

AGENDA**ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES****ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR****MONDAY, MARCH 26, 2012****4:00 P.M. - STATE CAPITOL ROOM 126****INFORMATIONAL CALENDAR**

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INFORMATIONAL-ONLY**4265 DEPARTMENT OF PUBLIC HEALTH****INFORMATIONAL-ONLY ISSUE 1: DEPARTMENT OF PUBLIC HEALTH BUDGET OVERVIEW**

The mission of the California Department of Public Health (DPH) is dedicated to optimizing the health and well-being of the people in California, primarily through population-based programs, strategies, and initiatives. The DPH's goals are to achieve health equities and eliminate health disparities; eliminate preventable disease, disability, injury, and premature death; promote social and physical environments that support good health for all; prepare for, respond to, and recover from emerging public health threats and emergencies; improve the quality of the workforce and workplace; and promote and maintain an efficient and effective organization.

Budget Overview

As summarized in the table below, the Governor's proposed 2012-13 budget provides \$3.4 billion for DPH programs and services, a decrease of 2.2 percent from the 2011-12 budget. General Fund dollars make up just 3.6 percent of the department's total budget. Federal funds make up approximately 58 percent of the total budget.

DEPARTMENT OF PUBLIC HEALTH					
Fund Source	2010-11 Actual	2011-12 Projected	2012-13 Proposed	CY to BY Change	% Change
General Fund	\$181,405,000	\$132,380,000	\$124,805,000	(\$7,575,000)	-6
Federal Funds	\$1,884,492,000	\$1,989,065,000	\$1,998,122,000	\$9,057,000	0.4
Special Funds & Reimbursements	\$1,204,804,000	\$1,383,045,000	\$1,304,742,000	(\$78,303,000)	-5
Total Expenditures	\$3,270,701,000	\$3,504,490,000	\$3,427,669,000	(\$76,821,000)	-2.2
Positions	3,277.0	3,577.3	3,807.4	230.1	6.4

The General Fund in the Department of Public Health has been reduced dramatically over the past few years. In 2008-09, the DPH budget included approximately \$350 million in General Fund, as compared to the currently proposed \$125 million, a 64 percent reduction.

The Governor's Budget reflects already-implemented reductions to State Operations and workforce that were undertaken to comply with the Governor's Work Force Cap executive order. Specifically, the budget proposes \$244.3 million for operating expenses and equipment, a \$7.5 million (3 percent) reduction from the current year budget.

Furthermore, the Governor's Budget estimate for the current year for the DPH is \$90.9 million General Fund less than the 2011-12 enacted budget. This \$90.9 million is made up of a \$14.1 million reduction to the Every Woman Counts program, and a \$76.8 million reduction to the AIDS Drug Assistance Program (ADAP), both of which are explained by estimated decreases in caseload as people move from these programs to newly-formed Low-Income Health Programs (LIHPs), county-based programs that are extending health insurance coverage to low-income people as a part of the state's new 1115 Medicaid "Bridge to Reform" Waiver.

INFORMATIONAL-ONLY ISSUE 2: WORKFORCE CAP PLAN

This Budget Change Proposal (EX-01), which is informational only, describes recent State Operation staff reductions related to the "Workforce Cap" pursuant to Executive Order S-1-10, Control Section 3.90 of the Budget Act of 2010, and Budget Letters 10-31 and 10-38. Effective July 1, 2010, the DPH reduced its budget by \$14.2 million (\$2.7 million General fund) in salaries, wages, and operating expenses and equipment, and set forth a plan for the reduction or redirection of 171.5 authorized positions. The chart below shows the recent history of the department's State Operations budget. It is important to note that this chart shows *authorized* expenditures and positions, which is often different from *actual* expenditures and positions.

DPH State Operations History <i>(Dollars in thousands)</i>						
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Authorized Expenditures	\$718,762	\$730,765	\$638,729	\$655,820	\$657,306	\$647,075
Authorized Positions	3,174.7	3,408.5	3,332.6	3,277	3,771.6	3,711.4

The DPH is proposing to re-establish 145.5 positions to: 1) meet current workload; 2) provide position authority for previously approved Spring Finance Letters and other Budget Change Proposals; 3) convert existing contract positions to civil service; and, 4) transition permanent civil service personnel from the temporary help blanket into budgeted positions. Specifically, the budget proposes the following:

- 26.0 positions – have been abolished.
- 15.5 positions – proposed for redirection to meet workload requirements for the Center for Infectious Disease and the Center for Chronic Disease Prevention and Health Promotion, as described and approved of in two Spring Finance Letters in 2011-12 and one in 2010-11.
- 8.0 positions – proposed for redirection to critical workload needs within the Occupational Lead Poisoning Prevention program and the Healthcare Associated Infections Program.
- 22.0 positions – proposed for redirection to convert contracts to state civil service positions within the Childhood Lead Poisoning Prevention Program.
- 100 positions – for redirection to Federal Special Projects (FSP) and Reimbursement positions, as described in more detail below under the Budget Change Proposal specifically on this proposed blanket positions conversion.

INFORMATIONAL-ONLY ISSUE 3: BLANKET POSITION CONVERSION FOR FEDERAL SPECIAL PROJECTS AND REIMBURSEMENTS

The Governor's budget (BCP EX-04) proposes to retain and redirect 100 existing authorized positions from the Work Force Cap savings and requests 248 additional authorized positions in order to accommodate a total of 348 permanent staff that currently are classified as temporary help staff. All of the funding for these positions is already included in the DPH budget and all of the federal grants have been reviewed and approved. According to the DPH, this will result in more transparency in the budget with regard to department positions; neither the total number of actual state employees nor the total level of expenditures for the DPH will increase or change as a result of this proposal.

BACKGROUND

This proposal addresses positions related to the following two situations, for which personnel have been appointed to the temporary help blanket:

- 1) Federal Special Projects (FSP) – The DPH receives many federal grants for special projects; and,
- 2) Reimbursement Activities – The DPH has the following agreements with other state agencies to provide services: a) Supplemental Nutrition Assistance Program-Education Program (SNAP-Ed) at the Department of Social Services; b) Safe and Active Communities Branch funded by the Department of Alcohol and Drug Programs, and the Office of Traffic Safety; c) Network for a Healthy California at the Department of Education; and, d) Center for Environmental Health at the Department of Defense Radiologic Oversight Program, with an agreement with the Department of Toxic Substance Control.

The "temporary help blanket" was created in response to the nature of federal grant funding, which is most often temporary grants available for 3-5 years. In the past, these grants were not deemed of sufficient length to request regular, permanent budgeted positions. The renewal of these grants from one term to the next is not guaranteed, adding to the uncertainty that made the temporary help blanket an appropriate way to hire staff to work on these grants. However, over the past several years, most of the FSP grants have become consistent and stable from year to year. Furthermore, when the federal funding for a project has not been renewed, the DPH has been able to transfer the affected personnel to other federally funded grants or other authorized permanent positions. The result is that there are hundreds of positions included in the blanket, that are filled with staff who continue to work for the department for many years, and therefore should not be help blanket employees but rather permanent authorized positions. By converting these to authorized positions, the budget will more accurately reflect the actual number of positions at the department. As stated above, neither the total number of actual state employees nor the total level of expenditures for the DPH will increase or change as a result of this conversion.

VOTE-ONLY

VOTE-ONLY ISSUE 1: NETWORK FOR A HEALTHY CALIFORNIA

The Governor's proposed budget reflects a current year (2011-12) increase in Local Assistance reimbursements expenditure authority of \$33.1 million in federal funds to implement the CalFresh Outreach Program by providing funding to community-based organizations in order for them to promote healthy eating and participation in the CalFresh (food stamps) program. The funding source is the USDA Supplemental Nutrition Assistance Program (SNAP-Ed and Outreach) flowing through an Interagency Agreement with the California Department of Social Services (CDSS).

This is a competitive grant program and the program is evaluated on an annual basis. Local contractors are evaluated using process and impact evaluation methods and state-wide surveys are utilized to monitor state level activities. Results of the evaluation efforts are submitted annually to the United States Department of Agriculture (USDA) and are posted on the DPH web site.

VOTE-ONLY ISSUE 2: CALIFORNIA HEALTHY HOMES AND LEAD POISONING PREVENTION

The Governor's proposed budget reflects an increase in Current Year federal expenditure authority of \$495,000 (\$328,000 for Local Assistance and \$167,000 for State Operations) to be used to continue conducting outreach and education, case finding and case management, and data analyses to identify high-risk populations for housing-related health issues, including hazards related to lead poisoning, asthma, burns, injuries, and toxic exposures.

VOTE-ONLY ISSUE 3: STAFF CONVERSION IN THE CHILDHOOD LEAD POISONING PREVENTION BRANCH (CLPPB)

The Governor's proposed budget (BCP CD-13) requests Budget Year authority to retain 22.0 full-time Workforce Cap positions to be redirected to the CLPPB and supported by the Childhood Lead Poisoning Prevention (CLPP) Fund, by way of shifting \$2.8 million in special funds from external contracts to support these positions. These are positions that are proposed to be converted from contracted positions to state staff. The proposal is expected to save approximately \$381,000 and would have no impact on the General Fund.

BACKGROUND

Lead poisoning is the most common environmental health problem affecting children, leading to lowered IQ, learning deficits, and neurodevelopmental problems. In 2009, over 2,700 children were found to have high blood lead levels.

The CLPP Act, enacted in 1991, established the CLPP Program including surveillance and screening for lead, follow-up services for lead-poisoned children, and strategies to reduce children's exposure to lead. In 2010, direct outreach efforts reached 12,426 medical providers, 5,686 childcare providers and 11,308 other stakeholders. In 2009, over 700,000 children received blood lead testing; over 4,700 children had evidence of lead exposure and received public health services.

The CLPP is supported by fees assessed on industries that contribute to environmental lead contamination. In 2002-03, an approved BCP authorized an increase in CLPP fee collections up to \$22 million per year, which allowed for an expansion of program staff including permanent funding for 22 new contract positions to address workload needs identified in a 1999-2001 Bureau of State Audits report.

Justification. The Administration states that substantial state savings can result from maintaining a well-resourced lead poisoning prevention program in the form of reduced need for, and therefore reduced costs of, special education, health, social and criminal justice services.

This BCP is necessary to meet the requirements of Government Code (GC) 19130, which stipulates that services that can be performed by civil service employees must be performed by civil service employees. The current contracts for CLPPB are up for renewal and are unlikely to be approved by the Department of General Services because they are not compliant with GC 19130. In addition, converting these positions to state staff will result in \$381,000 in State Operations savings to the CLPP Fund.

VOTE-ONLY ISSUE 4: EARLY CASE CAPTURE OF PEDIATRIC CANCERS

The Governor's proposed budget (BCP CD-19) requests approval of an increase in federal expenditure authority of \$342,000 annually for three years in federal CDC grant funds, for a total of \$1 million over three years beginning September 29, 2011. These funds will be used to enhance the California Cancer Registry infrastructure to facilitate more rapid reporting of pediatric cancer cases, called Early Case Capture (ECC), and to increase availability of the data for surveillance activities, locally and nationally.

BACKGROUND

The CCR was created in legislation in 1985 to collect information about almost all cancer diagnoses in California. As of 2010, the CCR had collected information on over 3.4 million cases of cancer and adds approximately 162,000 new cases each year. This information is used to develop strategies and policies related to cancer prevention, treatment, and control. In California, nearly 1,900 children were diagnosed with cancer in 2008. Survival rates for children have improved dramatically, from an estimated 10 percent in the 1950s to nearly 80 percent currently. The CCR is a critical tool in cancer research. These funds will be used to develop:

1. Sustainable methods of ECC activities and relationships with reporting facilities and pediatric oncology researchers; and,
2. Sustainable infrastructure that will support the statewide expansion of ECC of pediatric cancers and will allow statewide data to be available for surveillance and research on an expedited basis.

VOTE-ONLY ISSUE 5: REDUCTION OF DOMESTIC VIOLENCE TRAINING AND EDUCATION FUND

The Safe and Active Communities Branch of DPH requests (BCP CD-21) a Budget Year and ongoing spending authority reduction of \$280,000 from the Domestic Violence Fund (DV Fund) reflecting a decrease in anticipated revenues. Revenue for the DV Fund is generated from fines levied against convicted batterers, which has declined over the past few years potentially for various reasons, such as: varying conviction rates, judgments of the courts on whether fines should be imposed, the amount of fines imposed, and the efficiency of fines collections. Since the decline in revenue coincides with the current economic crisis, a potential factor may be an increase in the number of defendants who have the fines waived by the court or are unable to pay.

BACKGROUND

The DV Fund was created through SB 1682 (Solis), Chapter 707, Statutes of 1998 to support statewide training and education programs to increase public awareness of domestic violence (DV) and to improve the scope and quality of services provided to DV victims. The DV Fund is administered as a competitive grant program. The program has trained thousands of probation officers, judges, court personnel, home visitor personnel, faith leaders, disability service providers, and DV practitioners. In 2008, the program launched a teen dating violence initiative. Current program State Operations expenditures are \$108,308 to support 2.0 FTE positions to provide programmatic oversight and to provide technical assistance to contractors and grantees.

VOTE-ONLY ISSUE 6: CALIFORNIA HOME VISITING PROGRAM – FORMULA FUNDING/EXPANSION GRANT

For the Maternal Infant and Early Childhood Home Visiting Program (MIECHV), the Governor's proposed budget (BCP FH-05), in the Current Year (2011-12), reflects a decrease of \$843,000 in State Operations and a \$4.7 million increase in Local Assistance in federal expenditure authority. The decrease in State support funding reflects a decrease in California's Title V MCAH Block Grant. The increase in local assistance funding is a result of a competitive expansion grant of \$9.3 million annually for four years that California was awarded in September 2011. In the Budget Year (2012-13), the budget proposes a \$20.4 million increase (\$650,000 State Operations and \$19.8 million Local Assistance) in federal expenditure authority.

The MIECHV is a program created with federal funding from the Affordable Care Act to improve coordination of services, and identify and implement evidenced-based home visiting programs to improve outcomes for low-income families in at-risk communities. The \$4.7 million in new local assistance funding from the competitive grant will expand the Home Visiting Program to eight additional communities.

The Maternal Infant Early Childhood Home Visiting (MIECHV) Formula Funding Grant and Competitive Expansion Grant provide state support and local assistance funding to twenty-one local sites to implement and operate the California Home Visiting Program using two federally approved, evidence-based home visiting models: Healthy Families America (HFA) and Nurse Family Partnership (NFP). Funding is contingent upon strict model fidelity, as well as demonstrated success via data collection and evaluation in achieving specific primary and secondary outcomes in identified benchmark areas. The six-benchmark areas include: 1) Maternal and Newborn Health; 2) Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of

Emergency Department Visits; 3) School Readiness and Achievement; 4) Crime or Domestic Violence; 5) Family Economic Self Sufficiency; and, 6) Coordination and Referrals for Other community Resources and Supports.

Local Assistance funding is distributed to twenty-one local sites for:

- Start-Up Services and Fees (HFA and NFP);
- Initial Education Services and Fees (HFA and NFP);
- Model specific curriculum materials;
- Implementation Support Services and Fees (NFP);
- Affiliation Fees (HFA);
- First year model implementation costs (home visitor training, data systems, materials);
- Nurse or social worker home visitors' and supervisors' salaries and benefits;
- Fifteen percent of the MCAH director's salary and related benefits;
- Data collection;
- Local weekly travel to homes of each of the families in the program;
- Operating expenses and indirect costs; and,
- Educational and safety materials (e.g. books for parents to read to children, safety latches, plug covers).

VOTE-ONLY ISSUE 7: BEACH WATER QUALITY MONITORING (AB 411/AB 1876)

The Governor's budget requests a Current Year (2011-12) increase in Local Assistance reimbursement authority of \$984,000 for the Environmental Management Program. The DPH plans to contract with the State Water Resources Control Board (SWRCB) to continue the Beach Safety program funded by the Proposition 13 Clean Beaches Program. This funding will assist in administering agreements with local environmental agencies for performance of beach water quality monitoring and public notification programs, as required by AB 411 and AB 1876, described below.

AB 411 (Shelley/Wayne), Chapter 765, Statutes of 1997, requires the DPH to establish public-health bacteria standards and monitoring requirements for ocean water quality at California's public beaches during the high-traffic summer season. The duties imposed upon the local government pursuant to this statute are mandatory only during fiscal years in which the Legislature has appropriated sufficient funds to cover the costs of those agencies associated with the performance of these duties. This funding had been appropriated continuously since the passage of AB 411. AB 1876 (Chan), Chapter 709, Statutes of 2004, amended statute to include public beaches located within a coastal zone and a public beach located within the jurisdiction of the San Francisco Bay Conservation and Development Commission.

The DPH enters into contracts with local health departments to perform the beach monitoring activities and receives Proposition 13 funds through a reimbursement contract with the SWRCB. This contract will expire at the end of this fiscal year, after which the DPH will no longer receive funding for this purpose. Under the new statute, the SWRCB will fund the local health agencies directly.

VOTE-ONLY ISSUE 8: SAFE DRINKING WATER STATE REVOLVING FUND

The Governor's budget (BCP EH-01) requests approval to convert 23.0 limited term positions into permanent positions within the Safe Drinking Water State Revolving Fund program (SDWSRF). Of these 23 positions, 10 have been limited term-since 1999, and 13 since 2010. All of the positions expire on June 30, 2012. The DPH states that making these positions permanent will ensure sufficient staff is available to provide technical assistance and funding support to public water systems that apply for SDWSRF loans and grants.

BACKGROUND

Congress created the national SDWSRF Program in 1996, and subsequent state legislation created California's SDWSRF in 1997 and authorized the DPH to establish a loan fund and separate funds for Administration, Small Water System Technical Assistance, and Water System Reliability (capacity development). According to the federal Environmental Protection Agency (EPA), the national need for public water system infrastructure improvements exceeds \$324 billion; California's total need for water system infrastructure improvements exceeds \$39 billion, per a 2007 national report. In 2009, the DPH requested applications for American Recovery and Reinvestment Act (ARRA) stimulus funds and received more than 2,200 applications, totaling over \$6 billion, for "shovel ready" projects. The SDWSRF is responsible for:

- Conducting ongoing surveillance and inspection of public water systems;
- Issuing operational permits to the systems;
- Ensuring water quality monitoring is performed by water systems; and,
- Taking enforcement actions when violations occur.

The SDWSRF project priority list currently has over 3,000 pre-applications for infrastructure projects from public water systems with a total value of over \$8 billion. The DPH provided the following chart that illustrates the workload history in this program over the past several years:

SDWSRF Workload History					
	2007-08	2008-09	2009-2010	2010-11	2011-12
Funding Commitments	48	23	35	31	60

Funding for the SDWSRF comes from the U.S. Environmental Protection Agency (EPA) annual capitalization grant for low-interest loans and grants. In order for the DPH to obtain the Federal Funds, the State must provide a 20 percent state match for each capitalization grant. California's 20 percent match portion comes from bond funds. Specifically, the DPH has used Proposition 13 bond funds for the 1999 through 2002 grants, Proposition 50 bond funds for the 2003 through 2008 grants, and Proposition 84 bond funds for 2009 through 2011 grants. AB 1292 (Hernández), Chapter 518, Statutes of 2011, provides the DPH the authority to sell revenue bonds to provide a permanent source of funds for the state match.

VOTE-ONLY ISSUE 9: RENEWAL OF PROPOSITION 50 LIMITED TERM POSITIONS

The Governor's budget (BCP EH-02) proposes to extend 12.0 limited-term positions (that currently expire on June 30, 2012) to June 30, 2013 in order to continue the Proposition 50 initiative. In addition, the DPH requests a new State Operations appropriation of \$1.5 million and a Local Assistance appropriation of \$98.9 million from the Water Security, Clean Drinking Water, Coastal and Beach Protection Fund of 2002.

BACKGROUND

In 2002, California voters approved Proposition 50 (Prop 50), a \$3.44 billion water bond measure, known as the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002. Under Prop 50, the DPH is responsible for administering Chapter 3 (Water Security) and Chapter 4 (Safe Drinking Water), which provide grants to public water systems for projects related to water security, reducing reliance on Colorado River water, source water protection, treatment for disinfection byproducts, demonstration treatment studies, and water quality monitoring. The 12 limited-term positions that are proposed to be extended carry out the programs financial, accounting, engineering, and California Environmental Quality Act activities necessary to administer the grants. All of these activities are expected to continue through at least June 30, 2014. The chart below provides the recent history of resources and workload in the Prop 50 program.

Proposition 50 History of Resources and Workload						
<i>(Dollars in millions)</i>						
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Authorized Expenditures	\$95.2	\$94.4	\$170.7	\$91.7	\$76.0	\$100.4
Actual Expenditures	\$34.1	\$52.1	\$14.3	\$70.2	\$91.3	N/A
Funding Agreements Executed	9	9	0*	16	30	18

*Bond funds frozen at this time; only ARRA funding was administered.

VOTE-ONLY ISSUE 10: RADIATION SAFETY PROGRAM

The Governor's budget (BCP EH-04) requests approval to convert 5.0 limited term positions into permanent positions within the Radiation Safety Program, and \$672,000 in permanent appropriation authority from the Radiation Control Fund. These 5 limited-term Health Physicist positions expire on June 30, 2012, and are needed on an ongoing basis to address mandated inspection and enforcement activities within the Radiation Machine Inspection and Radioactive Materials Inspection programs.

BACKGROUND

The mission of the Radiologic Health Branch is to protect public health and safety by decreasing excessive and unnecessary exposure to radiation, and reducing the release of radioactive material into the environment, by: 1) licensing radioactive material users; 2) registering radiation producing machines; 3) certifying individuals using radiation sources for medical and industrial purposes; and, 4) inspecting facilities using radiation sources and conducting enforcement actions. This proposal would make permanent 3 positions in the Radiation Machine Inspection Program and 2 positions in the Radioactive Materials Inspection Program. The following chart shows workload trends for these two programs:

Workload History for Radiation Machines and Radioactive Materials Programs				
	2007-08	2008-09	2009-2010	2010-11
Radiation Machines				
Inspections	7,469	7,562	8,019	7,774
Investigations	196	110	78	207
TOTAL	7,665	7,672	8,097	7,981
Radioactive Materials				
Inspections/Increased Controls	578	561	565	465
Investigations	198	247	327	259
TOTAL	776	808	892	724

VOTE-ONLY ISSUE 11: ENVIRONMENTAL LABORATORY ACCREDITATION PROGRAM

The Governor's budget (BCP EH-08) requests a decrease in budget authority of \$450,000 for the Environmental Laboratory Improvement Fund (ELIF). This fund receives fee revenue from labs through the Environmental Laboratory Accreditation Program and, according to the DPH, the revenue has decreased in recent years and therefore current budget authority exceeds revenues. This reduction will be absorbed within operating expenses by reducing travel, general expenses and training.

BACKGROUND

Legislation in 1989 created the fee-supported accreditation program for environmental health laboratories and a special fund to support the program. Accreditation is required of a laboratory to produce analytical data for California regulatory agencies, including the DPH, Department of Toxic Substances Control, State Water Resources Control Board, and the Department of Food and Agriculture. The data is used to demonstrate compliance with applicable requirements of drinking water, wastewater, pesticide residues, shellfish testing, and hazardous waste. According to the DPH, revenue has decreased as a result of some small, isolated labs closing as a result of the recession. They also state, however that workload does not decrease despite fewer labs operating.

The DPH explains that this reduction will have the following impacts on the program:

- 1) Travel – This will reduce the number of inspections and follow-up;
- 2) Training – This will reduce the frequency of staff trainings; and,
- 3) General Expenses – This will reduce equipment and result in delays in detection of compliance issues.

VOTE-ONLY ISSUE 12: REDUCTION OF PREVENTABLE MEDICAL ERRORS AND MEDICATION ERRORS

The Governor's budget (BCP HQ-06) requests one time expenditure authority of \$1 million (spread equally over three years: 2012-13, 2013-14, 2014-15) for a contract with the University of California to support ongoing efforts to reduce preventable medical errors and associated health care costs in health care facilities. The specific focus of this project will be on medication errors and identifying solutions to medication safety system vulnerabilities. The proposed funding is to come from the Internal Departmental Quality Improvement Account (IDQIA), which as of June 30, 2011 had a fund balance of \$6.345 million.

BACKGROUND

Health and Safety Code Section 1280.15 (f) (adopted in 2008) allows the DPH to impose administrative penalties on hospitals for deficiencies constituting an immediate jeopardy (to health or safety). The DPH may assess penalties up to a maximum of \$100,000 and revenue from these penalties is deposited into the IDQIA. Moneys in this fund must be expended for internal quality improvement activities. Between 2007 and 2010, the L&C program issued 170 administrative penalties for hospital deficiencies constituting immediate jeopardy, for which the largest number (28 percent) were medication/pharmacy errors.

A November 2010 federal study ("Adverse Events in Hospitals: National Incidence among Medicare Beneficiaries") found that one in seven Medicare patients were seriously harmed while in hospitals, and that there are approximately 15,000 deaths each month, due to lapses in care by hospitals and their employees. The report also found that medication errors were the most frequently identified cause of harm and that 50 percent of these were preventable. The national costs associated with medical errors (including medication errors) is \$324 million each month (\$4.4 billion annually). Extrapolating to California, based on population size, it is estimated that approximately 1,800 Californians die in hospitals each month due to medical errors, at a cost of \$38.9 million monthly (\$528 million annually).

The DPH has undertaken the following initiatives specifically to reduce medication errors. First, the Medication Error Reduction Plan (MERP) program, launched in 2009, is an enforcement program in which a pharmaceutical consultant surveys hospitals for compliance with their own plans to reduce errors. Second, implemented in partnership with the Department of Health Care Services in 2010, the Long-Term Care Antipsychotic collaborative examines the safe use of antipsychotics in nursing homes. Finally, the DPH has launched the Medication System Event Tracking (Med-SET) to have pharmaceutical consultant surveyors code their findings related to medication safety into defined causation categories in order to identify system failures.

As of June 30, 2011, the balance in the IDQIA fund was \$6.345 million; at the end of FY 2011-12, the balance is projected to be \$9.768 million. There is a substantial fund balance because revenues (projected at \$3.815 annually) far exceed the expenditure authority obtained to date of \$1.178 million (\$392,000 continuous annual appropriation for development and maintenance of the California Healthcare and Event Reporting Tool (CalHEART) web-based portal).

This new proposal would fund the additional activities related to Med-SET:

1. Identify common medication safety system vulnerabilities;
2. Explore expanding Med-SET beyond the pharmaceutical consultant surveyors to all L&C surveyors;
3. Coordinate and build on current statewide medication safety activities developed by the major hospital associations;
4. Collaborate with stakeholders; and,
5. Develop and refine medication safety policy.

The DPH states that it will continue to monitor progress in this area by reviewing the types and frequency of immediate jeopardy administrative penalties related to medication safety. Success will be measured by whether fewer deficient practices are identified during survey investigations conducted by the DPH.

ITEMS TO BE HEARD

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: AIDS DRUG ASSISTANCE PROGRAM (ADAP)

There are three issues for discussion related to the ADAP: 1) the base estimate; 2) transferring ADAP clients to the Low-Income Health Program; and, 3) the Governor's cost-sharing proposal. These issues may be presented and discussed together.

1. ADAP Estimate

ADAP is a subsidy program for low- and moderate-income persons (up to \$50,000 annual income) living with HIV/AIDS who could not otherwise afford HIV/AIDS drugs. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the ADAP Pharmacy Benefit Manager (PBM).

The Office of AIDS (OA) estimates that 39,146 people living with HIV/AIDS will receive drug assistance through ADAP in 2012-13, or a decrease of 2,741 clients over the current year. The budget estimates expenditures of \$403.8 million, which reflects a *net* decrease of \$78 million as compared to the revised current year.

ADAP Expenditures <i>(Dollars in Thousands)</i>				
Fund Source	2011-12 Actual	2011-12 Projected	2012-13 Proposed	Change from CY Budget Act to Proposed BY
General Fund	82,625	\$5,785	\$6,445	(\$76,180)
ADIS Drug Rebate Fund	253,827	\$283,184	\$245,520	(\$8,307)
Federal Funds (Ryan White)	100,632	\$118,797	\$102,572	\$1,940
Reimbursements (Medicaid Waiver)	74,064	\$74,064	\$49,300	(\$24,764)
Proposed New Premiums			(\$16,486)	
TOTAL EXPENDITURES	511,148	\$481,830	\$387,351	(\$123,797)

General Fund. The OA attempts to minimize the need for General Fund support by maximizing the use of special funds, and federal funds. Consequently, compared to the 2011 Budget Act, which included General Fund expenditures of \$82.6 million, the 2012 budget proposes General Fund of only \$5.8 million CY and \$6.4 million BY. The *net* decrease of \$76.8 million in General Fund is due to:

- A projected decrease based on updated actual expenditure information (as a result of the new Pharmacy Benefit Manager Contract including lower transaction fees, higher split fee savings, lower drug reimbursement rates and ADAP counting towards True-Out-of-Pocket Costs);
- The transition of ADAP clients to the Low Income Health Program;
- The receipt of additional federal funds; and,
- An increase in special fund expenditure authority.

Funding Sources & General Fund Shifts. Historically, three funding sources have supported ADAP: General Fund, the AIDS Drug Rebate Fund, and federal Ryan White CARE Act Funds. Both the AIDS Drug Rebate Fund and federal funds are used as offsets to General Fund support when applicable. As noted below, there is an annual federal maintenance of effort (MOE) requirement for General Fund support.

A new resource available to support ADAP is federal funds available from the state's 1115 Medicaid Waiver administered by the Department of Health Care Services. Federal funds are available through this Waiver since General Fund expended within the ADAP can be counted as "state certified public expenditures" (state CPE) and are used to obtain federal funds through the Waiver financing mechanism. A total of \$74 million (Reimbursements from DHCS—federal funds) was identified for current year and \$49.3 million for budget year.

BACKGROUND

ADAP Rebate Fund. Drug rebates constitute a significant part of the annual ADAP budget. This special fund captures all drug rebates associated with ADAP, including both *mandatory* (required by federal Medicaid law) and *voluntary* supplemental rebates (additional rebates negotiated with drug manufacturers through the ADAP Taskforce). Generally, for every dollar of ADAP drug expenditure, the program obtains 48 cents in rebates. This 48 percent level is based on an average of rebate collections (both "mandatory" and "supplemental" rebates).

Federal HRSA Maintenance of Effort (MOE) for Ryan White CARE Act. The federal HRSA requires states to provide expenditures of at least one-half of the federal HRSA grant award. For example, California's 2011 HRSA grant award is \$140 million; therefore, the State match requirement for 2011-12 is \$69.3 million. Additionally, HRSA requires grantees to maintain HIV-related expenditures at a level that is not less than the prior fiscal year. California's MOE target, based on 2009-10 expenditures, is \$502.5 million.

Cost-Beneficial to the State. Without ADAP assistance to obtain HIV/AIDS drugs, individuals would be forced to: 1) postpone treatment until disabled and therefore Medi-Cal eligible; or, 2) spend down their assets to qualify, increasing expenditures under Medi-Cal. According to the Administration, 50 percent of Medi-Cal costs are borne by the State, whereas only 30 percent of ADAP costs are borne by the State. Studies consistently show that early intervention and treatment adherence with HIV/AIDS-related drugs prolongs life, minimizes related consequences of more serious illnesses, reduces more costly treatments, increases an HIV-infected person's health and productivity, and reduces HIV transmission rates.

STAFF COMMENT / QUESTIONS

Several concerns have been raised regarding the ADAP estimate particularly in regards to the timeline for the transition of ADAP clients to the Low Income Health Program (LIHP) and the estimated savings resulting from this transition. The OA estimates that beginning January 1, 2012, ADAP clients in the first ten counties initiating their LIHPs would begin to transition from ADAP to LIHP. However, Alameda and Los Angeles counties have delayed the implementation of their LIHPs until July 1, 2012. These counties serve potentially two-thirds of the eligible population, and consequently should not be reflected in the current year transition.

The Administration indicates that the ADAP estimate does not account for the updated schedule of LIHP implementation. It will update this estimate in the May Revision.

2. Transition of ADAP Clients to the Low-Income Health Program (LIHP)

Concerns have been raised that OA's oversight and engagement in the transition of ADAP clients to LIHP has been inadequate. Counties that are implementing LIHPs are struggling with little or no guidance from the OA on the LIHP transition. Currently eight counties have implemented the LIHP. Consequently, clinics and providers serving persons with HIV do not have information to ensure treatment is not interrupted.

For example, LIHP drug formularies may not include anti-retrovirals that were covered under the ADAP formulary. Not all clinics are aware that all medically necessary drugs are required to be provided under the LIHP (per federal regulations) even if they are not covered under the LIHP formulary. A lack of guidance and clarity such as this may cause interruptions in drug treatments.

Furthermore, on March 1, the system that is used to enroll individuals into ADAP was updated to include the ability to track ADAP client enrollment in the LIHP. Counties were given less than a day's notice regarding these changes and not provided any training or guidance on how to operationalize these changes.

The OA has indicated that it will routinely work with the eight counties to identify ADAP clients that have been enrolled in the LIHP and require, as an interim process, for ADAP enrollment workers to notify the ADAP statewide pharmacy benefit manager (Ramsell Public Health Rx) that a client has been enrolled in the LIHP, yet it is unable to provide an estimate for the number of ADAP clients that have transitioned to the LIHP.

BACKGROUND

As part of California's Bridge to Reform section 1115 Medicaid Demonstration, counties are implementing LIHP. The LIHP consists of two programs: Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). MCE will provide coverage for very-low income adults with incomes under 133 percent of the FPL and its federal funding through the waiver is capped. HCCI is coverage for low-to-moderate income adults with incomes between 133 and 200 percent of FPL and federal funding for HCCI is capped.

The State projects that 512,000 adults would be eligible for the LIHP, with 385,000 eligible for MCE and 127,000 eligible for HCCI. Both programs are at county option and each county determines its own eligibility rules and sets its own income eligibility standards. For example, Los Angeles county set its MCE eligibility level at 133 percent of FPL, whereas San Francisco county set its MCE eligibility level at 25 percent of FPL.

The first ten counties (legacy counties) to implement the LIHP are Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. Los Angeles and Alameda plan to begin enrollment on July 1, 2012. The OA projects that, under current law, 9,089 ADAP clients are eligible for LIHP in the ten legacy counties. See table below for the estimate by county.

Estimated Number of ADAP Clients Eligible for LIHP in 10 Legacy Counties	
Legacy County	Number of ADAP Clients Eligible for LIHP
Alameda	678
Contra Costa	146
Kern	93
Los Angeles	5,152
Orange	700
San Diego	1,321
San Francisco	535
San Mateo	96
Santa Clara	267
Ventura	101
TOTAL	9,089

Ryan White – Payer of Last Resort. In the summer of 2011, the federal government provided guidance to California regarding the Ryan White statutory “payer of last resort” requirement in relationship to the LIHP. Specifically, Ryan White funded services, including ADAP, can no longer be available to individuals once they are determined to be eligible for, and enrolled in a LIHP. Additionally, such low-income persons with HIV who otherwise meet LIHP eligibility standards may not be excluded by the LIHP. This means that low-income persons with HIV previously covered by a Ryan White system of care will, upon enrollment in LIHP, be required to receive their medical care and pharmaceuticals under the LIHP.

LIHP Screening Plan. Local health jurisdictions receiving Ryan White Part B funds were required to submit to the OA a plan for screening of Ryan White clients for LIHP eligibility by November 15, 2011. According to the plan submission guidelines, these plans were “high-level” plans and not to be more than three to five pages. These plans did not address client level issues such as continuity of care, care coordination, and transition of care.

HIV Transition Incentive Program. In order to assure that persons with HIV transition from coverage under Ryan White to coverage under the LIHP with continuity of care, without loss of either core or other critical services, and with minimal disruption to critical patient/provider relationships, the Department of Health Care Services submitted a section 1115 Demonstration amendment to create the HIV Transition Incentive Program. Under the HIV Transition Incentive Program, \$150 million would be available annually in 2011-12 and 2012-13 and \$75 million in 2013-14 for the development of projects that support the LIHP systems’ efforts to address the continuity of care, care coordination, and coverage transition issues for persons with HIV. The department expects a response from the federal government on the requested amendment on April 1, 2012.

Senate Action. The Senate Budget and Fiscal Review Subcommittee on Health and Human Services heard this issue on March 8, 2012, and took the following action:

- 1) Adopted placeholder trailer bill language that would strengthen consumer protections for ADAP clients as they transition to LIHP and create a stakeholder advisory committee to give expert advice on transition policy decisions; and, 2) Added a Health Program Specialist II position at the Department of Health Care Services to manage the HIV Transition Plan Waiver Program and coordinate with DPH’s Office of AIDS.

3. ADAP Share of Cost Proposal

The budget proposes changes to ADAP’s cost-sharing by instituting a monthly premium estimated to generate \$16.47 million in revenue from ADAP clients. These revenues are offset by \$2 million in expenditures for administrative costs associated with the monthly premium. Therefore, a net reduction of \$14.49 million in program expenditures is assumed from this effort. Trailer bill language is required for this action and a July 1, 2012, implementation date is assumed. The OA estimates that 2,692 ADAP clients would leave the program because of the proposed share of cost.

This proposal would significantly change the existing ADAP client cost-sharing by requiring all clients above 100 percent of poverty to pay monthly premiums based upon a percent of gross income. There are four categories of ADAP clients and the cost-sharing reflects differences based on these categories, as follows.

ADAP-Only, ADAP-Medi-Cal, and Medicare Part D. These clients would have the highest premium payment. For Medicare Part D clients, the cost-sharing obligation excludes clients reaching catastrophic coverage, those dually enrolled in Medicare and Medi-Cal with no Medi-Cal share-of-cost, and all others who qualify for full-subsidy Medicare. The table below summarizes the share-of-cost assumptions, which are the maximum allowed under federal law.

Proposed Cost Sharing for: ADAP-only, ADAP-Medi-Cal, & ADAP-Medicare Part D			
Percent of Federal Poverty Level	Income Range	Share of Cost	Number of Clients Affected
0-100%	Up to \$10,890	None	11,314
101-200%	\$10,890 - \$21,780	5% of Gross Income	9,736
201-300%	\$21,781 - \$32,670	7% of Gross Income	7,048
301 to ADAP Maximum	\$32,671 - \$50,000	10% of Gross Income	4,008

Private Insurance. These clients would have a smaller premium payment of two percent of gross income. The Administration states that these clients generate considerable funding for ADAP as the program is able to collect full drug rebate funds on their prescriptions even though the program is only paying a co-pay for their drugs. In addition, some co-pays for this population are already being paid under their private coverage. Therefore, it is not in the program’s fiscal interest to discourage participation by privately insured clients.

BACKGROUND

ADAP Eligibility and Current Cost-Sharing. Individuals are eligible for ADAP if they:

- Reside in California;
- Are HIV-infected;
- Are 18 years of age or older;
- Have an adjusted federal income that *does not exceed* \$50,000;
- Have a valid prescription from a licensed CA physician; and,
- Lack private insurance that covers the medications and do not qualify for no-cost Medi-Cal.

The ADAP is the *payer of last resort*. Individuals who have private health insurance, are eligible for Medi-Cal, or are eligible for Medicare, must access these services *first*, before the ADAP will provide services. ADAP clients with incomes between \$43,561 (401 percent of poverty) and \$50,000 are charged monthly co-pays for their drug coverage, which is established annually at the time of enrollment or recertification.

The current cost-sharing formula is based on twice the client's individual income tax liability, minus any health insurance premiums paid by the individual. The final amount due can vary greatly depending on the client's tax deductions, that are used to reach their final income tax liability (based on tax return). This amount is then split into 12 equal monthly payments, which are collected at the pharmacy at the time the client picks up their medication. The client's payment is then credited and the amount the pharmacy bills the ADAP Pharmacy Benefits Manager is adjusted to account for this credit.

LAO Recommendation. The Legislative Analyst's Office (LAO) recommends approval of the Administration's proposal to increase the share of cost borne by ADAP clients due to the State's fiscal situation, not on a policy basis. The LAO also suggests that the Legislature could impose a lower level of cost sharing than the level proposed under the Governor's plan.

STAFF COMMENT / QUESTIONS

The Administration submitted a similar proposal last year and it was rejected by the Legislature. Under this proposal, the level of cost-sharing is unaffordable for the level of income for individuals enrolled in the program. This could cause some ADAP clients to drop out of the program because they cannot afford to pay the increased costs; and consequently, they would stop taking their medications. Research confirms that increases in drug copayments reduces medication compliance.

The consequences of people going without treatment would be dire. In addition to the significant decline in the clients' own health, when individuals are unable to obtain appropriate treatment, drug-resistant strains of HIV can develop. Rates of transmissions could subsequently increase because the viral loads of those individuals not receiving treatment would drop.

Questions for the Department of Public Health:

1. Please provide a *brief* description of the ADAP estimate.
2. Please discuss the OA's efforts and guidance to counties regarding the transition of ADAP clients to LIHP.
3. What specific actions has the OA taken to avoid interruptions to treatment and prevent barriers to accessing treatment for ADAP clients transitioning to LIHP?
4. Please provide a brief description of the share-of-cost proposal and how it would operate.
5. What consequences could be anticipated as a result of the proposed increased cost-sharing?

Questions for the Department of Health Care Services:

1. Please provide a brief description and status of the HIV Transition Incentive Program.
2. What specifically is the DHCS doing to ensure a smooth and safe transition for ADAP clients into the LIHP?

PANEL 1

- Department of Public Health
- Department of Health Care Services
- Legislative Analyst's Office
- Department of Finance

PANEL 2

- Anne Donnelly, Director of Health Care Policy, Project Inform
- Courtney Mulhern-Pearson, Director of State and Local Affairs, San Francisco AIDS Foundation
- Aaron Fox, Health Policy Manager, LA Gay & Lesbian Center
- Judith Reigel, Executive Director, County Health Executives Association of California

PUBLIC COMMENT

ISSUE 2: REDUCTION IN FEDERAL EXPENDITURE AUTHORITY FOR MATERNAL, CHILD, ADOLESCENT HEALTH BLOCK GRANT

The Governor's proposed budget (BCP FH-07) reflects a decrease of 6.0 positions and a decrease in federal expenditure authority of \$6.8 million (\$2.2 million State Operations and \$4.6 million Local Assistance). These reductions are a result of a reduction in the federal Title V Block Grant funding, which is a result of: 1) the elimination of General Fund from the Maternal Child and Adolescent Health program in 2010; and, 2) the erosion of the second year set-aside from the Title V Block Grant. The Department of Health Care Services has a corresponding request to reduce 4.0 positions and \$1.2 million in reimbursement expenditure authority, which is described in more detail below.

BACKGROUND

The Federal Title V Block Grant funding is appropriated annually and can be spent over two federal fiscal years. California's MCAH expenditures have exceeded grant revenues for the following reasons cited by the Administration:

1. To ensure that local health jurisdictions (LHJs) spent down the local assistance portion of the Title V Block Grant, the MCAH has awarded LHJs with contracts that, collectively, exceed the actual annual grant amount. For many years, LHJs spent less than the amount of local assistance provided, however this trend ended in recent years and now the DPH anticipates that the full amount of funding will be spent in 2011-12.
2. The Federal Title V Block Grant to California has been reduced by \$1 million over the past two years.
3. Since 2007-08, \$13.4 million in Title V Block Grant funds have been redirected to programs previously funded with General Fund.

General Fund History

In the 2009 May Revise, the Governor proposed elimination of all General Fund Support for MCAH programs. The Legislature rejected this proposal and instead agreed to the following more modest reductions:

- Black Infant Health Program (\$.9 million);
- Adolescent Family Life Program (\$1.75 million);
- Local County Maternal and Child Health Grants (\$2.1 million); and,
- MCH state support (\$3.5 million).

Nevertheless, the Governor subsequently vetoed all remaining \$12 million in General Fund support for these programs. In 2010, the Legislature restored a portion of this funding: \$3 million General Fund for the Adolescent Family Life Program, and \$2 million General Fund for the Black Infant Health Program; however, Governor Schwarzenegger also vetoed this \$5 million.

The elimination of General Fund in 2009-10 removed the LHJs' ability to draw down Federal Title XIX funds using State funds as a required match. While LHJs that contribute local agency funds to their MCAH Programs are still able to use those funds to draw down Title XIX matching funds, the ongoing recession has decreased local agency funding to MCAH programs.

Proposed Budget Year Reductions

In the January 2012 proposed budget, in order to align expenditures with Grant revenues, the DPH prioritized making reductions that would have minimum impact on the LHJs, in order to maintain an adequate infrastructure for MCAH programs throughout the State. The secondary priority was to make reductions to programs that would have the least impact to public health in California. The DPH states that it conferred with MCAH Directors and stakeholders in order to develop the following proposed reductions of \$6.8 million:

- \$2.2 million – State Operations (DPH) and 6.0 FTE positions;
- \$3.4 million – Local Assistance (DPH); and,
- \$1.2 million – Reimbursements (DHCS) and 4.0 FTE positions.

\$999,000 – Adolescent Family Life Program (AFLP). The AFLP provides case management services to pregnant and parenting teens and seeks to: 1) improve the health of pregnant and parenting teens, and therefore the health of their babies; 2) improve graduation rates for pregnant and parenting teenagers; 3) reduce repeat pregnancies; and, 4) improve linkages and networks for pregnant and parenting teens. The AFLP serves approximately 4,200 and this proposed reduction will result in 700 fewer teens served. Most of this reduction (\$749,000) will come from two agencies that plan to discontinue their AFLP programs.

The two agencies that eliminated their AFL programs were Riverside and San Bernardino County public health departments. With the elimination of General Fund in 2009, these agencies determined that they could not sustain the level of service that they determined was necessary. There was not sufficient agency support for continuing the programs without the additional state funding. Even though the amount of available Title V funding remained, these agencies both relied on General Fund to leverage Title XIX for a large portion of their AFLP funding:

- Elimination of General Fund and local agency funding resulted in nearly a 75 percent reduction in AFLP funding for Riverside County
- Even with maintenance of local agency funding, elimination of General Fund resulted in a 50 percent reduction in total funding for San Bernardino County

\$140,000 – Black Infant Health Program (BIH). The BIH provides health education, health promotion, social support, and services coordination to pregnant and parenting African American adult women in the 15 LHJs where 75 percent of all African American live births in California occur. The BIH aims to improve the health of African American mothers and babies and reduce the health and social disparities gap between Black and White maternal and infant populations. The program serves approximately 1,700 clients and this reduction will result in a 3 percent reduction in services.

\$330,000 – Local MCAH Program. The MCAH seeks to improve the health of mothers, infants, children, adolescent and families, in part by connecting this population to needed programs and services such as the Medi-Cal and Healthy Families programs. This proposed reduction would eliminate the Local Assistance for Maternal Health (LAMH) Demonstration Project, which facilitates local health department leadership to implement maternal quality care improvement projects.

\$324,000 – Maternal Infant Health Information (MIHA). The MIHA is a survey tool that collects information on maternal and infant health outcomes and performance measures, and is used to meet multiple federal reporting mandates. Many State programs rely on MIHA data to receive federal funding, including the Office of Family Planning, Alcohol and Drug Programs, the California Home Visiting Program and WIC. The DPH proposes to “charge” the cost of the MIHA survey contract to the DPH Center for Family Health, rather than specifically to the MCAH Program.

\$350,000 – California Birth Defects Monitoring Program (CBDMP). The CBDMP collects and reviews data from birthing hospitals and maintains a database of birth defects in the State. This proposed 20 percent Title V reduction will limit availability of public health surveillance and research, including collaborative efforts with the federal Centers for Disease Control.

\$1,063,000 – California Diabetes and Pregnancy Program (CDAPP). The CDAPP promotes best practices of care for pregnant women who have pre-existing diabetes or who develop gestational diabetes over the course of their pregnancy. The CDAPP strives to optimize maternal and fetal birth outcomes, prevent diabetes, and reduce complications of diabetes. The CDAPP is implemented through a network of regional providers called “CDAPP Sweet Success affiliates” (affiliates) who provide health care to pregnant women. There are over 100 affiliates serving approximately 17,240 clients and this reduction would eliminate funding for affiliates.

\$191,000 – Advanced Practice Nurse Training (APN) Program. The APN recruits and enrolls nursing students who reflect the linguistic, cultural, and geographic diversity of California into specialty area programs. Approximately 80 nurses are trained annually and this reduction would result in 20 fewer trained nurses.

Reduction of \$1.2 million in DHCS reimbursements, as follows:

\$605,000 – Children’s Medical Services (CMS). Of this \$605,000 reduction, \$200,000 is proposed to come from the CMS program's operating expenses and equipment budget. The remaining \$405,000 will be reduced from the High-Risk Follow-Up Program (HRIF) under the California Children’s Services Program (CCS). The CCS HRIF identifies infants who are at high risk of developing CCS-eligible conditions after discharge from a CCS-approved Neonatal Intensive Care Unit (NICU), which conducts post-discharge follow-up with high-risk infants. This funding reduction will reduce: 1) support for one coordinator position at each of the contracted NICUs; 2) activities to identify, measure and improve outcomes of NICU graduates; 3) assistance for a collaborative which helps reduce hospital acquired infections; and, 4) oversight and training of hospital staff on the Data Management System.

\$373,000 – Primary and Rural Health Division (PRHD). The PRHD provides training, technical assistance, and funding to primary care providers to meet the needs of high risk, underserved populations, including women and children. Targeted clinics include those in rural areas and those serving migrant farm-workers and American Indians. This program supports the American Indian Infant Health Initiative, which provides home visitation services to high-risk pregnant and parenting American Indian families. This reduction would result in 4.0 fewer FTE positions at the DHCS.

\$182,000 – DHCS Audits and Investigations (A&I). A&I performs audits on MCAH local contractors to ensure fiscal accountability and ensure compliance with federal requirements. This reduction would result in 50 percent less annual audits.

STAFF COMMENT / QUESTIONS

1. Please provide an overview of this proposal.
2. Please describe the impact on public health that the DPH anticipates as a result of these reductions.
3. Please describe any alternative reductions that could be made to programs within both the DPH and the DHCS to absorb these reductions

PANEL

- Department of Public Health
- Department of Health Care Services
- Legislative Analyst's Office
- Department of Finance

PUBLIC COMMENT

ISSUE 3: PROPOSITION 99: REDUCTION TO HEALTH EDUCATION ACCOUNT

The Governor's budget reflects a Budget Year reduction of \$5.4 million in Proposition 99 (tobacco tax) Health Education Account (HEA) funding for the California Tobacco Control Program (CTCP). This reduction reflects decreasing revenue in the fund, and the need to maintain a prudent reserve in the fund, according to the DPH. The purpose of the reserve is in cases when the amount of revenue received is less than projected. The \$5.4 million reduction is proposed to be implemented as follows:

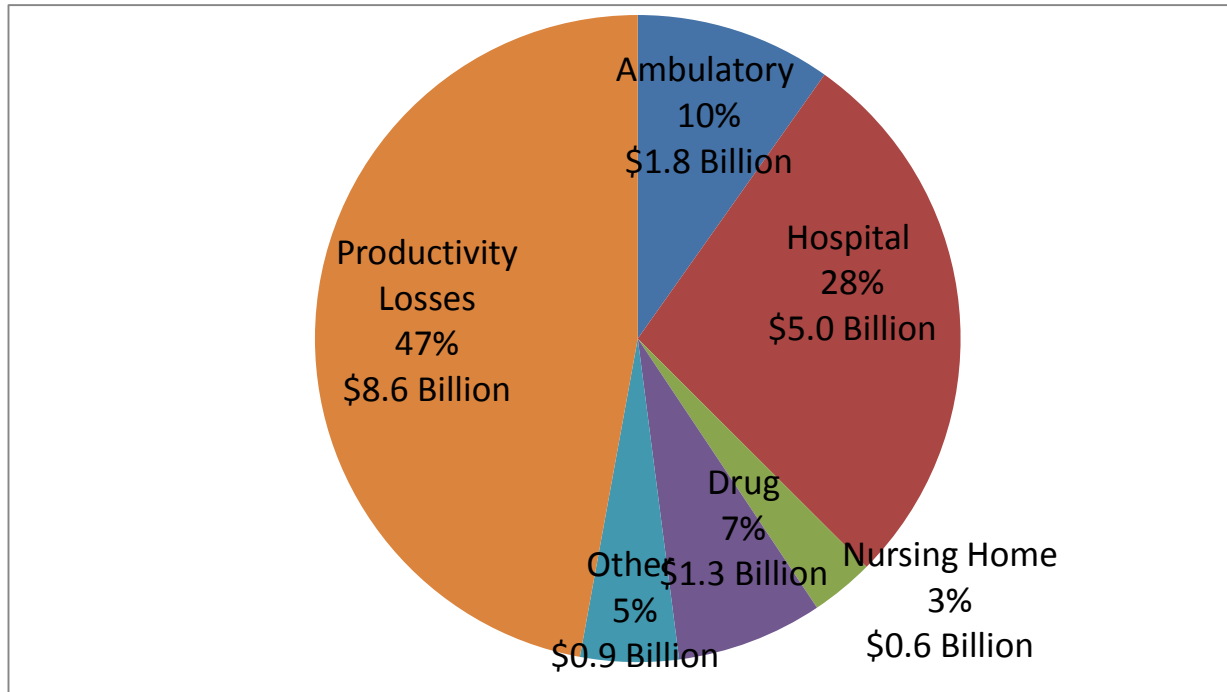
- *\$1.6 million for Media Campaign (Local Assistance)*
This will result in the DPH significantly reducing the placement of media in the rural and smaller markets. This will also reduce outreach to priority populations such as various ethnic groups.
- *\$600,000 for Competitive Grants (Local Assistance)*
This will result in the elimination of 5 University of California contract positions, which provide office support, and contract management functions within the CTCP. The DPH is proposing to offset these reductions by filling currently vacant federally funded positions under the Collaborative Chronic Disease, Health Promotion, and Surveillance Program Grant.
- *\$2.6 million for Local Lead Agencies (Local Assistance)*
This will reduce appropriations to "Local Lead Agencies", resulting in 13 local health departments receiving reductions. The size of the reduction is estimated to range from \$7,374 in Solano County to \$1 million in Los Angeles County. The number of counties receiving the minimum base allocation of \$150,000 will increase from 48 to 52, including Alameda, Fresno, Long Beach, and Solano. This funding is for local agencies to implement comprehensive tobacco control programs. The DPH states that this reduction may be offset by a \$21 million federal Community Transformation Grant (CTG) with awards to most counties for local efforts to reduce chronic diseases such as heart disease, cancer, stroke, and diabetes by promoting healthy lifestyles, including tobacco-free living, physical activity, healthy eating, and others.
- *\$597,000 for Tobacco Education and Research Oversight Committee Evaluations (State Operations)*
This will result in the elimination of one University of California contract position and a reduction in the size and scope of a study that the CTCP conducts to help understand what helps smokers quit.

BACKGROUND

In November 1988, California voters enacted Proposition 99, the Tobacco Tax and Health Protection Act of 1988, which established a surtax of 25 cents per pack on cigarettes and other tobacco products. Proposition 99 revenues are allocated to six separate accounts established by the measure as follows: 1) the Health Education Account (20 percent of revenues); 2) Hospital Services Account (35 percent); 3) Physician Services Account (10 percent); 4) Research Account (5 percent); 5) Public Resources Account (5 percent); and, 6) Unallocated Account (25 percent). Under the terms of the initiative measure, the funds in the Proposition 99 accounts may only be used for the purposes described in the measure and can only be used to supplement existing levels of services. Proposition 99 revenues have been declining for many years, mirroring declining smoking rates resulting from both taxes and other successful public health strategies. For the budget year, 2012-13, the Administration estimates an overall decrease of \$8 million in new Budget Year Prop 99 revenue.

Proposition 99 Revenue Recent History						
FY	05-06	06-07	07-08	08-09	09-10	10-11
Revenue	\$335m	\$336m	\$327m	\$315m	\$294m	\$285m

Although smoking rates have decreased dramatically, on-going health care costs attributable to tobacco use continue to be substantial as indicated in the following chart.



Sou

Source: Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC). Accessed on March 25, 2009. Prepared by: California Department of Public Health, California Tobacco Control Program, September 2009.

STAFF COMMENT / QUESTIONS

Please provide an overview of this proposal and please explain what options the DPH has to reflect this reduction in funding.

PANEL

- Department of Public Health
- Legislative Analyst's Office
- Department of Finance

PUBLIC COMMENT

ISSUE 4: ACA COORDINATED CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION PROGRAM

The Governor's Proposed Budget includes increases in federal expenditure authority for State Operations of \$1.6 million in 2011-12 and \$1.9 million in 2012-13 from federal Affordable Care Act funds, from the federal Centers for Disease Control and Prevention (CDC), for creating a "Coordinated Chronic Disease Program (CCDP)." The DPH is requesting authority for 7.0 positions associated with this grant; these positions are being requested through the BCP on the blanket position conversion (described earlier in this agenda).

BACKGROUND

The CCDP will provide coordination and leadership on chronic disease and also will create a State Chronic Disease Prevention and Health Promotion Plan to address preventive services and chronic disease management, and improve policies, environments, programs and infrastructure related to the five leading chronic disease causes of death and disability: heart disease, cancer, stroke, diabetes, and arthritis. It will also address associated risk factors including tobacco use, nutrition, physical activity, and obesity.

STAFF COMMENT / QUESTIONS

Please provide an overview of this proposal.

PANEL

- Department of Public Health
- Legislative Analyst's Office
- Department of Finance

PUBLIC COMMENT

ISSUE 5: SMALL WATER SYSTEM PROGRAM

The Governor's budget (BCP EH-05) requests authority for \$183,000 and 2.0 permanent positions within the Drinking Water Program to carry out small water system (SWS) regulatory programs in Marin, San Mateo and Tuolumne Counties as a result of these counties' decisions to return regulatory primacy over SWS to the DPH. As provided in Statute, the DPH collects fees from regulated SWS and the fees charged to SWS in these three counties will be sufficient to cover the cost of the 2 positions.

BACKGROUND

The DPH is responsible for regulating approximately 8,000 public water systems that provide drinking water to over 98 percent of California's population. State statute authorizes the DPH to conduct ongoing surveillance and inspections of public water systems, issue operational permits to the systems, ensure water quality monitoring is conducted, and take enforcement actions when violations occur. This includes public water systems that supply small communities as well as "non-communities" systems such as restaurants, hotels, parks, schools, and businesses. Health and Safety Code Section 116565 established annual fees to be paid by SWS and allows the State to enter into "Local Primacy Agency" agreements with local health jurisdictions that allow counties to regulate SWS with less than 200 service connections. 32 counties have such agreements and the State regulates all public water systems in the remaining 26 counties. Of the 7,000 SWS in California, the DPH directly regulates 2,939, including the recent addition of SWSs in Marin, San Mateo, and Tuolumne Counties.

U.C. Davis Report. As required by SB 1 2X (Perata), Chapter 1, Statutes of 2008, the State contracted with U.C. Davis to research and publish a report on the safety and quality of well water in certain areas of the State with proximity to substantial agriculture, including the Salinas Valley and the Central Valley. The report finds that nitrate contamination is pervasive in drinking water and that the main source of nitrates is chemical fertilizers and livestock manure. The State provides oversight of public and non-community water systems, which does not include private domestic wells, which is the subject of this report. The population using private wells throughout the State is estimated to be less than 1 percent of California's population, which would be a few hundred thousand people. This report looks specifically at two geographic areas of the State where private wells are utilized.

STAFF COMMENT / QUESTIONS

1. Please provide an overview of this proposal.
2. Please describe the recent UC Davis report on well water and nitrates, the State's involvement in the report, and the State's role and responsibility with regard to well water.
3. What options does the State have for addressing water quality in these communities?

PANEL

- Department of Public Health
- Legislative Analyst's Office
- Department of Finance

PUBLIC COMMENT

ISSUE 6: HOSPITAL ASSOCIATED INFECTIONS PUBLIC REPORTING

The Governor’s budget (BCP HQ-02) proposes an increase of \$493,000 in State Operation expenditure authority from the L&C Special Fund for four positions that will be redirected from within the DPH for statutorily mandated public reporting of healthcare associated infections (HAIs) in California public hospitals. These positions are proposed to be funded through an increase in facility fees paid by General Acute Care Hospitals (GACHs).

BACKGROUND

In California’s GACHs, an estimated 240,000 infections, 13,500 deaths, and \$3.1 billion in excess health care costs result annually from HAIs. In 2009, the DPH implemented the HAI Program to reduce the harm and cost of HAIs, as required by the following pieces of legislation: 1) SB 739 (Spier), Chapter 526, Statutes of 2006; 2) SB 158 (Florez), Chapter 294, Statues of 2008; and, 3) SB 1058 (Alquist), Chapter 296, Statutes of 2008. The program is required to take specific actions to protect against HAI in GACHs statewide, including receiving reports on implementation of infection surveillance, infection prevention process measures and the occurrence of HAI. The program originally included 12 authorized positions. However, the DPH’s recent reinterpretation of the statutes increased the number of surgical procedures for which hospitals must report surgical site infections (SSIs) from 3 to 29, thereby increasing the data from 71,000 procedures to more than 900,000. The Department seeks to address this increased workload with these four proposed new positions.

STAFF COMMENT / QUESTIONS

1. Please provide an overview of this proposal.
2. What are the specific increases to the fees being proposed?

PANEL

- Department of Public Health
- Legislative Analyst's Office
- Department of Finance

PUBLIC COMMENT

ISSUE 7: CREATION OF OFFICE OF HEALTH EQUITY

The Governor's budget (BCP EX-03) proposes trailer bill to create a new "Office of Health Equity" (OHE) within the DPH to focus on health disparities between various populations. This OHE would integrate various offices and projects that currently are spread across three different departments. As proposed, it would comprise the Office of Women's Health (currently in the DHCS), the Office of Multicultural Health, the Health in All Policies Task Force, the Health Places Team, and the Office of Multicultural Services (currently in the DMH). Currently, three different departments have three separate offices addressing health disparities as follows:

- The Office of Women's Health (DHCS) – addresses disparities for women;
- The Office of Multicultural Health (DPH) – addresses disparities affecting racial and ethnic populations; and,
- The Office of Multicultural Services (DMH) – same core mission as the Office of Multicultural Health but with a focus on mental health.

The OHE would report directly to the Department director and would operate with the assistance of a stakeholder advisory council.

BACKGROUND

Office of Multicultural Health. The Office of Multicultural Health was created in 1993 and its mission is to eliminate health disparities and improve access to quality health care for diverse populations. Key areas of responsibility include: health planning and policy development, technical assistance and training, health initiatives and program services, impact of program activities on communities and program evaluation.

Office of Women's Health. Also created in 1993, the Office of Women's Health seeks to guide women's health policy to promote health and reduce the burden of preventable disease and injury among women and girls. The Office of Women's Health is located in both the DHCS and the DPH.

Office of Multicultural Services. This office, currently within the Department of Mental Health, was established in 1998 to coordinate efforts to reduce disparities in access and quality of care for California's racial, ethnic, and cultural un-served and underserved communities. The office seeks to foster change in policy, access, language, clinical practice, research, and intervention practices in mental health programs and services.

Health In All Policies Task Force. This Task Force provides a structure for a systematic exploration of the ways in which state agencies can promote better health outcomes through public policy and programs to improve community health environments. Several state agencies and departments participate in the Task Force to identify and address the social, political, and environmental determinants of health outcomes in California.

Healthy Places Team. The Healthy Places Team coordinates multiple programs that address ways to improve health outcomes through urban greening and sustainable communities planning. It also brings together data from multiple sources to develop cross-cutting analyses.

Justification. The Administration cites three key reasons to support the creation of the Office of Health Equity and to transfer these various programs to this one office:

1. **Need for Integration.** The Administration cites research that provides evidence of the overlaps between different types of disparities and the impacts they have on each other. For example, mental health access and treatment has a major impact on the overall health status of women. The Administration believes that the OHE will take a more holistic approach to health and the many types of disparities.
2. **Expanding the Definition of Disparities.** In addition to the traditional types of disparities, such as gender, ethnicity, and income, that are already addressed by existing State programs, there are additional disparities that are not being addressed but could be through this new office. This includes disparities based on geographic regions and sexual orientation, among others.
3. **Economies of Scale.** The recent economic downturn has both exacerbated health disparities and reduced resources available for these purposes. Specifically, the DPH anticipates federal funding of the Office of Multicultural Health to be eliminated in 2012. By integrating these various programs together, the DPH believes that it can pool resources and generate economies of scale to mitigate the impact of funding reductions.

STAFF COMMENT / QUESTIONS

Stakeholders report that the OMS, within the DMH, is extremely effective and therefore are concerned about its future effectiveness within the DPH. Specifically, they fear that the focus and resources (Mental Health Services Act funding) will be diluted once shared with other programs and functions, per this proposal.

1. Please respond to stakeholder concerns regarding the future effectiveness of the OMS.
2. Please clarify the level of staffing that is proposed to move from the DHCS and DMH to the DPH related to this proposal.
3. Please describe the California Reducing Disparities Project and how that project would be funded and implemented under this proposal.

PANEL

- Department of Public Health
- Legislative Analyst's Office
- Department of Finance

PUBLIC COMMENT

ISSUE 8: TRANSFER OF DIRECT SERVICES TO DEPARTMENT OF HEALTH CARE SERVICES

In order to maintain the focus of the DPH on prevention and population health, the Governor's budget (BCP EX-02) proposes trailer bill to move the following three direct-service programs from the DPH to the Department of Health Care Services (DHCS): 1) Every Woman Counts Program; 2) Prostate Cancer Treatment Program; and, 3) Family Planning Access Care and Treatment Program. This proposal shifts 33.6 positions, \$16.5 million General Fund, \$7.2 million Federal Funds, and \$33.3 million in Special Funds from the DPH to the DHCS. Descriptions of these three programs are below.

BACKGROUND

In 2007, the "Department of Health Services" was split into the two existing departments: DHCS and DPH. When this split occurred, these three programs were placed at the DPH due to the fact that all of them maintain core public health goals and principals. Nevertheless, at the same time, they also provide direct services to low-income Californians. The Administration believes that the direct service aspect of these programs is better suited at the DHCS, which operates many other direct service programs with similar income eligibility requirements. They also state that as the federal Affordable Care Act continues to be implemented, with expansions to Medi-Cal and other programs, the DHCS will be able to facilitate a more seamless transition to Medi-Cal for many of the people served in these three programs, and maximize opportunities for federal financial participation.

Every Woman Counts Program (EWC). The EWC seeks to raise the quality and accessibility of cancer screening services for low-income under-insured and uninsured women. Women receive free clinical breast exams, mammograms, other breast cancer diagnostic testing, pelvic exams, and Pap tests, with the goal of reducing breast and cervical cancer deaths. When women are diagnosed with cancer through the EWC, they are referred to the Breast and Cervical Cancer Treatment Program, operated by the DHCS. The EWC provides support services to recruit providers, conduct outreach, assure quality and collect and analyze data through the support of Regional Contractors and other contracts. The Regional Contractors conduct health education and maintain provider networks. To be eligible for EWC services, women must be 25, and older for cervical cancer screening, and 40 and older for breast cancer screening and diagnostic services. The DPH projects a screening caseload of 340,000 women in the current year.

Prostate Cancer Treatment Program (PCTP). The PCTP provides free prostate cancer treatment to low-income (under 200 percent of the federal poverty level), uninsured men who have been diagnosed with the disease and have no other means to pay for treatment. This program is administered through a contract with UCLA, called "IMPACT." The program serves approximately 300 men per year and nearly always maintains a waiting list. UCLA estimates that more than 5,000 Californians are eligible for the program, but limited funding limits the number served and does not allow for outreach to be conducted.

Family Planning Access Care and Treatment Program (FPACT). The goals of FPACT are to promote optimal reproductive health and to reduce unplanned pregnancies by lowering the barriers that many people face in obtaining family planning services. The FPACT provides comprehensive family planning services to low-income women and men with a family income at or below 200 percent of the federal poverty level with no other source of family planning coverage. Clients are individuals with a medical necessity for family planning services who do not have Medi-Cal and do not have access to health insurance. Medi-Cal clients with an unmet share of cost may also be eligible. Family PACT providers include private physicians in individual or group settings, nonprofit community-based clinics, OB/GYNs and physicians representing general practice, family practice, internal medicine, and pediatrics. Medi-Cal licensed pharmacies and laboratories also participate by referrals from enrolled Family PACT clinicians.

Justification. In addition to the Administration's assertion that direct services fit the DHCS's mission better than the public health mission of the DPH, the DHCS also points out that in various ways these programs may benefit from being located at the DHCS. For example, the claims processing function of the EWC program and the local assistance portion of FPACT are handled through the DHCS already. Moreover, given the myriad of programs and services for the same population already operating through the DHCS, it is possible that information about all of the programs will flow more easily between programs operated within one department. The DHCS states that they have no plans from the outset to make policy changes to any of these programs, and will work with stakeholders on future policy development. The DHCS also notes that the EWC and PCTP would be located together in a new small division at DHCS.

STAFF COMMENT / QUESTIONS

1. Please provide an overview of this proposal.
2. Please explain the reasons that the Administration believes that the benefits of moving these programs outweigh the costs.
3. Please explain how the public health aspects of these programs will be preserved.

PANEL

- Department of Public Health
- Department of Health Care Services
- Legislative Analyst's Office
- Department of Finance

PUBLIC COMMENT