AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

MONDAY, MARCH 4, 2013
4:00 P.M. - STATE CAPITOL ROOM 127

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ITEMS TO BE HEARD

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 1: DEPARTMENT OVERVIEW

The Subcommittee has asked the Emergency Medical Services Authority (EMSA) to provide an overview of the department and its proposed budget. The overview should cover major new and on-going initiatives at the department, major new proposals, and a review of changes to EMSA activities and functions that have occurred over the past four years as a result of the state's fiscal crisis.

PANELISTS

- Emergency Medical Services Authority
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

EMSA's mission is to coordinate emergency medical services (EMS) statewide; develop guidelines for local EMS systems; regulate the education, training, and certification of EMS personnel; and coordinate the state's medical response to any disaster. The EMSA is comprised of the following three divisions:

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

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

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

EMSA Budget
The proposed 2013-14 EMSA budget is summarized in the table below. Overall expenditures are proposed to increase very slightly by just $590,000, including a General Fund increase of $62,000.

EMERGENCY MEDICAL SERVICES AUTHORITY					
Fund Source	**2011-12 Actual**	**2012-13 Projected**	**2013-14 Proposed**	**BY to CY Change**	**% Change**
General Fund	$6,644,000	$6,695,000	$6,757,000	$62,000	.9%
Federal Trust Fund	1,401,000	2,554,000	2,605,000	51,000	2%
Reimbursements	13,313,000	14,714,000	14,749,000	35,000	.2%
Special Funds	3,072,000	3,477,000	3,919,000	442,000	13%
Total Expenditures	**$24,430,000**	**$27,440,000**	**$28,030,000**	**$590,000**	**2%**
Positions	**65.7**	**64.3**	**64.3**	**0**	**0%**

Fiscal Crisis
Due to the state's severe fiscal crisis, substantial reductions have been made over the past few years to the state's emergency preparedness infrastructure, most of which falls under the authority of the EMSA.

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

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

However, there are on-going storage and maintenance costs for the MFHs. The EMSA explored various potential shared responsibility arrangements with various non-state entities, such as the Red Cross, in order to find an affordable way for the state to continue to have access to the MFHs in a major disaster. Ultimately, the EMSA did the following: 1) consolidated the MFHs into two storage facilities in order to reduce warehouse space costs; and, 2) entered into a 1-year, no-cost contract with Blu-Med (a subsidiary of Alaska Structures) to continue providing minimal maintenance for the MFHs, at no cost to the state, with the stipulation that Blu-Med could rent out one or two MFHs to any state or country dealing with a major disaster. The contract with Blu-Med has since ended, and EMSA has cobbled together sufficient resources to cover current year maintenance costs. A separate DPH reappropriation is covering storage costs, and this funding will run out in May of 2013.

Poison Control Centers. The State's system of poison control centers came close to being eliminated more than once during the past few years due to General Fund reductions to the program. The Poison Control Centers are a statewide network of experts that provide free treatment advice and assistance to people over the telephone in case of exposure to poisonous or hazardous substances. It provides poison help and information to both the public and health professionals and is accessible, toll-free, 24 hours a day, 7 days a week, and every day of the year. The system maintains interpreting services in over 100 languages. All fifty states have poison control systems.

The program was initially established in 1987 in ten different hospitals, which operated independently and served different geographic regions, without guidance or regulation by the state. The system was eventually consolidated into seven regional poison centers required to meet minimum operational standards. In 1997, a new statewide system was created to provide uniform poison control services, and EMSA contracted with the University of California San Francisco to administer the program.

The General Fund support for the program has been reduced from $6.9 million in 2007-08 to $2.95 million in 2009-10 and each year since then. In order to avoid closure, in 2009 the EMSA successfully sought out federal matching funds under the federal Children's Health Insurance Program (CHIP), which it has received since 2009. Without this new federal funding (which is matched with General Fund), the Poison Control Centers would have ceased operations in January 2010. The EMSA works closely with the Managed Risk Medical Insurance Board (MRMIB) to secure the federal CHIP funds.

Poison Control Centers Funding 2010-2011 through 2013-14	
General Fund	$2,950,000
Federal (CHIP) Funds	$5,300,000
Medi-Cal Reimbursements	$800,000*
Federal Stabilization Grant to UCSF	$1,800,000*
TOTAL (ALL FUNDS)	**$10,850,000**

Approximate funding amounts

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked the EMSA to provide an overview of the department, as well as a brief analysis of the impacts of the fiscal crisis on the department and emergency medical services in the state. It would be extremely helpful and timely to have a more thorough analysis of the state's remaining emergency preparedness infrastructure and capacity in light of the reductions adopted over the past four years.

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

Staff Recommendation: Informational item; no action recommended

ISSUE 2: PARAMEDIC LICENSING & ENFORCEMENT BUDGET CHANGE PROPOSAL

EMSA is requesting increased Emergency Medical Services Personnel (EMSP) Fund authority of $270,000 (special funds) to: 1) decrease paramedic application processing time; 2) implement electronic payments for the paramedic licensing process; and, 3) increase travel for monitoring of paramedics on probation and streamline the investigatory process. The EMSA states that this increased authority will align the budget authority of the EMSP Fund with program expenditures.

PANELISTS

- Emergency Medical Services Authority
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

As authorized in statute, the EMSA charges fees for the licensure and licensure renewal of paramedics, in an amount sufficient to support the licensure and enforcement program. The licensure program seeks to ensure that paramedics are qualified to provide high quality care. The fee revenue is deposited into the Emergency Medical Services Personnel (EMSP) Fund. State law requires EMSA to maintain a reserve balance of 5 percent of the fund balance at the end of each fiscal year. This request is for the following three purposes:

1. *Decrease paramedic application processing time*. Currently, it takes EMSA 45 days to process a licensing application, from the time the application is received until the application is evaluated, and 4-6 weeks for licensure renewal applications (or longer if information is missing). The 2010-11 budget approved of a staffing augmentation that resulted in an average processing time for new and renewal licensure applications of one hour, decreased a backlog of applications, and ensured that random audits of continuing education credits reported by paramedics were continued. In 2011-12, due to the budget crisis, staffing was reduced, resulting in an increase in application processing time to 1.76 hours, the discontinuation of the random audits of CEs, and a new backlog of applications. EMSA expects these new positions to decrease the processing time from 1.76 hours to 1.19 hours per application.

   The EMSA proposes to transfer the needed positions from other programs within the department. The EMSA states that these other programs will not suffer as they are experiencing reduced workloads.

2. *Implement electronic payments for the paramedic licensing process*. Current Government Code Section 6163(a)(1) requires all state agencies to accept payments via credit cards or other types of electronic payments. This BCP will enable the EMSA to institute a credit card payment system for individuals to pay

new and renewal licensure application fees. According to the EMSA, this will bring the program into compliance with the Government Code, enhance customer convenience, achieve operational efficiencies, expedite the availability of the funds, and increase collection rates for payments. This BCP requests EMSP fund authority of $96,000 to align program expenditures with budget authority.

3. *Increase travel for monitoring of paramedics on probation and streamline the investigatory process.* The EMSA hopes to streamline and improve the investigative processing time of Special Investigators (SIs). According to the EMSA, SIs have begun to function as probation monitors while in the field, gathering documents directly from law enforcement, courts, and district attorneys. As a result of budgetary reductions at all levels of government, it has been taking longer for the Paramedic Enforcement Program to receive documentary evidence from courts and law enforcement agencies necessary to complete the investigative process. The EMSA estimates that 10-25 percent of the SIs' travel will be spent obtaining this documentation. This will extend the length and cost of travel, but will increase due process, increase the effectiveness of interviews and collection of physical evidence and improve probation monitoring. Therefore, this BCP requests an increase in EMSP fund authority of $40,000 to align program expenditures with budget authority.

The EMSA states that this proposal involves the redirection of staff from other programs that will decrease budget authority in various funds resulting in an overall increase in departmental budget authority of only $136,000, despite this overall request of $270,000.

STAFF COMMENTS/QUESTIONS

Please provide an overview of the BCP.

1. How does the EMSA have extra unneeded positions in other programs that can be transferred as a component of this BCP?

Staff Recommendation: Staff recommends approval of this BCP as proposed.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: DEPARTMENT OVERVIEW

The Subcommittee has asked the Department of Public Health (DPH) to provide an overview of the department and its proposed budget. The overview should cover major new and on-going initiatives at the department, major new proposals, and a review of changes to DPH activities and functions that have occurred over the past four years as a result of the state's fiscal crisis.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

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

Reorganization

In 2012, the Governor proposed, and the Legislature approved, moving various programs between different departments, several of which involved the DPH, including:

1. ***Direct Services***. In order to maintain the focus of the DPH on prevention and population health, the following three direct-service programs were moved from the DPH to the DHCS: 1) Every Woman Counts; 2) Prostate Cancer Treatment; and, 3) Family Planning Access Care and Treatment.

2. ***Mental Health***. As part of the elimination of the Department of Mental Health (DMH), the Office of Multicultural Services and Disaster Services and Response were transferred to the DPH.

3. ***Office of Health Equity***. The 2012 budget created a new Office of Health Equity within the DPH to focus on health disparities between populations. This Office comprises the Office of Women's Health (formerly at DHCS), the Office of Multicultural Health, the Health in All Policies Task Force, the Health Places Team, and the Office of Multicultural Services (formerly at DMH).

DPH BUDGET

As summarized in the table below, the Governor's proposed 2013-14 budget provides $3.4 billion for DPH programs and services, a decrease of 3 percent from the 2012-13 budget. General Fund dollars make up just 3.3 percent of the department's total budget. Federal funds make up approximately 58 percent of the total budget.

DEPARTMENT OF PUBLIC HEALTH					
Fund Source	**2011-12 Actual**	**2012-13 Projected**	**2013-14 Proposed**	**BY to CY Change**	**% Change**
General Fund	$125,304,000	$130,602,000	$114,499,000	($16,103,000)	(12%)
Federal Funds	1,882,227,000	2,009,497,000	2,014,499,000	5,002,000	.2%
Safe Drinking Water State Revolving Fund	50,977,000	-	-	-	-
WIC Manufacturer Rebate Fund	227,000,000	253,000,000	255,000,000	2,000,000	.8%
ADIS Drug Assistance Program Rebate Fund	289,045,000	309,583,000	265,075,000	(44,508,000)	(14%)
Special Funds & Reimbursements	757,546,000	837,321,000	787,385,000	(49,936)	(6%)
Total Expenditures	**$3,332,099,000**	**$3,540,003,000**	**$3,436,458,000**	**($103,545,000)**	**(3%)**
Positions	**3,229.2**	**3,762.2**	**3,777.5**	**15.3**	**.4%**

Fiscal Crisis

The General Fund in the DPH has been reduced dramatically over the past few years. In 2008-09, the DPH budget included approximately $350 million in General Fund, as compared to the currently proposed $115 million, a 67 percent reduction. Furthermore, the Governor's Budget for the budget year includes $16 million General Fund less than the current year budget. This $16 million is primarily a reduction to the AIDS Drug Assistance Program (ADAP), reflecting an estimated decrease in caseload as people move from ADAP to newly-formed Low-Income Health Programs (LIHPs), county-based programs that are extending health insurance coverage to low-income people as a part of the state's new 1115 Medicaid "Bridge to Reform" Waiver. This is discussed further under item #4 on the ADAP estimate.

Reductions at the DPH. Funding cuts were made to the Black Infant Health Program, Adolescent Family Life Program, Maternal and Child Health Program, Rural Health Clinics, the Expanded Access to Primary Care Program, and the Seasonal Migratory Worker Clinic program. All Office of AIDS programs and services (excluding the AIDS Drug Assistance Program (ADAP)), including HIV education, prevention, counseling and testing, early intervention, therapeutic monitoring, and home and community-based care were eliminated. Funding reductions were made to domestic violence shelters and Alzheimer's Research Centers. Funding was eliminated for the Dental Disease Prevention Program, the Asthma Public Health Initiative, injury prevention, and medical stockpiles.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked the DPH to provide a brief overview of the department, as well as of the impacts of the fiscal crisis on the department, the state's public health capacity, and local public health capacity.

1. Please provide a brief analysis of the impacts of the General Fund reductions at the DPH.

2. What does the DPH consider the highest priority public health issues/challenges for the state and what more could the state be doing on these issues, including with increased resources?

Staff Recommendation: Informational item; no action recommended

ISSUE 2: OFFICE OF HEALTH EQUITY

As proposed by the Governor, last year's health budget trailer bill AB 1467 (Budget Committee), Chapter 23, Statutes of 2012 required the DPH to establish the Office of Health Equity (OHE). The OHE consolidated the functions of five state-level organizations: Office of Multicultural Services at the former Department of Mental Health, Office of Multicultural Health at DPH and DHCS, Office of Women's Health at DPH and DHCS, Health in All Policies Task Force at DPH, and Healthy Places Team at DPH.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

The goals of the OHE are to:

1. Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities;

2. Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health;

3. Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services; and,

4. Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.

The OHE is comprised of three units: Community Development and Engagement Unit; Policy Unit; and Health Research and Statistics Unit. The OHE will include a Deputy Director, who will be appointed by the Governor and will be subject to confirmation by the Senate. The Deputy Director of the OHE will report to the DPH Director and work closely with the DHCS to ensure compliance with the requirements of the office's strategic plans, policies, and implementation activities. Currently, the OHE consists of fourteen positions; seven of which are filled. DPH will be adding contract positions to the OHE based on recent grant funding opportunities.

The law requires the DPH to establish an advisory committee within OHE to provide input and recommendations on issues related to eliminating mental and health disparities and achieving health equity amongst California's vulnerable population groups. The committee will actively participate in four meetings per year and make recommendations on a broad range of health and mental related issues that address the diversity of multicultural communities in California as a whole. The department received 108 applications from individuals wishing to serve on the advisory committee.

The OHE is also in the process of establishing an interagency agreement between DPH and DHCS. Statute requires the interagency agreement in order to outline the process by which the departments will jointly work to advance the mission of the office, including responsibilities, scope of work, and necessary resources.

The OHE currently receives funding from the Centers for Disease Control and Prevention; the National Office of Minority Health; Proposition 99 Fund/Climate Change; and Proposition 63, Mental Health Services Act.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked the department to provide an overview and update on the establishment of the OHE.

Staff Recommendation: Informational item; no action recommended

ISSUE 3: ZERO-BASE BUDGETING

On December 8, 2011, the Governor issued an Executive Order to begin utilizing "Zero-Base Budgeting" (ZBB). The DPH was one of four departments selected to pilot ZBB for 2013-14. The DPH began the first phase of implementing ZBB in three of its programmatic areas: 1) contracting functions; 2) the Baby BIG program; and, 3) the Women, Infants and Children (WIC) program. The DPH states that initial findings from these efforts will be provided to the Legislature in March of 2013.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

Governor Brown issued the following Executive Order On December 8, 2011:

EXECUTIVE ORDER B-13-11

WHEREAS substantial steps have been taken to reduce California's fiscal deficit, but additional measures are necessary both to cut state spending and improve operational efficiency; and

WHEREAS the State's budgeting method focuses on incremental changes to the prior year's funding, rather than a deeper review of a department or program; and

WHEREAS California needs a better approach to its budgeting; and

WHEREAS there are many methods, including zero-based budgeting, performance measures, strategic planning, audits, cost-benefit analyses, and program reviews, that can assist in increasing effectiveness and achieving a balanced budget; and

WHEREAS many departments have effective methods to evaluate and improve programs, yet these successes are often not shared with the public or other departments; and

WHEREAS employing these methods requires close collaboration with the Legislature to establish mutual agreement on establishing program goals and how to measure performance.

NOW, THEREFORE, I, EDMUND G. BROWN JR., Governor of the State of California, issue this Order to become effective immediately:

IT IS HEREBY ORDERED that the Director of Finance shall create a plan for modifying the budget process to increase efficiency and focus on accomplishing program goals. The plan should be developed in collaboration with agency secretaries and department directors and submitted to the Governor's Office within 90 days of this Order.
It should outline the following:

1. *A strategy to incorporate program-evaluation methods into the budget process for selected activities and programs. These methods include zero-based budgeting, performance measures, strategic planning, audits, cost-benefit analyses, and program reviews.*

2. *Ways to ensure transparency about program goals, outcomes, and funding.*

3. *A process for collaborating with the Legislature, particularly in establishing program goals and measuring program outcomes.*

4. *A structure to work with local governments to develop methods to measure and evaluate performance of state-funded, locally-administered programs.*

5. *An implementation timeline beginning with the release of the 2012–13 Governor's Budget.*

The ZBB approach differs significantly from traditional budgeting. Whereas in traditional budgeting a department incrementally builds upon its prior year budget by either adding or subtracting funds from existing programs, in ZBB, the department builds its budget from the ground up, reassessing how it currently spends and allocates resources within each program.

DPH staff describes the process undertaken with these first three programs as not a pure ZBB approach, but rather a hybrid that focuses on program outcomes. According to DPH, the ZBB process has been very time-intensive, so much so that any department undertaking this process needs to recognize that it will take the place of other work. Moreover, DPH's goal has been to take the time to study these programs deeply in order to gain an accurate understanding of the strengths and weaknesses of the programs, what aspects of the programs are working well, what aspects are not, and what ways the same services could be provided in more efficient ways. DPH states that this is not strictly a budget cutting exercise, and instead describes it as a way to improve the quality and efficiency of programs.

As stated above, DPH has drafted a report on their findings from implementing ZBB with these three programs. The Administration anticipates releasing the report to the Legislature in early March. If the ZBB has led to DPH recommending fiscal or policy changes to any of the programs, proposals to make those changes would be presented either in the Governor's May Revision, or perhaps in next year's Governor's Budget.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked the department to provide an overview of ZBB and how this has been implemented thus far at DPH.

1. When will the Legislature receive the department's report?

Staff Recommendation: Informational item; no action recommended

ISSUE 4: AIDS DRUG ASSISTANCE PROGRAM ESTIMATE

The Governor's Budget for 2013-14 proposes $416.8 million in total funding for ADAP, which includes no General Fund. This represents a $38.6 million ($13.2 million GF) reduction from the current year ADAP budget. The substantial General Fund reduction reflects the anticipated decreased demand for the program given an expected caseload shift from ADAP to both the existing county-operated Low-Income Health Programs (LIHPs) as well as through Medi-Cal and the Health Benefits Exchange once the ACA is fully implemented in 2014.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

ADAP provides HIV/AIDS drugs for individuals who could not otherwise afford them (up to $50,000 annual income). Drugs on the ADAP formulary slow the progression of HIV disease, prevent and treat opportunistic infections, and treat the side effects of antiretroviral therapy.

ADAP LOCAL ASSISTANCE BUDGET
(In thousands)

Funding Source	2011-12 Actual	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
General Fund	$4,651	$13,285	$0	($13,285)	(100%)
Federal Fund	118,767	125,876	105,179	(20,697)	(16%)
Special Fund	284,298	299,274	250,547	(48,727)	(16%)
Reimbursements	74,064	17,150	61,161	44,011	256%
Total Expenditures	**$481,780**	**$455,585**	**$416,887**	**($38,698)**	**(8%)**

As shown in the table above, the Governor's proposed budget reflects a net decrease in ADAP local assistance General Fund of $13.2 million from the 2012-13 budget. The General Fund reduction reflects the expected caseload shift from ADAP to LIHPs in 2013 and to Medi-Cal and the Health Benefits Exchange in 2014.

Caseload in ADAP is projected to be 37,167 in 2013-14 as compared to 40,464 in 2012-13, reflecting this caseload transition to LIHPs and other new ACA-created coverage.

Current Year (2012-13)
In last year's budget, the Office of AIDS (OA) at DPH projected a substantial caseload shift from ADAP to LIHPs, as they have done in the current proposed budget for

2013-14. The updated November 2012 estimate reflects that last year's caseload shift was approximately 20 percent less than projected, thereby resulting in less savings than anticipated. Nevertheless, increases in federal funds and ADAP rebate funds have provided the necessary funding for the current year, without affecting the level of General Fund in the program.

Budget Year (2013-14)
The Governor's proposed budget reflects a decrease of $38 million over the revised current year budget. This decrease allows for the reduction of all $13 million in General Fund from the program. In order to develop the ADAP estimate, the OA uses a linear regression model to estimate caseload and corresponding program costs. This is then adjusted to reflect various assumptions about the program, including the following:

- *Increase in Pharmacy Benefit Manager (PBM) Costs*. The federal Health Resources and Services Administration (HRSA) instituted a new mandate on states to conduct six-month ADAP client eligibility re-certification, which results in increased workload and costs for the ADAP PBM. The increased PBM costs are $778,539 in 2012-13 and $671,484 in 2013-14.

- *Revised and Updated Estimate of Caseload Shift to LIHPs*. All of the following have led to a revise caseload shift estimate: 1) availability of updated data; 2) lengthening the average delay from when ADAP screens clients for LIHP eligibility to when LIHP makes an eligibility determination; 3) changing Alameda County's LIHP implementation date; 4) merging the impact of the Pasadena LIHP with the Los Angeles County LIHP; and, 5) allowing potentially LIHP-eligible ADAP private insurance and Medicare Part D clients to remain co-enrolled in ADAP for coverage of medication co-pays and deductibles.

ADAP to LIHPs Transition
The OA reports that 6,269 ADAP clients will shift from ADAP to LIHPs in 2012-13 and 2,530 more in 2013-14. The following table describes the cost and caseload assumptions made by the Administration associated with the LIHPs:

ADJUSTED LIHP IMPACTS		
Impact Estimates	FY 2012-13	FY 2013-14
Client Shift	6,269	2,530
Reduced Expenditures	$59,440,611	$164,819,698
Reduced Rebate Revenue	($3,830,066)	($43,996,352)
NET LIHP SAVINGS	**$55,610,544**	**$120,823,346**

The OA reports that the transition, thus far, has gone well. The OA states that they have worked closely with stakeholders, consumers, advocates, and DHCS to ensure a smooth transition. The OA also has worked with the LIHPs on drug formularies and pharmacy and provider networks. The OA also conducted trainings for providers and case managers.

STAFF COMMENTS/QUESTIONS

According to the OA, most ADAP clients transitioning to LIHPs did not have to change pharmacies or providers, however a small number did. The OA states that they have only limited, anecdotal information on clients who have experienced significant difficulties in the transition to LIHPs. This is due to the lack of data resulting from privacy issues making data sharing between the state and counties difficult. However, based on budget trailer bill last year that facilitates this type of data sharing, the OA is in the process of developing data use agreements with LIHPs, that will allow the OA to track clients in order to ensure that they have not experienced an interruption in care or otherwise lost access to their medications. It is unfortunate that the time involved in adopting statute necessary to share data, coupled with the time required to develop data sharing agreements with all of the counties, is long enough that it may not have value given that the LIHPs will likely cease operating, at least in their current form, on January 1, 2014.

The AIDS Healthcare Foundation (AHF) has expressed the following concerns: 1) that the projected caseload shift is over-estimated; and 2) that the amount of difficulty experienced by clients transitioning has been under-reported. AHF points out that the transitions from ADAP to other programs over the next year may be quite complex with more clients moving to LIHPs in 2013, other clients moving to Medi-Cal in 2014 (assuming California implements the Medicaid expansion provided for in the Affordable Care Act), others moving to coverage through the Health Benefits Exchange, some not moving at all, and still others gaining coverage but still needing ADAP services due to unaffordable drug costs or copays in other programs.

The Subcommittee has asked the department to present the ADAP estimate, including an overview of the transition, thus far, of ADAP clients to LIHP programs.

1. Please describe any challenges ADAP clients have faced in transitioning from ADAP to LIHPs.

2. If the projection of the caseload shift to LIHPs were to turn out to be inaccurate, (i.e., an overestimate of how many people will leave ADAP), how would the Administration deal with the resulting deficiency in the program?

3. Please describe what changes you forsee for ADAP in 2014 with the implementation of the Affordable Care Act. Is the Administration proposing changes to the program? Will premium assistance still be available to people who receive comprehensive coverage elsewhere?

Staff Recommendation: Hold open pending updated information at May Revise

ISSUE 5: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

The DPH proposes total expenditures for both the current and budget years to remain at $87.7 million (Genetic Disease Testing Fund) for local assistance. This program is fully fee supported. According to DPH, this program has experienced reductions in costs in some past years directly reflecting reductions in the birth rate in those years; however, this year the birthrate has remained fairly constant, and therefore program costs are constant as well.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

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

Prenatal Screening Program. This program provides screening of pregnant women who *consent* to screening for serious birth defects. The fee paid for this screening is about $150. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. There are three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester. Women who are at high risk based on the screening test results are referred for follow-up services at state-approved "Prenatal Diagnosis Centers." Services offered at these Centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary, and the November 2012 estimate projects to screen approximately 408,022 pregnant women in 2012-13 and 413,999 in 2013-14.

Newborn Screening Program. This program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is $113. Where applicable, this fee is paid by prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. The Newborn Screening Program screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment that mitigates more severe health problems. Informational materials are provided to parents, hospitals and other health care entities regarding the program and the relevant conditions and referral information is provided where applicable.

The November 2012 estimate projects to screen approximately 510,028 newborns in 2012-13 and 517,499 in 2013-14.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DPH to provide an overview of this program and budget estimate.

Staff Recommendation: Hold open pending updated information at May Revise

ISSUE 6: CONVERSION OF CONTRACT POSITIONS TO STATE STAFF BUDGET CHANGE PROPOSAL

The Division of Environmental and Occupational Disease Control is requesting authority to convert 11 contract positions into full-time permanent state positions, in order to minimize the use of contract staff. This conversion is expected to result in annual savings of $48,000 (special funds).

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

Historically, the Division of Environmental and Occupational Disease Control has hired contractors (contract staff) to perform various state functions and fill state positions; however, in recent years, the state has become increasingly aware of the many negative aspects of this practice, including: 1) the state is unable to obtain and retain skilled staff; 2) the state is vulnerable to legal action from employee unions and the State Personnel Board due to Government Code Section 19130; 3) contracts for staff limit staff development and destabilize the state workforce; and, 4) the work lacks continuity.

For these reasons, DPH and other departments have converted many formerly contracted positions into state staff, usually as contracts reach their expiration. This request involves positions in the following programs:

- Division of Environmental and Occupational Disease Control – 3 positions
- Occupational Lead Poisoning Prevention Program – 2 positions
- Asthma Prevention Program, Disease Cluster, and Environmental Health Programs – 6 positions

STAFF COMMENTS/QUESTIONS

No concerns have been raised with this proposal.

The Subcommittee has asked DPH to present this BCP.

Staff Recommendation: Approve BCP as proposed

ISSUE 7: EXPORT DOCUMENT PROGRAM BUDGET CHANGE PROPOSAL

The Food and Drug Branch within DPH is requesting permanent expenditure authority ($287,000 in 2013-14 and $281,000 ongoing) and three full-time permanent positions for the Export Document Program, which is statutorily required to respond to requests for issuance of export documents within five working days of receipt of the request.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

The main purpose of the Food and Drug Branch (FDB) is to ensure citizens the safety of foods, drugs, medical devices, and cosmetics. FDB is able to ensure products are safe and effective through inspection, regulation and education of all foods, drugs, cosmetic and medical device manufacturers.

The Export Document Program was established with the passing of AB 3942 (Statutes of 1989) and was later amended by AB 3703 (Statutes of 1991). These two pieces of legislation delegated the responsibility to FDB to issue export documents to California's food, drug, medical devices, and cosmetics manufacturers. FDB is required to respond within five days to each request for issuance of an export certificate.

There are two factors that FDB uses to determine whether an export document should be issued to manufacturers. First, following inspections of the state's manufacturers, distributors, and wholesalers, FDB determines whether the system of manufacture and quality control used to produce the product is adequate. The second factor the FDB considers is whether the product is labeled properly, which is determined by a review of the product at the time the export document is requested.

Recently, processors of the state's food, drugs, medical devices and cosmetics have told the FDB that a significant amount of foreign countries are now requiring export documents before any products can be exported from California. FDB has acknowledged a 38 percent increase in the number of export document applications that also include requests to have the documents notarized. Some of these requests that include multiple product labels, labeling and advertising, special wording, and notary requirements, involve labor intensive processing and specialized review. Specialized applications such as these have led to the current eight week review timeframe, which now exists.

During the 1991-92 fiscal year, 1.5 permanent positions were established for the Export Document Program. Currently, the program has permanent positions of 1.0 Staff Service Analyst (SSA) and a 0.5 Office Technician (OT). The program has seen a major rise in requests over the last 10 years, going from 1,731 requests in 2001, to 9,500 requests in 2012. The current staff is unable to provide adequate staffing resources due to the increased level of demand for export certificates. A good amount of these requests require technical and scientific label review and the Export Document Program currently has no scientific or research/investigative staff.

STAFF COMMENTS/QUESTIONS

The Grocery Manufacturers Association (GMA) is supportive of this BCP, as reducing the backlog will be helpful to them, however they would like to see the department do more, such as to implement an on-line (electronic) renewal and application system. They are also proposing to change statute to extend the certificate validity timeframe from 6 months to one year, similar to other states.

The Subcommittee has asked DPH to present this BCP and to provide a response to the GMA proposals.

Staff Recommendation: Approve BCP as proposed

ISSUE 8: STOP TOBACCO ACCESS TO KIDS ENFORCEMENT (STAKE) ACT BUDGET CHANGE PROPOSAL

The DPH is requesting $129,000 (special funds) and 1.0 permanent position to implement the provisions of AB 1301 (Hill), Chapter 335, Statutes of 2012, which requires the DPH to notify the Board of Equalization when a third, fourth, or fifth STAKE Act violation is committed by the same retailer within a five-year period.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

The goal of the Stop Tobacco Access to Kids Enforcement (STAKE) Act is to reduce the illegal sale of all tobacco products to minors within the state. The California Tobacco Control Program (CTCP), which was established as a result of the passage of the Tobacco Tax and Health Protection Act of 1988 (Prop 99), is responsible for supporting a statewide tobacco control program using a variety of methods to reduce tobacco sales to minors. These methods include a statewide media campaign, evaluations, community outreach, policy, surveillance activities, and cessation activities. The DPH has administered the STAKE Act program jointly through CTCP and FDB since 1995.

The FDB, CTCP, and DPH all play vital rolls in the implementation of the STAKE Act. FDB is responsible for administering tobacco surveillance checks as well as managing the toll-free telephone line used to report the illegal sale of tobacco to minors. CTCP is responsible for writing a portion of the report that is required as part of the Alcohol and Drug Program's block grant from the Substance Abuse and Mental Health Services Administration. The DPH uses a retailer list created by the CCTPL Act to help enforce the STAKE ACT.

AB 1301 (Hill), Chapter 335, Statutes of 2012 is intended to further curb the sale of tobacco to minors by delegating to the California Board of Equalization (BOE) enhanced enforcement of BOE licensed retailers who violate the STAKE Act. This bill also requires DPH to cite a third, fourth, or fifth violation of the STAKE Act by the same retailer within a five-year period, and to notify BOE of such violations.

FDB is anticipating a higher volume of appeals to STAKE Act violations by retailers throughout the state, as these violations will affect the revenues and BOE licenses of retailers. These appeals will require the DPH legal staff to sort through the facts of the case as well as to prepare and litigate the case in front of an Administrative Law Judge (ALJ). The ALJ would then issue a proposed decision, which DPH has 100 days to adopt. Once adopted, the final decision is received by the FDB and a 60-day period to notify BOE begins. The anticipation of an increased number of appeals led to the development of this BCP.

STAFF COMMENTS/QUESTIONS

No concerns have been raised with this proposal.

The Subcommittee has asked DPH to present this BCP.

Staff Recommendation: Approve BCP as proposed

ISSUE 9: EMERGENCY PREPAREDNESS LIMITED-TERM POSITIONS BUDGET CHANGE PROPOSAL

The DPH is requesting $9.4 million (federal funds) and authority to extend 76.8 existing limited-term positions for an additional four years, which will align the positions with the federal grant period (2012/13–2016/17). These positions were originally established in 2003-04, and have been extended every two years since.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

These 76.8 positions are fully federally funded to support public health emergency preparedness responsibilities. The positions are located throughout the department in many different programs, including in the Emergency Preparedness Office, the Center for Infectious Diseases, the Center for Environmental Health, the Center for Chronic Disease Prevention and Health Promotion, and others. These positions work on a myriad of activities and functions, including the following:

- Medical surge capacity to respond to outbreaks, epidemics, etc.
- Receipt and distribution of medical countermeasures (Strategic National Stockpile)
- Laboratory testing
- Disease surveillance and epidemiology
- Monitoring drinking water and food safety
- First responder and health care worker health and safety
- Public information in disasters
- Emergency communications
- Educating and training healthcare workers

STAFF COMMENTS/QUESTIONS

No concerns have been raised with this proposal.

The Subcommittee has asked DPH to present this BCP.

Staff Recommendation: Approve BCP as proposed

4700 DEPARTMENT OF COMMUNITY SERVICES AND DEVELOPMENT

ISSUE 1: DEPARTMENT OVERVIEW AND PROGRAM UPDATE

BACKGROUND AND OVERVIEW

The mission of the Department of Community Services and Development (CSD) is to administer and enhance energy and community services programs that result in an improved quality of life and greater self-sufficiency for low-income Californians.

Energy Programs. The Energy Programs assist low-income households in meeting their immediate and long-term home energy needs through financial assistance, energy conservation, and weatherization services.

- The Low-Income Home Energy Assistance Program (LIHEAP) provides financial assistance to eligible households to offset the costs of heating and/or cooling dwellings, payments for weather-related or energy-related emergencies, and free weatherization services to improve the energy efficiency of homes. This program may include a leveraging incentive program in which supplementary LIHEAP funds can be obtained by LIHEAP grantees if non-federal leveraged home energy resources are used along with LIHEAP weatherization related services.

- The federal Department of Energy Weatherization Assistance Program provides weatherization related services, while safeguarding the health and safety of the household.

- The Lead Hazard Control Program provides for the abatement of lead paint in low-income privately owned housing with young children.

Community Services. The Community Services Block Grant Program (CSBG) is designed to provide a range of services to assist low-income people in attaining the skills, knowledge, and motivation necessary to achieve self-sufficiency. The program also provides low-income people with immediate life necessities such as food, shelter, and health care. In addition, services are provided to local communities for the revitalization of low-income communities, the reduction of poverty, and to help provider agencies to build capacity and develop linkages to other service providers.

California receives $60.3 million in CSBG funds, administered through 59 agencies in all California counties. California CSBG agencies provided services to 3.3 million low-income individuals in 661,432 families, among them children (403,239), people with disabilities (92,254), seniors (190,277), and people who lacked health insurance (133,041).

Weatherization Under ARRA. On October 30, 2012, CSD announced that nearly 60,000 low-income homes have been made more energy efficient around the state under the American Recovery and Reinvestment Act (Recovery Act) Weatherization Assistance Program. The Recovery Act provided $5 billion nationally to the U.S. Department of Energy (DOE) weatherization program, of which California was awarded $185.8 million. With these funds, California was able to serve 59,066 low-income homes as of September 30, 2012, three months before the end of California's grant term. This significantly surpasses California's original goal of reaching 43,150 households under the Recovery Act, by serving almost 16,000 additional homes than originally anticipated. CSD partnered with 40 nonprofit and local government providers to deliver weatherization services to low-income households around the state.

FISCAL OVERVIEW

Fund Source	2011-12 Actual	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
Federal Trust Fund	$251,663	$261,951	$261,899	(52)	0%
Total Expenditures	**$251,663**	**$261,951**	**$261,899**	**(52)**	**0%**
Positions	97.3	107.4	111.4	4	4%

BUDGET CHANGE PROPOSAL

The Governor's Budget requests position authority for four new permanent positions for the Utility Assistance Call Center, to be paid utilizing federal funds. The requested positions will replace eight Retired Annuitants, who, as such, were working at half-time, who are currently handling the workload, and no additional funding will be requested to support the Department's mission to serve the low-income population. There will be a corresponding change in the temporary help and wages/authorized positions that will be reflected in the 2014-15 Salaries and Wages for the 2013-14 requested adjustment. CSD is 100 percent federally funded, and the call center costs will continue to be funded by the federal Low Income Home Energy Assistance Program. CSD will absorb the marginal difference associated with staff benefits earned by the permanent employees within the current state operation authority.

The expected workload includes providing call center services to the public such a program information requests, complaint calls, requests for appeals, status on benefit payments, benefit payment reissuance, and service referrals to local administrators of energy programs. The Utility Assistance Call Center received approximately 12,000-15,000 calls per month, depending on the seasonal periods and energy needs (summer and winter months normally run higher). On average, each staff member can take approximately 2,000 calls per month. Based on the number of calls on average that the

Utility Assistance Call Center receives each month, CSD states that an additional 4.0 PYs are needed.

CSD has been awarded over $2.8 billion in LIHEAP funding since 1982, 95 percent of the LIHEAP funding is awarded to 43 community-based organizations through local assistance contracts to provide assistance to the low-income population in California. Approximately 65 percent of the local assistance funding is used specifically for Utility Assistance, including but not limited to Wood, Propane & Oil.

PANEL

- Department, please provide an overview of the conditions of programs and services provided under your purview, highlighting major changes or shifts in funding, operation, and impact where this is significant for the Subcommittee's working knowledge of your program and fiscal state.
- Department, please describe the recent history of General Fund expenditures for programs at CSD.
- Department, please describe the Budget Change Proposal that was submitted as part of the Governor's Budget.
- Department of Finance (DOF), please provide any additional comments.
- Legislative Analyst's Office (LAO), please provide any comments or additional insight regarding the overview topic of which the Legislature should be aware.
- Public Comment on any issue not otherwise agendized that relates to this department.

Staff Recommendation: Staff recommends approval of the BCP for the Utility Assistance Call Center.

ISSUE 2: NATURALIZATION SERVICES PROGRAM

BACKGROUND

Advocates have written to the Subcommittee to request this hearing item and public comment regarding the Naturalization Services Program (NSP), a program once administered by the CSD. NSP was administered by CSD from 1998 to 2008. Under this program, CSD contracted with community based organizations (CBOs) to assist legal permanent residents in obtaining citizenship. Activities and services performed included outreach, intake, referrals, citizenship application assistance, citizenship testing, interview preparation, and follow up activities.

NSP was funded from the state General Fund (GF) as follows:

CSD Naturalization Services Program	
Fiscal Year	Total Funding (GF)
2000-01	$7,000,000
2001-02	$4,889,000
2002-03	$2,864,783
2003-04	-
2004-05	$1,500,000
2005-06	$1,500,000
2006-07	$3,000,000
2007-08	$3,000,000

In the last year of the program (2007/08 SFY), CSD was awarded $3 million (GF) and contracted with 23 CBOs around the state. In the same year, 9,743 clients were served, and 5,502 received certificates of naturalization. A total of 118,488 clients were served during the life of the program.

The California Immigrant Policy Center and Asian Americans for Civil Rights and Equality have requested that the Subcommittee consider this program for reinvestment. The advocates state that with federal immigration reform on the horizon, it is urgent to reconsider this valuable program so that immigrants who are eligible to naturalize not only have access to naturalization services, but also the opportunity engage in a process toward citizenship that emphasizes increased civic engagement and skills building. Under federal reform, over two million undocumented Californians may be eligible for some type of provisional status. The advocates also state that it is important to ensure that a mechanism exists to serve the huge backlog of legal permanent residents who are currently eligible for naturalization or in process.

PANEL

- Department, please respond to the following:
    - Please describe the funding and program history of the Naturalization Services Program.
    - Please describe the demonstrated outcomes of the NSP when it was in effect and what it provided to the state.
- Department of Finance (DOF), please provide any additional comments.
- Legislative Analyst's Office (LAO), please provide any comments or additional insight regarding the topic of which the Legislature should be aware.
- Public Comment.

Staff Recommendation: This item does not require action.