AGENDA
ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER GILBERT CEDILLO, CHAIR

MONDAY, MARCH 18, 2002
STATE CAPITOL, ROOM 127
4:00 P.M.

CONSENT CALENDAR

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ISSUE 1: GRADUATE MEDICAL EDUCATION - CONSENT

BACKGROUND:

The University of California is requesting that the Medi-Cal Medical Education Supplemental Payment Fund (Med Ed Fund), which is scheduled to expire on June 30, 2002, be extended to June 30, 2004.

The Med Ed Fund is a state-federal Medicaid matching program that provides supplemental payments to eligible hospitals through negotiations with the California Medical Assistance Commission (CMAC). Under this program, the University of California funds the state portion of funds that are matched by federal dollars and then distributed to hospitals with accredited medical education programs that provide inpatient care to Medi-Cal patients. In 1997-98, the University collaborated with the leadership of the California Association of Public Hospitals, the California Children's Hospitals Association and the Private Essential Access Community Hospitals to sponsor budget trailer bill language that expanded the Med Ed Program to include a total of 26 hospitals, including the University of California teaching hospitals, the children's hospitals and major non-university teaching hospitals.

There is no cost to the State General Fund for this program, which annually provides approximately $144 million in University and federal dollars to support the costs of graduate medical education at hospitals throughout the state that provide inpatient care to Medi-Cal patients. The Med Ed Fund is supported entirely through intergovernmental transfers from the University of California that are matched by federal Medicaid dollars. Last year, the University provided the $72 million for the state's share of the matching funds needed to support the program. On average, the University has provided $61.8 million per year in matching funds to support the Med Ed Fund.

Twenty-six public and private teaching institutions currently participate in the program: the five University of California teaching hospitals, Loma Linda University, Stanford, Los Angeles County, Highland General, Kern Medical Center, San Bernardino County Medical Center, San Francisco General, Valley Medical Center of Fresno, Riverside General Hospital, Santa Clara Valley Medical Center, White Memorial Medical Center, and the Children's Hospitals of California.

COMMENTS:

The University of California requests the Subcommittee to reauthorize the Medical Education program.

CMAC/DHS, please provide the Subcommittee with your assessment of the reauthorization.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 2: DONOR DEFERRAL REGISTRY - CONSENT

BACKGROUND:

The Blood Centers of California requests the Subcommittee repeal the Donor Deferral Registry (DDR). The functions of the DDR are as mandated in the Section 1603 of the Health and Safety Code. Mandatory reports to the DDR from blood banks and plasma centers are for individuals that test positive for HIV or hepatitis B virus (HBV). While reporting of hepatitis C virus (HCV) and HTLV-1 positive individuals is voluntary, reporting of these to the DDR is a standard practice. Also reported are individuals involved as a donor to a post-transfusion hepatitis case, although if they are one of two or more donors to that case they are not officially on the DDR unless another such case occurs. Lastly, cases of HBV, HCV, and AIDS are reportable to public health authorities in California – reports for these diseases received by our office are also placed on the DDR, whether or not the individual has a known history of blood or plasma donation. The DDR includes basic identifiers for each person listed, but does not include the reason for an individual's listing (i.e., doesn't specify which disease or positive test). This list is distributed by the Department of Health Services to blood banks and plasma centers twice monthly in either microfiche or electronic format, and these entities are prohibited from accepting blood for donation from anyone listed on the DDR. Turn-around time from report of additions or changes to receipt of an updated DDR by a blood center is typically 3-6 weeks. The DDR is maintained with the same standard of confidentiality as all medical information handled by the DHS (e.g., reports of communicable diseases).

The DDR was first enacted by legislation in 1974, at that time referring to "serum hepatitis" (HBV was the only known cause at that time). After the recognition of AIDS and subsequent discovery of HIV in the 1980s, the Health and Safety Code was amended in 1985 and later in 1988 to include AIDS diagnosis and HIV infection as conditions requiring a report to the DDR. The DDR was created prior to the development of the tests currently used to screen blood, and has never been modified to be consistent with developments in testing methodology. As a practical matter, current testing standards and requirements (FDA) meet or exceed the ability of the DDR to preclude the use of blood or blood components from an individual carrying a blood-borne disease, both in terms of sensitivity and timeliness.

COMMENTS:

DHS, please briefly review the history and purpose of the Donor Referral Registry.

DHS, please briefly describe the current state in blood testing methodology, does it meet or exceed the current testing standards and requirements of the FDA?

DHS, do you agree there is no longer any need for the Donor Referral Registry?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 1: OVERSIGHT – CROSSCUTTING ISSUES AFFECTING ACCESS

BACKGROUND:

Health care is confronting a fairly unique environment as the state's budget is being crafted. The state's economy is not growing nearly as rapidly as it had during the past few years. The number of people in California that do not have health coverage is still close to 7 million people. The state's budget is in deficit and it is possible that it could deteriorate before it gets better.

Concomitantly, funding for health care is problematical, revenues from the federal government to reimburse providers for the care they provide to the Medi-Cal and indigent could decline sharply. At the same time expenses that accrue as a result of the state's efforts to achieve a higher quality of care in a safer environment are soon to increase.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 1: HOSPITAL OUTPATIENT LAWSUIT

CURRENT YEAR	PROPOSED CHANGE	PROPOSED BUDGET EXPENDITURES
350,000,000		

BACKGROUND:

In the Orthopaedic Hospital lawsuit against the state the hospital industry reached agreement with the state for $350 million, $175 million General Fund, retroactive reimbursement for hospital outpatient rates. Additionally, the state and hospital industry agreed to an immediate 30 percent increase in hospital outpatient rates. Also, the state and the hospitals agreed that hospital outpatient rates would be increased 31/3 percent each year for the succeeding three years. The federal government has not agreed to its share of the retroactive payment of $175 million, negotiations are continuing. The state's share of the retroactive payment is projected to be paid in the 2001-2002 state fiscal year. The 30 percent increase is also expected to be paid in the 2001-2002 state fiscal year, as the federal government has agree to the increased reimbursement on a prospective basis.

COMMENTS:

DHS please provide the Subcommittee an update on the status of the lawsuit settlement. Will the payments to providers be made in the current year or the budget year?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 2: UPPER PAYMENT LIMIT

BACKGROUND:

The Medicaid UPL is the maximum amount the federal government will pay states and specified groups of providers for Medicaid services. The limit is 150 percent of what the federal government pays for the same service to a Medicare beneficiary. The federal government issued a final rule in the *Federal Register* on January 18, 2002 to eliminate the 150 percent Medicaid upper payment limit for public hospitals. The rule becomes effective March 19, 2002.

Although the higher payment limit applies only to public hospitals, the structure of California's Medi-Cal program intrinsically links public- and private-sector hospitals. Private safety net hospitals, children's hospitals and teaching hospitals—as well as public hospitals—all receive supplemental Medi-Cal payments and all will be seriously affected by the implementation of the final rule.

For the first three years of the transition period California will not suffer any loss of federal funds. Over the course of the 8-year transition period of the rule, according to the affected hospitals, California will lose approximately $1 billion in federal Medicaid payments to safety net hospitals. Once the rule is fully implemented, the loss to California is projected to be at least $300 million per year. Contrary to what a number of states have done, California has directed its supplemental Medicaid funds to healthcare. California provides the supplemental payments affected by final rule to eligible hospitals through the SB 1255 program administered by the California Medical Assistance Commission. Two related Medi-Cal supplemental payments programs are the Disproportionate Share Hospital SB 855 program and the capital assistance SB 1742 program.

COMMENTS:

CMAC, what are the expectations of the CMAC relative to the upper payment limitation, do you concur with the cumulative loss projections of the providers over the span of the transition and the annual amount?

What will the effect of the reduction in the upper payment limit on CMAC negotiations?

LAO, please provide the Subcommittee with its view of the pending reduction in the upper payment limit.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 3: DISPROPORTIONATE SHARE HOSPITAL FUNDING CLIFF

BACKGROUND:

The Balanced Budget Act of 1997 (BBA) reduced funding to health care providers, including a 20 percent reduction in Medicaid DSH funding to states. In 2000, Congress passed the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act ("BIPA") and postponed until 2003 the severe reductions in Medicaid DSH funding required by the BBA. BIPA, however, only provided a stopgap to a looming fiscal crisis. Under BIPA, the deep reductions enacted under the Balanced Budget Act of 1997 will begin in federal fiscal year 2003.

If the federal DSH funding reduction occurs the Federal Medicaid DSH payments to California will be cut approximately $184 million in the 2002-2003 fiscal year. If the federal DSH reduction occurs, California will receive $907 million. If the reduction does not occur, California will receive $1.091 billion, a $184 million reduction.

There are now no further DSH cuts scheduled in federal law. Beginning in the 2003-2004 federal fiscal year the DSH funding will increase as a result of a statutory cola. California's DSH allotment would go from $907 million in 2002-2003 to $938 million in 2003-2004. If the cliff were to be averted, California in 2003-2004 would receive $1.129 billion, $191 million more than it would receive if the federal reduction does not occur. The combined two-year loss to California that would result from the DSH reduction required by BBA 97 is $375 million.

COMMENTS:

DHS, is the 2002 federal fiscal year reduction in the DSH payments included in the budgeted amount for distribution in the 2002-2003 fiscal year?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 4: SEISMIC SAFETY – REFERENCE ONLY

BACKGROUND:

SEISMIC SAFETY COMPLIANCE – Related issue but not a subject in the hearing

SB 1953, Chapter 740, Statutes of 1994, requires that by 2008 all general acute care hospital buildings be at a seismic safety level where they will not collapse in a major earthquake. SB 1953 was enacted following the structural and nonstructural damage hospitals experienced as a result of the 1994 Northridge earthquake. By 2030, they must be at a level where they will remain operational.

There are approximately 900 hospital buildings (the Structural Performance Category 1) that must that must be brought into compliance by 2008. The California Healthcare Association (CHA) states that it will cost in the neighborhood of $10 billion to accomplish this conformance to the provisions of SB 1953. According to CHA approximately 25 percent of hospitals lack sufficient financial capacity to meet the 2008 deadline.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 1: DSH ADMINISTRATIVE FEE

CURRENT YEAR	PROPOSED CHANGE	PROPOSED BUDGET EXPENDITURES
$29.2 million	**$55.2 million**	**$84 million**

BACKGROUND:

The budget proposes to raises the DSH Administrative Fee from $29.8 million in the 2002-2003 fiscal year to $84.4 million, a $55 million increase, in the Budget Year. The Legislature established the Medi-Cal DSH Payment Program in 1991 to provide supplemental funding to a limited number of hospitals that treat large volumes of low-income patients. Local entities that operate DSH hospitals – select counties, hospital districts and the University of California – fund the state share of the Medi-Cal DSH program through intergovernmental transfers (IGTs) made to the state, which then uses the funds to obtain federal matching funds. The federally matched DSH funds are distributed to eligible public and private hospitals.

In the early 1990s, during the state's worst recession since the Great Depression in the 1930s when the state was suffering huge budget deficits, the public entities were required to provide the state with IGTs in excess of the amount necessary to fund the federal DSH payments to eligible hospitals. The arrangement effectively reduces the amount of federal DSH payments available for distribution to DSH eligible hospitals and has been referred to as an administrative fee. The highest the administrative fee was $239 million. Over time, as the state's economy improved and the federal government cutback on its Medicaid disproportionate share program, the legislature has reduced the fee.

COMMENTS:

DHS, in the development of the proposed budget what policy principles did you employ?

DHS, what is the logic of the proposed reduction, i.e. why that amount?

LAO, what is your assessment of the impact of reduced supplemental reimbursement to the providers?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 2: PROVIDER RATE DECREASE

CURRENT YEAR	PROPOSED CHANGE	PROPOSED BUDGET EXPENDITURES
$9.509.9 Billion	**$155.2 Million**	**$9.354.7 Billion**

BACKGROUND:

The budget proposes to reduce Medi-Cal provider rates by $77.6 million General Fund, $155.2 million total funds. Budget Bill language would direct the Director to minimize the impact of the rate reductions on services for persons under 18 years of age and the long term care**.**

The 2000-2001 budget raised provider rates as follows:

Provider Rate IncreaseFunds Appropriated for Budget Act FY 2000/2001

Non-institutional Providers	Percent Increase	GF Dollars Appropriated	Federal Funds *
Physician Services (includes 40% increase specific to ER physician services)	16.7%	95.30	95.30
CCS physician services (including non-Medi-Cal)	39%	7.80	7.80
Comprehensive perinatal services	11%	2.60	2.60
EPSDT screening (including non-Medi-Cal CHDP)	20%	3.30	3.30
Neonatal intensive care	30%	5.40	5.40
Dental			
General rates	6.8%	17.70	17.70
Medical/Other Services			
Psychologists	30%	3.00	3.00
Physical/Occupational/Speech Therapy/Audiology	30%	2.70	2.70
Respiratory Care	10%	0.06	0.06
Chiropractic Care	130%	0.50	0.50
Mammograms	54%	1.03	1.03
PAP Smear laboratory rates	53%	2.90	2.90
Breast pumps	150%	0.50	0.50
Milk banks	20%	0.02	0.02
Blood banks	70%	0.60	0.60
Wheelchair/Litter Van transportation	20%	4.60	4.60
Hearing aids and dispensing fee	100%	2.80	2.80
Home Health			
Shift nursing rates for EPSDT and Waiver services	10%	8.40	8.40
Home health agencies	10%	1.40	1.40
Institutional Providers			
Small and rural hospitals-outpatient rate supplement	NA	2.00	2.00
Long Term Care			
LTC Wage Pass-through	7.5%	67.00	65.80
LTC annual rate increase	10.1%	161.40	156.80
DP/NF one time increase	NA	10.70	10.70
Adult Day Health Care	4.54%	1.10	1.10
TOTAL		**402.80**	**397.01**

Footnotes:

1. Rate adjustments only (GF appropriations do not reflect the costs associated with expanded benefits).
2. GF appropriations include fee-for-service and managed care where applicable.
3. Rate increase percentages are expressed as averages per service category. Actual increases for specific services will be set by DHS, in consultation with stakeholders, and will vary by procedure within individual service categories. Rate increases do not overlap increases in other categories.
4. * Federal funds presumed to be 50/50. Actual FMAP adjustments included overall FMAP adjustment in the May 2000 Estimate.

09/05/2000
Prepared by the Department of Health Services, MCPD, RDB
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The rate reduction amounts noted below are expressed as overall savings per service category. The budget proposes that the actual rate reductions per service category will be decided in discussions between provider groups and the Department of Health Services.

Proposed Provider Rate Reduction

Service Categories	Total Savings ($1,000)	General Fund
Physicians	$116,900	$58,450
Comprehensive Perinatal Services	$2,100	$1,050
Dental Services	$13,900	$6,950
Psychologists	$3,760	$1,880
PT, OT,ST, Audio*	$2,300	$1,150
Respiratory Care	$120	$60
Chiropractic Services	$1,500	$750
Wheelchair/Litter/Van	$3,740	$1,870
Shift Nursing/Waiver	$9,200	$4,600
Home Health	$1,600	$800
Total	$155,120	$77,560

*Physical, Occupational and Speech Therapy and Audiology
Note: The reductions include reductions to managed care

COMMENTS:

DHS, please provide the Subcommittee with an overview of the stakeholder process that you began on March the 7.

How will that process affect the decision making on the distribution of the rate reduction?

LAO please provide the Subcommittee with your assessment of the impact of the rate reduction?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 3: MEDI-CAL CO-PAYMENTS

CURRENT YEAR	PROPOSED CHANGE	PROPOSED BUDGET EXPENDITURES
-0-	**$30.6 million**	**$30.6 million**

BACKGROUND:

The budget would impose co-payments on Medi-Cal beneficiaries and raise $30.6 million. The co-payments would be applicable for non-emergency services for those over 18.

Medi-Cal Co-Payment Amounts

Services	Co-payment Amount	Savings
Physician	$2	$2,032,670
Hospital Outpatient	$5	$863,252
Drug Prescriptions	$1	$12,746,084
Med. Trans (Ambulance)	$1	$1,609
Med. Trans (Van)	$1	$804,573
Home Health	$1	$1,560,780
Dental	$3	$10,414,224
Outpatient Professional Services		
Acupuncture	$1	$213,593
Chiropractic	$1	$18
Clinic		
Outpatient	$3	$169,989
Heroin Detox	$3	$73,049
Rehabilitation	$3	$225,480
Rural	$3	$369,495
Surgical	$3	$22,792
Occupational Therapy	$1	$1,451
Optician	$2	$551,063
Optometric	$2	$250,158
Physical Therapy	$1	$5,539
Podiatry	$2	$99,760
Psychology	$2	$35,732
Speech & Audiology	$1	$124,614
Other Services		
Hearing Aids	$3	$47,477
Orthotic	$0	$0
Prosthetic	$0	$0
DME	$0	$0
TOTAL		$30,613,401

Federal law precludes the imposition of co-payment on children and pregnancy services. Providers cannot deny medical services because the patient cannot make the co-payment; however, the patient will be liable to the provider for any co-payment amount. The state will collect the co-payments through reduced reimbursements to providers. In effect, the co-payment proposal is a further rate reduction because the providers will rarely if ever collect the co-pay at the time of service and it will cost more to pursue the collection than to forget the co-pay. During the recession in the 1990s the prior administration proposed the imposition of co-payments on beneficiaries.

COMMENTS:

DHS please outline for the Subcommittee why an indirect method used to reduce provider reimbursement? Why not the more direct reduction?

LAO, what is your assessment of the impact of the provider rate reduction?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 4: OUTSTATIONED ELIGIBILITY WORKERS

CURRENT YEAR	PROPOSED CHANGE	PROPOSED BUDGET EXPENDITURES
$14.210 Million	**$4 Million**	**$10.210 Million**

BACKGROUND:

The budget would eliminate the federally optional perinatal out stationed eligibility workers. The funding for the optional perinatal out stationed workers began in 1988. Federal law requires the Medi-Cal program to provide eligibility workers in Disproportionate Share Hospitals and Federally Qualified Health Centers. In addition the Department of Health Services has encouraged counties to outstation eligibility workers in clinics, hospitals, and emergency centers.

Out stationed workers are independent, more experienced and require less supervision than their colleagues who work in county offices. Also, counties frequently supply equipment to clinics and reimburse the worker for travel costs. Therefore, the counties' expense for these workers is higher than for other workers. As a result DHS provided enhanced funding for the out-stationed workers. The counties, nonetheless, would still be required to outstation eligibility workers.

The elimination of funding for preinatal eligibility workers would reduce General Fund expenditures by $4 million and total funds by $8 million.

COMMENTS:

DHS, please discuss the reasoning of reducing the optional perinatal eligiblity workers.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 1: CHDP – INFORMATIONAL ONLY

BACKGROUND:

The Child Health and Disability Prevention Program provides health assessments and immunizations to children in families with incomes 200 percent or below of the Federal Poverty Level. Children up to 21 years of age are eligible for the health assessments and immunizations. For the state only component of the program health assessments and immunizations are provided to children up to the age of 19.

The budget proposes to eliminate the CHDP program. Those children who are Medi-Cal eligible would be enrolled in the Medi-Cal program. Those who are Healthy Families eligible would be enrolled in the Healthy Families Program. Those who are eligible for neither program, primarily undocumented children, would be shifted to receiving their care at community clinics in the Expanded Access to Primary Care Program.

It is unclear how many children are receiving services from the CHDP Program because the data is collected on the basis of the screens given and not to the number of children receiving services. Of the estimated 1.141 million children in the CHDP program, 241,000 are ineligible for Healthy Families or Medi-Cal. An estimated 99,000 of the children would be enrolled in Medi-Cal. An estimated 20,700 would be enrolled in Healthy Families. The funding necessary to provide health care services to the children in the three programs cannot be determined with any precision because of the encounter data is for the screen and not the person.

Elimination of CHDP necessitates shifting the undocumented children to other medical care providers. The budget proposal would have the children receive their care from the clinics that are funded by the Expanded Access to Primary Care. There are 262 EAPC clinics and 513 other clinics capable of providing care to the children. In contrast the CHDP program has 4100 providers. Not all counties have EAPC providers (six do not), but all counties have EAPC providers.

According to the Legislative Analyst's Office the **advantages** of the budget proposal include the elimination of duplicative eligibility, net budgetary savings, elimination of double payment for children in Medi-Cal or Healthy Families, maximize federal funds and provide more comprehensive care for children moving into Medi-Cal and Healthy Families.

The Legislative Analyst's Office notes the budget proposal is incomplete. The implementation plan doesn't have adequate detail; it does not provide funding for

outreach and enrollment of CHDP children in Medi-Cal and Healthy Families and does not address access issues for children who are ineligible for Medi-Cal or Healthy Families. Also, the plan does not include funding for transitioning the children from one program to the other. The children not moving to Medi-Cal and Healthy Families will not have health care coverage like the other children; they only will have a limited scope of services.

Elimination of the CHDP Program saves General Fund and Tobacco Settlement Fund money. Medi-Cal costs will increase by a projected $36.4 million and Healthy Families will increase $5.9 million. EAPC costs will increase by $17.5 million. Thus the elimination of CHDP will save $52.4 million, $12.5 million in General Fund and $39.9 million in Tobacco Settlement Fund. Additional funds will be saved as a result of the reduced expenditures in the Childhood Lead Prevention Program.

The Department of Health Services has convened a series of stakeholder meetings. Four subgroups have been formed. Each subgroup is identifying concerns, barriers and opportunities. The subgroups are:

1. **Workgroup A** – Children receiving CHDP services who are already enrolled in Medi-Cal or Healthy Families.

2. **Workgroup B** – Children receiving CHDP services that are eligible for Medi-Cal or Healthy Families but are not enrolled.

3. **Workgroup C** – Children receiving CHDP services that are in eligible for both Medi-Cal and Healthy Families.

4. **Workgroup D** – Interaction with the Public Health Infrastructure.

The Workgroup efforts have above all focused on improving the integration of CHDP and Healthy Families and Medi-Cal. The improved integration would facilitate easier access to health care and provide a much broader health benefit package for the affected children. The children who are not eligible for Medi-Cal and Healthy Families, the undocumented children, some Foster Children and children in juvenile hall, would be provided services in a reshaped CHDP program. There is one inescapable difference between the two groups of children, one has access to a full scope of health care benefits and the other does not.

COMMENTS:

DHS, please describe the Workgroup process for the Subcommittee. How long do you see the Workgroup process continuing? Do you expect it to be resolved before the May Revision or will work continue after that?

DHS, how will the results of the Workgroups be synthesized and how will that synthesis be conveyed to the Legislature and various stakeholder groups? Will the Legislature and the Workgroups have an opportunity to comment on the end product before it is submitted to the Legislature for a vote?

The LAO reserved judgement on the budget proposal. LAO please describe for the Subcommittee why it reserved judgement. Did the Workgroup process elicit the relevant details to satisfy the LAO's concerns?

Is a state only Healthy Families or Medi-Cal health coverage program a viable option for the children who are not eligible for Medi-Cal or Healthy Families? Why or why not?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 1: CANCER RESEARCH

CURRENT YEAR	PROPOSED CHANGE	PROPOSED BUDGET EXPENDITURES
$25 million	**Eliminate**	**$0**

BACKGROUND:

The budget proposes to repeal the Cancer Research Program. The program was established in Chapters 755 and 756 of the Statutes of 1997. Senator Ortiz was the author of AB 154, Chapter 756 and Senator Burton was the author of SB 273. The repeal would eliminate state support for gender based cancer research, noting that many billions of dollars are spent by the federal government for Cancer Research.

COMMENTS:

DHS, is any of the money charged as indirect overhead used in the research projects? If so, how?

DHS, please describe for the Subcommittee the Department's guidelines for the amount of indirect overhead that may be charged by the research institutions participating in the program.

LAO, what is your perspective on the indirect overhead included as parted of the research grants?

ISSUE 2: CALIFORNIA BIRTH DEFECTS MONITORING PROGRAM

CURRENT YEAR	PROPOSED CHANGE	PROPOSED BUDGET EXPENDITURES
$3.7 Million	**$1.571 Million**	**$2.1 Million**

BACKGROUND:

The budget proposes to cut $1.6 million from the California Birth Defects Monitoring Program. The reduction in State funding will stop promising research, jeopardize matching federal funds and eliminate the public education component of the Program.

The California Birth Defects Monitoring Program was established in l982. The Program is funded by the state and it receives additional funding from the Centers for Disease Control and Prevention and the National Institutes of Health. The program has been jointly operated with the March of Dimes since l988.

The March of Dimes believes federal funding is threatened by the state budget reduction. The organization thinks prestigious grants now received from the Centers for Disease Control and Prevention and National Institutes of Health are less likely to be awarded in the future to a downsized program. Also, the March of Dimes believes its award winning public health communication program will be damaged. And, eliminating the Community Service Division means new results won't be quickly disseminated to health professionals, policy makers and the public as in the past.

COMMENTS:

DHS, please describe the research efforts of the program. Please describe for the Subcommittee some of the recent accomplishments of the research program.

DHS, please describe the public health communication program and how it will be affected by the proposed reduction
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ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 3: COUNTY MEDICAL SERVICES PROGRAM

CURRENT YEAR	PROPOSED CHANGE	PROPOSED BUDGET EXPENDITURES
$5 Million	**$5 Million**	**$0**

BACKGROUND:

The County Medical Services Program Board urges the Subcommittee to reject the budget proposal to charge it for administrative services provided by the Department of Health Services. The Board also has requested the Subcommittee to reauthorize it for another five years.

The proposed budget would require the County Medical Services Program (CMSP) program to reimburse the state $5 million for the administrative services provided to the CMSP program by the County Health Services Branch of the Department of Health Services. In addition, the state would postpone $20.2 million state funding for the program. In both cases the state committed to providing the administrative services and the $20.2 million to the small county medically indigent program.

The County Medical Services Program was established in 1982 to provide medical and dental care to low income medically indigent adults in the state's 34 small counties that have less than 300,000 people residing in them. In 1995 the program was restructured to give the counties the policy, administrative and fiscal control of the program. Prior to 1995, the counties only had an advisory capacity to the program. As part of the restructuring, the state committed to provide an unconditional $20.2 million per year to CMSP. And, the state committed to provide the administrative support to the program.

The program has accumulated reserves and the administration sought in the 1999, 2000 and 2001 budgets to end the state's $20.2 million contribution to the program. The Legislature, in the health budget trailer bills for 1999, 2000 and 2001 has provided a year-by-year deferral of the General Fund contribution in lieu of permanent elimination. In the proposed budget for 2002-2003, the Administration has proposed deferring its contribution to CMSP until the 2003-2004 fiscal year.

The CMSP Governing Board maintains a reserve to pay providers for services delivered to the medically indigent in the 34 small counties. Each year the state questions the size of the reserve and the CMSP Board responds the counties are fiscally liable in the event that program costs exceed program revenues. In the past when expenses exceeded revenues the program unilaterally lowered provider reimbursement rates and

eliminated services to the eligible population. It took several years to reestablish the provider rates and add the benefits back.

The CMSP program was not made a permanent program when the counties took over fiscal and programmatic control in the middle 1990s. The authorizing legislation expires this year and the counties have requested the program be extended for another five-year period.

COMMENTS:

DHS and Finance, is charging an administrative fee consistent with the agreement the state made with the small counties when they took over the medically indigent program?

DHS, what administrative services to CMSP are included in the $5 million fee estimate?