AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

MONDAY, APRIL 11, 2016

2:30 P.M. - STATE CAPITOL, ROOM 127

ITEMS TO BE HEARD

ITEMS TO BE HEARD

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: DEPARTMENT OVERVIEW

PANELISTS

- **Karen Smith**, MD, MPH, Director and State Public Health Officer, Department of Public Health
- **Barbara Taylor**, Principal Program Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

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

DPH Budget

The Governor's proposed 2016-17 budget provides the Department of Public Health (DPH) approximately $2.9 billion overall, representing a $12 million (total funds), or 0.4 percent, decrease from the current year DPH budget. General Fund dollars of $130 million make up just 4.4 percent of the department's total budget while federal funds make up approximately 57 percent of the total department budget.

DEPARTMENT OF PUBLIC HEALTH
(Dollars In Thousands)

Fund Source	2014-15 Actual	2015-16 Projected	2016-17 Proposed	CY to BY $ Change	CY to BY % Change
General Fund	**$117,668**	**$129,352**	**130,170**	**818**	**0.6%**
Federal Funds	$1,594,040	$1,755,820	$1,685,024	($70,796)	-4.0%
Special Funds & Reimbursements	$365,885	$441,673	$431,724	($9,949)	-2.3%
Licensing & Certification	$87,589	$133,045	$143,517	$10,472	7.9%
Genetic Disease Testing Fund	$111,289	$114,485	$118,488	$4,003	3.5%
WIC Manufacturer Rebate Fund	$227,711	$221,369	$216,740	($4,629)	-2.1%
AIDS Drug Assistance Program Rebate Fund	$212,106	$179,704	$237,887	$58,183	32.4%
Total Expenditures	**$2,716,288**	**$2,975,448**	**$2,963,550**	**($11,898)**	**-0.4%**
Positions	3,271.1	3,377.1	3,452.2	75.1	2.2%

The following table shows the proposed expenditures by program area:

DPH Program Expenditures (In Thousands)			
Program	**2014-15 Actual**	**2015-16 Estimate**	**2016-17 Proposed**
Emergency Preparedness	$82,309	$113,959	$72,307
Chronic Disease Prevention & Health Promotion	264,870	341,553	306,725
Infectious Disease	517,415	528,001	525,564
Family Health	1,529,298	1,590,575	1,651,042
Health Statistics & Informatics	26,074	28,203	28,195
County Health Services	7,299	15,112	4,101
Environmental Health	86,608	93,545	98,055
Health Facilities	190,658	251,045	264,154
Laboratory Field Services	11,758	13,456	13,408
Total Expenditures	**$2,716,288**	**$2,975,448**	**$2,963,550**

BACKGROUND

The overall structure of DPH is as follows:

Department Director / State Public Health Officer

- Civil Rights
- California Conference of Local Health Officers
- Office of Health Equity
- Office of Quality Performance and Accreditation
- Administration and Public Affairs
- Center for Health Statistics and Informatics
- Emergency Preparedness Office
- Office of the State Public Health Laboratory Directors

Policy and Programs

- Emergency Preparedness Office
- Center for Health Statistics and Informatics
- Legislative and Governmental Affairs
- Office of State Laboratory Director
- Laboratory Field Services

Center for Chronic Disease Prevention and Health Promotion

- Chronic Disease and Injury Control
- Environmental and Occupational Disease Control
- Office of Problem Gambling

Center for Environmental Health

- Environmental Management
- Food, Drug, and Radiation Safety

Center for Family Health

- Family Planning
- Genetic Disease Screening Program
- Maternal, Child, and Adolescent Health
- Women, Infants, and Children

Center for Health Care Quality

- Healthcare Association Infections Program
- Licensing and Certification

Center for Infectious Diseases

- AIDS
- Communicable Disease Control
- Binational Border Health
- Office of Refugee Health

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to provide an overview of the department and its proposed budget, and to respond to the following:

1. Please explain how the department sets public health priorities for the state.

2. What are or should be the state's public health priorities in 2016?

Staff Recommendation: This is an informational item and no action is necessary.

ISSUE 2: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

PANELISTS

- **Connie Mitchell**, Deputy Director, Center for Family Health, DPH
- **Leslie Gaffney**, Assistant Deputy Director, Center for Family Health, DPH
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

GDSP BUDGET

The Genetic Disease Screening Program (GDSP) consists of two programs - the Prenatal Screening Program and the Newborn Screening Program. Both screening programs provide public education, and laboratory and diagnostic clinical services through contracts with private vendors meeting state standards. Authorized follow-up services are also provided to patients. The programs are self-supporting on fees collected from screening participants through the hospital of birth, third party payers, or private parties using a special fund - Genetic Disease Testing Fund.

The total GDSP proposed 2016-17 budget is $92.2 million, a $7 million increase (8.2%) over the current year (2015-16) budget of $84.1 million. Of the proposed $92.2 million, $13.4 million is for state operations while $78.8 million is proposed for local assistance. The 8.2 percent increase in the program budget primarily reflects the implementation of screening for adrenoleukodystrophy (ALD), required through AB 1559 (Pan, Chapter 565, Statutes of 2014), which is described in more detail below. The decrease in expenditures between the 2015 Budget Act and the current year November estimate reflects fluctuating caseload, according to DPH.

Genetic Disease Screening Program Budget

	2015 Budget Act	2015-16 Estimate	2016-17 Proposed
PNS Local Assistance	$39,975,652	$35,724,295	$36,002,304
NBS Local Assistance	$36,357,366	$36,039,031	$42,769,479
State Operations	$13,379,000	$13,379,000	$13,379,000
TOTAL	**$89,712,018**	**$85,142,327**	**$92,150,783**

BACKGROUND

Prenatal Screening Program (PNS). This program screens pregnant women who consent to screening for serious birth defects. The fee paid for this screening is about $207. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. There are three types of screening tests for pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of

test used is contingent upon the trimester. Women who are at high risk based on the screening test results are referred for follow-up services at state-approved "Prenatal Diagnosis Centers." Services offered at these Centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

Newborn Screening Program (NBS). This program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is $111.70 (and is proposed to be increased to $122.70 in this budget, as described below). Where applicable, this fee is paid by prepaid health plans and insurance companies. Medi-Cal also covers the fee for its enrollees. The NBS screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment that mitigates more severe health problems. Informational materials are provided to parents, hospitals and other health care entities regarding the program and the relevant conditions, and referral information is provided where applicable.

Medi-Cal Reimbursement Rate

According to DPH, DHCS applied the 10 percent Medi-Cal provider rate reduction contained in AB 97 (Committee on Budget, Statutes of 2011), to the GDSP consistent with applying AB 97 to lab rates in general. As a result, the GDSP has received a 10 percent rate reduction for GDSP participants enrolled in Medi-Cal. However, DPH has negotiated a change to this policy with DHCS, which will end this reduction and provide the GDSP with a refund. The following describes recent Medi-Cal rate reductions in recent years that have had an impact on this program:

TIME PERIOD	REDUCTION
July 2008 – February 2009	10% reduction (AB X3 5)
March 2009 – December 2011	Prior 10% reduced to 1% reduction
January 2012 – November 2013	10% reduction to lab services (AB 97)
December 2013 -	No reduction and GDSP expects a refund for June 2011 to November 2013

AB 1559 Newborn Screening 2015 Budget Change Proposal

Last year DPH requested, and the 2015 Budget Act includes, 1.0 permanent position and $1.975 million Genetic Disease Testing Fund in 2015-16. Of this request, $1.825 would be one-time funding to upgrade the computer system and $150,000 would be ongoing. DPH requested these resources to comply with AB 1559 (Pan, Chapter 565, Statutes of 2014) which expands the NBS Program to include screening for adrenoleukodystrophy (ALD) as soon as ALD is added to the federal Recommended Uniform Screening Panel (RUSP), which occurred earlier this year.

The NBS is fully supported by fees, paid by insurance or individual patients, and therefore DPH proposes to raise the fee in order to cover the costs of this proposal. DPH proposes to raise the fee by $11.00 for a total fee of $122.70 beginning July 2016. DPH states that the new funding will cover the costs of: upgrading the Screening Information System, processing blood specimens, performing blood screens, testing

chemicals, equipment and supplies used to assay results, and follow-up costs for screen positive cases, including case management, diagnostic work-up, confirmatory processing, provider and family education, and informative result mailers.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the GDSP estimate and respond to the following:

Please describe the proposed newborn screening fee increase proposal. Who pays the fee? Has anyone raised concerns or opposition to the fee increase?

Staff Recommendation: Staff recommends holding open the GDSP estimate.

ISSUE 3: WOMEN INFANTS & CHILDREN (WIC) PROGRAM ESTIMATE

PANELISTS

- **Connie Mitchell**, Deputy Director, Center for Family Health, DPH
- **Christine Nelson**, Chief, Women Infants & Children Division, Center for Family Health, DPH
- **Kimberly Harbison**, Staff Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

WIC BUDGET

As shown in the table below, the WIC estimate proposes total expenditures of $1.4 billion in 2016-17, a $20.5 million (1.5%) increase over the revised estimate for 2015-16, and a $46.5 million (3.3%) decrease from the 2015 Budget Act.

WIC Expenditures					
	2015 Budget Act	**2015-16 Estimate**	**2016-17 Proposed**	**CY to BY Change**	**% Change**
Local Assistance (FFP)	$1,126,206,368	$1,075,229,926	$1,094,093,548	$18,863,622	1.8%
Local Assistance (Rebate Funds)	$237,437,089	$221,369,550	$216,739,700	($4,629,850)	-2.1%
State Operations	$55,140,136	$55,140,136	$61,429,198	$6,289,062	11.4%
Total Expenditures	**$1,418,783,593**	**$1,351,739,612**	**$1,372,262,446**	**$20,522,834**	**1.5%**

The WIC program is funded almost entirely with federal funds, including a Food Grant from the United States Department of Agriculture (USDA) as well as Nutrition Services and Administration (NSA) grant. The state also contracts for rebates from infant formula providers, which amounts to approximately 15% of the program funding.

WIC Revenue					
	2015 Budget Act	**2015-16 Estimate**	**2016-17 Proposed**	**CY to BY Change**	**% Change**
Food Grant	$852,101,579	$859,508,309	$859,043,481	($464,828)	-0.1%
Nutrition Services Admin (NSA) Grant	$366,705,007	$376,864,505	$376,778,517	($85,988)	-0.02%
Rebate Funds	$237,437,089	$221,369,650	$216,739,700	($4,629,950)	-2.1%
Total Revenue	**$1,456,243,675**	**$1,457,742,464**	**$1,452,561,698**	**($5,180,766)**	**-0.4%**

BACKGROUND

WIC provides supplemental food and nutrition for low-income families (185 percent of poverty or below) with pregnant women, breastfeeding and early postpartum mothers, infants, and children up to age five. WIC services include nutrition education, breastfeeding support, help finding health care and other community services, and checks for specific nutritious foods that are redeemable at retail food outlets throughout the state. WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

DPH administers contracts with 84 local agencies (half local government and half private, non-profit community organizations) that provide 650 locations statewide. Approximately 3,000 local WIC staff assesses and document program eligibility based on residency, income, and health or nutrition risk, and issue 4.8 million food checks each month. Local WIC agencies issue WIC participants paper vouchers to purchase approved foods at authorized stores. Examples of WIC foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter, and iron-fortified infant formula.

The goal of WIC is to decrease the risk of poor birth outcomes and improve the health of participants during critical times of growth and development. The amounts and types of food WIC provides are designed to meet the participant's enhanced dietary needs for specific nutrients during short but critical periods of physiological development.

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support, and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged as being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

WIC Funding

DPH states that California's share of the national federal grant appropriation has remained at about 17 percent over the last 5 years. Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:

- **Food**. Funds reimburses WIC authorized grocers for foods purchased by WIC participants. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.

- **Nutrition Services and Administration.** Nutrition Services and Administration (NSA) Funds that reimburse local WIC agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition education, breastfeeding support, and referrals to health and social services, as well as support costs. States manage the grant, provide client services and nutrition education, and promote and support breastfeeding with NSA Funds. Performance targets are to be met or the federal USDA can reduce funds.

- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with infant formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down Federal WIC food funds.

Maximum Reimbursement Rate Methodology

The maximum amount that vendors are reimbursed for WIC food is based on the mean price per redeemed food instrument type by peer group with a tolerance for price variances (referred to as MADR). Effective May 25, 2012, USDA directed CA WIC to remove 1-2 and 3-4 cash register WIC vendors from the MADR-determination process and instead set MADR for these vendors at a certain percentage higher than the average redemption value charged by vendors with five or more registers in the same geographic region. The USDA was concerned that California was paying 1-2 and 3-4 cash register stores up to 50 percent higher than prices paid to other vendors. The WIC program submitted a plan to USDA to address price competitiveness, MADR methodology and cost containment, which was approved and implemented. The program has experienced lower overall food costs as a result.

WIC Store Moratorium

The state implemented a moratorium on new WIC stores several years ago which was lifted in phases over the past year. As of February 1, 2015, the moratorium was lifted fully for all types of new stores. Although new stores have come into the program, the overall number of WIC stores has declined, in part due to stores closing in response to the new reimbursement system put into place.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the WIC estimate and describe significant changes to, and challenges and trends in, the program, and to respond to the following:

1. Typically, are there federal WIC funds that revert to the federal government that could have been expended on California's WIC program? If yes, please describe the magnitude of this problem.

2. Please describe the WIC program's efforts to modernize its communications with WIC families and the public.

3. Please describe any on-going stakeholder participation that the program utilizes? Does DPH believe that its stakeholder participation is adequate? robust? maximized?

Staff Recommendation: Staff recommends holding this item open pending changes and updates included in the May Revision.

ISSUE 4: WIC PARTICIPATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Connie Mitchell**, Deputy Director, Center for Family Health, DPH
- **Christine Nelson**, Chief, Women Infants & Children Division, Center for Family Health, DPH
- **Kimberly Harbison**, Staff Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DPH requests $513,000 in federal fund expenditure authority and 4.0 permanent positions to enhance the Women, Infants, and Children (WIC) Division's outreach activities and improve data sharing with the California Department of Social Services' (CDSS) CalFresh Program to increase child enrollment in both programs.

BACKGROUND

The WIC Division operates a $1.3 billion program serving approximately 1.3 million of California's economically and nutritionally vulnerable residents. The WIC program is not an entitlement program; rather it is fully funded by an annual grant from the U.S. Department of Agriculture. WIC provides nutrition services and food assistance to low-to-moderate income families for pregnant and postpartum women, infants, and children up to their fifth birthday. In addition to the categorical eligibility requirement, participants must be at or below 185 percent of the federal poverty level, and have a nutritional risk. Applicants are deemed adjunctively eligible due to participation in other programs such as Medi-Cal, CalFresh, and California Work Opportunity and Responsibility to Kids (CalWORKS). The WIC program assists families by providing nutrition education, breast feeding support, vouchers to purchase healthy supplemental foods, and referrals to healthcare and other community services.

According to the National Center for Children in Poverty, about 48 percent of California's young children under the age of six live in low-income households. Of the total amount of young children, 23 percent live in households with incomes that are between 100-200 percent of the federal poverty level. Food insecurity, defined as a lack of consistent access to adequate food, has been rising among California households with children. DPH sites data that shows that in 2001-2002, 11.7 percent of households reported food insecurity, which rose to 15.6 percent of households in 2010-2012. Statistically significant findings related to health and food insecurity in children include: lower bone mineral content in adolescent boys, iron deficiency anemia among children, less mental proficiency in toddlers, higher rates of developmental risk, more frequent minor complaints like stomach aches, headaches, and colds, higher hospitalization rates, increased behavioral problems, poorer psychosocial functioning, higher rates of depression and anxiety, lower math achievement and reading gains, and increased risk of repeating a grade level.

DPH reports that California is more successful than any other state in reaching individuals eligible for the WIC program (82 percent in 2012 compared to the national average of 63 percent), however California's coverage rates vary across participant categories, namely pregnant women, postpartum women, infants, and children. The most recent 2011 California-specific data indicates that while the largest participation category served is children, the child coverage rate is the lowest at 73 percent; coverage for postpartum women is the highest at 91.2 percent, followed by infants at 90.7 percent, and pregnant women at 83.4 percent. Applying this 73 percent coverage estimate to the current number of children served results in an estimated 270,000 California children (age 1 year to under 5) eligible for, yet not enrolled in, the WIC program. To date, WIC has been unable to close the gap between those who are eligible for services and do not apply, as well as those who have been certified but do not actively receive benefits. WIC data analyses suggest a smaller decline in WIC participants if they were also enrolled in CDSS/CalFresh and/or Medi-Cal. Hence, this proposal seeks to increase participation rates by researching and developing data and program linkages.

WIC and CDSS/CalFresh have made a commitment to work together to increase enrollment of children in these programs. The goal is to increase California's coverage rate of eligible children participating in WIC by five percent, or 48,000 children, and to assist CDSS with increasing their enrollment of children in CalFresh by 400,000 by June 30, 2018.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 5: CALIFORNIA PERSONAL RESPONSIBILITY EDUCATION PROGRAM BUDGET CHANGE PROPOSAL

PANELISTS

- **Connie Mitchell**, Deputy Director, Center for Family Health, DPH
- **Kimberly Harbison**, Staff Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DPH requests $6.4 million ($700,000 in State Operations and $5.7 million in Local Assistance) in federal fund expenditure authority, and the conversion of 5.0 limited-term positions to permanent positions, to continue the California Personal Responsibility Education Program (CA PREP), which is administered through the Maternal, Child and Adolescent Health Program.

BACKGROUND

The Patient Protection and Affordable Care Act of 2010 amended Title V of the Social Security Act (42 U.S.C. 701 et. seq.) to include a new formula grant program entitled the Personal Responsibility Education Program (PREP). The purpose of PREP funding is to reduce birthrates and sexually transmitted infections among high-need adolescents through evidence-based sexual health education.

DPH reports that the adolescent birth rate in the United States decreased significantly over the past 30 years, reaching a record low of 26.5 live births per 1,000 female youth aged 15 to 19 in 2013. In California, the decline has been even more substantial, from an adolescent birth rate of 70.9 per 1,000 in 1991 to 23.2 per 1,000 in 2013. Nevertheless, there are still substantial disparities in rates of adolescent childbearing and sexually transmitted infections based on race, ethnicity, geography, and other social and demographic characteristics. Notably, in California nearly three out of four adolescent births are to Hispanic mothers, although Hispanic females account for only one-half of the adolescent population. Other vulnerable populations include youth in the foster care and juvenile justice systems, homeless/runaway youth, female adolescents with major mental illnesses, and male and female youth who identify as lesbian, gay or bisexual. These populations tend to have higher rates of early pregnancy, childbearing and/or sexually transmitted infections including the Human Immunodeficiency Virus when compared to other adolescents. Thus, these vulnerable adolescents are in substantial need of targeted sexual health education and support services.

CA PREP has received five years of continuous funding, and on April 2014, the U.S. Senate approved H.R. 2, "The Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015," extending PREP through Federal Fiscal Year 2017 at its current annual funding level of $75 million nationwide. California will receive $6.4 million of this national allocation in Federal Fiscal Year 2016, which began October 1, 2015.

Based on strong federal interest in and support for evidence-based adolescent pregnancy prevention, and an invitation to re-apply for funding, DPH anticipates annual funding for CA PREP to continue beyond the current Federal Fiscal Year 2017 extension.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 6: STAKEHOLDER PROPOSAL: ADOLESCENT FAMILY LIFE PROGRAM

PANELISTS

- **Nancy Ballard** MA, LMFT, Ventura County Public Health Adolescent Family Life Program, Director, AFLP Regional Representative Co-Chair
- **Connie Mitchell**, Deputy Director, Center for Family Health, DPH
- **Kimberly Harbison**, Staff Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

Stakeholders are requesting the restoration of $6 million General Fund for the Adolescent Family Life Program (AFLP).

BACKGROUND

AFLP addresses the social, health, educational, and economic consequences of adolescent pregnancy by providing comprehensive case management services to expectant and parenting teens and their children. AFLP emphasizes promotion of positive youth development, focusing on and building upon adolescents' strengths and resources to work towards improving the health of the teen and their child, improving graduation rates, reducing repeat pregnancy and births, and creating networks of support for these young parents.

The AFLP was established in 1985 and since then has provided support services to over 150,000 teen parents and their children. In 2009, the budget eliminated the program's General Fund appropriation of $10.7 million, which resulted in the additional reduction of $5.4 million in federal matching funds. Since 2009, the programs has also experienced an additional $2.8 million reduction in federal funds, for a total loss of $18 million in funding. The AFLP had sufficient funding in 2008-09 to serve a high of 18,000 adolescent families and dropped to serving 3,956 teens in fiscal year 204-15.

The Subcommittee has received support for this proposal from El Nido Family Centers, First 5 Monterey County, Maternal Child and Adolescent Health Directors, AltaMed Health Services Corporation, California WIC Association, Brighter Beginnings, Community Action Commission, Monterey County Department of Health, Ventura County Public Health, March of Dimes, California Adolescent Health Collaborative, Foothill Family Teen Family Services, Children's Hospital Los Angeles, Community Action Commission of Santa Barbara County, Fresno Economic Opportunities Commission and a variety of other public health organizations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Nancy Ballard to present this proposal.

The Subcommittee also requests DPH to provide an overview of the program, its funding history, and respond to the following:

1. How many fewer teens are served by this program today as compared to prior to the recession funding cuts?

2. How much additional federal funding could result from appropriating $6 million General Fund into this program?

3. How many more teens could be served with the addition of $6 million General Fund to the program?

Staff Recommendation: Staff recommends holding this item open.

ISSUE 7: ACTIVE TRANSPORTATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Greg Oliva**, Assistant Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DPH, Division of Chronic Disease and Injury Control, Safe and Active Communities Branch requests $733,000 in reimbursement expenditure authority and an increase of 4.5 positions to implement the Active Transportation Safety Program with funds provided through an Interagency Agreement with the California Department of Transportation (Caltrans).

BACKGROUND

The Active Transportation Program was created within Caltrans and funded by SB 99 (Chapter 359, Statutes of 2013) and AB 101 (Chapter 354, Statutes of 2013). The legislation consolidated existing federal and state transportation programs, including the Transportation Alternatives Program, Bicycle Transportation Account, and State Safe Routes to School, into a single program with a focus to make California a national leader in active transportation. Caltrans has executed an Interagency Agreement with DPH Safe and Active Communities Branch to be a part of the new program.

Since 2007, Caltrans had contracted with the University of California, San Francisco to operate a Safe Routes to School Technical Assistance Resource Center at a cost of approximately $700,000 annually. This amount supported 5.0 positions to provide trainings, technical assistance, and resources to local communities to help them develop and implement Safe Routes to School Non-infrastructure programs throughout California. The Technical Assistance Resource Center was housed with and overseen by staff from CDPH Safe and Active Communities Branch, who provided support in-kind for nearly eight years, with no contract or funding from Caltrans. The prior contract between Caltrans and University of California, San Francisco was operating on a no-cost extension and originally expired on September 30, 2015. Caltrans has sought to partner with the Safe and Active Communities Branch to be a major component in their new Active Transportation Program. DPH explains that the University of California, San Francisco staff have been involved in discussions about the transition of the contract between Caltrans and University of California, San Francisco to DPH, and have expressed no objections. Most of University of California, San Francisco's staff that have been providing these services to Caltrans are eligible and encouraged to apply for the newly established DPH positions.

Specific goals of the Active Transportation Program include reducing pedestrian and bicycle injuries and fatalities, reducing greenhouse gas emissions, improving air quality, increasing safe, physical activity among youth, and improving equity for disadvantaged communities. Caltrans seeks DPH expertise and public health partnership to implement this program. The relationship between DPH and Caltrans, solidified through an Interagency Agreement, ensures that training and technical assistance services will be provided by CDPH to support California communities that are implementing vibrant Safe Routes to School and other educational programs funded by Caltrans' Active Transportation Program.

Caltrans is committed to continuing technical support services provided by DPH to increase public health expertise in the implementation of its Active Transportation Program to ensure public health-related goals are met. Caltrans and DPH began exploring the possibility of an Interagency Agreement in May 2013 and worked through the spring of 2015 to identify a mutually agreed upon Interagency Agreement. To ensure continuity of services to Caltrans, an Interagency Agreement between Caltrans and DPH has been executed to avoid the lapse in services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 8: PROTECTING CHILDREN FROM LEAD EXPOSURE BUDGET CHANGE PROPOSAL

PANELISTS

- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Greg Oliva**, Assistant Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

CDPH, Division of Environmental and Occupational Disease Control, Childhood Lead Poisoning Prevention Branch (CLPPB) requests an increase in expenditure authority by $8.2 million annually ($1.4 million in State Operations and $6.8 million in Local Assistance) for 4 years from the Childhood Lead Poisoning Prevention Special Fund and to establish 7.0 positions to extend services to children who have been exposed to lead as now defined by a lower blood lead level by the Centers for Disease Control and Prevention.

BACKGROUND

The Childhood Lead Poisoning Prevention (CLPP) Program is statutorily required to perform the following functions: 1) prevent childhood lead exposure; 2) set standards for testing children for blood lead; 3) monitor laboratory reported blood lead test results; 4) educate and counsel families about lead; 5) provide public health nursing and environmental home inspections and follow-up services to children Identified with the highest blood lead levels; and 6) identify sources of lead exposure and ensure that they are corrected. Other mandates include requiring laboratory reporting to CLPPB of all blood lead tests and taking measures to reduce childhood lead exposure. DPH states that while the CLPP Program has been successful in reducing the number of children exposed to high levels of lead, direct case services could be expanded to a larger child population with lower lead exposure levels.

In adults, a low level of lead exposure isn't always considered dangerous. However, in babies and young children whose brains are still developing, even a small amount of lead can cause learning disabilities, behavioral problems, and anemia. At higher levels, lead exposure can cause seizures, coma, and even death. Children considered at increased risk for lead exposure are primarily young, in a publicly funded program for low-income children, or living in deteriorated or recently renovated older housing (which may be associated with lead-based paint and lead-contaminated dust and soil). These children are targeted by program activities (described immediately below) and are required to be blood lead tested (California Code of Regulations, Title 17, Division 1, Chapter 9, §37000 et seq.). In order to reach this population and have them tested, outreach and educational materials are produced in multiple languages. Additionally, all

families of young children receive guidance about preventing lead exposure during routine health care visits. Children of any background and age may be blood lead tested, if circumstances have put them at risk for lead exposure, and children identified with high blood lead levels are eligible for services regardless of documentation status or income.

Direct services to children are provided by 43 local CLPP programs in 40 counties and 3 cities which contract with the CLPPB for funding (The contracted CLPP programs are in the cities of Berkeley, Long Beach, and Pasadena and most of the counties in California, with the exception of the 18 counties noted in the footnote^). Funding is provided to these local programs by CLPPB contract criteria based on their: population of high-risk, young, low-income children; number of children with evidence of increased lead exposure on blood testing; and the proportion of children living in older housing (often associated with lead exposure).

The state CLPPB is responsible for public health nurse and environmental investigations and services in 18 non-contracted jurisdictions which may collaborate with CLPPB on some individual CLPP activities but do not choose to formally contract (see listing of these non-contracted counties. Additionally, CLPPB provides environmental services in 14 contracted counties who do not currently have available environmental professionals but do have public health nurses (for more description, see the justification section). CLPPB also: 1) provides information on laboratory reported lead tests to the local CLPP programs; 2) provides statewide surveillance, data analysis, oversight, outreach, and 3) technical assistance; and assists all counties with services not available locally. Please see Table 2: Workload History, which provides current relevant workload.

According to the California Health and Safety Code 124130, all blood lead tests are required to be reported to the CLPPB. Approximately 700,000 tests are reported each year by over 300 laboratories and processed by CLPPB to assure receipt of accurate and complete information, including identification and location of children who have increased blood lead levels needing services. Test results are stored in the CLPPB web-based data system and are viewable by local health jurisdictions. In 2012, approximately 650,000 individual children up to age 21 were blood lead tested in California (some children are tested more than once); about 600,000 were under age six.

Children with the highest blood lead levels (> 20 micrograms per deciliter (mcg/dL) or persistent values of >15 mcg/dL) are currently deemed "cases" of lead poisoning requiring follow-up case management. Approximately 200 new children are identified as cases of lead poisoning each year.

Alerts are sent by the CLPPB data system to initiate interventions by public health nurses and environmental professionals to reduce lead exposure in these children. The nurses and environmental professionals make home visits to educate the family about reducing lead exposure and to carry out inspections to detect sources of lead. The children receive special health care referrals as needed and ongoing collaboration

occurs with their health care providers. They receive follow-up treatment for two to three years to ensure that blood lead levels decline and remain low.

According to DPH, the annual number of children identified as cases of lead poisoning has decreased fivefold since the program began in the early 1990s and the percent of tested children identified with increased blood lead levels > 10 mcg/dL has decreased more than twofold since complete laboratory reports of these blood lead levels became available in 2007. This proposal is intended to expand case services to children with lower lead exposure levels.

The Centers for Disease Control and Prevention recommends that a lower blood lead level (>5 mcg/dL) be used to define need for services for, and follow-up of, lead-exposed children. Most lead-exposed children with blood lead levels not high enough to be "cases," do not currently receive extensive services. They may receive some educational or home inspection services to decrease lead exposure, as resources allow. Approximately 12,500 children in 2012 were identified with blood lead levels that would not currently qualify them as lead poisoning cases, but are levels that are now known to be harmful. Numbers vary by year but only 4,200 to 6,400 of such children receive any services each year.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal and respond to the following:

1. What are the most common sources of lead exposure for children in California?

2. Has DPH ever found drinking water to be a source of lead exposure in California?

3. Please describe the state's response to the clean-up of the closed Exide battery plant in Vernon (as covered by the *Sacramento Bee* on March 27, 2016, page 3A). Is there data that DPH should be sharing with other state departments in order for the state to be able to protect the community most effectively?

Staff Recommendation: Staff recommends holding this item open.

ISSUE 9: BIOMONITORING PROGRAM LIMITED-TERM FUNDING BUDGET CHANGE PROPOSAL & STAKEHOLDER AUGMENTATION PROPOSAL

PANELISTS

- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Greg Oliva**, Assistant Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Nancy Buermeyer**, Senior Policy Strategist, Breast Cancer Fund
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DPH, Division of Environmental and Occupational Disease Control requests 2.0 positions (set to expire June 30, 2016) and $350,000 (in 2016-17 and 2017-18) from the Toxic Substances Control Account. The request is to make the 2.0 positions permanent, however the funding is limited-term.

Stakeholders request a $1 million augmentation, above the Governor's proposed budget, for the Biomonitoring program.

BACKGROUND

Biomonitoring California was established through SB 1379 (Chapter 599, Statutes of 2006). The Program is a collaborative effort involving DPH as the designated lead, the Office of Environmental Health Hazard Assessment (OEHHA), and the Department of Toxic Substances Control (DTSC). It receives technical advice and peer review from a Scientific Guidance Panel and input from the public. The content of this Budget Change Proposal (BCP) reflects only the programmatic needs of DPH.

Biomonitoring California's principal mandates are to: 1) measure and report levels of specific environmental chemicals in blood and urine samples from a representative sample of Californians; 2) conduct community-based biomonitoring studies; and 3) help assess the effectiveness of public health and environmental programs in reducing chemical exposures. Biomonitoring provides unique information on the extent to which people are exposed to a variety of environmental chemicals and on how such exposures may be influenced by factors such as age, gender, ethnicity, diet, occupation, residential location, and use of specific consumer products. This information is essential to inform policy decisions in public health and environmental protection (e.g., the reformulation and enhanced safety of consumer products under the Safer Consumer Product Regulations implemented by DTSC).

Biomonitoring California is funded through five special funds including the Toxic Substances Control Account (TSCA), the Air Pollution Control Fund (APCF), the

Department of Pesticide Registration Fund (DPRF), the Childhood Lead Poisoning Prevention Fund (CLPPF), and the Birth Defects Monitoring Fund (BDMF). CDPH has 8.0 permanent staff positions for Biomonitoring California and 8.0 limited-term positions created in BCPs in 2014-15 (2.0 positions ending on June 30, 2016) and 2015-16 (6.0 positions ending on June 30, 2017.

The Biomonitoring program was recently a key partner in research conducted by youth from Salinas California, who partnered with U.C. Berkeley researchers to learn how teenage girls are exposed to harmful chemicals in cosmetics and other personal care products, find ways to reduce exposure and improve the health of this population. The study involved the testing urinary samples of 100 Latina girls, and the study demonstrated that labeling of personal care products can reduce exposure to endocrine disrupting chemicals, such as phthalates, parabens, triclosan, and BP-3.

STAKEHOLDER PROPOSAL

Stakeholders, including the Breast Cancer Fund, believe that the program could accomplish more and be more effective with additional resources, particularly in light of decreasing federal funding. Specifically, they would like to see the program increase its focus on environmental justice, such as toxic chemical exposures on environmental justice communities. They state that $1 million would allow the program to complete 1-2 studies per year that examine chemical exposures in specific populations, places and over time. They state that there are special toxic exposure needs in the Central Valley, Los Angeles, the Bay Area and the Inland Empire. The Breast Cancer Fund states the following:

> " A comprehensive biomonitoring program would include statewide surveillance, state of the art laboratory facilities with the ability to develop new analytical methods to keep pace with changing chemical profiles in commercial products, and 1-2 targeted community studies per year. It has been estimated that a program of this breadth would cost $12-15 million per year. We believe that the current focus of the funding augmentation request on overburdened communities is the right place to start."

Supporters of this proposal include: the Breast Cancer Fund, Black Women for Wellness, California Environmental Justice Alliance, California Health Nail Salon Collaborative, California League of Conservation Voters, Californians for a Healthy and Green Economy, Californians for Pesticide Reform, Clean Water Action, Coalition for Clean Air, Communications Workers of America - District 9, Natural Resources Defense Council, Physicians for Social Responsibility - Los Angeles, San Francisco, USW Local 675, and Worksafe.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present their proposed BCP and respond to the following:

1. Please provide a brief overview of the funding history of this program (i.e., how much federal funding has been lost and what percentage of that funding has been replaced with state funds?)

2. Please explain the rationale for proposing permanent positions with limited-term funding. Is this occurring in other areas of the budget?

The Subcommittee requests Nancy Buermeyer to present the stakeholders' proposal.

Staff Recommendation: Staff recommends holding these items open.

ISSUE 10: STAKEHOLDER PROPOSAL: ALZHEIMER'S EARLY DIAGNOSIS

PANELISTS

- **Charles DeCarli**, MD, Professor of Neurology, Director, Alzheimer's Disease Center and Imaging of Dementia and Aging (IDeA) Laboratory, Department of Neurology and Center for Neuroscience, University of California at Davis
- **Ken Cooley**, Member, California State Assembly
- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Greg Oliva**, Assistant Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The California Council of the Alzheimer's Association requests $2.5 million for DPH to implement their proposed Health Outcomes and Professional Education ("HOPE") Act (detailed below) to increase early and accurate diagnoses of Alzheimer's.

BACKGROUND

The Alzheimer's Association cites research that predicts a 42 percent increase in the state's population with dementia, and a 59 percent increase in Medi-Cal spending on Alzheimer's disease alone. They quote a report by The Lewin Group that states that California will experience a $1.7 billion increase in Medi-Cal spending on dementia over the next decade. They also provide the following statistics:

- Alzheimer's disease is the 5th leading cause of death in California.
- In 2013, there were 11,891 deaths from Alzheimer's in California.
- The number of deaths from Alzheimer's has increased 169 percent since 2000.

In response to these alarming statistics, they propose the HOPE Act which includes the following:

Phase 1 – Close the Knowledge Gap ($400,000)
CDPH's Alzheimer's Disease Centers will cooperatively determine the current standard of care in early and accurate diagnosis drawing on peer-reviewed evidence, best practices, Medicare and Medicaid policy/reimbursement, and firsthand experience working with thousands of California patients over three decades seeking services at their state-of the art diagnostic centers. By consensus, the group will endorse and disseminate low-cost, accessible detection and diagnosis tools for broad use by health

professions practicing in a variety of settings (community health clinics, medical groups, health plans, etc.). Phase 1 Goal: Limit unnecessary referrals to high cost specialty physicians and expensive imaging tests when patients can be appropriately and accurately diagnosed at the primary care level.

Phase 2 - Implement Practice Change among Health Professionals and Consumers ($1.9 million)

In partnership with key stakeholders, such as the Alzheimer's Association, the 10 university-affiliated disease centers will conduct targeted outreach to health professionals through medical school instruction, hospital grand rounds, continuing education, community education, and free online resources, e.g. webinars and podcasts. Low-cost, accessible detection and diagnosis tools will be made available via open source portals, such as University of California and other state entities. This phase will address unique health disparities that exist within diverse populations, with special focus and attention on reaching African Americans, Latinos and women. Phase 2 Goal: Leverage the CADCs as an asset and resource for high volume practitioners in community settings, and actively refer patients to non-government, community-based resources for care and support.

Phase 3 – Evaluate and Sustain Results ($200,000)

Traditional methods of evaluating educational effectiveness and measuring impact will be used including pre and post tests for health professionals, metrics, documented practice change, etc. In addition, the CDPH coordinating center for this one-time funding will be responsible for maintaining a website with open, free access to all tools developed, and to serving as a resource for the state. Phase 3 Goal: Ensure public and private entities are able to access at no cost all resources developed through this funding.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Dr. DeCarli to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 11: STAKEHOLDER PROPOSAL: CHRONIC DISEASE TRUST FUND

PANELISTS

- **Kat DeBurgh**, MPH, Executive Director, Health Officers Association of California
- **Jimmy Gomez**, Member, California State Assembly
- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Greg Oliva**, Assistant Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Health Officers Association of California (HOAC) requests $380 million General Fund for a Community Health Improvement and Innovation Fund to prevent chronic disease.

BACKGROUND

This is a public fund that would be used to help people stay healthy and avoid the costs, both personal and economic, associated with chronic illnesses such as heart disease, stroke, diabetes, and cancer. These conditions are the leading causes of premature death and disability in California. The current health care system is overwhelmed with patients who have one or more of these conditions. Most of these illnesses are preventable through healthy lifestyles and environments that promote health. This fund would help control health care costs, help children grow up healthy and achieve their full potential, decrease suffering for individuals and families, and increase the productivity of our workforce. Massachusetts, Minnesota and Washington have created wellness investment systems.

Prevention-oriented public health programs have a well-documented return on investment. The Trust for America's Health estimated that an investment of $10 per person per year in proven community-based disease prevention will yield nearly $1 over and above the cost of the program for the first 1 to 2 years, rising to $5.6 within 5 years and $6.2 for every dollar invested within 10 to 20 years. HOAC states that by reducing disease and health care costs, a wellness fund will save California funds, rather than deplete them, after just one to two years.

The fund would support activities that fall into the following broad categories:

- Promoting health equity by building on local efforts that ensure that all Californians have full and equal access to opportunities to lead healthy lives

- Decreasing tobacco and e-cigarette use and second hand smoke exposure.

- Increasing physical activity—for example, working with cities to create more walkable and bikeable communities; encouraging development of parks and recreational programming.

- Improving nutrition—for example, increasing access to and affordability of fresh fruits and vegetables, tap water and other healthy foods in a variety of community environments.

- Creating safer neighborhoods. Lack of community safety is a strong impediment to being outdoors and physically active, limits mobility for needed services, and can be associated with substantial stress and social isolation, both of which further predispose to chronic disease.

The Community Health Improvement and Innovation Fund would be administered by DPH which would retain 20% of the funds for statewide activities, including evaluation. The remaining 80% of the funds would be distributed for local disease-prevention activities. Half of the distributed funds would go to local health jurisdictions (LHJs) for disease prevention. Each jurisdiction would receive a minimum of $250,000. The remaining funds would be distributed according to the population in each jurisdiction, and the percentage of that population below the federal poverty level. Funds would be spent on each jurisdiction's priority areas for chronic disease prevention, with oversight from DPH. Each jurisdiction would be required to prioritize communities in the 3rd and 4th quartiles of the California Health Disadvantage Index. The remaining 30% of the funds would be given in competitive grants.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Kat DeBurgh to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 12: OVERSIGHT: VIOLENT DEATH DATA COLLECTION

PANELISTS

- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Greg Oliva**, Assistant Deputy Director, Center for Chronic Disease Prevention and Health Promotion, DPH
- **Kimberly Harbison**, Staff Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

BACKGROUND

More than 38,000 people died by suicide in the US in 2010, and homicide claimed another 16,000 people. The CDC further notes that the total costs associated with nonfatal injuries and deaths due to violence in 2000 were more than $70 billion. Most of this cost ($64.8 billion or 92%) was due to lost productivity. However, an estimated $5.6 billion was spent on medical care for the more than 2.5 million injuries due to interpersonal and self-directed violence.

In 2002, the National Violent Death Reporting System (NVDRS) was established at the federal Centers for Disease Control (CDC) as surveillance system that collects data on violent deaths from participating states. NVDRS collects information from death certificates, coroner or medical examiner reports, police reports, and crime laboratories. The goal of NVDRS is to gain a better understanding of violence, upon which to base the development of effective public health strategies that prevent violent injuries and fatalities. NVDRS accomplishes this by: informing decision makers and program planners about the magnitude, trends, and characteristics of violent deaths so that appropriate prevention efforts can be put into place; and facilitating the evaluation of state-based prevention programs and strategies. In 2008, Congress appropriated more than $3.2 million for CDC to continue funding the implementation of NVDRS in 17 states. Currently, states participating in the NVDRS include: Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, Oklahoma, Oregon, Utah, Virginia, and Wisconsin. Historically, participation in the NVDRS has been a costly and difficult undertaking and therefore has seen little participation by large states.

From 2005-2008, California was one of the 17 states participating in the NVDRS. The California Violent Death Reporting System (CalVDRS) was established to collect data from the City of Oakland, City and County of Santa Francisco, and Santa Clara County. CalVDRS eventually expanded in 2006-2007 to include data collection from the counties of Los Angeles, Riverside, Alameda, and Shasta. During these years, DPH contracted with county health departments to collect data on violent deaths from four data sources - death certificates, coroner/medical examiner records, police reports, and crime laboratory records. During its four years of data collection, DPH compiled detailed information on the circumstances of more than 10,000 violent deaths, including homicides and suicides. Participation of Alameda, Los Angeles, Riverside, San

Francisco, Santa Clara, and Shasta Counties in the system meant that DPH had valuable information on approximately half of the state's violent deaths during this time. Unfortunately, due to its size, decentralized government, privacy concerns, and lack of resources among law enforcement agencies, California was unable to obtain law enforcement records required by NVDRS and could not reapply for funding. As a result, DPH developed CalEVDRS, and with the creation of the Electronic Death Registration System in 2005 which allowed counties to file death certificates online instead of mailing paper forms, DPH was able to capture information from coroners on violent death. In 2010, 14 counties were contributing data to the system, which operated with funding from the California Wellness Foundation, funding that has since expired.

In response to the Sandy Hook Elementary School shootings in Newtown, Connecticut, President Obama unveiled his plan called "Now is the Time" which calls for public health research on gun violence. Now is the Time states that the country needs better data to help Americans better understand how and when firearms are used in violent deaths and to inform future research and prevention strategies. The President's 2014 budget includes $30 million in new funding to track gun violence and to research strategies that might prevent it. Specifically, $20 million of these funds is appropriated for the NVDRS to allow the CDC to expand the system to all 50 states and the District of Columbia.

DPH confirms that Congress has approved of increased funding for the NVDRS and, as well, the CDC has begun implementing simplifications and other reforms to make it easier for large states to participate. DPH is in the process of applying for a new CDC grant in order to resume participation in the NVDRS, which, if successful, would begin in September of this year.

The CDC grants vary in funding level based on the percentage of violent death cases on which a state will be able to collect data. California has already demonstrated that it can collect data on approximately 50 percent of California's cases with 14 counties participating. DPH estimates that data could be collected on 90-100 percent of the state's cases with 35-40 counties participating.

The CDC funding is based on a per case cost estimate of approximately $27.50, and DPH explains that this might be based on the smaller states that participate in NVDRS, however it does not accurately reflect actual data collection costs in California, which they estimate at approximately $50 per case. While DPH cannot predict the level of funding that the CDC will grant California, if any, they estimate that at most the CDC funding could cover approximately 1/3 to ½ of the costs of a fully-developed statewide active surveillance system that covers close to 100 percent of California's violent death cases.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this issue and respond to the following:

1. Please describe the national and state violent death reporting systems, their histories, and current status.

2. Please explain how this data could benefit the national system, and also how it could be used to benefit and potentially reduce violent injuries and deaths in California.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 13: OFFICE OF ORAL HEALTH OVERVIEW

PANELISTS

- **Jay Kumar**, State Dental Director, CDPH
- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, CDPH
- **Greg Oliva**, Assistant Deputy Director, Center for Chronic Disease Prevention and Health Promotion, CDPH
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

BACKGROUND

The 2014 Budget Act included funding for DPH to fill the position of State Dental Director, which had been vacant for many years. DPH has hired Dr. Jay Kumar to serve as the new State Dental Director to provide much-needed vision and leadership on oral health policy in California.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Dr. Kumar to share his vision for oral health promotion in California, describe the primary functions of the Office of Oral Health, and respond to the following:

1. Please describe any stakeholder participation efforts underway in this area.

2. Please describe the State Oral Health Plan. When will it be complete?

Staff Recommendation: Staff recommends no action on this issue.

ISSUE 14: STAKEHOLDER PROPOSAL: CALIFORNIA CHILDREN'S DENTAL DISEASE PREVENTION PROGRAM (CCDDPP)

PANELISTS

- **Eileen Espejo**, Senior Managing Director, Media and Health Policy, Children Now
- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, CDPH
- **Greg Oliva**, Assistant Deputy Director, Center for Chronic Disease Prevention and Health Promotion, CDPH
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

Children Now requests funding to restore the CCDDPP which was defunded during the recent recession and is no longer in operation. Prior funding was $3.2 million General Fund.

BACKGROUND

We recommend restoring CCDDPP in order to mitigate the consequences detailed above. Governor Brown signed the program into law in 1980, however, it was suspended in 2009 due to fiscal constraints. Over the course of the program's almost 30 years, CCDDPP operated in 31 counties and provided preventive dental services to elementary school children each year in schools where at least 50 percent of the student population qualified for free and reduced price meals. CCDDPP was the only school-based statewide program providing oral health preventive services to California children including education and dental screenings.

One of most critical components of CCDDPP was the capacity it provided to counties to develop the necessary infrastructure to assess and address the needs of students. When in operation, CCDDPP was managed by the local health department, the county superintendent of schools or a nonprofit agency, which was required to maintain an active oral health advisory committee. This component is currently missing at a time when it's most needed given the task of Dr. Kumar, California's new dental director, to develop a statewide oral health plan. Once the plan is finalized, we expect that the entities mentioned above and through restoration of CCDDPP, will play a key role in implementing the plan and ultimately help the state achieve its oral health goals.

Oral health is critical to overall health. Unfortunately, dental disease is the most common chronic, yet preventable health problem among children in California, and has academic, physical, and social-emotional effects, as follows:

Academic consequences: Dental disease is one of the top reasons children in California miss school. In 2007, more than half a million of California's school-aged children missed at least one school day due to a dental problem—a total of 874,000 missed school days—costing schools in lost average daily attendance (ADA) dollars. Additionally, studies have shown that students who report oral pain are four times more likely to have a below average GPA compared to students who report having no pain.

Physical consequences: Dental decay can affect a child's ability to eat and sleep. Furthermore, untreated dental disease is linked to a variety of additional health issues, including ear and sinus infections, weakened immune systems, diabetes, as well as lung and heart disease.

Social-emotional consequences: Dental disease in children can lead to slower social development and lack of self-esteem due to cosmetic issues caused by tooth decay and effects on speech development.

In addition to Children Now, all of the following organizations are in support of this proposal:

Anderson Valley Healthy Smile
ARCH
California Pan-Ethnic Health Network
Child Abuse Prevention Council of Contra
Child Start INC
Children Now
Clinic
County of Sacramento
Evangelical Lutheran Church in America
FASD Network of SoCal
First 5 SLO County
Frente Indígena de Organizaciones Binacionales
Friends Committee on Legislation of California
Half Moon Bay Brewing Co
Healthy Cities Tutoring
Hillside Health Center
Hillside Health Center
Hillside Medical Center
Hillside Medical Center
La Clinica de La Raza
Little Lake Heath Clinic
Mendocino Community Health Centers
Mothers' Club Family Learning Center
PDI Surgery Center
Positive Discipline Community Resources
Regarding Baby
Santa Barbara County Education Office
Schwab Charitable
Smile In Style, Solano County
Sunnyvale School District
The L.A. Trust
Tutorworks
Watch Me Grow
Women's Empowerment

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Eileen Espejo to present this proposal.

The Subcommittee requests DPH to respond to the following:

1. Would CCDDPP help with implementation of the state oral health plan? If so, which elements will be the most helpful?

2. Approximately how many children and at how many schools/sites would a $3.2 million restoration of the program serve?

Staff Recommendation: Staff recommends holding this item open.

ISSUE 15: STAKEHOLDER PROPOSAL: VIRTUAL DENTAL HOMES

PANELISTS

- **Kathryn Dresslar**, Director, Sacramento Governmental Affairs, The Children's Partnership
- **Evan Low**, Member, California State Assembly
- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, CDPH
- **Greg Oliva**, Assistant Deputy Director, Center for Chronic Disease Prevention and Health Promotion, CDPH
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Children's Partnership, with support from the California Dental Association, requests $4 million General Fund for DPH to implement the Virtual Dental Home (VDH) Grant Program.

BACKGROUND

Through the VDH, specially-trained dental hygienists and assistants collect dental information from patients in community settings -- such as schools, Head Start sites, and nursing homes. They send that information electronically via a secure web-based system to the supervising dentist at a clinic or dental office. The dentist uses the information to establish a diagnosis and create a dental treatment plan for the hygienist or assistant to carry out. The hygienists and assistants refer patients to dental office for procedures that require the skills of a dentist.

AB 1174 (Chapter 662, Statutes of 2014) established a VDH pilot program, within which nearly 3,000 patients were seen at more than 50 sites around California with very positive results, according to an evaluation that demonstrated patient safety with no adverse outcomes. Approximately two-thirds of the patients seen were able to receive the care they needed at the community site, and the other one-third were referred and treated by a dentist.

Supporters state that the VDH is an innovative and cost-effective model for providing quality dental care to underserved communities. They also state that the model has been proven to be beneficial by providing preventive dental services to children early on in their lives, thereby preventing more serious and costly dental conditions later on. The VDH serves children who are not likely to receive dental care at all.

Stakeholders state that the proposed $4 million would enable the expansion of the program into 20 additional communities, thereby serving an additional 20,000 people. The grants are proposed to be used for training, equipment, technical assistance and related activities.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Kathy Dresslar to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 16: OVERSIGHT: ORAL HEALTH AND DENTAL CARE

PANELISTS

- **Jennifer Kent,** Director, Department of Health Care Services
- **Mari Cantwell,** Chief Deputy Director, Health Care Programs, DHCS
- **Jay Kumar**, State Dental Director, CDPH
- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, CDPH
- **Greg Oliva**, Assistant Deputy Director, Center for Chronic Disease Prevention and Health Promotion, CDPH
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Kofi Kouassi**, Finance Budget Analyst, Department of Finance
- Barbara Taylor, Principal Program and Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

BACKGROUND

The Subcommittee discussed the Denti-Cal program at its hearing on March 2, 2016 and the agenda for that hearing includes a detailed summary of several audits and reports on the program that have been highly critical of the program, particularly with regard to children's utilization of dental services. Since that hearing, an additional very critical report was released on April 1, 2016 by the Little Hoover Commission.

The following is a passage from the Executive Summary of the report, "Fixing Denti-Cal:"

> "For these 13 million or more Californians of modest or little means, Denti-Cal is the only ticket to dental care outside of an emergency room. Yet by many accounts provided to the Commission during a seven-month review, its thicket of rules and outdated processes is baffling, frustrating and ultimately, often harmful to beneficiaries. The statistics portray a vicious circle of dysfunction. Most California dentists don't participate in Denti-Cal due to its low reimbursement rates and administrative obstructions. And fewer than half of people eligible for benefits use them in any given year because there are so few dentists who will see them. Millions of Californians, consequently, are going through life with rotting or missing teeth, debilitating pain, poor oral health habits and no preventative care."

The report includes the following recommendations:

1. The Legislature should set a target of 66 percent of children with Denti-Cal coverage making annual dental visits. Additionally, the Legislature should:

    - Conduct oversight hearings to assess progress or lack of movement on all initiatives designed to reach this target, and particularly on implementation of the five-year $740 million Denti-Cal targeted incentive plan to increase children's preventative dental visits.

    - Ensure the state dental director has adequate authority to see that the Denti-cal targeted incentive program aligns with the 2016 oral health plan

2. The Department of Health Care Services should simplify the Denti-Cal provider enrollment forms and put them online in 2017.

3. The Department of Health Care Services should overhaul the process of treatment authorization requests.

4. The Department of Health Care Services should implement a customer-focused program to improve relationships with its providers.

5. The Department of Health Care Services should purge outdated regulations.

6. The Legislature and Governor should enact and sign legislation in 2016 to create an evidence-based advisory group for the Denti-Cal program.

7. The Legislature and Governor should fund a statewide expansion of teledentistry and the virtual dental home.

8. State government, funders and non-profits should lead a sustained statewide "game changer" to reorient the oral health care system for Denti-Cal beneficiaries toward preventative care.

9. The Legislature and Department of Health Care Services should expand the concepts of Washington State's Access to Baby and Child Dentistry program and Alameda County's Healthy Kids, Healthy Teeth program to more regions of California

10. The Department of Health Care Services and California counties should steer more Denti-Cal-eligible patients into Federally Qualified Health Centers with capacity to see them.

11. Medical societies and non-profit organizations should recruit more pediatricians to provide preventative dental checkups during well-child visits.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to respond to the recent Little Hoover Commission report and respond to the following:

1. Please discuss how DPH and DHCS work together on improving the oral health of Californians.

2. DHCS and DPH: Please describe the Governor's vision of how California can do much better in terms of providing quality dental care and promoting good oral health.

Staff Recommendation: Staff recommends no action at this time.

ISSUE 17: MEDI-CAL DENTAL PROGRAM INTEGRITY BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent,** Director, Department of Health Care Services
- **Mari Cantwell,** Chief Deputy Director, Health Care Programs, DHCS
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Department of Health Care Services (DHCS), Medi-Cal Dental Services Division (MDSD), requests 4.0 full-time permanent positions and $503,000 ($222,000 General Fund (GF) and $281,000 Federal Fund). The staff is needed to address current and anticipated increases in workload due to ongoing efforts in connection with the findings and recommendations of the California State Auditor (CSA) and Office of Inspector General (OIG) audits.

BACKGROUND

MDSD is responsible for overseeing the provision of dental services to Medi-Cal beneficiaries through two different delivery systems: Dental Fee-for-Service (FFS) and Dental Managed Care (DMC). Under the FFS model, MDSD contracts with a dental Fl to provide dental care to over 11,500,000 Medi-Cal beneficiaries statewide. Under the DMC model, MDSD contracts with several DMC plans that provide dental care to over 800,000 Medi-Cal beneficiaries in Sacramento and Los Angeles counties. The Medi-Cal population has continued to grow through transitions, as well as expanded services. The Medi-Cal program has additionally expanded the scope of dental services to the adult population, resulting in increased programmatic utilization of benefits and support services.

The Medi-Cal Dental Program is funded at a minimum of 50 percent Federal Financial Participation (FFP) for both the DMC and FFS contracts. FFP in the state Medicaid dental program is contingent upon compliance with CMS requirements, including but not limited to:

Reporting Requirements

- CHIP Annual Report Template System (CARTS)
- DMC Performance Measures and Benchmarks per Welfare and Institutions code (W&I) 14459.6
- FFS Performance Measures and Quality and Access Criteria per W&I 14132.915

Other Reporting

- Updates to the California Oral Health Action Plan

Additionally, the state Medicaid dental program is allocating resources towards advancing the following CMS goals:

- Increase in each state by ten percentage points the proportion of children enrolled in Medicaid who receive a preventive dental service; and

- Increase by 10 percentage points the proportion of children ages six to nine enrolled in Medicaid who receive a dental sealant on a permanent molar tooth.

The Medi-Cal Dental Program has continued to see an increasing number of beneficiaries enroll in the program particularly in connection with the Affordable Care Act that became effective January 1, 2014. Additionally, select adult optional dental benefits were restored effective May 1, 2014 for approximately 5,000,000 adults, necessitating the need for increased monitoring to proactively address any access to care issues particularly as they apply to the findings of the 2014 CSA audit and the dental program's ability to monitor the program performance. As a result of these changes, expanded responsibilities have been required by CMS and the State Legislature which include but are not limited to:

- Monitoring and reporting of Fee-for-Service (FFS) 11 performance measures per W&I 14132.915 as mentioned above

- Monitoring and reporting of grievances and outcomes per W&I 14132.915

- Monitoring and reporting on access to care

- Regularly establishing and updating appropriate quality and access criteria and benchmarks

- Consulting with the stakeholder community to ensure appropriate measures are being considered and that potential access issues are recognized and corrected proactively

Pursuant to the CSA audit recommendations, MDSD plans to implement additional tangible measurements to more effectively oversee and monitor the Fiscal Intermediary's (FI) contractual obligations and plans to increase monitoring of beneficiary utilization and provider network adequacy to ensure adequate access to care, which will increase workload in all units within MDSD. Additionally, as a result of the OIG audit findings, an increased workload is anticipated in connection with pertinent administrative modifications to help mitigate fraudulent billings, and an increased workload is anticipated in connection with work on program integrity assurance efforts and expanded utilization monitoring responsibilities as required by the Center for Medicaid and Medicare Services (CMS) and the State Legislature. With the new

positions, MDSD will be able to meet operational needs in order to ensure compliance with State law and Medicaid State Plan requirements and will be able to maintain transparency with the stakeholder community and the general public.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.