# AGENDA

## ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

### ON HEALTH AND HUMAN SERVICES

### ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

### MONDAY, MARCH 20, 2017

### 2:30 P.M. - STATE CAPITOL ROOM 437

(PLEASE NOTE ROOM CHANGE)

**ITEMS TO BE HEARD**

# LIST OF PANELISTS IN ORDER OF PRESENTATION

## 4265 DEPARTMENT OF PUBLIC HEALTH

### ISSUE 1: CENTER FOR INFECTIOUS DISEASES OVERVIEW AND PROGRAM UPDATES

- **Gil Chavez, MD, MPH,** Deputy Director, Center for Infectious Diseases, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### ISSUE 2: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE AND PROGRAM UPDATES

- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Courtney Mulhern-Pearson**, Senior Director of Policy and Strategy, San Francisco AIDS Foundation

***Public Comment***

### ISSUE 3: RYAN WHITE PROGRAM COMPLIANCE WITH STANDARDS, QUALITY AND TIMELINESS MANDATES BUDGET CHANGE PROPOSAL

- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

## ISSUE 4: EXPANSION OF ADAP DATA SHARING TRAILER BILL

- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

## ISSUE 5: INFECTIOUS DISEASE STAKEHOLDER PROPOSALS

- **Emalie Huriaux,** Director of Federal and State Affairs, Project Inform
- **Courtney Mulhern-Pearson**, Senior Director of Policy and Strategy, San Francisco AIDS Foundation
- **Rand Martin,** Legislative Advocate, AIDS Healthcare Foundation
- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

## ISSUE 6: CENTER FOR ENVIRONMENTAL HEALTH OVERVIEW

- **Mark Starr, DVM, MPVM**, Deputy Director, Center for Environmental Health, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

## ISSUE 7: YOUTH TOBACCO ENFORCEMENT STAFFING BUDGET CHANGE PROPOSAL

- **Mark Starr, DVM, MPVM**, Deputy Director, Center for Environmental Health, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

**ISSUE 8: TOBACCO TAX ACT OF 2016 TOBACCO LAW ENFORCEMENT BUDGET CHANGE PROPOSAL**

- **Mark Starr, DVM, MPVM**, Deputy Director, Center for Environmental Health, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

**ISSUE 9: CENTER FOR HEALTH STATISTICS AND INFORMATICS OVERVIEW**

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

**ISSUE 10: IMPROVED ACCESS TO VITAL STATISTICS DATA BUDGET CHANGE PROPOSAL**

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

**ISSUE 11: DEMOGRAPHIC DATA COLLECTION OF ASIAN, NATIVE HAWAIIAN AND PACIFIC ISLANDER POPULATIONS (AB 1726) BUDGET CHANGE PROPOSAL**

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

**ISSUE 12: CERTIFIED COPIES OF MARRIAGE, BIRTH, AND DEATH CERTIFICATES: ELECTRONIC APPLICATION (AB 2636) BUDGET CHANGE PROPOSAL**

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

**ISSUE 13: EMERGENCY PREPAREDNESS OFFICE OVERVIEW AND BUDGET CHANGE PROPOSAL**

- **Barbara Taylor**, Deputy Director, Emergency Preparedness Office, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

**ISSUE 14: PUBLIC HEALTH EMERGENCY PREPAREDNESS ALLOCATION UPDATE TRAILER BILL**

- **Barbara Taylor**, Deputy Director, Emergency Preparedness Office, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

# ITEMS TO BE HEARD

## 4265 DEPARTMENT OF PUBLIC HEALTH

## CENTER FOR INFECTIOUS DISEASES

### ISSUE 1: CENTER FOR INFECTIOUS DISEASES OVERVIEW AND PROGRAM UPDATES

#### PANELISTS

- **Gil Chavez, MD, MPH,** Deputy Director, Center for Infectious Diseases, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

#### PROPOSAL

This is an informational item and the Subcommittee requests DPH to provide an overview of the Center for Infectious Diseases, its major programs, and how recent legislative augmentations specifically for infectious disease prevention have been used. The January budget proposes approximately $597.8 million for this Center, about 18.1 percent of the total budget of the Department of Public Health.

#### BACKGROUND

The Center for Infectious Diseases (CID) seeks to protect the people in California from the threat of preventable infectious diseases and assists those living with an infectious disease in securing prompt and appropriate access to healthcare, medications and associated support services. The CID is made up of the following Division and Offices which are described below:

- Division of Communicable Disease Control (DCDC)
- Office of AIDS
- Office of Binational Border Health
- Office of Refugee Health

**The Division of Communicable Disease Control (DCDC)**
The DCDC works to promptly identify, prevent and control infectious diseases that pose a threat to public health, including emerging and re-emerging infectious diseases, vaccine-preventable agents, bacterial toxins, bioterrorism, and pandemics (e.g. avian influenza in humans). The DCDC branches also work closely with the Office of AIDS (a separate program within the Center for Infectious Diseases) on comprehensive prevention, diagnosis and treatment services for sexually transmitted diseases, viral hepatitis, tuberculosis and HIV. The DCDC includes the following:

- ***Communicable Disease Emergency Response Program***
  The mission of the Communicable Disease Emergency Response Branch (CDER) is to: 1) monitor reportable infectious diseases, emerging pathogens and unusual outbreaks: and 2) prepare for infectious disease emergencies.

- ***Immunization Branch***
  The Immunization Branch provides leadership and support to public and private sector efforts to protect the population against vaccine-preventable diseases.

- ***Infant Botulism Treatment and Prevention Program (IBTPP)***
  The mission of the IBTPP is to provide and improve the treatment of infant botulism and to prevent infant botulism and related diseases. Infant Botulism is an orphan ("rare") disease that affects infants primarily between one and 52 weeks of age. First recognized in 1976 in California, infant botulism occurs globally and is the most common form of human botulism in the United States.

  Infant botulism is a novel form of human botulism in which ingested spores of Clostridium botulinum colonize and grow in the infant's large intestine and produce botulinum neurotoxin in it. The action of the toxin in the body produces constipation, weakness (notably of gag, cry, suck and swallow), loss of muscle tone, and ultimately, flaccid ("limp") paralysis. Affected infants have difficulty feeding and often, breathing. However, in the absence of complications, patients recover completely from the disease. After an approximate 15-year development period, in October 2003, the U.S. Food and Drug Administration licensed to the California Department of Public Health its public service orphan drug for the treatment of infant botulism, Human Botulism Immune Globulin, under the proprietary name BabyBIG(R).

- ***Infectious Diseases Branch***
  The Infectious Diseases Branch (IDB) conducts investigation, surveillance, prevention, and control of general communicable diseases of public health importance that are not covered by the specific programs of the Immunization Branch, the Tuberculosis Control Branch, the Sexually Transmitted Diseases Control Branch, and the Office of HIV/AIDS. IDB implements its program through its four Sections: Disease Investigations Section, Surveillance and Statistics Section,

Vector-Borne Disease Section, and Veterinary Public Health Section. Diseases followed by IDB include foodborne, waterborne, vector-borne, zoonotic, and emerging infectious diseases. The IDB provides:

- consultation and assistance to local health jurisdictions in the control and prevention of communicable diseases and outbreaks;
- collection, coordination, and tabulation of surveillance data of over 60 infectious diseases;
- investigations of local, regional, statewide, or multistate outbreaks;
- information on infectious diseases to CDPH, local health jurisdictions, the medical community, and the public through emails, press releases by the Office of Public Affairs, postings of pamphlets and fact sheets on the IDB webpage, and publications in medical journals; and
- recommendations, guidelines, policies, and regulations on communicable disease prevention and control.

- ***Microbial Diseases Laboratory Program***
  The Microbial Diseases Laboratory (MDL) of CDPH provides reference, diagnostic and applied research activities for the detection, epidemiologic investigation, control and prevention of bacterial, mycobacterial, fungal and parasitic diseases in humans, food, water and other environmental sources.

- ***Sexually Transmitted Diseases (STD) Control Branch***
  The mission of the STD Control Branch is to reduce the transmission and impact of sexually transmitted diseases and viral hepatitis in California. The branch supports the prevention efforts through providing statewide leadership, guidance, training, technical assistance, surge capacity and safety net support for delivering services throughout the state.

- ***Tuberculosis Control Branch (TBCB)***
  TBCB provides leadership and resources to prevent and control tuberculosis (TB). The vision of TBCB is to speed the decline of TB morbidity and mortality.

- ***Viral and Rickettsial Disease Laboratory Program (VRDL)***
  VRDL provides laboratory support, technical assistance, and research required for the diagnosis, investigation, and control of viral diseases and for the development and maintenance of high quality local viral laboratory services in California. VRDL also provides consultation services to the staff of local public health laboratories, and state agencies. For counties not having available public health laboratory services, VRDL functions as the reference and local public health laboratory in its field of expertise. As part of the Department's laboratory science training program, VRDL trains local public health laboratory personnel in state-of-the-art standardized laboratory procedures.

**Office of AIDS**

As designated by California Health and Safety Code Section 131019, the Office of AIDS (OA) has lead responsibility for coordinating state programs, services, and activities relating to HIV/AIDS. OA's mission is to:

- Assess, prevent, and interrupt the transmission of HIV and provide for the needs of infected Californians by identifying the scope and extent of HIV infection and the needs which it creates, and by disseminating timely and complete information;
- Assure high-quality preventive, early intervention, and care services that are appropriate, accessible, and cost effective;
- Promote the effective use of available resources through research, planning, coordination, and evaluation; and
- Provide leadership through a collaborative process of policy and program development, implementation and evaluation.

The OA is comprised of the Division Office and five branches: Surveillance, Research & Evaluation, HIV Care, HIV Prevention, AIDS Drug Assistance Program, and the OA Support Branch, as follows:

- *Division Office*. The Division Office leads policy development, partnerships with statewide and national HIV/AIDS stakeholders, legislation, and the administration for OA. The Division Office coordinates all division activities.

- *Office of AIDS Support Branch*. The OA Support Branch is responsible for administrative functions which support OA program areas including: budgets, personnel, contracts, grants, clerical support, information technology, procurement, and business services. The OA Support Branch includes the Grants Management Section, Personnel Section, Contracts Unit, Operations Unit.

- *Surveillance, Research & Evaluation Branch*. The Surveillance, Research & Evaluation Branch conducts a variety of epidemiologic studies, evaluates the efficiency and effectiveness of publicly funded HIV/AIDS prevention and care programs, and maintains California's HIV/AIDS Case Registry.

- *HIV Care Branch*. The HIV Care Branch has responsibility for programs related to the delivery of care, treatment, and support services for people living with HIV/AIDS. Programs are designed to provide an effective and comprehensive continuum of care to underserved individuals.

- *HIV Prevention Branch*. The HIV Prevention Branch funds initiatives to assist local health departments and other HIV service providers to implement effective HIV detection and prevention programs.

- *AIDS Drug Assistance Program Branch*. The AIDS Drug Assistance Program (ADAP) helps ensure that people living with HIV and AIDS who are uninsured and under-insured have access to medication. OA works closely with the pharmacy benefits manager (PBM), to administer and manage ADAP for the clients served.

**Office of Binational and Border Health (OBBH)**
The mission of the OBBH is to facilitate communication, coordination, and collaboration between California and Mexico health officials, health professionals, and communities in order to optimize border and binational health. The goals of the OBBH include:

1. Assess, monitor, and report on border and binational public health issues.
2. Promote and optimize communication, coordination, and collaboration on border and binational health issues and policies.
3. Build capacity to effectively address border and binational public health issues.
4. Increase awareness about border and binational public health issues and the role of OBBH in addressing them.

**Office of Refugee Health**
The Federal Refugee Act of 1980 created the Office of Refugee Resettlement (ORR) to fund and coordinate post-arrival health assessments, time-limited medical services and cash assistance, and other benefits to newly arrived refugees, asylees, and other eligible entrants to help them achieve economic self-sufficiency as quickly as possible after their arrival to the United States. In California, the Office of Refugee Health (ORH) coordinates the following programs supported with ORR funds:

1. *Refugee Health Assessment Program (RHAP).* Impacted local health jurisdictions provide culturally and linguistically-appropriate comprehensive health assessments to newly arrived refugees, asylees, federally-certified victims of severe forms of trafficking, and other eligible entrants. The RHAP focuses on screening of and prevention of communicable diseases; early identification and diagnosis of chronic diseases and other important conditions; assessment of immunization status for children and adults; mental health screening; and referral to health providers for further medical evaluation, treatment, and follow-up.

2. *Refugee Medical Assistance Program (RMA).* In coordination with the Department of Health Care Services, Medi-Cal Eligibility Division, the RMA provides time-limited RMA-based Medi-Cal benefits to refugees, asylees, federally-certified victims of human trafficking, and other entrants who are not eligible to receive Title XIX Medi-Cal benefits. This benefit is available only for the first eight months from the date admitted to the U.S. or from the date of certification.

***Recent Legislative Budget Augmentations***

The following augmentations were spearheaded by the Legislature, and DPH provided the updates on the use of the funds:

*2015 Budget Act:*

- ***$3 million General Fund (on-going) for syringe exchange programs (SEPs).*** DPH now has a contract with a distributor of supplies to SEPs which have provided positive feedback about the positive fiscal impact this assistance has had on their programs overall. Many SEPs used to run out of supplies before the end of the year, which this funding has prevented. Also as a result of this funding, new SEPs are developing and becoming operational.

- ***$2.2 million General Fund (on-going) for Hepatitis C linkages to care projects***. DPH issued a Request For Proposals (RFP) for this funding and received 19 applications, resulting in 5 3-year awards (operating through June 2019). The five awardees include:

    1. Access Support Network – San Luis Obispo and Monterey Counties
    2. Butte County Health Department
    3. Family Health Centers of San Diego
    4. St. John's Well Child and Family Center – South East Los Angeles County
    5. San Francisco Department of Public Health

- ***$2 million General Fund (on-going) for HIV Pre-Exposure Prophylaxis (PrEP) Demonstration Projects***. DPH awarded 9 grants to implement this funding for "PrEP Navigators" who help people at high risk of HIV to get connected to care and gain access to PrEP, resulting in the creation of a statewide network of navigators. The 9 grantees are as follows:

    1. Alta Med Health Services Corporation – Los Angeles
    2. Asian Health Services – San Francisco
    3. Desert AIDS Project – Coachella Valley
    4. Friends Research Institute – Los Angeles
    5. Humboldt County Department of Health
    6. Kern County Department of Health
    7. La Clinica De La Raza – Alameda
    8. Alta Bates Medical Center – Alameda
    9. Tarzana Treatment Centers – Los Angeles

*2016 Budget Act:*

- ***$5 million General Fund (one-time) to prevent the spread of sexually transmitted diseases (STDs).*** DPH issues an RFP to local entities offering the opportunity to respond as they see most appropriate and effective for their local communities.

- ***$1.4 million General Fund (one-time) to prevent the spread of hepatitis.*** This funding was split between the Viral Hepatitis Program (VHP) and OA as follows:

    - VHP: This program has used the funding to purchase and distribute Hepatitis C rapid test kits and for purchase and distribution of the Hepatitis B vaccine; and

    - OA: The OA used this funding for Hepatitis C rapid test kits and to provide technical assistance to local jurisdictions and community based organizations interested in establishing new SEPs.

- ***$1 million federal and special funds (on-going) and trailer bill to cover PrEP-related copays, coinsurance and deductibles incurred by individuals accessing PrEP with annual incomes below 500 percent of the Federal Poverty Level.*** DPH explains that the pharmaceutical company offers financial assistance for PrEP users and stated that they will not continue to pay for any costs being covered by these state funds. DPH is negotiating with them to resolve this issue.

## STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to provide an overview of the Center for Infectious Diseases, its proposed budget, provide updates on the use of the recent legislative augmentations that are detailed above, and respond to the following:

1. Please present morbidity and mortality data on infectious diseases in California.

2. Where are infectious disease rates highest, by county or other geographic region?

3. What is DPH's strategic plan for reducing rising rates of STDs?

4. How does DPH provide refugee health assessments to unaccompanied minors?

5. Are the refugee programs seeing a decrease in the number of refugees in light of new federal immigration policies, and does DPH anticipate a significant decrease?

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## ISSUE 2: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE AND PROGRAM UPDATES

### PANELISTS

- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Courtney Mulhern-Pearson**, Senior Director of Policy and Strategy, San Francisco AIDS Foundation

***Public Comment***

### ADAP ESTIMATE

The ADAP Estimate for the 2016 November Estimate provides a revised projection of Current Year [Fiscal Year (FY) 2016-17] local assistance costs for the medication and health insurance programs for ADAP, along with projected local assistance costs for the Budget Year (FY 2017-18).

- For FY 2016-17, CDPH estimates that ADAP expenditures will be $362.5 million, which is a $29.5 million increase compared to the 2016 Budget Act. The increase in expenditures is mainly due to growth in medication-only clients and continuing increases in medication prices.

- For FY 2017-18, CDPH estimates that ADAP expenditures will be $382.2 million, which is a $49.2 million increase compared to the 2016 Budget Act, and a $19.7 million increase compared to the revised FY 2016-17 estimate. The overall number of clients receiving ADAP services will continue to increase each year at rates similar to pre-ACA implementation due to persons becoming newly infected with HIV. Additionally, medication prices increase annually. However, OA estimates a decrease in medication-only clients due to the proposed implementation of ADAP case management services, thereby lowering program costs as medication-only clients transition to private insurance clients.

**ADAP Local Assistance Estimate**
*(Dollars in Millions)*

| Fund | 2016 Budget Act | 2016-17 Estimate | 2017-18 Proposed | CY Act to BY $ Change | CY Act to BY % Change |
|---|---|---|---|---|---|
| Federal Fund | $126.9 | $121.8 | $117.4 | -$9.5 | -7.5% |
| Rebate Fund | $206.2 | $240.7 | $264.8 | $58.6 | 28.4% |
| **TOTAL FUNDS** | **$333.0** | **$362.5** | **$382.2** | **$49.2** | **14.8%** |

**TABLE 4: ESTIMATED ANNUAL CASELOAD AND EXPENDITURES BY CLIENT GROUP AND SERVICE TYPE, FY 2016-17**

| CLIENT GROUP | CASELOAD | | SERVICE TYPE EXPENDITURE | | | |
|---|---|---|---|---|---|---|
| | NUMBER | PERCENT | MEDICATIONS | INSURANCE PREMIUMS | MED OUT-OF-POCKET | TOTAL EXPENDITURE |
| Medication-Only | 12,892 | 44.01% | $299,933,593 | $0 | $0 | $299,933,593 |
| Medi-Cal SOC | 152 | 0.52% | $728,786 | $0 | $0 | $728,786 |
| Private insurance* | 7,735 | 26.41% | $11,057,328 | $17,393,988 | $1,437,918 | $29,889,234 |
| Medicare Part D+ | 8,462 | 28.89% | $18,915,167 | $514,013 | $0 | $19,429,180 |
| **SUBTOTAL** | **29,242** | **99.83%** | **$330,634,874** | **$17,908,001** | **$1,437,918** | **$349,980,793** |
| PrEP | 50 | 0.17% | $461 | $0 | $4,321 | $4,782 |
| **TOTAL** | **29,292** | **100.00%** | **$330,635,334** | **$17,908,001** | **$1,442,240** | **$349,985,575** |

*** Subgroup of 4,737 clients receiving assistance for premium payments and medical-out-of-pocket costs.**

**+ Premiums for Medicare Part D clients include Part D, Part B, and Medigap policies.**

**Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.**

- For FY 2016-17, CDPH estimates ADAP revenue will be $302.6 million, which is a $41.9 million increase compared to the 2016 Budget Act.

- For FY 2017-18, CDPH estimates ADAP revenue will be $305 million, which is a $44.3 million increase compared to the 2016 Budget Act.

For both FYs, the increase in revenue is due mainly to the increase in the overall medication expenditures and an increase in the overall rebate percentage rate.

*Key influences on ADAP expenditures:*

FY 2016-17: Compared to the 2016 Budget Act, OA estimates that expenditures during FY 2016-17 will increase by 8.8 percent. This increase is largely due to a growth in medication-only clients since January 2016, because the number of Californians living with HIV continues to rise due to new infections and most Medi-Cal Expansion clients have transitioned out of ADAP. As a result, the number of ADAP clients is starting to increase again at a rate similar to what was seen before ACA implementation. In addition, medication prices continue to increase, including an unexpected 6.9 percent mid-year hike for elvitegravir/cobicistat/emtricitabine/tenofovir (Stribild) and emtricitabine/rilpivirine/tenofovir (Complera), which are among ADAP's most frequently prescribed antiretroviral (ARV) medications.

FY 2017-18: Compared to the 2016 Budget Act, OA estimates that expenditures during FY 2017-18 will increase by 14.8 percent. The overall number of clients receiving ADAP services will continue to increase each year at rates similar to pre-ACA implementation due to persons becoming newly infected with HIV. Additionally, medication prices increase annually. However, OA estimates a decrease in medication-only clients due to

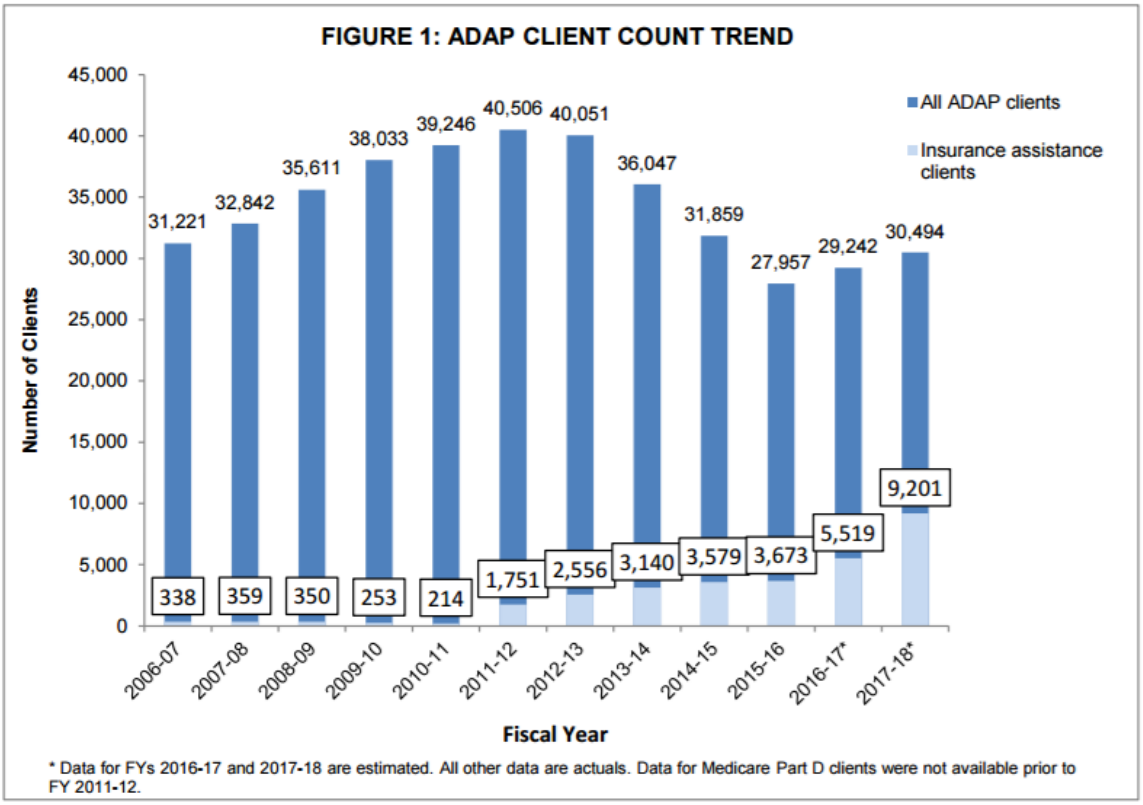
the proposed implementation of ADAP case management services, thereby lowering program costs as medication-only clients transition to private insurance clients.

*Caseload*

As described above, the OA states that the overall number of clients receiving ADAP services will continue to increase each year at rates similar to pre-ACA implementation due to persons becoming newly infected with HIV.

| | 2016 Budget Act | 2016-17 Estimate | 2017-18 Proposed | CY Act to BY $ Change | CY Act to BY % Change |
|---|---|---|---|---|---|
| Caseload | 29,155 | 29,292 | 30,994 | 1,839 | 6.3% |

Figure 1 (below) is a summary of total client counts in ADAP, excluding PrEP clients, by FY; the number of ADAP medication program clients who are also receiving insurance assistance is also shown. In 2014, the state began implementing the ACA which explains the significant decrease in caseload that begins that year, reflecting the large number of former ADAP-clients who gained comprehensive coverage primarily through the ACA Medi-Cal expansion.



## BACKGROUND

ADAP provides access to life-saving medications for eligible California residents living with HIV, and assistance with covering costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV. ADAP services, including support for medications, health insurance premiums, and medical out-of-pocket costs, are provided to five groups of clients:

1. **Medication-only clients** are people living with HIV (PLWH) who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals. This group only receives services associated with medication costs.

2. **Medi-Cal share of cost (SOC) clients** are PLWH enrolled in Medi-Cal who have a SOC for Medi-Cal services. ADAP covers the SOC for medications for these clients. This group only receives services associated with medication costs.

3. **Private insurance clients** are PLWH who have some form of health insurance, including insurance purchased through Covered California, privately purchased health insurance, or employer-based health insurance; therefore, this group is sub-divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive services associated with medication costs, health insurance premiums, and medical out-of-pocket costs. Currently, employer-based insurance clients only receive medication services, but they will be offered health insurance premium and medical out-of-pocket cost services starting in the spring of 2017.

4. **Medicare Part D clients** are PLWH who are enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group receives services associated with medication co-insurance and Medicare Part D health insurance premiums. As part of this budget proposal, starting July 1, 2017, qualifying Medicare Part D clients will have the option for premium assistance with Medicare Part B medical insurance and Medi-gap policies, which cover their medical out-of-pocket costs.

5. **PrEP clients** are individuals who are at risk for, but not infected with HIV, and have chosen to take PrEP as a way to prevent infection. This PrEP Assistance Program will start in the spring of 2017 and this group will receive services associated with medication costs and medical out-of-pocket costs.

ADAP collects full rebate for prescriptions purchased for all client types listed above except Medi-Cal SOC and PrEP clients. As the primary payer, Medi-Cal has the right to claim federal mandatory rebate on prescriptions for Medi-Cal SOC clients. In order to ensure duplicate rebate claims are not submitted to manufacturers by both programs, which is prohibited, ADAP does not invoice for rebates on these claims.

Historically, the majority of clients ADAP served were ADAP-only clients without health insurance, because PLWH were unable to purchase affordable health insurance in the private marketplace. However, with the implementation of the ACA, more ADAP clients have been able to access public and private health insurance coverage. ADAP clients are screened for Medi-Cal eligibility, and potentially eligible clients must apply. Clients who enroll in full-scope Medi-Cal are dis-enrolled from ADAP, because these clients have no SOC, drug co-pays, or deductibles, and no premiums. All clients who obtain health coverage through Covered California or other health plans can remain in ADAP's medication program to receive assistance with their drug deductibles and co-pays for medications on the ADAP formulary. Eligible clients with health insurance can co-enroll in ADAP's health insurance assistance programs for assistance with their insurance premiums. Assisting clients with purchasing health insurance is more cost effective than paying the full cost of medications. In addition, assisting clients with purchasing and maintaining health insurance coverage improves the overall health of Californians living with HIV because clients have comprehensive health insurance and access to the full spectrum of medical care, rather than only HIV outpatient care and medications through the Ryan White (RW) system.

***ADAP Operational Contracts***

The ADAP program experienced significant operational problems over the past approximately 8 months, a direct result of a new contract with a new vendor (AJ Boggs) that began in July of 2016 for enrollment services. Prior to July 2016, the ADAP program had a contract with Ramsel, a vendor that managed both enrollment and pharmacy benefits for ADAP for many years. When the contract with Ramsel came up for renewal, DPH issued an RFP, as usual, which resulted in not renewing the contract with Ramsel, and instead DPH signed three separate contracts with three new, separate vendors: 1) AJ Boggs for enrollment; 2) Magellan for pharmacy benefits; and 3) Pool Administrators, Inc. that handles a new contracted function involving processing of all out-of-pocket cost payments, thereby protecting consumers from having to pay out of pocket costs, to be reimbursed later.

CDPH explains that they had two goals in splitting one contract into three: 1) to reduce costs; and 2) to enhance consumer services and increase quality of the program. The goal of reducing costs was the focus of the pharmacy benefits contract while the second goal, to improve the program, was primarily the goal associated with the enrollment benefits contract. DPH explains that while there were no problems with the enrollment system and services provided by Ramsel, the Ramsel system had limits to its

functionality, and their RFP did not offer the kinds of program improvements that DPH was looking for, and that were included in the AJ Boggs' proposal.

Legislative staff began hearing complaints from key HIV/AIDS advocates in the fall of 2016 about significant disruptions and problems for ADAP clients in the form of delays in accessing medication, insurance policies being cancelled, difficulty for clients to access reimbursements for medical expenses, and eventually the enrollment website going off-line due to security concerns. For several months, the OA attempted to address these problems, working with AJ Boggs and advocates. These efforts finally culminated in early March 2017 with the termination of the contract with AJ Boggs, effective March 31, 2017.

In light of ending the contract for enrollment services, DPH has taken steps to bring this function in-house. DPH has temporarily redirected 20 positions from other areas of DPH for up to four months to do this work, and DPH is still developing its long-term plans with regard to performing eligibility and enrollment functions for ADAP.

## STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the ADAP estimate, explain the history and current status of the operational contracts, and respond to the following:

1. Please explain the significant (15 percent) increase in the cost of the ADAP program, and, specifically, what recourse does the state have with regard to excessive pharmaceutical price increases?

2. How much money is being saved as a result of the new ADAP contracts?

3. Since it is possible for DPH to perform the eligibility and enrollment functions in-house, please explain the reasons that it has not been done in-house before now.

4. Please provide morbidity and mortality statistics on HIV and AIDS in California.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## ISSUE 3: RYAN WHITE PROGRAM COMPLIANCE WITH STANDARDS, QUALITY AND TIMELINESS MANDATES BUDGET CHANGE PROPOSAL

### PANELISTS

- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### PROPOSALS

The CDPH Office of AIDS (OA) is requesting $1,239,000 State Operations expenditure authority in fiscal year (FY) 2017-18 and ongoing comprised of $740,000 from the Federal Trust Fund and $499,000 from the AIDS Drug Assistance Program (ADAP) Rebate Fund, and 7 permanent positions to address Health Resources and Services Administration (HRSA) site visit findings, improve client health outcomes, and reduce health disparities through the implementation of Standards of Care and a Clinical Quality Management Program. The budget authority request will also fund 2 additional Associate Governmental Program Analyst positions that will be redirected from within CDPH.

### BACKGROUND

The OA is funded by HRSA Ryan White HIV/AIDS Program (Part B) to provide HIV care and treatment services in California to achieve the three primary goals of the National HIV/AIDS Strategy:

1. Reduce the number of people who become infected with HIV;
2. Increase access to care and improve health outcomes for people living with HIV; and
3. Reduce HIV-related health disparities.

At the end of 2014, there were 126,241 persons living with diagnosed HIV infection in California. Among these persons, an estimated 29 percent were not in care and 43 percent were not virally suppressed. Viral suppression turns HIV from a fatal disease into a chronic, lifelong manageable condition, and also, reduces a person's likelihood of HIV transmission to partners by 96 percent.

CDPH is the grantee for the federal HRSA Ryan White HIV/AIDS Program (Part B) in California. CDPH's HIV Care Program and ADAP are central to CDPH's efforts to link and retain people living with HIV into care and treatment. HIV/AIDS drug therapies have helped HIV-infected people live longer, healthier lives. Fewer individuals now progress to an AIDS diagnosis, thus the HIV Care Program and ADAP have helped avoid the higher health cost of treating patients with advanced HIV disease. As mandated in federal law, both programs serve clients with no other payer source for these services.

- The HIV Care Program is solely funded by the federal HRSA Ryan White HIV/AIDS Program grant. The program funds 42 contractors, which provide up to 12 types of core medical services and 16 types of supportive services to about 15,500 low-income HIV-positive clients.

- ADAP is funded by both the federal HRSA Ryan White HIV/AIDS Program grant and the ADAP Rebate Fund. As reported in the ADAP FY 2017-18 November Estimate, ADAP is expected to provide medication and health insurance assistance to 29,242 HIV-positive clients enrolled in the program in FY 2016-17 through contracted ADAP enrollment sites.

During a comprehensive site visit in March 2016, HRSA found that CDPH did not have adequate staffing or infrastructure to implement a Clinical Quality Management Program, lacked Standards of Care for all funded service categories for all regions of the state, and did not meet state law regarding timely payment of invoices. Therefore, CDPH was found to be out of compliance with three federal mandates:

- *Standards of Care* - Ryan White HIV/AIDS Program legislation (Title XXVI of the Public Health Service Act §§ 2618 [b][6] and [b][3][C&E]) requires grantees to establish a unique set of service standards for each of the 28 funded services to define the basic level of service. The HIV Care Program has not established Standards of Care due to insufficient resources. HRSA is requiring the HIV Care Program to develop standards of care/service for every funded service category for all regions of the state. By establishing parity and equity between HIV Care Program providers, the Standards of Care will address geographic health disparities within the program.

- *Clinical Quality Management Program* - Ryan White HIV/AIDS Program legislation (Title XXVI of the Public Health Service Act §§ 2604[h][5], 2618[b][3][E], 2664[g][5], and 2671 [f][2]) requires grantees to establish Clinical Quality Management Programs to assess the extent to which their services are consistent with the United States Department of Health and Human Services guidelines for the treatment of HIV disease and related opportunistic infections. HRSA requires that CDPH's Clinical Quality Management Program be supported by adequate infrastructure to develop and implement corresponding activities. HRSA found, "Although the CDPH

has a quality management nurse and portions of other staff time, the current staff level is not sufficient to implement the Clinical Quality Management Program and corresponding activities." The Clinical Quality Management Program provides the infrastructure and processes for identification, collection, reporting, analysis, and disposition of performance data and information on HIV Care Program and ADAP's services. By enhancing the infrastructure, CDPH will be able to strategically utilize Quality Management processes to systematically improve HIV-positive clients' health outcomes such as increasing viral load suppression.

- *Timely Payment of Invoices* - HRSA noted the long timeframe for the HIV Care Program to pay some invoices. The California Prompt Payment Act requires that state agencies pay properly submitted invoices within 45 days of receipt. Delayed payments to some contractors, particularly small non-profit agencies, may jeopardize program stability and could subject CDPH to interest penalty according to the Prompt Payment Act. Beginning in FY 2013-14, CDPH Office of AIDS instituted a 100 percent review of all HIV Care Program invoices and backup documentation to ensure that expenditures were accurate and allowable, and to minimize the risk of fraud or abuse. This accountability measure increased the staff workload and resulted in the processing time increasing from an average of 36 days in FY 2013-14 to an average of 51 days in FY 2015-16.

- *ADAP Case Management Services* - During the same site visit, HRSA recommended that CDPH consider utilizing a portion of the ADAP Rebate Funds "to enhance services to engage people in care, including linkage and retention in health care services, and to support transitioning activities to secure comprehensive health care coverage for people living with HIV and AIDS in the state including case management." A key element in getting people living with HIV in care and virally suppressed is removing barriers that prevent the client from accessing care and staying in care. Such barriers include the systems people living with HIV must navigate to acquire insurance, lack of stable housing, lack of transportation, lack of steady income, and food insecurities. The use of ADAP Rebate Funds for these purposes is supported by the Ryan White HIV/AIDS Treatment Extension Act of 2009 and aligns with Goal 2 of the National HIV/AIDS Strategy to increase access to care and improving health outcomes for people living with HIV. ADAP currently does not provide case management services. ADAP is requesting local assistance expenditure authority to support case management services in the ADAP FY 2017-18 November Estimate.

As grantee for the federal HRSA Ryan White HIV/AIDS Program (Part B), CDPH has the sole responsibility for managing the program, addressing the problems identified by HRSA, and achieving compliance with federal requirements. There are no other public or private entities that can address the problems identified by HRSA.

This proposal addresses HRSA's site visit findings of CDPH being out of compliance with three federal mandates. The previous HRSA site visit conducted in November 2013 focused only on ADAP and did not identify any findings in these three areas. This proposal will allow for the completion of the federal statutory mandate to establish Standards of Care, and will address the additional site visit findings related to Clinical Quality Management Program staffing and late payment of invoices, as well as provide for overall improvements to ADAP's management of enrollment site contracts and ability to case manage clients. CDPH expects to be fully compliant with the HRSA findings on or before FY 2019-20. CDPH also expects that it would risk further HRSA findings and potential decreases in federal funding should this proposal not be approved.

Additionally, by providing comprehensive case management, ADAP could support eligible people living with HIV in becoming stable and linking and retaining them in on-going medical care and treatment. CDPH would focus its case management efforts on getting individuals enrolled in ADAP and private health coverage. Ensuring people living with HIV are linked to care and treatment soon after diagnosis and retained in care and treatment will help maximize the benefits for early treatment and reduce risk of transmission.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to present this proposal and explain how the OA became out of compliance with HRSA requirements.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## ISSUE 4: EXPANSION OF ADAP DATA SHARING TRAILER BILL

### PANELISTS

- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### PROPOSAL

The CDPH OA proposes trailer bill to expand authority for CDPH to share HIV health information to improve linkage to, and retention in, HIV medical care and treatment, consistent with *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*. This bill would add HIV prevention staff to the list of persons authorized to disclose the information to local health jurisdictions (LHD) staff. This bill would also add HIV prevention and surveillance staff to the list of persons authorized to disclose the information to the PLWH and/or the health care provider who provides HIV care to a PLWH. All disclosure would be for the purpose of proactively offering and coordinating HIV care and treatment services.

To simplify enrollment into the multiple Ryan White (RW) programs throughout the state, this bill additionally would allow RW staff within LHDs and community based organizations (CBOs) to use information collected for the administration of ADAP services. This bill clarifies that this information is confidential and cannot be further used or disclosed, except for any of the following:

- For the purposes of administering the program;
- For coordinating client eligibility for programs funded by RW;
- Where disclosure is otherwise authorized; or,
- Pursuant to a written authorization by the person who is the subject of the record or by his or her guardian or conservator.

### BACKGROUND

ADAP receives federal funds from the U.S. Health Resources and Services Administration (HRSA) through grants, which are provided by Part B of the Ryan White (RW) HIV/AIDS Treatment Extension Act of 2009. These Part B grants are used to fund

the provision of medication and assistance with insurance premiums for persons living with HIV/AIDS (PLWH). Other RW provisions fund medical care and supportive services through grants to LHDs and CBO. A PLWH may receive services at all of these levels through multiple parts of the RW program.

Comprehensive case management services support PLWH in becoming stable and getting linked to, and retained in, ongoing medical care and treatment. Ensuring PLWH are linked to care and treatment quickly after their diagnosis and retained in on-going care and treatment will maximize the personal health benefits of early treatment and reduce HIV transmission in the community.

Currently, ADAP staff and care services staff are authorized to disclose personally identifiable HIV/AIDS-related health information to the PLWH and/or their health care provider for the purpose of proactively providing linkages to care. In addition, ADAP staff, care services staff, and HIV surveillance staff are authorized to disclose personally identifiable HIV/AIDS-related health information to LHDs for the purpose of providing proactive linkages to care. Under existing disclosure laws, HIV prevention staff is not authorized to share this information with an outside entity for linkage to care purposes.

The role of HIV prevention and HIV surveillance staff has expanded from studying only aggregate data to reviewing disaggregated health information. This review allows the surveillance and prevention staff to better target prevention and treatment efforts. The current data, used by prevention and surveillance staff, often identifies gaps in treatment that can be addressed by providing information to LHDs, health care providers, and patients.

Under current state law, public health records of state and LHDs relating to HIV/AIDs containing personally identifying information are considered confidential and may only be disclosed for very limited purposes, including to other public health agencies when deemed necessary for disease control, investigation & surveillance and by state public health department HIV surveillance staff, ADAP staff, and care services staff to LHD staff for the purpose of proactively offering and coordinating care and treatment services. The proposed case management trailer bill language (TBL) would add authorization for state health department HIV prevention staff to disclose public health records to LHD staff for the purpose of proactively offering and coordinating care and treatment services. The TBL would still make such public health records disclosure subject to other existing state confidentiality laws, including Health and Safety Code section 121025 (c), which provides that such disclosure would include only the information necessary for the purpose of that disclosure, made only upon the agreement that the information will be kept confidential and only further disclosed as otherwise authorized by law.

As the sole statewide program providing services to PLWH, ADAP is able to collect client information in one place. LHD and CBO RW programs must separately collect and maintain client eligibility documentation. In 2012, HRSA conducted an operational site visits to CDPH and Cares Community Health (a sub-grantee) to assess the state's compliance with federal statutes and regulations. The resulting report found ADAP programs "require the same eligibility documentation and are currently unable to share this information within the Part B Ryan White program. This creates an unnecessary burden on clients, enrollment workers, and case managers." However, ADAP is unable to share eligibility documentation due to current restrictions in the Health and Safety Code. Access to state information could allow RW programs, housed in LHDs or CBOs, to view ADAP eligibility data, thereby simplifying enrollment and access to local RW services.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to present this proposal.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## ISSUE 5: INFECTIOUS DISEASE STAKEHOLDER PROPOSALS

### PANELISTS

- **Emalie Huriaux,** Director of Federal and State Affairs, Project Inform
- **Courtney Mulhern-Pearson**, Senior Director of Policy and Strategy, San Francisco AIDS Foundation
- **Rand Martin,** Legislative Advocate, AIDS Healthcare Foundation
- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### CALIFORNIA HIV ALLIANCE PROPOSALS

The California HIV Alliance requests the following:

1. $4 million Federal and Rebate Fund to restore stability in the ADAP and OA-HIPP programs;

2. $12.5 million General Fund to support HIV and hepatitis C virus testing and linkage to care services; and

3. Trailer bill to clarify trailer bill adopted in 2016 on the PrEP Assistance Program to ensure access to financial assistance for both insured and uninsured individuals.

The California HIV alliance provided the following background on these three proposals:

***$4 million Federal and Rebate Fund – Restore stability in the ADAP and OA-HIPP programs***

The AIDS Drug Assistance Program (ADAP) and Office of AIDS Health Insurance Premium Payment Program (OA-HIPP) are key affordability and coverage programs that help low income people living with HIV to purchase, retain, and use comprehensive health insurance coverage to access care and treatment. ADAP also allows those who are unable to obtain health insurance to access lifesaving medications free of charge. In order for these programs to effectively serve people living with HIV, they depend on a knowledgeable and adequate enrollment worker network as well as effective state oversight and management.

The state transferred administration of these programs to three new contractors last July, but communication between the groups has been poor and there have been numerous technical glitches. As a result, the ADAP website has been down for over two months, clients have experienced delays accessing medication, some insurance policies have been cancelled, and it has been difficult for clients to receive reimbursement for medical expenses. The transition has resulted in dramatically increased and complex workloads for many enrollment workers across the state. Additionally, the State Office of AIDS has indicated that they intend to utilize the ADAP enrollment worker network to enroll clients in the state's new PrEP Assistance Program. This will require a significant investment in the ADAP enrollment worker network to meet the anticipated demand for the program.

The state currently provides $4 million to support local ADAP enrollment services. These funds are allocated directly to ADAP enrollment sites based on ADAP's medication and insurance assistance enrollment numbers at each site. However, given the increased workload of ADAP enrollment workers due to the transition and PrEP Assistance Program, additional investment is needed to restore stability within the ADAP and OA-HIPP programs. This additional $4 million is a necessary step to ensure adequate capacity in the field. In addition, the current funding allocation model should be reviewed and adjusted to ensure that enrollment entities are sufficiently compensated for the clients they enroll.

***$12.5 million State General Fund – Support HIV and hepatitis C virus testing and linkage to care services in drug treatment programs and other programs that serve people who use drugs***

Robust HIV and hepatitis C virus (HCV) testing and linkage to care programs are critical to ensure that people know their status and, if infected, are linked to appropriate medical care and treatment. Both the HIV and HCV epidemics are driven, in part, by substance use and there is an urgent need to ensure people who use drugs and those engaged in drug treatment programs have access to HIV and HCV testing and linkage to care services.

For many years, the state of California was required by federal law to utilize 5% of its Substance Abuse & Mental Health Service Administration (SAMHSA) Substance Abuse Prevention & Treatment (SAPT) block grant (approximately $12.5 million) for HIV "early intervention services" in drug treatment programs. The SAMHSA SAPT block grant HIV early intervention services set-aside (a.k.a., HIV Set-Aside) requirement is in place for HIV-designated states, which are states whose rate of AIDS is 10 or more per 100,000 individuals.

In 2015, California's AIDS cases fell below the threshold of 10 per 100,000 individuals, thus the state is no longer an HIV-designated state. In FY 2016-17, the state was prohibited from utilizing SAMHSA SAPT block grant funds for HIV Set-Aside services. Ironically, one of the reasons that California has had success preventing AIDS diagnosis, and therefore falling below the threshold, is because of funding such as the HIV Set-Aside that supported comprehensive testing services and contributed to diagnosing HIV cases earlier in the course of disease. Earlier detection of HIV allows for prompt linkage to care and treatment and prevents the progression of HIV to AIDS.

HIV Set-Aside services in California included HIV education, HIV testing, linkage to care, and related infectious disease education and testing (e.g., for a number of years programs utilized funds to provide both HIV and HCV testing). To provide the smallest counties with sufficient funding to operate a viable program, each participating county received a minimum allocation of $7,500 in HIV funds. All counties in the state received HIV Set-Aside funds, except for six that declined the funds (Alpine, Calaveras, Colusa, Mariposa, Sierra, and Trinity).

California provided HIV Set-Aside funds based on a funding methodology that only considered HIV epidemiology and did not consider HCV case reports or any other proxy measures of HIV and HCV risk such as drug treatment program utilization, cases of sexually transmitted diseases, or drug arrests. Advocates request that the state consider a more robust methodology that considers HIV and HCV case reports and other proxy data to allocate funding to priority counties. They also request that rather than having these funds managed by DHCS, through the Division of Alcohol & Drug Programs, these funds be managed by CDPH, through the Center for Infectious Diseases, to ensure funds are coordinated with other resources for HIV and HCV prevention, testing, and linkage to care around the state.

***Modify PrEP Assistance Program trailer bill language to ensure access to financial assistance for both insured and uninsured individuals***

Pre-exposure prophylaxis (PrEP) is an HIV prevention strategy in which HIV-negative individuals take a daily medication to reduce their risk of becoming infected with HIV. PrEP is a key component of the National HIV/AIDS Strategy and California's Laying a Foundation for Getting to Zero Integrated Plan. The CDC recently estimated that reaching national targets for HIV testing and treatment and scaling up use of PrEP could reduce new HIV infections in the US by as much as 70% by 2020.

Cost is a major barrier to PrEP use. Truvada, the medication currently approved for use as PrEP, is roughly $1,500 for a 30-day supply. Individuals using PrEP are also required to see a doctor on a regular basis for routine HIV testing and lab work. Long-term success of PrEP will require that individuals have access to these services at low or no

cost. PrEP is covered by Medi-Cal, Medicare, and most major health insurance plans in California. And Gilead Sciences, the manufacturer of Truvada, has patient assistance programs which provide free drug to uninsured individuals with annual incomes below 500 percent of the Federal Poverty Level and up to $3,600 per year for individuals with insurance. However, these programs do not cover costs associated with doctors' visits, HIV testing, and labs. These expenses can render PrEP cost prohibitive, particularly for uninsured and underinsured individuals.

In the 2016 Budget Act, ADAP received statutory and budgetary authority to cover PrEP medications on the ADAP formulary and related medical co-pays, co-insurance, and deductibles incurred by insured individuals with annual incomes below 500 percent of the Federal Poverty Level. However, uninsured individuals are currently prohibited from enrolling in the program because of an interpretation in the language of the statute. Advocates propose modifying California's PrEP Assistance Program trailer bill language to ensure access to financial assistance for both insured and uninsured individuals.

## AIDS HEALTHCARE FOUNDATION PROPOSALS

The AIDS Healthcare Foundation (AHF) requests:

1. $5 million General Fund to sustain the $5 million one-time General Fund augmentation included in the 2016 Budget Act for STD prevention; and

2. Trailer bill to increase the quality and effectiveness of state STD control efforts (as described below).

AHF provided the following background on these proposals:

STDs remain a large and persistent public health challenge for the citizens of our state. The large number of cases makes STDs the most commonly reported communicable disease in California. Exacerbating the problem is the fact that because STDs are often asymptomatic, the burden of the disease is far greater than the number of reported cases. In addition, the prevalence of STDs is correlative to the incidence of HIV. The fact that we continue to experience 5000 new infections of HIV every year is attributable in part to the fact that we have been unable to wrestle down the high rates of all STDs.

According to data from the Department of Public Health, incidence rates of sexually transmitted diseases have increased dramatically in the last five years of complete records. Chlamydia has risen by 11.2% from 2011 to 2015. During the same period, gonorrhea has increased by 90.1%; the rate increased by 20% just between 2014 and 2015. Primary and secondary syphilis have smaller raw numbers but have grown at the alarming rate of 98.4%.

From 2011 to 2015, not a single county has experienced a decrease in gonorrhea rates. Large urban counties have experienced increases ranging from 70% (Los Angeles) to 89% (San Francisco) to 130% (Orange). Some increases are so high as to defy rationality, including:

- Butte County – 532% increase
- Humboldt County – 444% increase
- Santa Barbara County – 209% increase
- Santa Clara County – 166% increase
- Tulare County – 586% increase.

The incidence rates of STDs are excessively high. The gonorrhea rate in 2015 for all Californians was 138.9 cases per 100,000 population; in 2014, it was 116 cases. However, the rate for females 20-24 was 415.9 per 100,000 population and for all males 20-24 was 529.4 per 100,000; in 2014, it was 370 cases and 457 cases, respectively.

The problem is even more acute in communities of color. In 2015, in every age and gender group, the rate of gonorrhea in African Americans exceeded the rate in every other group. Among black females 15-19 the rate was more than 11 times the rate among white females in the same age range. The highest raw numbers were among black males (1646.7 per 100,000) and females (1675.6 per 100,000) ages 20-24.

In a 2011 study, DPH looked at HIV co-infection rates for people with STDs based on 2009 data. High rates of HIV co-infection were observed among male primary and secondary syphilis cases (43 percent) and male gonorrhea cases (14 percent). DPH also indicated that by comparing HIV prevalence among STD cases, persons living with HIV who have not been previously reported to the Office of AIDS might be identified.

AHF is requesting trailer bill language that would:

- Prioritize funding for counties that have high incidence rates of STDs while being mindful that allocations must be sufficient to have a meaningful impact.
- Direct counties to identify target populations and lay out effective outreach protocols.
- Urge counties to develop relationships with community-based organizations for outreach and screening services, recognizing the value that CBOs bring to the table in terms of leveraging other resources and providing services in a cost-effective manner.
- Allow the department to contract directly with a CBO in a county in which the county declines state funding.
- Encourage innovative outreach and screening services.
- Widespread voluntary testing in adult and juvenile correctional facilities.

- Social media platforms that allow a person to receive and share test results and to access treatment services.
- State-of-the-art, community-based testing.
- Require the department to develop accountability measures for counties and CBOs funded by the state.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests stakeholders to present their proposals and requests DPH to provide reactions and technical support information on these proposals, and respond to the following:

1. How much resources, and for what purposes, would the state need in order to effectively reduce the STD infection rates?

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

# CENTER FOR ENVIRONMENTAL HEALTH

## ISSUE 6: CENTER FOR ENVIRONMENTAL HEALTH OVERVIEW

### PANELISTS

- **Mark Starr, DVM, MPVM**, Deputy Director, Center for Environmental Health, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### PROPOSAL

This is an informational item and the Subcommittee requests DPH to provide an overview of the Center for Environmental Health and its major programs. The January budget proposes approximately $108.5 million for this Center, about 3.3 percent of the total budget of the Department of Public Health.

### BACKGROUND

The Center for Environmental Health administers programs that protect the public from unsafe drinking water; regulate the generation, handling, and disposal of medical waste; oversee the disposal of low-level radioactive waste; protects and manages food, drug, medical device, and radiation sources and will soon license manufacturers of medical cannabis. The Center comprises the Division of Food, Drug, and Cannabis Safety and the Division of Radiation Safety and Environmental Management.

**Division of Food, Drug, and Cannabis Safety (DFDCS)**
The Division of Food, Drug and Cannabis Safety protects and improves the health of all Californians by assuring the safety of foods, drugs, medical devices, and manufactured cannabis products through investigation, inspection, and control of the sources of these products. DFDCS is comprised of the Food and Drug Branch, the Food and Drug Laboratory Branch and the Office of Manufactured Cannabis Safety.

- The Food and Drug Branch (FDB) assures that food, drugs, medical devices are safe and not adulterated, misbranded nor falsely advertised, and that drugs and medical devices are effective. FDB also conducts underage tobacco enforcement activities. FDB works in conjunction with the Food and Drug Laboratory Branch

(FDLB) to ensure proper analysis throughout the state and uses FDLB's test results to assess public health concerns.

- The FDLB provides services and leadership as a public health reference and research laboratory. To ensure the safety of all Californians, FDLB provides the necessary analytical support to screen for, identify, and quantify chemical and microbiological contaminants in food, drugs, and manufactured cannabis. FDLB also provides regulatory services for substances of abuse laboratories. All lab activities implement and support legislatively-mandated programs.

- The Office of Manufactured Cannabis Safety (OMCS) was created by the enactment of the Medical Cannabis Regulation and Safety Act of 2015. OMCS is currently developing statewide standards, regulations, and licensing procedures, and is addressing policy issues in support of cannabis manufacturers. OMCS will be responsible for issuing licenses to manufacturers of cannabis products beginning January 1, 2018.

**Division of Radiation Safety and Environmental Management (DRSEM)**
The Division of Radiation Safety and Environmental Management (DRSEM) protects and improves the health of all California residents through its environmental programs including radiation safety, inspection, laboratory testing, and regulatory activities. DRSEM is comprised of the Radiologic Health Branch, the Environmental Management Branch, and the Drinking Water and Radiation Laboratory Branch.

- The Drinking Water and Radiation Laboratory Branch (DWRLB) is the State's primary drinking water quality testing laboratory and is the only state laboratory capable of measuring chemical, microbiological, and radiochemical contaminants in drinking water and drinking water supplies. DWRLB is also the only State laboratory capable of measuring environmental radiation and radionuclides. Its primary mission is to provide analytical services, reference measurements, and technical support for RHB, EMB, and for the State Water Resources Control Board's Division of Drinking Water.

- The Environmental Management Branch (EMB) regulates the medical waste industry, pre-harvest commercial shellfish operations, and recreational health (public swimming pools, ocean beaches and organized camps); provides sanitary surveillance of state institutions; administers the Registered Environmental Health Specialist (REHS) program; oversees radiological cleanup at military base closure facilities, coordinates the State's Indoor Radon Program, the Medical Waste Management Program and CDPH's Nuclear Emergency Response Program.

- The Radiologic Health Branch (RHB) enforces the laws and regulations designed to protect the public, radiation workers, and the environment. RHB is responsible for providing public health functions associated with administering a radiation control program. This includes licensing of radioactive materials, registration of X-ray producing machines, certification of medical and industrial X-ray and radioactive material users, inspection of facilities using radiation, investigation of radiation incidents, and surveillance of radioactive contamination in the environment.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to provide an overview of this Center.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## ISSUE 7: YOUTH TOBACCO ENFORCEMENT STAFFING BUDGET CHANGE PROPOSAL

### PANELISTS

- **Mark Starr, DVM, MPVM**, Deputy Director, Center for Environmental Health, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### PROPOSAL

CDPH requests the conversion of 9 limited-term positions to permanent positions and $1,130,000 in reimbursement expenditure authority to meet contractual agreements of the U.S. Food and Drug Administration (FDA) Tobacco Enforcement contract.

### BACKGROUND

In 2009, the U.S. Family Smoking Prevention and Tobacco Control Act (FSPTCA) was signed into federal law. The FSPTCA provides the FDA authority to regulate tobacco products and ban the sale of tobacco to youth. The FSPTCA requires the FDA to contract with states and territories in the U.S. to conduct youth tobacco enforcement (illegal tobacco sales to youth and advertising/labeling inspections). As of May 2016, 63 states, territories, and tribes were contracted with the FDA to conduct tobacco retailer inspections.

Beginning in September 2011, CDPH was awarded a three-year contract with the FDA to conduct tobacco retailer inspections. CDPH conducted approximately 8,500 tobacco retailer inspections during that three-year contract. On September 14, 2014, the FDA renewed its contract with CDPH to continue FSPTCA-required tobacco enforcement activities. The CDPH is currently in year two of a three-year contract. The contract requires CDPH to inspect a minimum of 20 percent of California's tobacco retailers on an annual basis (approximately 8,000 inspections).

CDPH received authorization to conduct the work associated with each of these prior contracts through the Budget process. The program currently has 7 permanent Investigators. The 2015 Budget Act authorized an additional nine limited-term positions (1 Investigator and 8 Associate Governmental Program Analysts), which are set to expire on June 30, 2017.

CDPH anticipates that in the spring of 2017, the FDA will renew the contract with CDPH for another three years to continue FSPTCA enforcement activities in California.

Due to safety protocols when working with youth operatives, CDPH conducts Undercover Buy (UB) inspections by using a two-person team to complete the FDA contract. Eight two-person teams are used to conduct UB inspections. An Investigator is the designated lead for UB inspections, supervises the operative, and handles and processes evidence. An AGPA provides support during the UB inspections, and checks equipment for undercover operations. In addition, the AGPA conducts advertising and labeling activities that do not require a youth operative under the FDA contract. CDPH is responsible for planning, conducting, and documenting the inspections, while the FDA is responsible for all enforcement actions that may arise from the inspections.

The FDA's tobacco program is supported by industry user fees and thus is well-established and will continue to provide contracts to states and territories per FSPTCA mandates. CDPH has worked to create a partnership with the FDA that will continue to lay the foundation for future contracts, and has the personnel, expertise and experience to implement the requirements of the FSPTCA.

CDPH states that, by converting the 9 limited-term positions to permanent positions, CDPH would be in a position to plan for long-term goals and for future contracts without having to request personnel for each new contract. CDPH believes that continuation of these positions is necessary to give CDPH the ability to conduct the required annual inspections. Permanent positions provide more stability and retention of skilled and trained staff within the program. Candidates in limited-term positions will likely seek permanent positions elsewhere, which can result in not meeting work plan objectives.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to present this proposal.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## ISSUE 8: TOBACCO TAX ACT OF 2016 TOBACCO LAW ENFORCEMENT BUDGET CHANGE PROPOSAL

### PANELISTS

- **Mark Starr, DVM, MPVM**, Deputy Director, Center for Environmental Health, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### PROPOSAL

The California Department of Public Health (CDPH) requests expenditure authority of $223.5 million for Fiscal Year (FY) 2017-18 and ongoing (subject to revenue levels), and 57 positions to implement the requirements of the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) for Public Health's oral health, tobacco law enforcement, and tobacco prevention programs. This request also includes a reduction of $3.7 million General Fund for the oral health program. The three major components of this proposal include:

- CDPH Food and Drug Branch (FDB) requests an increase of 20.0 permanent positions and $7.5 million expenditure authority for tobacco law enforcement. (*This component of the proposal will be discussed here in this agenda today.*)

- CDPH Oral Health Program (OHP) requests an increase of 11.0 permanent positions and $37.5 million expenditure authority for oral health programs. (*This component of the proposal will be heard by the Subcommittee on Monday, April 24th, 2017*.)

- CDPH Tobacco Control Branch (TCB) requests an increase of 26.0 permanent positions and $178.5 million expenditure authority for tobacco control. (*This component of the proposal was heard by the Subcommittee on Monday, March 6th, 2017, Issue 3 of the agenda*.)

## BACKGROUND

Beginning April 1, 2017, the 2016 Tobacco Tax Act increases the excise tax on cigarettes by $2.00 per pack (based on a pack of 20 cigarettes) and imposes an equivalent excise tax on other tobacco products. A portion of the 2016 Tobacco Tax Act revenues will be transferred into three newly created funds: the State Dental Program Account (Fund 3307), the Tobacco Law Enforcement Account (Fund 3308), and the Tobacco Prevention and Control Programs Account (Fund 3309).

The Proposition specifies allocations to various entities, including $6 million annually for Public Health to provide enforcement related activities and $30 million annually for Public Health's state dental program. Proposition 56 requires 82 percent of the remaining funds be transferred to the Department of Health Care Services. Of the remaining 18 percent, 13 percent is for the Department of Public Health and the Department of Education for tobacco prevention, and 5 percent to the University of California for medical research.

CDPH has enforced the provisions of the Stop Tobacco Access to Kids Enforcement (STAKE) Act since 1995. The Act requires retailer compliance checks using teenage decoy operatives and requires that violators are served legal notices, assessed fines and penalties, and allowed penalty appeal hearings. The Act also requires that a toll-free telephone number exists to report illegal tobacco sales to minors. On June 9, 2016, the STAKE Act was amended by Senate Bills X2-5 (Leno, Chapter 7, Statutes of 2016) and X2-7 (Hernandez, Chapter 7, Statutes of 2016) to expand the definition of tobacco products to include electronic smoking devices, cigar, pipe, and hookah tobacco and nicotine or other vaporized liquid solutions and increase the minimum age of sale for tobacco products from 18 years old to 21 years old (active duty U.S. military personnel with a military identification card are exempt). The STAKE Program currently conducts approximately 1,600 tobacco product compliance checks annually. With the passage of Senate Bill X2-5, resources were allocated to conduct an additional 1,200 electronic cigarettes compliance activities on an annual basis.

## STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the tobacco law enforcement component of this proposal.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

# CENTER FOR HEALTH STATISTICS AND INFORMATICS

## ISSUE 9: CENTER FOR HEALTH STATISTICS AND INFORMATICS OVERVIEW

### PANELISTS

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### PROPOSAL

This is an informational item and the Subcommittee requests DPH to provide an overview of the Center for Health Statistics and Informatics and its major programs. The January budget proposes approximately $27.5 million for this Center, about 0.8 percent of the total budget of the Department of Public Health.

### BACKGROUND

The Center for Health Statistics and Informatics (CHSI) is responsible for department-wide initiatives to improve the effectiveness of CDPH's work through better health information systems, increased application of epidemiologic methods of analysis, strong liaisons with public health organizations and schools of public health, and effective partnerships with local health agencies and professionals. This Center is made up of the following five branches:

***Vital Records Registration Branch***. The Vital Records Registration Branch (VRRB) ensures the timely and accurate registration of all vital events occurring in California. Annually California registers:

- more than 540,000 Births
- more than 240,000 Deaths
- more than 210,000 Marriages
- more than 40,000 Amendments
- fetal deaths and stillbirths

VRRB works closely with Local Registrars, County Clerks, Recorders, Hospitals, Funeral Homes and Coroners. All amendments to vital records in California are processed by VRRB including preparing new birth records for all adoptions.

***Vital Records Issuance and Preservation Branch***. The Vital Records Issuance and Preservation Branch (VRIPB) ensures timely and accurate issuance of vital event records registered in California, in addition to the preservation of all records since 1905. VRIPB is charged with the responsibility of:

- Maintaining a permanent central registry of all birth, death, fetal death, still birth, marriage, and dissolution records for vital events which occur in California.
- Preserving over 45 million records dating back to 1905. Over 15 million of these records are digitally imaged. Over one million events are added annually.
- Issuing certified copies of registered vital events. Approximately 120,000 certified copies are issued annually.
- Protecting the integrity of California's vital records in compliance with state and federal laws.

***Public Health Policy and Research Branch***. The Public Health Policy and Research Branch (PHPRB) develops and evaluates policy to support Public Health programs, support State Registrar data management and reporting requirements and administers CHSI local service programs.

***Public Health Informatics Branch***. The Public Health Informatics Branch (PHIB) supports CDPH informatics requirements and the State Registrar systems and functions. Informatics requirements include:

- eHealth program, policy and planning
- Public Health Informatics Workforce Development
- Geographic Information Systems (GIS)
- CDPH web services coordination and administration of CDPH Internet/Intranet web sites

State Registrar systems include business applications and data systems to support core functions of the Vital Records Registration and Vital Records Issuance Branch and the data management needs of the Public Health Policy and Research Branch.

***Operations Branch***. The Operations Branch (OB) meets and supports all CHSI business functions through the provision of accurate and timely administrative services. OB is composed of the Fiscal Services Section (FSS), the Employee Services Section (ESS) and the Contracts and Procurement Section (CPS).

- The FSS is responsible for recording and monitoring revenue and expenditures from all CHSI fund sources. FSS also creates and updates the Vital Records Fee Schedule.
- The ESS is responsible for providing a wide array of employee services to CHSI, such as telecommunications, inventory and supplies, and space management.
- The CPS is responsible for the timely processing of all CHSI procurements and contracts in compliance with Department of General Services' requirements, guidelines and opportunities.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to provide an overview of this Center.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## ISSUE 10: IMPROVED ACCESS TO VITAL STATISTICS DATA BUDGET CHANGE PROPOSAL

### PANELISTS

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### PROPOSAL

CDPH, Center for Health Statistics and Informatics (CHSI) requests expenditure authority of $75,000 in Fiscal Year (FY) 2017-18 and $325,000 in FY 2018-19 from the Health Statistics Special Fund to replace the California Vital Statistics Query (CA-VSQ) system. This replacement is expected to help protect privacy, and increase access and availability of timely data for online vital statistics custom queries for the public, policy makers, state departments, and the media. Additionally, CDPH requests $15,000 in FY 2019-20 and annually thereafter for maintenance and operations.

### BACKGROUND

CHSI is responsible for the registration of vital events, the issuance of legal vital records documents and the collection and management of public health and vital statistics data. CHSI annually compiles vital statistics data from birth, death, and fetal death certificates on more than 750,000 Californians annually. This data is foundational to the federal government, state agencies, local government agencies, policy makers, and researchers for measuring population health, research on health outcomes, and state and local public health reporting and surveillance.

CHSI is utilizing an outdated database system that is not optimally responsive to the needs of the public for tabular summaries and statistical reports on California's births and deaths. As a 20 year-old legacy system that cannot accept data from the newly developed Vital Records Business Intelligence System (VRBIS), CA-VSQ is programmed to only upload data in a fixed length format with limited reporting functions. VRBIS is CHSI's newly developed data warehouse for vital records data. In addition, CA-VSQ does not apply small cell size suppression creating a re-identification risk to individuals.

CHSI requests resources for the development costs of $75,000 in FY 2017-18, $325,000 in FY 2018-19 to replace the CA-VSQ system, and $15,000 in FY 2019-20 and annually thereafter for maintenance and operations.

Historically, data was made available through applications for annual data files, the web-based interactive CA-VSQ system, and publication of static data tables. CHSI staff also support the CHHS Agency Open Data Portal by generating vital statistics datasets for the Open Data Portal. The Open Data Portal is a component of the CHHS Agency data management strategy (https://chhs.data.ca.gov/).

CHSI is using a 20-year old system (CA-VSQ), posing limitations. The CA-VSQ only contains birth and death data for years 1994 to 2013, has limited reporting functionality, and is unable to apply small cell size suppression. Therefore, CA-VSQ creates a re-identification risk and is not optimally responsive to the needs of the public. In addition, while CA-VSQ is programmed to accept historic files, it would need reprogramming to accept data files from CHSI's new VRBIS system. Increasingly, the public expects data to be available in near real-time. In an effort to be more responsive to the public, CDPH intends to leverage existing technology investments in the development of a replacement query system that would be replicable for other CDPH programs and other state departments with similar needs. CDPH states that replacing CA-VSQ with a modern, interactive data query system with robust data visualization will more efficiently and effectively serve the needs of the media, policy makers, community-based organizations, and the general public for timely vital statistics data.

This new system would provide functionality not available in CA-VSQ, including:

Visualization of results
- Maps, tables, charts and graphs
- Cross-tabulations of two sets of complex queries
- Results available in Excel tables

Geography
- Census tract level, and geographic aggregation of data to county and region
- Complex queries
- Results for queries on multiple geographic units, demographic categories, time periods, ICD-10 categories, etc.

Reliable statistics
- Crude and age-adjusted rates
- Reliable/unreliable statistic indicator
- Demographics

CHSI historically published data tables about births and deaths, but nearly none of these tables have been published since 2010. CHSI receives approximately 100 annual Public Records Act or media-related data requests for updated or new data tables, adding to the need for additional support. The new replacement system is intended to help fill the gap for tabulated data requested by the public, policy makers, and the media.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to present this proposal.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## ISSUE 11: DEMOGRAPHIC DATA COLLECTION OF ASIAN, NATIVE HAWAIIAN AND PACIFIC ISLANDER POPULATIONS (AB 1726) BUDGET CHANGE PROPOSAL

### PANELISTS

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### PROPOSAL

CDPH requests expenditure authority of $326,000 in Fiscal Year (FY) 2017-18, $316,000 in FY 2018-19, and $314,000 ongoing, and 2.5 full-time positions to meet the new mandate to collect demographic data on ancestry or ethnic origin of persons. This data will be used for a report that will include rates for major diseases, leading causes of death per demographic, and subcategories for leadings causes of death in California as specified by AB 1726 (Bonta, Chapter 607, Statutes of 2016).

Of the requested funding, the Center for Health Statistics and Informatics requests expenditure authority of $244,000 in FY 2017-18, $236,000 in FY 2018-19, and $234,000 ongoing from the Health Statistics Special Fund (Fund 0099). The Center for Chronic Disease Prevention and Health Promotion, Childhood Lead Poisoning Prevention Branch (CLPPB) requests expenditure authority of $82,000 in FY 2017-18, $80,000 in FY 2018-19, and ongoing, from the Childhood Lead Poisoning Prevention Fund (Fund 0080).

### BACKGROUND

AB 1726 requires, on or after July 1, 2022, CDPH to use additional separate data collection categories and other tabulations for specified Asian American, Native Hawaiian, and other Pacific Islander (AANHPI) sub-groups including, but not limited to, Bangladeshi, Hmong, Indonesian, Malaysian, Pakistani, Sri Lankan, Taiwanese, Thai, Fijian, and Tongan. In addition, AB 1726 requires CDPH to make any data collected publicly available, except for personal identifying information, by posting the data on CDPH's website and updating the data annually.

Existing law requires state agencies, boards, and commissions that directly, or by contract, collect demographic data as to the ancestry or ethnic origin of Californians to use separate collection categories and tabulations for each major Asian Pacific Islander group, including, but not limited to, Chinese, Japanese, Filipino, Korean, Vietnamese, Asian Indian, Laotian, Cambodian, Hawaiian, Guamanian, and Samoan.

AB 1726 establishes a new requirement for CDPH programs to collect demographic data, prior to and no later than July 1, 2022, to expand the demographic categories including, but not limited to, Bangladeshi, Hmong, Indonesian, Malaysian, Pakistani, Sri Lankan, Taiwanese, Thai, Fijian, and Tongan. The expansion of ANNHPI subcategories supports the mandate to collect the race and ethnicity data for both the selection of single and multiple race and ethnic designations in reports provided to other state departments, as well as research institutions and public request for data, and enables programs to more accurately assess program outcomes.

*Staffing Requirements*: As a result of AB 1726, CDPH will require staff in multiple programs to determine the appropriate methods to collect data and ensure confidentiality in reporting data in small population sizes for the AANHPI sub-group categories. CDPH requests 2.5 full-time positions: 2 Research Program Specialist I positions for CHSI and 0.5 Research Scientist III position for CLPPB.

The 2 Research Program Specialist I for CHSI will support the mandate to include all of the sub-groups specified in demographic reports produced using vital statistics data. Staff will determine whether the disaggregated data produced is statistically reliable, and will ensure that re-identification of individuals is not possible for confidential data. This work applies to County Health Status Profiles, Death Data Trend Summaries, Birth Profiles, and other statistical tables derived from birth and death data prepared with breakdowns by race and ethnicity. The analysis to prevent re-identification of individuals is complex and time-consuming at the level of detail required by this new law. AB 1726 creates new categories of tabulation and reporting that will require a more complex statistical analysis than is currently performed.

*Data Systems Upgrades*: CDPH/CLPPB will be required to modify the electronic blood lead reporting system in order to capture and report the required data elements specified in this new statute.

The 0.5 Research Scientist III for CLPPB will modify the system initially, and within 18 months of each succeeding census, as well as determine appropriate methods to collect and ensure confidentiality in reporting data on small racial/ethnic categories and ensure continuous quality improvement of the data collection and report.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to present this proposal.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## ISSUE 12: CERTIFIED COPIES OF MARRIAGE, BIRTH, AND DEATH CERTIFICATES: ELECTRONIC APPLICATION (AB 2636) BUDGET CHANGE PROPOSAL

### PANELISTS

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### PROPOSAL

CDPH, Center for Health Statistics and Informatics (CHSI) requests expenditure authority of $257,000 in Fiscal Year (FY) 2017-18 from the Health Statistics Special Fund (Fund 0099), $253,000 in FY 2018-19 and FY 2019-20, and $127,000 in FY 2020-21, and 2 permanent full-time positions to meet the mandated workload to implement the acceptance of electronic acknowledgements when requests for certified copies of birth, death, or marriage records are made electronically, as specified by AB 2636 (Linder, Chapter 527, Statutes of 2016).

### BACKGROUND

CHSI is responsible for the registration of vital events, the issuance of legal vital records documents and the collection and management of public health and vital statistics data. CHSI annually compiles vital statistics data from birth, death and fetal death certificates on more than 750,000 Californians annually. This data is foundational to the federal government, state agencies, local government agencies, policy makers, and researchers for measuring population health, research on health outcomes, and state and local public health reporting and surveillance.

By statute, the State Registrar operates under the authority of Division 102 of the Health and Safety Code (HSC). Division 102 makes the State Registrar responsible for registering each live birth, fetal death, death, and marriage that occurs in California, and for providing certified copies of vital records to the public. HSC Section 102230 requires the State Registrar to permanently preserve vital records in a systematic manner and to prepare and maintain a comprehensive and continuous index of all registered certificates.

When applying for a certified copy of a birth, death, or marriage certificate, existing law requires applicants to provide a notarized sworn statement that the applicant is an authorized person, as defined in HSC Section 103526. The current notarized sworn statement requirement effectively prohibits the use of electronic submissions for birth, death, and marriage certificates. Currently, the State Registrar only accepts requests for authorized copies of vital records via the mail. AB 2636 permits the State Registrar and local officials to accept electronic acknowledgements, which will modernize the process for applicants requesting certain vital records.

AB 2636 authorizes, until January 1, 2021, an official (e.g., the State Registrar, local registrar, or county recorder) to accept electronic acknowledgment sworn under penalty of perjury when a request for a certified copy of a birth, death, or marriage record is made electronically. AB 2636 requires the use of a multilayered "remote identity proofing process" for the electronic acknowledgement to establish the identity of the requester as an authorized person. AB 2636 provides that a notarized sworn statement shall accompany the request if the identity cannot be established electronically through a verification service. In addition, AB 2636 requires state and local agencies fulfilling electronic vital records requests to report requests for certified copies of birth, death, or marriage records without being provided a notarized statement that the requester is an authorized person to the Attorney General and the Legislature by January 1, 2019.

AB 2636 requires that the "remote identity proofing process" complies with applicable state and federal laws to protect the requester's information and guard against identity theft. This verification process shall include dynamic knowledge-based authentication or a method consistent with the electronic authentication guidelines of the National institute of Standards and Technology, and comply with the provisions of the Uniform Electronic Transactions Act.

To implement the provisions of this bill, CHSI requires:

- The CDPH's Information Technology Services Division (ITSD) to modify the existing electronic submission interface into the Center Request Tracking System (CRTS) to accept requests for authorized copies. Currently, the existing interface only accepts electronic submission requests for informational copies.

- The CDPH to solicit bids for contracts for multiple companies to provide the electronic submission services (website, data transmission, and payment transmission) in a similar fashion as the current VitalChek process.

- One Associate Governmental Program Analyst (AGPA) to manage the contract(s) including contract development, contract review, compliance, payment processing, and payment reconciling.

- One Systems Software Specialist (SSS) II to modify the Customer Request Tracking System and to support the gathering of requirements, system design, application programming efforts, testing, and ongoing maintenance and operations.

CHSI's explains that it is their mission is to provide customers with timely, high quality, accessible data and information in convenient and readily useable formats to support public health research, planning, policy and programs. One of CHSI's main responsibilities is to register vital events and issue legal documents. Increasingly, the public expects an electronic application process for vital records requests.

Nationwide, California is one of a handful of states not using an electronic process. Implementing these statutes would provide greater ease and efficiency for those seeking to obtain copies of vital records.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to present this proposal.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## Emergency Preparedness Office

### ISSUE 13: EMERGENCY PREPAREDNESS OFFICE OVERVIEW AND BUDGET CHANGE PROPOSAL

#### PANELISTS

- **Barbara Taylor**, Deputy Director, Emergency Preparedness Office, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

#### PROPOSAL

CDPH, Emergency Preparedness Office requests permanent establishment of 88.3 limited-term positions and associated expenditure authority of $11.75 million to support public health emergency preparedness responsibilities. This request includes 11.5 positions and $2.35 million for the conversion of contract positions to state positions. There are currently 76.8 positions that were established in Fiscal Year (FY) 2013-14 as four-year limited-term positions to match the federal grant cycle. These positions are scheduled to expire on June 30, 2017.

#### BACKGROUND

CDPH receives federal funds to support public health emergency preparedness responsibilities through the following grant awards:

*Public Health Emergency Preparedness Cooperative Agreement (PHEP)*

The PHEP Cooperative Agreement, issued by the Centers for Disease Control and Prevention (CDC), funds state and local health departments to enhance the California public health system's preparedness and response to public health emergencies. Based on Health and Safety Code Sections 101315-101319, CDPH allocates 70 percent of this grant to fund local health department preparedness activities and funds state operations with the remaining 30 percent.

The PHEP grant is delineated by 15 Public Health Preparedness Capabilities with supporting Functions, Resource Elements and Performance Measures that state health departments must meet.

*Hospital Preparedness Program (HPP)*

The HPP Cooperative Agreement, issued by the Assistant Secretary for Preparedness and Response (ASPR), provides funding to prepare hospitals, clinics and other health care facilities and emergency medical services systems to respond to disasters. The HPP grant has eight Health Care Preparedness Capabilities with supporting Functions, Resource Elements and Performance Measures that states are required to meet.

Federal funds have been reduced from $98.1 million in FY 2004-05 to $62 million in FY 2016-17; a reduction of 37%. Given general economic decline, federal emergency preparedness funds have been reduced along with most other federal programs. However, the federal funds have remained relatively stable for the last couple of years. The reduction between 2015-16 and 2016-17 was one-time reduction of base PHEP dollars from all states to provide Zika Virus designated funding. California has received some additional funds for its Zika Virus response and anticipates restoration of the PHEP base in 2017-18. Under funding reductions, CDPH has prioritized the retention of staff for public health and medical preparedness activities.

CDPH responds to numerous public health events on a daily basis. Since FY 2003-04, CDPH has responded to significant disasters such as the California wildfires of 2003, 2007, 2008 and 2012; Hurricane Katrina in 2005; floods in 2006; extreme heat events in 2006, 2007, 2008, 2013, and 2016; HI N1 in 2009; the tsunami and radiation threat from the Fukushima earthquake in 2011; the 2011 Southern California power outage; the Napa Earthquake; Ebola Virus Disease; Drought, H1N1 Outbreak of 2014; the Valley & Butte Fires in 2015; the June 2016 Heat Event; and the 2016 Zika Virus Outbreak.

With the events of September 11, 2001, and subsequent anthrax attacks, CDPH's public health emergency preparedness responsibilities increased significantly to include activities related to countering potential bioterrorism, chemical, nuclear, or radiologic threats. Federal funds to build and maintain capabilities to address these threats are provided to states through the PHEP/HPP Cooperative Agreements. (Los Angeles receives its PHEP and HPP funds directly from CDC and ASPR).

The Budget Act of 2003 provided 94.8 limited-term positions to enable CDPH to build its capacity for public health preparedness. Although the PHEP and HPP grants have declined since FY 2003-04, public health preparedness is a staff-intensive function, and CDPH has placed its highest priority on retention of state staff resources supported through these grants. With decreased funding, the Emergency Preparedness Office (EPC) has worked diligently to remain within budget while keeping all staff resources. As the post September 11, 2001, emergency preparedness activities have continued, the field of trained and experienced individuals has grown, increasing the ability of EPC to hire state staff with relevant experience in these activities instead of contractors. This has allowed the EPC to fulfill this mission by converting former contract positions to

State positions. The conversion of contract positions to State positions results in cost savings. This change in hiring practices results in the additional 11.5 positions being requested with this BCP. However, due to grant funding reductions (5.5 position lost due to funding) and position reductions related to the Budget Letter 12-03 (17 positions lost under BL12-03), this proposal requests a total of 88.3 positions.

CDPH states that this proposal addresses California's continuing efforts to be prepared for public health emergencies. The structure and protocols established through CDPH's public health emergency preparedness efforts are invaluable in ensuring an appropriate public health response to large-scale emergencies, such as food safety, food or drug tampering, health-related threats from infectious agents such as anthrax or other harmful materials, mass immunizations to prevent influenza epidemics, chemical, radiologic, or nuclear incidents, and other natural or man-made disasters or disease outbreaks.

***Accomplishments and ongoing efforts include:***

*Preparedness for Medical Countermeasures*: In 2008, California was the first state to receive a Technical Assistance Review tool score of 100 percent on its annual Strategic National Stockpile review and subsequently sustained the same score in its 2009 and 2011 assessments. California is continuing its efforts to maintain this high level of readiness using the Medical Countermeasure Operational Readiness Review tool with a goal of being able to accomplish all of the required deliverables for each capability, which would be achieving an implementation level of "established" by the year 2022 in all PHEP Capabilities.

In November 2015, California conducted one of the nation's largest full-scale medical countermeasures distribution and dispensing exercises titled SoCalREADI 2015. Eleven counties and thirteen local health departments participated in this exercise. Another large full-scale medical countermeasures exercise will be required in the next five-year project period. Additionally, the CDPH continues to work with all sixty-one local health departments to achieve and maintain readiness in all PHEP capabilities.

*Catastrophic Plans*: CDPH and the Emergency Medical Services Authority (EMSA) designed a Tabletop Exercise (TTX) and Functional Exercise (FE) for Cascadia Rising 2016 Exercise. The Cascadia Rising 2016 TTX and FE scenarios were based on the September 2013 California Cascadia Subduction Zone Earthquake and Tsunami Response Plan (Cascadia Plan). The TTX was conducted on April 25, 2016, and engaged the co-leads from the Finance, Logistics, Operations, Planning and Intelligence, Management and Emergency Function 8 / Agency Representative Emergency Response Teams (ERT). The TTX allowed CDPH and EMSA to refine a recently developed process to streamline fulfillment of resource requests submitted to

the Medical and Health Coordination Center (MHCC). The FE was conducted on June 2, 2016, and was designed to test the resource requesting process under more realistic conditions. The exercise identified the strengths and areas for improvement necessary in how resource requests are processed. In addition, the exercises gave ERTs the opportunity to come together to resolve issues associated with how the MHCC functions and how ERTs interact during MHCC activations. CDPH EPC is also working in coordination with the Governor's Gal CES on the development of the Northern California Catastrophic Flood Plan.

*Enhanced Disease Reporting*: CalREDIE is a web-based software application for disease reporting and surveillance reporting. CDPH's Center for Infectious Diseases has implemented the CalREDIE system in all sixty-one local health departments (*Note: fifty-seven local health departments use CalREDIE for all communicable disease reporting, and the counties of Los Angeles, San Diego, and San Francisco currently use CalREDIE for a subset of communicable disease reporting (e.g. TB and/or STD only). Health care providers can use CalREDIE to meet their regulatory reporting requirements for reporting reportable conditions to public health. Electronic Laboratory Reporting has been in Production since October 2013, and to date over 300 laboratories report lab results to CDPH in real-time using the CalREDIE Electronic Laboratory Reporting module. Prior to CalREDIE, the statewide system for disease reporting was largely paper based, resulting in untimely information. CDPH reports that having a statewide system that provides information to both CDPH and local health departments has strengthened California's surveillance activities and early detection of public health emergency incidents.

*Transition of California's Health Alert Network (CAHAN):* With approximately 33,000 users and an average of over 4,000 alerts issued annually, California's public health and medical alerting and notification system is a widely-used response tool. As of 2015, all of California's acute care hospitals, skilled nursing facilities, and clinics are CAHAN users, replacing an inefficient, untimely hard copy mailing system. In 2015, the CAHAN system was upgraded from the original Response Manager platform to the more efficient and target alerting capable Everbridge system. During the upgrade, all state and local partners and stakeholders reviewed and made current the contacts that would receive alerts and developed a methodology for administering alerts that provided delivery to a much more targeted and relevant audience.

*Maintenance of the California Respiratory Laboratory Network (RLN):* To enhance the capacity and capability of California's public health system to respond to the possible threat of the H5N1 avian influenza virus or other influenza pandemics, the Viral and Rickettsial Disease Laboratory (VRDL) led the development of the RLN in 2003. The RLN is a network of 27 public health laboratories, including VRDL, established to enhance surveillance and diagnostic testing for influenza across the state. VRDL

coordinates and supports the RLN by providing 1) training and technical consultation, 2) testing protocols, and 3) reagents for influenza testing. VRDL works closely with the CDC to allow the RLN laboratories to use federally approved influenza virus disease kits to rapidly detect the pandemic strain of influenza virus. The RLN was able to manage the surge in testing during the 2009 H1N1 Influenza Pandemic with nearly 45,000 specimens tested, far exceeding other State public health laboratories in the nation. VRDL maintains a stockpile of influenza reagents for 30,000 Polymerase Chain Reaction tests with an additional reagent stockpile for 2,000 screening Polymerase Chain Reaction tests by RLN member labs. Although the primary focus of the RLN is for influenza laboratory testing and surveillance, the RLN may also respond to other non-influenza emergencies and outbreaks, as demonstrated in 2014-15, when VRDL deployed the Ebola Virus Polymerase Chain Reaction screening test kit to 22 RLN labs in response to the nation-wide Ebola Virus Disease 68 outbreak.

*Development of California's Public Health and Medical Emergency Response System*: The PHEP and HPP programs have provided the resources for California to establish a statewide structure for responding to public health and medical emergencies that is horizontally and vertically coordinated. CDPH has department and program-specific response and continuity plans supported by written procedures, trained staff, and evaluated exercises. The CDPH 24/7 Duly Officer Program responds to over 2,300 incidents annually. In issuing the Public Health and Medical Emergency Operations Manual, CDPH and the EMSA have delineated standardized procedures for situation reporting and resource requesting for use at the local, regional and state levels. The Emergency Operations Manual was developed by representatives from local health departments, local Emergency Medical Services agencies, the Regional Disaster Medical and Health Specialists, CDPH and the EMSA. The use of the protocols identified in the Emergency Operations Manual are now considered foundational for statewide public health and medical emergency response and has resulted in improved situation reporting from the local level and more timely regional and state response to emergencies.

*Emergency Public information and Warning*: In 2005, CDPH developed the Crisis Emergency Risk Communication Toolkit which defines public information communication protocols to be used in a public health emergency. It is used by local health departments and HPP entities during public health emergencies throughout California. The Crisis Emergency Risk Communication Toolkit was revised and reissued in 2011 and includes new content on pandemic influenza based on the H1N1 experience. The Crisis Emergency Risk Communication Toolkit is nationally and internationally recognized and has received awards for innovation and comprehensiveness. The Emergency Preparedness Office continues to work with the Office of Public Affairs, the Center for Environmental Health and the Division of Communicable Disease Control to further enhance public information protocols for emergencies such as Ebola Virus Disease, a nuclear detonation, Zika Virus, Pandemic Influenza, and other naturally occurring disasters like wildfires and earthquakes.

CDPH believes that public health emergencies are unlikely to diminish in the foreseeable future. Whether a natural disaster, communicable disease outbreak, or terrorist event, CDPH argues that it must have the proper staffing and capacity to provide public health leadership and support to local health departments and health care facilities. The consequences of an inadequate response to a major public health emergency on the health of Californians could be catastrophic. The need to protect the public against such threats is the primary justification for this initiative.

All proposed positions are dedicated to working on public health emergency preparedness activities which include:

- Providing medical surge capacity to care for a massive influx of patients
- Coordinating the receipt and distribution of medical countermeasures (Strategic National Stockpile)
- Conducting laboratory testing
- Disease surveillance and epidemiology
- Monitoring food safety
- Radiologic/Nuclear Power Plant safety
- Environmental health
- Licensing and certification of health facilities
- First responder and health care worker health and safety
- Providing public information in preparation for and response to a disaster
- Providing emergency communications
- Tracking hospital bed and resource availability
- Pre-hospital care, triage and patient transportation
- Developing systems to register and activate licensed health care professionals to volunteer during disasters
- Decontaminating patients
- Educating and training health care workers
- Supporting fatality management and evacuation plans

The positions are located in several organizations throughout CDPH, including the Emergency Preparedness Office; the Center for Infectious Diseases; the Center for Environmental Health; the Center for Chronic Disease Prevention and Health Promotion; the Office of Public Affairs; the Office of Compliance; Information Technology Services Division; and the Administration Division. CDPH states that the establishment of these limited-term positions to permanent positions will improve hiring practices and resolve retention issues within the Department, as recruitment to limited-term positions is difficult.

## STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to provide an overview of the Emergency Preparedness Office, present this proposal, and respond to the following:

1. Has there ever been an emergency preparedness exercise (drill) in the Central Valley?

2. What would be required to plan for such an exercise in the Central Valley?

**Staff Recommendation: Subcommittee staff recommends no action at this time.**

## ISSUE 14: PUBLIC HEALTH EMERGENCY PREPAREDNESS ALLOCATION UPDATE TRAILER BILL

### PANELISTS

- **Barbara Taylor**, Deputy Director, Emergency Preparedness Office, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

### PROPOSAL

CDPH proposes trailer bill to continue to provide allocations of federal emergency preparedness funding to local health jurisdictions (LHJs). Specifically, this bill would amend the Health and Safety Code to do the following:

- Change the use of funds from "bioterrorism" to "public health emergency" to be consistent with current uses allowable under federal grants.

- Codify that the initial quarterly payment of grant funds would be made to LHJs upon CDPH approval of the application for funding and that subsequent payments would be made as reimbursements upon submission of documentation.

- Allow CDPH to accept certification from a designee, authorized by the chair of the board of supervisors or mayor, regarding non-supplantation requirements.

- Remove the requirement for LHJs to place federal emergency grant funds into an interest bearing trust fund account, if exempted from this requirement by federal funding guidance.

- Require LHJs to remit earned interest in excess of $500 annually to CDPH in accordance with federal regulations.

- Adjust the baseline allocation for emergency preparedness, including pandemic influenza preparedness, in accordance with current appropriations.

**BACKGROUND**

Current law establishes procedures and requirements governing allocation and expenditures of federal public health emergency preparedness (PHEP) and Hospital Preparedness Program (HPP) funds to local health jurisdictions (LHJ), hospitals, long-term health care facilities, clinics, emergency medical systems, and poison control centers or their trade associations. These funds are appropriated by the Legislature in the Budget Act and administered by the Emergency Preparedness Office (EPO) within the California Department of Public Health (CDPH).

Federal funding was initially granted for purposes of preparing for bioterrorism events in response to the 9-11 attacks and the subsequent anthrax threats. As the grant program grew the intent of the funding opened to include a range of public health threats including infectious diseases (including the 2009 H1N1 influenza pandemic), natural disasters, and biological, chemical, nuclear, and radiological events. As the grant award became more comprehensive of more than just bioterrorism, the terminology of Public Health Emergency Preparedness was used by the federal government. This bill would update state code to reflect that federal funding is no longer reserved only for bioterrorism preparedness.

Current law states that a first payment of the fiscal year would be made to LHJs upon submission of an application for funding, then quarterly thereafter. In practice, CDPH ensures that the application is complete and meets the requirements of the program before making the first allocation. CDPH also requests invoices for spending under the grant. This bill would clarify that the initial payment would be received upon approval of the application and that the department will thereafter have the authority to reimburse LHJs upon receipt of invoices. This allows the funding to get to the LHJs in a more timely manner.

Current law requires that the application include a certification by the chair of the county board of supervisors or the mayor of the city that the funds will not be used to supplant other funding sources. This bill would allow the chair or mayor to authorize a designee to submit this certification.

Current law requires that LHJs deposit the allocated funding into a trust fund account prior to expending the funds for public health emergency purposes. At the time the statute was enacted, this was consistent with federal guidance. However, local governments found it difficult and expensive to maintain interest bearing accounts for their federal awards. Therefore, the federal guidance was updated to exempt the requirement for interest-bearing accounts under the following circumstances:

- The local entity receives less than $120,000 per year in Federal funds.
- The interest-bearing account would not be expected to earn interest in excess of $500 per year.
- The depository requires a minimum balance so high that it would not be feasible to maintain cash resources.

Most of the LHJs receiving federal emergency response funding fall under the second category of exemption. The LHJs are finding it less burdensome to follow the federal guidance and accept state audit findings than to maintain an interest bearing account. This bill would allow LHJs to deposit PHEP funds into a non-interest bearing account if done in accordance with federal requirements.

According to the requirements of 45 CFR 75.305, a local entity may only retain up to $500 per year in interest for administrative purposes. Any excess amount of interest must be remitted to the federal government. This proposal would address this federal regulation by requiring excess earned interest to be remitted to CDPH on an annual basis. CDPH would then return the funds to the federal government.

Starting in 2003, $16 million General Fund was appropriated annually to CDPH for the purposes of preparing California for public health emergencies, including a potential pandemic influenza event. However, SB 409 (Kehoe) of 2006 reduced this appropriation to $4.9 million annually. The 2006 Budget set baseline funding for each LHJ at $125,000—through Trailer Bill language, AB 1807 of 2006. This bill would adjust the baseline allocation in code to be in line with the current statewide annual appropriation.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to present this proposal.

**Staff Recommendation: Subcommittee staff recommends no action at this time.**