

M00F04
AIDS Administration
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	FY 06	FY 07	FY 08	FY 07-08	% Change
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>	<u>Prior Year</u>
General Fund	\$4,941	\$4,664	\$4,703	\$39	0.8%
Special Fund	579	11,396	10,835	-561	-4.9%
Federal Fund	<u>48,923</u>	<u>57,553</u>	<u>57,054</u>	<u>-498</u>	<u>-0.9%</u>
Total Funds	\$54,443	\$73,612	\$72,592	-\$1,020	-1.4%

- The fiscal 2008 allowance decreases the AIDS Administration budget by \$1.0 million, but the actual growth in costs is masked by one-time health insurance savings being used to fund a portion of health insurance premiums. Excluding spending on health insurance in fiscal 2007 and 2008, costs decrease by \$685,000.
- Funding for direct services through the Maryland AIDS Drug Assistance Program (MADAP) is decreasing by \$2.0 million while contracts are increasing by \$1.2 million to expand the case management contract. The allowance also provides an additional \$0.9 million for local health departments.

Personnel Data

	FY 06	FY 07	FY 08	FY 07-08
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>
Regular Positions	132.00	124.00	121.00	-3.00
Contractual FTEs	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>
Total Personnel	132.00	124.00	121.00	-3.00

Vacancy Data: Regular Positions

Turnover, Excluding New Positions	4.84	4.00%
Positions Vacant as of 12/31/06	20.00	16.13%

- Over the past two years, the staff for the AIDS Administration has almost doubled. In fiscal 2005, the AIDS Administration had 62 full-time equivalent authorized employees, and the fiscal 2008 allowance includes 121 regular positions. The growth in positions was caused

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

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by the conversion of employees at the Maryland Institute for Policy Analysis and Research (MIPAR) at the University of Maryland Baltimore County to Department of Health and Mental Hygiene employees.

- The fiscal 2008 allowance decreases the regular positions for the AIDS Administration by three positions, and each of these positions has been vacant for more than a year.
- The actual turnover is four times higher than the budgeted turnover. However, more than half of the 20 positions that were vacant December 31, 2006, had been vacant for less than six months.

Analysis in Brief

Major Trends

Distribution of Cases Remains Constant While Incidence Is Mixed: In recent years, the distribution of HIV and AIDS cases throughout the State has remained constant with Baltimore City having almost half the cases. Since 1999, the number of new reported AIDS and HIV cases has dropped overall, but for the past two years the incidence of HIV has increased.

MADAP Enrollment and Expenditures Steadily Increasing: MADAP is the largest program run by the AIDS Administration, and from fiscal 2003 to 2006 the program has experienced an aggressive growth rate. The enrollment for the Maryland AIDS Insurance Assistance Program and MADAP-Plus has also increased since fiscal 2003.

Case Management Levels Remain Static: The AIDS Administration provides funding to the local health departments to provide case management services for individuals enrolled in MADAP. The number of clients provided case management services, and the budget for case management has remained level for the past five years.

Prevention Activities Decrease: More pre-test counseling sessions were provided in fiscal 2006 than fiscal 2003, but the AIDS Administration estimates the number of sessions will decrease in fiscal 2007 and 2008. The number of educational contacts and the amount of literature distributed has declined significantly since fiscal 2004. The downward trend corresponds with the budget for literature distribution, but this is not the case for pre-test counseling and educational contacts.

Issues

Federal Reauthorization Requires Name-based HIV Reporting: Congress reauthorized the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act that provides significant funding to the AIDS Administration. The reauthorization changes the basis for the funding distribution to name-based HIV reporting, which means the AIDS Administration must change from a code-based to a name-based system to continue to receive Ryan White CARE funding.

Centers for Disease Control (CDC) Recommends Universal HIV Testing: In September 2006, the federal CDC issued revised recommendations for HIV testing. The major revision is that all Americans between the ages of 13 and 64 should be routinely tested for HIV to help catch infections early and stop the spread of the deadly virus.

Performance Contracting with AIDS Administration Contracts: Over the last few years, the State has emphasized results and accountability. To ensure the State's vendors are focused on the State's objectives, payments or continuation of the contract should be linked to specific performance measures. This issue will analyze the use of monitoring, reporting, performance measures, incentives, and penalties for the larger AIDS Administration contracts.

Recommended Actions

1. Concur with Governor's allowance.

Updates

Plan for Spending \$1.7 Million for Direct Services: The fiscal 2007 budget terminated the MIPAR contract and reallocated the \$1.7 million for the contract to unspecified direct services. However, the AIDS Administration used the funds to convert the remaining MIPAR employees to State employees.

Accounting Change for Drug Rebate Revenue: Legislation was adopted during the 2006 session that established a special fund to receive the MADAP drug rebate funds. In past years, the AIDS Administration had difficulty spending all of the rebate revenue. As a result, MADAP appears to be overbudgeted in fiscal 2007 and 2008 with the funding exceeding the estimated spending.

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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 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, 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 (MFR)

Distribution of Cases Remains Constant While Incidence Is Mixed

Based on data through March 2006, there are currently an estimated 29,247 Marylanders living with HIV or AIDS (16,412 with HIV and 12,835 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. The distribution of persons living with HIV/AIDS shows little change from the prior year.

Exhibit 1
Distribution by County of Prevalent HIV/AIDS Cases for 2005

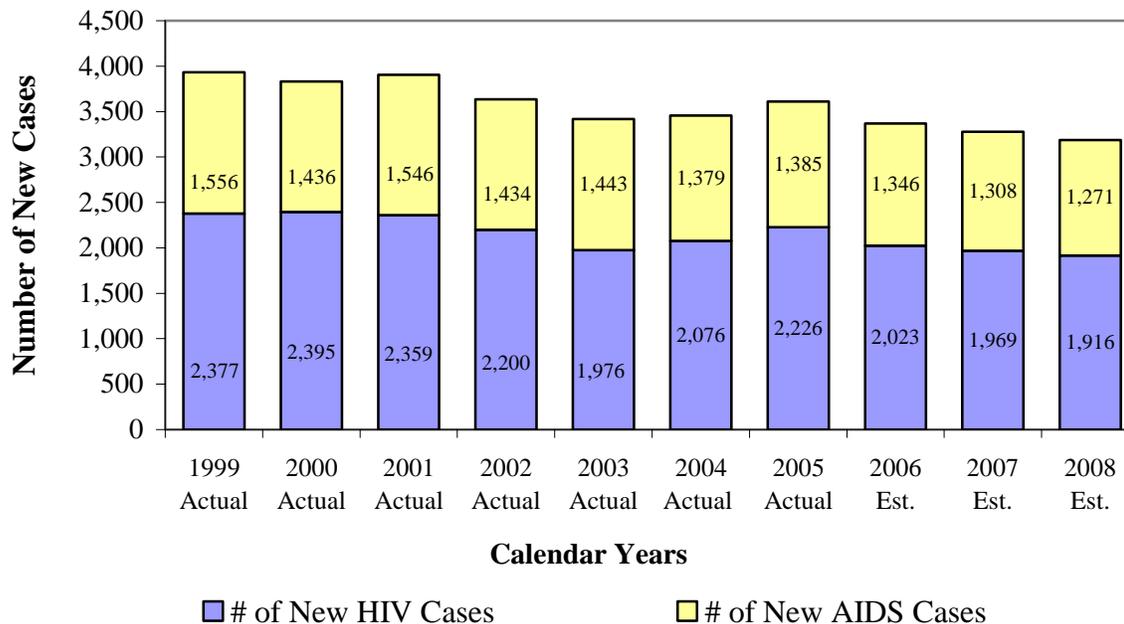
<u>Jurisdiction</u>	<u>Number</u>	<u>Percent</u>
Baltimore City	14,443	49.5%
Prince George's Corrections	4,535	15.2%
Montgomery	2,660	9.4%
Baltimore County	2,295	7.8%
Anne Arundel	2,076	7.0%
Harford	862	2.9%
Howard	322	1.1%
Remainder of State	285	1.0%
	1,769	6.1%
Total	29,247	100.0%

Source: AIDS Administration

Exhibit 2 details trends in new reported cases of HIV and AIDS in Maryland. The exhibit illustrates that new reported AIDS cases, as measured over the six-year period 1999 through 2005, shows an average annual decline of 1.4%. With the advent of new drug therapies, new reported AIDS cases, which were running at about 2,300 per year in the mid-1990s, have fallen gradually each year with the most recent actual data reporting 1,385 new AIDS cases.

Over the same six-year period, the number of new HIV cases has overall decreased 6.3%. However, in the past two years, the new reported HIV cases have increased by 5.1% in 2004 and 7.2% in 2005. The AIDS Administration estimates that new reported HIV cases will decrease almost 14.0% over the next three years.

Exhibit 2
Managing for Results
Incidence of HIV and AIDS in Maryland



Source: AIDS Administration

The rate of Maryland's new reported AIDS cases is roughly double the national average. The federal Centers for Disease Control and Prevention (CDC) reports that nationally there were 14.0 new AIDS cases per 100,000 population in 2005 compared to the Maryland average of 28.5 per 100,000 population. Maryland's AIDS rate grew 2.4 per 100,000 since last year making Maryland's AIDS rate the third highest in the country with only New York and the District of Columbia having higher rates.

Maryland's AIDS population continues to show some striking differences to the nation as a whole. Specifically, for new AIDS cases reported in 2005:

- **Gender** – Female cases comprise a higher percentage of all adult/adolescent cases in Maryland at 37% compared to nationwide at 26%.
- **Race/Ethnicity** – Compared to the national AIDS cases, a higher percentage of Maryland cases are African American (Maryland 84% versus national 48%), while a much lower percentage are Hispanic (Maryland 2% versus national 20%), and white (Maryland 13% versus national 29%). It is important to note, these racial differences are due in part to the differences between the Maryland population and the United States population.

- **Exposure Category** – Maryland male AIDS cases are more likely to report injection drug use (Maryland 43% versus national 23%), and less likely to report that they are MSM (men having sex with men) than national cases (Maryland 27% versus nation 44%).

MADAP Enrollment and Expenditures Steadily Increasing

The AIDS Administration provides three major health services programs, which are MADAP, MADAP-Plus, and the Maryland AIDS Insurance Assistance Program (MAIAP). MADAP and MADAP-Plus are federally funded programs, while MAIAP is supported through general funds.

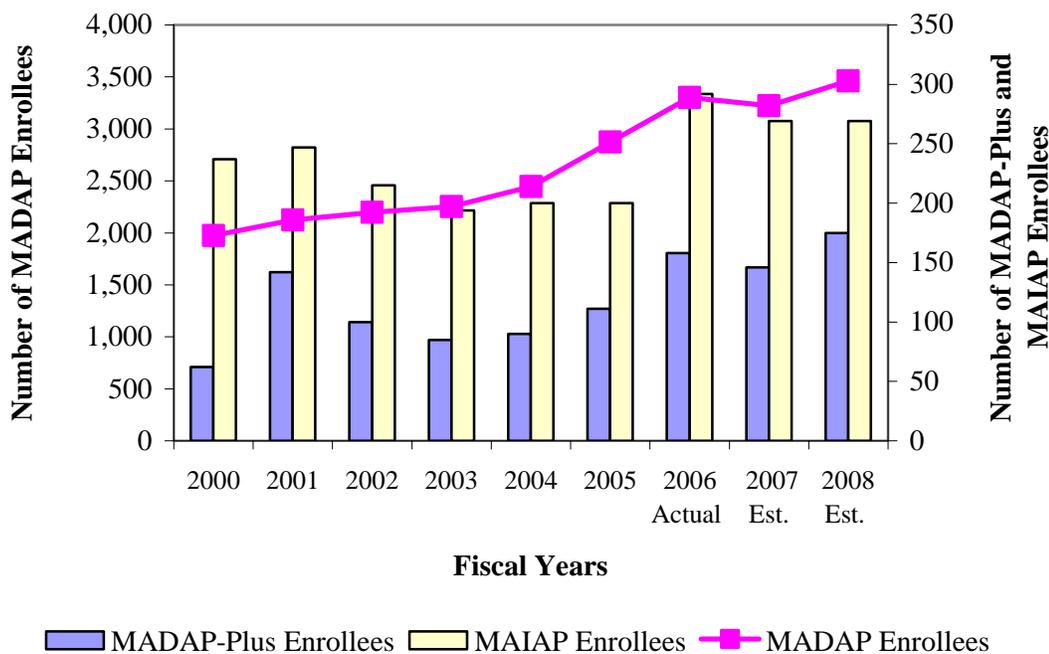
MADAP is the largest program run by the AIDS Administration. MADAP assists persons diagnosed with HIV/AIDS who meet certain income eligibility criteria (above 116% and below 500% of the federal poverty level (FPL) or \$11,368 to \$49,000 for a single person) with HIV/AIDS-related drug costs. Clients are certified eligible for MADAP for a one-year period, after which time they may reapply for certification. 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.

MAIAP maintains 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 actual enrollment is much lower. In fiscal 2006, less than 300 individuals were enrolled in the insurance program. MAIAP was due to sunset in 2002, but Chapter 30 of 2002 extended the program until 2010.

MADAP-Plus complements MAIAP in that it targets persons at risk of losing private health insurance but who are not eligible for MAIAP. The upper income limit is the same as that for MADAP. Enrollment in this program has failed to live up to expectations. The 300 average monthly enrollments that were originally hoped for have never materialized. A few years ago, the caseload appeared to level out at an enrollment of a little more than 100, but in recent years the enrollment in MADAP-Plus has been increasing. In fiscal 2006, just over 150 individuals were enrolled in the program.

As shown in **Exhibit 3**, MADAP and MADAP-Plus have been in a growth trend since fiscal 2003. On the other hand, enrollment in MAIAP had been relatively stable for a few years, and then in fiscal 2006 the program enrollment jumped 32%. In fiscal 2007, all three programs are expected to experience a slight increase in enrollment.

**Exhibit 3
Managing for Results
Enrollees in MADAP and MAIAP**



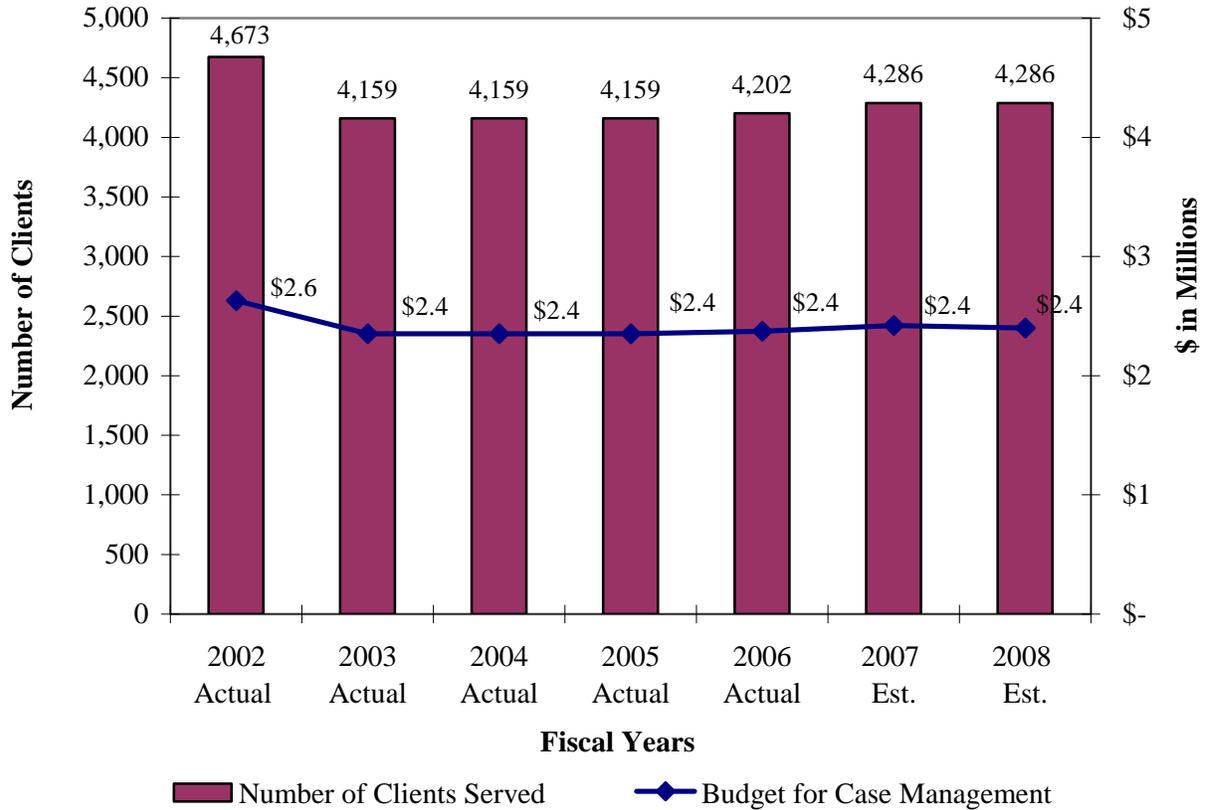
MADAP: Maryland AIDS Drug Assistance Program
 MAIAP: Maryland AIDS Insurance Assistance Program

Source: AIDS Administration

Case Management Levels Static

The AIDS Administration provides funding to the local health departments to provide case management services for people enrolled in MADAP. The number of clients served with case management services and the budget for case management has remained level for the past five years, as shown in **Exhibit 4**. Between fiscal 2002 and 2003, a \$200,000 drop in funding caused 500 fewer clients to receive case management services. Since that point, the budget has remained constant, while the number of clients served increased slightly in fiscal 2006. The AIDS Administration estimates the number served will increase again in fiscal 2007. Then, in fiscal 2008, the budget and the number served is anticipated to remain level.

**Exhibit 4
Managing for Results
Case Management and the Budget**



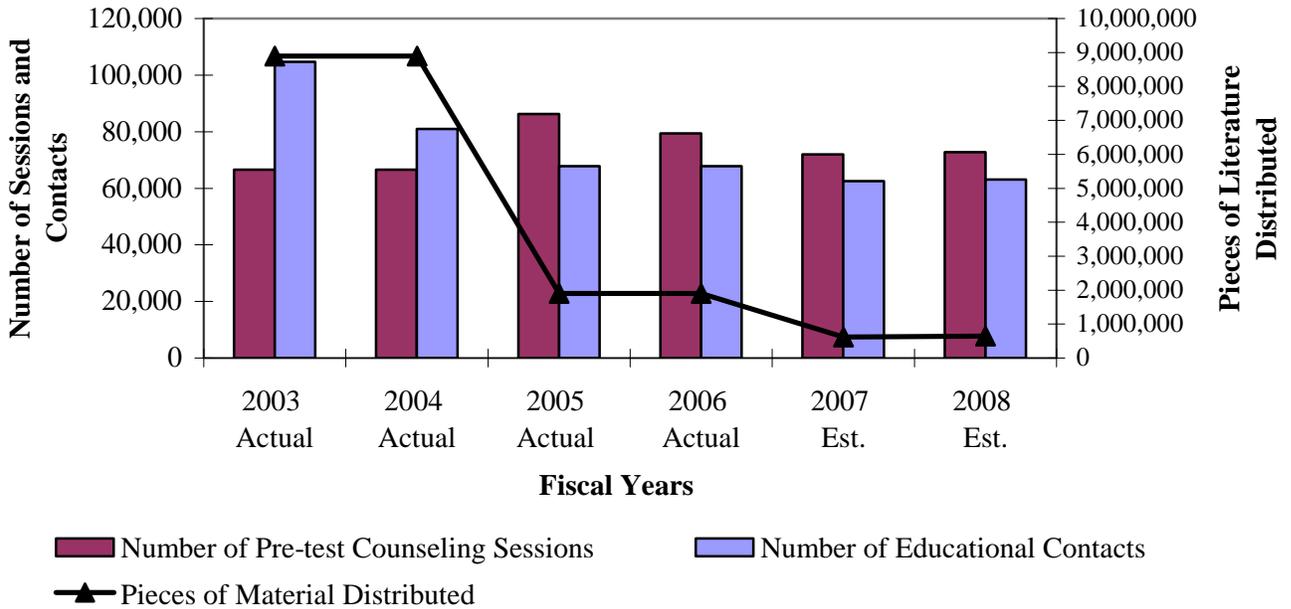
Source: AIDS Administration

The fiscal 2008 allowance includes funds to enhance the case management services provided by local health departments. The department claims the contract is needed because the local health departments are having trouble meeting the need for case management services. **The department should explain why MFR data does not reflect the \$1.2 million in additional funding for case management services in the budget figure or the number of additional clients to be served.**

Prevention Activities Decrease

The AIDS Administration performs a number of prevention activities, and the MFR data includes performance measures for three of those activities. **Exhibit 5** shows the information for the number of pre-test counseling sessions, the number educational contacts, and the pieces of education material distributed.

**Exhibit 5
Managing for Results
Prevention Activities and the Budget
(\$ in Millions)**



	<u>2003 Actual</u>	<u>2004 Actual</u>	<u>2005 Actual</u>	<u>2006 Actual</u>	<u>2007 Est.</u>	<u>2008 Est.</u>
Budget for Pre-test Counseling	\$4.5	\$4.5	\$3.9	\$3.9	\$3.9	\$4.0
Budget for Educational Contacts	6.3	3.8	3.8	3.8	3.8	3.9
Budget for Literature	1.3	1.3	0.3	0.5	0.2	0.2

Source: AIDS Administration

The number of pre-test counseling sessions increased 30% in fiscal 2005, while the funding for pre-test counseling decreased \$600,000, or 13%. In fiscal 2006, pre-test counseling remained level with respect to the number provided and the funding. The AIDS Administration is estimating that the number of pre-test sessions provided will decrease slightly in fiscal 2007 even though the funding remains constant. Then in fiscal 2008, both the funding and the number of sessions provided are expected to increase slightly.

Educational contacts decreased 23% in fiscal 2004 due to a 40% reduction in funding. Exhibit 5 shows the funding for educational contacts is expected to remain at the fiscal 2004 level, while the number of educational contacts is expected to fall another 23% from fiscal 2004 to the fiscal 2007. However, the number of educational contacts is expected to increase slightly in fiscal 2008 caused by a \$40,000 increase in funding.

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As shown in Exhibit 5 the amount of literature distributed by the AIDS Administration is also falling, and this trend directly correlates with the budget for distributing literature. Between fiscal 2004 and 2008, the amount of literature being distributed is expected to decrease by 93%, while the budget for literature is expected to decrease by 87%. In fiscal 2008, the amount of material distributed is expected to increase by 30,000 caused by an \$8,000 increase in funding.

Governor's Proposed Budget

As shown in **Exhibit 6**, the AIDS Administration budget decreases \$1.0 million, or 1.4% in the allowance with special and federal funds decreasing by \$560,000 and \$498,000 respectively. However, the actual cost of the allowance is masked by the use of one-time health insurance savings to fund retiree health insurance costs. The AIDS Administration's underlying costs are decreasing by \$685,000, or 0.9%.

Personnel

Personnel costs are shown as decreasing \$200,500 in Exhibit 6, but the actual cost of personnel is increasing by \$142,000. The AIDS Administration retiree health insurance premiums are projected to cost \$335,000 in fiscal 2008, but a portion of the health insurance premiums are going to be funded with health insurance savings from previous years. Therefore, the funds are not included in the AIDS Administration allowance.

The AIDS Administration loses three positions in the allowance because these positions have been vacant for more than a year. Two of the deleted positions worked with surveillance activities as a program administrator and an administrative officer. The other deleted position was an epidemiologist for prevention activities.

Over the past two years, the budgeted staff for the AIDS Administration has almost doubled. In fiscal 2005, the AIDS Administration had 62 full-time equivalent authorized employees, and the fiscal 2008 allowance includes 121 regular positions. The growth in positions was caused by the termination of a significant interagency agreement with the Maryland Institute for Policy Analysis and Research (MIPAR) at the University of Maryland Baltimore County through which 87 positions were funded that worked side-by-side with the AIDS Administration employees. Throughout fiscal 2006, the AIDS Administration converted the filled MIPAR positions to State employees. Then, in fiscal 2007, DHMH transferred five positions out of the AIDS Administration to other agencies within DHMH. Finally, the deletion of the three long-term vacancies in fiscal 2008 brings the number of regular positions to 121.

MADAP Case Management Contract

The allowance includes \$1.2 million for the AIDS Administration to supplement the case management services for Carroll, Hartford, Howard, Montgomery, Washington, and Wicomico counties and Baltimore City. The department claims that the need for additional case managers is caused by increased numbers of people needing the case management services.

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

How Much It Grows:	<u>General</u> <u>Fund</u>	<u>Special</u> <u>Fund</u>	<u>Federal</u> <u>Fund</u>	<u>Total</u>
2007 Working Appropriation	\$4,664	\$11,396	\$57,553	\$73,612
2008 Governor's Allowance	<u>4,703</u>	<u>10,835</u>	<u>57,054</u>	<u>72,592</u>
Amount Change	\$39	-\$561	-\$498	-\$1,020
Percent Change	0.8%	-4.9%	-0.9%	-1.4%
Where It Goes:				
Personnel Expenses				
Decrease budgeted turnover to 4%				\$431
Salary increments.....				152
Three abolished positions.....				-150
Retirement overbudgeted in fiscal 2007				-171
Health insurance costs decline due to one-time savings				-542
Other fringe benefits				79
Other Changes				
Additional funding for MADAP case management services.....				1,169
Increased federal funding to the local health departments for health services.....				884
Increased funding for MADAP-Plus.....				434
Additional MAIAP health insurance premium assistance				45
Cost of travel, equipment replacement, subscriptions, and rent.....				28
Communication costs overfunded in fiscal 2007				-13
Adjustments to current contracts.....				-42
Elimination of prevention activities targeting ecstasy and other club drug users.....				-262
Decreased federal funding for HIV counseling and testing contracts.....				-317
Funding eliminated for HOPWA Rural				-327
Decrease in federal funding for prevention programs.....				-404
MADAP overbudgeted in fiscal 2007.....				-2,043
Other				29
Total				-\$1,020

HOPWA: Housing Opportunities for People with AIDS
MADAP: Maryland AIDS Drug Assistance Program
MAIAP: Maryland AIDS Insurance Assistance Program

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

Issues

1. Federal Reauthorization Requires Name-based HIV Reporting

In December 2006, Congress passed the reauthorization of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which funds almost 60% of the AIDS Administration budget. The Ryan White CARE 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 CARE Act reauthorization is the change to the basis for distributing funding. 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 currently collects HIV data.

Background

The collection of HIV data is a longstanding debate between the public health community and the HIV/AIDS advocacy community. The public health community supports name-based collection of HIV data in order to most accurately track the disease. However, HIV case reporting by name has traditionally been opposed by the affected community due to concerns of invasion of privacy, discrimination, and discouraging people from getting tested.

Name-based AIDS case surveillance has existed in Maryland since 1985 because in the early years of the AIDS epidemic, the affected community generally accepted AIDS surveillance by name. In 1994, Maryland was the first State to successfully implement a code-based HIV reporting system. However, since that time the treatment of HIV has matured, and the length of time that people live with HIV before being diagnosed with AIDS has increased.

Confidential name-based reporting is favored by CDC and the Institutes of Medicine because the method has been shown to routinely achieve high levels of accuracy and reliability. Also, HIV is the only infectious disease (including AIDS) that does not report the case data by name.

In fact, a couple of years ago, CDC strengthened its official guidance to states, and encouraged "...all states to use a single, accurate system that can provide national data to monitor the scope of the HIV/AIDS epidemic." The CDC letter explains that "HIV surveillance that is conducted using coded patient identifiers has not been shown to routinely produce equally accurate, timely, or complete data to that conducted using confidential name-based surveillance methods."

Maryland's AIDS Administration disputes the CDC's claim that data collected by unique identifiers is unreliable or inaccurate, stating that multiple evaluations of the Maryland HIV surveillance system have been conducted. Using data from states that do collect HIV data by name, CDC released estimates of the numbers of people diagnosed with HIV for states that do not collect HIV data by names. There was a 99.7% agreement between the CDC estimates and the Maryland

number. The AIDS Administration claims that such evidence demonstrates that Maryland's HIV reporting system provides a highly accurate and unduplicated count.

The legislation reauthorizing the Ryan White CARE Act in 2000 gave states six years to establish a system of name-based HIV reporting. Currently, 36 states have fully implemented name-based HIV reporting while five states use a code-based system. In order to receive Ryan White CARE funding, Maryland must establish a name-based HIV reporting system.

The Plan

States that do not currently have a sufficiently accurate and reliable name-based HIV reporting system have received a waiver from the federal government to establish a system by April 1, 2008. In federal fiscal 2009, the Secretary of the Department of Health and Human Services (HHS) may terminate the waiver for any state that does not substantially follow the transition plan submitted to obtain the waiver. However, the waiver may be continued through federal fiscal 2010 if the state can demonstrate that it is in substantial compliance with the transition plan submitted.

States not currently reporting HIV information by name are eligible for the federal waiver as long as the states do one of the following things:

- submit a plan to the federal government to make the transition to a name-based HIV reporting system by October 1, 2006; or
- ensure that all statutory changes necessary to provide for a name-based HIV reporting system have been made by October 1, 2006. (*Sections 102 and 203*)

DHMH has submitted a plan to CDC, and the department plans to submit the plan to HHS. Also, the change from a system of unique identifiers to name-based surveillance requires changes to the Maryland statute, and DHMH plans to submit legislation to allow for the implementation for the transition to name-based HIV reporting. **The department should provide the committees a status report on whether legislation has been submitted.**

Federal Funding

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

Over the next two years, the reauthorization imposes a penalty of sorts to states that submit code-based HIV data. Since the reliability of the code-based data has been deemed questionable, the funding for states submitting code-based HIV information to HHS will be reduced by 5% to adjust for possible duplicative case reporting.

After the AIDS Administration implements a name-based system of HIV reporting, there is a chance that the administration may not obtain the level of funding that it has in the past. The AIDS Administration contends that the more mature the surveillance system, the more individuals the State is likely to identify. Since the amount of federal money received by a state corresponds to the number of individuals with HIV in that state, the administration argues a more mature system will increase the funds the state is likely to receive.

The AIDS Administration receives almost 60% of its funding through the Ryan White CARE Act. In order to continue receiving this funding, the AIDS Administration will need to establish a name-based HIV reporting system. **The AIDS Administration should explain to the committees the plan for implementing name-based HIV surveillance, specifically detailing the schedule and need for additional resources.**

2. Centers for Disease Control and Prevention Recommends Universal HIV Testing

This past September, the federal 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 13 through 64 to help catch infections early and stop the spread of the virus.

Universal HIV testing is part of an all-out effort to address three problems: 250,000 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 one quarter of people living with HIV are unaware of their status is troubling because researchers estimate 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 are estimated to 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.

Eight months ago, the emergency department of Johns Hopkins Hospital in Baltimore set out to offer testing to every patient but has found that goal difficult to achieve. The main cause for the difficulty in following the CDC recommendations is Maryland's legal requirements for written consent, which takes time and effort beyond what is feasible in a busy emergency department. Johns

Hopkins began using a facilitator who counsels patients and obtains consent, which has dramatically increased the number of tests offered.

The Supreme Court has held that CDC guidelines have considerable weight in legal analyses (Bragdon vs. Abbott, 524 US 624 (1998)). If health care professionals do not offer testing in accordance with CDC policy, they could be found negligent. In order to follow the new CDC recommendations, Maryland is going to need to make a number of changes. **The AIDS Administration should explain to the committees how the CDC recommendations will change the work of the administration; what efforts have and will take place to inform the public and the health care profession about the new CDC recommendations; and how do Maryland regulations need to change so that health care professionals can adhere to the CDC guidelines.**

3. Performance Contracting with AIDS Administration Contracts

Over the last few years, the State has taken steps to better evaluate the outcomes produced by its programs. The Department of Budget and Management (DBM) is spearheading this effort through its MFR Initiative which attempts to link State spending to outcomes. DBM has required every agency to develop a mission, vision, key goals, objectives, and performance measures for each budgetary program. For the State's emphasis on results and accountability to be effective, it must permeate throughout the agency, as well as throughout all vendors doing business on the State's behalf. Managers in public agencies and vendors delivering services on the State's behalf must be equally aware of the relevant goals and objectives and share responsibility for producing the desired outcomes. The best way to ensure that vendors focus on the State's objectives is to link payments or continuation of the contract to specific performance measures.

Performance contracting is especially critical for the DHMH AIDS Administration because the agency relies heavily on the services provided through contracts. The AIDS Administration funds a number of programs administered by local health departments and community organizations. The funding for these programs is predominantly provided through contract arrangements.

The contracts administered by the AIDS Administration are generally quite small in financial terms. However, for two services, the total expenditures for all contracts providing the same services are significant. First, the AIDS Administration contracts with local health departments to provide health support services, and this contract will cost just over \$7.0 million in fiscal 2007. The second type of contract is for counseling, testing, and referral through local health departments and community organizations. These contracts will cost \$2.5 million in fiscal 2007. Contracts for vendors providing the same services are identical. Below, the use of monitoring, reporting, and performance measure requirements in each type of contract is analyzed.

Health Support Services

The AIDS Administrations contracts with local health departments to provide health support services, which are health services for people living with HIV throughout Maryland. The contract's service categories include:

- ambulatory outpatient care;
- case management;
- client advocacy;
- direct emergency financial assistance;
- transitional case management;
- oral health;
- transportation;
- housing;
- treatment adherence; and
- psycho-social support.

These contracts are monitored by health services administrators housed in the Center for HIV Health Services in the AIDS Administration. The health services administrators conduct a site visit to each program once every three years. A site visit report is written within 45 days of the visit, and the vendor has 30 days to respond to the report. If necessary, the vendor must supply a corrective action plan detailing the steps and expected implementation dates of required changes.

Each vendor is required to submit quarterly reports including narrative and financial and performance measure information by service category. The quarterly reports are reviewed by the health services administrators to ensure that all programs are on target financially and in accordance with program guidelines. Since the health support services contracts are directly funded through federal Ryan White II funds, the contracts are monitored extensively by the federal Health Resources and Services Administration (HRSA). The AIDS Administration is required to report information included in the vendor's quarterly reports to HRSA annually.

The health support services contract has a number of performance measures. Each service category listed above has specific performance measures dictated in the conditions of award. The following is a list of some of the health support services performance measures:

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- number of clients seen;
- number of face-to-face or group counseling and treatment adherence sessions; and
- number of bed nights.

The AIDS Administration's health support services contracts have an extensive amount of monitoring and reporting. Also, the contract includes a number of meaningful performance measures. **Since the services provide through the health support services contracts are client-focused, the AIDS Administration should consider amending the current contract to include client surveys when the contracts are up for renewal.**

Counseling, Testing, and Referral (CTR)

The AIDS Administration contracts with 21 local health departments and a few community organizations to provide counseling, testing, and referral services. Under the terms of the contract, the vendors are to:

- increase knowledge of transmission and risk-reduction strategies;
- perceive risk for and severity of the HIV/AIDS infection;
- support consistent condom use;
- reduce high-risk sexual and needle-sharing behavior;
- teach how to use a condom and how to clean needles;
- have knowledge of local medical and support services and intention to use these services; and
- have knowledge of the individual's serostatus.

In addition, the vendors are to provide partner counseling and referral services (PCRS), which include contacting sexual and needle-sharing partners of persons with HIV/AIDS and notifying the partner of their need to be tested.

The AIDS Administration's monitoring roles and responsibilities go above and beyond the Centers for Disease Control guidelines. Four AIDS Administration employees monitor the CTR aspects of the contracts, and one employee monitors the PCRS. The monitors conduct annual site visits.

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For each CTR or PCRS client, the vendors are required to fill out a five-page booklet containing treatment and demographic information, and the booklet is sent to the AIDS Administration. Quarterly, the AIDS Administration compiles the data from the booklet for each vendor, and the AIDS Administration sends the data back to the organizations. Then, the AIDS Administration has a phone call with each vendor to discuss areas where improvement is needed. After the phone call, the vendor is required to put together a work plan for how they are going to achieve these goals. Other reporting requirements include quarterly documentation of all CTR activity and bi-annual activity for all PCRS activity.

The CTR contract requires the vendors to collect data including:

- number of persons tested newly identified and confirmed HIV positive;
- **number of high risk persons tested;**
- **percent of HIV-positive persons with counseling;**
- **percent of HIV-negative persons with counseling;**
- **percent of contacts with unknown or negative serostatus who receive HIV test after PCRS notification;**
- percent of contacts with a newly identified, confirmed HIV-positive test among contacts who are tested; and
- percent of contacts with a known, confirmed HIV-positive test among all contacts.

The contract does not include any performance measures, but some of the data collected (above in bold) lends itself to being performance measures.

The CTR contracts have a good level of monitoring and reporting requirements, but the contracts include no specific performance measures. The AIDS Administration does have certain expectations of the CTR vendors, which are conveyed orally throughout the term of the contract. However, none of those goals are spelled out in the contract. In addition, the services provided through the CTR contracts are client-focused, but there is no knowledge about how the clients perceive the services or whether the services have an impact on the client's behavior. **The AIDS Administration should consider amending the current contract to include performance measures and client surveys when the contracts are up for renewal.**

Recommended Actions

1. Concur with Governor's allowance.

Updates

1. Plan for Spending \$1.7 Million for Direct Services

For a number of years, the AIDS Administration had a significant interagency agreement with MIPAR at the University of Maryland Baltimore County to provide administrative and technical support services for virtually every aspect of the AIDS Administration's policies. Interagency agreements between executive departments and institutions of higher education are neither new nor unusual. However, the MIPAR contract was abnormal because the 87 employees authorized under the contract was the largest number authorized through an interagency agreement. Furthermore, the number of employees working on the MIPAR contract was higher than the number of authorized State employees in the AIDS Administration. Also, the MIPAR employees worked side-by-side with State employees with the same management, pay, and job requirements.

The major difference between the MIPAR employees and the State employees was the benefit package which the General Assembly saw as an issue of equity. During the 2005 legislative session, the General Assembly added budget bill language authorizing the AIDS Administration to create regular positions for the MIPAR employees. At the beginning of fiscal 2006, the AIDS Administration had 74 MIPAR employees, and the administration made a Board of Public Works request, which was approved, to convert 41 of these employees to Position Identification Numbers (PINs). This left 33 positions under the MIPAR contract.

The fiscal 2007 allowance kept the funds that had previously paid for the MIPAR contract, but instead of paying salaries, the \$1.7 million was to be spent on unspecified direct services. During the 2006 legislative session, budget bill language was added to the fiscal 2007 budget restricting \$1.7 million in AIDS Administration funding until the MIPAR positions were converted to State employees and a report was submitted detailing the expenditure of the \$1.7 million.

In the report submitted June 16, 2006, the AIDS Administration indicated that the Board of Public Works approved the creation of 32 new PINs for MIPAR conversions in May 2006. As a result, all MIPAR employees were offered State positions effective June 30, 2006. Also, the report detailed that the \$1.7 million allocated for unspecified direct services will be used to pay a portion of the salaries and benefits for the 32 new regular positions.

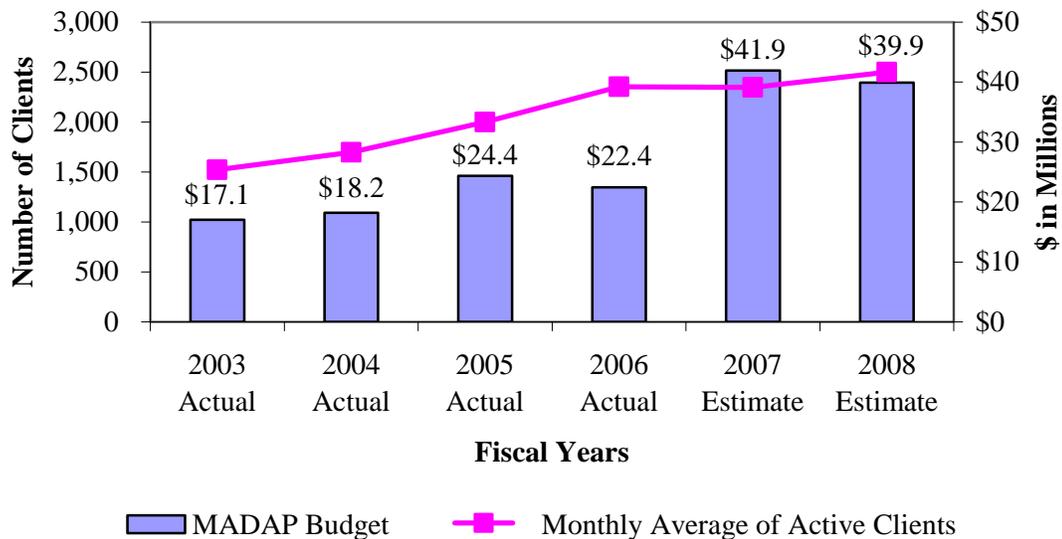
2. Accounting Change for Drug Rebate Revenue

MADAP helps low- to moderate-income Maryland residents with HIV/AIDS receive assistance purchasing the medications they need. Due to federal law, the AIDS Administration is eligible to receive drug rebates from the pharmaceutical companies. This provision was implemented to lower the cost of acquiring outpatient drugs so that more patients could be served with better service quality.

In past years, the drug rebate revenue was not included in the budget process. The funds would go to the AIDS Administration with some of the rebate funds going directly back into MADAP and the rest accruing and carrying over to the next fiscal year. The fiscal 2007 allowance proposed changing the accounting of the drug rebate funds by having the rebate funds go into the State’s general fund. However, legislation was adopted during the 2006 session to avoid that accounting change by establishing a special fund to receive the rebate funds. The legislation specified the funds could only be used to fund MADAP. Also, this change brings the rebate funds into the budget as special funds.

Now that the full amount of the rebate is included in the budget, MADAP appears to have experienced a significant increase in funding. As shown in **Exhibit 7**, the monthly average of active clients increases steadily from fiscal 2003 through 2008, but the budget for direct services to these clients significantly increased and almost doubled from fiscal 2006 to 2007.

Exhibit 7
MADAP Enrollees Compared to Budget for MADAP

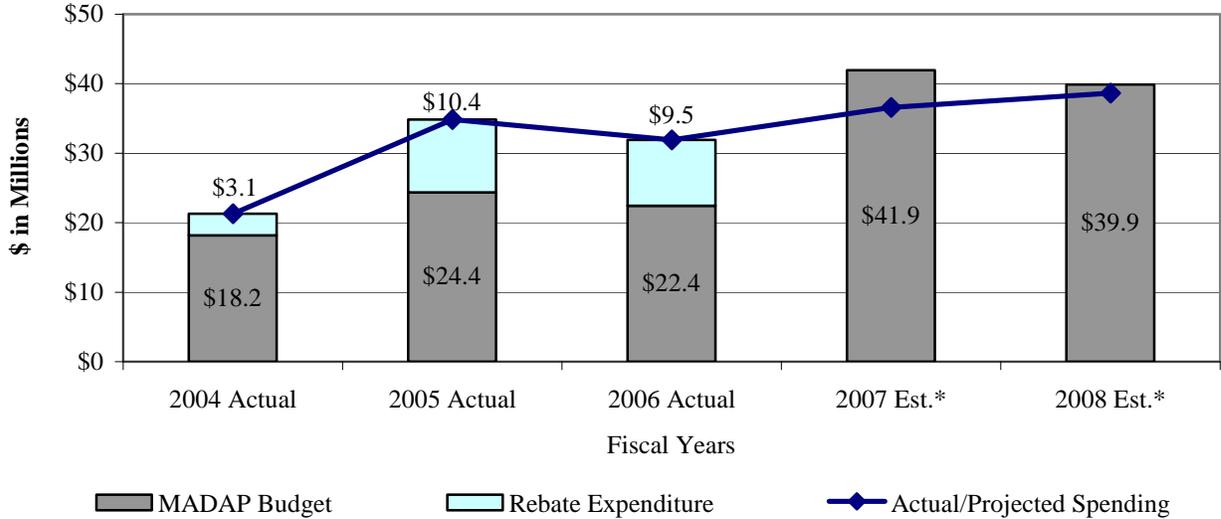


MADAP: Maryland AIDS Drug Assistance Program

Source: Department of Health and Mental Hygiene

Whereas the budget for direct services to MADAP clients has increased significantly in the past couple years, the actual amount spent has increased at a rate comparable to the increase in the monthly average of active clients. In past years, a portion of the rebate revenue was used to cover the costs of direct services above what was available in the budget. **Exhibit 8** shows the actual spending on MADAP direct services increasing at a reasonable rate, and the exhibit shows the portion of spending the rebates accounted for prior to rebate revenue being included in the budget. Exhibit 8 also shows that the budget exceeds the estimated actual spending in fiscal 2007 and 2008.

**Exhibit 8
MADAP Rebates and Balances**



MADAP: Maryland AIDS Drug Assistance Program

*Rebate revenues are included in the fiscal 2007 and 2008 MADAP budgets due to the legislative change during the 2006 legislative session.

Source: Department of Health and Mental Hygiene

In the past, only a portion of the rebate revenue was used to fund MADAP direct services. Any rebate funds not expended at the end of the federal fiscal year are frozen, and halfway through the next federal fiscal year the AIDS Administration is able to request the ability to spend the funds not expended in the previous fiscal year. Then, about three months later, the federal government informs the AIDS Administration about the amount of unspent funds they will be reawarded. The AIDS Administration has a couple months to obligate these funds or else the funds become part of the unspent federal funds that are frozen at the end of the federal fiscal year.

For the past three fiscal years, the AIDS Administration received roughly \$10 million in re-awarded funds. However this amount is suppose to drop to \$4 million in fiscal 2007, as reflected in Exhibit 8.

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 2006					
Legislative Appropriation	\$4,878	\$111	\$48,928	\$0	\$53,917
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	68	473	0	0	541
Reversions and Cancellations	-5	-5	-5	0	-15
Actual Expenditures	\$4,941	\$579	\$48,923	\$0	\$54,443
Fiscal 2007					
Legislative Appropriation	\$10,640	\$51	\$57,553	\$0	\$68,243
Budget Amendments	-5,976	11,345	0	0	5,369
Working Appropriation	\$4,664	\$11,396	\$57,553	\$0	\$73,612

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

Fiscal 2006

The AIDS Administration spent \$54.4 million in fiscal 2006, which is \$525,827 more than the legislative appropriation. General funds increased by a net of \$68,268. The increases in general funds are due to lower than budgeted turnover (\$144,683) and cost-of-living adjustments (COLA) (\$23,752), and offset by a realignment of the health insurance appropriation (\$100,167).

A majority of the increase in the AIDS Administration's budget is from a \$472,763 increase in special funds to provide short- and long-term housing assistance in Montgomery County and to cover the cost of medicine and drugs for low-income individuals with AIDS.

In fiscal 2006, the AIDS Administration cancelled a total of \$15,204, which consisted of \$5,331 in general funds intended for educational supplies; \$5,109 in special funds due to spending less than expected on contracts; and \$4,765 in federal funds intended for advertising.

Fiscal 2007

The AIDS Administration's fiscal 2007 working appropriation is \$5.4 million more than the legislative appropriation of \$68.2 million. Most of the difference between the legislative appropriation and the working appropriation was brought about by legislation passed during the 2006 legislative session.

The fiscal 2007 allowance proposed changing the accounting of the drug rebate funds by having the rebate funds go into the State's general fund. Since the accounting change would have caused a significant decrease in funding for MADAP, the allowance allocated \$6 million in general funds. Legislation was enacted during the 2006 session to avoid the accounting change by establishing a special fund to receive the rebate funds and only to be used to fund MADAP.

Since the proposed accounting change was not implemented, the allocation of \$6.0 million in general funds was not necessary. As a result, the AIDS Administration's general funds decreased by \$6.0 million, which was distributed as follows: \$2.9 was disbursed throughout DHMH to cover higher than expected electric costs; \$2.0 million funded a grant to the Prince George's Hospital Center; and \$1.1 million partially funded a flu mist vaccination initiative for school children. General funds also increased slightly for the employee COLA (\$23,994).

Special funds increased by \$11.3 million recognizing the receipt of the drug rebates as required by Chapter 503 of 2006 as special funds.

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

<u>Object/Fund</u>	<u>FY06 Actual</u>	<u>FY07 Working Appropriation</u>	<u>FY08 Allowance</u>	<u>FY07-FY08 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	132.00	124.00	121.00	-3.00	-2.4%
Total Positions	132.00	124.00	121.00	-3.00	-2.4%
Objects					
01 Salaries and Wages	\$ 4,717,955	\$ 7,877,270	\$ 7,676,717	-\$ 200,553	-2.5%
03 Communication	66,050	94,301	81,728	-12,573	-13.3%
04 Travel	48,393	61,257	78,647	17,390	28.4%
07 Motor Vehicles	9,932	10,040	9,780	-260	-2.6%
08 Contractual Services	26,646,338	23,103,185	24,567,326	1,464,141	6.3%
09 Supplies and Materials	22,543,910	42,113,938	40,077,483	-2,036,455	-4.8%
10 Equip – Replacement	15,302	0	3,177	3,177	N/A
11 Equip – Additional	45,536	0	464	464	N/A
12 Grants, Subsidies, and Contributions	262,356	262,356	0	-262,356	-100.0%
13 Fixed Charges	87,158	90,052	97,073	7,021	7.8%
Total Objects	\$ 54,442,930	\$ 73,612,399	\$ 72,592,395	-\$ 1,020,004	-1.4%
Funds					
01 General Fund	\$ 4,941,207	\$ 4,663,929	\$ 4,702,617	\$ 38,688	0.8%
03 Special Fund	578,706	11,395,825	10,835,281	-560,544	-4.9%
05 Federal Fund	48,923,017	57,552,645	57,054,497	-498,148	-0.9%
Total Funds	\$ 54,442,930	\$ 73,612,399	\$ 72,592,395	-\$ 1,020,004	-1.4%

Note: The fiscal 2007 appropriation does not include deficiencies, and the fiscal 2008 allowance does not reflect contingent reductions.

**Fiscal Summary
DHMH – AIDS Administration**

<u>Program/Unit</u>	<u>FY06 Actual</u>	<u>FY07 Wrk Approp</u>	<u>FY08 Allowance</u>	<u>Change</u>	<u>FY07-FY08 % Change</u>
G101 Executive Direction	\$ 524,459	\$ 488,885	\$ 574,508	\$ 85,623	17.5%
G102 Exec. Dir.-Prevention Cooperative Agree (Ff)	298,455	316,730	298,890	-17,840	-5.6%
G104 Surveillance	132,594	82,192	83,571	1,379	1.7%
G198 Prior Years Grant Activity	0	5,127	5,127	0	0%
G201 Epidemiology & Health Services Research	87,373	81,376	79,174	-2,202	-2.7%
G202 Epi. and Health Svcs – Prevent Coop Agree (Ff)	1,201	2,370	1,888	-482	-20.3%
G204 Epi. and Health Svcs – Ryan White (Ff)	242,846	158,177	164,084	5,907	3.7%
G401 Surveillance	80,428	60,589	57,850	-2,739	-4.5%
G403 Surveillance – Surveillance Coop Agree (Ff)	2,017,281	1,762,130	1,698,113	-64,017	-3.6%
G413 Aids-Antiretroviral Surveillance	220,769	119,087	121,637	2,550	2.1%
G433 Eval. Web-based HIV Risk Behavior	129,446	191,911	135,903	-56,008	-29.2%
G443 Morbidity and Risk Behavior Surveillance	362,299	226,053	227,481	1,428	0.6%
G453 Enhanced Surveillance for Perinatal Prevention	0	0	55,130	55,130	0%
G501 HIV Health Services	2,130,592	1,738,671	1,677,698	-60,973	-3.5%
G504 HIV Health Svcs – Ryan White (Ff)	9,872,310	9,094,519	10,061,140	966,621	10.6%
G505 HIV Health Svcs – HRSA Pediatric Svcs (Ff)	970,073	1,010,449	1,056,839	46,390	4.6%
G507 HIV Health Svcs – HOPWA Rural (Ff)	362,778	326,984	0	-326,984	-100.0%
G511 HIV – MADAP/MAIAP Programs	992,881	1,127,316	1,162,507	35,191	3.1%
G514 HIV – Ryan White Programs	24,811,943	43,873,392	43,200,966	-672,426	-1.5%
G517 HIV Health Services/HOPWA Formula	125,000	205,495	215,770	10,275	5.0%
G525 Youth Services Initiative	402,575	338,773	355,009	16,236	4.8%
G601 Education and Training	414,549	454,334	458,484	4,150	0.9%
G602 Educ. and Trng. – Prevent Coop Agree (Ff)	4,491,053	5,351,142	4,996,556	-354,586	-6.6%
G606 Aids – Samhsa (Ff)	312,703	430,049	386,598	-43,451	-10.1%
G701 Prevention Programs	732,218	812,348	822,181	9,833	1.2%
G702 Prev. Pgms. – Prevent Coop Agree (Ff)	4,079,790	4,808,684	4,285,799	-522,885	-10.9%
G706 Ecstasy Other Club Drugs Prevention	289,215	262,830	0	-262,830	-100.0%
G709 Alcohol – Drug Abuse	358,099	282,786	409,492	126,706	44.8%
Total Expenditures	\$ 54,442,930	\$ 73,612,399	\$ 72,592,395	-\$ 1,020,004	-1.4%
General Fund	\$ 4,941,207	\$ 4,663,929	\$ 4,702,617	\$ 38,688	0.8%
Special Fund	578,706	11,395,825	10,835,281	-560,544	-4.9%
Federal Fund	48,923,017	57,552,645	57,054,497	-498,148	-0.9%
Total Appropriations	\$ 54,442,930	\$ 73,612,399	\$ 72,592,395	-\$ 1,020,004	-1.4%

Note: The fiscal 2007 appropriation does not include deficiencies, and the fiscal 2008 allowance does not reflect contingent reductions.