AGENDA
ASSEMBLY BUDGET SUBCOMMITTE NO. 1 ON HEALTH AND HUMAN SERVICES

Assemblymember Mervyn Dymally, Chair

MONDAY, MARCH 15, 2004
STATE CAPITOL, ROOM 447
4:00 P.M.

ITEMS TO BE HEARD

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 1: PROSTATE CANCER TREATMENT PROGRAM (IMPACT)

BACKGROUND:

When Section 4.10 cuts were implemented in December 2003, the General Fund (GF) appropriation for the Prostate Treatment Program was reduced by $4.457 million. Funding for direct services, administration, case management, outreach and evaluation provided through an external contract with UCLA was reduced by $4.259 million. State administration was reduced by $198.2 thousand. The reduction left $545,000 for the revised budget for the fiscal year (FY) 2003-2004. The program suspended all new enrollments as well as re-enrollments of men needing continued treatment beyond the end of their currently authorized period of program eligibility.

The Prostate Treatment Program provides free prostrate cancer treatment to low-income Californians who are uninsured. To enroll in the program a man must be a California resident, have an income at or below 200 percent of the Federal Poverty Level, have no health insurance and be ineligible for Medi-Cal or Medicare. Since the enrollment was suspended a waiting list has been started. Men who are on the waiting list have been directed to seek treatment from the public healthcare systems in the counties in which they live.

In FY 2002-2003 budget the program was appropriated $20 million. In the Mid-Year Reduction $10 million of the appropriation was rescinded because of the lower than anticipated participation in the program. The funding was further reduced in FY 2003-2004 budget by $5 million because of under-utilization in the program. In the Control Section 4.10 appropriation, reductions made at the end of December, the program was further reduced to the $545,000.

As a result of re-appropriations from prior years, the Department expects that program expenditures for the 2003-2004 will total $5 million by the end of the fiscal year June 30, 2004. The number of men served by the program in 2003-2004 will be 291, of which 103 are new enrollees and 188 are continuing enrollees from previous fiscal year.

For FY 2004-2005 the GF appropriation is $570,000. Remaining unspent Tobacco Settlement Funds from FY 2001-2002 and 2002-2003 total $6.530 million are available for re-appropriation for FY 2004-2005 Budget Bill. The Governor's proposed budget for FY 2004-2005 contains language to re-appropriate the funds and extend the availability of funds for the program and will allow the Department of Health Services (DHS) to continue to enroll men..

UCLA estimates that the average annual treatment costs per individual is $15,627. The Prostate Treatment Program could use the estimated $6,529 million to provide treatment for 230 men, irrespective of whether they are a new enrollee or a continuing patient for 12 months.

COMMENTS:

DHS, please summarize for the Subcommittee what the FY 2004-2005 budget will, as proposed, provide for the Prostate Treatment Program?

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to put Prostate Cancer Treatment Program on the solutions list, what the impact of the Prostate Cancer Treatment Program will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of eliminating or reducing funding for the Prostate Cancer Treatment Program to be:

1. Low-income men in need of cancer treatment would be denied necessary medical care.

2. A portion of those who are in need of care could lose their lives to cancer because appropriate medical care was unavailable.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 2: AIDS DRUG ASSISTANCE PROGRAM (ADAP)

BACKGROUND:

The AIDS Drug Assistance Program (ADAP) was established in 1987 to help ensure that HIV-positive uninsured and underinsured low and moderate income individuals have access to pharmaceutical (drug) therapies. The goal of ADAP is to make available, in an effective and timely manner to persons living with HIV, drug treatments that can reliably be expected to increase the duration and quality of life. Currently, 151 drugs are available through ADAP, and there are approximately 3,300 pharmacies statewide where clients can purchase these drugs. Without the drugs available through ADAP, thousands of HIV-positive Californians would face rapidly deteriorating health and possibly death.

AIDS drugs (antiretrovirals) delay progression of the disease and help prevent the life-threatening infections that HIV-positive individuals are susceptible to due to their suppressed immune systems. As a result, AIDS drugs enhance the quality of life for many HIV-positive persons, and enable them to remain healthy working for as long as possible, thus reducing the cost of publicly-funded health care

There are nearly 240 enrollment sites throughout the state. Individuals are eligible to apply for ADAP if they:

- are a resident of California;
- are HIV-infected;
- are 18 years of age or older;
- have an adjusted gross income below $50,000 per year;
- have a valid prescription from a licensed California physician; and
- lack private insurance that covers the medications or do not qualify for Medi-Cal.

A co-payment is required for anyone whose annual adjusted gross income is between 400 percent of the federal poverty level (currently $35,440) and $50,000. Persons with an annual adjusted gross income below 400 percent of the federal poverty level receive ADAP drugs free.

FUNDING HISTORY

The funding and caseload history of the ADAP for the current year and the four prior years are as follows.

FUNDING SOURCE	FY 1999-00 BUDGET	FY 2000-01 BUDGET	FY 2001-02 BUDGET	FY 2002-03 BUDGET	FY 2003-04 BUDGET
STATE	$42,366,205	$44,600,000	$59,947,000	$67,442,980	$64,063,000
REBATE	$13,129,000	$14,000,000	$19,210,000	$26,176,850	$50,342,000
TITLE I	$0	$0	$0	$0	$0
TITLE II	$81,100,000	$87,100,000*	$87,233,000*	$95,930,170*	$98,275,000*
TOTAL	$136,595,205	$145,700.000	$166,390,000	$189,550,000	$212,680,000
CASELOAD	21,964	23,744	24,102	25,759	23,891**

*__Includes $600,000__ in federal __ADAP__ support funding.
**Projected caseload based on caseload cap proposed in the FY 2004-05 Governor's Budget.
Source: __D__epartment of __H__ealth Services

For FY 2004-2005 program expenditures are projected to total $207.285 million, a $5.39 million reduction from the current year with the caseload capped at 23,891. The budgeted amount for FY 2003-2004 is $205.680 million. The FY 2003-2004 budget gave the Director of the Department of Health Services authority to shift $7.0 million from the Therapeutic Monitoring Program to the ADAP if it was necessary to fully fund the caseload growth in the budget year. As a result, program expenditures are projected to be $212.780 million in FY 2003-2004.

The expenditures for the ADAP program have increased each year over the last five years and are projected to decline for the first time in FY 2004-2005 as a result of the proposed caseload cap. The relative shares of GF, Rebates and Federal Funds have remained relatively stable over the six years. The Generally Fund has ranged from 30 percent of the total appropriation to 36 percent of the appropriation.

REBATE HISTORY

ADAP receives approximately a 15 percent rebate from the pharmaceutical manufacturers on the drugs in the ADAP formulary. The table below charts the recent history of the program. In the FY 1997-1998 the program collected $10.085 million in rebates and expended $7.829 million. From FY 1997-1998 through 2002-2003 the program collected $140 million dollars but it had only spent $91.8 million leaving an accumulated rebates of $48.2 million. The budget proposes to spend $21.374 million of the accumulated rebates in the current year and $5.822 million in the budget year. Thus reserving $21 million in accumulated rebates. These funds are not included in the Governor's Budget.

Fiscal Year	Total Collected	Total Expenditures/ Budget Authority	Proposed Use of Prior Year Rebates	# of Drugs on Formulary
FY 1997-98	$10,085,779.46	$7,829,000.00		54
FY 1998-99	$14,287,056.29	$11,429,000.00		102
FY 1999-00	$19,271,487.35	$13,129,000.00		143
FY 2000-01	$24,138,051.28	$14,039,000.00		146
FY 2001-02	$30,930,504.56	$19,210,000.00	a/	147
FY 2002-03	$41,290,230.76	$26,176,850.00	a/	148
Subtotal		*$91,812,850.00*		
FY 2003-04	Billed, not yet rec'd.	$50,342,000.00	$21,374,000.00	151
FY 2004-05 b/		$45,822,000.00	$5,822,000.00	
TOTAL	$140,003,109		$27,196,000.00	151

a/ The Total Expenditures/Budget Authority column includes one-time augmentations approved through Section28.50 requests as follows: $3,543,000 in FY 2001-02 and $2,216,000 in FY 2002-03. The approval of theserequests allowe for expenditure of previously accumulated excess drug rebates.
b/ Proposed in FY 2004-05 Governor's Budget.
Source: Department of Health Services

CASELOAD CAP

The Governor's Mid-Year Reduction proposed establishing a cap on the ADAP Program effective January 1, 2004. The Administration's proposal would cap the program enrollment at the projected January 1, 2004 level of 23,891. The program grows by 116 persons per month. For the six months of the current year there would be 696 persons placed on the waiting list. For the Budget Year the waiting list would grow by 1,392. Thus the total waiting list at the end of the budget year would be 2,088. The projected budget savings from the cap are $275,000 in the current year and $550,000 in the Budget Year.

If ADAP were not available to provide drugs to those individuals that have HIV/AIDS they would have to delay their treatment until they became eligible for Medi-Cal. The result of any delay would be more expensive treatment and possibly greater expenditures. Also, the GF costs for the Medi-Cal program exceed the GF costs for the ADAP program per dollar expended. The logic is of short term-savings at the expense of higher long-run costs.

ADMINISTRATIVE SAVINGS

To achieve savings in the ADAP, advocates have proposed prohibiting prescription refills before the 27th day. Under current practice, a prescription refill is for a 30-day supply with an automatic refill at the 24th day. It has been estimated that the state would reduce expenditures by approximately $500,000 GF if refills were to be limited to the 27th day or after.

Another savings option is limiting automatic refills of prescriptions to 6 months. ADAP does not limit refills because the physician doing the prescribing limits the number of possible refills without prior authorization and the ADAP client must contact the pharmacy to fill the prescription. New York has recently adopted a five-month refill limit on its ADAP drug program. It is estimated the state could save approximately $300,000 if it limited automatic prescriptions to six months.

Total savings from the two formulary changes would be approximately $800,000 in the budget year.

The Office of AIDS is working with the University AIDS Research Program (UARP) at UCLA and UCSF to analyze alternative drug purchasing methodologies for administering ADAP. Currently, the contract utilizes a price of drugs model, the most client friendly model. Alternative models include an administrative cost model and a bulk-purchasing model. The Office of AIDS projects it will release a Request for Proposal for the ADAP Program administration in October of this year and will have the contract awarded so the contractor would begin administering the program on July 1, 2005.

REBATE APPROPRIATION

If the ADAP program were to fully fund caseload in the Budget Year, additional resources above the Administration's recommended appropriation of $207 million would be necessary. In addition, additional resources would be necessary to offset the potential elimination of drugs from the ADAP formulary. The accumulated rebates total $21 million. The accumulated rebates could be a source of additional funding for the ADAP program in the budget year.

SPECIAL DEPOSIT FUND

Advocates have proposed a Special Deposit Fund for the ADAP Drug Rebates. A Special Fund would facilitate administrative and manufacturer accountability through the publication of a annual Fund Condition Statement in the budget and through standardized accounting procedures. In addition, if the fund were to be continuously appropriated the rebate proceeds would be available for the program's purposes once they are collected.

COMMENTS:

Caseload Cap

- DHS, please describe how the caseload cap would function?
- What costs would the Department incur to operate the program with a cap on it?
- Legislative Analyst Office (LAO), what is your reaction to the creation of a caseload cap in the ADAP?
- DHS, if those individuals who are denied access because of the cap on ADAP become Medi-Cal enrollees and receive their care under the Medi-Cal program what would the cost to the state be?

Administrative Savings

- DHS, can refill modifications be easily incorporated into the operations of the contractor?
- DHS, are the estimates of the revenue available achievable by the Department?

Rebate Appropriation

- DHS, will fully funding ADAP in 2004-2005 require additional resources?
- DHS, please describe how the state has an accumulated rebate reserve of $21 million?

Special Deposit Fund

- DHS, what benefits would be achieved if the Legislature were to adopt a deposit fund that was continuously appropriated?
- Department of Finance (DOF), please provide the Subcommittee with the perspective of the Department on adopting a special fund.
- LAO, please provide the Subcommittee with the LAO's perspective on adopting a Special Fund.

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to put capping of the ADAP caseload on the solutions list, what the impact of the ADAP caseload cap will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of the ADAP caseload cap to be:

1. Low and moderate income people in need of anti-retroviral drugs would be denied necessary medical care.

2. A portion of those who are in need of care could lose their lives to HIV/AIDS because appropriate medical care was unavailable.

3. A portion of those who were capped out of the program would become eligible for Medi-Cal and cost the state more for their health care as ADAP is 30 percent GF and Medi-Cal is 50 percent GF.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 3: AIDS DRUG ASSISTANCE PROGRAM CO-PAYMENT

BACKGROUND:

The LAO in its Perspectives and Issues suggests that the Legislature should consider implementing a co-payment for the ADAP. The LAO states that implementing a co-payment structure for ADAP could produce potential GF savings of $1.6 million.

The LAO writes:
The AIDS Drug Assistance Program (ADAP) is a drug subsidy program for persons with HIV with incomes up to $50,000 annually who have no health insurance coverage for prescription drugs and are not eligible for Medi-Cal. Currently, clients with incomes up to 400 percent of the FPL pay no co-payment or premium, while individuals with incomes above that level pay a "sliding scale" co-payment that increases with their income.

Last May, the administration proposed a three-tiered co-payment structure in which clients with federal adjusted gross incomes between 201 of the FPL and $50,000 would pay either $5, $10, or $15 per prescription, depending on income and family size.

The LAO estimates that this option would result in approximately $1.6 million in GF savings in the budget year. Although the Legislature did not accept this proposal last year, it is an option for the members to consider particularly during this difficult budget year. Compared to the Governor's proposal for an enrollment cap, this option would allow all of those currently or later eligible for ADAP to continue to access the program. This option, however, would increase the out-of-pocket expenses for ADAP participants.

COMMENTS:

- LAO, please describe your suggestion for an additional co-payment in the ADAP program.
- DHS, please comment on the proposal by the LAO.

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to put an expansion of the ADAP co-payment on the solutions list, what the impact of the expansion of the ADAP co-payment will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of the expansion of the ADAP co-payment to be:

1. Some individuals would have to choose between a prescription and other necessities in their lives.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 4: THERAPEUTIC MONITORING PROGRAM

BACKGROUND:

Advocates propose increasing the funding for the Therapeutic Monitoring Program by $7 million, raising the total funding to $8 million.

The HIV Diagnostic Assay Program was renamed HIV Therapeutic Monitoring Program (TMP) in the 2003 health budget trailer bill. The program provides two test services, Viral Load and HIV Resistance. Viral Load test services were commenced by the state in FY 1997-1998. HIV Resistance Test Services were initiated in FY 2001-2002.

What are the differences and how are they used?

The Viral Load test services were a partnership between the Office of AIDS and the Department of Health Services' Viral and Rickettsial Disease Laboratory. The laboratory manages standard

agreements with several regional public health laboratories that process and analyze specimens. The HIV Resistance test services began through a competitive process for processing and analyzing genotypic and phenotypic HIV resistance test services. The Office of AIDS manages contracts with a variety of public health, commercial and academic laboratories for resistance test services.

The funding history for the Viral Load Testing has been $3.8 million for the first three years of the program. The funding was decreased to $2.8 million for the next two years and for FY 2002-2003 funding was increased to $4.8 million. For the three years of the Resistance Testing it has been funded at $3.2 million, $2 million in Ryan White Funds and $1.2 million GF. In FY 2003-2004 budget $7 million was transferred to the ADAP to avoid co-payments in that program. $1 million was left in the Therapeutic Monitoring Program to fund the HIV Resistance Test Advisory Group, Early Intervention Project Directors and several medical providers recommended to the Office of AIDS to continue Viral Load services over Resistance Testing services. Therefore, the Office of AIDS funds Viral Load services with the remaining funding.

The budget proposal FY 2004-2005 for the Therapeutic Monitoring program would provide $1 million in funding for the program.

COMMENTS:

- DHS, please describe the testing, its uses and need in the ADAP program.
- DHS, are there alternatives to the tests?

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to increase funding for the Therapeutic Monitoring Program on the solutions list, what the impact of increases of funding for the Therapeutic Monitoring Program will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of the increase in the Therapeutic Monitoring Program to be:

1. Very important to developing and maintaining the proper mixture of drugs to treat people with HIV/AIDS

2. Without Viral Load and Resistance testing some individuals will not achieve a optimum mixture of drugs to treat HIV/AIDS and may, therefore, severe adverse life threatening consequences may occur.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 5: HIV EDUCATION & PREVENTION SERVICES:

BACKGROUND:

The LAO suggests the Legislature consider reducing funding for the HIV Education and Prevention Services by up to $3 million GF.

The LAO writes:

The Governor's budget includes approximately $38.5 million ($23.8 million from the General Fund and $14.7 million in federal funds) for the HIV Education and Prevention Services Branch within the Department of Health Services Office of AIDS. This level is unchanged from the 2003-04 budget amount. Of this portion, approximately $18.5 million is awarded to 61 local health jurisdictions (LHJs) in California for HIV prevention activities consisting of interventions targeting individuals most at risk of contracting or transmitting HIV. Examples of LHJ activities include: educational events targeting men of color and incarcerated individuals; partner counseling and referrals; prevention work in Internet chat rooms, and support groups.

Without prejudice to the possible merit of the contracts with the local health jurisdictions, the Legislature could reduce General Fund support for local health agencies by as much as $3 million and still maintain funding to provide prevention services at a reduced level. Last year, the legislature indicated interest in prioritizing direct services over other activities. To the extent that the resources—made available by this reduction—are used to offset General Fund support for direct services, this approach would be consistent with the Legislature's intent.

COMMENTS:

- LAO, please outline your suggestion for the Subcommittee.
- DHS, please outline for the Subcommittee the funding history for the Education and Prevention Services over the past few years.
- DHS, what are the possible short and long-term consequences to reducing funding for programs targeted at reducing high-risk behavior?

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to put a reduction in funding for the HIV Education and Prevention Services on the solutions list, what the impact of the reduction in the funding for the HIV Education and Prevention Services will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of the reduction of funding for the HIV Education and Prevention Services to be:

1. Programs that are targeted to high-risk individuals, high-risk behavior and communities of color play an important role in slowing the increase in the number of people with HIV/AIDS.

2. In addition to the avoidance of the personal losses, such programs help to restrain the increase of state expenditures in the ADAP and Medi-Cal Programs.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 6: TISSUE BANK LICENSURE PROGRAM

BACKGROUND:

The Department proposes to increase spending authority for the Tissue Bank Special Fund from $166,000 to $259,000 to allow the program to hire one permanent position to conduct onsite inspections of Tissue Banks.

California now licenses over 300 tissue banks and the number continues to grow rapidly. The tissue banks supply reproductive tissue, human milk and bone marrow from living donors and ocular tissue, bone, veins, tendons and heart valves from deceased donors to recipients dependent upon human tissue. Since inception in 1993 the number of tissue banks has grown each year. Since 2000 the number of new banks per year has been 45 to 50. Routine onsite inspections of tissue banks will improve the quality of human tissue used for treatment of patients and, therefore, improve health conditions of patients dependent on human tissue.

Chapter 801, Statutes of 1991, AB 2209, Speier, authorized the Department of Health Services to conduct inspections of tissue banks. The statute requires that no tissue bank can operate without a license after July 1, 1992. However, the statute does not specify the frequency of the inspections. The Department believes the tissue banks should be inspected every two years to protect the public, living donors and recipients of tissue. Tissue, like blood, which is separately

regulated, is subject to infectious diseases and contamination. A single donor may affect hundreds of recipients, which could generate significant harm. Because of the diversity and complexity of tissue banks, the inspection process is difficult and demanding. The additional staff will permit the Department to conduct an additional 60 investigations, initial inspections or routine investigations per year. The Department now has the capacity only to conduct 30 investigations per year, a frequency of one inspection every 10 years for the 300 tissue banks. The addition of the additional staff person will permit inspections once every 3.3 years.

The authorizing statute set the license fees. According to the Department the program collects sufficient funds to support the requested position. The balance of the Tissue Bank Special Fund is $407,000 and is projected to be $369,000 by the end of the FY 2004-2005.

COMMENTS:

- DHS, please briefly outline the Department's proposal for increased onsite inspections of tissue banks.

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to put the hire of additional staff members in the Tissue Bank Program on the solutions list, what the impact of the additional staff member in the Tissue Bank Program will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of the adding an additional staff member in the Tissue Bank Program to be:

1. Adding an additional staff member will permit more frequent inspections of Tissue Banks which provide human tissue for use, in the care, and treatment of individuals needing health care. Safe and sanitary conditions are necessary to preserve the life and safety of many that are receiving tissue transplants in their health care. Increased inspections will provide an additional measure of safety in the delivery of health care.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 7: CALIFORNIA NUTRITION NETWORK

BACKGROUND:

The California Nutrition Network for Healthy Active Families, a social marketing campaign in the Department of Health Services' Cancer Prevention and Nutrition Section (CPNS) of the Cancer Control Branch, is requesting an increase of $39.7 million in GF Reimbursements and local assistance expenditure authority. The Network is funded principally by federal funds from the U.S. Department of Agriculture to the California Department of Social Services (DSS). Through an annual interagency agreement, DSS reimburses DHS for activities conducted by the Network. No state resources are being requested.

The increase in expenditure authority will be used in large part for interventions at the local level in projects conducted by organizations such as local health departments, low-resource public schools, after school programs, community based organizations, faith-based organizations, food security projects and not-for-profit coalitions at the local level. All funds going to local agencies and special projects with community-based organizations are leveraged by in-kind matching funds that local agencies provide to DHS. The Network interventions are targeted to the primary audience of households headed by single, separated, or divorced white or African-American women with children of lower elementary age and married Latina mothers with children of upper elementary age. The secondary audience is school-aged children from low-income households.

The broad-based social marketing campaign includes:

- Partnership and Resource Development: The Network currently funds over 130 projects, including Local Incentive Awardees (LIAs), special projects, California Project LEAN regions, and *5 a Day-Power Play!* regions, and Network partners that serve as "ambassadors" in delivering the *5 a Day* and physical activity messages.

- Research and Evaluation: CPNS conducts the only statewide surveys focusing exclusively on healthy eating and physical activity. The surveys are used to help set state and local priorities and to raise public awareness. Focus groups, pilot tests and economic studies also are conducted.

- Media and Retail: The Network and the *5 a Day* Campaign conduct media and public relations activities, including the purchase of television and radio airtime; placement of outdoor ads, such as mobile billboards and bus wraps; regional media tours conducted by trained state and local spokespeople, supported by public relations activities at the community level. The retail merchandising components of the program include customized point-of-sale materials; ad slicks for print advertisements; in-store recipe booklets and brochures; and a CD-ROM containing advertising copy, graphics, health tips, and nutrition information to be used by retailers.

- Community Interventions/Development: The Network and the *5 a Day* Campaign facilitate the efforts of a wide range of community-based organizations to promote healthy eating and physical activity by increasing access to tested social marketing interventions, fostering partnerships, stimulating community development initiatives, and encouraging new interventions by Local Incentive Awardees. They include 34 school districts, 24 local health departments, 12 food security organizations, 13 African American faith organizations, 12 California Project LEAN regions, 11 *5 a Day-Power Play!* Campaign regions, 13 public colleges and universities, 3 Healthy Cities and Communities, 7 tribal organizations, 3 park and recreation departments, 3 city government agencies, and 3 Cooperative Extension agencies. Seven Cancer Research Projects also support Network interventions.

- Policy, Environmental and Systems Change: The Network asks all its funded projects to change organizational policies and the physical environment and help low income families eat more fruits and vegetables, be more active, and participate in USDA nutrition assistance programs.

- Children's Nutrition and Physical Activity: The Network is working to facilitate the efforts of a wide range of physicians, health departments, school districts, and community-based organizations to promote healthy eating and physical activity habits in school-aged children and their parents.

COMMENTS:

- DHS, please briefly describe the Nutrition Network and its social marketing campaign and the proposed uses of the increased federal funds.

- Department of Finance (DOF), please discuss the differences in the amount of money that the DSS and DHS show for the program. How will the DOF reconcile the differences in the two budgets?

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to increase the GF reimbursements budget authority for the Nutrition Network on the solutions list, what the impact of the increased GF reimbursement budget authority for the Nutrition Network will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of the increase of the increase in Federal Funds budget authority for the Nutrition Network to be:

1. The funds for the program are all reimbursements from the federal government.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 8: ELECTRONIC DEATH REGISTRATION SYSTEM

BACKGROUND:

The budget proposes to expend $338,000 from the Health Services Special Fund to support the maintenance and operations of the Electronic Death Registration System.

Chapter 857, Laws of 2002, AB 2550, Nation, mandated the development and implementation of an Electronic Death Registration System in California. The legislation was part of a package of legislation to improve vital records administration and combat identity theft and fraud. The legislation established funding for the development, implementation, maintenance and operation of the Electronic Death Registration System through an increase in the disposition permit fees. The fees were raised from $7 to $13 in 2003. In January 2005 the fees will decline by $2, leaving the remaining $4 increase to fund the maintenance and operation of the Electronic Death Registration System.

The University of California, Davis Health System, developed the Electronic Death Registration System software for the State. The maintenance and operations contract proposed by the budget is necessary to keep the system in production, to enroll new counties into the electronic death registration domain and further re-engineer the statewide vital records process.

COMMENTS:

DHS, please describe for the Subcommittee the new registration system and the status of its implementation.

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to put Electronic Death Registration System software on the solutions list, what the impact of the Electronic Death Registration System software will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of the Electronic Death Registration System to be:

1.The software is funded by a dedicated fee.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 9: VITAL RECORD CONVERSION

BACKGROUND:

DHS is requesting 6 two-year limited term positions and $1,580,000 from the Vital Records Special Fund to complete the Feasibility Study Report begun in FY 2003-2004, perform initial tasks to lay the foundation for implementing Chapter 914, Statutes of 2002, SB 247, Speier, and to generate the Request for Proposal to select a contractor to accomplish the project. SB 247 increased the fee for a certified copy by $2 to provide funding to implement a single statewide database of imaged birth and death records, electronically redact signatures from these certificates and make the results electronically available in each county recorder's office and county registrar's office. The fee was instituted in July 2003 and will extend through December 2005. Beginning January 2006 the fee will be reduced by $1 leaving a $1 net fee increase to provide ongoing maintenance and operations for the vital record systems.

The funding will provide the resources to perform the following tasks in the 2004-2005 budget year: (1) finalize the Feasibility Study Report; (2) perform historical birth index analysis for years 1940- 1969; (3) perform historical death index analysis for years 1940- 1969; (4) perform historical birth forms analysis for 1905-2003; (5) perform the historical death form analysis for 1905-2003; (6) develop the Request For Proposal and conduct the competitive procurement process; (7) convert record corrections residing in a security file; and (8) provide six two-year limited term Personnel Years (PY), along with the necessary expenditure authority to complete the activities.

COMMENTS:

DHS, please describe the need for the conversion and its status.

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to put vital record conversion on the solutions list, what the impact of the vital record conversion will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of the vital record conversion to be:

1. A dedicated fee for the conversion of records and maintenance of the system.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 10: RICHMOND LABORATORY IT SUPPORT

BACKGROUND:

The budget proposes funding for (1) one-time network equipment costs; (2) one-time server costs; (3) one-time installation and project management costs; and (4) ongoing data center network and support costs. The request is for $1,250,000, $424,000 GF. $633,000 Federal Funds and the remaining $197,000 from several special funds and no additional state positions. The funding for the IT project had been proposed in FY 2003-2004 budget but it was withdrawn in a Finance Letter due to construction delays.

The Richmond Campus is one of the most modern, technologically advanced public health laboratories in the world. It represents the consolidation of seven decentralized laboratories. The laboratory is innovative and will enhance the Department's ability to continue providing services that strengthen public health programs and respond to bio-terror threats. Lack of funding for the IT support of the laboratory will limit the Department's ability to accomplish the mission of the laboratory to protect public health. The network equipment and servers are necessary to physically connect the additional Richmond Campus staff to the facility's Local Area Network and Health and Human Services Agency Data Center's Wide Area Network.

COMMENTS:

DHS, please describe for the Subcommittee the need for the network connectivity.

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to put the laboratory computer technology on the solutions list, what the impact of the laboratory computer technology will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of the laboratory computer technology to be:

1. The Richmond Laboratory will fulfill significant public health purposes that are critical to the health and well being of the people of California.

ITEM 4260 DEPPARTMETN OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 11: EXPANDED ACCESS TO PRIMARY CARE

BACKGROUND:

The LAO suggest the Legislature consider reducing the GF appropriation for the Expanded Access to Primary Care Program by $2.4 million

The LAO writes:

The Expanded Access to Primary Care Program (EAPC) reimburses qualified community clinics for primary and preventative health care services provided to individuals at or below 200% of the Federal Poverty Level (FPL). The Governor's budget for the current and budget year reflects $33.3 million in funding for EAPC. This amount includes approximately $25 million from the General Fund, $1.6 million in federal funds, and $6.8 million in Prop 99 funds.

Last May, the administration proposed a $2.4 million reduction in General Fund support for the EAPC program in lieu of the realignment proposal. Although the Legislature did not accept this proposal last year, it is an option for the members to consider particularly during this difficult budget year. The proposed option reflects a 7% reduction in the amount budgeted for EAPC and would reduce the amount of funding clinics would have to provide primary and preventative care to the uninsured.

Without prejudice to the possible merit of the program, the LAO has included this in its list of options for the Legislature's consideration for two primary reasons. First, counties currently receive funding for the provision of uncompensated care under realignment. Second, the EAPC program is one of the few programs that have been spared reductions in Proposition 99 funds in the Governor's Budget.

COMMENTS:

LAO, please briefly describe your suggestion for reducing the appropriation for the Expanded Access to Primary Care Program.

DHS, please provide the Subcommittee your assessment of the impact of the reduction on the provision of health care to the indigent population.

SOLUTIONS LIST:

Subcommittee 1 is required to create a solutions list. This list is to include solutions approved by the subcommittee as well as other potential solutions.

The subcommittee needs to take action on whether to reduce the funding for the Expanded Access To Primary Care Program on the solutions list, what the impact of the reduced funding for the Expanded Access To Primary Care will be, and assign a 1-5 ranking (least difficult to most difficult).

Staff identifies the impact of the reduction in funding for the Expanded Access to Primary Care to be:

1. A financial risk for the health care providers who provide health care to those who are without health insurance. Other issues in the budget would decrease funding from another program and combined they would cause some clinics to become financially at risk of closure. Closure would affect many that are without health insurance, public or private.