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

Assemblymember Judy Chu, Chair

MONDAY, APRIL 28, 2003
STATE CAPITOL, ROOM 444
4:00 PM

ITEMS TO BE HEARD

ITEM 4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: GENERAL FUND BACKFILL – FINANCE LETTER

BACKGROUND:

The Finance Letter would shift $220.0 million of the program funding to the General Fund. The budget had proposed using $220.0 million from the Tobacco Settlement Fund bond financing. The bond has not been sold and an alternative to funding the program was needed. Therefore, the Finance Letter proposes to utilize General Fund for the program.

The Managed Risk Medical Insurance Board (MRMIB) projects the enrollment in Healthy Families will be 768,232 as of June 30, 2004. The enrollment projected for June 30, 2003 is 668,517, a gain of 99,715 children enrolled in the Healthy Families Program.

COMMENTS:

Managed Risk Medical Insurance Board, please provide the Subcommittee with an overview of the growth of Healthy Families from the current year through the budget year.

No issues have been raised.

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ISSUE 2: ACCESS FOR INFANTS AND MOTHERS (AIM)

BACKGROUND:

The budget proposes to enroll Access for Infants and Mothers (AIM) infants into the Healthy Families Program at birth while continuing to provide women eligible for the AIM program comprehensive prenatal and postpartum care (see trailer bill and MRMIB graphic handout). There are several benefits to the proposal. First, enrolling the infants into the Healthy Families Program would reduce health plan costs, as California Children Services (CCS) are available in the Healthy Families Program. Additionally, health plans would charge lower rates if the infants were covered in the Healthy Families Program because the plans could spread the risk over a larger population in Healthy Families than in AIM. Also, it allows the state to utilize the federal funding in the Healthy Families Program for the declining funding under Proposition 99. Finally, it will provide the infants with two years of Healthy Families Program coverage.

AIM was established in 1991 to cover perinatal health care for women and infants in low- to moderate-income families who do not qualify for Medi-Cal. Funding for the program has been Proposition 99, the 25 cent-per-pack cigarette tax increase adopted on the 1988 ballot. The program covers women in families between 200 percent and 300 percent of the Federal Poverty Level. AIM provides comprehensive health coverage for women during pregnancy, delivery and for 60 days postpartum. Infants born to women in the AIM program receive comprehensive health coverage up to their second birthday. The cost to the subscriber is 2 percent of family income plus $100 for coverage of the baby from 1 to 2 years of age. Since inception, the program has covered over 53,000 women and 47,000 babies.

To address the issues of declining Proposition 99 revenues, the increasing demands for the funds and the growth in AIM, MRMIB is proposing to enroll infants born to women enrolled in the AIM program directly into the Healthy Families Program. Infants in families with incomes between 200 percent and 250 percent of the Federal Poverty Level would be funded by the state's General Fund and federal State Children Health Insurance Program (SCHIP) funds. Infants in families with income between 250 percent and 300 percent of the Federal Poverty Level would be covered by 100 percent state funds. To further enhance federal funds, California submitted a State Plan Amendment (SPA) on March 31, 2003 to expand its Healthy Families Program to cover all infants between 0-2 up to 300 percent of the Federal Poverty Level. The SPA would allow the state to receive federal SCHIP funding for these infants in the Healthy Families Program as well as the CCS program.

The cost/savings estimate for the proposal will be updated as part of the May Revision. The update will include the additional cost in the CCS program resulting from the influx of AIM infants into the HEALTHY FAMILIES PROGRAM. Other revisions to the estimate will be based on updated AIM caseload and rate projections and the potential availability of federal SCHIP funds for infants from 250 to 300 percent Federal Poverty Level. Because of the change in the implementation date, no cost/savings will occur in AIM, Healthy Families Program, and CCS until FY 2004-05 and will take several years to be fully implemented.

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COMMENTS:

Managed Risk Medical Insurance Board, please provide the Subcommittee with an overview of the incorporation of AIM infants into the Healthy Families Program and the advantages it provides the state.

Managed Risk Medical Insurance Board, please review the proposed Trailer Bill Language for the Subcommittee. Are any amendments to the language necessary?

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ISSUE 3: RURAL HEALTH DEMONSTRATION PROJECTS

BACKGROUND:

The statute authorizing the Rural Health Demonstrations Projects (RHDPs) expires June 30, 2003. The projects included in the 2002-2003 budget are proposed to be the last.

Up to five RHDPs were authorized in the enabling legislation for the Healthy Families Program (Assembly Bill 1126, Dutton, Chapter 623, Statutes of 1997). The purpose of the demonstration projects is to fund rural collaborative health care networks to alleviate unique access problems to health, dental and vision care in areas with significant numbers of uninsured children.

The State of California adopted three strategies for implementing the RHDPs. Each strategy comprises one of the five RHDPs authorized by the legislation. The three strategies that have been implemented are:
Geographic Access: Projects designed to address the lack of health care services in rural geographic areas of California.
Special Populations: Projects designed to address unique access problems of special populations (children of migrant and seasonal farm workers, fishing and forestry workers, and American Indians).
Infrastructure: Projects designed to address the development or enhancement of infrastructure in rural areas where health care services are not accessible.

The Managed Risk Medical Insurance Board (MRMIB) has administrative responsibility for the implementation of the ***Geographic Access*** and ***Special Populations*** project strategies. The California Department of Health Services (DHS) has administrative responsibility for the ***Infrastructure*** strategy.

To be eligible for **Geographic Access** project funding, a project proposal must demonstrate:
• An area's need for additional services as identified by the unique access barriers;
• The potential number of eligible children, and the current HEALTHY FAMILIES PROGRAM network (including traditional and safety net providers as defined by the MRMIB) available to subscribers in the area;
• A proposed project's potential for increasing the plan's provider network. New providers to the health plan's network receive special consideration; and
• Cost-effectiveness of a proposal, including administrative overhead costs.

To be eligible for **Special Populations** project funding, a project proposal must demonstrate:
• Methodology for addressing the unique access needs of one or more identified special populations and the extent to which the proposal is designed to reduce health disparities among children in the target special populations;
• The plan's proposed network of providers, including other facilities available to special populations and/or additions to the plan's network;
• The inclusion of providers that have experience serving the specific target populations; and
• Cost-effectiveness of the project, including the amount of funding used for administrative overhead and direct services.

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The RHDP is comprised of individual projects administered by health, dental, or vision plans. Plans administer these projects consistent with the contractual arrangements between plans and the MRMIB. Clinics or other health care providers willing to partner with the Healthy Families Program participating plans must submit proposals to MRMIB through the participating plans. All health, dental, and vision plans participating in the Healthy Families Program are eligible to participate in the RHDP. Since fiscal year 1998-99, six health plans and three dental plans have participated in the RHDP.

Through March 2002, 238 projects have been funded through the Healthy Families Program Rural Health Demonstration Project. The individual projects are grouped into six major categories: (1) Extended Provider Hours, (2) Mobile Dental and Health Vans, (3) Increase Available Providers, (4) Rate Enhancements, (5) Portability of Coverage, and (6) Telemedicine.

COMMENTS:

Managed Risk Medical Insurance Board, please briefly review for the Subcommittee the history of the program and the ongoing benefits that have resulted from it.

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ISSUE 4: ORAL HEALTH DEMONSTRATION PROJECT – FINANCE LETTER

BACKGROUND:

The Children and Families Commission has provided a three-year $3.0 million grant to the Managed Risk Medical Insurance Board (MRMIB) to implement an oral health demonstration project. MRMIB will try to match the Commission funds with Federal State Children's Health Insurance funds for each year of the project. The plan is to increase the utilization of preventive dental techniques among children who are 5 years old and younger. The grant provides for one three-year limited term position to administer the project.

COMMENTS:

Managed Risk Medical Insurance Board, please provide an overview of the project to the Subcommittee.

No issues have been raised.

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ISSUE 5: IMPLEMENT COUNTY HEALTH INITIATIVE MATCHING FUND – FINANCE LETTER

BACKGROUND:

AB 495 (Diaz), Chapter 648, Statutes of 2001 established the Children's Health Initiative Matching Fund Program to be administered by the Managed Risk Medical Insurance Board (MRMIB). The program would match county or local public agency funds with unused federal State Children's Health Insurance Program funds to provide health care to children in families who do not have private health insurance and have incomes between 250 and 300 percent of the Federal Poverty Level. The name of the program would be changed to the County Health Initiative Matching Fund (CHIMF) program. The budget would provide $153.6 million in the budget year for the program.

In addition, the Finance Letter language would authorize the transfer of funds between MRMIB's support and local assistance items for the effective administration of the program. Also, language would be added to ensure federal State Children's Health Insurance Program funds are available for the CHIMF program to the extent the funds are not needed for other state-funded health insurance programs, Healthy Families, Medi-Cal and Access for Infants and Mothers. Finally, the Department of Finance would be authorized to establish positions to allow the MRMIB to effectively administer the CHIMF program.

The counties most ready to begin the program are: Santa Clara; Alameda; San Mateo; and San Francisco.

COMMENTS:

Managed Risk Medical Insurance Board, please provide an overview of the initiative to the Subcommittee.

Managed Risk Medical Insurance Board, when do you think the counties will begin to take advantage of the program and where might we first expect the program to begin?

No issues have been raised.

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ISSUE 1: TEENSMART OUTREACH PROGRAM

BACKGROUND:

The budget proposes to eliminate the Office of Family Planning TeenSMART Outreach Program in the Family PACT (Planning, Access, Care and Treatment) Program. The elimination will result in no community-based prevention education program for adolescents. The elimination would provide $848,000 in General Fund savings.

TeenSMART Outreach targets adolescents at risk for pregnancy or causing pregnancy, including those who may already be parenting, are homeless, in foster care, victims of abuse, and/or school dropouts. The purpose of the TeenSMART Outreach Program is to help adolescents make and sustain "smart" decisions related to their sexual behavior and use of family planning reproductive health services including contraception. Intensive educational sessions are provided either individually, or in group settings, to ensure pregnancy prevention messages are given to teens. The information helps teens make decisions about their sexual behavior and to prevent pregnancies.

COMMENTS:

Department of Health Services, please provide an overview of the TeenSMART Outreach Program. With how many agencies does the Department contract? How many clients are served in total and how many new clients are added annually?

How will the affected population access the information if the program is eliminated?

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ISSUE 2: INFORMATION AND EDUCATION PROJECTS

BACKGROUND:

The budget proposes to save $1.741 million General Fund in the budget year from a 50 percent reduction of funds for Information and Education Projects of Family PACT (Planning, Access, Care and Treatment). The reduction is part of the Administration's effort to reduce or eliminate outreach efforts throughout all state programs.

The Information and Education projects have been in place for 30 years. The goal of the projects is to decrease teen and unintended pregnancy through prevention education. The projects are designed to equip Californians at high risk of unintended pregnancy with knowledge, attitudes, and behavioral skills necessary to make responsible decisions. Target populations include youths in grades 6-12, as well as parents and other adults responsible for serving youth at risk. Services are provided in partnership with school, juvenile justice facilities, churches, social service and youth agencies and foster care settings.

COMMENTS:

Department of Health Services, please provide an overview of the Information and Education projects.

Department of Health Services, with how many community agencies does DHS contract? How many people does the program serve? What is the demographic profile of those people served?

How will the affected population access the information if the program is cut in half?

How would the proposed funding reduction be allocated amongst the projects? Why?

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ISSUE 3: TEEN PREGNANCY PREVENTION MEDIA CAMPAIGN

BACKGROUND:

The budget proposes to eliminate Teen Pregnancy Prevention Media Campaign for budgetary savings of $7.817 million General Fund in the budget year.

Using research as a foundation, the Teen Pregnancy Prevention Media Campaign uses the power of mass media to tailor culturally sensitive messages, in six languages, to reach the state's high-risk populations. Through the use of proactive messages aimed at teens, parents, young men and the general public, the Teen Pregnancy Prevention Media campaign produces ethnically diverse mass media messages for the millions of the state's residents. Since the launch of the Media Campaign with the theme "It's Up To Me" in 2000, nearly 35,000 commercials have appeared on television, 62,000 ads have aired on the radio and 28,000 print pieces have appeared in malls, on lunch trucks, on billboards and in newspapers throughout the state.

Public relations activities, involving grassroots community agencies, complement the advertising effort throughout California. The "It's Up To Me" media campaign has proven to be an extremely effective way to deliver proactive messages of teen pregnancy: providing information and access to contraceptive services for low-income men, women and teens through promotion of the Family PACT program; delivering messages of male responsibility; assisting teens with information to make "smart" choices; and by encouraging adults to talk to their teens about sex and peer pressure.

COMMENTS:

Department of Health Services, please provide an overview of the Teen Pregnancy Media Campaign for the last few years. What percentage of the state's population has been reached? How many advertising impressions have been achieved? (Advertising impressions are the total number of times a member of the media message target audience is exposed to an advertisement.)

How will the affected population access the information if the program is almost eliminated?

Department of Health Services, what has been the effect of the campaign on the reduction of teen pregnancies?

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ISSUE 4: GYNECOLOGICAL CANCER INFORMATION

BACKGROUND:

The Gynecological Cancer Information Program was established to increase awareness and education regarding gynecological cancers. The budget proposed to save $150,000 General Fund in the Budget Year through the elimination of the program. The Program was established by AB 833 (Ortiz) Chapter 754, Statutes of 1997. The statute requires medical providers to provide information to their patients on gynecological cancers, including signs and symptoms. The material must be presented in a standardized summary in a layperson's language that can be understood by patients at the time of patients' annual gynecological examination. The program produces and distributes patient education materials to health care providers to assist them comply with the statutory mandate to provide the materials

The Administration eliminated the $150,000 in the Section 3.90 process of the Mid-Year reduction. Under Section 3.90 of Chapter 1023, Statutes of 2002 (a trailer bill to the Budget Act of 2002), authority was provided to the Administration to reduce state support expenditures by up to 5 percent. The Department of Health Services was given a target amount to reduce and the Department identified the $150,000 for Gynecologic Cancer Information for reduction. The reduction was taken in mid-February when the State Controller chose to implement all Section 3.90 reductions.

Through a nationwide class action settlement agreement (State of Florida, et al., versus Nine West Group, Inc.), California received $2.9 million in funds (one-time dollars for expenditure through 2006**)** for several programs, including law enforcement, domestic violence shelters, breast cancer and gynecological cancer information.

Of the amount the Department of Health Services received, $500,000 was identified for expenditure for Gynecologic Cancer Information. The settlement also provides that any unspent settlement funds, as well as interest, shall be directed to the Gynecologic Cancer Information program for use. About $62,000 in interest has been earned and $130,000 in unexpended funds is available. The Senate proposed using the $192,000 to reinstate the program.

COMMENTS:

Department of Health Services, please provide the Subcommittee with an overview of the Nine West Settlement Agreement. To what purposes can the remaining funds be put?

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ISSUE 5: UNSERVED/UNDERSERVED DOMESTIC VIOLENCE PROGRAM

BACKGROUND:

The budget proposal would reduce funding to the Unserved/Underserved Domestic Violence Program by $1.25 million General Fund, a 50 percent reduction. The program is the only source of funding to provide services to populations not accessing domestic violence services, women of color and teens. The populations served by the funding do not access domestic violence services for many reasons related to the nature of domestic violence and how relationships differ among different groups. The Department of Health Services works with local shelters to provide services in a unique manner so that the affected population may access these services. The programs are cooperative arrangements between battered women's shelters that have expertise and services available to victims of domestic violence and non-profit organizations and governmental entities who have access to, experience with and understanding of the cultural norms, language needs and barriers to seeking help in this population. The Unserved/Underserved component of the program was established in a legislative budget augmentation in FY 1999-2000.

There are currently 15 contractors in the Unserved/Underserved program. Reducing the allocation to the Unserved/Underserved by 50 percent would require seven or eight of the contracts to be canceled. According to the Department of Health Services, a 50 percent reduction to each of the 15 contractors would cause all of the programs to close because they could not sustain themselves on the diminished funding level.

The Domestic Violence Advisory Council recommends the Technical Assistance and Training Contracts be reduced from 10 to one for a one-year period to provide funding for the Unserved/Underserved Domestic Violence Program (see handout for contract listing). Statute requires keeping the statewide Technical Assistance and Training Contract. The reduction from 10 to one contract will save $1.39 million, freeing up enough to retain the Unserved/Underserved Program. The Domestic Violence Advisory Council recommends the remaining funds should go directly to shelters to provide their technical assistance in a manner that meets their individual needs.

COMMENTS:

Department of Health Services, please provide a brief overview of the Unserved/Underserved Domestic Violence Program.

How will the affected population access services if the program is reduced?

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How is the program different from outreach programs generally?

Department of Health Services, what would be the effect of a 50 percent funding reduction be on the programs?

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ISSUE 6: OFFICE OF AIDS

BACKGROUND:

Three issues in the Office of AIDS budget are at issue. They are: imposition of a co-payment that would be required of ADAP beneficiaries; elimination of education funding reduction in the HIV Education and Prevention Services Branch; and suspension of eligibility determinations to limit enrollment when the Department of Health Services determines there is inadequate funding for an increased enrollment.

Issue 1. Budget trailer bill language would grant the Department the authority to suspend eligibility determinations to limit enrollment in the program when it has concluded that there will be insufficient funds in the program to provide necessary drugs to existing eligible clients for the remainder of the fiscal year. The growth in caseload, from 1000 to 2000 per year, and the costs of new drugs are driving the costs of the program up significantly. New drugs, such as Fuseon, can cost as much as $16,000 to $18,000 per year. It is estimated the program costs would increase in the budget year by $25 million. An additional step the Department will be taking to control the growth of the costs of the program is the removal of drugs from the formulary, primarily those that address the side effects of other drugs.

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Issue 2. For FY 2003-04 the major changes to the Office of AIDS budget are included in the following Department of Health Services Table.

FY 2003-04 Proposed Funding Adjustments	Fund Source	Comments
+$8,303,000	General Fund	Increases ADAP's base augmentation; may be partially offset by additional Federal Funds
-$8,000,000	General Fund	Budget reduction offset by one-time excess drug rebates
+$8,000,000	Reimbursements	Excess drug rebates; one-time increase to offset the FY 2004-05 General Fund reduction
+$1,240,000	Reimbursements	Increases ADAP's Reimbursement authority to expend additional drug rebates collected
-$7,205,000	General Fund	Reduces ADAP's GENERAL FUND base; offset by additional co-payments collected from ADAP beneficiaries
$2,338,000		**SUBTOTAL ADAP ADJUSTMENT**
-$1,254,000	General Fund	Reduces HIV Education and Prevention Services Branch budget
$1,084,000		**TOTAL OFFICE OF AIDS**

The AIDS Drug Assistance Program is proposed to increase to $186.383 million ($60.541 million General Fund, $92.641 million Federal Fund and $33.201 million Reimbursements) in FY 2003-04. For 2002-2003 the funding for ADAP is $184.045 million ($67.443 million General Fund, $92.641 million Federal Fund and $23.961 million Reimbursements). The funding for the ADAP program includes the substitution of additional drug manufacturer rebates for General Fund. Also, the funding total includes $7.205 million from the imposition of a co-payment for the ADAP program.

ADAP is the program of last resort. To qualify for the program an individual must demonstrate that no other health care coverage is available. Currently, co-payments are required for those people that have incomes above 400 percent of the Federal Poverty Level. The payment obligation is the lesser of two times a person's annual income tax liability, less funds expended by the person for health insurance, and the cost of the drugs. The budget trailer bill would amend that and require co-payments of $35 for each prescription for those with incomes between 200 percent and 300 percent of the Federal Poverty Level. For those with incomes

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between 300 percent and 400 percent of the Federal Poverty Level the co-payments would be $45 prescription. For those with incomes above 400 percent of the Federal Poverty Level, the co-payment for each prescription would be $50. On average an individual would be on five or six prescriptions per month that are covered the program, plus others that are not.

AIDS CO-PAY CHART

Percentage Poverty Level	Dollars Poverty Level (2003 Fed. Pov. Level, Single Person)	Estimated Annual Co-Pay	Percentage of Income (Minimum of Range)	Percentage of Income (Maximum of Range)
100% or less	0-$8,980			
101%-200%	$890-$17,960			
201%-300%	$17,960-$26,940	$1,026	5.7%	3.8%
301%-400%	$26,940-$35,920	$1,588	5.9%	4.4%
401% or more	$35,920 or more			

Prepared by Department of Finance

Issue 3. The HIV Education and Prevention Services' Program is budgeted in FY 2003-04 at $37.2 million, a $1.245 million General Fund Reduction from FY 2002-03. This reduction affects education and prevention activities, including funding for legislatively mandated public school HIV education ($1.020 million), federally required evaluation of local intervention activities ($150,000), studies of risk behaviors for gay men who have sex with men ($50,000), and HIV related training for clinical staff who work with inmates in correctional facilities ($34,000). The State Superintendent of Instruction, Jack O'Connell, has written to express his concern over the elimination of school-based HIV/AIDS prevention education, which has for many years been contracted to the California Department of Education. The Superintendent notes that this is the only program that targets students in school (See handout for a brief description of several programs that have been implemented with the funds of the Office of AIDS).

COMMENTS:

Department of Health Services, please outline for the Subcommittee the co-payment proposal. What will be the effect of the proposal on access to the medications?

Department of Health Services, please outline for the Subcommittee what is happening at the national level with respect to supplemental rebates. What is your assessment of California's chances of receiving additional rebates?

Department of Health Services, please outline for the Subcommittee what the state will be foregoing with the elimination of the education funding.

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Department of Health Services, please provide the Subcommittee with an overview of the mandated public school HIV education program.

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ISSUE 7: DRUG PRICING

BACKGROUND:

The cost of acquisition of pharmaceuticals for AIDS patients has acquired a particular poignancy in the budget climate of the state. Large deficits in successive years are causing the search for less expensive alternatives in conducting the business of the state. With co-payments, a cap on enrollment and elimination of education programs being proposed in the Office of AIDS programs, measures to control costs or raise revenue to mitigate if not eliminate the proposed programmatic reductions are being considered. Specifically, in the AIDS program, reducing pharmaceutical costs may have an important bearing on mitigating the proposed budget reductions.

Questions arise:

- What is the state doing to reduce drug prices; what obstacles has the state encountered in reducing drug prices; which of the obstacles have been overcome; and which have proven to be intractable? Have resource problems been a problem in resolving the obstacles and achieving savings?
- To what extent can utilization controls lead to reduce costs?
- What are the differences between Medi-Cal contracting and ADAP contracting with pharmaceutical manufacturers? Are there lessons to be learned and tools to be imported?
- Does the state pay more for drugs than branches of the federal government; should the state pay no more than what the federal government pays for pharmaceuticals in the state?

COMMENTS:

Department of Health Services, please respond to the above questions.

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ISSUE 8: PC-SPES

BACKGROUND:

PC-SPES was a commercial product that could be used in the treatment of Prostate Cancer. In February 2002, a laboratory analysis of PC-SPES capsules by Department of Health Services found the product contained warfarin, a synthetic blood thinner that is available by prescription. The cause of the contamination was never established. In June 2002, the manufacturer of the compound closed and ceased operations. The product was used by 10,000 men on a routine basis before it was withdrawn from the market.

Under the proposed trailer bill language, the Department of Health Services would be required to allow the distribution, sale and use of any product that contains the contaminant free formula of ingredients contained in PC-SPES. Additionally, the product only would be available for use if prescribed by a physician and surgeon, and the prescribing physician: explains to the patient the potential benefit of using the product; discloses to the patient the risks, complications, and other side effects of using the product; and discloses to the patient alternatives to the product, if any, including procedures, drugs or devises, along with their potential benefits, risks and complications.

COMMENTS:

Department of Health Services, please provide an update on the status of PC-SPES.

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ISSUE 9: OFFICE OF WATER QUALITY

BACKGROUND:

An Office of Water Quality would be created in the Department of Health Services. The Board would have responsibility for all water quality control issues of the Department of Health Services. All current water quality control staff of the Department would be transferred to the Office and report to the Board. On the advice of staff, the Board would make all decisions with respect to water quality issues raised by water districts and the public. All initial decisions of the Board could be appealed. The appeal to the Board would be to review its decision. The Board would have to review the appeals and issue a written statement with its decision and the reasoning for such conclusion.

The Office would be governed by a Board appointed by the Governor, the Speaker of the Assembly and the President Pro Temp of the Senate. The Governor would appoint three members of the Board and the Chairperson. The Speaker would appoint one and the President Pro Temp would appoint one. One member of the Board would be appointed from a large water district, one from a medium sized district and one from a small district. In addition one member would be an environmentalist and the other would be a person with a water quality background.

COMMENTS:

Department of Health Services, please outline for the Subcommittee how water quality control decisions are made and how issues between water districts, the public and water control decision making are resolved.

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ISSUE 10: PROPOSITION 50 POSITIONS – FINANCE LETTER

BACKGROUND:

The Finance Letter authorizes 15.5 positions for the Drinking Water Program on a three-year limited-term basis. The positions would facilitate the provision of safe drinking water grants and loans to approximately 8,500 local water agencies. These grants and loans are issued pursuant to Chapters 3 and 4 of the Proposition 50 Water Security, Clean Drinking Water, Coastal, and Beach Protection Act of 2002. The Finance letter would make a technical change in the amount proposed in the Governor's Budget. It also would reflect a shift of funding from State Operations to Local Assistance in the Safe Drinking Water Revolving Fund.

COMMENTS:

Department of Health Services, please provide an overview of how the 15.5 positions will be allocated between Chapters 3 and 4 activities of the water bond.

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ISSUE 11: LUNG DISEASE AND ASTHMA RESEARCH PASS-THROUGH – FINANCE LETTER

BACKGROUND:

AB 2127 (Matthews), Chapter 620, Statutes of 2002 reinstate a personal income tax check-off to fund asthma and lung disease research. The check-off funds are distributed by the Department of Health Services directly to the American Lung Association of California. The Association funds asthma research with the funds.

The check-off collected $183,000 in voluntary contributions in 2001, and was discontinued. It was required to achieve $250,000 dollars in contributions in order to stay on the tax form. Therefore, the request only is for the budget year.

COMMENTS:

No issues have been raised.

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ISSUE 12: ELECTRONIC DEATH REGISTRATION SYSTEM – FINANCE LETTER

BACKGROUND:

The Finance Letter proposes to increase the amount paid from the Health Statistics Special Fund to the General Fund by $2.025 million. The funding reflects the first year of a two-year development effort. The purpose of the expenditure is to develop and implement an Electronic Death Registration System. The system is projected to be operational by January 2005, as required by AB 2550 (Nation), Chapter 857, Statutes of 2002.

COMMENTS:

No issues have been raised with the Finance Letter.

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ISSUE 13: RICHMOND LABORATORY FACILITIES – FINANCE LETTER

BACKGROUND:

The Finance Letter would re-appropriate the Phase II construction funding for the replacement laboratory facilities at Richmond. The re-appropriation of the unencumbered balance of construction funds is necessary for the reason that a delay occurred in finishing construction of the project.

COMMENTS:

No issues have raised with the Finance Letter.

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ISSUE 14: CLINIC CONTRACTING LANGUAGE

BACKGROUND:

The California Primary Care Association (CPCA) has requested trailer bill language be adopted to permit contracts for a minimum of three years for the Rural Health Service Development Program (RHSD) and the Seasonal, Agriculture and Migratory Worker Program (SAMW).

The two programs are at the end of statutory three-year funding cycle and new contracts need to be executed for the programs. The Request For Application (RFA) will be processed by the Primary and Rural Health Branch of the Department of Health Services in the May-to-June time frame. Once the RFAs are processed, the information will be transferred to the DHS contract departments. Execution of the contracts will take up to six months, completed sometime in November and December. Therefore, the clinics will receive funding under their new contracts well after the current contracts have concluded, placing them in harm's way financially.

The issue arose because the Department was required to develop the Administration's Realignment proposal. After the proposal was developed, the Department commenced work on the RFA and will soon release it.

CPCA proposes the authorizing statute be amended to permit contracts for a minimum of three years. This would permit the Department of Health Services to continue the existing contract so the clinics do not suffer from a lapse of funding that is related to the timing of signing clinic contracts.

The handout contains the proposed language.

COMMENTS:

Department of Health Services, please provide the Subcommittee with an update on the contractual process and where the Department is in the process. Is it likely the Department will be able to finish the contracts sooner than the November/December time frame?

Should the same contract extension be extended to the Indian Health Program and the Essential Access to Primary Care Program?