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

Assemblymember Mervyn Dymally

MONDAY, APRIL 19, 2004
STATE CAPITOL, ROOM 437
4:00 PM

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ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 1: BREAST & CERVICAL CANCER TREATMENT PROGRAM ELIGIBILITY PROCESSING

BACKGROUND:

The Administration's 2004-05 budget proposes the transfer of eligibility determinations for the Breast and Cervical Cancer Treatment Program to the counties effective January 1, 2005 because the caseload for the program is much higher than originally anticipated—almost triple the estimate initially used to determine the staffing needs. The budget also increased funding for the program to address a backlog in processing applications for these benefits.

The 2002 Budget established two new state programs for individuals who have a diagnosis of breast or cervical cancer. The two programs together are known as the Breast and Cervical Cancer Treatment Program (BCCTP). One new program expanded Medi-Cal eligibility to specified women who were previously ineligible for these benefits. Specifically, full-scope services became available for women under age 65 with no other health coverage, who are in need of treatment for breast and cervical cancer, and whose incomes are below 200 percent of the federal poverty level (FPL). Federal matching funds equal to about 66 percent of the cost of these services are used to match state funds.

The second step was the expansion of existing state programs to provide a comparable "state-only" breast and cervical cancer treatment program for individuals who did not qualify for Medi-Cal. The state-only program provides only cancer treatment and cancer-related services that are limited to 18 months of coverage for breast cancer treatment and 24 months of coverage for cervical cancer treatment. Women and men of any age including undocumented persons who may or may not have another source of health coverage, and whose incomes are below 200 percent of the FPL, are eligible for the state-only program.

The Department currently has 12 staff dedicated to completing BCCTP eligibility determinations and re-determinations at a cost of about $1 million ($480,000 General Fund). The administration proposal is to eliminate one of these positions beginning January 2005 and to strike all but two of the remaining positions by June 30, 2005. The budget plan estimates that this would result in General Fund savings of $20,000 in the budget year, increasing significantly to about $800,000 ($400,000 General Fund) in 2005-06.

The administration further proposes to increase Medi-Cal program spending for county eligibility activities by $2.4 million ($1.2 million General Fund) in 2004-05 and by $5.4 million ($2.7 million General Fund) in 2005-06 due to the shift to counties of the BCCTP workload. The state would continue to operate and financially support the Internet-based application system, so that signed applications for BCCTP benefits could be forwarded to counties for completion of the eligibility process.

The Department indicates that if eligibility determinations are not shifted to the counties it would need at least 11 new positions to manage the BCCTP workload at an estimated cost of $460,000 in 2004-05 and $920,000 in 2005-06. Combined with the annual cost of the existing staff, this would bring the total cost to DHS for administering BCCTP eligibility to $1.5 million

($710,000 General Fund) in 2004-05 and about $1.9 million ($940,000 General Fund) in 2005-06.

The Governor's proposal, however, to shift most eligibility processing activities for BCCTP to the counties would be more expensive. The total cost (including the retention of some DHS activities) would be $3.3 million ($1.7 million General Fund) in 2004-05 and $5.6 million ($2.8 million General Fund) in 2003-04.

A comparison of the cost of the two alternatives is shown in the **Legislative Analyst Office figure below**. The Governor's proposal would cost nearly $1.9 million more (about $950,000 General Fund) in 2004-05 and about $3.6 million more ($1.8 million General Fund) in 2005-06 than adding DHS staff for the same purpose.

Figure 1
Retaining State Eligibility Process for BCCTP Costs Less Than Shift to Counties

(In Thousands)

	2004-05			2005-06	
Eligibility Process	General Fund	Total Funds		General Fund	Total Funds
State Staff (a)					
Current staff (12 positions)	$480	$1,000		$480	$1,000
Additional staff (11 positions)	230	460		460	920
Total costs	$710	$1,460		$940	$1,920
Governor's Proposals (b)	$1,660	$3,310		$2,780	$5,560
Net Savings From Keeping Eligibility Work at DHS	-$950	-$1,850		-$1,840	-$3,640

a Current process.

b Shift eligibility process to the counties. For comparison purposes, includes cost of staff that would be retained by the state after the shift.

Source: Legislative Analyst Office

The LAO recommends the Legislature not adopt the Governor's proposal to shift BCCTP eligibility determinations to the counties as the approach is more costly than the alternative of increasing DHS staff for this same purpose. Accordingly, The LAO recommends that the proposed increase in the Medi-Cal budget for county eligibility activities be deleted. Because the existing DHS staff is clearly insufficient to handle the BCCTP workload the LAO recommends that the Legislature instead approve 11 additional staff. This would require an augmentation to the DHS operations' budget of $460,000 ($230,000 General Fund) for 2004-05. A net savings to the state General Fund of $950,000 ($1.9 million all funds) in 2004-05 in comparison to the Governor's budget proposal.

COMMENTS:

LAO, please compare the costs of your staffing recommendation to that of the DHS.

DHS, do you agree with the LAO's analysis.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 2: NON-INSTITUTIONAL PROVIDER AUDITS

BACKGROUND:

DHS proposes the transfer of responsibility for Medi-Cal non-institutional providers from the State Controllers Office to the Department. The proposal would transfer 20 of the 26 positions from the Controllers Office to DHS. The transfer would eliminate the remaining 6 positions for a General Fund Savings of $300,000 $600,000 Total Funds.

Currently, the Controllers Office performs the audit for the Department through an Interagency Agreement. As a result of the Single State Agency responsibility, DHS directs the State Controllers Office on which audits to perform, reviews the State Controllers Office findings, issues the final audit report and recovery demand and conducts all administrative appeals. The audits conducted by the Controller's Office are they same type of audits conducted by the Department's staff. In addition to the audits requested by the Department the Controller's auditors also audit rebates from the pharmaceutical manufacturers, securing $24 million in rebates over the last two years. The State Controllers Office has successfully conducted the audits for DHS since the early 1990s.

The Department asserts that the need for in-depth medical audits has increased as the level of medical record keeping sophistication by abusive providers has increased over time. The Department states that it has the medical professional staff expertise to conduct the audits and the State Controllers Office does not have the staff. The Controller notes however, that irrespective of where the auditor is located, consultation with the medical professional must occur and there is no inherent location advantage of one agency over the other.

The Controllers Office states that DHS spends only 30 minutes per audit to review the Controllers audits, a savings of less than the six positions that will be lost if the transfer were to occur. In addition, the Controllers Office notes that it has a constitutional responsibility to provide independent oversight of state disbursements.

COMMENTS:

DHS, please outline for the Subcommittee the role the Controller's Office currently plays in the Medi-Cal auditing process.

State Controller's Office, please outline for the Subcommittee how the Controller's Office fulfills its role in the Medi-Cal auditing process?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 3: NON-CONTRACT HOSPITAL AUDITS

BACKGROUND:

The budget proposes to add 41 staff to increase the number of field audits of home offices of large corporate healthcare chains and hospitals that do not contract with the Medi-Cal Program. The projected net savings to accrue from the increased audits is $3.83 million General Fund, $7.65 million Total Funds in the budget year. The annualized savings are projected to be $15.3 million General Fund, $30.6 million Total Funds. The staff costs are projected to be $4.709 million, $2.354 million General Fund. $2.998 million would be for salaries and $1.711 million for operating expenses and equipment.

The Medi-Cal Program reimburses hospitals approximately $3.5 billion for acute care services delivered to Medi-Cal beneficiaries. Of that, 20 percent, $700 million is paid to hospitals that do not contract with the state to provide general acute care services to Medi-Cal beneficiaries. All hospitals that receive reimbursement from the Medi-Cal Program must file an annual cost report with DHS. There are 440 licensed hospitals in the state and 428 of them submit cost-reports to the state. Of the 428 cost reports that are filed with the state, 210 are for non-contract hospitals. Annual cost-settlements are performed by the state to determine the proper amount of cost reimbursement due the hospital. The remaining 218 cost reports are for hospitals that are under contract with the California Medical Assistance Commission (CMAC) but they are cost-base reimbursed for services that are not covered by their contract with CMAC.

There are 62 large corporate healthcare chains that own many hospitals in the state. The home offices are required to file cost reports annually to report total costs and the methods for allocating costs to individual hospitals and non-healthcare businesses they own. The home office costs are reimbursed through allocating the costs to individual hospital cost reports. The Audits and Investigation Unit of DHS performs primarily limited field/desk audits of the non-contracting hospitals and limited field audits of 13 of the 62 home office cost reports. The remaining 49 are accepted as filed without an audit.

Full field audits allow the Department to do a detailed analysis of the hospitals' books and records to determine the proper amount the Medi-Cal program should reimburse the hospitals for health care services delivered to Medi-Cal beneficiaries.

COMMENTS:

DHS, please outline for the Subcommittee the importance of auditing the home offices of health care corporations.

LAO, please provide the Subcommittee with your analysis of the need for the additional positions to audit the home offices of the healthcare corporations.

DHS, please describe for the Subcommittee how the new staff be assigned to the home offices for auditing purposes.

ITEM 4260 DEPARTMENT OF HEALTH SERVICE – MEDI-CAL

ISSUE 4: TREATMENT AUTHORIZATION REQUESTS

BACKGROUND:

The Governor's 2004-05 budget would increase by 36, the number of staff that review prior authorizations for certain prescription drugs and medical services for Medi-Cal patients. The additional staff are expected to cost $4 million ($1 million from the General Fund) in 2004-05. These additional resources would bring the total budget for Treatment Authorization Requests (TARS) reviews to roughly $70 million ($20 million General Fund) and the total staffing level to 685.

State law requires Medi-Cal providers to submit Treatment Authorization Requests (TAR) to obtain authorization for reimbursement for specific procedures and services. Some of the services that require TARs include certain prescription drugs, long-term care claims, and inpatient hospital claims. The volume of TARs has increased significantly during the past three years. The number of TAR reviews conducted by DHS increased 17 percent in calendar year 2002, and another 17 percent in 2003. The department anticipates the upward trend in TARs reviews will continue, primarily driven by a surge in the number of TARs submitted for drug prescriptions.

The budget also proposes statutory language that would give DHS the discretion to examine a sample of TARs for medical services and prescription drugs, instead of the current requirement that every such request be reviewed.

A study commissioned last year by the Medi-Cal Policy Institute, a non-profit group which studies Medi-Cal and other state health programs, found significant problems with the Medi-Cal TAR process. Among the study's findings:

- **Relatively Larger State Staff.** Department of Health Services (DHS) uses a relatively larger staff than private health plans to process TARs. This may be partly justified by Medi-Cal's

sicker and older patient population, which is more likely to require services subject to prior authorization.

- **Lack of Cost-Benefit Evaluations.** The Department does not conduct routine cost-benefit evaluations to determine if requiring prior authorization for specific services and drugs helps to contain overall program costs. For example, state law requires that any prescription for drugs exceeding the limit of six per month be subjected to a TAR. This requirement is a major factor driving up the TAR workload. However, the Department has not determined if this limit reduces prescription drug costs for the state. Given that only 10 percent of such TARs are disallowed, and that drugs addressing chronic conditions are routinely approved, it is possible that requiring TARs for selected drugs and medical services might be a better approach.
- **Inconsistent Decision-Making.** The study also found that decision making on TARs is inconsistent and often lacking formal criteria. An Internet-based system called Service Utilization Review Guidance and Evaluation developed by DHS, should result in faster TAR decisions, uniform criteria for decision making, and a reduction in the number of DHS staff needed to process TARs. The Department has indicated that the technology and data systems are now available to implement the system for pharmacy TARs, but that the department has not implemented the system for this purpose. The state would also benefit if Service Utilization Review Guidance and Evaluation (SURGE) were placed in service to process medical claims. However, it will most likely be a couple of years before the necessary data systems for such an effort would be available.

As noted above, the 2004-2005 budget proposes statutory changes to give the Department greater flexibility in terms of how many TARs must be reviewed for certain services and drugs. The Legislative Analyst Office (LAO) notes the language would be effective in helping the department to better manage its workload. For example, the Department could choose to review only a sample of certain drugs, such as over-the-counter drugs, that generate a high volume of prescriptions but that are low-cost and low-risk to patients. Similarly, the Department could spend less staff time reviewing hemodialysis or other services that have high TARs approval rates and are less likely to be abused.

The LAO believes the Department could better address the increasing volume of TARs by focusing initially on actions that reduced its workload rather than by increasing the number of staff who process TARs. Therefore, the LAO recommends that the Legislature adopt the proposed trailer bill language that gives the Department the discretion it needs to manage the TAR workload more effectively.

COMMENTS:

LAO, please outline for the Subcommittee its analysis and recommendation on increasing the staffing for the Treatment Authorization Requests.

DHS, what is the status of the SURGE system and its projected statewide implementation date.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 5: ADULT DAY HEALTH CARE

BACKGROUND:

The Administration's budget proposes a one year moratorium on new Adult Day Health Centers (ADHC) and a moratorium on certification for increased capacity of existing ADHC centers. The proposal also would remove therapy and transportation from the bundled ADHC rate, requiring the ADHCs to bill for these rates separately.

There are about 300 Adult Day Health Centers (ADHCs) throughout California with the largest concentration in the Los Angeles region. There are approximately 120 ADHCs pending in the Department of Aging. Generally, the facilities have the capacity to serve between 40 to 80 people per day. The ADHCs provide: (1) psychological assessment; (2) physical therapy; (3) occupational therapy; (4) speech therapy; (5) social services; (6) dietary assistance; (7) transportation; and (8) recreational activities. Medi-Cal authorizes how many days per week an individual may attend an ADHC and reimburses services on a per-person, per-day basis.

The ADHCs are licensed by DHS and certified by the Department of Aging. The licensing and certification process for a new ADHC facility can take up to 15 months to complete. Under the budget proposal, no new ADHCs would be licensed or certified as Medi-Cal providers. The moratorium would run from July 1, 2003 through June 30, 2004 and it would save approximately $30.1 million in the budget year. The Department would have the authority to indefinitely extend the moratorium.

The May Revision for the 2003-2004 budget also proposed to impose a moratorium on the certification of new adult day health care centers and changing the ADHC reimbursement methodology. The moratorium would have been extendable for as long as the Director of the Department determined it was necessary. The Department estimated that both the General Fund and federal fund expenditures would decrease by $9.85 million in the Budget year. If the moratorium were to be extended the savings would increase.

The Department notes that many of the ADHCs are unable to operate at full capacity. Many centers, particularly in Los Angeles, have fewer Medi-Cal beneficiaries than they would like. This has led to allegations of “stealing patients” or bribing beneficiaries to attend specific centers. Also, the Department states that it does not gain the benefit of economies of scale in the centers with required staffing overseeing centers that are operating with minimal

beneficiaries. Therefore, the Department wanted authority to impose a moratorium for one year and authority to continue the moratorium as determined by the Director.

ADULT DAY HEALTH CARE EXPENDITURE HISTORY

Calendar Years 1999 through 2003

Calendar Year	No. of Providers 1/	Payments 2/
1999	137	$62,091,000
2000	183	$100,885,000
2001	225	$143,378,000
2002	268	$205,046,000
2003	323	$278,079,000

1/ Providers who had at least one payment in the fiscal year.

Sizes of facilities vary, and existing providers may have had increases in licensed capacities

2/ Based on date of payment data.

Source: Department of Health Services

The California Association of Adult Day Services (CAADS) noted there was significant potential for litigation with the Department's proposal as over 120 providers had significant economic investments in the licensing process of the state. CAADS developed a slow growth proposal that does not have the litigation prospect. The slow growth proposal was drafted as an alternative to the extended moratorium proposed by the DHS. The Association proposed creating a two-step process with the California Department of Aging (CDA) screening an applicant prior to identification of a property location. It required applicants to demonstrate local need based on demographic and competitive data. It also required provider orientation as data indicates that providers who attend technical assistance classes have fewer deficiencies. It required CDA to conduct face-to-face interviews with the applicant. The proposal included a six-month moratorium to allow CDA and the Department to re-tool their processes. Finally it created an updated fee schedule for initial applications and licensing renewals.

The Legislative Analyst's Office found the alternative viable relative to that proposed by the Department. The LAO estimates the cost savings from the alternative proposed by the California Association of Adult Day Services would be $5.5 million in Budget year plus one and $13 million in Budget Year plus two. The Legislature adopted the alternative proposed by CAADS and the Governor vetoed the alternative.

The DHS was notified in December 2003 that it had to convert the ADHC program to a federal waiver. The state must submit a Home and Community Based Waiver proposal before the end of the calendar year. The change to a waiver program will require changes in state law and potentially to the rate methodology. The Centers for Medicare and Medicaid Services (CMS) has indicated that it will not approve a waiver that uses bundled rates.

COMMENTS:

DHS, please provide the Subcommittee with an update on the CMS developments.

DHS, please describe for the Subcommittee how the new requirements from CMS on ADHC fits into the Medi-Cal reform effort.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 1: BIOTERRORISM

BACKGROUND:

The DHS is requesting budget authority of $108.876 million in federal funds for the 2004-2005 budget year. Of the total amount $76.509 million is additional federal funding for 2004-2005. Of the $76.509 million new funding, $29.270 million is for state operations and $47.239 million is for local assistance. The base allocation for 2004-2005 is $32.367 million. The Department also requests 18.8 new limited term positions.

Of the $108.776 million in expenditure authority $70.102 million is for the Centers for Disease Control and Prevention (CDC) co-operative agreement and $38.774 million is for the Health Resources and Services Administration (HRSA) co-operative agreement. Of the CDC funding, $23.308 million is for state operations and $47.064 is for local assistance. Of the HRSA funding, $13.574 million for state support and $25.200 million is for local assistance.

CDC Co-operative Agreement
The funding requires the state to meet new critical benchmarks and activities for both grants. CDC grants are for the purpose of upgrading state and local public health jurisdictions' critical capacities related to preparedness for and response to bioterrorism in seven areas: Planning and Readiness Assessment; Surveillance and Epidemiology capacity; Communications and Information Technology; Health Risk Communications and Information Dissemination; and Education and training. As a condition of the funding, the Department must meet 16 critical

capacities and 25 critical benchmarks. CDC has expanded the requirements to include two new benchmarks and nine new activities. Therefore, the Department is requesting additional resources for: public health command and control; training; incident response; water and food bio-security; additional laboratory support; health facility preparedness; providing information to the public; and rapid surveillance. The funding for the Local Health Districts – the entities with primary responsibility for responding to public and environmental health aspects of disasters, outbreaks or bioterrorism attacks – will be continued in 2004-2005 with a greater proportion of available funds, 72 percent, directed to meet local needs.

HRSA Co-operative Agreement
The HRSA grant has been for Hospital Bioterrorism Preparedness Program. The Department contracted with Emergency Medical Services Authority to administer the grant to complete a needs assessment of hospitals' and clinics' capabilities to respond to a bioterrorist occurrence. A lot of concern has been expressed because there is no inter-hospitals or regional planning to manage a bioterrorist incident. This leads to non-standardized plans that may conflict or be unable to mesh with county or regional approach to incidents. The new HRSA funding will no longer be contracted out to EMSA and it will be co-ordinated within DHS through the newly established Joint Advisory Committee.

COMMENTS:

DHS, what is the status on Guidance form the Federal Government?

DHS, what is the status of the state-local negotiations on co-operative agreement?

DHS, will there be focus groups involved this year?

DHS does the Department expect the negotiations to proceed rapidly, will there few changes that need to be responded to or will there be substantial changes?

DHS, please outline for the Subcommittee the need for the additional positions.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 2: BIOTERRORISM – FINANCE LETTER

BACKGROUND:

The Department is requesting 10 permanent positions to continue implementing the CDC co-operative agreement.

The additional staff positions will be to co-ordinate on a regional basis local establishment of bioterrorism plans and protocol. In addition, the new staff will perform fiscal monitoring of grant expenditures awarded by the Department on funds received from the Federal Government.

- One position will be responsible for co-ordinating at the local level the national stockpile, a reserve of pharmaceuticals, medical supplies and equipment to be accessed by the government during periods of emergency.
- Six positions will provide local guidance and liaison activities to maintain proper direction of local activities consistent with federal guidelines.
- Three positions will provide fiscal monitoring and accounting of local grant expenditures to ensure consistency with federal guidelines and rules.

The CDC Co-operative Agreement for Public Health Preparedness and Response for Bioterrorism is organized around seven focus areas: Planning and Readiness Assessment; Surveillance and Epidemiology capacity; Communications and Information Technology; Health Risk Communications and Information Dissemination; and Education and training. In addition to the seven primary focus areas, the Co-operative Agreement also includes two areas of emphasis: Strategic National Stockpile for pre-positioning of medical supplies to respond to emergencies; and Smallpox Preparedness to continue efforts to vaccinate public health and hospital care responders. The Department must meet 16 critical capacities and 25 critical benchmarks to fulfill terms of the CDC co-operative agreement and to qualify for future funds.

The Department currently has 76 limited-term positions to address the requirements of the CDC bioterrorism co-operative agreement. Ten technical positions in the Bay Area are open because of attrition and the state's inability to recruit and retain technical people because of its inability to offer competitive compensation in a highly competitive job market for scientific expertise. The positions would be redirected to management of the CDC co-operative agreement and would be located outside the Bay Area.

COMMENTS:

DHS, please outline for the Subcommittee the need for the additional positions.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 3: GENETIC DISEASE TESTING PROGRAM

BACKGROUND:

The budget for the Department proposes an additional $5 million General Fund loan to the Genetic Disease Testing Fund for the ongoing development of the Genetic Disease Branch

Screening and Information System Project. The project is to replace an obsolete automation system used to screen newborns for genetic diseases.

The purpose of the project is to replace aged (23 years) legacy systems for the DHS Genetic Disease Program. The GDB annually collects and processes newborn metabolic and prenatal defect screening data for about 525,000 babies and more than 350,000 pregnant women statewide. The SIS project will replace the existing systems with an integrated system that will house both prenatal and newborn information and allow the GDB the flexibility to meet current and future screening requirements for California, e.g. the addition of data for other disorders or diseases.

The system is projected to cost $25.874 million, $14.248 million in one-time development costs and $11.626 million in ongoing operational costs for seven years. The fees collected by the Genetic Disease Testing Fund were increased by $4 per newborn for each screening test to fund the project's costs. The fund did not have a balance large enough to pay the project's up front cost, the Legislature approved a General Fund loan for the Genetic Disease Branch Screening Information System in the 2003-2004 Budget Act. The Administration is seeking a second $5 million loan in the 2004-2005 fiscal year

As a condition of the approval of the initial loan, the Department is required to provide several reports to the Legislature. The reports are to detail the costs, schedule and status of the project. At the time the projected was started, up-to-date costs and schedule were unknown. The first report was due in July of 2003. Quarterly reports were to be submitted to the Legislature beginning October 2003 and expenditures, revenues and the overall fund condition status of the Genetic Disease Testing Fund. To date the Legislature is still waiting to receive quarterly reports on the project, expenditures to date, and fund condition summaries from the DHS.

On April 1,2004 the Department of Finance submitted to the Legislative Fiscal Committees an Oversight Report on the DHS Screening Information System. Finance has two primary areas of concern: Lack of timely decisions from the project steering committee and DHS management; and inadequate project schedule.

Finance supports continuation of the project, provided the following DHS actions are completed by May 1, 2004:

- Provide Finance with an accurate, realistic, and comprehensive project schedule for approval. All known issues must be considered, including, but not limited to, state staffing requirements and assignments, adequate review time for the IV&V vendor given the delayed start, the effect of any GDB programmatic position backfilling, and time for completion of all project plans.
- Finalize and approve all project plans. Present a strategy to ensure roles and responsibilities are not just included in plans, but are implemented, practiced, and supported.
- Provide complete project cost information, demonstrating, at a minimum, the capability to track costs against budget for each category in the FSR, with separation by fiscal year and by one-time and ongoing costs.
- Provide either a cost management plan, or a description of the cost tracking practice(s) to be employed on the project.
- The IPOC will continue to provide monthly oversight reports to Finance.

Based upon the May 1 response, subsequent implementation of these planned actions, and/or additional risks identified by the IPOC, Finance may schedule a follow up assessment of the project

COMMENTS:

DHS, to what extent has the state's IT procurement process played a role in the development of the System?

LAO, please provide the Subcommittee with your assessment of the DHS Screening Information System Project.

DHS, please outline for the Subcommittee when will the Legislature receive quarterly reports on the project, expenditures to date, and fund condition summaries?

Department of Finance, when will we receive the required status and financial reports?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 4: LOW LEVEL RADIOACTIVE WASTE OVERSIGHT

BACKGROUND:

In September 2002, Chapter 891, Statutes of 2002 (SB 2065, Kuehl) was signed into law. The legislation directs the California DHS to conduct an annual inventory of California's 2000-plus licensed low-level radioactive waste (LLRW) generators. They must record how much and what kinds of LLRW are produced and the transport, storage, treatment, disposal or other disposition of this waste, and to hold public hearings to establish reporting procedures. Chapter 891 also requires that a copy of the shipping manifest accompanying each waste shipment for disposal be forwarded immediately to the state. All other toxic waste industries are required to report annually on the production and disposition of their wastes.

According to the Committee on Science and Technology for Countering Terrorism of the National Research Council of the National Academy of Sciences:

- "Low-level waste may be a particularly attractive terrorist target: It is produced by many companies, universities and hospitals, it is not always stored or shipped under tight security, and it is routinely shipped across the country. Although labeled "low-level," some of this waste has high levels of radioactivity and could potentially be used to make an effective terrorist device."

SB 2065 grew out of the Governor's Advisory Group on Low-Level Radioactive Waste (LLRW), headed by U.C. President Atkinson, which for a full year reviewed the management of LLRW in California. The Advisory Group recommended in August 2000 that California institute an annual survey of waste generators and receive notification of all LLRW shipments, as SB 2065

requires. The Advisory Group found that, "Current reporting requirements for LLRW do not provide adequate data for informed decision-making. Although federal law provides for a nationwide reporting system, it does not provide a level of detail that includes the identification of generators, potential segregation of waste or utilization of on-site storage procedures. These data are needed to better protect the public health and to respond to the needs of the generators."

A registry of generators in California is already required under current law (Health & Safety Code Section 115255 Article 4 (F)(4)). A year and a half after the passage of SB 2065, the legislation has not been implemented, resulting in the potential for significant adverse public health impacts, illegal dumping and serious security breaches. Currently, no state agency has comprehensive real time information that would enable them to track shipments or storage of LLRW that could be used in a radiation dispersal device (RDD) or dirty bomb. Radioactive waste is stored in unsecured locations and the only database available to the Department is collected by the federal government and is one and half to two years old.

With SB 2065, the state will be better prepared to respond as promptly as needed in an emergency dealing with radioactive waste which has been stolen, lost, or released in an attack or accident. SB 2065 is needed for tracking shipments of waste, accountability throughout the system, source reduction, projecting future waste streams, and projecting the ability of generators to store waste with the possible loss of access to disposal sites.

COMMENTS:

DHS, please outline for the Subcommittee the status of the revenues and expenditures of the Radiation Control Fund.

DHS, how does the possible insolvency of the fund affect the implementation of Low-Level Radioactive Waste inventory? What other functions of the Radiological Control Branch could be affected by the potential insolvency of the fund?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 5: 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.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 6: 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 thousand General Fund. $633 thousand Federal Funds and the remaining $197 thousand from several special funds and no additional state positions. The funding for the IT project had been proposed in the 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.