

**AGENDA****PART II****ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES****ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR****THURSDAY, MAY 24, 2012  
2:00 P.M. - STATE CAPITOL ROOM 4202**

<b>VOTE-ONLY CALENDAR</b>		
<b>ITEM</b>	<b>DESCRIPTION</b>	
<b>4280</b>	<b>MANAGED RISK MEDICAL INSURANCE BOARD (MRMIB)</b>	<b>2</b>
ISSUE 1	ELIMINATION OF MRMIB AND TRANSFER PROGRAMS TO DHCS	2
ISSUE 2	HEALTHY FAMILIES PROGRAM RATE REDUCTION	2

<b>ITEMS TO BE HEARD</b>		
<b>ITEM</b>	<b>DESCRIPTION</b>	
<b>4280</b>	<b>MANAGED RISK MEDICAL INSURANCE BOARD</b>	<b>3</b>
ISSUE 1	HEALTHY FAMILIES PROGRAM ESTIMATE	3
ISSUE 2	COUNTY HEALTH INITIATIVE MATCHING FUND UPDATE	5
ISSUE 3	AIM UPDATE	6
ISSUE 4	MANAGED RISK MEDICAL INSURANCE PROGRAM UPDATE	7
<b>4265</b>	<b>DEPARTMENT OF PUBLIC HEALTH</b>	<b>8</b>
ISSUE 1	EVERY WOMAN COUNTS ESTIMATE	8
ISSUE 2	GENETIC DISEASE SCREENING PROGRAM ESTIMATE	10
ISSUE 3	EXPANSION TO NEWBORN SCREENING PROGRAM	12
ISSUE 4	WIC PROGRAM ESTIMATE	14
ISSUE 5	LICENSING & CERTIFICATION PROGRAM ESTIMATE	16
ISSUE 6	AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE & COST-SHARING	17
ISSUE 7	PUBLIC HEALTH LABORATORY TRAINING PROGRAM	20
ISSUE 8	BIOMONITORING FUND SHIFTS	22
ISSUE 9	GENERAL FUND LOAN FROM CHILDHOOD LEAD POISONING PREVENTION FUND	25
ISSUE 10	KIDS' PLATE – CHILDHOOD INJURY PREVENTION	26
ISSUE 11	PROPOSITION 99 – RESEARCH ACCOUNT ADJUSTMENT	28

**VOTE ONLY****4280 MANAGED RISK MEDICAL INSURANCE BOARD**

---

---

**ISSUE 1: ELIMINATION OF MRMIB AND TRANSFER PROGRAMS TO DHCS**

The Governor's January 2012 Budget proposes the elimination of MRMIB by transferring all children in the Healthy Families Program to Medi-Cal, and by shifting all of the other MRMIB programs to the Department of Health Care Services (DHCS). The proposal requires all of the programs (MRMIP, PCIP, AIM & CHIM), excluding the HFP, to shift to DHCS by July 1, 2013. There are no savings assumed as a result of this proposal in the Budget Year. The Subcommittee heard this proposal on April 16, 2012.

---

**Staff Recommendation:** Staff recommends denial of this proposal.

---

**ISSUE 2: HEALTHY FAMILIES PROGRAM RATE REDUCTION**

The Administration proposes trailer bill language to reduce the HFP rates paid to health, dental and vision plans, to mirror the estimated combined Medi-Cal rate of \$83.91. The Medi-Cal "combined rate" reflects the average amount paid for health, dental and vision services. Currently, the HFP's statewide average rate is \$101.77. The HFP rates are over 25 percent higher (on average) than Medi-Cal rates for children up to age 19. The new rates would be effective October 1, 2012. The May Revision assumes \$48.6 million General Fund savings in 2012-13 as a result of this proposal. The Subcommittee heard this proposal on April 16, 2012.

---

**Staff Recommendation:** Staff recommends denial of this proposal.

---

## ITEMS TO BE HEARD

### **4280 MANAGED RISK MEDICAL INSURANCE BOARD**

---

---

<b>ISSUE 1: HEALTHY FAMILIES PROGRAM ESTIMATE</b>
---

**Overview.** In the May Revision, MRMIB estimates that if no Healthy Families Program (HFP) children are transferred to Medi-Cal, the projected caseload for HFP is 878,112. This is an increase of 5,185 children over the current year, and represents a 0.6 percent annual growth rate over the current year.

Funding for the full HFP caseload (878,112) for 2012-13 would be \$1.1 billion (\$381.7 million General Fund, \$727.5 million federal funds, \$8.1 million in reimbursements, and \$8.7 million from the Children's Health and Human Services Fund).

The average benefit cost per month per eligible member under HFP is \$101.77.

The May Revision also reflects an increase in General Fund due to HFP enrollees selecting higher cost plans and increased program expenditures due to wraparound payments to Federally Qualified Health Centers and Rural Health Clinics.

**Copayment and Premium Increases Savings Erosion.** MRMIB requests an increase of \$22.8 million General Fund and \$42.4 million in federal funds to reflect the full year erosion of budget year savings previously adopted by the Legislature related to premiums and copayments for the HFP.

The Governor's January budget assumed premiums would have increased by \$14 per child for children in families with income between 200 percent and 250 percent of the federal poverty level (FPL) and by \$18 per child for children in families with income between 200 percent and 250 percent of FPL. However, the federal government has indicated that this increase would be a violation of the state's maintenance of effort requirements imposed by federal health care reform.

The Governor's January budget also assumed increased copayments for emergency room visits from \$15 to \$50. However, in the May Revision, the Administration has altered this proposal to assume only \$15 for non-emergency visits to the emergency room. Since HFP plans already impose an emergency room copayment of \$15, there are no longer savings attributable to this proposal.

**Managed Care Organization Tax – Technical Adjustment.** Finally, the May Revision reflects an increase of \$2.6 million General Fund as a result of a reduction of managed care organization (MCO) tax revenue carryover from the current year.

**LAO Comment.** Based on its analysis of HFP enrollment data, the LAO finds that the Governor's projection of continued flat enrollment into HFP is reasonable.

**BACKGROUND**

The HFP, California's version of the federal Children's Health Insurance Program (CHIP), provides subsidized health, dental and vision coverage through managed care arrangements for children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are not eligible for Medi-Cal but meet citizenship or immigration requirements. Eligibility is conducted on an annual basis. A 65 percent federal match is obtained through a federal allotment (Title XXI funds). In addition, infants born to mothers enrolled in the AIM program (200-300 percent of federal poverty) are immediately enrolled into the HFP and can remain in the program until age two. At age two, the family income must not exceed 250 percent FPL in order for the child to stay in the HFP.

The Governor's budget proposes to transfer all children in the HFP to Medi-Cal. The Subcommittee heard this proposal on April 16, 2012 and approved of transferring only children up to 133 percent of the federal poverty level to Medi-Cal, consistent with federal law.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has requested MRMIB to provide an update on the HFP caseload and May Revision funding adjustments.

**PANEL**

- Managed Risk Medical Insurance Board
- Department of Finance
- Legislative Analyst's Office

---

**Staff Recommendation:** Staff recommends approval of the adjustments to funding for the Healthy Families Program, with any changes to conform as appropriate to other actions that have been or will be taken that affect this program's budget.

---

**ISSUE 2: COUNTY HEALTH INITIATIVE MATCHING FUND UPDATE**

The May Revision reflects an increase to the County Health Initiative Matching (CHIM) Fund (\$15,000) and federal funds (\$29,000) as a result of a slight increase in program enrollment.

**BACKGROUND**

The CHIM offers counties the opportunity to use local funds to obtain federal matching funds for their Healthy Children's Initiatives, which provides health coverage to uninsured children. Currently, four counties participate in CHIM.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has requested MRMIB to provide an update on the CHIM caseload and May Revision funding adjustments.

**PANEL**

- Managed Risk Medical Insurance Board
- Department of Finance
- Legislative Analyst's Office

---

**Staff Recommendation:** Staff recommends approval of the adjustments to the CHIM program.

---

**ISSUE 3: AIM UPDATE**

The May Revision includes adjustments to the Access for Infants and Mothers (AIM) budget to reflect a shift of program funding from state funds to federal funds and a reduction in Proposition 99 revenue transfers due to a decrease in program costs.

The MRMIB is no longer pursuing the option of using fee-for-service for AIM because federal funds cannot be claimed for post-partum care. In contrast, the current managed care bundled rate includes post-partum care (as well as labor and delivery) and MRMIB can claim federal funds for the entire bundled rate.

**BACKGROUND**

The AIM program provides low cost insurance coverage to uninsured, low-income pregnant women, up to 300 percent of the federal poverty level (FPL), who do not qualify for Medi-Cal. The subscriber cost is 1.5 percent of their adjusted annual household income. AIM is supported with Proposition 99 Funds, as well as federal funds to supplement the participant's contribution to cover the cost.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has asked MRMIB to provide an update on the AIM program.

**PANEL**

- Managed Risk Medical Insurance Board
- Department of Finance
- Legislative Analyst's Office

---

**Staff Recommendation:** Staff recommends approval of the adjustments to the AIM program budget.

---

**ISSUE 4: MANAGED RISK MEDICAL INSURANCE PROGRAM UPDATE**

As a condition for obtaining federal funding for the Pre-Existing Condition Insurance Plan (PCIP), the state must meet maintenance of effort requirements to maintain Managed Risk Medical Insurance Program (MRMIP) annual funding of \$31.8 million (effective 2011-12). Consequently, the May Revision requests an increase in Proposition 99 funds (\$226,000) to ensure that the level of state funding meets these requirements.

**BACKGROUND**

MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. Proposition 99 (tobacco tax) Funds are used to supplement premiums paid by participants to cover the cost of care in MRMIP. MRMIP was the state's pre-existing conditions program (PCIP) prior to the passage of the federal Affordable Care Act (ACA) and creation of the federal PCIP.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has asked MRMIB to provide an update on the MRMIP program.

**PANEL**

- Managed Risk Medical Insurance Board
- Department of Finance
- Legislative Analyst's Office

---

**Staff Recommendation:** Staff recommends approval of the adjustments to the MRMIP program.

---

## 4265 DEPARTMENT OF PUBLIC HEALTH

### ISSUE 1: EVERY WOMAN COUNTS ESTIMATE

For the Every Woman Counts Program (EWC), the May Revision proposes Total Funds of \$56.6 million (\$45.1 million Local Assistance and \$7.5 million State Operations) as compared to the Current Year estimate of \$50.6 million total funds.

#### BACKGROUND

EWC is a quality improvement and outcome-driven public health program that serves to raise the accessibility and quality of cancer screening and diagnostic services for low-income underserved women. EWC provides support services to recruit, screen, and follow-up underserved populations of African-American, Asian-Pacific Islander, and American Indian women as well as older and rural women. EWC serves 20 percent of eligible uninsured and underinsured women age 40 and older in California.

Every Woman Counts Comparison of Current Year & Budget Year Expenditures (Dollars in Thousands)								
Activity	2011-12 Revised Estimate				2012-13 Proposed			
	TF	Tobacco Tax Rev	FF	GF	TF	Tobacco Tax Rev	FF	GF
Local Assistance	44,819	29,993	4,509	10,317	45,157	34,955	4,459	5,743
State Operations	5,826	3,382	2,444	0	7,502	5,008	2,494	0
<b>TOTAL</b>	<b>\$50,645</b>	<b>\$33,375</b>	<b>\$6,953</b>	<b>\$10,317</b>	<b>\$52,659</b>	<b>\$39,963</b>	<b>\$6,953</b>	<b>\$5,743</b>

Historically, EWC was funded entirely by tobacco tax revenue (Proposition 99 and Breast Cancer Fund) and federal funds; however, in 2009, the program faced a major shortfall as a result of increasing costs combined with decreasing tobacco tax revenue. The Department of Public Health took steps to contain costs by freezing enrollment and increasing the minimum age for annual mammograms from 40 to 50. In response, the Legislature directed the department to rescind these cost-containment measures and appropriated approximately \$20 million in General Fund to the program.

Key fiscal issues and assumptions incorporated into the proposed EWC budget include:

- The Governor's budget proposes moving EWC (along with two other direct services programs) from DPH to DHCS. The subcommittee heard this proposal on March 26, 2012 and took no action on the proposal at that time. This proposed shift is not expected to have a major impact on the EWC budget.
- Many counties are in the process of establishing and implementing Low-Income Health Programs (LIHPs) which will provide comprehensive health coverage to uninsured Californians. The administration assumes that the LIHPs will result in decreased demand for EWC services, however the expected full impact and estimated EWC



savings is unknown due to a wide variety of uncertainties surrounding LIHP implementation.

- EWC will experience increased costs in 2013-14 due to the sunset in AB 359 which allows the state to reimburse for digital mammography at the lower reimbursement rate for analog mammography. Once AB 359 sunsets on January 1, 2014, the state will be required to reimburse for digital mammography at a higher rate than for analog mammography.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has asked DPH to provide a brief overview of this program and its proposed budget.

**PANEL**

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

---

**Staff Recommendation:** Staff recommends approval of the EWC estimate.

---

**ISSUE 2: GENETIC DISEASE SCREENING PROGRAM ESTIMATE**

The DPH proposes total expenditures of \$87.8 million (Genetic Disease Testing Fund) for local assistance. This reflects a net decrease of \$6.25 (Genetic Disease Testing Fund) as compared to the current-year. This program is fully fee supported. The May Revise includes no changes to the November 2011 (January budget) estimate.

The proposed expenditures for each of the programs are outlined below.

**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.

The *Prenatal Screening 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.

The *Newborn Screening 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 (which includes the \$9.95 fee increase implemented on January 1, 2013 for implementation of AB 395, as discussed below). 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.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has asked DPH to provide a brief overview of this program and its proposed budget.

**PANEL**

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

---

**Staff Recommendation:** Staff recommends approval of the Genetic Disease Screening Program estimate.

---

**ISSUE 3: EXPANSION TO NEWBORN SCREENING PROGRAM**

The DPH requests 10 permanent positions and the associated \$5.3 million in state operations expenditure authority (from the Genetic Disease Testing Fund) to implement Assembly Bill 395, Chapter 461, Statutes of 2011, which requires DPH to add Severe Combined Immunodeficiency (SCID) to the panel of disorders screened for by the Genetic Disease Screening Program Newborn Screening Program. The screening for SCID began on January 1, 2012.

The positions requested are:

- Research Scientist Supervisor I (1) – This position will supervise the new staff and oversee the SCID laboratory.
- Research Scientist IV (1) – This position will review results submitted by the SCID laboratory and evaluates the quality controls.
- Senior Clinical Laboratory Technologist (5) – These positions will be responsible for the daily testing, review, and reporting of SCID laboratory results to ensure that all tests are performed appropriately.
- Senior Laboratory Assistants (3) – These positions will be responsible for the daily, nontechnical duties such as laboratory set-up, laboratory equipment operation, process specimens, and assist in quality control efforts.

**BACKGROUND**

The Newborn Screening Program screens for more than 75 disorders in over 500,000 newborns and diagnoses more than 700 babies each year. The DPH was involved in a pilot study (which ended February 2012) to screen California newborns for SCID, SCID variants, and related T-cell lymphopenias. Over a 12-month period, 18 California newborns have been diagnosed with SCID. Literature and other state's experience reflect an incidence of SCID to be approximately 1 in 100,000 births. Medical treatment is available to eradicate SCID.

It is expected that 256,451 specimens will be processed annually for SCID. Because the Newborn Screening Program is fully fee supported, a fee increase of \$9.95 was implemented on January 1, 2012, to support the ongoing workload associated with processing blood specimens and follow-up activities such as diagnostic work-up, confirmatory processing, and provider and family education.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has asked DPH to provide an overview of this proposal.

PANEL

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

---

**Staff Recommendation:** Staff recommends approval of this BCP for resources to implement AB 395.

---

**ISSUE 4: WIC PROGRAM ESTIMATE**

The budget proposes total expenditures of \$1.489 billion (\$1.262 billion federal funds and \$227 million Manufacturer Rebate Funds) for WIC local assistance, which reflects an increase of \$29.293 million (federal funds) for 2012-13.

The May Revision includes an increase of \$26 million from the WIC Manufacturer Rebate Fund in 2012-13, and a corresponding decrease in federal expenditure authority. The increase in rebate funds is a result of a new contract award for infant formula rebates effective August 1, 2012. Federal law requires the use of WIC manufacturer rebate revenues prior to using federal WIC food funds.

DPH states that approximately 1,5214,110 WIC participants will access food vouchers in 2012-13. An estimated \$63.14 is the monthly average participant cost for food. Of the total federal grant amount, \$961.3 million is for Base Food and \$300.867 million is for Nutrition Services and Administration. The \$227.7 million in Manufacturer Rebate Funds are continuously appropriated and must be expended on food.

**BACKGROUND**

WIC is 100 percent federal fund supported. It provides supplemental food and nutrition to low-income women (185 percent of poverty or below) who are pregnant and/or breastfeeding, and for children under age five who are at nutritional risk. WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

WIC participants are issued paper vouchers by 84 Local WIC Agencies (that operate 650 WIC sites) to purchase approved foods at authorized stores. Examples of foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter, and iron-fortified infant formula.

The goal of WIC is to decrease the risk of poor birth outcomes and improve the health of participants during critical times of growth and development. The amount and type of food WIC provides are designed to meet the participant's enhanced dietary needs for specific nutrients during short but critical periods of physiological development.

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support, and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged as being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

- **WIC Funding.** DPH states that California's share of the national federal grant appropriation has remained at about 17 percent over the past 5 years. Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:
- **Food.** Funds for food that reimburses WIC authorized grocers for foods purchased by WIC participants. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.

- **Nutrition Services and Administration.** Funds for Nutrition Services and Administration (NSA) Funds that reimburse Local WIC Agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition, education, breastfeeding support, and referrals to health and social services, as well as support costs. States are to manage the grant, provide client services and nutrition education, and promote and support breastfeeding with NSA Funds. Performance targets are to be met or the federal USDA can reduce funds.
- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with Infant Formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down Federal WIC food funds.
- **Vendor Reimbursement Rate.** The Maximum Departmental Reimbursement Rate (MADR) Methodology is used to reimburse vendors for WIC food. It is based on the mean price per redeemed food instrument type by peer group with a tolerance for price variances. WIC has contracted with agricultural economists to evaluate the peer group structure and MADR methodology for alternative cost containment policies. The results will be submitted to USDA for approval effective October 1, 2012 and may result in changes to food costs for 2012-13.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has asked DPH to provide an overview of the WIC program and any significant recent or anticipated changes or developments to the program or its budget.

**PANEL**

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

---

**Staff Recommendation:** Staff recommends approval of the WIC estimate.

---

**ISSUE 5: LICENSING & CERTIFICATION PROGRAM ESTIMATE**

The Governor's budget proposes total expenditures of \$187.2 million for 2012-13, as compared to \$180.1 million in 2011-12.

The May Revision reflects a decrease of \$1.2 million (\$1.3 million General Fund and \$112,000 reimbursement fund increase) for the Licensing and Certification Program (L&C). The reduction in General Fund is a result of technical workload adjustments for state-owned facilities.

L&C is requesting an increase of \$112,000 in reimbursement authority associated with the amount in the current Title 19 Non-Long Term Care contract with the Department of Health Care Services (DHCS). No positions are requested with this request.

**BACKGROUND**

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

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

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

**STAFF COMMENT / QUESTIONS**

The Subcommittee has asked DPH to provide an overview of the L&C program and its proposed budget.

**PANEL**

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

---

**Staff Recommendation:** Staff recommends approval of the L&C estimate.

---



**ISSUE 6: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE**

The May Revision updates expenditures for the ADAP program. See table below.

<b>Proposed ADAP Budget Comparison for 2012-13</b>			
<i>(Dollars in Thousands)</i>			
Fund Source	January Budget	May Revise	Difference
General Fund	\$4,446	\$4,843	\$397
AIDS Drug Rebate Fund	\$245,520	\$300,756	\$55,236
Federal Funds – Ryan White	\$102,572	\$113,605	\$11,033
Reimbursements – Medicaid Waiver	\$49,300	\$17,150	-\$32,150
Proposed New Premiums	\$2,000	\$1,361	-\$639
<b>TOTAL FUNDS</b>	<b>\$403,838</b>	<b>\$437,715</b>	<b>\$33,877</b>

This updated estimate reflects the following:

- An increase in federal Ryan White funding of \$11 million. This includes \$2.6 million awarded on April 9, 2012 for ADAP Earmark and Ryan White Part B ADAP Supplemental federal funds and \$8.4 million for the 2012 Ryan White Part B ADAP Supplemental Grant.
- The impact of full implementation of the “non-legacy” Low Income Health Program (LIHP) County Programs on ADAP. It is estimated that 1,991 ADAP clients will shift to LIHP in the non-legacy counties for an ADAP savings of \$20.9 million. This was not accounted for in the January estimate.
- The impact of implementation of the legacy LHIP County Programs on ADAP. It is estimated that 8,076 ADAP clients will shift to LIHP in the legacy counties for an ADAP savings of \$66.7 million. This updated estimate reflects the delay of implementation of the LIHP in Los Angeles and Alameda counties (estimated to begin July 1, 2012). The January estimate projected a larger shift of ADAP clients to LIHP in the current year and did not reflect the delayed implementation.
- An increase in the rebate percentage from an estimated 48 percent in January to 50 percent in the May Revision. Generally, for every dollar of ADAP drug expenditure, the program estimates it will obtain 50 cents in rebates. This 50 percent level is based on an average of rebate collections (both “mandatory” and “supplemental” rebates).
- A change to the Administration’s share-of-cost (SOC) budget proposal, to eliminate the SOC for ADAP clients with private insurance due to antiretroviral manufacturer’s co-pay assistance programs, delaying the implementation date to October 1, 2012.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has requested DPH to provide an overview of the May Revision estimate for ADAP and discuss the key changes.

**PANEL**

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

---

**Staff Recommendation:**

---

Staff recommends the following actions related to the ADAP program:

1. Adopt placeholder trailer bill language that would strengthen consumer protections for ADAP clients as they transition to LIHP and create a stakeholder advisory committee to give expert advice on transition policy decisions. The proposed trailer bill language is as follows:

Section 15917 is added to the Welfare and Institutions Code:

- a) By no later than August 1, 2012, the State Department of Public Health, in collaboration with the State Department of Health Care Services, shall provide guidance on the transfer of clients living with HIV/AIDS from Ryan White funded programs to the Low Income Health Program (LIHP). This guidance shall be provided to LIHP participating counties, providers, and clients as applicable. This guidance shall conform to the provisions of Special Terms and Conditions of the section 1115(a) California Bridge to Reform Medicaid Demonstration to provide timely access to coordinated health care services to all LIHP enrollees. The guidance shall also minimize disruption of services to clients.
  - b) The State Department of Public Health together with the State Department of Health Care Services shall consult with community representatives to obtain expert advice on policy decisions regarding the transition of clients living with HIV/AIDS from Ryan White funded programs to LIHP. This consultation shall inform the creation of the guidance described in paragraph (a). The State Department of Public Health and the State Department of Health Care Services shall communicate with these representatives on how their advice is used and how final decisions were made.
2. Within the Department of Health Care Services, redirect an existing vacant Health Program Specialist II position created for the Low-Income Health Program to manage

the HIV Transition Plan Waiver Program and coordinate with the Department of Public Health's Office of AIDS.

3. Adopt placeholder uncodified trailer bill language to require the Department of Public Health to report to the Joint Legislative Budget Committee by October 1, 2012 on if any of the projections or assumptions used to develop ADAP's estimated budget for the Budget Act of 2012-13 may result in a potential funding shortfall or an inability of ADAP to provide services to eligible ADAP clients. If a potential funding shortfall occurs before October 1, 2012 and ADAP is unable to provide services to eligible ADAP clients, the Department of Public Health shall provide notification to the Joint Legislative Budget Committee within 15 calendar days of this determination.
4. Deny the proposed cost-sharing proposal.

**ISSUE 7: PUBLIC HEALTH LABORATORY TRAINING PROGRAM**

The May Revision proposes to eliminate the Public Health Laboratory Training Program for savings of \$2.2 million General Fund.

This program provides local assistance grants to subsidize training, support, outreach and education, and provides funding for doctoral candidate stipends and post-doctoral fellowships for individuals training for public health laboratory directorships.

Fifteen individuals currently participate in this program:

- Assistant Laboratory Directors (4) – These individuals are currently obtaining required supervisory and management experience and are within two years of completing the multi-year program and then obtaining a job in a California local health jurisdiction as a Lab Director.
- Post-doctoral Fellows (6) - This group has completed their PhD and are enrolled in a post-doctoral fellowship program. They are currently employed at the DPH Microbial Disease Lab or the L.A. County Public Health Lab. They are in the process of obtaining board certification. After post-doctoral training, the subsequent two years will be gaining management experience as Assistant Lab Directors (above).
- Doctoral Students (5) - These students are several years into their training and have agreed to work for several years in a public health setting after completion of their training.

**BACKGROUND**

There are 36 local public health labs in California. Public health lab directors must meet state and federal requirements to run a lab, that tests human specimens, and must have the leadership and public health training needed to oversee the functions of a laboratory that protect the health of the public. Federal law (the Clinical Laboratory Improvement Amendments of 1991) requires that public health lab directors have a doctoral degree, national board certification, and four years of supervisory experience post-doctorate. Lab directors that were in place prior to 1991 that do not meet these requirements were grandfathered-in and do not need to meet these requirements.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has requested DPH to present this proposal and respond to the following questions:

1. Has the department explored alternative funding sources for this program?
2. Please explain the specific impacts of this proposal. What will happen to the participants in this program? What will the impact on labs be?

PANEL

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

---

**Staff Recommendation:** Staff recommends holding this item open to allow for development of an alternative proposal from stakeholders.

---

**ISSUE 8: BIOMONITORING FUND SHIFTS**

DPH requests a fund shift to support the California Environmental Contaminant Biomonitoring Program (CECBP). Currently, all eight DPH CECBP positions are funded by the Toxic Substances Control Account (TSCA). This request would result in two positions being supported by TSCA and six positions being supported by the Birth Defects Monitoring Program Fund, Air Pollution Control Fund, Department of Pesticide Regulation Fund, and the Childhood Lead Poisoning Prevention Fund.

**BACKGROUND**

<b>Proposed Funding for Biomonitoring Program</b>	
<b>Fund</b>	<b>Amount</b>
Toxic Substance Control Account	\$242,000
Birth Defects Monitoring Program Fund	\$240,000
Childhood Lead Poisoning Prevention Fund	\$240,000
Department of Pesticide Regulation Fund	\$205,000
Air Pollution Control Fund	\$204,000

This request is being made because the TSCA (a Department of Toxic Substances Control account) does not have sufficient revenues to support the fund's projected expenditure authority. The Administration has provided the following rationale for the use of these special funds for this program:

**Birth Defects Monitoring Program Fund.** The causes of most birth defects remain unknown. The Birth Defects Monitoring Program was established to provide information on the incidence and trends of birth defects, stillbirths, and miscarriages, and data on whether these adverse reproductive outcomes are associated with environmental hazards, as well as to develop appropriate prevention strategies. Biomonitoring can detect chemicals capable of causing birth defects and impaired fetal development and, thus, inform public health and environmental policies to reduce such exposures, and also help focus etiologic research by university and government scientists.

CECBP measures toxic chemical levels in people, including pregnant women and fetuses (i.e., in umbilical cord blood). A principal focus of the CECBP has been on chemicals in consumer products, some of which are currently regulated and others not. Ultimately, CECBP data will help shape California regulatory programs intended to reduce exposures to fetotoxic chemicals.

**Childhood Lead Poisoning Prevention Fund.** The Childhood Lead Poisoning and Prevention Program (CLPPP) is a comprehensive approach to identify occurrences of high blood lead levels and reduce excessive lead exposures in children. Blood testing is the only method to quantitatively determine health risks of lead exposure.

CLPPF already provides support to the Department of Public Health (DPH) Environmental Health Laboratory (EHL) for lead testing. EHL staff currently: (a) provide reference blood lead analyses for confirmatory testing of children with clinical lead poisoning; (b) perform lead

analyses of environmental samples (e.g., paint chips, dirt, toys, etc.) for case investigations and management; (c) certify proficiency of clinical laboratories; (d) serve as technical experts on current and emerging testing methods; and (e) ensure quality assurance. The additional resources to be provided to CECBP will support core CLPPP activities by offering enhanced surveillance on the prevalence, risk factors, and geographic occurrence of high childhood blood lead levels, and identifying populations where childhood lead exposures are especially significant. EHL can test all CECBP samples collected (from infants, children and pregnant women) for lead. These results will offer community-based and population-based surveillance data to augment clinic-based screening, among several other enhancements to the CLPP.

**Air Pollution Control Fund and Department of Pesticide Regulation Fund.** The Air Pollution Control Fund (APCF) and the Department of Pesticide Regulation Fund (DPRF) primarily support the broad spectrum of regulatory and other activities of the Air Resources Board (ARB) and the Department of Pesticide Regulation (DPR), respectively. Both ARB and DPR include among their responsibilities assessing exposure to air pollutants and pesticides, and educating the public about such exposures.

The CECBP objectives include measuring and tracking trends in human exposure to chemicals and making this information public in summary form, which can help inform environmental regulatory policies. The CECBP “designated” and “priority” chemicals comprise a variety of air pollutants and pesticides. Among the air pollutants are metals (e.g., antimony, arsenic, lead, and mercury), volatile organic chemicals, diesel exhaust, and polycyclic aromatic hydrocarbons (PAHs). Also included are cyclosiloxanes, which have been introduced statewide in dry cleaning establishments as perchloroethylene has been phased out to comply with an ARB regulation. All major pesticide classes or their metabolites are within the CECBP universe of chemicals to measure, including organophosphates, carbamates, pyrethroids, and fungicides. The DPH EHL is currently measuring PAHs, metals, and multiple classes of pesticides in blood and urine specimens from biomonitoring participants. Over time, the CECBP will be developing additional advanced laboratory methods to measure other air pollutants and pesticides. This information can help inform the ongoing efforts of the ARB and DPR to assess and regulate human exposure to the chemicals under their jurisdictions, providing a logical nexus between the CECBP and both the APCF and the DPRF.

The CECBP was established by SB 1379 (Ortiz), Statutes of 2006. The legislation provides for DPH, the Office of Health Hazard Assessment, and the Department of Toxic Substances Control to conduct the program collaboratively, with DPH as the lead entity. The program’s overall purpose is to measure and track levels of environmental chemicals in California residents as a way to inform policy makers and to alert them to the presence and associated health risk of chemicals in the environment, home, and workplace.

<b>STAFF COMMENT / QUESTIONS</b>
----------------------------------

The Subcommittee has requested DPH to provide an overview of this proposal.

PANEL

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

---

**Staff Recommendation:** Staff recommends approval of this proposal.

---



**ISSUE 9: GENERAL FUND LOAN FROM CHILDHOOD LEAD POISONING PREVENTION FUND**

The Senate Budget and Fiscal Review Committee proposes (and has approved) a \$15 million loan from the Childhood Lead Poisoning Prevention Fund (CLPPF) to the General Fund, for \$15 million in General Fund savings in 2012-13. This loan would be paid back to the CLPPF in 2014-15.

**BACKGROUND**

The CLPPF is funded from fees from companies involved in manufacturing or selling of lead based products or products containing lead. The funds support the Childhood Lead Poisoning Prevention Program.

The CLPPF has a reserve of \$39.5 million, which reflects a 165 percent reserve margin. This reserve level is considerably higher than the 5 percent reserve margin that the Department of Finance (DOF) normally considers prudent. With a \$15 million loan, the CLPPF would still have a reserve margin of 102 percent, well beyond DOF's recommended margin.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has requested the DPH and DOF to respond to the following question:

1. Does the administration have any technical issues or concerns with this proposal?

**PANEL**

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

---

**Staff Recommendation:** Staff recommends approval of this Senate proposal to provide a \$15 million loan to the General Fund from the Childhood Lead Poisoning Prevention Fund.

---

**ISSUE 10: KIDS' PLATE – CHILDHOOD INJURY PREVENTION**

The budget includes \$494,000 in local assistance from the Child Health and Safety Fund for DPH. According to the Administration, these funds cannot be distributed to local entities because DPH does not have administrative expenditure authority over the funds (there is no state operations funding for the department for these funds). Therefore, in order to ensure that these funds are distributed to local entities for childhood injury prevention efforts and to maximize the amount of funding available for the local entities, the following is proposed:

Direct DPH to create a regional grant program for these funds. DPH would issue a Request for Assistance (RFA) for entities interested in regionally coordinating the distribution of this grant funding. The regional entity would also be responsible for providing actual services (in order to avoid DGS' concerns discussed above). The goal of this regional grant program would be to maximize the amount of funding local entities receive for activities related to childhood injury prevention, such as child passenger safety, bicycle safety, and unintentional injury prevention. There would be no more than three regions (north, south, and central) to reduce the amount of state funds necessary to execute these grants. Additionally, since these are local assistance funds, they are not required to be bid out competitively, per section 3.17 of the State Contract Manual. In order to reduce the administrative overhead of this grant program, the regional grantees could be awarded under a two-year term and have the option to extend the contract for an additional two-years based on satisfactory performance. Allow for up to 5 percent of DPH's allocation from Child Health and Safety Fund to be used for state operations for administration of this program.

**BACKGROUND**

AB 3087 (Chapter 1316, Statutes of 1992) established the *Have a Heart, Be a Star, Help Our Kids* specialized license plate program. Revenues from these license plate fees, totaling \$4.1 million in 2009-10 and \$4.0 million in 2010-11, are deposited into the Child Health & Safety Fund. State law (Welfare & Institutions Code Sections 18285 and 18285.5) specifies how those revenues are distributed. Currently, the first 50 percent supports specific Department of Social Services responsibilities for child day care licensing. Of the remaining 50 percent, up to 25 percent supports child abuse prevention and the rest supports programs that address injury prevention. It should be noted that under a Department of Social Services' budget proposal, more funds would be allocated for child day care licensing activities to achieve \$501,000 in General Fund savings.

DPH has been receiving funds from this license plate program since 1996-97 and entered into a contract with San Diego State University Research Foundation (SDSURF) to distribute these funds to local organizations for activities related to the prevention of unintentional childhood injuries and accidents. When the department went to renew its contract with SDSURF in July 2010, the Department of General Services (DGS) raised two issues with the contract. First, DGS indicated that the nature of the contract was creating a role for SDSURF as a fiscal agent for the state (since SDSURF was not a state entity, but rather a nonprofit associated with the San Diego State University) and that this was not appropriate. Second, DGS argued that DPH was contracting out work that could be done by state employees. These issues could not be worked out, and; consequently, this contract expired in 2010-11.

Since the end of the grant program contract managed by SDSURF, DPH has initiated one-time-only grants to conduct small-scale projects like Bike to School Day Events, childhood pedestrian safety education and awareness, child passenger safety fitting stations, and education for parents on safe sleeping practices and on the need for pool barriers. The DPH secured assistance from outside agencies/partners to help with outreach to solicit applications and in preparing agreements. DPH indicates that this method for awarding grants is not sustainable as an ongoing approach.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has requested DPH to provide a brief overview of this issue and identify any concerns of the administration.

**PANEL**

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

---

**Staff Recommendation:** Staff recommends approval of the proposal described above.

---

**ISSUE 11: PROPOSITION 99 – RESEARCH ACCOUNT ADJUSTMENT**

In the May Revision, DPH proposes a \$1.049 million reduction in Proposition 99 Research Account funding (\$936,000 for support of the California Cancer Registry and \$113,000 for community outreach efforts for the California Cancer Registry). This proposal aligns Proposition 99 revenues with expenditures.

**BACKGROUND**

The reduction in the Research Account (0234) was necessary due to an accounting correction needed. The administration split the corresponding reduction in 2012-13 between the University of California (\$2,570,000 reduction) and the DPH Cancer registry (\$1,049,000 reduction) proportionally to the funding split between the programs. The administration believes that making proportional reductions is the fairest approach for the two programs. If the Legislature chooses not to make any cuts to the cancer registry, the entire reduction would need to be applied to the U.C., for a total reduction of \$3,619,000.

**STAFF COMMENT / QUESTIONS**

The Subcommittee has asked the Administration to present and explain this adjustment.

**PANEL**

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

---

**Staff Recommendation:** Staff recommends approval of this proposal.

---