

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

***Operating Budget Data***

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(\$ in Thousands)

	<u>FY 02</u>	<u>FY 03</u>	<u>FY 04</u>	<u>FY 02-04</u> <u>Change</u>	<u>FY 05</u>	<u>FY 04-05</u> <u>Change</u>
Operations	\$18,985	\$22,038	\$24,812	\$5,827	\$29,164	\$4,353
Contractual Services	25,937	26,535	23,179	-2,758	24,846	1,667
Contingent & Back of Bill Reductions	0	0	0	0	-27	-27
<b>Adjusted Grand Total</b>	<b>\$44,922</b>	<b>\$48,573</b>	<b>\$47,991</b>	<b>\$3,069</b>	<b>\$53,983</b>	<b>\$5,992</b>
General Funds	6,073	6,067	5,782	-291	5,797	15
Contingent & Back of Bill Reductions	0	0	0	0	-12	-12
<b>Adjusted General Funds</b>	<b>\$6,073</b>	<b>\$6,067</b>	<b>\$5,782</b>	<b>-\$291</b>	<b>\$5,785</b>	<b>\$3</b>
Special Funds	178	164	158	-19	80	-79
Federal Funds	38,671	42,342	42,051	3,380	48,134	6,083
Contingent & Back of Bill Reductions	0	0	0	0	-15	-15
<b>Adjusted Federal Funds</b>	<b>\$38,671</b>	<b>\$42,342</b>	<b>\$42,051</b>	<b>\$3,380</b>	<b>\$48,119</b>	<b>\$6,068</b>
<b>Adjusted Grand Total</b>	<b>\$44,922</b>	<b>\$48,573</b>	<b>\$47,991</b>	<b>\$3,069</b>	<b>\$53,983</b>	<b>\$5,992</b>
<b>Annual % Change</b>		<b>8.1%</b>	<b>-1.2%</b>		<b>12.5%</b>	

- Cost containment has had a marginal impact upon the AIDS Administration since almost 90% of its budget is federal funds. While the administration has had to make cuts like most agencies, changes in federal fund streams drive the administration's budget.
- This point is underlined in the fiscal 2005 allowance. The allowance provides for an increase of almost \$6 million over the fiscal 2004 working appropriation. That increase is almost entirely due to the availability of federal funds.

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

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## ***Personnel Data***

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	<b><u>FY 02</u></b>	<b><u>FY 03</u></b>	<b><u>FY 04</u></b>	<b><u>FY 02-04</u></b> <b><u>Change</u></b>	<b><u>FY 05</u></b>	<b><u>FY 04-05</u></b> <b><u>Change</u></b>
Regular Positions	68.0	74.0	64.0	-4.0	64.0	0.0
Contractual FTEs	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total Personnel</b>	<b>68.0</b>	<b>74.0</b>	<b>64.0</b>	<b>-4.0</b>	<b>64.0</b>	<b>0.0</b>

### ***Vacancy Data: Regular Positions***

Turnover Expectancy	2.98	4.65%
Positions Vacant as of 12/31/03	7.00	10.94%

- After receiving an exemption from the hiring freeze to fill 12 federal funded vacant positions in fiscal 2003 to take its personnel complement to 74 full-time equivalents, 10 of those positions were abolished in the fiscal 2004 allowance. Two more were abolished in the latest round of position cuts in November 2003, but this reduction was offset by the transfer of two positions into the administration. The AIDS Administration also contracts with the University of Maryland, Baltimore County Maryland Institute for Policy and Research to provide contractual assistance for its programs, and that funding has increased.
- As of December 31, 2003, there were 7 vacancies in the AIDS Administration, 2 general funded positions, and 5 federal funded positions.

## ***Analysis in Brief***

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### **Major Trends**

***New Reported Cases of HIV/AIDS:*** The number of new reported cases of HIV and AIDS is falling.

***Maryland AIDS Drug Assistance Program (MADAP):*** MADAP enrollment and expenditures continue to increase, but federal funds continue to support the growth in the program.

### **Issues**

***Federal Dollars: An Island of Opportunity in a Sea of Cost Containment?*** Federal funds now comprise almost 90% of the AIDS Administration's budget. While programs supported by those funds continue to grow, the administration has accumulated a balance of Ryan White Title II funds. Ways to use this balance are explored.

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**Recommended Actions**

	<u>Funds</u>	<u>Positions</u>
1. Add language establishing a pilot program utilizing federal funds received by the AIDS Administration to expand insurance coverage through the Maryland Health Insurance Program for persons with HIV/AIDS who are currently disqualified from participating in that program.		
2. Delete one vacant position and associated funds.	\$ 65,778	1.0
3. Reduce funding for general funded education/prevention contracted services to current levels.	40,000	
4. Adopt narrative recommending that the AIDS Administration submit regulations to the Administrative, Executive, and Legislative Review Committee to enable the administration to add drugs to its formulary without the need for a change in regulation.		
<b>Total Reductions</b>	<b>\$ 105,778</b>	<b>1.0</b>

**Updates**

***Needle Exchange Program:*** Chapter 178, Acts of 1997 contained an annual reporting requirement on the status of Baltimore City’s needle exchange program. The report’s value is limited by lack of up-to-date evaluation data. However, since an extensive evaluation in 2000 indicated the value of the program and ongoing evaluation is not cost-effective, the reporting requirement should be repealed.

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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 2003, there are currently an estimated 25,847 Marylanders living with HIV or AIDS (14,332 with HIV and 11,515 with AIDS). As shown in **Exhibit 1**, most of the people living with HIV/AIDS are concentrated in Baltimore City, Prince George's County, or the prison system. While the AIDS Administration is prohibited from using federal Ryan White funds in State and federal prisons, the State does target prevention programming at the correctional system. The AIDS Administration estimates it currently spends approximately 22% of its available prevention program funds on this population.

**Exhibit 1**  
**Spatial Distribution of Persons Living with HIV/AIDS**  
**As Reported through September 2003**

	HIV		AIDS	
	<u>No.</u>	<u>% of Total</u>	<u>No.</u>	<u>% of Total</u>
Baltimore City	7,395	52%	5,607	49%
Prince George's County	1,821	13%	1,969	17%
Corrections	1,808	13%	797	7%
Baltimore County	915	6%	793	7%
Montgomery County	852	6%	1,013	9%
Remainder of State	1,541	11%	1,336	12%

Source: Department of Legislative Services; AIDS Administration

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**Exhibit 2** details trends in new reported cases in HIV and AIDS in Maryland. The exhibit illustrates that new reported HIV cases, as measured over the five-year period 1998 through 2002, show an average annual decline of 4.1%. New reported AIDS cases fall by an annual average of 2.5% over the same period. After falling steadily from the mid-1990s with the advent of new drug therapies, the number of new reported AIDS cases seems to be continuing their downward trend having briefly increased between 2000 and 2001.

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**Exhibit 2**  
**Performance Data**  
**Calendar 1998 – 2002**

	<u>CY 1998</u>	<u>CY 1999</u>	<u>CY 2000</u>	<u>CY 2001</u>	<u>CY 2002</u>	<u>% Change</u> <u>CY 1998-2002</u>
	New Reported HIV Cases	2,592	2,379	2,404	2,363	2,192
New Reported AIDS Cases	1,566	1,545	1,416	1,514	1,414	-2.5

Note: 2002 data based on reporting through September 30, 2003; 1998 through 2001 data as reported in The Maryland 2003 HIV/AIDS Annual Report.

Source: AIDS Administration

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Compared to national data, the rate of Maryland's new reported AIDS cases remains significantly above the national average. The federal Centers for Disease Control and Prevention (CDC) data reports that nationally there were 14.1 new AIDS cases per 100,000 population in 2002 compared to the Maryland average of 26.7 per 100,000 population, although this gap is lower than in 2001. Maryland's AIDS population continues to show some striking differences to the nation as a whole in terms of exposure categories. Specifically for cases reported in 2002:

- Nationally the leading exposure category to AIDS, 59%, is men having sex with men. In Maryland this category provides only 28% of reported AIDS cases.
- For Maryland, the leading exposure category to AIDS, 50% of all reported AIDS cases, is injection drug use. Nationally, this figure is only 21%.
- Nationally, 34.2% of all AIDS cases were among African Americans, compared to 82% in Maryland.

### **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 federal 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 level (FPL) or \$10,417 to \$35,920 for a single person) 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.

As shown in **Exhibit 3**, MADAP enrollment continues to show a healthy growth, growing almost 10% between 2002 and 2003. **Exhibits 4** and **5** detail trends in MADAP utilization and expenditures from 1996 (when HIV/AIDS therapy became more effective through new drugs) to 2003. Trends from those exhibits include:

- While the number of people using the program on a monthly basis grew by 10% in 2003, as a percentage of enrollees, utilization remained flat. In 2001 utilization by eligible enrollees fell for the first time since 1996, although the percent of eligible enrollees utilizing the program first fell in 2000 (from a high of 81 to 70%) and continued to decline in 2002 (68%), staying at that level in 2003. CDC revised treatment guidelines recommending less aggressive treatment regimens was the suggested explanation.

**Exhibit 3**  
**Program Data Selected Enrollment Trends**  
**Fiscal 1999 – 2003**

	<u>FY 99</u>	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>FY 03</u>	<b>Avg. Annual % Change <u>FY 99 - 03</u></b>	<b>% Change <u>FY 02 - 03</u></b>
MADAP Enrollees	1,349	1,975	2,123	2,196	2,412	15.6%	9.8%
MADAP-Plus Enrollees		62	142	100	100	n/a	0%
MAIAP Enrollees		237	247	215	230	n/a	7%

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

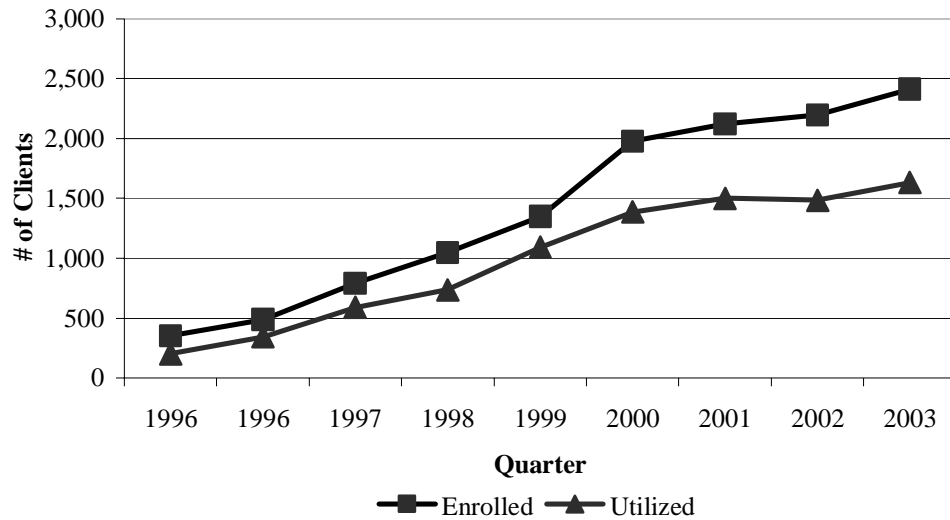
MADAP-Plus and MAIAP enrollment is average monthly enrollment in that fiscal year.

Source: Department of Legislative Services; AIDS Administration

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- Expenditures continue to rise. Per client average monthly costs rose only slightly, by \$30 to \$1,137 (2.7%) from 2002 to 2003; but the increase in the number of people using the program pushed average monthly expenditures up almost \$213,000, 13%.

**Exhibit 4**  
**MADAP Monthly Enrollment and Utilization Trends**  
**Calendar 1996 – 2003\***

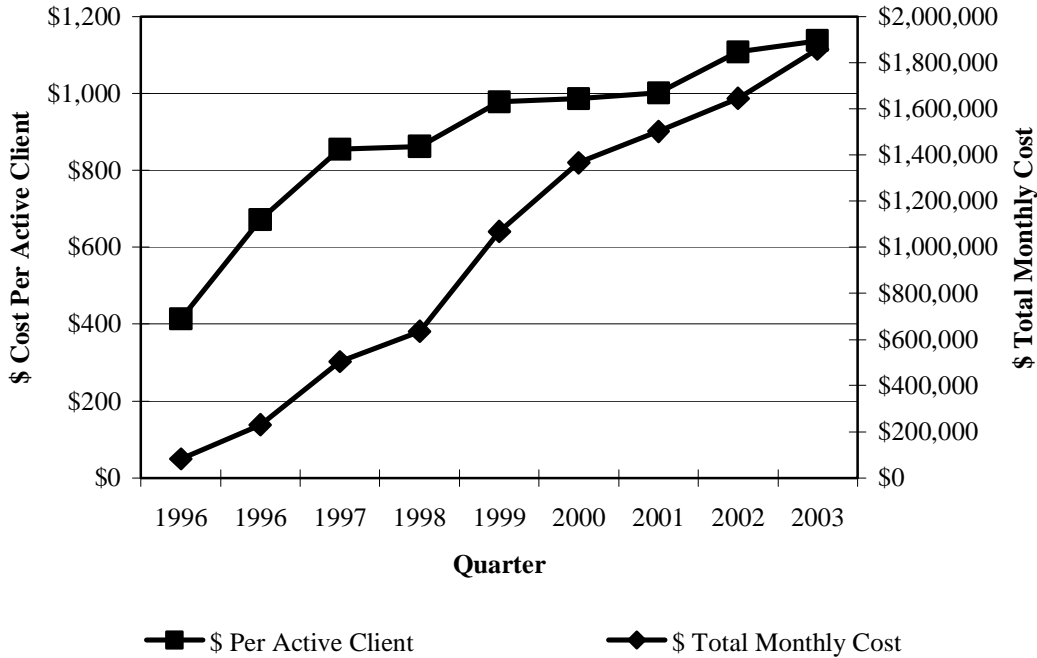


\* Data are three-month averages for the fourth quarter of each year except 1996 when the first and fourth quarters are shown.

Source: Department of Legislative Services; AIDS Administration

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**Exhibit 5  
MADAP Monthly Spending Trends  
Calendar 1996 – 2003\***



\*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 Legislative Services; AIDS Administration

Based on a review of the most recent annual report of the *National ADAP Monitoring Project* (April 2003), the AIDS Administration continues to run a program with expansive eligibility requirements (only five other states were identified as having higher income limits) and generous drug coverage (the AIDS Administration has a smaller formulary than eight other states although all of the major HIV/AIDS drugs are covered).

The administration has also avoided the experience of at least 14 other states which as of February 2003 reported having at least one program restriction such as capped enrollment, limited antiretroviral access, reduced formularies, and expenditure caps. Nine states had waiting lists. Southern states in particular have had to impose the most restrictions on AIDS Drug Assistance Program (ADAP) programs. The 13 states that have had chronic problems with their ADAPs (some restrictions in 5 of the past 7 years) were Alabama, Arkansas, Georgia, Idaho, Kentucky, Maine, Montana, North Carolina, Oklahoma, South Carolina, South Dakota, Texas, and Wyoming.

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Exhibit 3 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 FPL. Program enrollment is capped at 450, but as shown in Exhibit 3, 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. Maryland is one of 22 states that uses federal ADAP dollars for insurance premium assistance. However, enrollment in this program has failed to live up to expectations. The 300 average monthly enrollment that was originally hoped for has never materialized.

## **Fiscal 2004 Actions**

### **Impact of Cost Containment**

The cost containment actions taken to the AIDS Administration by the Board of Public Works (BPW) in July 2003 totaled \$264,000, or 4.4% of the AIDS Administration's general fund legislative appropriation. Of this reduction:

- \$60,000 supported 29 treatment slots through the Baltimore City needle exchange program and was thus a service reduction. However, this reduction was subsequently rescinded by DHMH with the cut being taken in the DHMH Administration budget. This reduces the general fund reduction to the AIDS Administration in fiscal 2004 to 3.4% of the general fund legislative appropriation.
- \$204,000 was a fund swap involving the substitution of federal funds for two general fund supported positions and various prevention activities. The fund swap was potentially problematic as the proposed substitution may not be allowed because of restriction involving the supplantation of federal funds for previously State-funded activities. At the time of writing, the AIDS Administration had not received permission to use federal funds for one of the two proposed positions or the prevention activities.

The AIDS Administration also lost two positions (federal funded) as a result of BPW action implementing the statewide position cap in November 2003. This loss was subsequently offset by the transfer of two positions back into the administration.

## **Governor's Proposed Budget**

As shown in **Exhibit 6**, the Governor's fiscal 2005 allowance for the AIDS Administration increases almost \$6 million over the fiscal 2004 working appropriation, 12.5%. That increase is driven by federal fund activity, with general funds increasing by only 0.1% over fiscal 2004.

**Exhibit 6**  
**Governor's Proposed Budget**  
**AIDS Administration**  
(\$ in Thousands)

	<u>FY 03</u> <u>Actual</u>	<u>FY 04</u> <u>Approp.</u>	<u>FY 05</u> <u>Allowance</u>	<u>FY 04-05</u> <u>Change</u>	<u>FY 04-05</u> <u>% Change</u>
General Funds	\$6,067	\$5,782	\$5,797	\$15	0.3%
Contingent & Back of Bill Reductions	0	0	-12	-12	
<b>Adjusted General Funds</b>	<b>\$6,067</b>	<b>\$5,782</b>	<b>\$5,785</b>	<b>\$3</b>	<b>0.1%</b>
Special Funds	\$164	\$158	\$80	-\$79	-49.7%
Federal Funds	\$42,342	\$42,051	\$48,119	\$6,068	14.4%
<b>Adjusted Grand Total</b>	<b>\$48,573</b>	<b>\$47,991</b>	<b>\$53,983</b>	<b>\$5,992</b>	<b>12.5%</b>

**Where It Goes:**

<b>Personnel Expenses</b>	<b>255</b>	
Cost containment and turnover adjustment.....		\$130
Increments .....		56
Employee and retiree health insurance .....		42
Other fringe benefit adjustments .....		27
<b>Surveillance Activities</b>	<b>65</b>	
HIV/AIDS surveillance in Baltimore City (FF) .....		363
Behavioral surveillance grant funding (FF) .....		-298
<b>Health Services</b>	<b>5,505</b>	
MADAP/MADAP-Plus (FF).....		4,000
Health services provided according to priorities established between the consortia (local health departments, providers, community-based organizations, and clients) and the AIDS Administration (FF).....		1,505
<b>Prevention</b>	<b>180</b>	
Baltimore City-based substance abuse and HIV program for high-risk groups identified within the Baltimore City Drug Court Program (FF) .....		180
<b>Other</b>		-13
<b>Total</b>		<b>\$5,992</b>

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

## Issues

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### 1. Federal Dollars: An Island of Opportunity in a Sea of Cost Containment?

The bulk of the AIDS Administration's federal funds come from two sources: HIV Care Formula grants (better known as Ryan White Funds) and HIV Prevention Activities grants. Increases in HIV Care Formula Grants are, as the name implies, formula-driven based primarily on the number of individuals with AIDS in each recipient jurisdiction. HIV Prevention Activities grants are also mostly awarded through formula.

#### **The Availability of Federal Funds Drive the AIDS Administration's Budget**

The fiscal information on the cover page demonstrates the importance of federal funds to the administration's budget. Federal funds comprise 89% of the administration's fiscal 2005 allowance, an all-time high. However, federal funds do come with strings. Specifically, the HIV Care Formula Grants funds, which make up 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 currently uses general fund expenditures made by the AIDS Administration and the Maryland Pharmacy Assistance Program (MPAP). However, this will change in the future as the State received a waiver to claim matching federal dollars for MPAP expenditures making these expenditures ineligible for use in meeting maintenance of effort requirements. In the future the State will use fund sources that it is now using to meet its matching requirements.
- **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 spending by the AIDS Administration as well as appropriate spending in State-run psychiatric hospitals and the Department of Public Safety and Correctional Services.
- **Supplantation:** Formula funds are intended to supplement and not supplant State funds.

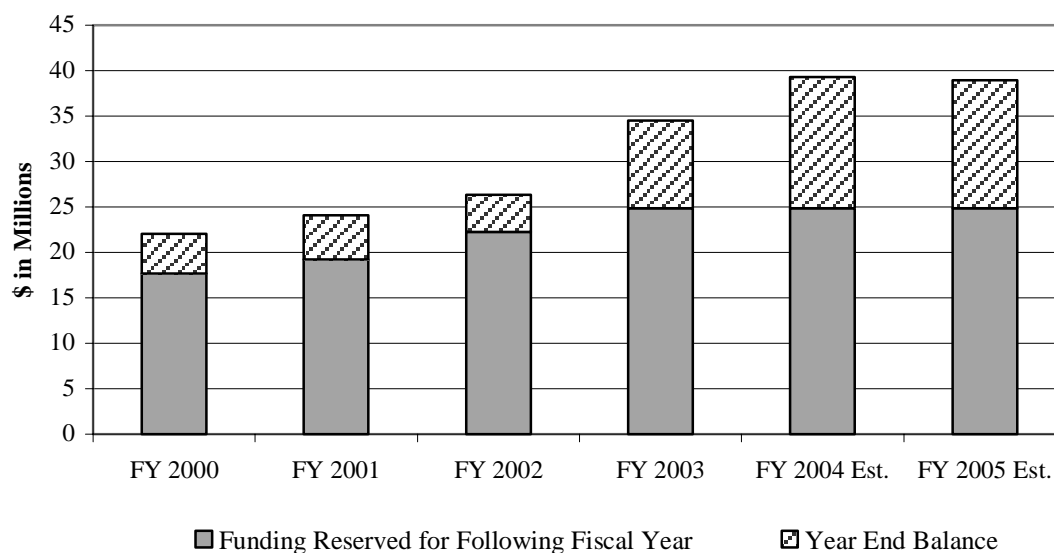
In addition, funds have strict programmatic use requirements.

The AIDS Administration has submitted documentation that demonstrates how the State intends to meet maintenance of effort requirements and matching requirements.

## Accumulating a Balance of Federal Funds

Despite various program expansions the AIDS Administration has not been able to spend all of the federal dollars, specifically Ryan White Title II funds (those that support, among other activities, MADAP and MADAP-Plus). **Exhibit 7** illustrates the growing year-end balances in these funds as well as funding reserved by the administration from the current federal award for the following year. While it would appear that the State's expenditure of these funds is now beginning to match attainment, a healthy balance has accumulated. The administration is projecting to have a fund balance of just over \$14 million at the end of fiscal 2005 in addition to almost \$25 million reserved for fiscal 2006.

**Exhibit 7**  
**Ryan White Title II Funds**  
**Year-end Balances and Reserved Future Funding**  
**Fiscal 2000 – 2005**  
**(\$ in Millions)**



Source: AIDS Administration

## How to Take Advantage of the Fund Balance

Strictures on the use of those funds and other federal requirements appear to limit any attempt to use these funds to offset general fund expenditures. Thus, it should be asked if the State can make better use of these funds. Certainly, there are reasons to be cautious about ways to spend down some of these funds:

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- Given the State's deep structural imbalance, it should not be developing ongoing commitments that might at some point become a State-funded responsibility.
- If, as it appears, expenditures are now more closely aligned with attainment, the cushion of federal funds will be a useful tool to maintain what is one of the more expansive ADAP programs nationwide.
- Having a cushion of funds can be useful given the historically rapid pace of HIV/AIDS drug development and availability and the cost of those drugs. The average annual monthly drug expenditure per client in MADAP is almost \$14,000, and costs will surely only increase. For example, the *2003 National ADAP Monitoring Report* noted the introduction of a new antiretroviral drug, Fuzeon, that had an annual cost of almost \$20,000 for a single person and in many cases had to be used in combination with other medications.

Interestingly, the formulary for the AIDS Administration can only be changed by amending the regulation that lists the current formulary. This can often be a time-consuming process (even through the use of emergency regulations) and delays the availability of the newest HIV/AIDS drugs. For example, Fuzeon was only available on the MADAP formulary in December 2003 even though it had been available for almost a year. The administration is contemplating a change to this process by having regulations refer to a formulary as designated by the AIDS Administration. The formulary would continue to be reviewed by the MADAP Advisory Committee. The advantage of this change, making new HIV/AIDS drugs available more quickly, is one that works well in a time of plentiful funds but has the potential for adverse public reaction if funds were not available and drugs were removed from the formulary (irregardless of motives of sound fiscal management). **Since making this significant change would still require approval of the Administrative, Executive, and Legislative Review (AELR) committee, the Department of Legislative Services (DLS) recommends that committee narrative be adopted requesting the AIDS Administration to develop such a proposal for AELR's consideration.** The General Assembly would still retain oversight over the AIDS Administration's management of the MADAP program through the budget.

- The recent introduction of a HIV rapid test that can be used at the point of care (including many non-clinical and outreach settings) is likely to result in more high-risk individuals who would not normally seek testing becoming aware of their HIV status and seeking care. This is likely to increase demand for services such as that provided by MADAP.

At the same time, if used prudently the available fund balance could be used to foster limited, but real improvements in service delivery. Options to appropriately utilize this fund balance include:

- Expanding eligibility and services provided through MADAP. There are five states with income eligibility requirements that are more liberal than Maryland. Based on the current income distribution of MADAP recipients, expanding income eligibility to 500% of FPL could perhaps add 100 to 200 people to the MADAP rolls. The administration could also expand its existing

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formulary. While generous compared to most other states, the MADAP formulary is smaller than that in eight other states. However, it should be noted that some of these states are beginning to cut back on drug coverage for cost containment.

- Adding funding to improve adherence to medication regimens. Adherence to medication has been shown necessary to achieve viral load suppression and avert drug resistance. Drug resistance is becoming a more pressing problem, and the AIDS Administration has just begun a federal funded study on drug resistance strains of HIV in Maryland.
- Expanding health insurance premium coverage. ADAP coverage can include premium assistance, something Maryland has done through MADAP-Plus. However, enrollment in MADAP-Plus has proved disappointing largely because of the unavailability of insurance products rather than people who might take advantage of such coverage.

One potential solution to this problem is to facilitate access for people with HIV/AIDS to the Maryland Health Insurance Program (MHIP) and to allow the AIDS Administration to use Ryan White Title II funds to provide premium assistance. Established by Chapter 153, Acts of 2002 MHIP (an independent unit of the Maryland Insurance Administration) replaced the former Substantial, Available, and Affordable Coverage program. Funded primarily through the hospital rate-setting system, MHIP is designed to decrease uncompensated care costs by providing access to affordable, comprehensive health benefits for clients whose medical conditions make them otherwise uninsurable.

However, the existing MHIP eligibility criteria appear to prevent this expanded access. For example, MHIP has a six-month exclusion for pre-existing conditions whereby people have to enroll and pay premiums but cannot receive services for pre-existing conditions. Under rules governing the use of Ryan White Title II funds, it appears that this would not be allowed. MHIP also has rules about third party coverage that might prohibit the AIDS Administration from making premium payments. Again, some HIV/AIDS clients have limited Medicare coverage (qualifying as disabled) but cannot enroll in MHIP to cover health costs not covered through their Medicare coverage.

Without passing judgment on the MHIP program eligibility criteria, some accommodation for persons with HIV/AIDS that would allow them to utilize premium assistance through the AIDS Administration could provide significant relief for persons with HIV/AIDS. A recent report in the *Journal of Health Economics* written by researchers at Stanford University concluded that after adjusting for the severity of illness, the mortality rate for publicly insured HIV-positive people is 66% lower than the mortality rate for uninsured HIV-positive people and that public insurance is a further 20% less effective than private insurance in preventing AIDS-related deaths. **Since the MHIP program has not enrolled as many people as it had hoped, DLS recommends budget bill language that establishes a pilot program to expand access to MHIP for persons with HIV/AIDS.** The AIDS Administration should work with MHIP to establish this program. For the purposes of the pilot program, costs to the AIDS Administration should not exceed \$250,000.

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**The AIDS Administration should comment on these and other options to expand programming and how it can best utilize the accumulated Ryan White Title II fund balance.**

## Recommended Actions

1. Add the following language:

Provided that the AIDS Administration and the Maryland Health Insurance Program shall establish a pilot program to expand insurance coverage through the Maryland Health Insurance Program for persons with HIV/AIDS who are currently disqualified from participating in that program. The AIDS Administration shall use up to \$250,000 in federal Ryan White Title II funds to cover the cost of eligible expenses for participation in the program. The AIDS Administration and the Maryland Health Insurance Program shall report back to the General Assembly by November 1, 2004, on progress in implementing the program and again on November 1, 2005, evaluating the pilot program.

**Explanation:** Recent research has demonstrated the marked benefit of insurance coverage for persons with HIV/AIDS versus those without insurance, specifically significantly better mortality rates. While the State provides insurance premium assistance, many persons cannot find insurance coverage. The Maryland Health Insurance Program (MHIP) was designed by the General Assembly to provide access to affordable, comprehensive health benefits for clients whose medical conditions make them otherwise uninsurable. However, as currently designed, there are a number of impediments for persons with HIV/AIDS to enroll in the program and also for the AIDS Administration to use its federal funds for program premium payments. Given that enrollment in MHIP is below what the program can support, improving access to MHIP for persons with HIV/AIDS offers the State a mechanism for improving access to insurance for a group that finds insurance very difficult to obtain.

<b>Information Request</b>	<b>Authors</b>	<b>Due Date</b>
Establishment of Pilot Program	AIDS Administration/MHIP	November 1, 2004
Evaluation of Pilot Program	AIDS Administration/MHIP	November 1, 2005

	<b><u>Amount Reduction</u></b>		<b><u>Position Reduction</u></b>
2. Delete one vacant position and associated funds. This still leaves the AIDS Administration with one vacant general funded position to meet its general fund turnover requirements. Other vacancies are federal funded.	\$ 65,778	GF	1.0
3. Reduce funding for general funded education/prevention contracted services to current levels.	40,000	GF	

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4. Adopt the following narrative:

**Speeding Changes to the Maryland AIDS Drug Assistance Program (MADAP) Formulary:** The committees are concerned that under current regulation, adding drugs to the MADAP formulary requires a change in regulations. This can often be a time-consuming process that delays access to the latest HIV/AIDS drugs although it does provide for appropriate public input should the AIDS Administration ever feel that fiscal constraints demand it limit the formulary. On balance, given the current availability of federal funds, the committees feel that quicker access is more important. Thus, the committees request that the AIDS Administration submit a regulatory change for the consideration of the Administrative, Executive, and Legislative Review Committee to allow it to alter the AIDS formulary without having to go through the regulatory process.

<b>Total General Fund Reductions</b>	<b>\$ 105,778</b>	<b>1.0</b>
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## *Updates*

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### **1. Needle Exchange Program**

Chapter 178, Acts of 1997 repealed the sunset on the establishment of a pilot needle exchange program in Baltimore City. However, DHMH continues to be required to submit an annual report concerning the program. While the report provides updated information about program activity and expenditures, the information on program evaluation dates back to extensive work completed in June 2000 that was conducted through the Johns Hopkins School of Hygiene and Public Health. That evaluation found that the needle exchange program was effective in reducing the incidence of HIV, improving participation in a detoxification program, reducing high-risk behaviors, did not lead to any increase in crime, and had community support. However, no further evaluation has been done. While total State funding for the needle exchange program is just over \$1 million including \$291,000 from the AIDS Administration, an annual extensive evaluation component is not realistic calling into question the value of an annual report.

**DLS recommends that the annual reporting requirement of Chapter 178, Acts of 1997 is deleted through the Budget Reconciliation and Financing Act.** Should an extensive evaluation be warranted in the future, a reporting requirement may be added through language in the *Joint Chairmen's Report*.

## *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 2003</b>					
Legislative Appropriation	\$6,342	\$286	\$42,345	\$0	\$48,973
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	-3	0	0	0	-3
Cost Containment	-262	0	0	0	-262
Reversions and Cancellations	-10	-122	-3	0	-135
<b>Actual Expenditures</b>	<b>\$6,067</b>	<b>\$164</b>	<b>\$42,342</b>	<b>\$0</b>	<b>\$48,573</b>
<b>Fiscal 2004</b>					
Legislative Appropriation	\$6,046	\$158	\$42,051	\$0	\$48,255
Cost Containment	-264	0	0	0	-264
Budget Amendments	0	0	0	0	0
<b>Working Appropriation</b>	<b>\$5,782</b>	<b>\$158</b>	<b>\$42,051</b>	<b>\$0</b>	<b>\$47,991</b>

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

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*M00F04 – DHMH – AIDS Administration*

**Fiscal 2003**

The fiscal 2003 legislative appropriation for the AIDS Administration was reduced by \$400,000. General fund reductions totaled \$275,000, of which \$262,000 was cost containment. Special fund cancellations totaled \$122,000, all of which represents pass-through funds from Baltimore City for a now-defunct Social Security eligibility program. Federal fund cancellations totaled \$3,000.

**Fiscal 2004**

To date, the fiscal 2004 legislative appropriation has been reduced by \$264,000. All of this decrease is due to general fund cost containment (see the earlier discussion of changes to the fiscal 2004 appropriation for additional detail).

**Object/Fund Difference Report  
DHMH - AIDS Administration**

<u>Object/Fund</u>	<u>FY03 Actual</u>	<u>FY04 Working Appropriation</u>	<u>FY05 Allowance</u>	<u>FY04 - FY05 Amount Change</u>	<u>Percent Change</u>
<b>Positions</b>					
01 Regular	74.00	64.00	64.00	0	0%
<b>Total Positions</b>	<b>74.00</b>	<b>64.00</b>	<b>64.00</b>	<b>0</b>	<b>0%</b>
<b>Objects</b>					
01 Salaries and Wages	\$ 3,792,237	\$ 3,863,507	\$ 4,145,525	\$ 282,018	7.3%
03 Communication	85,545	73,817	90,636	16,819	22.8%
04 Travel	38,300	112,899	95,544	-17,355	-15.4%
07 Motor Vehicles	4,918	8,887	9,838	951	10.7%
08 Contractual Services	26,535,284	23,179,481	24,846,134	1,666,653	7.2%
09 Supplies & Materials	17,988,144	20,711,470	24,747,753	4,036,283	19.5%
10 Equip - Replacement	5,286	0	0	0	0.0%
11 Equip - Additional	41,251	7,318	0	-7,318	-100.0%
13 Fixed Charges	81,853	33,804	75,134	41,330	122.3%
<b>Total Objects</b>	<b>\$ 48,572,818</b>	<b>\$ 47,991,183</b>	<b>\$ 54,010,564</b>	<b>\$ 6,019,381</b>	<b>12.5%</b>
<b>Funds</b>					
01 General Fund	\$ 6,066,893	\$ 5,781,681	\$ 5,797,043	\$ 15,362	0.3%
03 Special Fund	164,006	158,490	79,682	-78,808	-49.7%
05 Federal Fund	42,341,919	42,051,012	48,133,839	6,082,827	14.5%
<b>Total Funds</b>	<b>\$ 48,572,818</b>	<b>\$ 47,991,183</b>	<b>\$ 54,010,564</b>	<b>\$ 6,019,381</b>	<b>12.5%</b>

Note: The fiscal 2004 appropriation does not include deficiencies, and the fiscal 2005 allowance does not reflect contingent reductions.

**Fiscal Summary  
DHMH - AIDS Administration**

<u>Unit/Program</u>	<u>FY03 Actual</u>	<u>FY04 Legislative Appropriation</u>	<u>FY04 Working Appropriation</u>	<u>FY03 - FY04 % Change</u>	<u>FY05 Allowance</u>	<u>FY04 - FY05 % Change</u>
01 AIDS Administration	\$ 48,572,818	\$ 48,255,625	\$ 47,991,183	-1.2%	\$ 54,010,564	12.5%
<b>Total Expenditures</b>	<b>\$ 48,572,818</b>	<b>\$ 48,255,625</b>	<b>\$ 47,991,183</b>	<b>-1.2%</b>	<b>\$ 54,010,564</b>	<b>12.5%</b>
General Fund	\$ 6,066,893	\$ 6,046,122	\$ 5,781,681	-4.7%	\$ 5,797,043	0.3%
Special Fund	164,006	158,489	158,490	-3.4%	79,682	-49.7%
Federal Fund	42,341,919	42,051,011	42,051,012	-0.7%	48,133,839	14.5%
<b>Total Appropriations</b>	<b>\$ 48,572,818</b>	<b>\$ 48,255,625</b>	<b>\$ 47,991,183</b>	<b>-1.2%</b>	<b>\$ 54,010,564</b>	<b>12.5%</b>

Note: The fiscal 2004 appropriation does not include deficiencies, and the fiscal 2005 allowance does not reflect contingent reductions.