

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

***Operating Budget Data***

(\$ in Thousands)

	<u>FY 08</u> <u>Actual</u>	<u>FY 09</u> <u>Working</u>	<u>FY 10</u> <u>Allowance</u>	<u>FY 09-10</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$4,465	\$4,498	\$4,155	-\$343	-7.6%
Contingent & Back of Bill Reductions	0	0	-7	-7	
<b>Adjusted General Fund</b>	<b>\$4,465</b>	<b>\$4,498</b>	<b>\$4,148</b>	<b>-\$350</b>	<b>-7.8%</b>
Special Fund	9,309	15,036	15,713	677	4.5%
<b>Adjusted Special Fund</b>	<b>\$9,309</b>	<b>\$15,036</b>	<b>\$15,713</b>	<b>\$677</b>	<b>4.5%</b>
Federal Fund	53,679	51,165	50,938	-227	-0.4%
Contingent & Back of Bill Reductions	0	0	-39	-39	
<b>Adjusted Federal Fund</b>	<b>\$53,679</b>	<b>\$51,165</b>	<b>\$50,899</b>	<b>-\$266</b>	<b>-0.5%</b>
<b>Adjusted Grand Total</b>	<b>\$67,453</b>	<b>\$70,698</b>	<b>\$70,760</b>	<b>\$61</b>	<b>0.1%</b>

- In total, the fiscal 2010 allowance for the AIDS Administration remains relatively level with the fiscal 2009 working appropriation. However, there are some changes in the fund sources for the AIDS Administration with general and federal fund decreases being offset by an increase in special funds from the Maryland AIDS Drug Assistance Program (MADAP) rebate revenue.
- The allocations for the health services programs vary with the MADAP allocation decreasing by \$5.3 million while the MADAP-Plus allocation is increasing by \$3.4 million.
- The contingent reduction shown in the chart above is due to the Back of the Bill language eliminating funding for deferred compensation in fiscal 2010.

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

For further information contact: Alison Mitchell

Phone: (410) 946-5530

## *Personnel Data*

---

	<b>FY 08</b> <b><u>Actual</u></b>	<b>FY 09</b> <b><u>Working</u></b>	<b>FY 10</b> <b><u>Allowance</u></b>	<b>FY 09-10</b> <b><u>Change</u></b>
Regular Positions	111.00	105.00	105.00	0.00
Contractual FTEs	<u>2.11</u>	<u>11.17</u>	<u>1.00</u>	<u>-10.17</u>
<b>Total Personnel</b>	<b>113.11</b>	<b>116.17</b>	<b>106.00</b>	<b>-10.17</b>

### *Vacancy Data: Regular Positions*

Turnover and Necessary Vacancies, Excluding New Positions	4.20	4.00%
Positions and Percentage Vacant as of 12/31/08	11.00	10.48%

- The fiscal 2010 allowance keeps regular positions at the same level as the fiscal 2009 working appropriation, while the contractual positions decrease by 10.2 positions. The reduction in contractual positions is caused by the conclusion of a project to re-report HIV cases to the Centers for Disease Control and Prevention.
- As of December 31, 2008, the AIDS Administration had a vacancy rate of 10.5%, which is significantly higher than the budgeted turnover of 4.0%. There were a total of 11 vacant positions, and three of those positions had been vacant for more than a year.

## *Analysis in Brief*

---

### **Major Trends**

**Highest AIDS Case Rate of Any State:** In 2006, Maryland moved from having the third highest AIDS case rate in the nation to having the highest AIDS case rate of any state with only the District of Columbia having a higher rate. Also, Maryland's AIDS population continues to show some striking differences to the nation as a whole.

**Varying Enrollment Trends in Health Services Programs:** The enrollment for the AIDS Administration's largest health services program, Maryland AIDS Drug Assistance Program, is level. MADAP-Plus enrollment is increasing significantly, while the Maryland AIDS Insurance Assistance Program is experiencing declining enrollment due to level funding.

**Funding Focused Toward Case Management:** Managing for Results data shows a direct relationship between the funding level and the number of services provided. In recent years, funding for medical services has decreased while the funding for dental services has remained level and funding for case management has increased.

## **Issues**

***Transition to Name-based HIV Reporting:*** The AIDS Administration must change from a code-based to a name-based HIV reporting system to maintain the current level of federal funding. The deadline to complete the process of transitioning to a new HIV reporting system was the end of calendar 2008. The AIDS Administration surpassed its goal and was able to report 100% and is asked to comment on how federal funding may be impacted in the future.

***Centers for Disease Control and Prevention HIV Testing Recommendations:*** In September 2006, the federal Centers for Disease Control and Prevention (CDC) issued revised recommendations for HIV testing. Several studies indicate that the recommendations are not being followed throughout the country. Chapter 223 of 2008 revised the Maryland statute to comply with the CDC recommendations, and the AIDS Administration is educating physicians on the changes.

***The Graying of HIV/AIDS:*** Most medical experts agree that the older population in the United States is the most overlooked and, therefore, one of the more vulnerable populations to HIV/AIDS. Many consider the increasing prevalence of individuals age 50 and older with HIV and the complexities that ensue to be an issue the AIDS Administration will need to prepare for in the near future.

## **Recommended Actions**

1. Concur with Governor's allowance.

***M00F04 – DHMH – AIDS Administration***

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

## ***Operating Budget Analysis***

---

### **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 reduce the transmission of HIV and help Marylanders living with HIV/AIDS live longer and healthier lives. The administration works to accomplish this mission through providing education, prevention, and health and social services. 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, notably the Maryland AIDS Drug Assistance Program (MADAP) and two insurance assistance programs (one federal funded and one general funded);
- 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.

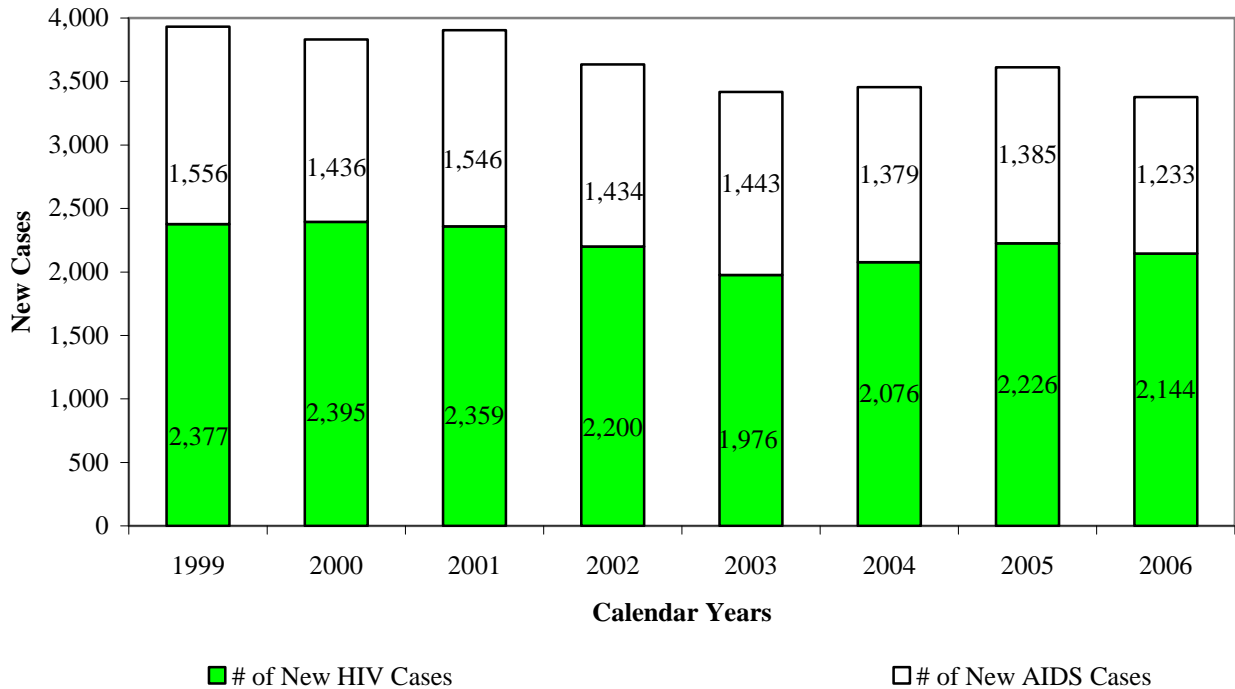
The AIDS Administration consults and coordinates its work with the 24 local health departments. Each local health department has counseling and testing sites where free tests and consultations are available. The administration also funds clinical activities for the diagnosis and evaluation of patients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

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

#### **Highest AIDS Case Rate of Any State**

In calendar 2006, there were an estimated 32,811 Marylanders living with HIV or AIDS (18,369 with HIV and 14,442 with AIDS). That same year the State had 2,144 newly reported HIV cases and 1,233 newly reported AIDS cases. **Exhibit 1** details trends in new reported cases of HIV and AIDS in Maryland.

**Exhibit 1  
Managing for Results  
Incidence of HIV and AIDS in Maryland  
Calendar 1999-2006**



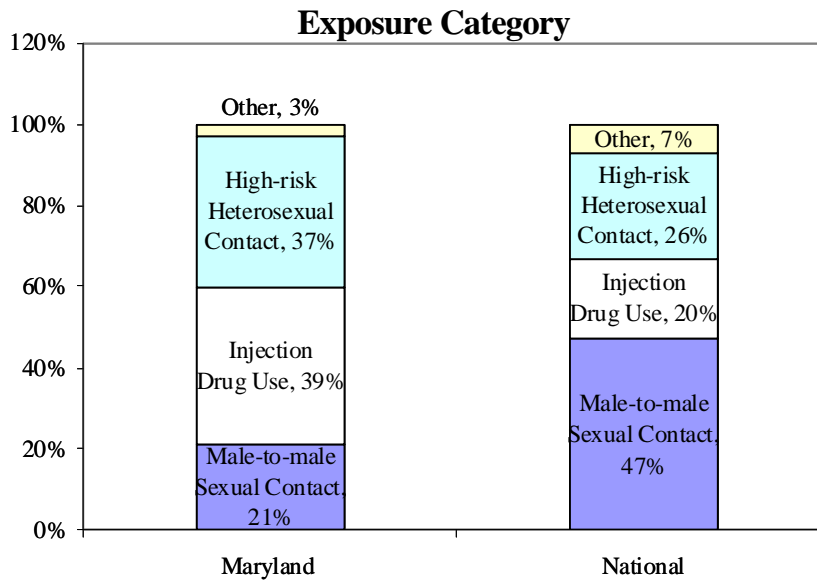
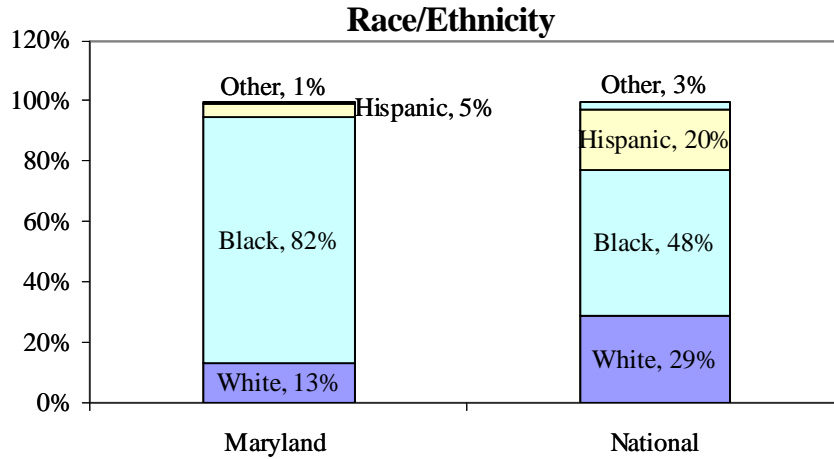
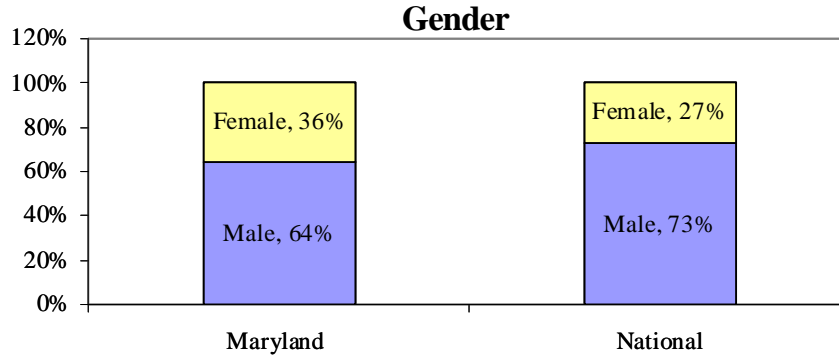
Note: All estimates are produced from trends in data through December 30, 2007. Figures are based on date of diagnosis, not the date of reporting.

Source: AIDS Administration

According to the nationwide comparison conducted by the federal Centers for Disease Control and Prevention (CDC) of the calendar 2006 data, Maryland had the ninth highest number of cumulative AIDS cases, the sixth highest number of newly reported AIDS, and the highest AIDS rate of any state in the nation with only the District of Columbia having a higher rate. The CDC analysis reported that in 2006 nationally the AIDS rate was 12.9 new AIDS cases per 100,000 population compared to the Maryland average of 29.0 per 100,000 population.

Maryland’s AIDS population continues to show some striking differences to the nation as a whole. As shown in **Exhibit 2**, Maryland’s AIDS population is more female and more African American than the national AIDS population. Also, Exhibit 2 shows Maryland’s exposure categories for the AIDS population include more injection drug use and heterosexual contact than the national AIDS population.

**Exhibit 2  
Demographics of Maryland’s AIDS Population versus the National AIDS Population  
Calendar 2005**



Source: AIDS Administration, Centers for Disease Control and Prevention

## Varying Enrollment Trends in Health Services Programs

The AIDS Administration provides three major health services programs, which are MADAP, MADAP-Plus, and the Maryland AIDS Insurance Assistance Program (MAIAP), which are outlined in **Exhibit 3** below.

---

### Exhibit 3 AIDS Administration’s Health Services Programs

	<u>Benefit</u>	<u>Income Eligibility</u>	<u>Fund Source</u>
<b>MADAP</b>	Assistance with HIV/AIDS-related drug costs	116 to 500% of the FPL	Federal Funds
<b>MADAP-Plus</b>	Maintains health insurance for individuals testing positive for HIV who can no longer work due to their illness	116 to 300% of the FPL	Federal Funds
<b>MAIAP</b>	Providing health insurance assistance to persons at risk of losing private health insurance coverage	301 to 500% of the FPL	General Funds

FPL: Federal Poverty Level

MADAP: Maryland AIDS Drug Assistance Program

MAIAP: Maryland AIDS Insurance Assistance Program

Source: AIDS Administration

---

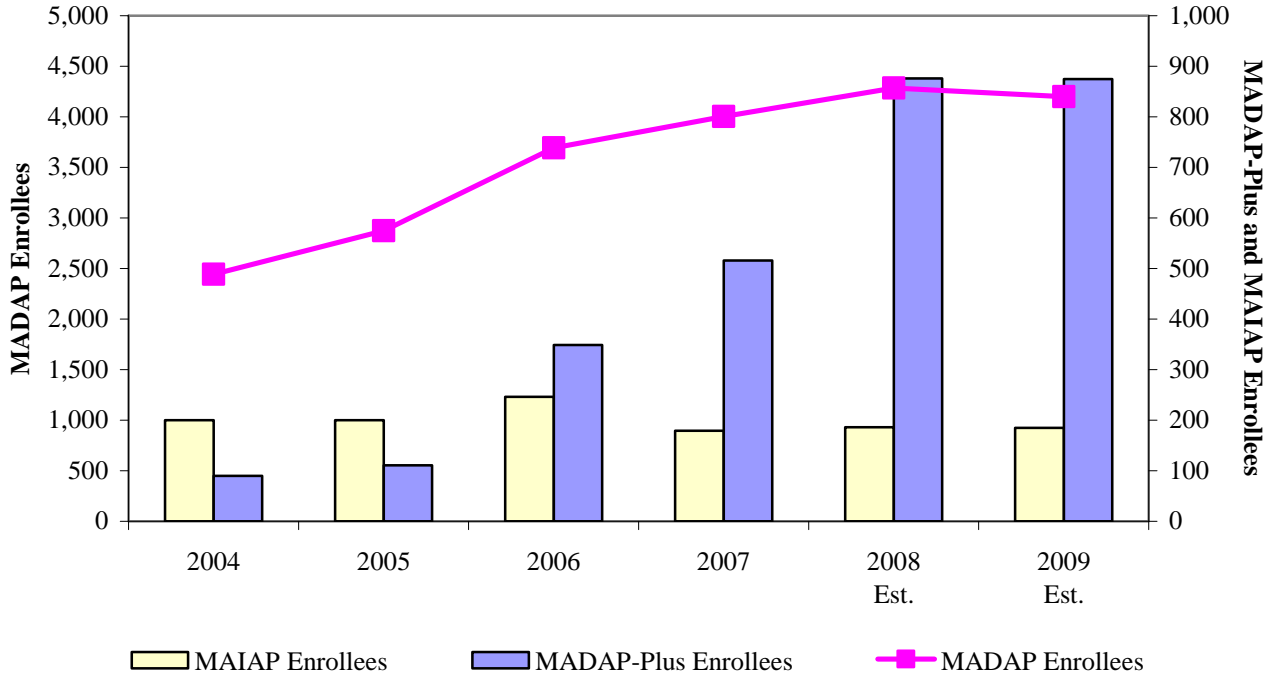
MADAP is the largest program run by the AIDS Administration with over 4,000 enrollees in 2007. Clients are certified eligible for MADAP for a one-year period, after which time they may reapply for certification. Following the increase in eligibility limits promulgated by the AIDS Administration in 2004, MADAP has one of the nation’s most expansive eligibility requirements alongside extremely generous drug coverage.

MADAP-Plus had failed to live up to enrollment expectations for a number of years, but with significant enrollment increases in calendar 2006 and 2007, the program finally surpassed the original enrollment target of 300 and has grown to over 500 enrollees.

MAIAP’s program enrollment is capped at 450, but actual enrollment has been much lower. In calendar 2007, fewer than 200 individuals were enrolled in the insurance program. MAIAP was due to sunset in 2002, but Chapter 30 of 2002 extended the program until June 30, 2010.

As shown in **Exhibit 4**, MADAP, MADAP-Plus, and MAIAP all experienced enrollment growth through calendar 2006. Since then, MADAP enrollment has stabilized, MADAP-Plus enrollment has significantly increased, and MAIAP enrollment has decreased.

**Exhibit 4**  
**MADAP, MADAP-Plus, and MAIAP Enrollment**  
**Calendar 2004-2009**



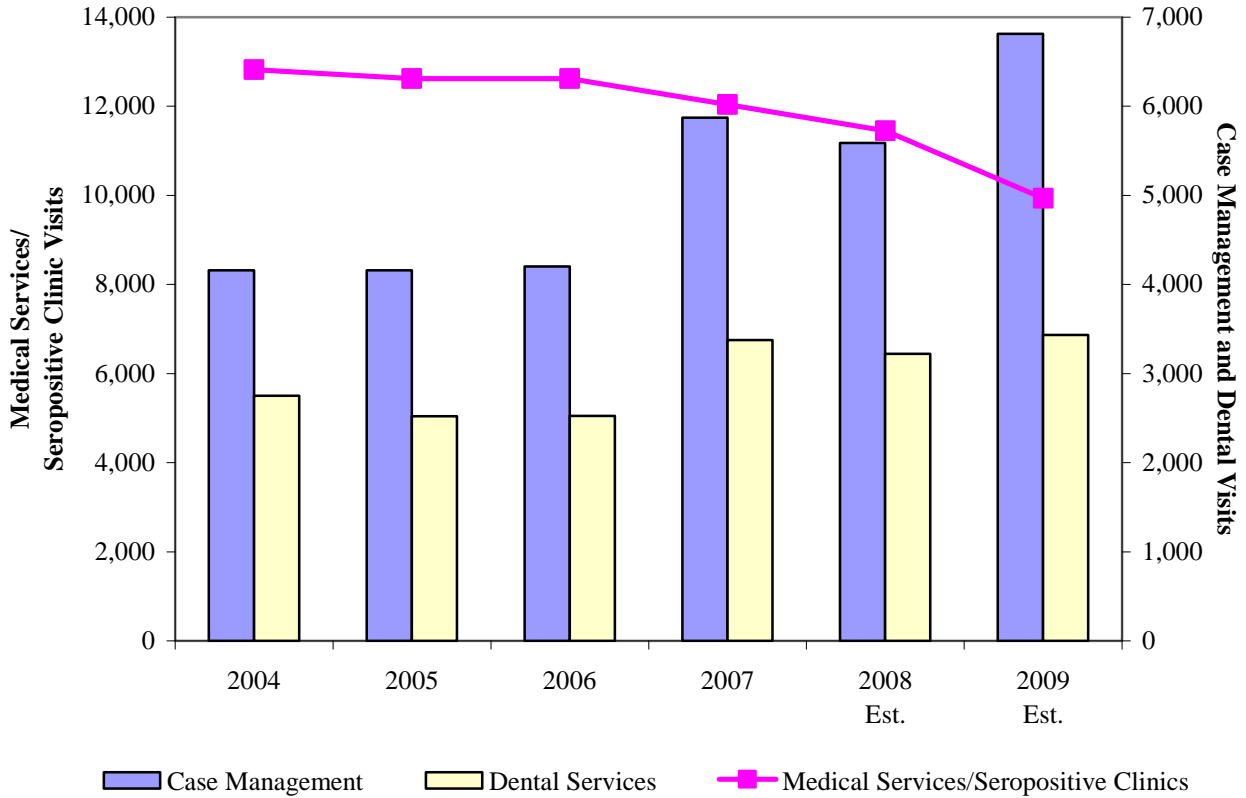
MADAP: Maryland AIDS Drug Assistance Program  
 MAIAP: Maryland AIDS Insurance Assistance Program

Source: AIDS Administration

### Funding Focused Toward Case Management

**Exhibit 5** demonstrates the direct relationship between funding level and amount of services provided by the AIDS Administration in the areas of medical services, case management, and dental services. In recent years, funding for medical services has decreased while the funding for dental services has remained level and funding for case management has increased.

**Exhibit 5  
Various Services and the Budget  
Calendar 2004-2009**



(\$ in Millions)

	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008 Est.</u>	<u>2009 Est.</u>
Budget for Medical Services/Seropositive Clinics	\$2.5	\$3.3	\$3.3	\$3.3	\$3.3	\$3.0
Budget for Case Management	2.4	2.4	2.4	3.5	3.5	4.5
Budget for Dental Services	0.4	0.4	0.4	0.6	0.6	0.6
<b>Total Budget</b>	<b>5.3</b>	<b>6.0</b>	<b>6.0</b>	<b>7.3</b>	<b>7.3</b>	<b>8.1</b>

Source: AIDS Administration

Medical services consist of doctor visits at the local health departments and community agencies. The level of funding for medical services was flat from calendar 2005 through calendar 2008, which caused the number of medical services provided to decrease because the cost to provide the services increased year-over-year. In calendar 2009, the funding for medical services is expected to be reduced by 9% which is expected to reduce the number of services provided by 13%.

## *M00F04 – DHMH – AIDS Administration*

The AIDS Administration provides funding to the local health departments to provide case management services for people enrolled in MADAP. Between calendar 2003 and 2006, the funding level and number of case management services remained flat. Then, in calendar 2007 the funding increased 46%, and the funding is expected to increase another 28% in calendar 2009. With the additional funding, the AIDS Administration expects the number of case management services provided in calendar 2009 to increase 22% above the calendar 2008 level.

Dental services are provided at some health departments and two dental clinics in Baltimore City. The funding for dental services was level from calendar 2005 to 2006, which caused the number of services provided to remain level. In calendar 2007, funding increased 41%, and the number of services provided increased by 34%. Then, in calendar 2008, the funding remained level causing the number of dental services provided to decrease by 5%. In calendar 2009, the AIDS Administration expects funding for dental services to increase 11% which will allow for a 6% increase in the number of dental services provided.

### **Impact of Cost Containment**

Cost containment actions reduced the AIDS Administration's fiscal 2009 appropriation by \$38,330 in general funds and \$41,013 in federal funds in the area of salaries and fringe benefits. Also, the AIDS Administration had an estimated \$17,000 in general fund savings due to furloughs of State employees.

### **Proposed Budget**

As shown in **Exhibit 6**, the fiscal 2010 allowance for the AIDS Administration remains relatively level from the fiscal 2009 working appropriation. However, there are some changes in the fund sources for the AIDS Administration with both general and federal fund decreases being offset by an increase in special funds.

The costs of the health services programs vary with the MADAP allocation decreasing \$5.3 million while the MADAP-Plus allocation is increasing \$3.4 million.

### **Personnel**

The fiscal 2010 allowance keeps regular positions at the same level as the fiscal 2009 working appropriation. However, from the fiscal 2009 legislative appropriation to the working appropriation, six positions were deleted from the AIDS Administration, but the funding for the deleted positions was not removed from the budget. As a result, the allowance appears to be reducing the salaries in the AIDS Administration by \$0.2 million.

The fiscal 2010 allowance removes 10.2 contractual positions from the AIDS Administration. These positions were provided to the AIDS Administration to assist with the task of re-reporting HIV cases to the CDC, which was completed December 31, 2008.

Another change to the funding of personnel is a reduction of \$0.2 million due to a decision not to fund the Other Post Employment Benefits liability. The contingent reduction shown in Exhibit 6 is due to Back of the Bill language eliminating the funding for deferred compensation in fiscal 2010.

**Exhibit 6  
Proposed Budget  
DHMH – AIDS Administration  
(\$ in Thousands)**

<b>How Much It Grows:</b>	<b><u>General Fund</u></b>	<b><u>Special Fund</u></b>	<b><u>Federal Fund</u></b>	<b><u>Total</u></b>
2009 Working Appropriation	\$4,498	\$15,036	\$51,165	\$70,698
2010 Allowance	<u>4,155</u>	<u>15,713</u>	<u>50,938</u>	<u>70,805</u>
Amount Change	-\$343	\$677	-\$227	\$107
Percent Change	-7.6%	4.5%	-0.4%	0.2%
Contingent Reductions	-\$7	\$0	-\$39	-\$46
Adjusted Change	-\$350	\$677	-\$266	\$61
Adjusted Percent Change	-7.8%	4.5%	-0.5%	0.1%

**Where It Goes:**

**Personnel Expenses**

Employee and retiree health insurance pay-as-you-go costs (after reducing fiscal 2010 for contingent reductions).....	\$84
Workers’ compensation premium assessment .....	61
Retirement contribution .....	55
Deferred compensation (after reducing fiscal 2010 for contingent reductions).....	-46
Other fringe benefit adjustments .....	-41
Delete funds reducing Other Post Employment Benefits’ unfunded liability .....	-155
Six PINs were abolished in fiscal 2009, but the funding was not removed .....	-161

**Other Changes**

MADAP-Plus underfunded in fiscal 2009 .....	3,419
New Expanded and Integrated HIV Testing federal grant .....	1,255
Increased funding for counseling, testing, and referral services .....	822
Increased funding for health and support services .....	183
Funding to local health departments .....	159
University of Maryland at Baltimore County Community Collaborative.....	150
Contract with Maryland Correctional Enterprises .....	100
Regional advisory committee funding increase .....	70
Software upgrades to comply with new federal requirements .....	61

*M00F04 – DHMH – AIDS Administration*

**Where It Goes:**

Increased travel and postage expenses .....	33
Increased federal funding for the Minority HIV/AIDS Initiative .....	21
MAIAP expenditures decreasing slightly in fiscal 2010.....	-89
Federal HIV/AIDS surveillance funding reduced.....	-137
Reduced federal funding for HIV prevention programs .....	-168
Reduction of 10.2 contractual employees that assisted with the transition to name-based HIV reporting .....	-350
Reduced pressure on MADAP expenditures due to increases in MADAP-Plus .....	-5,269
Other .....	4
<b>Total</b>	<b>\$61</b>

MADAP: Maryland AIDS Drug Assistance Program  
MAIAP: Maryland AIDS Insurance Assistance Program  
PINs: position identification numbers

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

---

**Health Services Programs**

In the fiscal 2010 allowance, the allocation for MADAP-Plus increases by \$3.4 million which would be a 20% increase in funding for the program. However, the fiscal 2009 working appropriation is significantly underfunded when compared to fiscal 2008 actual expenditures. **The AIDS Administration should share with the budget committees any plans to redistribute funds in the current fiscal year to reflect the anticipated actual expenditures of MADAP-Plus.**

Funding for the largest health services program, MADAP, is decreasing by \$5.3 million in the fiscal 2010 allowance. The AIDS Administration, however, expects that enrollment in the program will grow by roughly 3% in fiscal 2010.

Over the past couple of years, the AIDS Administration has been working to redirect funding from MADAP to MADAP-Plus. This strategy allows the AIDS Administration to cover more individuals because the cost per program participant is lower under MADAP-Plus. In addition, higher participation in MADAP-Plus reduces the demand for MADAP services because more individuals are covered by health insurance which usually covers prescription drugs. Also, the strategy of redirecting funds from MADAP to MADAP-Plus is expected to neutralize the reduced federal fund support experienced by the AIDS Administration in recent years, at least in the short-term.

Accounting for the AIDS Administration’s strategy of redirecting funds from MADAP to MADAP-Plus, it is still difficult to believe a 14% decrease in funding for MADAP will allow for a 3% increase in enrollment. **The AIDS Administration should be prepared to explain how MADAP enrollment can be expected to grow in fiscal 2010 when the funding for MADAP is decreasing by 14%.**

## **Expanded and Integrated HIV Testing**

The fiscal 2010 allowance includes \$1.3 million in new federal funds from the Centers for Disease Control and Prevention to expand HIV testing and HIV partner counseling and referral services for populations disproportionately affected by HIV. The AIDS Administration is focusing these funds in Baltimore City and Prince George’s County because they are both areas of high HIV prevalence. The goal of the program is to increase the number of Marylanders living with HIV who know their serostatus and are linked to appropriate HIV care and support services.

## ***Issues***

---

### **1. Transition to Name-based HIV Reporting**

In December 2006, Congress passed the reauthorization of the Ryan White Treatment Modernization Act, which funds roughly 50% of the AIDS Administration budget. The Ryan White Treatment Modernization Act provides primary health care and support services for persons living with HIV/AIDS.

With respect to Maryland, the major change in the Ryan White Treatment Modernization Act reauthorization was the change to the basis for funding distribution. With the reauthorization, Congress changed the requirements of funding from a formula based on AIDS surveillance to a formula based on HIV surveillance. Along with that requirement, the federal government will only accept name-based HIV data and not code-based data, which is how Maryland collected HIV data.

#### **Federal Funding**

Most of the Ryan White Treatment Modernization Act funding received by the State is through Part B, which provides grants to all 50 states for a variety of medical and support services. Part B also includes the funding for MADAP that supports the provision of HIV medications. In the reauthorization, the funding level for Part B of the Ryan White Treatment Modernization Act is held harmless at a rate of 95% of the federal fiscal 2006 formula grant awards.

Since the reauthorization, states with code-based HIV reporting systems have been penalized because the reliability of the code-based data has been deemed questionable. As a result, the funding for states submitting code-based HIV information to the Department of Health and Human Services (HHS) has been reduced by 5% to adjust for possible duplicative case reporting.

#### **The Plan**

States that did not have a sufficiently accurate and reliable name-based HIV reporting system at the time the bill was passed were given a waiver from the federal government to establish a system. To comply with the federal waiver, the Department of Health and Mental Hygiene submitted a transition plan to CDC and HHS. During the 2007 session, legislation was also passed that made the necessary statutory changes to enable the AIDS Administration to implement a name-based HIV reporting system. Almost immediately after the bill was signed, the AIDS Administration began reporting new HIV cases to the CDC in a name-based format.

In the late spring and early summer of 2007, the AIDS Administration focused on educating providers, laboratories, health officers, and professional associations about the change in reporting requirements. In the later half of calendar 2007, the administration set up a system internally to begin re-reporting the code data as name data to the CDC.

Throughout calendar 2008, the AIDS Administration, with the assistance of 10.2 contractual workers, diligently worked to re-report all HIV cases to the CDC in a name-based format. The cases of HIV that had been reported by code needed to be fully re-reported by December 31, 2008.

The AIDS Administration found the process of re-reporting HIV cases to the CDC challenging for three reasons: the CDC had prescriptive requirements to verify cases, the condensed timeframe, and the unavailability of historic medical records. For these reasons, the AIDS Administration had set a goal of re-reporting 80% of the HIV cases to the CDC by the December 31, 2008 deadline. However, the AIDS Administration surpassed its goal and was able to re-report 100% of the HIV cases to the CDC by December 31, 2008.

**The AIDS Administration should explain to the budget committees how future federal fund allocations might be impacted now that the transition to name-based HIV reporting is complete.**

## **2. Centers for Disease Control and Prevention HIV Testing Recommendations**

### **The Recommendation**

In September 2006, the CDC issued revised recommendations for HIV testing, which reversed the decade-old approach of HIV testing recommendations. For roughly the past 10 years, CDC recommended that individuals at high risk for HIV should be tested, and the test was to be accompanied with comprehensive counseling and informed consent elements. The new recommendations relax the counseling and informed consent elements and expand testing to everyone between the ages of 18 through 64 to help catch infections early and stop the spread of the virus. The CDC also revised the recommendations for testing pregnant women to advocating that HIV screening be included in the routine panel of prenatal screening tests for all pregnant women.

The new HIV testing recommendations are part of an all-out effort to address three problems:

- an estimated 220,000 Americans are infected with HIV and are unaware of their status;
- 40% of infected people are diagnosed when their infection is already in an advanced stage; and
- the number of new infections annually in the United States has not declined in 15 years.

The fact that 1 in 5 of the 1.1 million people living with HIV are unaware of their status is troubling because researchers have found that untested HIV-infected individuals are more than twice as likely to engage in high-risk sexual behavior. It is estimated that people who are unaware of their infections account for 50 to 70% of new sexually transmitted HIV infections.

Timely access to diagnostic HIV test results improves health outcomes. Currently, persons with the HIV infection often visit health care settings for HIV-related symptoms years before diagnosis but are not tested for HIV because they are not considered to be at risk. The recommendations are intended for providers in all health care settings, including hospital emergency departments, urgent care clinics, inpatient services, sexually transmitted disease (STD) clinics or other venues offering clinical STD services, tuberculosis clinics, substance abuse treatment clinics, other public health clinics, community clinics, correctional health care facilities, and primary care settings.

### **Implementation of the Recommendation**

In the two years since the CDC revised the HIV testing recommendations, several studies indicate that nationally the recommendations generally are not being followed. One of the most significant barriers was that the CDC recommendations were inconsistent with the law in a number of states, including Maryland. Over the past couple of years, states have wrangled with the decision to move away from the status quo of informed consent and test counseling to adhere to the CDC's recommendations. In Maryland, Chapter 183 of 2007 created a workgroup to be convened by the AIDS Administration to review and make recommendations regarding the CDC recommendations.

The major recommendation of the workgroup was for legislation to be introduced during the 2008 session to modify the informed consent and test counseling processes for HIV testing. With Chapter 223 of 2008 many of the changes recommended by the workgroup became law. The bill made Maryland law consistent with the CDC recommendations. Specifically, the bill:

- repeals the requirement that an individual's informed consent for being tested for HIV be in writing unless the test is ordered outside a health care facility;
- allows pretest counseling to be provided verbally, by video, or a combination of these strategies; and
- requires health care providers who provide prenatal care and labor and delivery services to follow specific guidelines.

Since May 2008, the AIDS Administration has been working to educate providers about the law changes and to inform providers about the revised CDC testing guidelines. This is a very important task for the AIDS Administration to continue because one of the most common reasons provided for not following the CDC's recommendations is misconceptions by clinicians. Other barriers include the unwillingness of health insurers to pay for the HIV tests and the continued stigma associated with HIV/AIDS.

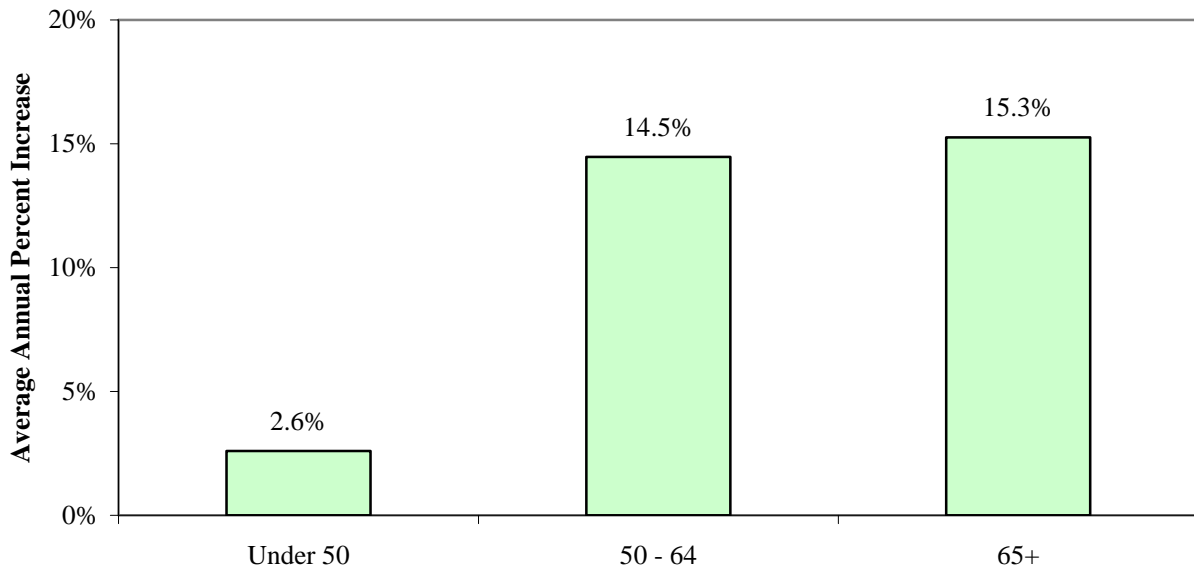
**The AIDS Administration should explain to the budget committees how the administration will continue to work toward ensuring health care providers throughout the State adhere to the CDC's HIV testing recommendations.**

### 3. The Graying of HIV/AIDS

Nationally, the fastest growing group of people living with HIV/AIDS is older adults, as shown in **Exhibit 7**. Most of these individuals have been living with the virus for many years, but some of them have recently contracted the disease.

---

**Exhibit 7**  
**Average Annual Percent Change in**  
**Number of People Living with HIV/AIDS by Age**  
**Calendar 2001-2006**

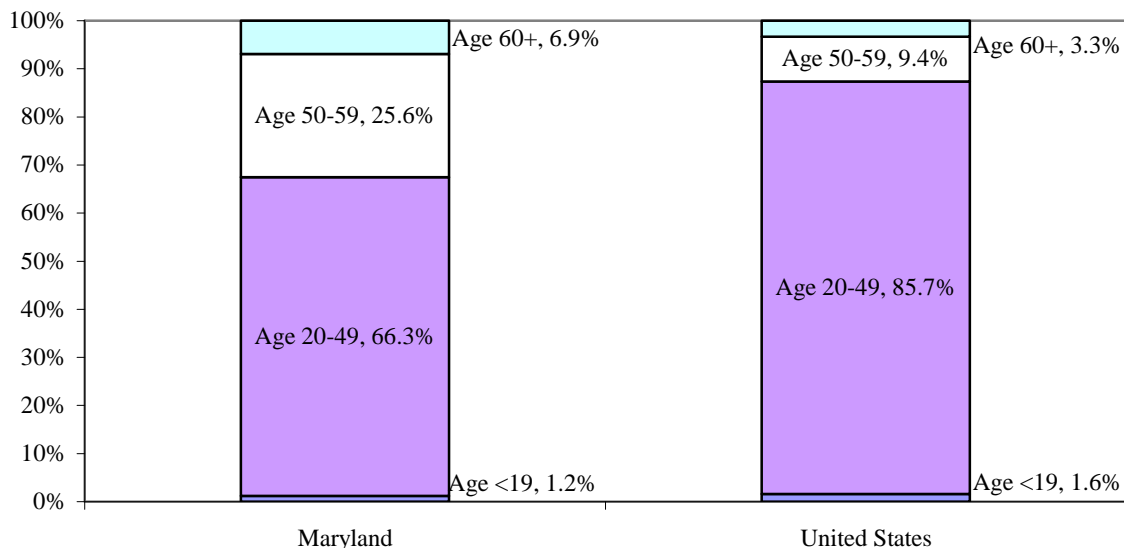


Source: Centers for Disease Control and Prevention

---

In Maryland, older adults comprise a larger proportion of the population of people living with AIDS than in the United States as a whole. This is shown in **Exhibit 8**.

**Exhibit 8**  
**Age Distribution of Individuals Living with AIDS**  
**In Maryland versus the United States**  
**Calendar 2006**



Source: AIDS Administration, Centers for Disease Control and Prevention

As there is more experience with older individuals living with HIV/AIDS, it is becoming clear that the effects of aging are particularly strong among people living with HIV/AIDS. Also, most medical experts agree that the older population is among the most overlooked and, therefore, one of the most vulnerable populations to HIV/AIDS because most of HIV/AIDS resources are aimed at populations that are seen to be at a greater risk, such as teenagers, urban residents, intravenous-drug use, and men who have sex with men.

### **Compounded Effect of HIV in Older Adults**

Being HIV-positive and elderly compounds the effects of both situations. Although the reason for this is unknown, there are several theories. One theory is that both aging and HIV degrade the immune system, so the HIV disease progresses more rapidly in older adults.

Another theory is the drug toxicity from the extended use of antiretrovirals might accelerate the natural aging process. However, very little is known about the drug interactions among older people living with HIV. More recently, research has emerged linking either HIV or the extended use of antiretrovirals with the increased risk of developing other diseases.

There is some evidence that individuals living with HIV/AIDS are at a greater risk of developing certain types of cancer. One study found that people living with HIV are twice as likely as the general population to develop certain cancers, while other studies have found that people living with HIV has as much as a 10 times greater chance of developing cancers.

HIV-positive individuals receiving treatment for the virus might be at an increased risk of developing heart disease and type-2 diabetes. Apparently, older drugs that are off-patent (which makes them more affordable) have the effect of redistributing fat around the waist, which increases an individuals' chance of developing both cardiovascular and metabolic disorders. There are newer drugs on the market that do not have this impact, but they are expensive.

### **Under-diagnosis in Older Adults**

Physicians do not perceive older adults to be at risk for the virus and, therefore, under-diagnosis occurs and HIV is detected later. One study of people between the ages of 60 and 79 who had died in a long-term care facility found that 5% were HIV antibody positive although none had been diagnosed with HIV.

Studies have found that untreated, older HIV-positive individuals are twice as likely to die as their younger, untreated counterparts. One study showed that three months after older adults begin antiretroviral treatment no significant difference in survival rate is detected. This is strong evidence that older adults are at greater risk when there is a failure to diagnose HIV infection, which results in delayed treatment.

### **Focus on the Issue in the State**

A few small community-based programs operating in the State provide education to seniors regarding HIV/AIDS. These programs also provide support services to those seniors living with HIV/AIDS. The AIDS Administration does provide some very limited financial support to these programs.

Many consider the increasing prevalence of individuals age 50 and older with HIV and the complexities that ensue to be issues the AIDS Administration will need to prepare for in the near future.

**The AIDS Administration should explain to the committees how they educate health care providers regarding issues of HIV/AIDS and older adults and how the AIDS Administration work assists the older adults living with HIV/AIDS and the associated complications.**

## ***Recommended Actions***

---

1. Concur with Governor's allowance.

## *Current and Prior Year Budgets*

---

### Current and Prior Year Budgets DHMH – 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 2008</b>					
Legislative Appropriation	\$4,688	\$10,835	\$57,054	\$0	\$72,578
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	-\$206	\$0	-\$3,159	\$0	-3,365
Cost Containment	-\$17	\$0	-\$189	\$0	-206
Reversions and Cancellations	0	-1,526	-27	0	-1,553
<b>Actual Expenditures</b>	<b>\$4,465</b>	<b>\$9,309</b>	<b>\$53,679</b>	<b>\$0</b>	<b>\$67,453</b>
<b>Fiscal 2009</b>					
Legislative Appropriation	\$4,514	\$15,036	\$51,206	\$0	\$70,756
Cost Containment	-38	0	-41	0	-79
Budget Amendments	22	0	0	0	22
<b>Working Appropriation</b>	<b>\$4,498</b>	<b>\$15,036</b>	<b>\$51,165</b>	<b>\$0</b>	<b>\$70,698</b>

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

---

## **Fiscal 2008**

The AIDS Administration expended \$67.5 million in fiscal 2008, which is \$5.1 million less than the legislative appropriation. The AIDS Administration's general funds decreased by \$0.2 million, mostly as a result of lower than anticipated expenditures for the Maryland Drug Maryland AIDS Insurance Assistance Program's purchase of care services (\$248,855). Also, cost containment reductions to fixed charges and supplies were directly offset by increased health insurance costs and cost-of-living adjustments.

Federal funds decreased by \$3.3 million mainly due to lower than anticipated costs of the Maryland Drug Assistance Program (MADAP) (\$3.1 million) and cost containment reductions to positions (\$0.2).

The AIDS Administration canceled \$1.6 million in special funds due to lower than anticipated MADAP expenditures.

## **Fiscal 2009**

The fiscal 2009 working appropriation for the AIDS Administration is \$70.7 million dollars, which is \$57,439 less than the legislative appropriation. The general fund appropriation increased \$21,904 due to the cost-of-living adjustments. This general fund increase was offset by \$38,330 in cost containment in the area of salaries and fringe benefits, which also reduced federal funds by \$41,013.

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

<u>Object/Fund</u>	<u>FY 08 Actual</u>	<u>FY 09 Working Appropriation</u>	<u>FY 10 Allowance</u>	<u>FY 09-FY 10 Amount Change</u>	<u>Percent Change</u>
<b>Positions</b>					
01 Regular	111.00	105.00	105.00	0	0%
02 Contractual	2.11	11.17	1.00	-10.17	-91.0%
<b>Total Positions</b>	<b>113.11</b>	<b>116.17</b>	<b>106.00</b>	<b>-10.17</b>	<b>-8.8%</b>
<b>Objects</b>					
01 Salaries and Wages	\$ 6,801,777	\$ 7,680,627	\$ 7,525,280	-\$ 155,347	-2.0%
02 Technical and Spec. Fees	82,148	378,216	44,779	-333,437	-88.2%
03 Communication	91,329	85,773	90,802	5,029	5.9%
04 Travel	78,689	99,348	127,081	27,733	27.9%
07 Motor Vehicles	8,534	10,505	10,104	-401	-3.8%
08 Contractual Services	28,874,132	24,799,818	30,619,743	5,819,925	23.5%
09 Supplies and Materials	31,438,403	37,582,986	32,321,392	-5,261,594	-14.0%
10 Equipment – Replacement	5,222	0	0	0	0.0%
11 Equipment – Additional	16,445	0	3,600	3,600	N/A
13 Fixed Charges	55,911	60,923	62,680	1,757	2.9%
<b>Total Objects</b>	<b>\$ 67,452,590</b>	<b>\$ 70,698,196</b>	<b>\$ 70,805,461</b>	<b>\$ 107,265</b>	<b>0.2%</b>
<b>Funds</b>					
01 General Fund	\$ 4,464,921	\$ 4,497,916	\$ 4,154,738	-\$ 343,178	-7.6%
03 Special Fund	9,308,996	15,035,527	15,712,803	677,276	4.5%
05 Federal Fund	53,678,673	51,164,753	50,937,920	-226,833	-0.4%
<b>Total Funds</b>	<b>\$ 67,452,590</b>	<b>\$ 70,698,196</b>	<b>\$ 70,805,461</b>	<b>\$ 107,265</b>	<b>0.2%</b>

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.

**Fiscal Summary  
DHMH – AIDS Administration**

<u>Program/Unit</u>	<u>FY 08 Actual</u>	<u>FY 09 Wrk Approp</u>	<u>FY 10 Allowance</u>	<u>Change</u>	<u>FY 09 – FY 10 % Change</u>
G101 Executive Direction	\$ 586,581	\$ 548,945	\$ 631,931	\$ 82,986	15.1%
G102 Exec Dir. – Prevention Cooperative Agreement	217,331	244,763	426,607	181,844	74.3%
G104 Surveillance	91,657	91,031	226,018	134,987	148.3%
G198 Prior Years Grant Activity	0	5,127	5,127	0	0%
G204 Epidemiology & Health Services	137,193	195,697	111,788	-83,909	-42.9%
G401 Surveillance	255,554	439,094	92,930	-346,164	-78.8%
G403 Surveillance – Cooperative Agreement	1,285,102	1,585,830	1,224,219	-361,611	-22.8%
G413 AIDS – Antiretroviral Surveillance	63,878	0	0	0	0%
G433 Evaluation of Web-Based HIV Risk Behavior	1,223	0	0	0	0%
G443 Surveillance – Medical Monitoring Project	513,839	325,605	247,066	-78,539	-24.1%
G453 Surveillance – Perinatal Prevention	122,734	127,687	131,938	4,251	3.3%
G463 HIV – Behavioral Surveillance System	162,648	0	143,940	143,940	0%
G501 HIV – Health Services	1,687,441	1,407,381	1,380,945	-26,436	-1.9%
G504 HIV – Health Services – Ryan White	9,619,599	9,542,311	9,780,209	237,898	2.5%
G505 HIV – Health Services – Pediatric Services	826,197	1,012,870	1,009,285	-3,585	-0.4%
G511 HIV – MADAP/MAIAP Programs	858,408	950,996	867,035	-83,961	-8.8%
G514 HIV – Ryan White Programs	38,109,596	41,783,523	40,357,260	-1,426,263	-3.4%
G517 HIV – Health Services/HOPWA Formula	971,082	843,110	932,000	88,890	10.5%
G524 HIV – Minority Aids Initiative	227,410	304,000	325,109	21,109	6.9%
G525 Youth Initiative	475,113	448,859	372,283	-76,576	-17.1%
G601 Education & Training	272,837	276,005	284,396	8,391	3.0%
G602 Education & Training – Cooperative Agree.	4,747,497	4,916,455	5,566,575	650,120	13.2%
G606 AIDS – SAMHSA	21,212	0	0	0	0%
G701 Prevention Programs	891,992	910,902	944,707	33,805	3.7%
G702 Prevention Programs – Prevent Coop. Agree.	3,434,358	4,317,291	4,066,455	-250,836	-5.8%
G709 Alcohol and Drug Abuse	585,940	420,714	422,595	1,881	0.4%
G712 Expanded Integrated HIV Testing	1,286,168	0	1,255,043	1,255,043	0%
<b>Total Expenditures</b>	<b>\$ 67,452,590</b>	<b>\$ 70,698,196</b>	<b>\$ 70,805,461</b>	<b>\$ 107,265</b>	<b>0.2%</b>
General Fund	\$ 4,464,921	\$ 4,497,916	\$ 4,154,738	-\$ 343,178	-7.6%
Special Fund	9,308,996	15,035,527	15,712,803	677,276	4.5%
Federal Fund	53,678,673	51,164,753	50,937,920	-226,833	-0.4%
<b>Total Appropriations</b>	<b>\$ 67,452,590</b>	<b>\$ 70,698,196</b>	<b>\$ 70,805,461</b>	<b>\$ 107,265</b>	<b>0.2%</b>

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.