



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

Testimony Submitted by

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Human Services, and Education

On the Fiscal Year 2010 budget including:  
Centers for Disease Control and Prevention's HIV/AIDS, Viral Hepatitis and STD  
prevention programs and 317 Vaccine Program;  
Health Resources and Services Administration's Ryan White Program Part B; and  
the multi-agency Minority AIDS Initiative

Wednesday, March 18, 2009, 2:00 p.m.

As the Director of the Maryland AIDS Administration and the incoming Chair of the National Alliance of State and Territorial AIDS Directors (NASTAD), I respectfully submit testimony for the record regarding federal funding for domestic HIV/AIDS, viral hepatitis, and STD programs in the FY2010 Labor, HHS and Education Appropriations legislation. State AIDS directors appreciate the longstanding support of the House Appropriations Committee for these important public health programs.

I have the privilege of having administered state public health HIV programs for both a high prevalence state – Maryland – and a low prevalence state – New Hampshire. Therefore, I have an understanding of the resource needs of small and large state AIDS programs. The mission of the Maryland AIDS Administration is to reduce HIV transmission in our state and to help Marylanders with HIV live longer and healthier lives. The Maryland AIDS Administration administers Maryland's HIV/AIDS prevention, surveillance, and care programs, which are funded by federal and state funds.

In this testimony, I will describe the funding needs of state governmental public health HIV/AIDS, viral hepatitis, and STD programs. State public health agencies serve an essential and unique role in the delivery of HIV/AIDS prevention and care and treatment programs. The agencies are entrusted through U.S. law as the “central authorities of the nation’s public health system” and as such, bear the primary public sector responsibility for health. State public health responsibilities include disease surveillance; epidemiology and prevention; provisions of primary health care services for the uninsured and indigent; and overall planning, coordination, administration, and fiscal management of public health services.

As you craft the FY2010 Labor-HHS-Education Appropriations legislation, we urge you to consider the following critical funding needs of HIV/AIDS, viral hepatitis, and STD programs:

- \$1.6 billion for the Ryan White Part B Program, including \$514 million for the Part B Base and \$1.1 billion for the AIDS Drug Assistance Program (ADAP);
- \$1.6 billion for CDC’s HIV/AIDS Prevention Program, including an additional \$249 million for state and local health department prevention cooperative agreements to include an additional \$49 million for state and local HIV/AIDS surveillance systems, and the expansion of the Domestic HIV/AIDS Testing Initiative to additional populations and jurisdictions;
- \$50 million for CDC’s Viral Hepatitis Prevention Program, including a doubling of resources for the Adult Viral Hepatitis Prevention Coordinator Program to \$10 million.
- \$16 million for hepatitis B vaccination for high-risk adults through the Section 317 Vaccine Program;
- \$451 million for CDC’s STD Prevention Program for prevention, treatment and surveillance cooperative agreements with state and local health departments; and
- \$610 million for the Minority AIDS Initiative to enhance capacity in communities of color.

#### Need for Federal Funding

States across the country are facing significant budget deficits. The Center for Budget and Policy Priorities has said that 46 states are currently facing budget shortfalls and that 26 states have made or are proposing cuts to their public health programs. NASTAD surveyed state AIDS programs and found that over half of the 36 states responding have received cuts in their state

funding for their programs. The anticipated cuts in state FY2010 AIDS program funding totals over \$87 million for the states responding. The Maryland Department of Health and Mental Hygiene has been cut by \$121 million in state FY2009. State cuts to Maryland's STD program have resulted in a 50 percent reduction in Chlamydia screening, while we have the thirteenth highest rates in the country. Therefore, it is critical that the federal government increase its commitment to state HIV/AIDS, viral hepatitis, and STD public health programs.

In addition to program funding cuts, states are experiencing a loss in public health capacity due to reductions in staff positions, freezes in the hiring of new staff, and elimination of vacant positions. Many states have also instituted furloughs and early retirement programs. Within the 36 states responding to NASTAD's survey, there are 263 unfilled positions within state AIDS programs and 138 positions cut in HIV/AIDS and viral hepatitis programs. In Maryland, we've lost 383 positions in the health department, some of which are HIV/AIDS positions and limit our capacity to monitor and evaluate our activities.

#### HIV/AIDS Care and Treatment Programs

The Health Resources and Services Administration (HRSA) administers the \$2.2 billion Ryan White Program that providing health and support services to over 500,000 HIV-positive individuals. NASTAD respectfully requests a minimum increase of **\$362 million** in FY2010 for state Ryan White Part B grants, including an increase of at least **\$113 million** for the Part B Base and at least **\$269 million** for AIDS Drug Assistance Programs (ADAPs). With these funds all states and territories provide care, treatment and support services to persons living with HIV/AIDS. People living with HIV need access to trained HIV clinicians, life-saving and life-extending therapies, and a full range of support services to live as healthy a life as possible and to ensure adherence to complicated treatment regimens. All states are reporting to NASTAD that they are seeing a significant increase in the number of individuals seeking Part B Base and ADAP services – for some states it's a doubling of new clients per month from the previous year. This is due to a number of factors including, increased testing efforts and unemployment.

Ryan White Part B Base programs include ambulatory medical services, case management, laboratory services, and an array of support services. As of October 10, 2008, four states report that 266 individuals are on either a medical or support service waiting list for services that include housing, mental health counseling, specialty medical care, and transportation. Five states report that funding is insufficient to ensure that all eligible patients attend medical appointments every three months, which is the standard of care. Eight Part B programs are also considering cost containment measures for their Part B services in light of high demand and reduced funding.

State ADAPs provide medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. While only three states currently have a waiting list with 53 individuals, the present fiscal condition of state ADAPs remain fragile. In FY2008, state ADAPs were relatively stable due to increased state contributions, increased rebates from drug companies, \$39.7 million in ADAP Supplemental grants, transfers of Part B Base funding into ADAP, and program savings from the Medicare Part D Prescription Drug Benefit. The continuing increase in clients and the cuts in state contributions to ADAP (one state has cut their ADAP contribution by \$70 million) render the fiscal future of ADAPs uncertain. On average, state spending accounts for 21 percent of the total ADAP budget. Additionally, the

Centers for Disease Control and Prevention (CDC) estimates that their on-going Domestic HIV/AIDS Testing Initiative will find 20,000 new infections over the next year.

While we are very supportive of the funding increases in recent years for the community health center (CHC) program, we want to be clear that this hasn't necessarily translated into more care for person living with HIV/AIDS. CHCs focus on primary care with most of the HIV/AIDS care being provided in centers with Ryan White Part C grants.

#### HIV/AIDS Prevention and Surveillance Programs

At the request of Congress, the CDC developed a Professional Judgment Budget detailing the needed resources to significantly reduce the number of Americans becoming infected with HIV each year. CDC identified the need for a funding increase of **\$878 million** for total funding of **\$1.6 billion** for CDC's HIV prevention program in FY2010. As Congress strives to reach the \$1.6 billion overall investment in HIV prevention, NASTAD respectfully requests an initial increase of **\$249 million** in state and local health department HIV prevention and surveillance cooperative agreements. This would include an additional **\$49 million** for state and local HIV/AIDS surveillance systems and the expansion of the Domestic HIV/AIDS Testing Initiative to additional populations and jurisdictions.

An estimated 56,300 new infections occur every year while state and local HIV prevention cooperative agreements have been cut by \$21 million between FY2003 and FY2008. CDC's 2007 surveillance reports showed a 15 percent increase in HIV diagnoses in the 34 states included in the national database while CDC's HIV prevention funding was cut in FY2008 and flat-funded in FY2009. Additionally, core HIV/AIDS surveillance funding has eroded over the last decade, while the importance of this data has become paramount for targeting prevention efforts and directing Ryan White resources.

The nation's prevention efforts must match our commitment to the care and treatment of infected individuals. State and local public health departments know what to do to prevent new infections, they just need the resources. First and foremost we must address the devastating impact on racial and ethnic minority communities. We must expand outreach and HIV testing efforts targeting high-risk populations including gay and bisexual men of all races, racial and ethnic minority communities, substance users, women and youth. But, testing alone can never end the epidemic. All tools in the prevention arsenal must be supported. Additional resources must be directed to build capacity and provide technical assistance to enable community-based organizations and health care providers to implement evidence-based behavior change interventions, ensure fiscal responsibility and refer partners of HIV-positive individuals to counseling and testing services.

The Domestic HIV/AIDS Testing Initiative is an important step to increasing knowledge of serostatus, particularly among African Americans. Currently 25 jurisdictions (20 states and five cities) receive \$36 million for the Expanded Testing Initiative (ETI), including rapid testing, in clinical settings such as emergency rooms, community health centers, correctional health facilities, and STD and tuberculosis clinics. Both CDC and NASTAD conducted assessments of year-one including progress and challenges faced. Following significant scale-up efforts in all jurisdictions, 21 of the funded jurisdictions conducted 446,503 tests in year one of the ETI.

Nearly 4,000 new HIV infections were identified, 80 percent of which were in clinical settings. During the first year, 86 percent of testing occurred in clinical settings. Of the total number of tests conducted in the first year, 64 percent were administered to African Americans. Seventy percent of the newly identified infections were among African Americans.

We are requesting that CDC receive sufficient resources to expand the number of jurisdictions participating in the initiative – all jurisdictions have a need for increased resources for testing if we are to truly commit to providing access to testing for all individuals who do not yet know their HIV status. Additional funding would also allow the targeting of additional populations such as gay and bisexual men of all races and Latinos. Another key component of the initiative to expand is identification, notification and counseling of partners of persons living with HIV/AIDS. Partner services are time and resource intensive but maximize prevention efforts. With twenty-one percent of HIV-infected persons unaware that they have HIV, increased funding for testing and partner services will avert millions in unnecessary health care costs.

We urge the Subcommittee to not include language banning use of federal funds for syringe exchange programs in the FY2010 Labor-HHS Appropriations bill. Abundant research, endorsed by the findings of eight federally commissioned reviews, has conclusively demonstrated that syringe exchange is effective in reducing the transmission of HIV without increasing drug use. In communities that fund and support access to sterile injection equipment using state and local funds, transmission of HIV and hepatitis in persons who inject drugs has declined as a proportion of all cases by mode of transmission. Unfortunately, state and locally funded syringe exchange are only reaching a small portion of persons who inject drugs. It's time for the federal government to use every tool at its disposal to arrest the further spread of HIV and hepatitis C.

We also urge you to eliminate funds for the three separate federal abstinence-only-until-marriage programs. Instead, we request that you create a dedicated federal funding stream of at least \$50 million in your 2010 budget to fund medically accurate, comprehensive sex education programs that teach young people about both abstinence and contraception.

Lastly, we thank you and ask that you continue to limit the funding for the duplicative Early Diagnosis Grant Program in Section 209 of the *Ryan White Treatment Modernization Act of 2006*. This program is a carve out of limited HIV testing resources when there is already \$10 million dedicated to perinatal prevention.

#### Viral Hepatitis Prevention Programs

NASTAD respectfully requests an increase of \$36.4 million for a total of **\$50 million** in FY2010 for the CDC's Division of Viral Hepatitis (DVH) to enable state and local health departments to provide basic core public health services. DVH currently receives \$18.3 million to address chronic viral hepatitis B and C impacting 6.2 million Americans. This is \$7 million less than its peak funding of \$25 million in FY2001. Currently CDC addresses viral hepatitis on outbreak at a time, which is neither cost-effective nor real prevention.

Of the DVH funding, \$5.2 million is used to fund the Adult Viral Hepatitis Coordinator Program with an average award to states of \$90,000. Doubling this program to \$10 million would allow

states to implement a hepatitis prevention strategy. The coordinator position receives precious little above personnel costs, leaving little to no money for the provision of public health services including public education, hepatitis counseling, testing, and hepatitis A and B vaccine. In addition, there are no funds for surveillance of chronic viral hepatitis, which would allow states to better target their limited resources. Given the recent hepatitis public health crises in Nevada and New York, the government has a choice - invest in prevention now or wait until public systems are overwhelmed by a lack of infrastructure to address future outbreaks.

The greatest remaining challenge for hepatitis A and B prevention is the vaccination of high-risk adults. High-risk adults account for more than 75 percent of all new cases of hepatitis B infection each year and annually result in an estimated \$658 million in medical costs and lost wages. In FY2007, CDC allowed states to use \$20 million of 317 Vaccine funds to vaccinate high risk adults for hepatitis B and \$16 million in FY2008. By targeting high-risk adults, including those with hepatitis C, for vaccination, the gap between children and adults who have not benefited from routine childhood immunization programs can be bridged. NASTAD requests a continuation of the **\$16 million** in Section 317 Vaccine funds in FY2010 for hepatitis B vaccination for high-risk adults with the request that in the future DVH receives dedicated funding for hepatitis A and B vaccine for high risk adults and funding to support the infrastructure necessary for vaccine delivery.

#### STD Prevention Programs

NASTAD supports an increase of **\$299 million** for a total of \$451 million in FY2010 for STD prevention, treatment and surveillance activities undertaken by state and local health departments. STD prevention programs at CDC have been cut by \$6 million since FY2004 while the number of persons infected continues to climb. The U.S. has the unwanted distinction of having the highest rates of STDs of all industrial nations with one in four adolescent girls in the U.S., or more than 3 million, having an STD. The rates of syphilis infection have increased for the seventh year in a row. In one year, our nation spends over \$8 billion to treat the symptoms and consequences of STDs. Additional federal resources are needed to reverse these alarming trends and reduce the nation's health spending.

#### Minority AIDS Initiative

NASTAD also supports a **\$200 million** increase for a total of \$610 million for the Minority AIDS Initiative (MAI) in FY2010. The MAI provides targeted resources to four agencies and the Office of the Secretary to address the HIV/AIDS epidemic in hard-hit communities of color. The data from CDC on the disproportionate impact on African Americans and Latinos continues to be alarming. Support for the MAI along with the traditional funding streams that serve these populations is essential.

As you craft the FY2010 Labor, HHS and Education Appropriations bill, we ask that you consider all of these critical funding needs. The Maryland AIDS Administration and the National Alliance of State and Territorial AIDS Directors thank the Chairman, Ranking Member and members of the Subcommittee, for their thoughtful consideration of our recommendations. Our response to the HIV, viral hepatitis and STD epidemics in the United States defines us as a society, as public health agencies, and as individuals living in this country. There is no time to waste in our nation's fight against these infectious and often chronic diseases.