

MF.04
AIDS Administration
 Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	FY 00	FY 01	FY 02		% Change
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>	<u>Prior Year</u>
General Fund	\$5,246	\$5,392	\$6,621	\$1,229	22.8%
Special Fund	125	305	418	113	37.0%
Federal Fund	<u>26,410</u>	<u>34,176</u>	<u>42,101</u>	<u>7,925</u>	<u>23.2%</u>
Total Funds	\$31,781	\$39,873	\$49,140	\$9,266	23.2%

- Spending on a variety of HIV/AIDS health services increase by \$8.2 million. Most of this increase derives from federal Ryan White Title II funds to support drug assistance and insurance assistance programs.
- The fiscal 2002 allowance sees a sharp increase in general funds, primarily due to the transfer of the Maryland AIDS Insurance Assistance Program to the AIDS Administration from the Medical Care Programs Administration.
- Spending on HIV prevention activities increases by \$596,000.

Personnel Data

	FY 00	FY 01	FY 02	
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>
Regular Positions	66.00	68.00	68.00	0.00
Contractual FTEs	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>
Total Personnel	66.00	68.00	68.00	0.00

Vacancy Data: Regular

Budgeted Turnover: FY 02	3.88	5.70%
Positions Vacant as of 12/31/00	12.00	18.18%

- As of December 31, 2000, the AIDS Administration had 12 vacancies, a vacancy rate of 18.18%. This is the third year in the last four years that calendar year-end vacancy rates exceeded 12%.

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

For further information contact: Simon G. Powell

Phone: (410) 946-5530

Analysis in Brief

Issues

The Fiscal 2002 Allowance Continues Fiscal 2001 Funding for the Baltimore City Needle Exchange Program: In Maryland, unlike the nation as a whole, most people exposed to AIDS are exposed through injection drug use. Some 42% of all Maryland AIDS cases are considered to result from injection drug use, compared to 25% nationally. One strategy to combat the spread of HIV and AIDS among the injection drug use population is the development of needle exchange programs. However, the establishment of these programs is controversial. Currently only one jurisdiction in Maryland has a needle exchange program: Baltimore City.

Recommended Actions

	<u>Funds</u>	<u>Positions</u>
1. Delete funds to support a needle exchange program in Prince George's County.	\$ 250,000	
2. Reduce funding for the Maryland AIDS Insurance Assistance Program based on current utilization.	275,000	
Total Reductions	\$ 525,000	

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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 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.

A reorganization of the administration effective April 1997 created two major divisions: "Epidemiology and Research" and "HIV Services." Units under Epidemiology and Research are responsible for maintaining the HIV/AIDS surveillance system, supporting community-based planning for HIV prevention and treatment programs, evaluating prevention and service programs funded through the AIDS Administration, and performing research studies. HIV Services includes education, prevention interventions, health services, housing, and other patient services.

Governor's Proposed Budget

The Governor's fiscal 2002 allowance for the AIDS Administration is \$9.3 million above the fiscal 2001 working appropriation. Federal funds show the biggest dollar increase, \$7.9 million, or 86% of the

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overall increase. The unusually large general fund growth (\$1.2 million, or 13.3% of the overall increase) is a result of the transfer of the Maryland AIDS Insurance Assistance Program (MAIAP) from the Medical Care Programs Administration into the AIDS Administration.

Funding by Activity

Exhibit 1 links funding in the AIDS Administration to activity for fiscal 2000 through 2002. Exhibit 1 shows:

- Significant growth in health services funding. Although the 34.4% growth from fiscal 2001 to 2002 is slightly overstated because of the transfer of MAIAP into the administration, it nonetheless represents continued strong growth in health services funding.
- Prevention and education funding continues to grow, although at a slower rate than between fiscal 2000 and 2001. Still, this is a positive trend considering funds for prevention activities actually dropped between fiscal 1999 and 2000. Attitudes towards HIV/AIDS, particularly among the young, are somewhat contradictory. For example, while teens are concerned about the impact of HIV/AIDS on society, their peers, and themselves, few get tested for the virus or know where to get tested. Many teens who have the virus do not know it. As many as one-third of teens who engage in sexual intercourse admit to not routinely using condoms.

Exhibit 1

**Funding by Activity
AIDS Administration
Fiscal 2000 through 2002**

	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>Ann% Change 00-02</u>	<u>Ann% Change 01-02</u>
Executive Direction	\$1,407,108	\$1,119,270	\$1,223,808	-6.7%	9.3%
Surveillance	1,768,115	1,675,292	1,805,410	1.0%	7.8%
Planning and Evaluation	1,127,584	1,344,210	1,273,194	6.3%	-5.3%
Health Services	18,888,706	24,742,053	33,256,191	32.7%	34.4%
Prevention and Education	8,589,068	10,992,590	11,581,000	16.1%	5.4%
Total	\$31,780,581	\$39,873,415	\$49,139,603	24.3%	23.2%

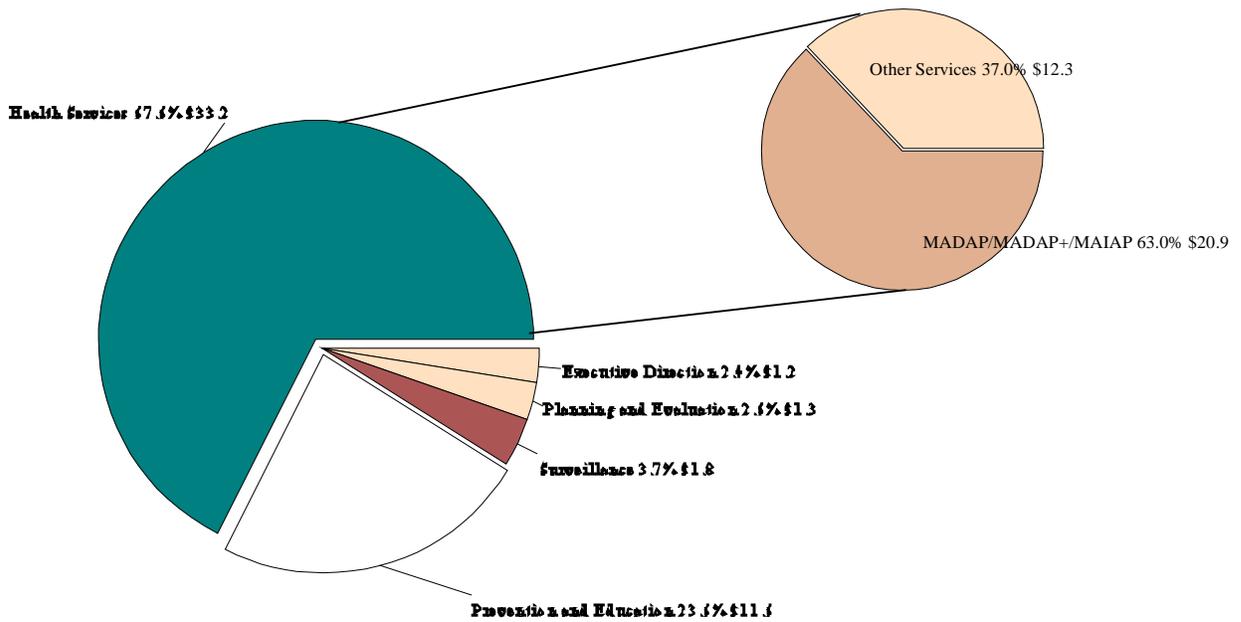
Source: Department of Health and Mental Hygiene

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As shown in **Exhibit 2**, fully two-thirds of the AIDS Administration's budget (\$33.3 million) is for health services, up from 62% in fiscal 2001. The addition of MAIAP to the expanding Maryland AIDS Drug Assistance (MADAP) and MADAP-Plus programs drives that growth. Prevention and education funding continues to be the other major budget component, 23.6% of the fiscal 2002 budget. However, the amount of the increase in health services funding dwarfs other changes to the extent that all other program activities shrank in terms of a percentage of the administration's budget from fiscal 2001 to 2002.

Exhibit 2

**Funding by Activity
AIDS Administration
Fiscal 2002
(\$ in Millions)**



Source: Department of Health and Mental Hygiene

Specific Program Changes

Exhibit 3 details the specific increases in the Governor's fiscal 2002 allowance. These increases include:

- **Personnel expenses** increase by \$323,000. The major components of this increase are increments, the annualization of the fiscal 2001 cost-of-living adjustment, the fiscal 2002 general salary increase (4% effective January 2002), and employee and retiree health insurance costs. Increases in personnel expenses account for much of the growth in the executive direction and surveillance activities.

Exhibit 3

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

How Much It Grows:	General Fund	Special Fund	Federal Fund	Total
2001 Working Appropriation	\$5,392	\$305	\$34,176	\$39,873
2002 Governor's Allowance	6,621	418	42,101	49,140
Amount Change	\$1,229	\$113	\$7,925	\$9,266
Percent Change	22.8%	37.0%	23.2%	23.2%
Where It Goes:				
Personnel Expenses				\$323
Increments, fiscal 2001 increase phase-in and other				\$179
Employee and retiree health insurance rate change				76
Fiscal 2002 general salary increase				67
Other fringe benefit adjustments				22
Turnover adjustments				8
Retirement contribution rate change				(29)
Health Services				\$8,203
Ryan White Title II, MADAP/MADAP-Plus funds (federal funds)				5,788
MAIAP (transferred from Medical Care Programs Administration)				996
Ryan White Title II, consortia contractual funding for health and support services (federal funds)				960
Increased funding for Maryland Institute for Policy Analysis and Research contract . .				459
Prevention/Education				\$596
Prevention Cooperative Agreement, contracts and grants to local health departments and other organizations for HIV prevention activities, e.g., counseling, risk reduction initiatives, distribution of education materials				596
Other Changes				144
Total				\$9,266

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

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For the third year in the past four years, the AIDS Administration ended the calendar year with a vacancy rate over 12%. For the year ending December 31, 2000, the administration had 12 vacant positions, a vacancy rate of 18.18%. The status of these vacant positions is summarized in **Exhibit 4**. According to the AIDS Administration, at least part of the explanation for the extent of vacancies related to delays at the Department of Budget and Management in processing personnel paperwork.

Exhibit 4

**Current Vacancy Status of Positions Vacant on December 31, 2000
AIDS Administration**

<u>PIN Number</u>	<u>Fund Source</u>	<u>Position</u>	<u>Status</u>
015809	General	Epidemiologist	Filled January 11, 2001
016130	General	Computer Network Specialist	Interviewing
019177	Federal	Program Administrator	Position marked for study*
024199	General	Administrator	Reclassification request pending
062198	General	Program Administrator	Reclassification request pending
062199	General	Program Administrator	Reclassification request pending
063381	General	Social Worker	Candidate selected
065192	General	Research Statistician	Vacant as of October 31, 2000
065195	Federal	Program Administration	Position marked for study*
065199	General	Nursing Program Consultant	Interviewing
065202	Federal	Administrative Officer	Position advertised January 2, 2001
046175	Federal	Office Secretary	Filled January 10, 2001

*Marked for study means the job classification is under review.

Source: AIDS Administration

- **Health services** funding makes up almost 90% of the increase in funding, a little over \$8.2 million. Consortia funding for health and support services increases by \$960,000. These are health and social services provided according to priorities established between the consortia (local health departments, a provider or community-based organizations, and clients) and the AIDS Administration. Funds to support drug purchases through MADAP and insurance costs through MADAP-Plus increase by almost \$5.8 million, with the transferred MAIAP program funds adding a further \$996,000 to the budget growth. There is also a significant increase in health services-related contractual funding (\$459,000) for the Maryland Institute for Policy Analysis and Research (MIPAR) at the University of Maryland Baltimore County (UMBC). MIPAR provides administrative and research support for many of the activities funded by the AIDS Administration and this increase reflects the overall growth in activities supported by federal Ryan White CARE funds.

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- **Prevention activities** increase by \$596,000.

Among the prevention activities for which fiscal 2002 funding was requested was \$250,000 in general funds to support the establishment of a needle exchange program in Prince George's County. In October 2000 the County Council voted not to establish such a program. **Therefore, the Department of Legislative Services (DLS) recommends a reduction of \$250,000 in general funds.**

Impact of Federal Actions -- Federal Dollars Still Drive Budget Growth

As has long been the case with the AIDS Administration, its budget is essentially driven by the availability of federal funds. Most of these federal funds come from HIV Care Formula Grants and funds for HIV Prevention Activities. Increases in the HIV Care Formula Grants are formula-driven based on the number of living AIDS cases, while funds for HIV Prevention Activities are awarded competitively.

Exhibit 5 illustrates that increases in federal funds have been on the order of 18.4% annually between fiscal 1998 and 2002, compared to a 6.9% increase in general funds. As noted earlier, the general fund increase is also exaggerated by the transfer of MAIAP into the Administration's budget. Without that transfer, general fund growth would average only 2.6%. However, federal funding continues to make up 85.7% of the AIDS Administration's proposed fiscal 2002 budget, the same proportion as fiscal 2001 and up from 79.2% in fiscal 1999.

Exhibit 5

**Funding by Fund Source
AIDS Administration
Fiscal 1998 through 2002**

	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	Ann. % Change <u>98-02</u>
General Funds	\$5,073,298	\$5,103,612	\$5,245,537	\$5,392,293	\$6,621,123	6.9%
Special Funds	(202,500)	816,664	124,802	305,127	417,956	n/a
Federal Funds	21,448,126	22,556,188	26,410,242	34,175,995	42,100,524	18.4%
Total	\$26,318,924	\$28,476,464	\$31,780,581	\$39,873,415	\$49,139,603	16.9%

Source: Department of Health and Mental Hygiene

The Ryan White federal funds received by the AIDS Administration (an estimated two-thirds of the total federal funds received by the State) come with two different matching requirements:

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- The State must maintain State spending on HIV-related activities at a level that is equal to or not less than the level of expenditures 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 matching requirement, State spending includes spending in the AIDS Administration, as well as Medicaid.
- For states such as Maryland with more than 1% of the national AIDS cases, a match of 50% of the grant award is established.

The proposed allowance meets those conditions for funding. Further, it should be noted, that the general fund reductions recommended by DLS, if adopted, do not reduce funding to a level where these conditions would not be met.

It should also be noted that in October, 2000, the U.S. Congress approved the reauthorization of the Ryan White CARE Act. That reauthorization included a change to the funding formula used to distribute treatment dollars. The revised formula is based on HIV infections and AIDS cases rather than just AIDS cases. According to the AIDS Administration, under the revised formula, the State is expected to see a slight increase in funds. However, the revised formula does not take effect until 2005.

Performance Analysis: Managing for Results

As noted in previous budget analyses, the AIDS Administration has formulated a Managing for Results (MFR) statement that communicates the work of the administration as well as providing a snapshot of the status of the HIV/AIDS virus and its management in Maryland. The MFR includes some minor changes suggested during last year's budget hearings.

If there is one hole remaining in the AIDS Administration's MFR, it relates to HIV prevention activity. The AIDS Administration appears to be at the forefront of the development of prevention activity programming. For example, it is appropriately targeting HIV prevention dollars utilizing available epidemiological data. It also conducting ongoing intensive evaluations on 27 different prevention projects. However, specific program outcomes are not reflected in the MFR. HIV incidence data from one year to the next is a macro-level indicator for the efficacy of prevention programs, but some indication that specific programs are meeting set goals would be a useful addition to the MFR and also add to our understanding of the success of specific programmatic approaches or the success in reaching specific targeted populations.

Exhibit 6 details performance data on HIV/AIDS in Maryland and the State's compliance with federal Centers for Disease Control (CDC) surveillance standards. The exhibit illustrates:

- The number of new reported HIV cases growing to an estimated 2,134 in 2000, an average annual increase of 4.9% over the six-year period. Interestingly, this annual average growth is higher than growth over the six-year period, 1994 through 1999, or 2.3%.

Exhibit 6

**Performance Data -- Selected Indicators
Calendar 1995 through 2000**

	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	Ann % Change 95-00
New Reported HIV Cases*	1,681	1,989	1,867	2,035	2,110	2,134	4.9%
New Reported AIDS Cases*	2,228	1,964	1,612	1,450	1,349	1,200	-11.6%
HIV/AIDS reporting within 6 months of diagnosis (%)					85.1	85.7	n/a
Unduplicated HIV/AIDS reporting (%)					<1	<1	n/a

*2000 data for HIV projected from data through 9/00; 1999 and 2000 data for AIDS projected from data through 9/00 based on lags in reporting.

Source: Department of Health and Mental Hygiene

- The number of new reported AIDS cases falls dramatically over the period 1995 through 2000, an average annual decline of 11.6%. This annual average decline is actually greater than the decline posted over the six-year period, 1994 through 1999, or 9.9%. Again, this reflects the impact of new AIDS drugs and therapies.
- In the surveillance area, for example, Maryland is one of the few states that tracks HIV cases through the use of a unique identifier rather than name-reporting. CDC guidelines allow states to use unique identifier case reporting providing they meet certain minimum performance standards. For example, more than 66% of all cases must be reported within six months of diagnosis, and no more than 5% of all cases should be duplicative or incorrectly matched. Indeed, meeting these CDC requirements is required in order to receive federal surveillance funding. As indicated in Exhibit 6, the AIDS Administration is easily meeting those federal standards.

Compared to national data, the AIDS rate in Maryland remains high (the CDC reports new AIDS rates of 27.2 per 100,000 population in Maryland for the year ending June 30, 2000, compared to 15.5 per 100,000 nationally). Only the District of Columbia, Florida, and New York have a higher rate of AIDS incidence than Maryland. Of metropolitan areas with over 500,000 in population, eight -- Columbia, Fort Lauderdale, Jersey City, Miami, New York, Newark, San Francisco, and West Palm Beach -- have a higher rate of AIDS incidence than Baltimore (35.9 per 100,000 population) for the year ending June 2000.

In terms of a profile of persons with AIDS by exposure category, Maryland continues to have some striking differences with the national profile:

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- Nationally, 47% of all AIDS cases are considered to result from men having sex with men, this compares to 31% for Maryland.
- Nationally, 25% of all AIDS cases are considered to result from injection drug use, compared to 42% for Maryland. Exposure to AIDS through injection drug use is the leading exposure category in Maryland.
- Nationally, 37% of all AIDS cases are in African Americans, compared to 75% in Maryland.

While drug therapies now offer significant hope to those infected with the HIV virus, the cost of those drugs (as much as \$15,000 annually) continues to place demand on programs administered by the AIDS Administration to cover drug or insurance costs.

MADAP

As shown in **Exhibit 7**, enrollment in MADAP continues to climb, with over 2,000 enrollees by the end of 2000. Almost all of those enrolled in MADAP are on Highly Active Anti-Retroviral Therapy (HAART), which is 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.

Exhibit 7

**Program Data -- Selected Indicators
Calendar 1996 through 2000**

	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	Ann % Change 96-00
MADAP Enrollees*	489	791	1,049	1,349	2,001	42.2
MADAP Combination Therapies. Enrollees on HAART (%)	47	90	91	95	98	20.2
MADAP-Plus Enrollees**					50	n/a
MAIAP Enrollees**				300	344	n/a

*Monthly year end total based on last quarter's enrollment (2000 is through November only and also includes Transitional Assistance Program enrollees).

**Average monthly enrollment in that fiscal year.

HAART - Highly Active Anti-Retroviral Therapy

Source: Department of Health and Mental Hygiene

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Eligibility for MADAP is open to any Maryland resident certified by a health care practitioner as being diagnosed with HIV/AIDS, and who also meets certain income eligibility criteria (for example, for a single person with an income above \$9,650 -- the upper income limit for Maryland Pharmacy Assistance Program -- and below 400% of the federal poverty limit or \$33,400). Clients are certified eligible for MADAP for a six-month period after which they may reapply for certification.

Exhibit 8 details trends in MADAP enrollment for the period 1996 through 2000. **Exhibit 9** shows cost data for the same period. Both exhibits detail the striking increase in MADAP utilization and expenditures since the availability of effective drug therapy:

- the number of persons enrolled in MADAP has increased from a monthly average of 350 for the first quarter of 1996 to 2,001 in the fourth quarter of 2000, an average annual increase of 54.6%;
- average monthly utilization has also increased, from 201 for the first quarter of 1996 to 1,394 in the fourth quarter of 2000, an average annual increase of 62.3%;
- total average monthly medicine cost for MADAP has increased from \$83,000 for the first quarter of 1996 to almost \$1.4 million in the fourth quarter of 2000, an annual average increase of 102.7%; and
- the monthly cost per active client has risen from \$414 at the beginning of 1996 to \$980 at the end of 2000, an annual average increase of 24%.

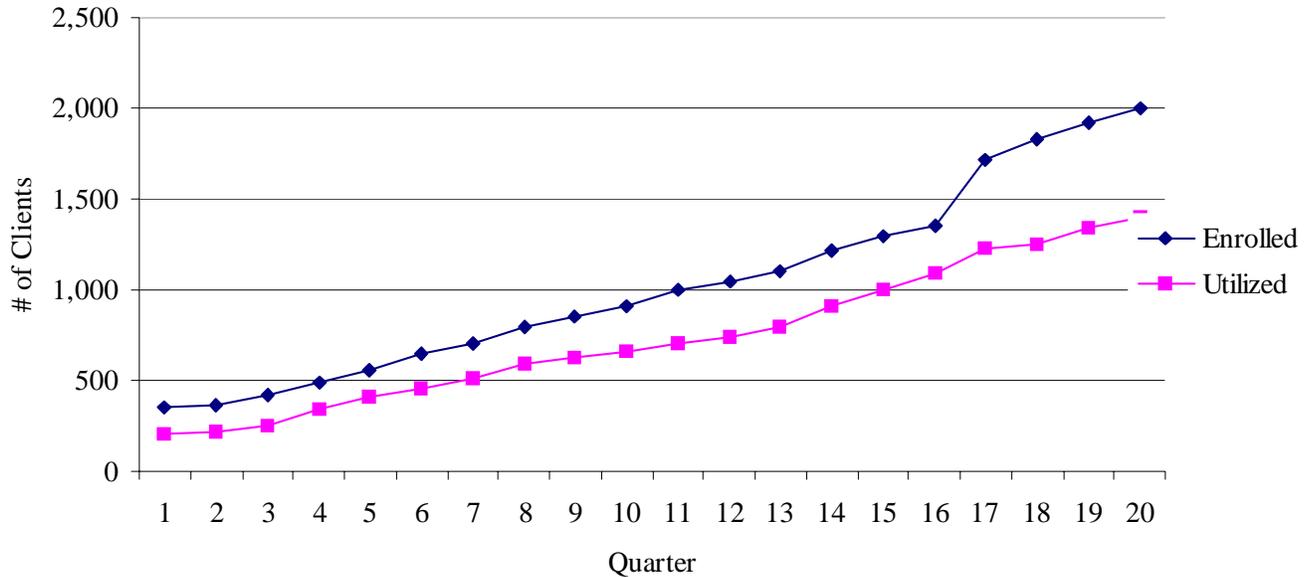
Interestingly, Exhibit 8 and Exhibit 9 also show that in 2000, three interesting things happened to MADAP:

- A significant jump in enrollment at the beginning of the year. This was due to the development of a rapid eligibility determination for MADAP allowing clients 90 days of MADAP coverage while they are pending eligibility determination for Medicaid or Pharmacy Assistance as well as clients who have temporarily lost coverage under Medicaid or Pharmacy Assistance. According to the AIDS Administration, this short-term coverage program -- Transitional Assistance Program (TAP) -- has been particularly effective in ensuring medication coverage for individuals released from prison.
- While the jump in MADAP utilization was not as great as the jump in enrollment that followed the implementation of TAP, the utilization increase was sufficient to result in no growth in average monthly drug costs per active client in calendar 2000.
- However, overall program expenditures did rise significantly beginning in the third quarter of calendar 2000 because of the addition of 12 new drugs to the formulary.

The AIDS Administration continues to operate an ADAP program that is both generous in terms of eligibility and drugs covered. Their ability to do this is due entirely to the continued flow of federal dollars to support the program. While the emergence of new therapies can quickly change expenditure trends, based on current trends MADAP should be able to handle the demands being placed upon it with the dollars currently available.

Exhibit 8

**MADAP Monthly Enrollment and Utilization
Calendar 1996 through 2000*
(Based on Three-month Averages)**

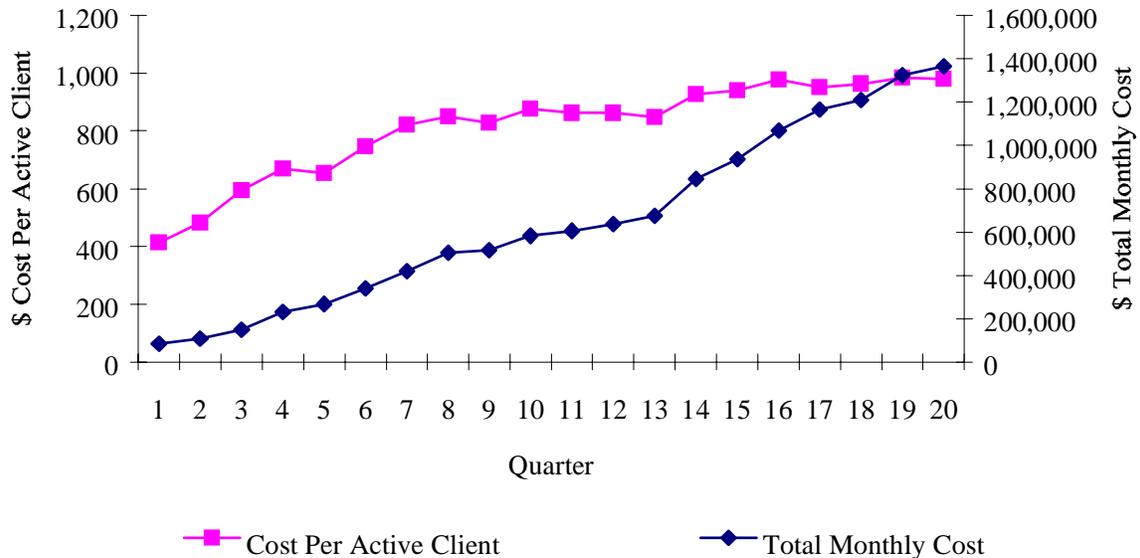


*Last quarter of 2000 based on October and November only. 2000 data includes TAP clients.

Source: Department of Health and Mental Hygiene

Exhibit 9

**MADAP Monthly Spending Patterns
Calendar 1996 through 2000*
(Based on Three-month Averages)**



*Last quarter of 2000 based on October and November only. 2000 data includes TAP spending.

Source: Department of Health and Mental Hygiene

MAIAP and MADAP-Plus

Beginning in April 2000, the AIDS Administration assumed full responsibility for operating the MAIAP. MAIAP is a general fund supported program that maintains employer-based health insurance for individuals who have tested positive for HIV and can no longer work due to their illness. Eligibility requirements include a diagnosis of HIV, an inability to work, income below 300% of the federal poverty limit, and certain asset limitations. By law, program enrollment is capped at 450. As indicated in Exhibit 7, MAIAP enrollment rose from 300 to 344 from fiscal 1999 to 2000. The fiscal 2002 allowance provides funding for 361 clients. However, current monthly enrollment is only 261. **Based on this enrollment level, DLS recommends reducing general funds by \$275,000.**

MADAP-plus is intended to complement the MAIAP program by addressing the needs of people who may be at risk of losing their private health insurance but are not eligible for MAIAP. Upper income limits are the same as those for MADAP. Applicants are responsible for paying at least 50% of their own total monthly health insurance costs. The AIDS Administration began this program in 2000 and had 50 enrollees at then end of fiscal 2000. That number is expected to rise to 300 by the end of fiscal 2001.

Issues

1. The Fiscal 2002 Allowance Continues Fiscal 2001 Funding for the Baltimore City Needle Exchange Program

In Maryland, unlike the nation as a whole, most people exposed to AIDS are exposed through injection drug use. Some 42% of all Maryland AIDS cases are considered to result from injection drug use, compared to 25% nationally. One strategy to combat the spread of HIV and AIDS among the injection drug use population is the development of needle exchange programs. However, the establishment of these programs is controversial. Currently only one jurisdiction in Maryland has a needle exchange program: Baltimore City. An attempt to establish a program in Prince George's County narrowly failed to win support from the County Council in October 2000.

Arguments Over Needle Exchange

Nationwide, needle exchange programs exist in over 80 cities in some 30 states. Worldwide, such programs are also found in Europe (Eastern and Western), South America, and Asia. Yet, despite the proliferation of needle exchange programs, there is no universal agreement on the impact of needle exchange programs in preventing HIV transmission among injection drug users. A recent forum in the *American Journal of Public Health* (September 2000, Vol. 90, No. 9) illustrates the debate on this issue. In the forum, it was noted that needle exchange programs were begun in the mid 1980s without any research to indicate that they would be successful in reducing HIV transmission among injection drug users. Indeed, initial research in the early 1990s did not provide any data to support such a conclusion. However, later research did point to some positive linkages between participation in needle exchange programs and a reduction in HIV transmission. This research has been called into question by two subsequent studies from Canada (from Vancouver and Montreal) as well as a different study in Seattle.

However, these more recent studies themselves are hardly definitive: the Vancouver study showing little impact on HIV transmission among needle exchange participants; the Montreal study actually demonstrating higher levels of HIV transmission among program participants to nonparticipants; and the Seattle study containing insufficient data relating to HIV transmission to allow analysis, but speaking instead to the lack of impact on the transmission of hepatitis B and C infections.

Further, as was pointed out by another author in the forum, comparing programs is fraught with difficulty because of the cultural context in which research occurs: in the United State for example, research has focused on comparing needle exchange program attendees to injection users without legal access to syringes whereas in Canada comparisons are between needle exchange program attendees and injection drug users who have an alternative source of syringes through legal access at pharmacies. In other words, Canadian program attendees may be more marginalized injection drug users which may influence program outcomes.

At the same time, while the research evidence showing a positive impact of needle exchange programs on HIV transmission may be mixed, there is no strong evidence that needle exchange programs do any harm in areas where drug use is already well established. For example, there is no evidence that the

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programs increase the use of illegal drugs or promote the transition from non-injection to injection drug use.

In summary, it would appear that the two questions initially asked of needle exchange programs can be answered as follows:

- Do needle exchange programs increase illicit drug use? None has been demonstrated.
- Do needle exchange programs lead to a reduction in HIV transmission among program participants? In the context of larger HIV prevention programs, they can, but not always, lead to lower rates of HIV transmission among injection drug users.

Final Report to the National Institute on Drug Abuse -- Evaluation of the Baltimore Needle Exchange Program

In July 2000 a final report evaluating the Baltimore Needle Exchange Program was submitted to the National Institute on Drug Abuse (NIDA). This report was the culmination of the second evaluation of the Baltimore Needle Exchange Program funded by NIDA, funded from July 1997 to June 2000. This second evaluation followed a NIDA-funded evaluation from September 1994 to September 1997. The study aimed to evaluate the impact of the program on HIV incidence and drug-related behaviors among injection drug users. Mindful of the controversies swirling around needle exchange programs, the evaluation has also looked to see if the needle exchange program is linked to negative societal effects.

There are also a “second wave” of research questions surrounding needle exchange programs such as: why are some programs more effective than others in reducing HIV transmission? How should programs be coordinated with other HIV prevention efforts, including the availability of drug abuse treatment? What services other than simply syringe exchange should be offered by these programs? Thus, the evaluation also looked at such questions as the linkage between the needle exchange program and drug abuse treatment.

Baltimore’s needle exchange program was begun in August 1994. Until this fiscal year (see discussion below), program funding came from the Baltimore City health department. The program operates through a network of mobile vans which operate at various sites throughout the city as well as at one pharmacy. Program participants can exchange used for sterile needles in unlimited quantities on a one-for-one basis provided program workers are satisfied that the needles being exchanged are needles issued for the participant. Participants can also receive other supplies including sterile swabs and condoms. HIV-testing and test counseling and Hepatitis testing is available on request as are referrals for TB testing and outpatient drug treatment.

The NIDA evaluation of the Baltimore City needle exchange program has generated a wealth of research that has been published in peer-reviewed journals and books as well as presented at conferences. Among the published findings generated by this second evaluation include:

- Data suggesting that the needle exchange program did not increase the number or distribution of discarded needles.

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- Less than 10% of all needle exchange program clients accounted for 64% of all needles distributed. These high volume exchangers access more drug networks than other injection drug users and thus can act as potential messengers to larger numbers of injection drug users spreading HIV prevention messages and materials.
- Findings suggesting that needle exchange programs represent an important entry point to drug abuse treatment for both HIV-infected and uninfected injection drug users. The caveat here though is that adequate services must be available, which is not the case.
- Reinforcement of previously learned lessons which indicate that the needle exchange program does encourage changed behavior in terms of syringe possession in ways that can reduce HIV transmission. Further, the program does not result in increased drug use among participants or the recruitment of first time users.
- The needle exchange program only led to the formation of new social contacts in 8% of a sample of 413 participants, which argues against the program promoting social (i.e., sexual) contacts which lead to the development of new disease transmission networks within the program.
- If syringes were available at pharmacies without prescriptions, 92% of program respondents indicated a willingness to buy syringes at pharmacies.
- Data which demonstrate the merit of linking the needle exchange program to comprehensive drug treatment centers. However, since needle exchange program participants typically have a greater history of severe drug use, the available treatment must be sufficiently intensive.

Other articles in press, submitted for publication or in preparation, speak to such issues as criminal activity in needle exchange program areas, behavior change, drug treatment referral and entry, and the reduction of HIV incidence by 35% in Baltimore City since the opening of the needle exchange program.

State Fiscal Support for Needle Exchange Programs

In fiscal 2001 the General Assembly withheld the expenditure of \$600,000 in general funds from the AIDS Administration appropriation until the administration provided detail on how the funds were to be spent. These were general funds which were first added to the administration's budget in fiscal 1996 (\$500,000 in fiscal 1996 and \$600,000 thereafter) to support MADAP when federal fund support for drug assistance programs was insufficient. The legislature took this action for the fiscal 2001 appropriation because of the abundance of federal funds to support MADAP and other initiatives like MADAP-Plus.

In October 2000 the AIDS Administration submitted its plan for the expenditure of the withheld allotment. Included in these plans was \$290,866 to support the needle exchange program in Baltimore City. This was the first time State funds had been explicitly designated to support the needle exchange program. Funds are to cover:

- additional staffing;

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- clinical and office supplies;
- equipment and communications costs;
- vehicle expenses; and
- drug treatment costs (32 outpatient substance abuse treatment slots for clients referred through the needle exchange program)

These funds are intended to allow for expanded hours of operations (evenings and weekends). The fiscal 2002 allowance continues this support at a level of \$200,000.

The AIDS Administration should speak to its involvement in the Baltimore City needle exchange program, outline expected outcomes from the program, and discuss how it intends to monitor progress towards those outcomes. The department should discuss if the link between the needle exchange program and substance abuse treatment should be and/or can be strengthened beyond that currently in place.

Recommended Actions

	<u>Amount Reduction</u>	<u>Position Reduction</u>
1. Delete funds to support a needle exchange program in Prince George's County. The County Council recently voted to reject the establishment of a needle exchange program in the county.	\$ 250,000	GF
2. Reduce funding for the Maryland AIDS Insurance Assistance Program based on current utilization. The fiscal 2002 allowance provides funding for an average monthly program utilization of 361 clients. Current utilization is 261 per month, and the trend is to lower, not greater, utilization.	\$ 275,000	GF
Total General Fund Reductions	\$ 525,000	

Current and Prior Year Budgets

**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>
Fiscal 2000					
Legislative Appropriation	\$5,241	\$835	\$23,502	\$0	\$29,578
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	17	45	5,235	0	5,297
Reversions and Cancellations	(12)	(755)	(2,326)	0	(3,093)
Actual Expenditures	\$5,246	\$125	\$26,411	\$0	\$31,782
Fiscal 2001					
Legislative Appropriation	\$5,392	\$305	\$34,176	\$0	\$39,873
Budget Amendments	0	0	0	0	0
Working Appropriation	\$5,392	\$305	\$34,176	\$0	\$39,873

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

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The major changes to the fiscal 2000 legislative appropriation, as is typical with the AIDS Administration, involve federal funds. Specifically, the \$5.235 million **federal fund budget amendment** increase is derived from the HIV Care Formula Grant and will be used for HIV-related drug therapies under MADAP and also to cover the cost of the limited health insurance program for persons with HIV, MADAP-Plus. The \$2.326 million in **federal fund cancellations** are Ryan White CARE Act funds which will be carried forward to fiscal 2001.

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

	<u>Object/Fund</u>	FY01					<u>Percent Change</u>
		<u>FY00 Actual</u>	<u>Working Appropriation</u>	<u>FY02 Allowance</u>	<u>FY01 - FY02 Amount Change</u>		
Positions							
01	Regular	66.00	68.00	68.00	0	0%	
Total Positions		66.00	68.00	68.00	0	0%	
Objects							
01	Salaries and Wages	\$ 3,543,542	\$ 3,576,854	\$ 3,899,487	\$ 322,633	9.0%	
03	Communication	96,278	94,301	95,710	1,409	1.5%	
04	Travel	51,884	91,242	114,957	23,715	26.0%	
07	Motor Vehicles	2,875	6,090	4,994	(1,096)	(18.0%)	
08	Contractual Services	19,407,651	21,775,511	23,913,647	2,138,136	9.8%	
09	Supplies & Materials	8,513,153	14,231,071	21,018,217	6,787,146	47.7%	
10	Equip - Replacement	2,648	2,900	3,000	100	3.4%	
11	Equip - Additional	49,788	73,585	68,816	(4,769)	(6.5%)	
13	Fixed Charges	112,762	21,861	20,775	(1,086)	(5.0%)	
Total Objects		\$ 31,780,581	\$ 39,873,415	\$ 49,139,603	\$ 9,266,188	23.2%	
Funds							
01	General Fund	\$ 5,245,537	\$ 5,392,293	\$ 6,621,123	\$ 1,228,830	22.8%	
03	Special Fund	124,802	305,127	417,956	112,829	37.0%	
05	Federal Fund	26,410,242	34,175,995	42,100,524	7,924,529	23.2%	
Total Funds		\$ 31,780,581	\$ 39,873,415	\$ 49,139,603	\$ 9,266,188	23.2%	

Note: Full-time and contractual positions and salaries are reflected for operating budget programs only.