AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER SHIRLEY N. WEBER, PH.D., CHAIR

MONDAY, MARCH 10, 2014

4:00 P.M. - STATE CAPITOL ROOM 126

ITEMS TO BE HEARD

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4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 1: DEPARTMENT OVERVIEW

The Emergency Medical Services Authority's (EMSA) mission is to coordinate emergency medical services (EMS) statewide; develop guidelines for local EMS systems; regulate the education, training, and certification of EMS personnel; and coordinate the state's medical response to any disaster.

BACKGROUND

The EMSA is comprised of the following three divisions:

- ***Disaster Medical Services Division*.** The Disaster Medical Services Division coordinates California's medical response to disasters. It is the responsibility of this division to carry out the EMS Authority's mandate to provide medical resources to local governments in support of their disaster response, and coordinate with the Governor's Office of Emergency Services, Office of Homeland Security, California National Guard, California Department of Public Health, other local, state, and federal agencies, private sector hospitals, ambulance companies and medical supply vendors to improve disaster preparedness and response.

- ***EMS Personnel Division*.** The EMS Personnel Division oversees licensure and enforcement functions for California's paramedics, personnel standards for pre-hospital emergency medical care personnel, trial studies involving pre-hospital emergency medical care personnel, first aid and CPR training programs for child day care providers and school bus drivers.

- ***EMS Systems Division*.** The EMS Systems Division oversees EMS system development and implementation by the local EMS agencies, trauma care and other specialty care system planning and development, EMS for Children program, California's Poison Control System, emergency medical dispatcher standards, EMS Data and Quality Improvement Programs, and EMS communication systems.

EMSA Budget

The department's proposed 2014-15 budget is summarized in the table below. Overall expenditures are proposed to increase very slightly by just $213,000 in special funds and federal funds. The primary source of funding for this department is federal funds, which is included in the line below labeled "reimbursements," as those are federal funds that come through other departments first, namely the Departments of Health Care Services and Public Health.

EMERGENCY MEDICAL SERVICES AUTHORITY *(Dollars In thousands)*					
Fund Source	**2012-13 Actual**	**2013-14 Projected**	**2014-15 Proposed**	**BY to CY Change**	**% Change**
General Fund	**$6,692**	**$6,771**	**$6,771**	**0**	**0%**
Federal Trust Fund	1,511	2,625	2,678	53	2.0
Reimbursements	11,276	14,801	14,801	0	0
Special Funds	3,351	3,972	4,132	160	4.0
Total Expenditures	**$22,830**	**$28,169**	**$28,382**	**213**	**0.75%**
Positions	67.4	64.2	65.2	1	1.5

Due to the state's severe recession and fiscal crisis, substantial reductions were made over the past several years to the state's emergency preparedness infrastructure, most of which falls under the authority of the EMSA. Despite these reductions, the Governor's proposed 2014-15 budget contains no major policy or fiscal changes to this department. The following describes the recent history of a few of the key components of the state's emergency medical response infrastructure:

Mobile Field Hospitals (MHFs). Since 2006, the EMSA has maintained three MFHs, each of which consists of approximately 30,000 square feet of tents, hundreds of beds, and sufficient medical supplies to respond to a major disaster in the state, such as a major earthquake in a densely populated area. The 2006 Budget Act allocated $18 million in one-time funds for the purchase of the MFHs and $1.7 million in on-going General Fund funding for the staffing, maintenance, storage, and purchase of pharmaceutical drugs, annual training exercises, and required medical equipment for the MFHs.

The original amount budgeted for the pharmaceutical drug cache was $23,000, which was later determined to be woefully inaccurate and insufficient. Recognizing that the value of the MFHs is quite limited in the absence of sufficient pharmaceutical supplies, the Governor put forth requests in 2009 and 2010 to augment the MFH budget by $448,000 General Fund, however the Legislature denied both requests. In 2011, the Governor instead proposed, and the Legislature approved, to eliminate the $1.7 million in on-going support for the MFHs. Nevertheless, there remain on-going storage and maintenance costs for the MFHs.

The EMSA explored various potential shared responsibility arrangements with various non-state entities, such as the Red Cross, in order to find an affordable way for the state to continue to have access to the MFHs in a major disaster. Ultimately, the EMSA did the following: 1) consolidated the MFHs into two storage facilities in order to reduce warehouse space costs; and 2) entered into a 1-year, no-cost contract with Blu-Med (a subsidiary of Alaska Structures) to continue providing minimal maintenance for the MFHs, at no cost to the state, with the stipulation that Blu-Med could rent out one or two MFHs to any state or country dealing with a major disaster. Since then, the contract with Blu-Med ended and EMSA cobbled together sufficient resources to cover maintenance costs over the past couple of years, including through a separate DPH re-appropriation of Hospital Preparedness Program (federal funds) funds which are currently covering the maintenance costs.

Food Link, a non-profit organization in Sacramento, now donates storage space indefinitely for all three MFHs. EMSA has sufficient funding, temporarily, to maintain the supplies in just one of the hospitals, which means that only one of the three can be deployed and utilized within 72 hours. EMSA expects this funding to diminish in the 2015 federal fiscal year.

Medical Stockpiles (Department of Public Health). In 2006-07, the state purchased a large supply of respirators, ventilators, and antivirals to be used in case of a natural disaster, act of terror or other public health emergency. In 2007-08, $8.5 million was re-appropriated to the DPH specifically to store and maintain that stockpile. That re-appropriation expired in FY 2010-11. In 2011, the Governor proposed, and the Legislature approved, of not providing the DPH with new General Fund of $4.1 million that they would need to continue storing and maintaining the stockpile.

Federal Funds. EMSA and DPH both anticipate further reductions in resources as a result of expected reductions to federal funds, such as the Hospital Preparedness Program (HPP) grant to the state. At EMSA, HPP funds support: MFHs, the Disaster Health Care Volunteer System, emergency planning and training, and storage of emergency equipment.

STAFF COMMENTS/QUESTIONS

For several years, the Legislature has grappled with the impacts and consequences of diminishing resources at both EMSA and DPH, with regard to the state's emergency medical preparedness capacity. It would be helpful and timely to have an analysis of the state's remaining emergency preparedness infrastructure and capacity.

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

1. Please provide an update on the status of the mobile field hospitals.

2. Please provide an overview of California's emergency medical response capacity. How does California compare to other large states? How does California's capacity today compare to what it was in the past?

3. Please provide an update on federal resources in this area.

4. Please provide a timeline and cost estimate for the state to provide the Legislature with a multi-departmental assessment and analysis of the state's emergency medical response capacity.

Staff Recommendation: This is an informational item and does not require Subcommittee action.

ISSUE 2: EPINEPHRINE AUTO INJECTOR TRAINING & CERTIFICATION PROGRAM

The EMSA is requesting 1.0 two-year limited term position and $135,000 (Specialized First Aid Training Approval Fund) beginning July 1, 2014 to address the new workload associated with the development and implementation of the Epinephrine Auto Injector Training and Certification Program created through SB 669 (Huff), Chapter 725, Statutes of 2013.

BACKGROUND

Existing law, prior to SB 669, authorized school districts to provide epinephrine auto-injectors to trained personnel to provide emergency medical aid to students experiencing anaphylactic shock. In order for school personnel to use auto-injectors, they must complete a training course on assessment and treatment of anaphylactic reactions and the use of epinephrine. SB 669 subsequently expanded the law to allow first responders to carry and use epinephrine auto-injectors. Specifically, SB 669 does all of the following:

1. Authorizes off-duty pre-hospital emergency medical care personnel and lay rescuers to obtain and use an epinephrine auto-injector (Epi-Pen) in emergencies, after receiving certification and training;

2. Requires EMSA to approve of authorized training providers and to establish and approve minimum standards for training and certification on the use and administration of Epi-Pens; and

3. Authorizes EMSA to impose a fee on training providers for the review, approval and certification of their training programs.

In order to implement SB 669, the EMSA intends to develop a program modeled after the existing Child Care & School Bus Driver First Aid Training program. The proposed Associate Governmental Program Analyst (AGPA) would: convene a taskforce of experts to assist with creating training standards; revise and draft changes to current regulations; complete and manage the rule-making process with the Office of Administrative Law; and develop and document the process and procedures for all aspects of SB 669 implementation.

The training program and certification revenues will not be collected until July 1, 2015, and therefore the EMSA requests a $135,000 loan from the Emergency Medical Services Personnel Fund to cover initial costs.

STAFF COMMENTS/QUESTIONS

No concerns have been brought to the Subcommittee's attention, and it appears that these resources are necessary to implement SB 669.

The Subcommittee requests EMSA to present this proposal.

Staff Recommendation: Staff recommends approval of this BCP to provide 1.0 2-year limited term position and $135,000 in expenditure authority, in the form of a loan from the Emergency Medical Services Personnel Fund, to be paid back with revenue from the Specialized First Aid Training Approval Fund.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: DRINKING WATER PROGRAM TRANSFER

The Governor's budget proposes to move the Drinking Water Program (DWP) from DPH to the State Water Resources Control Board (SWRCB). This would involve the transfer of $202 million ($5 million General Fund) and 291.2 positions from DPH to the Water Board. This includes an additional $1.8 million (General Fund) in one-time funds for technology and facility costs.

BACKGROUND

DPH administers the federal Safe Drinking Water Act (and the parallel state statute). The department's drinking water program (DWP) regulates 5,700 public water systems serving more than 15 service connections or 25 people. The department also oversees water-recycling projects, permits water treatment devices; and provides various technical assistance and financial assistance programs for water system operators—including bond and federally-funded programs for infrastructure improvements in public water systems—to meet state and federal safe drinking water standards. The department administers a revolving loan fund for water treatment infrastructure improvements that is funded by the U.S. Environmental Protection Agency (US EPA). The department responds to drinking water emergencies and provides oversight, technical assistance, and training for local water agencies.

The SWRCB and the nine semi-autonomous regional boards, administer the federal Clean Water Act (and the parallel state statute). Specifically, the board regulates the overall quality of the state's waters, including groundwater, to protect the beneficial uses of water by permitting waste discharges into water and enforcing water quality standards. The board administers the state's system of water rights and provides financial assistance to fund wastewater system improvements, underground storage cleanups, and other improvements to water quality. The board also administers a similar revolving loan fund for wastewater infrastructure improvements that is funded by the US EPA.

Over the past several years, the Legislature has focused oversight efforts on the provision of safe drinking water throughout the state, and in particular to small, disadvantaged communities mainly in rural areas. The 1969 Porter-Cologne Water Quality Act established the state's role in the protection of water quality and was followed by various groundwater and drinking water protection laws throughout the following decades. The Legislature, starting in 2008, has held numerous oversight hearings discussing groundwater and drinking water legislation, with a focus on providing clean drinking water, and looking at the root causes of water quality degradation. The conclusion of these hearings, as well as various reports, is that the majority of the water supply in California is safe and clean. However, there are gaps where the provision of clean, safe water is a challenge, particularly in small, disadvantaged, and rural communities.

SB 1 X2 (Perata), Chapter 1, Statutes of 2007-08 Second Extraordinary Session required the SWRCB, in consultation with other agencies, to prepare a report to the Legislature outlining the causes of groundwater contamination and identifying potential remediation solutions and funding sources to recover state costs of providing clean drinking water to all communities. This report, prepared by UC Davis researchers, was the basis for much of the groundwater and drinking water discussions this past year. In addition, AB 685 (Eng), Chapter 685, Statutes of 2012 declares that it is the established policy of the state that every human have the right to water for domestic uses. The law requires state agencies to consider this as they move forward with water policies in the future. Much discussion has gone on amongst various water advocacy organizations and legislative staff regarding complaints about the management of the drinking water program within DPH. Certain stakeholders have alleged that DPH is slow to make funds available to communities that need them and is fairly inaccessible and unresponsive to stakeholder requests.

In a report entitled *Evaluating the Potential Transfer of Drinking Water Activities from DPH to SWRCB*, the Legislative Analyst's Office (LAO) further documented stakeholders concerns with regard to DPH including: its lack of integration with overall water quality management; slow distribution of financial assistance; slow rulemaking process; insufficient fee structure leading to inadequate administrative resources; and, lack of transparent decision-making. The LAO's report stated that 30 states have consolidated drinking water and water quality programs in a single state entity and that some have consolidated their revolving loan programs. The LAO concluded transferring the DWP to SWRCB could have several potential advantages including greater policy integration on water issues; accelerated rulemaking; increased efficiencies and administrative capacity; heightened transparency and greater public participation by utilizing a board that meets in public. The LAO's report also cautioned that there could be potential disadvantages, including: loss of integration with public health programs that monitor infectious diseases and incidences of birth defects and cancer; temporary disruption in the program's capacity to perform regulatory activities; and, potentially increased, mainly short-term, costs to relocate staff, reclassify positions, and integrate information technology systems.

In 2013, the United States Environmental Protection Agency (EPA) submitted a letter to the California DPH stating that California has not administered the California Safe Drinking Water State Revolving Fund in accordance with applicable EPA requirements. California has received $1.5 billion in federal grants since 1998 to capitalize the California Safe Drinking Water State Revolving Fund. Specifically, the letter states:

> "States are required to make timely loans or grants using all available drinking water funds to eligible water systems for necessary projects, and California has failed to meet this standard. Additionally, the California Department of Public Health has issued loans or grants to many projects, which are not "shovel ready," resulting in funds not being paid out for years. As of October 2012, the drinking water fund had an unspent balance of $455 million in federal funds. This sum is the largest unliquidated obligation of any state in the nation."

The notice also states that states are required to have dedicated accounting and financial staff to track commitments, calculate balances, and plan expenditures and that DPH has not met these requirements. As a result, DPH has not accurately accounted for revenue from ongoing loan repayments into the fund, amounting to $260 million in unexpended loan capacity. The EPA states that California needs $39 billion in capital improvements in order to ensure safe drinking water to all Californians through 2026.

This proposal shifts all of the following programs and combines certain financial assistance programs:

Regulatory Program. The proposal seeks to consolidate all water quality regulation within one state agency. The DWP would be organized as a separate division under the State Water Board. Program regulatory staff would remain in locally-based offices and would not be integrated with the regional water quality control boards. The division would be overseen by a deputy director who would be required to have public health expertise and who would report directly to the executive director. The deputy director would have the authority to grant or deny water system permit applications. These decisions would not be subject to Board review, nor would permit issuance and enforcement be delegated to the regional water boards. The proposal does not include a proposal to extend statutorily-mandated minimum penalties for waste discharge violations to drinking water violations.

Maximum Contaminant Level (MCL)-Setting. MCLs are currently adopted as regulations by DPH. These are the health protective drinking water standards to be met by public water systems. MCLs take into account chemicals' health risks; factors, such as their detectability and treatability; and, costs of treatment. The MCLs would continue to be established through the regular rulemaking process under the Administrative Procedures Act. The deputy director would follow existing rulemaking procedures and the SWRCB would act on the proposed regulations in a public meeting, after which they would be subject to Office of Administrative Law review.

Recycled Water. As a result of this reorganization, the DPH functions related to recycled water would be coordinated through the SWRCB permit process. The Board does not propose to change how these permits are issued, but proposes to seek opportunities for more efficient and effective permitting of recycled water.

Emergency Response. The proposal plans to maintain the existing local emergency response structure of the DWP, including rotating district office duty officers, under the new division. The division would become part of the Cal-EPA Emergency Response Management Committee, which is Cal-EPA's coordinating body that assists in emergencies requiring cross-department or cross-agency solutions. For emergencies affecting water quality, such as sewage or chemical spills, the DWP would coordinate with the Regional Water Boards.

Operator Certification. The SWRCB plans to jointly manage both Operator Certification Programs within the Division of Financial Assistance (already existing at SWRCB). This will allow the DWP to take advantage of the SWRCB's new web-based data management system for wastewater operators and would expand this system to include drinking water operators.

Financial Assistance Programs. The proposal plans for the SWRCB to jointly manage the Clean Water and Drinking Water State Revolving Funds (SRFs) and both bond programs (Propositions 50 and 84) within the Division of Financial Assistance. This proposal will likely require statutory and regulatory changes to harmonize the programs. The division would combine the programs to streamline water quality infrastructure financing, in particular for application assistance for disadvantaged communities.

As a precursor to this proposal, the Administration hosted a series of stakeholder meetings and convened a reorganization task force to solicit feedback on the proposal. The Administration plans to prepare a transition plan in March 2014 that will take into account the efforts to date.

Objectives of Transfer

The Administration intends for the transfer to achieve several objectives. First, it believes consolidating the state's drinking water and water quality programs would result in more integrated water quality management. It considers that consolidating responsibilities for drinking water oversight and regulation with SWRCB's water quality and water rights regulatory activities could allow a single department to address interrelated water issues more comprehensively. For example, there could be a more coordinated focus on the sources of water pollution and their effects on drinking water. In addition, there may be opportunities to coordinate permitting processes for entities that are currently regulated by both DPH and SWRCB.

The Administration also believes this consolidation would improve the state's ability to provide financial assistance to small disadvantaged communities. A SWRCB–administered drinking water program may be more likely to have the expertise and administrative resources required to adequately run the program and get financial assistance out the door in a timely manner. For example, the SWRCB has significant expertise in financial management, including recent experience leveraging their revolving fund to increase the amount of loans the fund is able to offer. This expertise could be extended to Safe Drinking Water State Revolving Fund (SDWSRF).

Finally, the Administration believes the transfer would enhance accountability and transparency on drinking water issues because SWRCB's board structure with regular hearings provides a process for the public and stakeholders to offer comments on proposed rules or other issues. This could improve the ability of the public to hold decision–makers accountable for drinking water outcomes.

LAO Analysis

The LAO finds that the proposed transfer is likely to improve the effectiveness and efficiency of state water policy. However, it also finds that specific aspects of the transfer warrant legislative consideration, including: 1) the continuation of some potential enforcement concerns; 2) coordination between SWRCB and DPH in responding to emergencies and protecting public health; and, 3) statutory changes to the administration of Safe Drinking Water State Revolving Fund.

Consequently, the LAO recommends that the Legislature: 1) approve the proposed transfer of DWP to SWRCB; 2) require the Administration to report at budget hearings on the details of the transition plan and progress made by DPH and SWRCB on coordinating implementation of the transfer; and, 3) require reports on the outcomes of the transfer, including its effects on permitting, enforcement, and emergency response.

STAFF COMMENTS/QUESTIONS

This proposal is consistent with the Assembly Democratic Caucus's 2014-15 Blueprint for a Responsible Budget.

Please note that since this is a joint proposal between DPH and SWRCB, Assembly Budget Subcommittee # 3 on Resources and Transportation also will hear this issue on April 9, 2014.

The Subcommittee requests the department to present this proposal and explain the rationale for moving the program to a new department.

Staff Recommendation: Staff recommends approving of this proposal, stipulating that the action will conform to any action taken in Assembly Budget Subcommittee #3, including the adoption of trailer bill language to implement this program transfer.

ISSUE 2: SNAP-ED CONTRACT CONVERSION (CD-03) BCP

The DPH Nutrition Education and Obesity Prevention Branch (NEOPB) requests authority to convert 70 personal service contract positions into 45 full-time permanent state positions. Specifically, DPH proposes to fund these 45 positions by shifting $4.2 million (2014-15) and $5.3 million (2015-16) from Local Assistance (contract) to State Operations. DPH also proposes to shift an additional $1.2 million (2014-15) and $1.6 million (2015-16) from Local Assistance to Support in order to fund 13 research positions through a contract with either the University of California or California State University. The combined total for the shift from Local Assistance to State Operations is $5.4 million in 2014-15 and $6.9 million in 2015-16. In total, 70 of the contract positions would be converted to 58 state positions.

These positions are federally funded by the United States Department of Agriculture (USDA) through a reimbursement contract with the California Department of Social Services (CDSS). According to DPH, this conversion of staff will result in $12.7 million in annual savings of USDA federal funds, beginning in 2015-16.

BACKGROUND

California receives the largest portion of national funding ($136 million) from USDA's Nutrition Education and Obesity Prevention grant program also known as the Supplemental Nutrition Assistance Program for Education (SNAP-Ed). NEOPB manages a statewide obesity prevention initiative comprised of local, state, and national partners collectively working toward improving the health status of low-income Californians through increased fruit and vegetable consumption and daily physical activity.

The NEOPB's SNAP-Ed funded program provides nutrition education and obesity prevention services to qualifying residents. Depending on the type of services provided, it reaches between one million and 12 million Californians each year. The services provided through this program include: education; training; technical assistance; research and evaluation; advertising; promotion; public relations; consumer empowerment; community development; and public and private partnerships.

NEOPB consists of approximately 147 positions, 70 of which are funded through a personal services contract with the Public Health Institute (PHI). The PHI contract was awarded in November 2009 for a five-year term (October 1, 2009 – September 30, 2014) for approximately $20 million per year for a total of $100 million. PHI has been awarded this contract since 1996. The current contract was approved by the Office of Legal Services and signed by the Department of General Services (DGS) with a provision that another personal services contract of this nature in the future would not be submitted.

Under the existing contract, PHI provides leadership, local capacity building, services for specialized education, and marketing to California's communities. These efforts include special targeted campaigns for children and youth in preschool, school, after-school programs, and community locations. To do this, PHI provides subcontracts and grants to over 50 community agencies, nonprofits, faith-based organizations, small businesses, and small vendors.

New Funding Methodology

The federal Healthy, Hunger-Free Kids Act of 2010 revised the SNAP-Ed funding methodology program by eliminating matching funds to states and instead instituting an allocation method. In response, DPH states that the NEOPB is in the process of transitioning into a new funding model wherein the majority of funding will be granted to the 61 Local Health Departments. The department states that without the conversion of positions, NEOPB will not be able to: support this new funding model; provide experienced oversight; sustain needed activities; and continue to be a highly successful program.

Federal Funds Reduction

The adoption of the new methodology described above included four years of planned reductions to California's funding, beginning October 1, 2013 and continuing through 2017. Specifically, California's funding has been reduced from $144 million annually to approximately $94 million annually (a 35 percent reduction). Moreover, DPH reports that California received an additional unanticipated reduction of approximately $40 million in the current federal fiscal year (and on-going), due to the American Tax Reduction Act, resulting in a $23 million reduction for DPH.

Federal Funds Savings

DPH expects this proposal to result in $12.7 million in annual savings of USDA federal funds, beginning in 2015-16. However, DPH states that this will not have an impact on the reimbursement that is received from CDSS; although this is considered savings, the funds will continue to be used for direct services to the public through local agencies.

Civil Service Mandate

According to DPH, the proposed conversion will align this program with the Governor's directive to reduce reliance on external contracts, and comply with civil service mandates in the California Constitution and Government Code Section 19130, which states, in part:

> (b) Personal services contracting also shall be permissible when any of the following conditions can be met:
>
> > (3) The services contracted are not available within civil service, cannot be performed satisfactorily by civil service employees, or are of such a highly specialized or technical nature that the necessary expert knowledge, experience, and ability are not available through the civil service system.

DPH states that the positions proposed to be converted to state civil service positions are classifications within state government, and that they know of no reason that state employees could not perform these duties. DPH believes that in order to operate within state law and in accordance with the state constitution, they have no choice but to hire state civil servants to do this work, rather than entering into a new contract when this one expires later this year.

USDA Letter

On February 19, 2014, the USDA sent a letter to DSS expressing strong concerns about DPH's proposal to end this contract and utilize state staff to perform the work currently being done by PHI. They raise three concerns as follows:

1. "The California Department of Public Health NEOPB is making a significant mid-year change in the scope of its program without consultation and prior approval from FNS [USDA Food and Nutrition Services].

2. A proposed conversion of contract staff to 45 state staff in NEOPB may not produce a program benefit that justifies the administrative costs associated with recruiting, hiring, training, and maintaining new state staff.

3. California's five SNAP-Ed implementing agencies do not have proportionate levels of oversight, technical assistance and training to support program development and to achieve collective success in SNAP-Ed."

Stakeholder Opposition

The Subcommittee has received communication regarding substantial opposition to this BCP. All of the following have submitted letters to the Legislature: PHI, Diabetes Coalition of California, Hmong Women's Heritage Association, Chinatown YMCA, American Heart Association, Latino Coalition for a Healthy California, Del Norte County Office of Education, Chinese Community Health Resource Center, California Center for Civic Participation, Institute for Sustainable, Education, & Environmental Design. These stakeholders raise the following objections to this BCP:

1. "The BCP abandons a proven, effective model of public/non-profit partnership to provide expertise unavailable in state service.

2. The BCP increases CDPH staffing and costs while California's SNAP-Ed funding is being reduced.

3. The BCP increases state infrastructure at the expense of expertise and efficacy.

4. CDPH's new SNAP-Ed delivery model is vulnerable and needs strong, consistent support.

5. The BCP would eliminate vital community support services and grants to community groups."

STAFF COMMENTS/QUESTIONS

Stakeholders have raised significant issues with regard to this proposal. While it is clear that the law requires state departments to utilize state employees rather than contractors, whenever possible, there is an element of judgment involved in assessing whether or not state employees can perform the same duties, and at the same level of quality, as outside contractors. The department's contract with the PHI has resulted in a very successful and effective program, largely based on PHI expertise and resources that will be lost if the contract is not renewed. The proposal represents the loss of 12 positions, from 70 to 58, and it is unclear what this loss of positions represents in terms of loss of services. DPH cites increased local control as a benefit of this proposal, however increased local control also leads to services varying in both quality and quantity across counties.

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

1. Please explain the rationale for the proposal.

2. Please provide an update on the department's discussions with the USDA.

3. Please explain how DPH plans to partner with local community organizations to achieve the goals of this program and build trust with hard-to-reach populations.

Staff Recommendation: Staff recommends holding this item open to allow for more discussion with the department and stakeholders.

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

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. The WIC estimate proposes:

WIC
Expenditure Authority & Resources

	2013-14				2014-15		
	2013 Budget Act	**November Estimate**	**$ Change**	**% Change**	**November Estimate**	**$ Change from 2013 Budget Act**	**% Change**
Local Assistance	$1,209,569,000	$1,144,932,005	($64,636,995	(5.34%)	$1,154,050,778	($55,518,222)	(4.59%)
Food	908,702,000	844,,065,005	(64,636,995)	(7.11%)	853,183,778	(55,518,122)	(6.11%)
Nutrition Services & Admin	300,867,000	300,867,000	-	0%	300,867,000	-	0%
Support/ Admin	53,860,000	53,860,000	-	0%	53,860	-	0%
Federal WIC Grant	$1,265,416,000	$1,253,912,000	($11,504,000)	(0.91%)	$1,240273,000	($25,143,000)	(2%)
Manufac-turer Rebate Revenue	$260,000,000	$247,941,000	($12,059,000)	(4.64%)	$247,978,000	($12,022,000)	(4.62%)

2013-14

- Overall food expenditures of $1.1 billion, $64.6 million less than the 2013 Budget Act;
- Local assistance expenditure authority of $844.1 million Federal Trust Fund, and $247.9 million WIC Manufacturer Rebate Special Fund;
- $880.4 million Federal Trust Fund revenue, a $29.6 million decrease from the 2013 Budget Act; and
- $248 million in Rebate revenue.

2014-15

- Overall food expenditures of $1.1 billion;
- Local Assistance expenditure authority of $853.2 million Federal Trust Fund, and $248 million WIC Manufacturer Rebate Special Fund;
- $868 million in Federal Trust Fund Revenue; and
- $248.1 million in Rebate revenue, a $12 million decrease from the 2013 Budget Act.

BACKGROUND

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 assess 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 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 for food that 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.** Funds for 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.

Caseload

DPH projects a caseload decrease of approximately 2.26 percent, based on a three-year average decrease of -0.46 percent. DPH states that the decrease in participation reflects a decrease in the birth rate as a result of the recent recession. Using a 3-year average is part of the program's new caseload methodology using the average of the prior three years' participation change, as compared to five years. DPH states that this will provide a more accurate assessment of participation trends.

WIC Caseload		
Federal Fiscal Year	**Average Monthly Participation**	**Percent Change From Prior Year**
2007	1,378,794	
2008	1,412,210	2.42%
2009	1,439,006	1.90%
2010	1,459,406	1.42%
2011	1,466,321	0.47%
2012	1,472,347	0.41%
2013	1,439,073	-0.46%

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 case 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 on October 3, 2012 and USDA approved of the plan. DPH posted this plan for public comment in December 2013, and plans to post the final version in April. This new plan will go into effect two months later.

DPH states that the WIC program is working closely with the USDA to finalize and implement additional cost containment and program integrity strategies, including revising the reimbursement rates for authorized stores. The DPH intends to incorporate these changes into the 2014 May Revise.

STAFF COMMENTS/QUESTIONS

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

1. Please provide an update on the status of the peer group and reimbursement rate regulations and the lifting of the WIC vendor moratorium.

2. Please provide an update on the appointment of a WIC Division Chief. (The interim Division Chief was appointed in April 2012.)

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

ISSUE 4: LICENSING & CERTIFICATION PROGRAM ESTIMATE

The Licensing and Certification (L&C) program develops a budget estimate that details all L&C programmatic, fiscal, and workload factors that it uses to develop its budget. The 2014-15 estimated L&C budget is $188.8 million, which is an increase of $1.9 million from the current year. This increase is a result of two budget proposals discussed later in the agenda.

According to the L&C estimate, updated workload factors show a decrease of overall surveyor workload hours and staffing needs and projects that 70 less L&C field operations staff would be needed. However, L&C notes that it is undergoing a comprehensive program evaluation to improve the reliability of the estimate; consequently, it proposes to maintain the current year level of funding (with the addition of $1.9 million for specific budget proposals).

BACKGROUND

L&C licenses, regulates, inspects and/or certifies health care facilities in California, on behalf of both the state and federal governments. L&C regulates approximately 19 different types of health care facilities, such as hospitals and nursing homes, and also oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

L&C's field operations are implemented via 14 district offices, including approximately 800 positions, throughout the state, and through a contract with Los Angeles County. The field operations investigate complaints about facilities, primarily long-term care facilities, conduct periodic facility surveys, and assess penalties. L&C receives approximately 6,000 complaints per year, and 10,000 entity-reported incidents.

Funding for L&C is predominantly revenue from licensing fees, which are used to match federal funds. DPH also receives reimbursement funding from DHCS for conducting federal certification work for Medi-Cal and Medicare. The only General Fund in L&C is a $5 million appropriation for licensing work related to state-owned facilities.

Health Facility License Fee Report

Existing statute requires the L&C Program to annually publish a Health Facility License Fee Report (DPH Fee Report) by February of each year. The purpose of this annual DPH Fee Report is to provide data on how the fees are calculated and what adjustments are proposed for the upcoming fiscal year.

The DPH Fee Report utilizes the requirements of existing statute for the fee calculations, and makes certain "credit" adjustments. The DPH notes that these "credits" are most likely one-time only and that fees are calculated based solely on the statutorily prescribed workload methodology as contained in statute.

The “credits” are applied to offset fees (e.g., hold the fee stable or reduce the fee) for 2014-15 and total $15.3 million. They are as follows:

- "$3.8 million credit for miscellaneous revenues for change in ownerships and late fees.

- $11.5 million credit from the program reserve which is applied to each facility type to prevent fees from increasing “on the natural” and placing a cap of 20 percent on fees that would have decreased “on the natural.”

L&C Fee Methodology

Licensing fee rates are structured on a per “facility” or “bed” classification and are collected on an initial license application, an annual license renewal, and change of ownership. The fees are placed into a special fund—the Licensing and Certification Special Fund.

The fee rates are based on the following activities:

- Combines information on projected workload hours for various mandated activities by specific facility type (such as skilled nursing home, community-based clinic, or hospital).

- Calculates the State workload rate percentage of each facility type to the total State workload.

- Allocates the baseline budget costs by facility type based on the State workload percentages.

- Determines the total proposed special fund budget cost comprised of baseline, incremental cost adjustments, and credits.

- Divides the proposed special fund cost per facility type by the total number of facilities within the facility type or by the total number of beds to determine a per facility or per bed licensing fee.

The DPH Fee Report provides considerable detail regarding these calculations, data on L&C workload associated with the various types of health care facilities, and a description regarding the details of the methodology. For the second year in a row, L&C proposes to credit health facilities with over $11 million from the program reserve instead of using these funds to address the problems with this program. L&C fees are to be used to support the work associated with enforcing state laws and requirements. Since it is clear that L&C has not been able to enforce these mandates, it should evaluate how these reserve funds could be used to ensure that laws are enforced. The DPH Fee Report of February 2014 proposes modest changes to fees as shown in the table below.

LICENSING AND CERTIFICATION FEE SCHEDULE
FEBRUARY 2014

LICENSE FEES BY FACILITY TYPE			
FACILITY TYPE	FEE PER BED OR FACILITY	FY 2013-14 FEE AMOUNTS	FY 2014-15 PROPOSED FEE AMOUNTS
ACUTE PSYCHIATRIC HOSPITALS	BED	266.58	266.58
ADULT DAY HEALTH CENTERS	FACILITY	4,164.92	4,164.92
ALTERNATIVE BIRTHING CENTERS	FACILITY	2,380.19	2,380.19
CHEMICAL DEPENDENCY RECOVERY HOSPITALS	BED	191.27	191.27
CHRONIC DIALYSIS CLINICS	FACILITY	2,862.63	2,862.63
COMMUNITY CLINICS	FACILITY	718.36	718.36
CONGREGATE LIVING HEALTH FACILITIES	BED	312.00	312.00
CORRECTIONAL TREATMENT CENTERS	BED	573.70	573.70
DISTRICT HOSPITALS LESS THAN 100 BEDS	BED	266.58	266.58
GENERAL ACUTE CARE HOSPITALS	BED	266.58	266.58
HOME HEALTH AGENCIES	FACILITY	3,452.38	2,761.90
HOSPICE FACILITIES*	Bed	312.00	312.00
HOSPICES (2-YEAR LICENSE TOTAL)	Facility	3,713.56	2,970.86
ICF - DD HABILITATIVE	Bed	580.40	580.40
ICF - DD NURSING	BED	580.40	580.40
ICF - DEVELOPMENTALLY DISABLED	Bed	580.40	580.40
INTERMEDIATE CARE FACILITIES	Bed	312.00	312.00
PEDIATRIC DAY HEALTH/RESPITE CARE	Bed	150.41	150.41
PSYCHOLOGY CLINICS	Facility	1,476.66	1,476.66
REFERRAL AGENCIES	Facility	3,494.41	2,795.53
REHAB CLINICS	Facility	259.35	259.35
SKILLED NURSING FACILITIES	Bed	312.00	312.00
SPECIAL HOSPITALS	Bed	266.58	266.58
SURGICAL CLINICS	Facility	2,487.00	2,487.00

*Pursuant to SB 135 (Hernandez), Chapter 673, Statutes of 2012, a new Hospice Facility licensure category was established. In the first year of licensure, the fee shall be equivalent to the license fee for congregate Living Health Facilities.

CMS Concerns with L&C

On June 20, 2012, the federal Centers for Medicare and Medicaid (CMS) sent a letter to DPH expressing concern with the ability of DPH to meet many of its current Medicaid survey and certification responsibilities. In this letter, CMS states that its analysis of data and ongoing discussions with DPH officials reveal the crucial need for California to take effective leadership, management and oversight of DPH's regulatory organizational structure, systems, and functions to make sure DPH is able to meet all of its survey and certification responsibilities. The letter further states that "failure to address the listed concerns and meet CMS' expectations will require CMS to initiate one or more actions that would have a negative effect on DPH's ability to avail itself of federal funds." Finally, CMS acknowledges that the state's fiscal situation in the last few years, and the resulting hiring freezes and furloughs, has impaired DPH's ability to meet survey and certification responsibilities.

As a result of these concerns, CMS set benchmarks for DPH to attain and is requiring quarterly updates from DPH on its work plans and progress on meeting these benchmarks. In its July 2012 report to CMS, DPH reported that it met 30 of the 33 benchmarks for that quarter. In its September 2012 report to CMS, DPH reported that it met 38 of the 41 benchmarks for that quarter. Last year, DPH indicated that it still faced challenges with: 1) meeting the 10-day timeframe to forward certain non-compliances to the CMS regional office; and 2) closing complaints within 60-days. In its fourth quarter report for 2013 to CMS, DPH did not meet the benchmark to investigate and close 95 percent of hospital and nursing home complaints within 60 days of the investigation. It only closed 64 percent.

Recent Legislative Oversight Hearings on L&C

Multiple recent legislative oversight hearings (by the Assembly Committee on Aging and Long-Term Care, Assembly Committee on Health, Senate Committee on Business, Professions and Economic Development, and Senate Committee on Health) and media reports have highlighted significant gaps in state oversight of health facilities and certain professionals that work in these facilities. These gaps include a backlog of complaint investigations against certified nurse assistants and untimely health facility complaint investigations.

There has been long-standing concerns about L&C's ability to investigate and close complaints in a timely manner. The LAO (in 2006) and the Bureau of State Audits (in 2007) found that L&C had a backlog of complaints and that complaint investigations were not investigated or closed in a timely manner.

These concerns still exist today; the department has been unable to indicate how many reports were investigated in a timely manner (within 10 days per state law for complaints that do not pose imminent danger and 24 hours for those that pose imminent danger) nor a count of how many investigations currently remain open.

Workload and Staffing Needs

The Administration has admitted that its current methodology to assess workload demands and needs is flawed. For this reason, it is proposing no change to its budget even though it estimates that it would need 70 less staff. It notes that it is undertaking an evaluation and making an effort to develop a better timekeeping system and workload forecast.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the L&C estimate, provide an overview of the Fee Report, and respond to the following:

1. Please provide an update on DPH's progress in addressing CMS concerns and meeting CMS benchmarks.

2. Please explain the nature of the backlog; what types of cases does it comprise? What resources would be needed to address it?

3. Please describe how DPH plans to hold the L&C program accountable going forward?

4. Precisely what measures will DPH use to gauge progress and improvements in this program?

5. How often will DPH measure its progress?

6. How soon can DPH provide an update to the Legislature on its progress, improvements, and short-term plans for addressing the substantial challenges in this program?

7. What strategies is DPH using to increase its ability to fill vacancies within the department?

Staff Recommendation: Staff recommends holding this item open pending changes and updates at May Revise, and subsequent progress reports from DPH.

ISSUE 5: L&C EVALUATION PROJECT (HQ-01) BCP

DPH requests $1.4 million (one-time Internal Departmental Quality Improvement Account) to expand the Licensing and Certification Program Evaluation project. This project includes a contractor to evaluate ways to improve internal business practices and quality improvement efforts to achieve timely completion of both state and federal workload, in order to ensure that the department meets federal Center for Medicare & Medicaid Services benchmarks.

BACKGROUND

In a letter dated June 20, 2012, CMS informed DPH that the L&C Program was not adequately meeting the federal survey and certification workload required in accordance with the U. S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) Mission and Priority Document. In addition to laying out benchmark goals in this letter, CMS required DPH to:

> "Conduct a comprehensive assessment of DPH's entire survey and certification operations at not only its headquarters, but also at each of the District Offices and the offices covered by its contractual agreement with Los Angeles County…The assessment must identify concerns, issues, and barriers related to DPH's difficulty in meeting performance expectations."

A previous letter dated May 4, 2012, withheld $1,565,384 from CDPH's 2012 federal grant allocation, pending demonstrated performance improvement.

In order to fulfill the CMS requirement, the L&C Program contracted with an external organizational improvement contractor in 2013-14 to pursue three deliverables: 1) preliminary program assessment; 2) organizational gap analysis; and 3) develop preliminary recommendations. These deliverables are scheduled to be presented to the L&C Program by the current contractor by spring 2014.

According to DHP, the approval of this budget proposal will allow implementation of the preliminary remediation plan proposed by the contractor. The completion of this project will assist the L&C Program in identifying performance indicators and benchmarks to measure its compliance with state and federal regulations, in terms of both quality and quantity. It will help resolve challenges as follows:

1. Maintain and effectively manage its resources to meet statutory survey and certification responsibilities while successfully accomplishing other CMS workload mandates.

2. Ensure adequate CMS training activities are provided for the effective utilization and adherence to federal survey and enforcement processes.

3. Identify and eliminate barriers preventing the L&C Program from ensuring timely and accurate completion of mandated state and federal workload as outlined in existing state law and regulations.

The current contractor is performing high-level workload assessments and developing six scopes of work for improvements in the following areas: 1) workload assignment and workload management processes; 2) the Time Entry and Activity Management system (TEAM); 3) allocation of staff and funding resources; 4) best practices; 5) program efficiencies; and 6) quality improvement activities.

STAFF COMMENTS/QUESTIONS

As discussed in the previous agenda item, there is significant concern that L&C is not able to meet federal and state mandates and that a complete program evaluation is warranted. This proposal presents an opportunity to develop a long-term solution to challenges facing L&C. However, staff recommends urging DPH to develop short-term solutions to improve L&C's ability to complete its mandate to ensure individuals are safe and receive quality care in California's health care facilities.

Staff Recommendation: Staff recommends holding this item open to allow more time for the department to report back to the Subcommittee on short term strategies for addressing the challenges within L&C.

ISSUE 6: L&C FEDERAL CERTIFICATION STANDARDS (HQ-04) BCP

DPH requests expenditure authority of $201,000 (Internal Departmental Quality Improvement Account) in 2014-15 to contract with the University of California Davis to conduct independent research and analysis on the extent to which the federal certification standards are or are not sufficient as a basis for the state's licensing standards, as required by SB 534 (Hernández), Chapter 722, Statutes of 2013, for chronic dialysis clinics, rehabilitation clinics, and surgical clinics.

BACKGROUND

DPH licenses health care facilities and agencies in California through its Licensing and Certification (L&C) Program. Licensing is a state mandated and controlled function to assure that facilities providing health care services meet standards regarding qualifications and training of staff, the physical layout and condition of facilities, and systems governing the appropriateness and quality of the services provided.

L&C licenses approximately 30 different types of health care facilities including chronic dialysis clinics, rehabilitation clinics, and surgical clinics. L&C is also the state entity designated by the federal CMS to verify that health care facilities meet minimum certification standards to protect patient health and safety and qualify for Medicare and/or Medicaid reimbursement.

L&C develops regulatory standards for health care facilities and conducts periodic on-site inspections and investigations in response to complaints filed by the public. A longstanding policy has been to use federal certification standards to meet licensure requirements. SB 534 authorizes the DPH to continue this practice by formally adopting the federal certification standards for chronic dialysis clinics, surgical clinics, and rehabilitation clinics for a period of four years while the efficacy of the federal standards is evaluated.

DPH has contacted the Institute for Population Health Improvement at UCD to perform independent research and analysis and produce the required report on the sufficiency of the federal regulations. The analysis and report will consist of: 1) a review of the various certification, accreditation, and other relevant performance standards currently used to evaluate chronic dialysis clinics, surgical clinics, and rehabilitation clinics in other states, comparing requirements of the federal standards with these alternate standards; and 2) a systematic literature review of the peer-reviewed and grey literature on experiences with the implementation of those standards, including identification of areas in need of additional regulatory oversight. The projected cost is $201,000 for the required study.

SB 534 requires DPH to provide the results of this study to the Legislature by July 1, 2017, and DPH states that they will provide them sooner if possible.

STAFF COMMENTS/QUESTIONS

No concerns have been raised with this proposal and it appears to be consistent with the requirements of SB 534.

Staff Recommendation: Staff recommends approval of this BCP to provide expenditure authority of $201,000 (Internal Departmental Quality Improvement Account) to implement SB 534.

ISSUE 7: L&C MEDICAL PRIVACY BREACH ENFORCEMENT (HQ-03) BCP

DPH requests authority to transfer three investigator positions and $251,000 from the California Office of Health Information Integrity (CalOHII, within the California Health & Human Services Agency) to DPH Licensing and Certification (L&C) in order to improve efficiency by combining the authority and resources of two existing programs, both of which are charged with enforcing medical privacy violations. This proposed transfer of positions requires statutory changes and the administration has proposed budget trailer bill for this purpose.

BACKGROUND

In 2008, legislation was enacted to improve patient privacy laws and their enforcement. The resulting laws established two law enforcement responsibilities as follows:

Department of Public Health. Health and Safety Code Section 1280.15 requires health facilities, clinics, hospices, and home health agencies to prevent unlawful or unauthorized access to, and use or disclosure of, a patient's medical information. DPH, after investigation, may assess an administrative penalty of up to $25,000 per patient for a violation of these provisions, and up to $17,500 per patient for each subsequent occurrence. DPH may refer violations of this section to CalOHII for further follow-up enforcement actions.

CalOHII. Health and Safety Code Division 109 (Sections 130200 through 130205) established CalOHII to ensure the enforcement of state law mandating the confidentiality of medical information and to impose administrative fines for the unauthorized use of medical information. Upon receipt of a referral from DPH, CalOHII may assess an administrative fine against any person or provider of health care, for any violation of this division. CalOHII may also recommend further action be taken by various agencies or entities to impose administrative fines, civil penalties, or other disciplinary actions against persons or entities that violate state confidentiality of medical information laws.

Since 2009, DPH and CalOHII have established and maintained two distinct enforcement programs, one focusing on medical privacy violations by health facilities (at DPH) and the other focusing on violations by healthcare providers and other individuals (at CalOHI). The L&C Program of DPH is primarily responsible for regulating licensed healthcare facilities and ensuring their compliance to minimum standards of care and patient safety requirements. Since 2009-10, the number of deliberate breaches reported by healthcare facilities has nearly tripled and is expected to further increase**.**

Currently, licensed health facilities, clinics, hospices, and home health agencies report breaches of patients' confidential medical information to the L&C Program. DPH conducts an investigation into the breach and may assess an administrative penalty for substantiated violations against the reporting entity. When a violation is substantiated, DPH refers the violation to CalOHII for enforcement actions against individuals and other involved entities**.** This requires subsequent visits to the facilities by these investigators, resulting in additional travel time and costs. CalOHII conducts its own

investigation after DPH, often requiring interviews with the same individuals questioned by DPH. Furthermore, because CalOHII may only conduct an investigation after the DPH's referral, time lapses occur that often make it difficult for CalOHII to locate and contact individuals including victims, witnesses and subjects of violations. Finally, separate administrative and legal resources are necessary to support both functions.

According to the Administration, this proposal would improve efficiency by eliminating redundant investigations and related travel, improving timeliness, and by consolidating administrative and legal resources. Finally, they state that this proposal would allow current DPH and CalOHII staff to conduct concurrent investigations of violations by health facilities and individuals and eliminate or reduce redundancy and inefficiencies.

STAFF COMMENTS/QUESTIONS

No concerns have been raised regarding this proposal and it appears it would create efficiencies, and reduce redundancy between DPH and agency.

Please note that this is a joint proposal between DPH and the Health & Human Services Agency. Therefore, a related BCP from agency will be before the Subcommittee when agency issues are on the agenda on March 12, 2014.

Staff Recommendation: Staff recommends approval of the BCP to transfer three positions and $251,000 from CalOHI to DPH, and approval of "placeholder" trailer bill language to accomplish this transfer.

ISSUE 8: INFANT BOTULISM CONTRACT CONVERSION (ID-02 & ID-03) BCP

DPH requests increased expenditure authority of $3 million in 2014-15 and $951,000 in 2015-16 in the Infant Botulism Prevention and Treatment Fund to sustain statutorily required production, distribution, regulatory compliance, and other activities for the DPH public service orphan drug BabyBIG®

DPH also requests authority to convert two contract positions to two permanent state positions, thereby reducing expenditure authority by $46,000 (Infant Botulism Treatment and Prevention Fund). These positions will provide administrative support for the Infant Botulism Treatment and Prevention Program.

BACKGROUND

BabyBIG® [Botulism Immune Globulin Intravenous (Human) (BIG-IV)] is the DPH public service orphan drug for the treatment of infant (infectious) botulism. The drug is distributed nationwide to all patients with infant botulism, as required by the federal Orphan Drug Act and California Health & Safety Code (HSC) §123700-123709. The U.S. Food and Drug Administration (FDA) licensed BabyBIG® to CDPH in 2003; the department is the only entity in the world that produces, tests, and distributes BabyBIG® across the state, country, and internationally. The drug is also a recognized treatment for any domestic bioterrorist attack that uses botulinum toxin as a weapon.

The program was established as a fee-supported program. Parents of children receiving BabyBIG® and/or their health insurers pay a per-use fee of about $45,000. CDPH collects the medication use fee and deposits it into the Infant Botulism Treatment and Prevention Fund to be used for the purpose of producing and distributing BabyBIG®, performing mandated program activities, and other specified activities.

Increased Expenditure Authority

DPH is requesting an increase in expenditure authority in order to be able to sustain the program given rising costs. DPH explains that the costs of producing the vaccine consistently rise over time. They also state that program costs rise when the vaccine is actually being produced, and the program is on the cusp of beginning production of the next lot of the vaccine. The Infant Botulism Prevention and Treatment Fund has a healthy balance at this time.

Staff Conversion

External contract staff was initially hired to support the fluctuating workload associated with the development, production, and distribution of the infant botulism treatment and to address new regulatory mandates. However, as with all programs throughout the department, DPH is seeking to restore state positions to do any work that can be done by state employees as required by state law and the state constitution. DPH states that the existing contract includes ten positions which are primarily medical and scientific in nature, and the state cannot match the expertise and skills of these contracted personnel with state workers. However, two of the positions are administrative in nature, work that can be done by state employees. Therefore, this proposal is to convert just these two positions to state service.

Report Due to the Legislature

AB 82 (Committee on Budget), Chapter 23, Statues of 2013, a budget trailer bill, required DPH to submit a report to the Legislature by October 1, 2013 regarding its plans to address the findings and recommendations described in its "Zero-Based Budgeting (ZBB) Review" report concerning the Infant Botulism Treatment and Prevention Program. The Legislature has not yet received this report.

Continuous Appropriation Proposal

A group of families with children who have suffered from Infant Botulism act as advocates for this program, and they have brought a proposal to the Subcommittee to make the appropriation for the BabyBIG program a continuous appropriation. They believe that the requirement for an annual appropriation serves no useful purpose in this program and that it actually draws staff time and resources away from the program itself to manage the budget process. The program is funded through fees paid by insurers, or hospitals for uninsured patients, and this revenue goes into a special fund that can be used only to support the activities of this program. The families point out that the annual appropriation process requires substantial time and attention from stakeholders, legislators, legislative staff, and administration staff, all of whom play a role in monitoring the program and participating in the budget process. They also point out the difficulty in budgeting for this program on an annual basis in light of the cyclical, non-annual schedule of vaccine production.

STAFF COMMENTS/QUESTIONS

No concerns have been raised with regard to the two BCPs related to this program.

Although the special funds that are generated through this program can only be used for this program, there are a variety of ways in which the department could misuse these funds or otherwise mismanage the program. Maintaining an annual appropriation may be the only way for the Legislature to maintain oversight and control over the operation of this program.

The Subcommittee requests DPH to present these two proposals (BCPs) and respond to the following:

1. Please provide reactions to the stakeholder proposal to utilize a continuous appropriation for this program.

2. When will the Legislature receive the ZBB report?

3. How does DPH set the amount of the fee and what is the history of increases or decreases to the fee?

Staff Recommendation: Staff recommends approval of both BCPs, to increase the programs expenditure authority by $3 million 2014-15 and $951,000 in 2015-16, and to establish two permanent administrative positions within the program.

ISSUE 9: HEALTH IN ALL POLICIES TASK FORCE (EX-01) BCP

DPH requests $458,000 (special funds, federal funds, and reimbursements) and 4.0 permanent positions to staff the Health in All Policies Task Force (HiAPTF). DPH proposes that the funding for the proposed positions come from contributions from all of the different programs within DPH, thereby ultimately comprising special funds, federal funds and reimbursements.

BACKGROUND

Executive Order SO-04-10 established the HiAPTF, directed DPH to facilitate and staff it, and designated 19 state agencies, departments and offices to participate in the task force. This Task Force was initially staffed by the University of California San Francisco, and then the Public Health Institute, with financial support from The California Endowment. Subsequently, financial support for the Task Force has been provided by the Kaiser Foundation and the American Public Health Association.

By December 2010, the HiAPTF had held public workshops resulting in 11 priority recommendations on improving community health that were addressed in eight implementation plans. The HiAPTF creates collaboration across the other 18 state departments and agencies in consideration of the impacts of policies on social determinants of health, as well as the benefits achieved by improving health that are in alignment with the goals of other sectors. HiAPTF staff regularly provide technical assistance within DPH to encourage and support other cross-sectoral work, such as the Safe Streets Initiative and the Farm to Fork interagency agreement with the Department of Food and Agriculture.

In 2012, the Office of Health Equity (OHE) was created within DPH, through budget trailer bill that included provisions requiring OHE to work with the HiAPTF on:

1. Developing programs to address health and mental health inequities and disparities;

2. Prioritizing building cross-sector partnerships within and across departments to change policies and practices to advance health equity; and

3. Working with the advisory committee and stakeholders to provide a forum to address health and mental health inequities and disparities and to develop strategies to respond.

Some examples of health disparities, health inequities, and social determinants of health include the following from a recent DPH report, *The Burden of Chronic Disease and Injury*, California 2012:

- Asthma rates are highest in people with less education and lower income because they are more likely to live, work or go to school near busy roadways; thus increasing their exposure to triggers of asthma.

- The percentage of adults with diabetes is more than two times higher in those with a family income below 100 percent of the federal poverty level as compared to those whose income is 300 percent above the poverty level.
- Death rates due to stroke are 50 percent higher in African Americans than Whites in California.
- The rates of colorectal cancer have declined since 1988 but they have declined at the slowest rate for Latinos and have actually accelerated for Koreans.
- African-American men are over 78 percent more likely than Latino men to develop prostate cancer.
- Older adults have the highest suicide rate in California.
- The rate of violent deaths among African-Americans is ten times greater than rates for whites.

STAFF COMMENTS/QUESTIONS

As DPH describes, addressing the social determinants of health challenge the traditional divisions of government, and reducing inequity requires coherent policy responses across sectors. In order to effectively reduce health disparities, the state must engage in thoughtful collaboration and planning on the impacts on public health of the actions and policies of government sectors not traditionally associated with public health or health policy. No concerns have been raised with this proposal and DPH is proposing to cover the proposed HiAPTF staffing with existing resources.

Staff Recommendation: Staff recommends approval of this BCP for four full-time permanent positions and funding (as specified) of $458,000.