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

## Assemblymember Hector De La Torre, Chair

**MONDAY, APRIL 17, 2006, 4PM**
**STATE CAPITOL, ROOM 127**

**CONSENT CALENDAR**



**VOTE ONLY ITEMS**



**ISSUES TO BE HEARD**

# ITEMS ON CONSENT

## ITEM 2400 DEPARTMENT OF MANAGED HEALTH CARE

### ISSUE 1: MANAGED RISK MEDICAL INSURANCE BOARD MEDICAL LOSS RATIOS REVIEW

The Managed Risk Medical Insurance Board (MRMIB) proposes the Department of Managed Health Care (DMHC) conduct Medical Loss Ratio Reviews on the health and specialty plans that participate in Healthy Families Program. MRMIB's authority to conduct the reviews is established in the contract that each plan must sign. MRMIB is funded for the cost of the reviews. The Medical Loss Ratio is the amount of revenues from Health Insurance Premiums that is spent to pay for medical services covered by the plan. The proposal would increase reimbursement authority for the Department of Managed Health Care by $220,000 and increase staffing by two.

Price/Waterhouse Coopers (PwC) has conducted the Health Plan Medical Loss Ratio Reviews for the past three years. PwC has conducted seven Medical Loss Ratio during the three-year period and has billed MRMIB an average of $54,000 for each audit. MRMIB believes the contract PwC is not cost effective and is seeking an arrangement with DMHC that is more cost effective. Each plan is to be reviewed once every three years, thus 12 plans would be needed to be reviewed each year. DMHC's Division of Financial Oversight performs similar reviews during the routine Financial Exams of licensed Health Plans and could conduct the Medical Loss Ratio Reviews while performing these examinations. Through an Interagency Agreement with MRMIB, DMHC would conduct the Medical Loss Ratio Reviews.

# ITEM 4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

## ISSUE 2: REGISTERED NURSE EDUCATION FUND

The proposal would authorize the Office of Statewide Health Planning and Development (OSHPD), Health Professionals Education Foundation to redirect a portion of the Registered Nurse Education Program to support masters' or doctoral nursing students who agree to teach at a California nursing school for a period of five years. A portion of the Foundation's staff, .60 will be redirected within OSHPD for this purpose. The personnel and operating costs related to the Registered Nurse Educator Program can be supported through a redirection of existing Nurse Education funding that is generated by $10.00 surcharge on Registered Nurse license renewals along with a redirection of existing Registered Nurse Education Fund expenditure increase of $117,000 in the 2006-07 fiscal year.

The Registered Nurse Education Program was established in 1988 to address the shortage of registered nurses available to practice direct patient care in medically underserved areas of California. The program was initially funded with a $5.00 surcharge on Registered Nurses renewal. In 2004 the surcharge was raised to $10.00. The annual budget of the Registered Nurse Education Fund is over $1.4 million and 1,200 annual awards. Since its inception, the Registered Nurse Education Program has awarded nearly 1,400 associate and baccalaureate degrees, nursing scholarships, and loan repayments totaling over $8 million to individuals who have agree to provide direct patient care in medically underserved areas of the state for a minimum of two years.

Chapter 611, Statutes of 2005 authorized the Foundation to expand the focus of the Registered Nurse Education Program, and direct a portion of the Registered Nurse Education Fund from associate and baccalaureate degrees, nursing scholarships, or loan repayments to support the Nursing Education scholarships and loan repayments for master's or doctoral nursing students who agree to teach at a California nursing school for a period of five years.

The Foundation has developed the infrastructure to manage eight scholarship and loan repayment programs. Three of the programs target associate and baccalaureate nursing students and graduates. The other programs target other health professionals necessary for service in Medically Underserved Areas.

## ITEM 4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

### ISSUE 3: PHYSICIAN CORPS LOAN REPAYMENT AND VOLUNTEER PAYMENT PROGRAMS

Program management and administration for the Steven M Thompson Physician Corps Loan Repayment and Volunteer Physician Programs was transferred from the California Medical Board to the Health Professions Education Foundation (Foundation) of the Office of Statewide Health Planning and Development. In conjunction with the transfer, the Foundation proposes to add one and one-half positions to support its work. The personnel and operating costs related to the Physician Corps Loan Repayment and Volunteer Physician Programs will be supported through funds transferred from the California Medical Board to the Foundation and funds raised from the private sector including private foundations. The Program is being transferred from the California Medical Board to the Foundation to provide an incentive for donors who are willing to give money to a 501© (3) non-profit entity and receive a charitable deduction.

The California Medical Board has indicated that there will be approximately $2 million in the Medically Undeserved Account of the Board's when the two programs are transitioned to the Foundation. The start-up funding allows the Foundation to continue the administration of the existing Physician Corps Loan Repayment Program; award 17-18 physician loan re-payments; develop an implementation plan for the Volunteer Physician Program; and initiate fundraising activities to sustain both programs. For the 2006-07 fiscal year $194,000 would be spent on administrative costs and $1.847 million on awards.

The Foundation implemented its first scholarship and loan repayment programs targeting bachelor's of science degree nursing students and graduates in 1990. Since that time, the number of scholarship and loan repayment programs offered by the foundation has grown from two to eight. Accordingly, with the health professional licensee, private foundation and corporate support. The Foundation has increased the dollars awarded annually from approximately $500,000 to over $1.7 million. Through June of 2004, the Foundation has awarded nearly $11.5 million to 1,700 health professionals' students and graduates who have practiced in 51 of 58 California counties.

The administration of the Physician Corps Loan Repayment and Volunteer Professions Program will require the Foundation to focus attention on physician workforce issues, which go beyond the scope of its program. Long term raising funds for the two programs will require the Foundation to initiate a fundraising campaign solely on physicians. AB 327 (De La Torre), Chapter 293, Statutes of 2005, will allow physicians to voluntarily donate to the Physician Corps Repayment Loan and Volunteer Physician Programs at the time of their biennial license.

# ITEM 4260 DEPARTMENT OF HEALTH SERVICES FINANCE LETTER

## ISSUE 4: CALIFORNIA COALITION TO CURE PROSTATE CANCER PASS-THROUGH FUNDING

The augmentation provides an $182,000 pass-through from voluntary tax-payer-contributed funding for the program. The funding will be used too award grants to support prostate cancer research.

## ISSUE 5: REAPPROPRIATION OF 2005-2006 PROPOSITION 50 FUNDS

The Department is proposing to authorize reappropriation authority to the Proposition Fund. The Budget Act of 2005 authorized $90,951,000 Proposition 50 Fund and $17,000,000 Proposition Fund in another account. The Department of Health Services indicates that Proposition 50 project approvals are pending, but given the nature of construction contracting, additional time is necessary to obligate funding from the 2005-06 appropriation.

# VOTE ONLY ITEMS

## ITEM 4260 DEPARTMENT OF HEALTH SERVICES

### ISSUE 1: SAFE DRINKING WATER ACCOUNT

The Department of Health Services requests the authority to hire 11 permanent sanitary engineer positions and an increase in expenditure authority of $1.1 million for the Drinking Water Program to assure mandated oversight of large public water systems. Large Public Water Systems have over 1000 or more service connections. The funding to support the positions is generated from fees that are deposited in the Safe Drinking Water Account, a special fund. The Department states that there are sufficient funds within the Safe Drinking Water Account.

In addition, the Department of Heath Services is proposing trailer bill language that would relieve the Department from inspecting large water systems once a year. The Department is proposing to change the frequency of inspection as follow:

- A system with any surface water source with treatment annually;
- A system with any groundwater source subject to treatment with only groundwater sources, biennially; and
- A system with only groundwater sources not subject to treatment every three years.
- The trailer bill language permits the Department from inspecting the water systems on a more frequent basis.

Also, the Department is proposing additional trailer bill language that would permit it to: deny; award; amend; revoke; suspend; or restrict a water system's certification when in the judgement of the Department, the system's operator's background or behavior bears on the person's ability to safely perform activities under the certification.

The Drinking Water Program of the Department has been responsible for regulating and permitting Public Water Systems since 1915. The program oversees the activities of approximately 8,500 Public Water Systems that serve drinking water to more than 98 percent of the State's population. The State Drinking Water Account was established in the 1991-92 legislative session. The legislation established a fee-for-service approach to the larger community water system with 1,000 or more service connections. It also set a progressive set of flat fees for smaller water systems from 15 to 99 service connections and single flat fees for water systems with transient populations.

The State Drinking Water Act provides resources for 41 engineering positions that provide oversight and inspections of large water systems. The Department states that 20 more, 61 total, positions are needed to effectively carry out its oversight activities. The Department states the fee schedule only would support an additional eleven permanent staff. Also, to make up for nine fewer positions the Department believes are necessary, it has proposed the trailer bill language outlined above.

# ITEM 4260 DEPARTMENT OF HEALTH SERVICES

## ISSUE 2: ADULTERATED CANDY

The Department requests $1.002 million from the General Fund and eight staff to initiate the required activities of Chapter 707, Statutes of 2005. The statute requires the Department of Health services to regulate the lead content in candy by:

1. Testing candy to determine whether it contains lead in excess of the adulteration;
2. Establishing procedures for use by candy manufacturers for testing and certifying candy as being unadulterated;
3. Taking follow-up steps to ensure that adulterated candy would not be sold or distributed;
4. Convening an interagency collaborative to serve as an oversight committee; and
5. Work with the Office of Environmental Health Hazard Assessment in establishing and revising the adulteration level of lead.

The proposal would allow the Department to perform bilingual lead poisoning, prevention educational efforts and partner with the Mexican government with the help of the U.S.-Mexican Border Health Commission to reduce lead in candy.

In 2004 the Department of Health Services tested 167 imported candy samples and found 127 with measurable levels of lead. Eleven of the imported candy samples had lead levels that are deemed unsafe for consumption by current regulatory standards. The Food and Drug Branch of the Department of Health Services embargoed the candy brands that had levels of lead equal to or exceeding current regulatory standards and issued public health advisories. The United States Food and Drug Administration does not perform regulatory activities similar to those mandated by Chapter 707, Statutes of 2005.

Currently, the Department of Health Services activities have been limited to testing approximately 100 varieties of candy per year. Most of the candies were referred to the Department by complaints, are retests of brands previously found to contain elevated lead levels, or contain certain ingredients that tend to be associated with high lead levels. Approximately one to two percent of the candies tested are found to have excessive lead. As the regulatory limit is reduced a higher percentage of candy may be found to contain excessive lead. The Department estimates that approximately a billion pieces of candy are imported and sold annually in California. Assuming batch tests are run on one in every 100,000 candies sold, 11,000 individual pieces would need to be tested. With the newly revised regulatory limit, additional enforcement, re-sampling and re-testing would need to be completed, which limits the number of candies to be tested. The Departments objective would be to conduct tests on 11,000 pieces of candy per year. The Department expects to implement the program by testing 2,000 to 4,000 candies in the first year so that the development and quality control procedures could be well documented at the laboratory.

# ITEM 4260 DEPARTMENT OF HEALTH SERVICES

## ISSUE 3: CALIFORNIA SAFE COSMETICS

The Department of Health Services requests $495,000 four permanent staff for the 2006-07 fiscal year. The staff includes: An Associate Governmental Program Analyst in the Division of Environmental and Occupational Disease Control; a Food and Drug Program Specialist in the Food and Drug Branch; a Research Scientist II in the Food and Drug Laboratory Branch.

The funds would provide the staff resources to the Department so that it could address the public concern about the chemical composition and safety of cosmetics sold in California. Some cosmetic products contain chemicals know or suspected to cause cancer or reproductive health effects, even though alternative formulations with the toxic ingredients are available for the European. Cosmetics products are required by federal and state law to be manufactured and labeled for safe use by the public. Current state and federal statutes do not require pre-market safety testing, review, or approval of cosmetic products. Consequently, many cosmetic product formulations nave never been evaluated for safety prior to being introduced into the marketplace. These products are used by the general public and typically applied directly to the skin and lips. Chemicals in these products can enter the body directly from skin contact, inadvertently by entering the mouth and by breathing vapors or particles.

The Division of Environmental and Occupational Disease of the Department of Health Services is required to interface with other state agencies. They include the California Environmental Protections Agency (the Office of Environmental Health Hazard Assessment maintains the Proposition 65 list of chemicals know by the State to cause cancer or reproductive harm, the Attorney General's Office (the Attorney General is charged with enforcement of Proposition 65) and the Department of Industrial Relations (the Division of Occupational Safety and Health enforces worker protection regulations and man initiate new rulemaking to regulate hazards.

The staff includes:

1. Division of Environmental and Occupational Disease Control
    - An Associate Governmental Program Analyst
    - Office Technician
2. Food and Drug Branch
    - Food and Drug Program Specialist
3. Food and Drug Laboratory Branch
    - Research Scientist II

# ITEM 4260 DEPARTMENT OF HEALTH SERVICES FINANCE LETTER

## ISSUE 4: CLINICAL LABORATORY OVERSIGHT

The Department is proposing a $947,000 increase for Clinical Oversight. The augmentation will fund 13.5 positions in the Laboratory Field Services section. These funds will be used by the Department to perform mandated licensing workload in the areas of phlebotomy certification and medical laboratory technician licensure, expand federal Clinical Laboratory Improvement Act inspections and enable full licensure and registration of clinical laboratories over the next three years.

## ISSUE 5: NUCLEAR PLANNING ASSESSMENT SPECIAL ACCOUNT ADJUSTMENT

The Department is seeking a CPI increase of $29,000 to the Nuclear Planning Assessment Special Account.

The Department of Health Services will receive $802,000 from the Planning Assessment Special Account. The details follow.

In California, there are two operating nuclear power plant sites: Diablo Canyon in San Luis Obispo County has two active units and San Onofre Nuclear Generating Station (SONGS) in San Diego County has two active units. A third unit at SONGS is in a "safe storage" mode (fuel has been removed and stored). The operating life of the active units is expected to extend well into the 21st century.

The Rancho Seco plant in Sacramento County was shut down in 1989 and the entire plant is in a "safe storage" mode. Humboldt Bay, the first power plant built in the state has been shut down since the early 1980s.

Commercial nuclear power plants are fueled with uranium. Uranium atoms split, producing heat. The heat boils water, creating steam. The steam is used to spin turbines and the turbines turn generators, producing electricity.

Because of the potential health hazard associated with this type of fuel, power plants are built with multiple physical barriers to prevent the escape of radioactive material. In fact, the safety record of the industry is superior to those of other energy producing systems.

Still, the possibility exists for an accidental release of radiation into the atmosphere. People could breathe contaminated air and radioactive particles could be deposited on the ground, in water, on property and on agricultural crops. Food and dairy animals could graze on contaminated pasture, passing on the contamination to consumers through milk and meat.

In 1979, following the accident at Three Mile Island nuclear power plant in Pennsylvania, the California Legislature mandated that the Office of Emergency Services (OES), together with Department of Health Services (DHS) and affected counties, investigate the consequences of a serious nuclear power plant accident. Based on site-specific studies, Emergency Planning Zones (These zones are discussed later in this discussion) around the plant sites were established and detailed, and integrated plans were developed.

Legislation mandating the Nuclear Power Preparedness Program has been continuous since 1979, enacted as Government Code Section 8610.5, the Radiation Protection Act. The program is funded by the utilities through a special assessment fund managed through the State Controller.

Under state law, counties have the authority and responsibility to protect the lives and property of their citizens. The state supports their emergency response activities involved in nuclear power plant planning.

In the event of an emergency at one of California's nuclear power plants, the Governor's Office of Emergency Services (OES) is prepared to mobilize state resources, in support of the counties, to help mitigate the effects of radiation released into the atmosphere.

While State OES has absolute coordination authority during emergency response, the Department of Health Services (DHS) is assigned the technical lead responsibility during ingestion pathway and recovery phases of an emergency. The goal during ingestion pathway response is preventing contaminated water, food, and food animals from reaching the consumer. The goal during recovery is restoring areas to pre-accident conditions.

Consistent with Government Code Section 13308.05, the Department of Finance has approved a workload budget for Office of Emergency Services, which includes various workload adjustments. The following is information on the workload adjustment for the Nuclear Planning Assessment Special Account Annual CPI Adjustment.

Government Code 8610.5 requires that the funds appropriated from the Nuclear Planning Assessment Special Account for planning and exercises related to implementation of the State Nuclear Power Emergency Response Plan be adjusted annually using the prior calendar year's percentage change in the California Consumer Price Index (CPI). This section states, "The amounts available for distribution for state and local costs as specified in this section shall be adjusted and compounded each fiscal year by the percentage increase in the California Consumer Price Index of the previous year." The California CPI is released in late January or February each year, too late for inclusion in the Governor's Budget.

The baseline Nuclear Planning Assessment Special Account appropriations in the Budget Act of 2005 were multiplied by the 2005 Consumer Price Index of 3.7% to determine the amount of adjustment necessary and the Total Adjusted Base.

| | Ch 38/39, St. 2005 Base | CPI 3.7% Adjustment* | Total Adjusted Base |
|---|---|---|---|
| State Operations: | | | |
| OES (0690-001-0029) | 935,000 | 35,000 | 970,000 |
| DHS (4260-001-0029) | 773,000 | 29,000 | 802,000 |
| Local Assistance | | | |
| OES (0690-101-0029) | 2,291,000 | 85,000 | 2,376,000 |

## ISSUE 6: TECHNICAL ADJUSTMENTS: PROPOSITION 50, DRUG DEVICE AN FOOD SAFETY FUND

The Department is proposing an augmentation that will restore $175,000 Water Security, Clean Drinking, Costal and Beach Protection Fund of 2002 to support an existing interagency agreement with the Department of Water Resources to fund three permanent positions necessary to carry out the provisions of Proposition 50. The funding was inadvertently eliminated during the fall budget process.

In addition, the Department is proposing to increase staff by two. The resources were reduced as part off the Department's unallocated reduction in the Governor's January 10 Budget.

# ITEM 4260 DEPARTMENT OF SERVICES

## ISSUE 7: MEDICAL WASTE MANAGEMENT

The Department of Health Services is requesting six permanent Environmental Scientists for the Medical Water Management Program. Also, the Department is requesting and increase in budget authority of $642,000. The six positions will conduct inspections of medical waste generators in the 25 counties and two cities where the State acts as the local enforcement agency. Also, they respond to complaints of illegal disposal of medical waste, and audit local medical waste programs where the State has the statutory responsibility of assuring uniform enforcement of the Medical Waste Management Act.

The Department maintains the Medical Waste Management Program is understaffed and has not completed 86 percent of its current year inspections of medical waste generator facilities. There are 5,697 medical waste facilities in California; only 837 of the facilities are mandated to have annual inspections. The lack of inspections increases the probability of improper storage and disposal of medical waste. The Department states it does not have the resources to document incidents of illegal disposal of medical waste and believes there is significant no-compliance.

The Medical Waste Management Act sets fees for medical waste generators (primarily hospitals) and for the treatment of medical waste. The Medical Waste Management Program is requesting a fee increase for each pound of medical waste treatment in California. The fee increase will be paid by off-site medical waste treatment facilities and will be passed on to their customers. If the generator fees were also increased, it would appear that these entities would be paying for the increase twice, once as a generator and once in increased treatment costs. The current fee paid by off-site treatment facilities is two-tenths of a cent (.002) per pound of waste treated or $10,000, whichever is greater. The fee was established in 1991 and has never been increase. The proposed fees would be increased to one hundred twenty-seven (0.127) per pound pf waste treated or $12,000, whichever is greater. The fee structure is being proposed to provide the revenue to increase the inspection staff by six positions. The fee would be implemented on July 1, 2006 and permanently fund the six positions within the proposal and maintain the Medical Waste Management Fund. In addition, hospitals would have to pay an amount negotiated with the medical waste treatment compromise for treating the waste.

In addition to the staff, the Department is requesting trailer bill language that would increase fees to support the request for the six new positions. Also, the trailer bill language would allow the Medical Waste Management Program to recover the costs of follow up inspections of large quantity medical waste generators.

# ITEM 4260 DEPARTMENT OF HEALTH SERVICES

## ISSUE 8: RADIATION CONTROL PROGRAM

The Department is requesting eight permanent Associate Health Physicist positions. The staffing is to enable the Radiologic Health Branch to administer the public health functions associated with California's radiation safety program and to be compatible with federal and state mandates. The additional staff will assist the program to meet all federal and state mandates and will decrease the public's risk of excessive and improper exposure to radiation. The Department fulfills its responsibilities through licensing users of radioactive material, registration of radiation producing (X-Ray) machines, certification of individuals using radiation sources, inspection of facilities using radiation sources and conducting enforcement actions.

Radioactive material is used daily: to diagnose illness and treat cancer, in the construction industry to detect defective, pipelines, storage tanks, bridges and medical surgical products. The program is funded through a special fund, Radiation Control Fund. The legislation that enacted the fund was established in 1992. The fees have not been adjusted since 1997. New fees were implemented in 2005. In 1962, California ratified an agreement with the federal Atomic Energy Commission, by which the federal agency discontinued its regulatory authority over certain types of Radioactive Material. Nonetheless, the federal government retained some responsibility to regulate Radioactive Material. The federal government conducts performance evaluations to ensue adequate and consistent nationwide health and safety protection from the hazards of Radioactive Material. The state's program was evaluated in April 2004, and found to "adequate to protect public health and safety, but needs improvement, and not compatible with the federal program. Therefore, California has been placed on "heightened oversight and monitoring" status with potential to lose the program.

The Nuclear Regulatory Commission's inspection specifically identified lack of staff resources as an unsatisfactory finding that must be addressed to bring California into compliance with the Agreement State Program requirements. Staffing inadequacy is evident by the nearly 2,900 X-ray machines not inspected annually as required by law.

# ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

## ISSUE 9: MEDICAL AND MEDICAL DEVICE MANUFACTURER

The Department of Health Services is proposing to increase the expenditure authority from the Drug and Device Safety Fund by $815,000. Also, the Department is requesting the establishment of seven permanent positions: six Senior Food and Drug Investigators to conduct mandated new and renewal drug and medical device licensing inspections and one Management Services Technician to manage administrative activities of the drug and medical device licensing programs. Last year the Legislature authorized 11 positions to administer the Home Medical Device Retailer licensing program, this requests is distinct from last year's proposal.

Also, the proposal includes trailer bill language to establish a probationary period for new licensees and extend licensure to two years and thus collect fees biennially.

Since 1907 when the Legislature enacted the Pure Drug Law, the state has been monitoring the safety, effectiveness, manufacturing and labeling of drugs and medical devices. New and renewal manufacturing facility inspections and licensing fees have been required since 1970. Current staff of the drug and medical device licensing program inspect 240 firms requiring licensing inspection per year. Currently, there are seven staff investigators. The proposal would add six more investigators to allow Food and Drug Branch to significantly reduce the backlog of 167 new licensing inspections and annually inspect 320 mandate renewal drug and medical devices manufacturers. Once the back log is addressed the 167 will then become annual inspections, thereby increasing the annual inspections to 487 mandated renewal drug and medical device manufacturers

A new manufacturer license fee is $1,600; a renewal license is $1,300; a special or small renewal license is $850; Prescription Drug Marketing Act renewal license fee is $100. With the reliance upon fines and fees, the General Fund will not be used to provide resources for the program.

The proposal also contains a request for $64,800 in one-time funds to purchase six vehicles need by the investigators to perform necessary inspections statewide. On average, a vehicle from the Department of General Services would cost $11,400 per year. The average annual cost of a car purchased by the program would be $10,950.

# ITEM 4260 DEPARTMENT OF HEALTH SERVICES

## ISSUE 10: EXPORT DOCUMENT PROGRAM

The Department's proposal is to increase the expenditure authority by $228,000 from the Food and Drug Branch's Export Document Program. The expenditure authority would be to establish two limited Term positions. The length of the term would be two years. The purpose of the increased staff would be to provide resources to review export certification requests, including applications and product labeling, for conformance with state and federal regulations. Also, the funding would fund the development, printing and distribution of an informational brochure to be translated into several languages and made available to applicants needing assistance in a language other than English for their export certification needs.

According to the Department, the demand for export documents and the associated workload has increased by nearly 500 percent. The Food and Drug Branch is not able to meet the statutory requirement.

# ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

## ISSUE 11: ELECTRONIC DEATH REGISTRATION SYSTEM

The Department of Health Services proposes an increase in expenditure authority of $543,000 for the 2006-07 fiscal year for contractual services. The expenditure would facilitate the transition from development to statewide operation of the California Electronic Death Registration System (CA-EDRS). The funds for the come from the Health Statistics Special Fund, there is no General Fund. The Department notes that if the funds are not appropriated the consequences would include:

1. The public will face growing delays in death registration and receiving certified copies of death certificates needed to settle estates;

2. Government agencies who administer benefit programs or process estate collections will continue to overpay or underpay benefits because of delays in notification of a beneficiary's death;

3. Individuals will be able to commit identity theft and fraud, by obtaining driver's licenses using the deceased person's birth certificate until it has been annotated with the "Deceased" legend.

The Department notes that the CA-EDRS was constructed to meet nationwide standards with functionality to support more efficient interaction with the Social Security Administration and the National Center for Health Statistics. The system will include and interface with the Social Security Online Verification System that will verify the decedent's social security number at the time of registration. Functional Standards were recommended by the National Association of Public Health Statistics and information Systems (NAPHSIS). NAPHSIS is a national association of state vital records and public health statistics, which develops standards and principles to effectively administer public health statistics and information systems.

It is expected that when the CA-EDRS is operational and a majority of stakeholders are using the system, it will provide timely death data, timely cross matching with birth certificates for anti-fraud purposes, allow online verification of decedent's social security number and all online access to fact–of-death information.

Until the system is in place and operational, the public will continue to face delays. The Department of Health Services notes that surviving spouses or family members are often to obtain survivors benefits from the Social Security from the Social Security Administration, life insurance, retirement companies and many others pay benefits that are important for families.

# ISSUES TO BE HEARD

## ITEM 4260 DEPARTMENT OF HEALTH SERVICES

### ISSUE 1: AIDS DRUG ASSISTANCE PROGRAM (ADAP)

The Departments proposal for the AIDS Drug Assistance Program is $296.415 million ($107.65 million General Fund, $100.905 million Ryan White Dare Act and $87.860 million Special Fund 3080 Drug Rebate, (see accompanying tables and charts**).** The Ryan White Care Act funding level won't be known until the Spring of 2006.

The AIDS Drug Assistance program was legislatively established in October 1987 to provide drugs to individuals with HIV/AIDS who could not otherwise afford them. The objectives of ADAP are to provide AIDS drugs that have been determined to prolong life and prevent deterioration of health in individuals with HIV or AIDS. The ADAP caseload has grown from 10,000 clients served in 1995-96 to over 28,227 served in the 2004-05 fiscal year.

Since the advent of Highly Active Antiretroviral Therapy (HAART) in fiscal year (FY) 1995-96, ADAPs nationwide have experienced increased enrollment due to people living longer and aggressive outreach efforts, increased utilization of combination therapies and drugs to treat the toxicity and side-effects of HAART, and ever increasing drug prices. The convergence of these factors has resulted in rapidly increasing expenditures in ADAP. The economy has greatly reduced state tax revenues and resulted in state fiscal crises that limit the ability of states to meet the gap between federal appropriations and the needs of uninsured/underinsured people living with HIV/AIDS.

Nationally, ADAPs have had to implement cost-containing strategies, including closed enrollment to new clients, limited access to antiretroviral (ARV) and other treatments, changes in eligibility criteria, and reduced drug formularies. Through the annual budgetary process, California ADAP has also had to consider similar cost-containing options.

In response to this situation, California ADAP took a key leadership role in the creation of the ADAP Crisis Task Force (ACTF) by convening a meeting in California of state ADAP representatives in 2002 to discuss and formulate potential negotiating strategies. From this meeting, the ACTF was formed and became a national-level drug discount negotiating body representing all ADAPs in the country. The ACTF is comprised of ADAP/AIDS directors from eight key states, including California. The ACTF membership represents approximately 75% of the national ADAP expenditures.

Beginning in March 2003, the ACTF began negotiations with all the major ARV drug manufacturers (Abbott Laboratories, Boehringer Ingelheim, Bristol Myers-Squibb, Gilead Sciences, GlaxoSmithKline, Roche, Merck, and Pfizer Inc.) to pay ADAP rebates above those mandated by federal law. Each drug manufacturer came to the table individually to enter into confidential supplemental rebate agreements with the ACTF, and by October 2003 the negotiations were completed. The outcomes of these pricing negotiations were critical to the ability of ADAPs nationally to keep ADAPs open and provide continuing access to medications required for quality HIV/AIDS health care.

As the terms of the initial supplemental agreements were nearing expiration, the ACTF began re-negotiating the drug manufacturer agreements in October 2004. The ACTF has successfully re-negotiated one- to two-year agreements with all the major ARV manufacturers. Additionally, the ACTF is negotiating with a number of non-ARV drug manufacturers for supplemental rebates.

ACTF activities are ongoing for 2006, including negotiations for price concessions on new ARVs, continuing agreements with all ARV manufacturers, and discussions with more non-ARV drug manufacturers and generic drug manufacturers. Activities include:

- Monthly ACTF conference calls (e.g. discussions on updates on drug price increases, expiring agreements, strategy discussions, and data review to ensure manufacturers are honoring their agreements).
- Calls with drug manufacturers to address unresolved details of negotiations.
- Meet with manufacturers of other expensive drugs to negotiate rebates on these products. Two-day face to face meetings are generally held quarterly.

As the largest ADAP in the country, California's participation/presence at most of these discussions is critical to the credibility and strength of the ACTF negotiations.

The continuing success of ACTF negotiations is particularly significant to California, as 85% of ADAP expenditures are for ARV drugs alone. The proposed budget for FY 2005-06 includes $71.6M in drug rebates (27.3% of the total budget). Rebates for FY 2006-07 are projected to bring $87.860 million. Approximately 15% of the rebates now collected are due to supplemental rebate agreements.

ADAP now relies heavily on the additional rebates, as federal funding has not kept up with steadily increasing program demand. It is equally critical that ADAP assure every rebate dollar owed the program is accurately and effectively invoiced, received and tracked by drug manufacturer. All rebate dollars received are dedicated solely for the purchase of additional ADAP drugs.

ADAP faces a number of budget related uncertainties in the next few years:

- Office of AIDS initiated a new contract with the ADAP Pharmacy Benefits Manager in July 2005 under new terms for reimbursement of costs;
- Several Supplemental Rebate Agreement with drug manufacturers expire in the Spring of 2006; and Drug manufacturers can cancel these agreements at any time with 30-60 day notice.

Additionally, Medicare Modernization Act, Part D coverage began in January 2006 and it will affect ADAP beneficiaries. ADAP will require these beneficiaries to use their Medicare benefit first. They will in turn to ADAP in assistance in "subsidizing" their out of pocket costs. As of the most recent data received in mid-March from CMS, nearly 7,600 ADAP clients also have Medicare, and approximately 1,400 of these clients had not yet signed up for a Part D plan. As ADAP does not have access to CMS, data showing how many ADAP/Medicare clients will need subsidized coverage, estimating the effect of Part D on ADAP is difficult.

# ITEM 4260 DEPARTMENT OF HEALTH SERVICES

## ISSUE 2: AIDS PREVENTION AND EDUCATION PROGRAM

The Governor and Legislature approved an increase of $5.6 million in the 2005-06 budget year for HIV education and prevention programs. These funds were passed through the Office of AIDS to 51 counties that had suffered reductions in their prevention funding over a period of years.

Advocates believe it is critical that the state continue to maximize the prevention of new cases of HIV infection. The activities funded by this $5.6 million are vital to that effort. Therefore, the advocates request that $5.6 million be appropriated to the Office of AIDS for the 2006-07 FY.

Presently, approximately $18.4 million is appropriated for HIV prevention and education in the 2004-05 budget. This money is allocated to local health jurisdictions using a formula based on the recommendation of the California HIV Planning Group (CHPG) and approval of the Office of AIDS (OA). This is the statewide planning group that is required by federal law in order to receive CDC funds for HIV Education and Prevention.

In February 2003, on the recommendation of the CHPG, the OA adopted a new funding formula for the allocation of the HIV prevention and education money for the 2003-04 fiscal year. This change resulted in reductions for many jurisdictions. Thirty-six counties were placed in a category labeled historically "over-funded" for education and prevention funding. Seven jurisdictions were identified as being historically "under-funded." Eighteen were placed into a category called "floor" local health jurisdictions. These are rural counties, mostly in Northern California. When this formula was to be fully implemented, each of these counties were guaranteed floor funding of at least $60,000 each year.

| **The Adopted Funding Formula Was As Follows:** | |
|---|---|
| AIDS Cases Diagnosed in Prior Three Calendar Years | 25% |
| Living AIDS Cases | 25% |
| People of Color AIDS Diagnosed in Prior Three Calendar Years | 15% |
| People of Color Living AIDS Cases | 15% |
| People of Color in General Population | 10% |
| People Living Below Federal Poverty Level | 10% |

In October 2004, on the recommendation of CHPG, OA adopted another formula and it was implemented for the 2005-06 fiscal year. The formula was adopted in order to redirect education and prevention funds to those jurisdictions that have the greatest disease impact.

| **The new formula is as follows:** | |
|---|---|
| HIV Prevalence/HIV Counseling and Testing (positives)/Living AIDS Cases | 70% |
| Sexually Transmitted Diseases (Syphilis, GC, and Chlamydia in Men) | 15% |
| People Living Below Federal Poverty Level | 8% |
| People of Color in General Population | 7% |

HIV prevalence data will be excluded from the formula since this data is incomplete. The rationale for making this change is that "funding allocations (of prevention dollars) closely match disease impact. This tenet is a cost effective strategy to fight the epidemic." As a result of the adoption of this formula, all local health jurisdictions except for seven will see declines in their prevention and education dollars from their 2002-03 fiscal year allocations. The seven health jurisdictions that will see increases from 2002-03 are: Long Beach; Los Angeles; Orange; Riverside; San Bernardino; San Diego; and San Francisco.

Overall, these jurisdictions will see a $4.2 million increase in HIV prevention money over what they received for the 2002-03 fiscal year, which means that the other jurisdictions will see a decrease. To fully adjust for the change in the method of allocation it would require $5.6 million.

# ITEM 4260 DEPARTMENT OF HEALTH SERVICES

## ISSUE 3: REGISTERED ENVIRONMENTAL HEALTH SPECIALISTS

The Department proposes a $130,000 increase in budget authority for the Registered Environmental Health Specialist (REHS) program. The purpose of the funding is to establish a continuing education program for environmental health specialists. Statute established the requirement and standards for continuing education for registered environmental health specialists. The Department states the REHS program has sufficient resources to maintain its current program and the proposed education program. Environmental health specialists have identified continuing education as critical need for all environmental health professionals. The Department is proposing increasing the fees to support the program.

The REHS program was established by the Legislature in 1945 to assure that persons who perform activities related to environmental protection meet specific standards of health education, training and experience. REHSs are employed by local governmental agencies to conduct investigations and assessments of environmental conditions and public health problems. The specialists secure compliance with applicable laws and standards that have been established to protect health and safety. The scope of responsibility for an REHS covers public health issues related to food, water, sewage disposal, vector control, toxic substances, air quality, recreational health, bio-terrorism and housing.

The funding will be used to assess courses to determine if they meet specific content requirements to make them eligible for continuing education. The evaluation will be ongoing. The contractor will evaluate new trends in environmental health to determine if the core competencies should be broadened, develop forms to provide to the REHS program to identify those persons that have taken CEU credits, develop a database to track CEUs, prepare enforcement actions for those that have not taken required CEUs, assist in developing regulations, respond to inquiries relating to CEUs and review local environmental health programs to determine how they are incorporating CEUs into their training programs.

Increase existing registration/application fee from $69 to $95.
Increase examination fee from $60 to $126.
Increase biennial renewal fee from $87 to $175.

The increased fees will fund the new continuing education program for environmental health specialists (2006-07 BCP). The affected groups, including the California Council of Local Health Officers, are strongly in support of the continuing education program.

- ✓ Department of Health Services, please provide the Subcommittee with an overview of the Continuing Education proposals.
- ✓ LAO, what is your assessment of the need for the continuing education proposals?

## ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

### ISSUE 4: WOMEN, INFANTS AND CHILDREN (WIC): EXPENDITURE AUTHORITY

The Department of Health Services proposes an increase in its expenditure authority in the Manufacturer Rebate Fund (Fund 3023) of $35 million, from $262 million to $297 million, in 2006-07. In addition, the Department has proposed Budget Bill Language to allow the Department of Finance flexibility to increase Fund 3023 appropriation beginning 2007-08.

The WIC program offers participants infant formula, infant cereal and juice. To contain the food costs the WIC program contracts with manufacturers of these products, who in turn rebate the WIC program each time a participant purchases their product. Manufacturer's rebates are used to offset federal grant food expenditures, which extends food grant dollars to serve more participants and absorb food inflation costs. Federal regulations require states to spend rebate funds before drawing down funds from their federal grant Letter of Credit. WIC cannot draw down federal grant funds as long as rebate revenue remains in the Fund 3023 account. Rebates comprised approximately 30 percent of WIC food expenditures in the 2004-05 fiscal year.

The budget bill language proposed by the Department of Health Services would allow the Department of Finance the flexibility to increase the Fund 3023 appropriation. Annual adjustments will ensure WIC maintains sufficient authority to expend all rebate revenue it receives. Otherwise:

- WIC will be prohibited from spending rebate revenue in excess of expenditure authority;
- Excess rebate funds will remain in the account, thereby freezing WIC's ability to further draw down federal grant funds.

The state faces a risk of tens of millions of dollars in penalties for paying vendors more than permitted under federal limits.

- ✓ Department of Health Service, please provide the Subcommittee a status report on the federal enforcement actions related to the issue and what are its implications for the budget and the WIC Program.
- ✓ Department of Health Services, please provide the Subcommittee an overview of the Department's budget bill language.

- ✓ LAO please provide the Subcommittee with your assessment of the situation.

**New agreed to language.**

4260-111-3023 – For local assistance, State Department of Health Services, payment to Item 4260-111-0001, payable from the WIC Manufacturer Rebate Fund……297,401,000
Provisions:

1. Notwithstanding any other provision of law, if revenues to the WIC Manufacturer Rebate Fund are received in excess of the amount appropriated in this item, the Director of Finance may authorize expenditures for the Department of Health Services in excess of the amount appropriated not sooner than 30 days after notification in writing of the necessity therefore is provided to the chairpersons of the fiscal committees in each house and the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine.

# ITEM 2400 DEPARTMENT OF MANAGED HEALTH CARE

## ISSUE 5: PROVIDER OVERSIGHT PROGRAM

The Department of Managed Health Care requests 17 permanent positions, contract funding, and additional budget authority of $3.8 million. The request would establish a new Office of Provider Oversight. The Office will be responsible for program implementation mandate by legislation. The Office will include a Provider Solvency Unit, a Provider Complaint Unit, and an associated Provider Oversight Management group. The purpose is to conduct financial oversight of Risk Bearing Organizations and ensure prompt and full payment of provider claims. The contracting would be for medical coding and medical necessity of services provided. The Office of Provider Oversight would supplement and supplant the Department's existing Provider Compliant Unit, which was established on an interim basis with borrowed and temporary resources in 2004 as an initial response to its mandates.

SB 260 (Speier) Chapter 529, Statutes of 1999, established the Financial Solvency Standards Board (Board), and placed certain financial standards on RBOs and required DMHC to adopt related regulations. The initial regulations were challenged in court, and the Office of Administrative Law did not approve final regulations until 2005. DMHC indicates that three positions were added for SB 260-related activity in 2002-03; however, two of the positions were eliminated due to vacant position reductions.

AB 1455 (Scott) Chapter 827, Statutes of 2000, established new requirements for prompt and fair payment of provider claims by health plans, and authorizes DMHC to impose sanctions on a plan when an unfair payment pattern is found. Following the adoption of regulations, the Department established the Provider Complaint Unit (PCU) “pilot” in September 2004 with borrowed and temporary resources; however, no positions have ever been added to the DMHC budget for AB 1455 workload.

The Department should be prepared to discuss standards for initiating investigations, standards for assessing fines and the appropriate level of fines, and how these assumptions affect Department revenue and staffing.

The Governor’s Budget indicates expenditures exceeding revenues by approximately $800,000 in 2006-07 and the special fund balance ends 2006-07 with a balance of $2.0 million. The bill analysis for AB 1455 indicates an increase in assessments may be necessary, and the Department indicates a fee increase may be needed in the future. The Department has the ability to increase fees within existing statutory authority. The department estimates that it would not be in a defect as revenues will exceed expenditures by year's end.

# ITEM 2400 DEPARTMENT OF MANAGED HEALTH CARE

## ISSUE 6: WORKLOAD AND ADMINISTRATIVE ADJUSMENT

The Senate determined the 2006-07 fiscal year budget has 13 positions that were administratively added to the Department's budget in the 2005-06 fiscal year. Section 31.00, a budget control section, establishes the authority to add positions within the same fiscal year if the budgeted resources are sufficient.

It costs approximately $1.0 million per year for 13.0 positions.

The Administrative addition of 13 positions raises a few issues:

- • What workload are these positions performing?
- • Why didn't the DMHC submit a BCP last year to establish these positions?
- • Why does the Department have $1.0 million in "extra" budget authority? (How was the Department able to fund 13 new positions without needing a budget augmentation?)

If the Department does not adequately answer the concerns of the Subcommittee during testimony, the Subcommittee may want take action to reduce the DMHC budget by $1.0 million and consider restoring funding only after the Department submits a Finance Letter that justifies the activity and expenditure.

## ITEM 2400 DEPARTMENT OF MANAGED HEALTH CARE

### ISSUE 7: OFFICE OF LEGAL SERVICES APPROVE

The Department of Managed Health Care's Office of Legal Services (Office) is requesting two full-time permanent positions. Fees assessed on health care service plans fund the Department. The Department is requesting an increase in expenditure authority of $165,000 for the 2006-07 fiscal year.

In 2002, the Office had a staffing of 31. A consequence of the budget crisis in 2003 was the loss of six positions, the Office had 25 positions. In order to meet its responsibilities, the Office engaged in cross-program training of the staff. In addition, the Office also reviewed priorities that kept critical functions current and moved lesser activities to non-critical status. The Office acquired a timekeeping and workload management software system, ProLaw, in 2003. The program tracks time spent on specific programs and functions, providing data for calculating and projecting the resources necessary for each program and allows for staff and program accountability.

Managed health care has undergone a dramatic evolution over the last 30 years. Striking a balance between assuring California enrollees have access to quality and affordable health care and providing managed health care plans with a friendly environment conducive to a competitive an health market place, is a complex mission. The legislative process has a direct effect on the managed health care industry an on enrollees throughout California.

# ITEM 4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

## ISSUE 8: LOGBOOK REDESIGN

The Office of Statewide Health Planning and Development is second year financing for redesigning of the Office's Logbook Database System. The Facilities and Development Division uses the system to track healthcare facility construction in the state. The proposed solution would integrate the Division's business needs and requirements and replaces the current system consisting of add-modules and poorly integrated database tables.

The Office seeks one staff person and $2.619 million from the Hospital Building Fund. The request includes funding for the purchase of software hardware, licenses, telecommunications, contract services, and Data Center Services. All costs for the project are to be financed from the Hospital Building Fund, a special revenue fund. Fees charged to healthcare facilities for plan review and construction, observation support Building Fund. Currently the rate for skilled nursing facilities is 1.5 percent of estimated construction costs and hospitals are charged 1.64 percent.

The Office of Statewide Health Planning and Development is responsible for the review of hospitals and skilled nursing facility construction plans and monitoring the construction to ensure the safety of the state's healthcare facilities. The Logbook Database System is used by the Facilities Development Division to track healthcare construction projects through plan review and construction. Also, the Logbook contains additional modules to facilitate tracking health facilities compliance with SB 1953, tracking Inspector of Record certification, and facilitating Emergency Operations in the event of a natural disaster.

The Office's role in the construction of healthcare facilities is:

- Develop California building codes and regulations to ensure healthcare facilities are consistently built and structurally sound for healthcare recipients and providers;
- Approve construction plans and issue building permits pursuant to building codes and regulations;
- Monitor the construction of facilities pursuant to building codes and regulations;
- Review and approve seismic evaluations, compliance plans and structural and non-structural performance category ratings as mandated by the Alquist Seismic Safety Act; and
- Inspect the structural soundness of facilities following and emergency, such as an earthquake or other natural and man-made disasters.

The Logbook is use to monitor over 3,000 constructions projects per year and over 70,000 projects to date. The bulk of OSHPD's current workload results from the enactment of SB 1953, which mandates that acute care hospitals meet specific seismic safety requirements by a phased series of deadlines for the years 2001, 2002, 2008, 2013, and 2030. The seismic performance standard that beginning in 2008, require seismic retrofit of collapse hazard hospital buildings, if the facility plans to continue to provide acute care services. The requirements end in 2030 when all hospitals buildings must be fully compliant. By 2008 or 2013, with an approved extension, the State of California's 1,000 hospital buildings rated as a collapse hazard, Structural Performance Categories-1 (SPC-1) (See Description for structural and non-structural categories below) must be retrofitted, replaced, or removed from hospital service. The hospital association has sent out a questionnaire (see below) to determine the status of SPC-1 structures. OSHPD relies on the Logbook for the full spectrum of business operations including: plan review and construction project tracking; and emergency operation center activities, revenue collection; SB 1953 evaluation report and compliance plan tracking; Inspector of Record examinations; tracking the records management and archival as-built design.

The Budget Change Proposal is to provide some of the necessary technical resources. It is intended to provide funding and additional staffing for the second-year efforts of the project

**STRUCTURAL PERFORMANCE CATEGORIES (SPC)**

| SPC | DESCRIPTION |
|---|---|
| SPC 1 | Buildings posing a significant risk of collapse and a danger to the public. These buildings must be brought up to SPC 2 level by January 1, 2008 or be removed from acute care service. |
| SPC 2 | Buildings in compliance with the pre-1973 California Building Standards Code or other applicable standards, but not in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act. These buildings do not significantly jeopardize life, but may not be repairable or functional following strong ground motion. These buildings must be brought into compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act, its regulations, or its retrofit provisions by January 1, 2030. |
| SPC 3 | Buildings in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act, utilizing steel moment resisting frames in regions of high seismicity as defined in Section 7.2.10 and constructed under a permit issued prior to October 25, 1994. These buildings may experience structural damage which does not significantly jeopardize life, but may not be repairable or functional following strong ground motion. Buildings in this category will have been constructed or reconstructed under a building permit obtained through the OSHPD. These buildings may be used to January 1, 2030 and beyond. |
| SPC 4 | Buildings in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act, but may experience structural damage, which may inhibit ability to provide services to the public following strong ground motion. Buildings in this category will have been constructed or reconstructed under a building permit obtained through OSHPD. These buildings may be used to January 1, 2030 and beyond. |
| SPC 5 | Buildings in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act, and reasonably capable of providing services to the public following strong ground motion. Buildings in this category will have been constructed or reconstructed under a building permit obtained through the OSHPD. These buildings may be used without restriction to January 1, 2030 and beyond. |

# NONSTRUCTURAL PERFORMANCE CATEGORIES

| TIMEFRAMES | NONSTRUCTURAL PERFORMANCE CATEGORY | DESCRIPTION |
|---|---|---|
| | NPC 1 | Buildings with equipment and systems not meeting the bracing and anchorage requirements of any other NPC. |
| January 1, 2002 | NPC 2 | The following are braced or anchored in accordance with Part 2, Title 24:<br>♦ Communications systems;<br>♦ Emergency power supply;<br>♦ Bulk medical gas systems; and<br>♦ Fire Alarm Systems. |
| January 1, 2008 | NPC 3 | The building meets the criteria for NPC 2 and in Critical Care Areas, clinical laboratory service spaces, pharmaceutical services spaces, radiological service spaces, and central and sterile supply areas, the following components meet the bracing and anchorage requirements of Part 2, Title 24:<br>♦ Nonstructural components, listed in the 1995 CBC, Part 2, Title 24, Table 16A-O, Part 2; and<br>♦ Equipment, as listed in the 1995 CBC, Part 2, Title 24, Table 16A-O, "Equipment" including equipment in the physical plant that service these areas.<br>*Exceptions:*<br>1. Seismic restraints need not be provided for cable trays, conduit, and HVAC ducting. Seismic restraints may be omitted from piping systems, if an approved method of preventing release of the contents of the piping system in the event of a break is provided.<br>2. Only elevator(s) selected to provide service to patient, surgical, obstetrical, and ground floors during interruption of normal power need meet the structural requirements of Part 2, Title 24.<br>♦ Fire sprinkler systems comply with the bracing and anchorage requirements of NFPA 13, 1994 edition or subsequent applicable standards.<br><br>*Exception:* Acute care hospital facilities in both a rural area as defined by Section 70059.1, Division 5 of Title 22, and Seismic Zone 3 shall comply with the bracing and anchorage requirements of NFPA 13, 1994 edition or subsequent applicable standards by January 1, 2013. |
| | NPC 4 | The building meets the criteria for NPC 3 and all architectural, mechanical, electrical systems, components and equipment, and hospital equipment meet the bracing and anchorage requirements of Part 2, Title 24. This category is for classification purposes of the Office of Emergency Services. |
| January 1, 2030 | NPC 5 | The building meets the criteria for NPC 4 and on-site supplies of water and holding tanks for wastewater, sufficient for 72 hours emergency operations, are integrated into the building plumbing systems. As an alternative, hook-ups to allow for the use of transportable sources of water and sanitary wastewater disposal have been provided. An on-site emergency system, as defined in Part 3, Title 24, is incorporated into the building electrical system for critical care areas. Additionally, the system shall provide for radiological service and an on-site fuel supply for 72 hours of acute care operation. |

For each hospital building classified as SPC-1 on your campus(es), please provide the following information:

Name of Hospital _____

Name of person completing form _____

Phone _____ E-mail _____

1. Name of Building _____
2. How many licensed general acute care beds are currently in the building? _____
3. What was the average general acute care census in the building during 2005? _____
4. Approximately how many square feet are in the building? _____
5. Please check the following response which best pertains to the building:

    a. _____ Building has been or is in the process of being replaced with a hospital seismic compliant building (OSHPD project number _____).

    b. _____ Building has been or is in the process of being replaced with a non-hospital seismic compliant building (OSHPD Project Number if under OSHPD's jurisdiction _____).

    c. _____ Building has been or is in the process of being demolished but will not be replaced with another building. (Project number if under OSHPD"s jurisdiction _____).

    d. _____ Building has been or is in the process of being retrofitted to continue use as a general acute care hospital building (OSHPD project number_____).

    e. _____ Building has been or is in the process of being retrofitted but will not be used for general acute care hospital services. (OSHPD project number if under OSHPD's jurisdiction_____).

    f. _____ Building has been or is being converted to a non-general acute care building that doesn't require seismic retrofitting (OSHPD project number if under OSHPD's jurisdiction_____).

    g. _____ A decision has not yet been made on the building

    h. _____ Other (please specify)_____

6. Have you requested an extension to the 2008 deadline?

    a. _____ A request for an extension to meet the 2008 deadline by 2013 has been requested and granted by OSHPD.

    b. _____ A request for an extension to meet the 2008 deadline by 2013 has been requested but not granted by OSHPD to date.

    c. _____ A request for an extension to meet the 2008 deadline by 2013 will be submitted to OSHPD by January 1, 2007.

7. If you responded to question 5 by checking either a, b, c, d, e or f, please estimate what percent of the building project has been completed? _____%

## ITEM 4260 DEPARTMENT OF SERVICES – PUBLIC HEALTH

### ISSUE 9: WATER QUALITY MONITORING

Advocates are seeking an increase of $100,000 in the FY 2006-07 the Department of Health Services local assistance general funds to support Bay Area counties' water quality monitoring programs at Bay Area beaches. According to Save the Bay, the $100,000 is an estimate provided by county officials from Marin, San Francisco, San Mateo, Alameda, and Contra Costa. The county officials believed that $100,000 is the amount need to support public health monitoring of bayside beaches.

AB 1876 (Chan), was signed into law in 2004, it added San Francisco Bay beaches into the state's water quality monitoring program originally established for coastal beaches by AB 411 (Wayne) in 1997. The program requires county health departments to test for bacteria once a week from April to October at beaches, which have 50,000 or more annual users and are, located adjacent to a storm drain or other outfall. If bacteria levels pose a threat to public health, counties are required to post easy-to-understand signage advising residents of the risks.

Counties are required to monitor beaches only in years when the state provides funding from the Department of Health Services local assistance general fund. These state funds are committed to the counties in cycles of three-year contracts. The FY 2006-07 budget will be the first year of the next three-year cycle.

In FY 2005-06, the State provided $959,212 through the Department of Health Services local assistance general fund, which was distributed to coastal counties for water quality testing at beaches. The augmentation will provide the resources to accommodate the Bay Area counties' new beach water quality monitoring programs without negatively effecting existing monitoring programs in coastal counties.

Prior to AB 1876, Bay Area counties had been ineligible for state funding for water quality monitoring at beaches. Some local county health departments did use their own general funds to do some monitoring because of the need to protect the public health. State funding for this important program will relieve county funds for other important health programs and bring the Bay Area to equal funding with coastal counties.

Benefits of water quality monitoring:

1. Public health and safety standards

    - Human sewage and urban runoff contribute bacteria to beach waters, which is a known health risk to people who have direct water contact, especially children.

    - Water quality testing provides a safety net against the worst public health dangers to people who recreate in the Bay.

    - Residents have a right to know if the water poses a threat to their health, and testing/signage programs allow them to make informed choices.

2. Long-term improved water quality and better Bay health

   - Only consistent, long-term monitoring data can identify chronic contamination "hot spots." State funds for source investigation and infrastructure fixes, such as the Clean Beaches Initiative, are available for documented issues only.

   - Most Bay Area water quality was not documented until 2005 when all counties began to submit data to the State Beach Watch database.