.2%	
04 Travel	37,191	112,118	116,045	3,927	3.5%	
07 Motor Vehicles	5,667	8,785	8,887	102	1.2%	
08 Contractual Services	25,937,290	25,041,579	23,260,904	- 1,780,675	- 7.1%	
09 Supplies & Materials	14,875,904	19,309,279	20,711,470	1,402,191	7.3%	
10 Equip - Replacement	13,144	0	0	0	0.0%	
11 Equip - Additional	115,308	0	7,318	7,318	n/a	
13 Fixed Charges	54,674	76,948	91,613	14,665	19.1%	
<b>Total Objects</b>	<b>\$ 44,921,852</b>	<b>\$ 48,972,586</b>	<b>\$ 48,340,665</b>	<b>- \$ 631,921</b>	<b>- 1.3%</b>	
<b>Funds</b>						
01 General Fund	\$ 6,073,069	\$ 6,341,528	\$ 6,108,587	- \$ 232,941	- 3.7%	
03 Special Fund	177,883	285,741	158,490	- 127,251	- 44.5%	
05 Federal Fund	38,670,900	42,345,317	42,073,588	- 271,729	- 0.6%	
<b>Total Funds</b>	<b>\$ 44,921,852</b>	<b>\$ 48,972,586</b>	<b>\$ 48,340,665</b>	<b>- \$ 631,921</b>	<b>- 1.3%</b>	

Note: Fiscal 2003 appropriations and fiscal 2004 allowance do not include cost containment and contingent reductions.

Fiscal Summary  
DHMH - AIDS Administration

<u>Unit/Program</u>	<u>FY02 Actual</u>	<u>FY03 Legislative Appropriation</u>	<u>FY03 Working Appropriation</u>	<u>FY02 - FY03 % Change</u>	<u>FY04 Allowance</u>	<u>FY03 - FY04 % Change</u>
01 AIDS Administration	\$ 44,921,852	\$ 48,972,586	\$ 48,972,586	9.0%	\$ 48,340,665	- 1.3%
<b>Total Expenditures</b>	<b>\$ 44,921,852</b>	<b>\$ 48,972,586</b>	<b>\$ 48,972,586</b>	<b>9.0%</b>	<b>\$ 48,340,665</b>	<b>- 1.3%</b>
General Fund	\$ 6,073,069	\$ 6,341,528	\$ 6,341,528	4.4%	\$ 6,108,587	- 3.7%
Special Fund	177,883	285,741	285,741	60.6%	158,490	- 44.5%
Federal Fund	38,670,900	42,345,317	42,345,317	9.5%	42,073,588	- 0.6%
<b>Total Appropriations</b>	<b>\$ 44,921,852</b>	<b>\$ 48,972,586</b>	<b>\$ 48,972,586</b>	<b>9.0%</b>	<b>\$ 48,340,665</b>	<b>- 1.3%</b>

Note: Fiscal 2003 appropriations and fiscal 2004 allowance do not include cost containment and contingent reductions.