AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

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

WEDNESDAY, MAY 21, 2014

1:00 P.M. - STATE CAPITOL ROOM 444

ITEMS TO BE HEARD

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4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 1: POISON CONTROL CENTERS FUNDING

The Emergency Medical Services Authority (EMSA) requests $2,364,000 ($827,000 General Fund, $1,537,000 Reimbursements) for 2014-15 and $3,032,000 ($1,061,000 General Fund, $1,971,000 Reimbursements) in 2015-16 to support the California Poison Control System (CPCS).

PANELISTS

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

BACKGROUND

CPCS is a statewide network of health care professionals that provide free treatment advice and assistance to people over the phone in case of exposure to poisonous or hazardous substances. It provides help and information to both the public and to health professionals and operates 24 hours per day, 7 days per week. The system maintains interpreting services in over 100 languages. All fifty states have poison control systems.

Prior to 1987, ten different hospitals in California hosted their own poison control centers, each serving various geographic regions, without guidance or regulation by the state. CPCS was established in 1987, establishing statewide services and minimum requirements, through seven regional centers.

In March 1995, a study by the National Health Foundation recommended a single, consolidated poison control system for California, and EMSA issued an RFP to establish this new consolidated system. EMSA contracted with the University of California San Francisco to provide the services. CPCS also consolidated to four centers that now operate the program at: UC Davis Medical Center, San Francisco General Hospital, Children's Hospital Central California (Fresno), and the UC San Diego Medical Center..

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 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

federal funding (which is matched with General Fund), the Poison Control Centers would have ceased operations in January 2010. The EMSA works with the Department of Health Care Services to secure these federal CHIP funds.

Funding Source	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Federal & Miscellaneous						
HRSA Stabilization Grant	$2,392,000	$1,846,000	$1,782,000	$1,700,000	$1,700,000	$1,700,000
Special Projects	345,000	870,000	394,000	0	0	0
Miscellaneous	70,000	413,000	413,000	289,000	289,000	289,000
State Funds						
General Fund	2,950,000	2,950,000	2,950,000	2,950,000	2,950,000	2,950,000
Medi-Cal	800,000	800,000	800,000	800,000	800,000	800,000
S-CHIP	5,278,000	4,715,000	5,278,000	5,278,000	5,278,000	5,278,000
TOTAL FUNDS	**11,835,000**	**11,594,000**	**11,617,000**	**11,017,000**	**11,017,000**	**11,017,000**
Expenditures						
Personnel Costs	10,404,000	10,389,000	10,826,000	11,580,000	12,158,000	12,766,000
Operating Expenses	1,989,000	1,660,000	1,873,000	1,801,000	1,891,000	1,985,000
TOTAL EXPENSES	**12,393,000**	**12,049,000**	**12,699,000**	**13,381,000**	**14,049,000**	**14,751,000**
Deficit	**(558,000)**	**(455,000)**	**(1,082,000)**	**(2,364,000)**	**(3,032,000)**	**(3,734,000)**
HRSA Grant Carryover	381,000	455,000	519,000	0	0	0
SCHIP Carryover	177,000	0	563,000	0	0	0
FUNDING DEFICIT	**0**	**0**	**0**	**(2,364,000)**	**(3,032,000)**	**(3,734,000)**
May Revise Request						
General Fund (35%)				827,000	1,061,000	1,307,000
S-CHIP Funds (65%)				1,537,000	1,971,000	2,427,000
TOTAL REQUEST				**$2,364,000**	**$3,032,000**	**$3,734,000**

EMSA explains that rising personnel costs are the primary cause of the operating deficit. As personnel costs have risen, as determined by collective bargaining, revenue has remained flat.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA to present this proposal and to explain the cause of the program's operating deficits.

Staff Recommendation: Staff recommends approval of this proposal for $2.3 million in 2014-15 and $3 million in 2015-16 to support the Poison Control System.

ISSUE 2: STATEWIDE & LOCAL EMERGENCY MEDICAL RESPONSE CAPACITY

In light of diminishing resources over the past several years, it is unclear and concerning how much capacity the state has to respond to medical disasters. Related to this, support exists for re-funding the mobile field hospitals.

PANELISTS

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

BACKGROUND

At the Subcommittee's hearing on March 10, 2014, EMSA's Director, Dr. Howard Backer described EMSA as the designated agency for coordinating California's medical response to disasters. Dr. Backer also described EMSA's tiered response to medical disasters, including:

- Tier 1: 42 Ambulance Strike Teams to establish a field triage and treatment station within 2 hours;

- Tier 2: 3 California Medical Assistance Teams that can be deployed within 12 hours to treat patients in any standing facility with sufficient supplies; and

- Tier 3: 3 Mobile Field Hospitals.

Examples of diminishing resources in the area of emergency medical response include the following:

- ***Mobile Field Hospitals***. The mobile field hospitals are virtually defunct at this point, as described in more detail below.

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

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

Mobile Field Hospitals

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

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

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

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

EMSA provided the following cost estimate for funding the mobile field hospitals:

Program Funding Required to Maintain 3 Mobile Field Hospitals (MFHs) in Response Ready Condition

PROGRAM COMPONENT	DESCRIPTION	TOTAL PROJECTED GENERAL FUND COSTS
Storage	Two MFHs would be located in Sacramento ensuring rapid deployment in Northern California, including the San Francisco Bay area, and the central valley. The third hospital would be located in Southern California.	$475,000
Maintenance	The maintenance contract would include having logistical support available 24/7/365, set-up teams immediately available for deployments, maintenance of all support contracts, and on-going maintenance of the following MFH equipment: biomedical, batteries, generators, medical supplies, shelters, and other miscellaneous MFH items.	$975,000
Pharmaceutical Cache	Three pharmacy caches.	$510,000
	Total	**$1,960,000**

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Staff recommends requesting supplemental reporting language from EMSA that describes in detail the available state and local resources available in a medical disaster, a comparison of how the state's resources compare to other states and countries of similar size, and recommendations on California's unmet needs in this area.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 1: FEDERAL MENTAL HEALTH PARITY PROPOSAL & TRAILER BILL

In the May Revision, DMHC requests a one-time augmentation of $369,000 (special fund) for 2014-15 for clinical consulting services to conduct initial front-end compliance reviews to ensure oversight of California's implementation of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). In addition, DMHC requests trailer bill language to provide DMHC state authority to enforce these requirements.

PANELISTS

- Department of Managed Health Care
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The MHPAEA expands federal mental health parity protections beyond the limited requirements of the previously enacted federal Mental Health Parity Act of 1996 (MHPA). The MHPAEA requires that group health plans and health insurance coverage offered in connection with group health plans that offer mental health and substance use disorder (MH/SUD) benefits do so in a manner comparable to medical and surgical (med/surg) benefits. For most plans, the MHPAEA became applicable to plan years beginning on or after October 3, 2009.

According to DMHC, this proposal takes a proactive approach, through a front-end review of the methodologies plans will use to comply with the MHPAEA requirements. This work will be completed by actuarial and clinical consultants. Specifically, the DMHC will require health plans to certify to the DMHC's Office of Plan Licensing (OPL) that they are in compliance with the applicable MHPAEA requirements. Certifications will be filed with the OPL and must be accompanied by health plan explanations of methodologies for determining compliance.

The DMHC will contract with an actuarial consultant to determine whether the plans' methodologies for calculating expected plan payments is reasonable as required by the Final Rule. The DMHC will review the health plans' methodologies and other filings to determine if the plans are in compliance with federal law. The DMHC anticipates the additional workload for the actuarial analyses will be minimal and can be absorbed within existing resources.

The DMHC also will contract with clinical consultants to review the plans' methodologies and other filings. Of the 45 health plans that offer mental health benefits, 12 have the complexity of multiple product lines and group sizes; the remaining 33 plans do not have such complexity. The DMHC estimates that for health plans with multiple lines and group sizes an average of 56 hours of clinical compliance review will be needed. For health plans without multiple lines or group sizes, an average of 44 hours will be necessary to complete the review.

For both types of health plans, the clinical consultants will:

- Develop the standardized Parity Document Checklist and health plan instructions.
- Develop the Parity Compliance Findings tools and instructions.
- Provide clinical expertise in the review of health plan Filings and Findings Reports.
- Review health plan Filings to assess the sufficiency of submission, adequacy of methodology and procedures and completeness of documentation.
- Conduct an inter-rater reliability audit, which promotes reliability and consistency of the review process.
- Build a database of health plan Filings and review findings.
- Create a tracking database of Filings.
- Develop MHPAEA Compliance Health Plan-Specific Findings Report.
- Develop MHPAEA Compliance Aggregate Summary Report.

The number of hours and hourly rates identified in this request are based on an existing contract for similar clinical consulting services in which the contractor conducts medical survey and assessment activities that focus on health plan regulatory compliance filings. The DMHC will use existing resources to amend this contract for services to perform the pre-filing workload, including the development of pre-filing submission instructions and training, which must be completed prior to July 1, 2014.

The compliance findings reports will identify similarities and differences in benefit classifications and the underlying methodologies applied by health plans in their parity analysis. They also will identify best practices across submitted compliance methodologies. The findings reports will identify specific areas of concern for the DMHC to consider as it determines the need for rulemaking and prepares for focused retrospective implementation surveys/audits of each of the largest health plans' delivery of mental health and substance use disorder services.

This proposal ensures a front-end compliance review. However, it should be noted that this initial compliance review is intended to account only for the DMHC's anticipated initial compliance workload in FY 2014-15. For a retrospective, or back-end, compliance review, the DMHC intends to conduct focused medical surveys of all 45 full service and specialty health plans after the first year of compliance with the Final Rules, in addition to routine on-site medical surveys that are conducted every three years. As such, surveys will not begin until after January 1, 2016 and the DMHC will evaluate any fiscal impacts of such work as part of the FY 2015-16 budget process.

STAFF COMMENTS/QUESTIONS

The Governor's January budget did not include a proposal to implement the new federal rules requiring health plans, that offer mental health and substance use disorder benefits, to do so in a manner comparable to medical and surgical benefits. This issue was discussed at the April 21, 2014 Subcommittee hearing. Since that hearing, DMHC has convened a stakeholder workgroup to discuss implementation of federal mental health parity and submitted this proposal.

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends approval of this request for $369,000 and placeholder trailer bill for consulting services to implement and enforce the federal mental health parity law.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: CALIFORNIA INSTITUTE FOR MENTAL HEALTH & ALCOHOL & DRUG POLICY INSTITUTE MERGER

The California Institute for Mental Health (CiMH) requests statutory changes to reflect its merger with the Alcohol and Drug Policy Institute (ADPI) on July 1, 2014. On March 21, 2014, the boards of CiMH and ADPI voted to merge organizations and become the California Institute for Behavioral Health Solutions. They took this action to take advantage of opportunities to better serve their customers and improve outcomes for individuals and their families. CiMH's responsibilities are specified in statute; consequently, this proposal requests changes to specify that this new entity can work on substance use disorder services programs.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

CiMH was established in 1993 to promote excellence in mental health services through training, technical assistance, research and policy development. Local mental health directors founded CiMH to work collaboratively with all mental health system stakeholders. CiMH is defined in statute (Welfare and Institutions Code Section 4061[a][5]).

ADPI works toward the advancement of the substance use disorder (SUD) field in California through the creation and dissemination of knowledge regarding alcohol and other drug problems and culturally competent approaches to their prevention and amelioration. ADPI was incorporated in August 2000 as a nonprofit public benefit corporation and is organized and operated exclusively for educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code.

CiMH and ADPI find the following benefits with the merger:

a) For counties, a one-stop shop for consulting expertise related to the integration of services as well as the best practices in the provision of both mental health and SUD services.

b) For health care organizations, a one-stop source for assistance in getting better health outcomes for patients with complex and chronic health conditions.

c) For state departments who pay for health care services primarily through the Medi-Cal program, a one-stop shop for a training and TA interface with counties, service providers, and other stakeholders.

d) For individuals and their families: Through consulting and technical assistance to counties, health care organizations and state departments, expedite the adoption of evidence-based and community-based practices, resulting in improved health outcomes.

STAFF COMMENTS/QUESTIONS

This proposal and merger reflect the growing momentum towards integrating mental health and substance use disorder services to improve an individual's overall health.

The Subcommittee requests LAO to present this proposal, and requests DHCS to provide reactions to the proposal.

Staff Recommendation: Staff recommends adoption of placeholder trailer bill language to reflect this merger.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: WOMEN, INFANTS & CHILDREN (WIC) PROGRAM ESTIMATE

The May Revision requests a decrease of $17.7 million in federal funds and $8.9 million in WIC Manufacturer Rebate Special Fund as a result of updated caseload and food expenditure projections. In addition, the May Revision reflects the implementation of a new federal rule which requires an increase in the cash value benefit issued to child participants from $6 to $8. This rule will be implemented by June 2, 2014.

The full WIC estimate was heard by the Subcommittee on March 10, 2014.

PANELISTS

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

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the changes to the WIC program and estimate included in the May Revise.

Staff Recommendation: Staff recommends approval of the WIC estimate.

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

The 2013 Budget Act includes $406.3 million for ADAP. The May Revise is requesting an increase of $27.9 million in federal funds, an increase of $37.6 million in rebate funds and a decrease in reimbursement funds of $58 million due to a surplus in fiscal year 2013-14. For 2014-15, ADAP estimates a budget increase of $25.8 million compared to the revised current year budget of $413.8 million.

Table: Comparison of January and May Estimates for ADAP for Budget Year

(Dollars in thousands) **Fund Source**	**January Budget**	**May Revise**	**Difference**
AIDS Drug Rebate Fund	$259,769	$278,601	$18,832
Federal Funds – Ryan White	98,727	106,290	$7,563
Reimbursements-Medicaid Waiver	51,126	53,645	$2,519
Total	**$409,622**	**$438,536**	$28,914

BACKGROUND

Two new issues in the May Revise impacting the ADAP program are:

a. **Addition of Hepatitis C (HCV) Drugs to the ADAP Formulary.** DPH proposes to add simeprevir (Olysio) and sofosbuvir (Sovaldi) to the ADAP formulary. On January 24, 2014, the ADAP Medical Advisory Committee (MAC) voted to recommend that both of these drugs be added to the ADAP formulary, citing the large burden of HCV co-infection among HIV-infected patients with its resulting impact on mortality (about five percent of deaths among all persons living with HIV/AIDS in California are due to HCV), and the tremendous improvement in HCV cure rate that these new drugs offer over current HCV therapy.

DPH estimates that 4,545 ADAP clients are co-infected with HCV in 2014-15 and that of these, only 10 percent (454) would receive treatment with these new HCV therapies in 2014-15. DPH is in discussions with the ADAP MAC on establishing prior authorization criteria for these new HCV drugs that would make the new drugs available to those most in need and most likely to benefit from HCV treatment.

DPH estimates the net cost of adding this treatment would be $26 million. This net cost assumes that DPH would be able to get $5 million in rebates from these manufacturers.

b. **Office of AIDS-Health Insurance Premium Assistance Payment Program (OA-HIPP) Medical Cost Sharing Wrap.** DPH proposes trailer bill language to develop the capacity to pay out-of-pocket medical expenses, in addition to premiums for eligible OA-HIPP clients, for clients who choose to purchase insurance through Covered California. This would encourage more ADAP clients to enroll in comprehensive coverage and would result in a reduction in ADAP costs of $9.9 million in 2014-15.

This issue was discussed in Subcommittee at the request of advocates on March 3, 2014.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the May Revise adjustments and new proposals related to ADAP and the Office of AIDS.

Staff Recommendation: Staff recommends: 1) approval of the AIDS estimate; 2) approval of the proposal related to HCV drugs; and 3) approval of the OA-HIPP proposal including placeholder trailer bill for this purpose.

ISSUE 3: BIOMONITORING PROPOSAL

DPH and the Department of Toxic Substances Control (DTSC) jointly request four two-year limited-term positions and expenditure authority of $700,000 ($350,000 Toxic Substances Control Account/$350,000 Birth Defects Program Monitoring Fund) in 2014-15 and $696,000 ($346,000 Toxic Substances Control Account/$350,000 Birth Defects Program Monitoring Fund) in 2015-16 to support the California Environmental Contaminant Biomonitoring Program (CECBP).

DPH is the designated lead for Biomonitoring California, coordinating with two CalEPA departments: the Office of Environmental Health Hazard Assessment (OEHHA) and DTSC. The requested positions would replace some federal grant positions that will be lost when Centers for Disease Control and Prevention (CDC) funding is eliminated on August 31, 2014, ensuring that the mission of CECBP maintains its momentum.

PANELISTS

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

BACKGROUND

SB 1379 (Perata and Ortiz), Chapter 599, Statutes of 2006, established the tri-departmental CECBP. CECBP is a collaborative effort among DPH, OEHHA, and DTSC. CECBP's principal mandates are to measure and report levels of specific environmental chemicals in blood and urine samples from a representative sample of Californians, conduct community-based biomonitoring studies, and help assess the effectiveness of public health and environmental programs in reducing chemical exposures. CECBP provides unique information on the extent to which Californians are exposed to a variety of environmental chemicals and how such exposures may be influenced by factors such as age, gender, ethnicity, diet, occupation, residential location, and use of specific consumer products.

The three departments that constitute CECBP received $2.2 million in 2013-14 from five special funds: (1) Toxic Substances Control Account, (2) Birth Defects Monitoring Program Fund, (3) Department of Pesticide Regulation Fund, (4) Air Pollution Control Fund, and (5) Childhood Lead Poisoning Prevention Fund. This baseline state funding currently supports eight positions in DPH and five total positions within OEHHA and DTSC.

In 2009, CECBP was awarded a competitive five-year Cooperative Agreement (grant) of $2.65 million per year from CDC through the Sequoia Foundation as its designated bona fide agent. Although the funding was awarded directly to the Sequoia Foundation and is not included in DPH's or DTSC's budget, CECBP benefits from these resources as the Sequoia grant staff work with state staff to accomplish the tasks of the Cooperative Agreement. The CDC Cooperative Agreement with Sequoia Foundation funds approximately 15 non-state "grant" positions to supplement the 13 core state positions. This grant has complemented CECBP's state funding since 2009-10, and has played a critical role in establishing the program's current capabilities and proficiencies. The grant from CDC ends on August 31, 2014. When the grant ends, CECBP's resources will be reduced by nearly 60 percent, if resources are not renewed.

In February 2014, the CDC issued a new Funding Opportunity Announcement for state public health laboratories with biomonitoring capabilities. This new competitive five-year grant is restricted to funding only work that generates surveillance data to augment the national and state databases. It is not to be used for purposes of research or laboratory expansion. About five states will be awarded grants.

On May 5, 2014, the Sequoia Foundation, as DPH's designated bona fide agent, submitted a proposal to CDC to fund CECBP at the maximum allowable level of $1 million per year. If awarded, the new grant would support up to six Sequoia Foundation positions for five years between September 1, 2014 and August 31, 2019.

CECBP's current state funding of $2.2 million per year has been fairly stable since 2008-09. It has supported 13 permanent state staff positions (eight in DPH, three in OEHHA, and two in DTSC) that form the scientific core of CECBP.

When the CDC grant expires, the ongoing level of state funding will not be adequate to sustain the current program resource levels. Without this proposed funding, CECBP's ability to serve as an early warning system for new chemical exposures or promote state environmental and public health policies would be reduced. Furthermore, although the Sequoia Foundation recently applied for new federal funding of $1 million per year over a five-year funding cycle, this level of federal funding represents a reduction from the $2.65 million in federal funding received annually over the last five years. The CDC has stated that there would likely be no federal funding for state biomonitoring programs beyond that date when the next five-year funding cycle expires on August 31, 2019.

This proposal requests four two-year limited-term positions and expenditure authority of $700,000 in 2014-15 and $696,000 in 2015-16 from the Toxic Substances Control Account and the Birth Defects Monitoring Program Fund to support this program and partially offset the loss of federal funds on August 31, 2014. The requested four positions would replace some of the 15 grant positions that will be eliminated when current CDC funding ends.

The four limited-term state positions would help CECBP maintain a degree of proficiency and productivity after August 31, 2014, when the CDC grant ends and some Sequoia Foundation contract positions are eliminated. The four proposed state positions would continue to analyze specific toxic chemical contaminants in biological samples from on-going population-based investigations, establish methodologies, conduct statistical analyses of the data, and contribute to other mandated activities such as returning results to individual participants and conducting essential public health investigations.

This limited-term funding would allow CECBP to: (1) hire state staff to perform the duties currently accomplished by some of the grant staff for the next two years; (2) sustain productivity over the next two years in detecting and measuring chemical exposures; (3) begin developing capabilities to investigate emerging and as of yet unknown chemical threats in the environment and consumer products; and (4) continue collaborations with external (mainly university) investigators.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 4: FEDERAL GRANTS

Public health advocates have raised concerns that DPH has been reluctant to apply and/or reapply for federal grants because it finds that it does not have sufficient statutory authority to do so. In particular, concerns have been raised regarding the Wisewoman (a federal grant to address heart disease in women) and colorectal cancer federal grants.

PANELISTS

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

BACKGROUND

DPH contends that it has sufficient statutory authority to apply for federal grants and cites Health and Safety Code Section 131085 which reads:

(a) The department may perform any of the following activities relating to the protection, preservation, and advancement of public health:

(1) Studies.
(2) Demonstrations of innovative methods.
(3) Evaluations of existing projects.
(4) Provision of training programs.
(5) Dissemination of information.

(b) In performing an activity specified in subdivision (a), the department may do any of the following:

(1) Perform the activity directly.
(2) Enter into contracts, cooperative agreements, or other agreements for the performance of the activity.
(3) Apply for and receive grants for the performance of the activity.
(4) Award grants for the performance of the activity.

STAFF COMMENTS/QUESTIONS

DPH acknowledges the concerns that have been raised and indicates that it does not foresee this problem in the future, but it has not provided any rationale or explanation as to why these concerns occurred in the first place.

The Subcommittee requests LAO to present this issue, and requests DPH to explain their perspective on this issue.
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Staff Recommendation: Staff recommends adoption of placeholder trailer bill to clarify the department's authority related to applying for federal grants, similar to the language provided below.

Add Health and Safety Code 131058 as follows:

> 131058. The State Department of Public Health may investigate, apply for, and enter into agreements to secure, federal or non-governmental funding opportunities for the purposes of advancing public health, subject to the provisions of Section 13326 of the Government Code for federal funding or applicable administrative review and approval of non-governmental funding opportunities.

ISSUE 5: PROPOSITION 99 & MEDICAL MARIJUANA ADJUSTMENTS

The May Revision requests the following adjustments due to a reduction in Proposition 99 revenues:

- Reduce Health Education Account by $1,567,000 – This would result in a decrease in state operations for the Center for Chronic Disease Prevention and Health Promotion's California Tobacco Control Program (CTCP).

- Reduce Research Account by $360,000 – This would result in a decrease in funds available for CTCP external research contracts.

- Reduce Unallocated Account by $157,000 – This would result in a reduction in administrative support for the CTCP.

- Reduce Health Education Account by $2 million – This would result in a decrease in competitive grant and funding allocations to Local Lead Agencies.

The May Revision also requests to decrease expenditures by $84,000 in the Medical Marijuana Program Fund due to a decline in revenues since the January budget.

PANELISTS

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

BACKGROUND

Department of Finance describes the reduction to the Medical Marijuana Program as "technical," reflecting a decrease in projected revenue as compared to the November estimate and January Budget. However, DOF also states that $84,000 represents a 26 percent reduction to the program. This Fund contains revenue collected from fees paid by individuals seeking to obtain or renew identification cards that are required in order to use marijuana for a medical purpose.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present these issues and to respond to the following:

1. Please provide an overview of Proposition 99 revenues and how these reductions fit into the broader context of overall revenues.

2. Please provide information on the Medical Marijuana Program: i.e., what are the program's functions? What is the impact on the program of a 26 percent reduction in funding? What are some potential reasons that this revenue is decreasing?

Staff Recommendation: Staff recommends holding this item open.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 1: RESTORATION OF COMPETENCY PROGRAM EXPANSION

DSH requests 13.5 positions and $3,898,000 to expand the county-based Restoration of Competency (ROC) program by 45-55 beds.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

As discussed in the Subcommittee's March 24, 2014 agenda, the State Hospitals are experiencing a growing waiting list of Incompetent to Stand Trial (IST) patients. One of several solutions under consideration is the expansion of the ROC.

The 2007 Budget Act included $4.3 million for a pilot program to test a more efficient and less costly process to restore competency for IST defendants by providing competency restoration services in county jails, in lieu of providing them within state hospitals. This pilot operated in San Bernardino County, via a contract between the former Department of Mental Health, San Bernardino County, and Liberty Healthcare Corporation. Liberty provides intensive psychiatric treatment, acute stabilization services, and other court-mandated services. The State pays Liberty $278, well below the approximately $450 cost of a state hospital bed. The county covers the costs of food, housing, medications, and security through its county jail. The results of the pilot have been very positive, including: 1) treatment begins more quickly than in state hospitals; 2) treatment gets completed more quickly; 3) treatment has been effective as measured by the number of patients restored to competency but then returned to IST status; and, 4) the county has seen a reduction in the number of IST referrals. San Bernardino County reports that it has been able to achieve savings of more than $5,000 per IST defendant, and therefore total savings of about $200,000. The LAO estimated that the state achieved approximately $1.2 million in savings from the San Bernardino County pilot project.

The LAO produced a report titled*, An Alternative Approach: Treating the Incompetent to Stand Trial*, in January 2012 on this issue. Given the savings realized for both the state and the county, as well as the other indicators of success in the form of shortened treatment times and a deterrent effect reducing the number of defendants seeking IST commitments, the LAO recommends that the pilot program be expanded.

In 2012, budget trailer bill authorized the state to continue the pilot on an ongoing basis, and the DSH is in the process of actively encouraging expansion to other counties. The DSH reports that they have had significant discussions with 14 counties and that draft agreements have been developed and are being processed for Los Angeles, Alameda, and Sacramento Counties.

The DSH proposal includes funding to enter into a contract with additional counties to allow jail-based county staff to provide a per diem reimbursement to the county to cover county costs for custody staff associated with the program, as well as medication and other patient related supplies.

DSH is also requesting the flexibility (i.e., authority) to transfer personal services dollars to contract dollars should the department experience difficulties or delays in hiring the requested staff positions.

This proposal is for 6.0 positions at Napa and 7.5 positions at Metropolitan State Hospital to provide on-site treatment at the county facilities.

STAFF COMMENTS/QUESTIONS

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

1. What additional counties will be added to this program based on this proposal?

2. Are these funds supporting the same functions currently supported by state resources within this program, or does this propose to use General Fund for new purposes?

3. Does the existing pilot program include similar positions within state hospitals?

4. How much savings results from DSH operating the program directly as compared to operating it through a contract?

Staff Recommendation: Staff recommends holding this item open.

ISSUE 2: RECRUITMENT & RETENTION PAYMENT FOR PHYSICIANS & PSYCHIATRISTS

The Union of American Physicians and Dentists (UAPD) requests $1.6 million General Fund for the Department of State Hospitals (DSH) to provide a recruitment and retention incentive equal to 5 percent of salary for Physicians and Surgeons employed by State Hospitals.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

As a result of the Plata lawsuit and the court-ordered federal receivership of California's prisons, salaries for medical staff working within the prisons increased significantly in 2007. As a result, a substantial number of medical professionals left other state departments to work in the prisons. In response, the California Department of Personnel Administration (DPA) worked with several unions to equalize medical staff salaries across departments in order to prevent a staffing crisis. In January 2008, the DPA and UAPD reached an agreement on changes to the Memorandum of Understanding, thereby granting salary increases for Physician & Surgeons working for the former Department of Mental Health and the Departments of Developmental Services (DDS) and Veterans Affairs (DVA), raising salaries to within 5 percent of the prison salaries by January 2009.

Nevertheless, since 2009, prison-based physicians have continued to receive pay increases from the federal receiver, and physicians employed by DSH, DDS and DVA have fallen behind significantly. According to UAPD, the starting salary for physicians in the prisons is 26 percent higher than for DSH, DDS, and DVA.

UAPD reports that physician vacancies in state hospitals is significant. Specifically, between one quarter and one third of the physician positions are vacant as Coalinga, Vacaville, and Napa. The chart below details the physician vacancies in State Hospitals:

Facility	Positions	Filled Positions	Vacancies	Vacancy Rate
Coalinga	10.5	7	3.5	33%
Vacaville	3	2	1	33%
Napa	21	16	5	24%
Patton	23	19.75	3.25	14%
Metropolitan	20	18	2	10%
Atascadero	16	15	1	6%
Salinas Valley	3	3	0	0%

UAPD explains that DSH, DDS, and DVA physicians earn significantly less than prison doctors, despite having the same qualifications, the same work, and in some cases more dangerous working conditions.

DSH notes that it has formally requested an extension of Pay Differential (PD) 157 to include the classes Staff Psychiatrist, Correctional and Rehabilitative Services (Safety), Senior Psychiatrist (Supervisor), Correctional and Rehabilitative and Chief Psychiatrist, Correctional and Rehabilitative Services (Safety) at Salinas Valley, Stockton, and Vacaville; to extend PD 324 to all facilities and to include the classes Senior Psychiatrist (Specialist), Staff Psychiatrist (Safety) and Senior Psychiatrist (Supervisor; and has requested a Special Salary Adjustment to bring the DSH Physician and Surgeon class and Chief Physician and Surgeon class within 5 percent of the salary of comparable CDCR classifications. DSH states that, if approved, the salary adjustments will assist in addressing DSH's chronic and severe recruitment and retention problems and that DSH will absorb the cost of the adjustment and no new funding will be requested.

Legislative Analyst's Office

The LAO provided the following information on salary differentials.

The table below includes average salary information for some of the most common DSH health care provider classifications, as well as average salaries for comparable positions in the private sector and at CDCR. The table below reflects statewide average annual pay without benefits.

Classification	DSH Annual Compensation	CDCR Annual Compensation	Private Annual Compensation
Managing Physician and Surgeon	$187,698	$241,236	-
Physician and Surgeon	$191,670	$236,530	$199,328
Physician Assistant	-	$119,454	$98,830
Nurse Practitioner	$108,636	$118,218	$110,590
Supervising Registered Nurse	$102,411	$106,034	-
Nurse Instructor	$91,908	$103,680	-
Registered Nurse	$91,254	$101,160	$96,980
Nurse Anesthetist	-	$112,596	$163,570
Surgical Nurse	$86,724	$99,381	-
Public Health Nurse	$94,098	$93,119	-
Licensed Vocational Nurse	$45,036	$48,006	$51,800

It is important to note that there are several limitations to the available data, so direct comparison is not possible. For example, private providers do not use precisely the same classification system as DSH. In addition, salary is only one form of compensation – the table does not include any overtime, heath/retirement benefits, bonuses or other forms of compensation that might be available for DSH, CDCR, or private providers. It is also important to note that many factors besides compensation affect employment choices. For example, providers might make a decision about where to work based on location, job security, safety, feelings of fulfillment, or other factors.

As can be seen in the table, for all classifications except for Public Health Nurse, DSH pay is less than CDCR pay. In particular, in five of the classifications included in the table above, CDCR pay exceeded DSH pay by more than 10 percent. In addition, for all of the classifications for which there was data, private provider pay exceeded DSH pay.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests LAO to present this proposal, and requests DSH to provide reactions to the proposal and respond to the following:

1. Please quantify the shortage of physicians and psychiatrists in the state hospital system at this time.

2. How much do salary differentials contribute to the vacancy rates in state hospitals?

3. What is the impact on patient care of the vacancy rates in state hospitals?

4. What is the actual differential in salaries between physicians in state hospitals and those in very similar positions in state prisons?

5. Please explain the actions taken by DSH related to this issue, and described above; how do these actions address this proposal?

Staff Recommendation: Staff recommends holding this issue open.

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 1: TRIAGE GRANT OVERSIGHT

In the May Revise, the Mental Health Services Oversight and Accountability Commission (Commission) requests additional funding from the Mental Health Services Fund (MHSF), to support the ongoing administration and monitoring of SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statues of 2013, the Investment in Mental Health Wellness Act of 2013. SB 82 mandated the Commission to design and administer an ongoing competitive process to fund county grants to hire at least 600 mental health triage personnel statewide. The grants are funded with $32 million in MHSF and $22 million in federal Medi-Cal reimbursement ongoing.

The Commission requests three permanent positions and $296,000 for 2014-15 and a $290,000 ongoing allocation from the MHSF to administer and monitor the Triage Personnel Grant Program created by the Investment in Mental Health Wellness Act of 2013. The three positions are requested to oversee the triage grant program in counties within the five grant regions.

Additionally, the Commisson requests a reappropriation of $19.3 million in current year funding related to the triage grants. These funds were not all awarded in the current year and the Commission requests to reappropriate the funding to make additional grants. Budget bill language (BBL) is requested to make this reappropriation.

PANELISTS

- MHSOAC
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

On June 27, 2013, the Governor signed SB 82, the Investment in Mental Health Wellness Act of 2013, creating an opportunity to use Mental Health Services Act (MHSA) dollars to expand crisis services statewide that are expected to lead to improved life outcomes for the persons served and improved system outcomes for mental health and its community partners. Among the objectives cited in the Mental Health Wellness Act of 2013 is to "expand access to early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs." This objective is consistent with the vision and focus for services identified in the MHSA.

SB 82 mandated the Commission to establish and administer a new competitive grant program that supports local mental health departments in the hiring of 600 new mental health triage personnel statewide. Per SB 82, the Commission worked with stakeholders to define the grant criteria. The grants targeted rural, suburban, and urban areas, identified within the five regional designations utilized by the California Mental Health Directors Association. SB 82 also tasked the Commission with ongoing administration and monitoring of this new triage program.

According to the Commission, there is additional workload that will accompany the administration and monitoring of the $54 million total funds provided to fund the triage program grants. The Commission temporarily redirected multiple staff from other duties to develop the criteria for the RFA, award the grants and address appeals, resulting in an administrative backlog in other Commission responsibilities. The Commission currently has 27 authorized positions. Half of the staff were redirected to create the criteria for the Request for Application (RFA), develop the RFA, review and score the applications, create monitoring tools for fiscal and outcome evaluations, and manage the appeals from the counties that were not funded. In addition, staff had to create individual agreements for each county that was awarded funding. The RFA process will be evaluated, adjusted as needed, and implemented at least every three years based on the first grant awards. According to the Commission, given the new responsibilities associated with the administration and oversight of the Triage Personnel Grant Program, continuing to redirect existing resources is not a feasible alternative.

The triage program will also impact staff in the evaluation unit. There are specific data elements that will be collected that will be evaluated to determine the effectiveness of the triage grant program. As with most new programs, there will likely be a significant amount of training and technical assistance required for counties and triage program staff.

Additionally, according to the Commission, without additional positions, current evaluation staff may continue to be redirected, which could cause a delay in evaluations and implementation of the Evaluation Master Plan.

Funding for Suicide Prevention

A request has been received for state funding to support the addition of suicide nets on the Golden Gate Bridge. In 2013, 46 people committed suicide on this bridge and workers stopped 118 others. Unlike other iconic structures, the Golden Gate Bridge lacks a suicide barrier.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission to present this proposal and react to the proposed modification to the use of these funds related to suicide prevention.

Staff Recommendation: Staff recommends approving the requested staff positions and modifying the proposed Budget Bill Language as described below.

Modify requested budget bill language to reappropriate $19.3 million by providing that $7 million of these funds be made available for suicide prevention efforts. Given the one-time availability of unawarded MHSA funds, it is recommended to redirect $7 million for suicide prevention efforts at the Golden Gate Bridge. Modified budget bill language:

4560-491—Reappropriation, Mental Health Services Oversight and Accountability Commission. The balances of the appropriations provided in the following citations are reappropriated for the purposes specified below and shall be available for encumbrance or expenditure until June 30, 2017.

3085—Mental Health Services Fund
(1) Item 4560-001-3085, Budget Act of 2013 (Ch. 20, Stat. of 2013)
Provisions:

1. Of the funds reappropriated in this item, up to $7,000,000 shall be made available for suicide prevention efforts.

2. It is the intent of the Legislature, that the remaining funds continue funding triage personnel grants approved by the Commission. Therefore, notwithstanding any other provision of law, the balance of the appropriation may, upon approval of the Department of Finance, be reappropriated for additional grants. The funds reappropriated by this provision shall be made available consistent with the amount approved by the Department of Finance subject to the availability of funds within the state administrative cap of the Mental Health Services Fund for grants approved by the Mental Health Services Oversight and Accountability Commission not sooner than 30 days after providing notification in writing to the chairpersons of the fiscal committees in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee.

ISSUE 2: EVALUATION REAPPROPRIATION

The Mental Health Services Oversight and Accountability Commission (Commission) encumbered $400,000 for a contract with the University of California, Davis to support the Commission's evaluation efforts. The Contractor needs additional time to complete deliverables. The Commission is requesting to re-appropriate the unencumbered balance from fiscal year 2011-12 to extend the liquidation period allowing the Contractor to complete the deliverables and receive payment in fiscal year 2014-15.

The proposal includes the following proposed Budget Bill Language:

4560-490—Reappropriation, Mental Health Services Oversight and Accountability Commission. Notwithstanding any other provisions of law, the period to liquidate encumbrances of the following citations are extended to June 30, 2015:
3085—Mental Health Services Fund
(1) Item 4560-001-3085, Budget Act of 2011 (Ch. 33, Stat. of 2011)

PANELISTS

- Commission
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The Commission entered into an agreement with the University of California, Davis for $400,000 in 2011-12 to evaluate the impact of the MHSA and state and local policies and practices on the disparities in access to, quality of, and outcomes of the public mental health system by age, gender, race, ethnicity and primary language.

The Commission amended the contract twice to allow the contractor additional time to complete deliverables. The contractor informed the Commission in March 2014 that the deliverables will not be completed by the March 31, 2014 due date. Instead, the contract will be amended again to require completion of the deliverables by Spring of 2015.

STAFF COMMENTS/QUESTIONS

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

1. What is the reason that the contractor has been unable to complete the requirements of this contract, such that the contract has had to be amended and delayed three times?

2. What assurances can the Commission provide the Legislature that this work will actually be completed by the Spring of 2015?

Staff Recommendation: Staff recommends holding this issue open.