

AGENDA**PART I – HEALTH****ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES****ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR****FRIDAY, MAY 24, 2013****UPON ADJOURNMENT OF APPROPRIATIONS COMMITTEE - STATE CAPITOL ROOM 437****VOTE-ONLY CALENDAR**

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VOTE ONLY

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEDI-CAL ESTIMATE

The federal Medicaid Program (Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance.

Governor’s May Revision. The May Revision proposes total expenditures of \$69.2 billion (\$16.1 billion General Fund) for 2013-14 which represents *an increase* of \$9.4 billion (total funds), or 15.7 percent more than the current-year.

Medi-Cal caseload is projected to be 9,117,000, which represents a 15.5 percent increase compared to current year (and reflects the Administration’s assumptions on take-up regarding Medi-Cal expansion).

	2012-13 Revised	2013-14 Proposed	Difference	Percent
Benefits	\$55,901.3	\$64,829.5	\$8,928.2	16%
County Administration (Eligibility)	3,564.4	3,976.9	412.5	11.6%
Fiscal Intermediaries (Claims Processing)	312.7	355.7	43.3	13.8%
Total-Local Assistance	\$59,778.4	\$69,162.1	\$9,383.7	15.7%
General Fund	\$15,251.1	\$16,072.3	\$821.1	5.4%
Federal Funds	\$35,918.0	\$42,325.4	\$6,407.4	17.8%
Other Funds	\$8,609.3	\$10,764.3	\$2,155.0	25.0%

LAO Comment. Based on its review of recent caseload data, the LAO finds that the Administration’s revised estimates of Medi-Cal caseload, which are unrelated to the federal Affordable Care Act, are reasonable.

Staff Recommendation: Approve adjustments in caseload and budget, with any changes to technically conform as appropriate to other actions that have been or will be taken.

ISSUE 2: MANAGED CARE ORGANIZATION TAX

This issue was heard by the Subcommittee on Wednesday, May 22, 2013

The May Revision includes a revised proposal to re-establish the Gross Premiums Tax on Managed Care Organizations, often referred to as the "MCO Tax." Specifically, the May Revision proposes that the 2012-13 tax amount will be equal to the gross premiums tax, and in 2013-14 and on-going, the tax rate will be equal to the state sales tax rate. The MCO tax will result in current year General Fund savings of \$128.1 million for the Managed Risk Medical Insurance Board (Healthy Families Program), and \$342.9 million in General Fund savings in 2013-14 for Medi-Cal.

The Administration's January estimate included approximately \$136 million in General Fund savings in 2012-13 and \$233 million in General Funds savings in 2013-14.

BACKGROUND

AB 1422 (Bass), Chapter 157, Statutes of 2009 extended the State's existing 2.35 percent gross premium tax on insurance (all types) to Medi-Cal Managed Care Plans. This tax became effective January 1, 2009, and was then extended to July 1, 2011 by SB 853 (Budget and Fiscal Review Committee), Chapter 717, Statutes of 2010. Subsequently, AB 21 X1 (Blumenfield), Chapter 11, Statutes of 2011 extended the sunset date to July 1, 2012, and included provisions that made the extension of the tax inoperable should any eligibility changes be made to the Healthy Families Program.

Revenues from this tax are matched with federal funds and have been used to:

- Provide a reimbursement rate increase to Medi-Cal Managed Care Plans;
- Provide a reimbursement rate increase to health plans participating in the Healthy Families Program; and,
- Fund health care coverage for children through the Healthy Families Program.

AB 1422, and subsequent bills extending the tax, required the State to allocate 38.41 percent of the tax revenue to DHCS to provide enhanced rates to Medi-Cal Managed Care Plans. The remaining 61.59 percent of the tax revenue went to the Managed Risk Medical Insurance Board for essential preventive and primary health care services through the Healthy Families Program. The Medi-Cal Managed Care Plans affected by the tax included: 1) Two Plan Model (Local Initiatives); 2) County Organized Health Systems (COHS); 3) Geographic Managed Care; 4) AIDS Healthcare; and, 5) SCAN.

The Administration proposes to direct tax revenue to the Healthy Families Program in the current year, consistent with past use of the revenue, and in the budget year and beyond the revenue would fund children's health services through the Medi-Cal program, given the elimination of the Healthy Families Program agreed to through the 2012 budget. This proposal also seeks to redirect some MCO revenue to the Coordinated Care Initiative.

STAFF COMMENTS/QUESTIONS

At this point in time, health plans oppose this proposal in its current form. Generally, the plans state that they must know more about the managed care rates that will result from this tax in order to remove their opposition. They also argue that MCO tax revenue should not be used only as a General Fund offset. Finally, the plans argue that the tax should have a sunset rather than being established permanently. They are currently in discussions with the Administration on these issues.

Staff Recommendation: Adopt placeholder trailer bill to approve of the May Revise proposal to establish the MCO tax, and modify the language to include a sunset of June 30, 2016.

ISSUE 3: MEDI-CAL COUNTY ADMINISTRATION FUNDING

This issue was heard and acted on by the Subcommittee on Wednesday, May 22, 2013.

The Governor's May Revision proposes \$755 million General Fund for county administration. Within that amount, the administration proposes a \$71.9 million General Fund increase to pay for county administration associated with implementing the ACA, including \$65 million for processing applications and eligibility redeterminations for newly enrolled populations, \$4 million for training eligibility workers, and \$2.9 million for County/Statewide planning and implementation support. In addition, the budget includes a \$15.4 million Cost of Living Adjustment for county administration. Finally, the Administration proposes allowing counties to roll-over unspent Medi-Cal administrative funding from the current year, estimated at \$15 million.

BACKGROUND

Counties Administer Medi-Cal Eligibility Determinations And Case Management. The state delegates various administrative functions, including intake and eligibility determinations of new Medi-Cal applicants and ongoing eligibility case management activities, to counties—hereafter referred to as county administration. Generally, the state allocates funds to counties based on expected county workload and costs.

LAO Concerns

The Legislative Analyst's Office has expressed concerns regarding this funding proposal. They provided the following comments:

- ***"Net Effect Of The ACA On County Administration Is Uncertain.*** Certain aspects of the ACA—such as the potentially significant increase in Medi-Cal caseload—will increase costs. On the other hand, ACA provisions that simplify the eligibility determination process will likely reduce the average cost per enrollee across the entire Medi-Cal population. At this time, there is substantial uncertainty about the magnitude of these various fiscal effects and the degree to which potential savings would offset additional costs is unclear.
- ***Administration Has Provided Very Little Detail To Support Estimated County Administration Costs.*** At the time of this analysis, the administration has provided very little detail to support its estimated county administration costs to implement the ACA. In addition, based on our understanding of the administration's proposal, it does not assume any savings associated with the streamlined eligibility and enrollment process that may at least partially offset additional costs.

LAO Recommendation

Request Additional Information About Estimated County Administrative Costs. We recommend the Legislature require the administration to report at budget hearings and provide more detailed information about the assumptions and methodology used to estimate additional county administrative costs under the ACA and why it does not assume savings from the simplified eligibility process.

County Welfare Director's Association (CWDA)

CWDA is supportive of the May Revise proposal. CWDA conducted its own cost analysis related to ACA implementation and believes that counties will need \$120 million in order to implement the ACA efficiently and in a timely manner. Therefore, although CWDA supports the May Revision, they also believe that an additional approximate \$20 million will be necessary for counties. In order to achieve this additional \$20 million, CWDA proposes the adoption of budget bill language allowing for the one-time rollover of potential unspent funds from the current year CalWORKs single allocation, up to a maximum of \$120 million General Fund. Specifically, CWDA proposes budget bill language to:

- 1) Allow rollover of unspent Medi-Cal administrative funds from current year to budget year, on a one-time basis, and only to the extent that funds are necessary to meet the \$120 million General Fund figure after accounting for other funds available in the Medi-Cal budget.
- 2) Allow the county administration item to be increased with funds rolled over from CalWORKs unspent single allocation from current year, on a one-time basis, and only to the extent that funds are necessary to meet the \$120 million General Fund figure after accounting for funding available in the Medi-Cal budget.

STAFF COMMENTS/QUESTIONS

County welfare departments administer the Medi-Cal eligibility function, and have experienced suspended Cost of Living Adjustments and additional reductions through the past 4-5 years of the state's fiscal crisis. Therefore, given this series of reductions and underfunded budgets, coupled with the increased workload associated with the Medi-Cal expansion, and ACA implementation in general, it seems appropriate and critical to provide additional resources to counties for this purpose.

On May 22, 2013, the Subcommittee heard this issue and approved of: 1) the administration's proposed funding augmentation; and, 2) the two components of budget bill language described above. In subsequent stakeholder discussions on this issue, it has also been recommended to create a stakeholder process associated with this action, as described below.

Staff Recommendation: Adopt uncodified placeholder trailer bill language requiring the Department of Social Services to work together with counties, advocates for clients, and Legislative staff to ensure that there is no unintended impact of this action on clients' access to employment services or child care.

ISSUE 4: FAMILY PACT PROPOSAL

This issue was heard by the Subcommittee on Wednesday, May 22, 2013

The May Revise proposes several changes to benefits within the Family Planning Access Care and Treatment (Family PACT) program. These changes are for the purpose of utilization control as well as to meet federal requirements for funding. The budget assumes savings of \$32.6 million (\$9.7 million General Fund).

BACKGROUND

This proposal includes the following utilization controls to Family PACT benefits:

- Reduce Chlamydia screening of women over 25 years of age;
- Decrease over-utilization of emergency contraception;
- Adopt a Medi-Cal Preferred List of oral contraceptives;
- Eliminate urine culture; and
- Discontinue brand name anti-fungal drugs.

DHCS states that under the ACA, Family PACT services are limited to medical diagnosis and treatment services provided pursuant to a family planning service in a family planning setting. Therefore, effective July 1, 2013, DHCS plans to eliminate mammograms and pregnancy-test-only claims in order to comply with federal rules.

Benefit	FMAP	TOTAL FUNDS
Chlamydia Screening	90%	\$16,586,000
Emergency Contraception	90%	\$5,505,000
Medi-Cal List of Oral Contraceptives	90%	\$4,000,000
Urine Culture	50%	\$335,000
Brand Name Antifungal Drugs	50%	\$812,000
Mammograms	0%	\$5,042,000
Pregnancy Test Only	90%	\$325,000
TOTAL SAVINGS		\$32,605,000

STAFF COMMENTS/QUESTIONS

DHCS has provided insufficient explanatory information to justify making these changes and reductions to benefits.

Staff Recommendation: Deny this proposal to make various benefit reductions in the Family PACT program.

ISSUE 5: COORDINATED CARE INITIATIVE & MEDICARE PLAN CONTRACTS

This issue was heard by the Subcommittee on Wednesday, May 22, 2013

Thousands of frail, elderly, low-income seniors are currently enrolled in comprehensive, integrated Medicare managed care plans, for which the state's contracts expire on December 31, 2013. The administration intends to transition this population into plans participating in the dual eligible project that is a component of the Coordinated Care Initiative (CCI). However, CCI implementation is experiencing significant delays and, as reflected in the May Revision, may not begin sooner than January 2014.

Since the CCI implementation date has been delayed, it is important to maintain continuity of care for dual eligibles currently enrolled in these plans. If these Medicare contracts are not extended, dual eligibles covered by these Medicare plans will likely have their care interrupted and will return to fee-for-service Medi-Cal. Since these contracts must be extended by June 30, 2013, it is recommended to adopt placeholder trailer bill language.

Staff Recommendation: Approve of placeholder trailer bill to ensure the extension of certain Medicare contracts (MIPPA/D-SNP/FIDE-SNP) with the federal CMS.

ISSUE 6: NON-DESIGNATED PUBLIC HOSPITALS PAYMENT SYSTEM MAY REVISE PROPOSAL

This issue was heard by the Subcommittee on Wednesday, May 22, 2013

AB 1467 (a 2012 budget trailer bill) changed the non-designated public hospital (NDPH) reimbursement methodology to a certified public expenditure (CPE) methodology and eliminated NDPH supplemental payments. Additionally, under this change in methodology, DHCS would seek a state plan amendment (SPA) to increase Safety Net Care Pool (SNCP) and Delivery System Reform Incentive Pool (DSRIP) funding available to California. The additional funds would be made available to NDPHs to offset their uncompensated care costs and to support their efforts to enhance the quality of care and the health of the patients and families they serve.

DHCS submitted a SPA to the federal CMS for this proposal; however, CMS has not approved the SPA and has raised major issues regarding the DSRIP component. Consequently, in the May Revision, DHCS proposes that NDPHs continue to receive payments under their current methodology until December 31, 2013 and then transition to a diagnosis related group (DRG) payment system on January 1, 2014. This proposed change results in a loss of \$94.4 million General Fund (prior assumed savings) in the current year and \$94.4 million General Fund in the budget year.

NDPHs are publicly owned and operated facilities, the majority of which are operated by health care districts. There are approximately 46 NDPHs. Approximately 16 of the NDPHs are designated as Critical Access Hospitals (CAHs) under Medicare. To be designated a CAH, a hospital must be located in a rural area; provide 24-hour emergency services; have an average length of stay for its patients of 96 hours or less; be located more than 35 miles (or more than 15 miles in areas with mountainous terrain) from the nearest hospital; and have no more than 25 beds.

STAFF COMMENTS/QUESTIONS

District hospitals have expressed concerns with DHCS's decision to cease implementation of the CPE payment system. They believe that potential solutions to the concerns of the federal government have not been fully explored and would like to see DHCS spend at least six more months working towards federal approvals and implementation. They also point out that, regardless of the type of payment system used with these hospitals, the state can seek to obtain certain types of federal funds for these hospitals. However, the current statute is written in such a way that DHCS lacks authority to do so. Therefore, district hospitals are requesting trailer bill to make a clarifying change that authorizes DHCS to seek maximum federal funding for California's hospitals.

Staff Recommendation: Approve DHCS's proposal to restore \$94.4 million General Fund in the May Revision and adopt placeholder trailer bill language to authorize DHCS to pursue available federal funding for non-designated public hospitals.

ISSUE 7: AFFORDABLE CARE ACT MEDI-CAL EXPANSION MAY REVISE PROPOSAL
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The Subcommittee has heard various components of the administration's proposals to implement the federal Affordable Care Act (ACA) at the following hearings:

- *March 6, 2013 -- Optional Medi-Cal Expansion*
- *April 8, 2013 -- State-only programs within ACA implementation*
- *May 6, 2013 -- Fiscal estimate on the "mandatory expansion" & advocates' proposals on the remaining uninsured and funding for application assistors*
- *May 22, 2013 -- May Revise proposal on the optional expansion, proposed fiscal arrangement with counties and other aspects of ACA implementation*

BACKGROUND

The May Revise contains the following revised proposal for implementation of the ACA Medi-Cal expansion:

- Implements a state-based expansion of the Medi-Cal program, increasing eligibility for most childless adults up to 138 percent of the federal poverty level (FPL), including the following:
 - Newly eligible beneficiaries will receive the same benefits as the currently-eligible population, including county-administered specialty mental health services and county-supported substance use disorder services, with the following exceptions.
 - ✓ Long-Term Care services will be covered for the new population, provided federal approval is granted for retaining an asset test for these services.
 - ✓ Counties will be given the option of providing both currently and newly eligible beneficiaries enhanced benefits for substance use disorders.
 - Assumes \$1.5 billion Federal funds to implement the expansion.
 - Assumes an increase of \$21 million General Fund reflecting the following:
 - ✓ Transitions pregnant women, with income between 100 and 200 percent FPL, from Medi-Cal to Covered California and covers their share of cost, for savings of \$26.4 million;
 - ✓ Transitions newly qualified immigrants from Medi-Cal to Covered California and covers their share of cost, for savings of \$5.4 million;
 - ✓ Increases County funding for Medi-Cal administration by \$71.9 million to reflect increased workload related to implementing the expansion.
 - ✓ Bases future appropriations for county administration on a time study of resource needs, beginning in 2015-16.

- Establishes a mechanism to determine the level of county savings, based on actual experience, including the following components:
 - Each county will measure actual costs, for providing services to Medi-Cal and uninsured patients, and actual revenues, including patient care revenue, federal funds, health realignment dollars, and net county contributions.
 - Savings will be determined by the difference between actual costs and revenues, and these savings will be redirected to support human services programs.
 - Assumes a gradual shift, "over time" from the state to counties of financial responsibility for CalWORKs, CalWORKs-related child care programs and CalFresh. Proposes that counties would assume responsibility for the coordination of all client services and would gain the opportunity to reinvest caseload savings and revenue growth into these programs. Maintains authority for eligibility, grant levels, and rates at the state level.
 - Assumes a shift of \$300 million in 2013-14, \$900 million in 2014-15, and \$1.3 billion in 2015-16 and 2016-17 from health services to human services programs locally.
 - Requires the state to seek to develop a new Medicaid Waiver to replace the existing Bridge to Reform Waiver that expires in 2015, in order to maximize federal funding that supports county-run public hospitals and clinics.
 - Shifts financial responsibility for California Children's Services (CCS) from counties to the state "over time."
 - Requests that "consideration be given to the appropriate role of counties in the Medical Therapy Program."

Staff Recommendation:

1. Reject the May Revise request of \$186.7 million General Fund and \$216.9 federal funds and instead approve of the LAO proposal of \$104 million General Fund and associated federal funds in 2013-14 for the increase in Medi-Cal caseload costs, as a result of the Medi-Cal simplification provisions of the federal Affordable Care Act (ACA), referred to as the "mandatory" expansion.
2. Approve of \$300 million in General Fund savings in the 2013-14 budget associated with the implementation of a state-county savings sharing arrangement and the adoption of a methodology to determine on-going county savings. Lower out-year's savings assumption to \$700 million.

3. Reject the programmatic aspects of the administration's human services realignment proposal. To the extent that the Legislature takes actions with respect to health care reform that result in an amount of 1991 realignment funding that could become available to offset General Fund, adopt instead a fiscally-based transaction (e.g., tied to funding for Medi-Cal eligibility administration, CalFresh administration, or Child Support administration).
4. Adopt placeholder trailer bill to implement a methodology for calculating the savings that counties incur as a result of the anticipated expansion of the Medi-Cal program, per the Affordable Care Act. Require that these savings be shared between the state and counties in order to achieve the Governor's stated goal of maintaining a strong safety net. Require that the methodology ensures the protection and preservation of sufficient public health resources for the continuation of critical local public health functions.
5. Approve of \$31.7 million in General Fund savings assumed in the May Revision; reject the proposals related to coverage of pregnant women and legal immigrants; defer these policies to the policy process.

**4260 DEPARTMENT OF HEALTH CARE SERVICES
4280 MANAGED RISK MEDICAL INSURANCE BOARD****ISSUE 1: TRANSFER OF AIM-LINKED INFANTS TO MEDI-CAL**

This issue was heard by the Subcommittee on Wednesday, May 22, 2013

The Administration is proposing to transition Access for Infants and Mothers (AIM)-linked infants from MRMIB to DHCS, beginning October 1, 2013. This transition is expected to result in a reduction in the MRMIB budget, and an equivalent increase in the DHCS budget, of \$33.3 million (\$11.6 million General Fund, \$21.7 million federal funds).

The Administration will transition infants whose mothers have incomes up to 250 percent of the federal poverty level (FPL) into Medi-Cal, beginning August 1, as a part of the overall transition of children in the Healthy Families Program. This proposal is to transition 1,886 children with mothers who have incomes between 250 and 300 percent FPL to Medi-Cal beginning October 1, 2013.

BACKGROUND

The 2012 Budget Act approved of the transition of all children in the Healthy Families Program to Medi-Cal in 2013, a transition, which is in progress. The statute did not address the transition of "AIM-linked infants," 0-2-year olds born to mothers in the AIM program, and who are currently provided two years of coverage through Healthy Families. Per last year's statute approving of the Healthy Families transition, Medi-Cal eligibility for children now goes to 250 percent FPL. This proposal requires statutory changes although the Administration has yet to provide any proposed language.

Staff Recommendation: Approve of the proposal to transition AIM-linked infants between 250 and 300% FPL from Healthy Families to Medi-Cal, and adopt placeholder trailer bill to authorize this transition and ensure this transition is subject to the same consumer protections, requirements, accountability elements, and stakeholder involvement requirements as the already-authorized Healthy Families to Medi-Cal transition.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: SAFE COSMETICS PROGRAM PUBLIC WEBSITE

This issue was heard and acted on by the Subcommittee on Monday, April 15, 2013.

Proponents of the Safe Cosmetics Program have raised concerns regarding the delays in full implementation of the California Safe Cosmetics Act of 2005, specifically with regard to the website for consumers that DPH still has not launched.

The California Safe Cosmetics Act of 2005 requires that a manufacturer, packer, and/or distributor named on a label of any cosmetic product sold in California must provide to the California Safe Cosmetics Program (CSCP), within DPH, a list of all of their cosmetic products containing any ingredients linked to cancer, birth defects, or other reproductive harm. CSCP maintains an online reporting system, which has collected information from over 450 different companies to date; over 38,000 products, containing more than 85 distinct chemicals have been submitted to the CSCP database.

The following accomplishments illustrate the successes of the program and the degree to which DPH has implemented the law thus far:

- CSCP sent compliance letters to a large number of manufacturers, distributors, and packers of cosmetic products worldwide, resulting in a 30 percent increase in reporting. The program also conducted product audits and data verification to identify underreporting, however, due to resource constraints, these activities were discontinued.
- For approximately two years, beginning in March 2010, CSCP investigated health complaints from hair stylists and customers who used certain hair straightening solutions and procedures in salons containing the carcinogen formaldehyde, which can cause a number of non-cancer health effects such as respiratory problems, even from limited exposure. The product, "Brazilian Blowout," was labeled as formaldehyde-free though it contained up to 12 percent by volume. CSCP engaged in outreach and educational efforts, and provided technical expertise to the Attorney General as the state's legal case against the company proceeded.
- CSCP has investigated cosmetic product use, formulations, and health impacts. Some examples include: 1) mercury in skin whitening creams; 2) formaldehyde in baby bath products; 3) toxic ingredients in nail products; 4) heavy metals in lip balms; 5) and lead in diaper creams.
- CSCP has made significant progress on the development of a database that, when completed, will allow public access to the reported data through a public website. As the database and website are in development, DPH also has filed many Public Record Act requests for cosmetic ingredient information.

According to advocates, DPH staff is recognized as national experts and leaders in the field of cosmetics safety. However, despite all of these accomplishments, advocates highlight the following activities that should be occurring, particularly if additional resources were made available:

- ***Increased and improved enforcement of the Safe Cosmetics Act.***
- ***Increased and completed investigations and research on cosmetics-related health and safety issues.***
- ***Completion of a public website making the database of information on cosmetics available to the public.*** DPH states that the Program has put together a set of business rules describing the function and architecture of the website, and has produced mock-ups of the webpage. However, the programming to create the website, including query design to support the search function and actual webpage design, has not yet been initiated. Earlier this year, DPH anticipated that the website would be operational by March 2014, but was making efforts to have it operational this calendar year.

STAFF COMMENTS/QUESTIONS

The Safe Cosmetics Act was passed in 2005 in order to assist California consumers in the choice of non-toxic personal care products. The purpose of the program is to provide this data about the presence of carcinogens and reproductive toxin ingredients in products to consumers. This is especially important for subpopulations of consumers, specifically pregnant and lactating mothers, those undergoing medical treatments for serious acute and chronic diseases, and workers in the cosmetic and personal services industry such as nail and hair salons, many of whom are not native English speakers.

This information advances the public health by providing a database of reportable information that is available to consumers and others in order to make health based decisions. Consumer's knowledge and choice about these specified ingredients is the purpose of the submission of data by manufacturers to DPH.

When the Subcommittee heard this issue on April 15, 2013, the committee took an action to direct DPH to work with staff to develop a proposal to ensure that the website will be launched by December 31, 2013. In conversations between Subcommittee staff and the department, the department indicated that it fully expects to have the website launched by December 31, 2013. However, conversations involving stakeholders have raised additional concerns about the specific aspects of how the website will be structured, what information will be contained within it, and how user-friendly it will be. Therefore, additional action is recommended at this time.

Staff Recommendation: Adopt placeholder trailer bill to clarify and more clearly define the purpose and structure of the Safe Cosmetics Program website (as described below), and to require the website to be operational by December 31, 2013.

The public database (website) should be searchable to accommodate a wide range of users and accessible to people with limited technical or scientific literacy. Data should be presented in an educational context so that more information about what the data means to the user is readily available such as links that explain the carcinogenicity or reproductive toxicity of specific ingredients. Links to other educational and informational websites to enhance consumer understanding may be included. Most importantly, the User, or California consumer, should be able to navigate the site easily to make connections and distinctions between products and reportable ingredients. This consumer friendly website of the data required to be reported shall be operational and available to the public by December 31, 2013.

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 1: GUIDELINES FOR PREVENTION AND EARLY INTERVENTION PROJECTS

The Mental Health Services Oversight and Accountability Commission (OAC) is responsible for developing guidelines for prevention and early intervention (PEI) projects. However, AB 1467 (a 2012 budget trailer bill) implemented changes to the Mental Health Services Act (MHSA, Proposition 63) and gave the Department of Health Care Services (DHCS) authority to issue regulations regarding all aspects of the MHSA; this authority includes regulations on PEI projects, thereby potentially leading to conflicting regulations and guidelines from these two different departments. Therefore, stakeholders recommend technical clean-up trailer bill language to clarify the authority of the OAC, instead of DHCS, to issue regulations on PEI projects.

Staff Recommendation: Approve placeholder trailer bill to clarify the responsibility of the OAC regarding PEI guidelines and regulations.
