

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

Assembly Member Dave Jones, Chair

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4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 1: STATE MENTAL HOSPITALS – CRIPA

This issue was heard at the Subcommittee's hearing on May 3rd covering all DMH issues. However, the Subcommittee Chair requested a follow-up discussion on the item, focusing on the impact of furloughs.

Civil Rights for Institutionalized Persons Act (CRIPA)

In July 2002, the U.S. DOJ completed an on-site review of conditions at Metropolitan State Hospital. Recommendations for improvements at Metropolitan in the areas of patient assessment, treatment, and medication were then provided to the DMH.

Since this time, the U.S. DOJ identified similar conditions at Napa, Patton, and Atascadero (Coalinga was not involved). The Administration and US DOJ finally reached a Consent Judgment for an "Enhanced Plan" of operations on May 2, 2006.

The Consent Judgment also appointed a Court Monitor to review implementation of the Enhanced Plan and ensure compliance. Failure to comply with the Enhanced Plan would result in legal proceedings against the DMH and possible Receivership.

Under the Consent Judgment, the DMH has until *November 2011* to fully comply with the "Enhanced Plan" to improve patient treatment and hospital conditions. At that time the Court Monitor will depart and the DMH is to assume full responsibility for compliance.

The Enhanced Plan provides a timeline for the Administration to address the CRIPA deficiencies and included agreements related to treatment planning, patient assessments, patient discharge planning, patient discipline, and documentation requirements. It also addresses issues regarding quality improvement, incident management and safety hazards in the facilities.

Based on recent fiscal data, the Legislature has approved about \$29.4 million (General Fund) to enhance care at the four hospitals under the Consent Judgment (Coalinga State Hospital has not been formally included by the DOJ) to meet CRIPA requirements.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DMH to answer the following questions:

1. Please explain the impact of furloughs, and the related inconsistent staffing, on patients?
2. Is it the Department's expectation that the consent decree will end in November 2011?
3. Please provide an overview of the "Mall Program."

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: DEPARTMENT OVERVIEW AND BACKGROUND

Purpose of the Department

The Department of Public Health (DPH) delivers a broad range of public health programs. Some of these programs complement and support the activities of local health agencies in controlling environmental hazards, preventing and controlling disease, and providing health services to populations who have special needs. Others are solely state-operated programs, such as those that license health care facilities. According to the DPH, their goals include the following:

- Promote healthy lifestyles and appropriate use of health services
- Prevent disease, disability and premature death
- Protect the public from unhealthy and unsafe environments
- Provide and ensure access to critical public health services
- Enhance public health emergency preparedness and response

The department comprises five public health centers, as well as the Health Information and Strategic Planning section, and the Public Health Emergency Preparedness Program. The five public health centers are as follows:

1. Center for Chronic Disease Prevention and Health Promotion;
2. Center for Environmental Health;
3. Center for Family Health;
4. Center for Health Care Quality; and,
5. Center for Infectious Disease.

Summary of Funding for the Department of Public Health

The budget proposes expenditures of \$3.3 billion (\$304 million General Fund) for the DPH as noted in the table below. Most of the funding for the programs administered by the DPH comes from a variety of federal funds, including grants and subventions for specified areas (such as water, emergency preparedness and Ryan White CARE Act funds). Many programs are also funded through the collection of fees for specified functions, such as for health facility licensing and certification activities. Several programs are funded through multiple sources, including General Fund support, federal funds and fee collections.

Of the amount appropriated, about \$637 million is for state operations and \$2.706 billion is for local assistance. The budget for 2010-11 reflects a net decrease of \$99.8 million as compared to the revised 2009-10 budget.

Summary of Expenditures for Department of Public Health		2010-11
Public Health Emergency Preparedness		\$104,615,000
Public and Environmental Health		\$3,067,513,000
Chronic Disease Prevention and Health Promotion		292,779,000
Infectious Disease		650,846,000
Family Health		1,700,605,000
Health Information and Strategic Planning		25,495,000
County Health Services		21,132,000
Environmental Health		376,656,000
Licensing and Certification Program		\$171,071,000
Licensing and Certification of Facilities		158,731,000
Laboratory Field Services		12,340,000
Total Program Expenditures		\$3,343,199,000
Funding Sources		
General Fund		\$304,902,000
Federal Funds		\$1,753,323,000
Genetic Disease Testing Fund		\$117,813,000
Licensing and Certification Fund		\$86,523,000
WIC Manufacturer Rebate Fund		\$329,901,000
AIDS Drug Assistance Program Rebate Fund		\$211,958,000
Water Security, Clean Drinking Water, Beach Protection Fund		\$73,487,000
Safe Drinking Water Account of 2006		\$21,207,000
Childhood Lead Poisoning Prevention Fund		\$22,528,000
Radiation Control Fund		\$22,931,000
Food Safety Fund		\$6,877,000
Reimbursements		\$183,752,000
Other Special Funds (numerous)		\$207,997,000
Total Funds		\$3,343,199,000

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to:

1. Provide an overview of the department, its programs, and budget.
2. Provide information on the anticipated impact of federal health care reform on DPH programs and information on new funding opportunities through federal health care reform that the DPH will pursue.

ISSUE 2: MATERNAL, CHILD, ADOLESCENT HEALTH (MCAH) – GOVERNOR’S 2009 VETO

In the 2009 May Revise, the Governor proposed elimination of all General Fund Support for MCAH programs. The Legislature rejected this proposal and instead agreed to much more modest reductions as follows:

- Black Infant Health Program (\$.9 million);
- Adolescent Family Life Program (\$1.75 million);
- Local County Maternal and Child Health Grants (\$2.1 million); and
- MCH state support (\$3.5 million).

Nevertheless, the Governor subsequently vetoed all remaining \$12 million in General Fund support for these programs.

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ISSUE 3: DOMESTIC VIOLENCE SHELTERS – GOVERNOR’S 2009 VETO

In the 2009 May Revise, the Governor proposed elimination of all \$20.4 million in General Fund support for the Domestic Violence Shelter Program. The Legislature rejected this proposal and instead agreed to much a more modest reduction of \$4.1 million.

Nevertheless, the Governor subsequently vetoed all remaining \$16.3 million in General Fund support for this program.

Subsequent to the Governor’s veto, SB 3X 13 (Alquist, Chapter 29, Statutes of 2009) was passed and signed by the Governor to temporarily restore funding to this program, with a one-time \$16.3 million loan from the Alternative and Renewal Fuel and Vehicle Technology Fund (ARFVT), which must be repaid with interest, at the rate earned by the Pooled Money Investment Account, by June 30, 2013. SB 3X 13 also moved the program from DPH to Cal EMA.

On April 20th, 2010, Assembly Budget Subcommittee 4, which oversees Cal EMA, took action to restore the full \$20.4 million in General Fund to this program.

ISSUE 4: EVERY WOMAN COUNTS PROGRAM***Background***

The Every Woman Counts (EWC) program provides free breast cancer screening and diagnostic services to women aged 50 (40 until the beginning of this year) and over whose income is below 200 percent of the federal poverty level (FPL) and uninsured or under-insured. It also provides cervical cancer screening and diagnostic services to women aged 25 and over who meet similar eligibility criteria.

California began receiving federal funds for this purpose in 1991 through the National Breast and Cervical Cancer Early Detection Program administered through the federal Centers for Disease Control and Prevention (CDC). Subsequently, AB 478 (Friedman, Chapter 660, Statutes of 1993) created California's state program, to be funded by a two-cent per pack increase in the cigarette tax. This two cent tax revenue is collected and deposited into the Breast Cancer Fund, half of which is appropriated to DPH for the EWC program and the other half supports the California Cancer Registry and the University of California for California-specific breast cancer research.

According to DPH, an estimated 1.2 million Californians are eligible for breast cancer services through EWC and an estimated 3 million are eligible for cervical cancer services. DPH also estimates that approximately 350,000 women would request breast cancer services in 2010-11. The caseload has increased steadily over the life of the program.

When women who are screened through the EWC program are diagnosed with breast cancer, they are referred to the state's breast cancer treatment program, under Medi-Cal, for treatment. This program has a state-only component for women who do not qualify for federal financial participation due to immigration status; treatment for women in the state-only program is limited to 18 months.

EWC Budget

The EWC receives no General Fund support and has three funding sources: 1) Prop 99 – its primary funding source; 2) the Breast Cancer Control Account – the secondary two cent tobacco tax revenue, described above; and, 3) a federal CDC grant. The program's budget is summarized in the table below:

EVERY WOMAN COUNTS PROGRAM BUDGET		
FUND	Actual 2009-10	Proposed 2010-11
Prop 99 (Local Assistance)	\$22,081,000	\$22,081,000
Breast Cancer Control Account (Local Assistance)	\$17,877,000	\$6,661,000
Breast Cancer Control Account (State Support)	\$8,022,000	\$7,373,000
State Funding Total	\$47,980,000	\$36,115,000
CDC Federal Grant	\$6,324,811	\$6,324,811
Total Funding	\$54,304,811	\$42,439,811

The program is currently facing an extreme funding shortage which DPH states is the result of two concurrent trends over the past several years: 1) increasing caseload; and, 2) decreasing tobacco tax revenue. Also, the 2009 Budget Act shifted \$4.5 million of Proposition 99 funds from the EWC to backfill General Fund in Medi-Cal.

In order to address the projected funding shortfall in the program, DPH announced the following two significant policy changes to the program which were put into effect on January 1st, 2010:

- 1) A permanent increase in the minimum age eligibility for breast cancer screening services from age 40 to age 50; and,
- 2) A temporary six month enrollment freeze for all women seeking breast cancer screening services from January 1 through June 30th, 2010.

The projected savings from both of these actions is \$16 million in the current year and \$25 million in the budget year. The Governor also proposed in his January 2010 budget an additional reduction to this program of \$5.2 million in Breast Cancer Control Account funds reflecting the continuing decline in available resources from this fund (as discussed again under DPH BCPs).

DPH projects that these two program restrictions will result in 100,000 fewer women being screened through the program in the current year than otherwise would have been. DPH also states that approximately 1 percent of the women screened ultimately are diagnosed with cancer. Therefore, approximately 1,000 women with breast cancer are not being screened, thereby delaying their diagnosis and treatment, and increasing their mortality rate.

Audits

The Office of Statewide Audits and Evaluations (OSAE), within the Department of Finance, has completed an audit of the program which is expected to be released in time to inform the May Revision.

Assemblymembers Evans and Nava jointly requested an audit, which was approved by the Joint Legislative Audit Committee (JLAC), to be done by the Bureau of State Audits, completion of which is anticipated on June 10th, 2010.

Legislation

Assemblymember Evans has introduced AB 1640 which seeks to require DPH to provide at least a 90-day notice to the Legislature on intended changes to the EWC. Senator Oropeza has introduced SB 836 to require the EWC to provide services to women 40 years old or older and to all individuals, regardless of age, who are exhibiting symptoms.

Estimate

It has been difficult for the Legislature to provide adequate oversight of this program due to the absence of sufficient detail in the Governor's budgets on the program, as well as inadequate communication from the DPH. Therefore, the Subcommittee may wish to take action to require DPH to provide an estimate on the program, to be included in the Governor's annual proposed budget. An estimate package is standard for large caseload-driven programs such as Medi-Cal, Healthy Families, and many others. In 2008, the Legislature established a requirement that the DPH provide an estimate on the AIDS Drug Assistance Program (ADAP) as a solution to insufficient budget detail being provided by the Administration. The Legislature has found the first two ADAP estimates to be quite helpful.

Trigger Proposal

As part of the package of "trigger" proposals, the Governor has proposed elimination of all \$22 million in remaining Proposition 99 funds from the EWC in order to backfill General Fund in Medi-Cal, for General Fund savings of \$22 million. DPH estimates that if all Prop 99 funds were taken out of the EWC, the program would have sufficient resources to serve 62,000 women, as compared to the current demand of 350,000.

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ISSUE 5: PROSTATE CANCER TREATMENT PROGRAM

In order to be eligible for the Prostate Cancer Treatment program, men must be at least 18 years old, under 200 percent FPL, have already been diagnosed with prostate cancer, and have no other means to pay for treatment. According to UCLA, the contractor that runs the program, the program has run out of funds as a result of increasing demand combined with increased treatment costs.

The Prostate Cancer Treatment program received \$3.1 million General Fund in 2009-10. The program receives no other funding, except for substantial in-kind support from UCLA, including:

- Donation of 25% effort support of the Program and Medical Director;
- Donation of the time of the Executive Committee, which provides direction to the program regarding treatment strategies;
- Provision of salary support not covered by the contract for the Program Administrator, all nurse case managers, and various staff who provide support throughout the year on mandated reports to the Legislature or state agencies; and,
- Donation of all computer support.

While not a formal proposed reduction, the Prostate Cancer Treatment Program has run short of funds in the last month, in light of increasing treatment costs and increasing demand for the program, and therefore has instituted an enrollment cap and waiting list which currently has 36 men.

In the early years of this program, its budget was large enough that funding was carried over to the following year for several years in a row. However, as demand has increased, costs have increased, appropriations have decreased, and carry-over funds have dried up.

The Legislature and the program itself have undertaken various efforts to reduce costs including: 1) instituting a 13 percent cap on administration of the program; 2) successfully negotiating a new pharmaceutical contract which reduced the cost of hormone treatment by two-thirds; and 3) eliminating funding for outreach, community education, and recruitment.

HISTORY OF FUNDING FOR PROSTATE CANCER TREATMENT PROGRAM	
YEAR	TOTAL FUNDS
2001-02	\$16,742,380 (TF)
2002-03	\$9,614,753 (TF)
2003-04	\$4,614,753 9 (GF)
2004-05	\$5,929,954 (GF)
2005-06	\$2,404,000 (GF)
2006-07	\$3,178,000 (GF)
2007-08	\$3,178,000 (GF)
2008-09	\$3,010,050 (GF)
2009-10	\$3,010,500 (GF)
Proposed 2010-11	\$3.1 million (GF)
TF = Tobacco Settlement Funds GF = General Funds	

According to the Impact Program, the contractor at UCLA that operates the program, an increase of \$1.5 million in funding, for total funding of \$4.5 million General Fund, would ensure sufficient resources to meet the demand for the program and eliminate the waiting list. This amount recognizes the fact that evidence suggests that more than 5,000 men in California are eligible for the program, however the program serves fewer than 500 men per year due to limited funds, and therefore the absence of outreach for the program.

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ISSUE 6: ASTHMA PUBLIC HEALTH INITIATIVE

The 2009 Budget Act shifted \$438,000 of Proposition 99 funds from the California Asthma Public Health Initiative (CAPI) to backfill General Fund in Medi-Cal for General Fund savings of \$438,000.

The CAPI used to provide local assistance to ten community health centers serving a combined population of approximately 9,000 children with asthma in underserved communities. All ten of these contracts were cancelled as a result of this fund shift. The program also administers a local assistance program with central valley health departments designed to reach as many people with asthma, of all ages, as possible. Until this past year, the program worked with five counties (Fresno, Stanislaus, Kern, Tulare, and Madera); however this budget cut resulted in Tulare and Madera pulling out of the program. The three remaining counties reach an estimated 365,000 people.

The program also conducts four clinical collaboratives to promote improved pediatric asthma care. DPH states that these collaboratives have directly impacted over 25,000 children resulting in significant clinical care improvements, reduced morbidity, decreased emergency visits and hospitalizations. Finally, CAPI provides statewide asthma clinical expertise to health care providers and individuals affected by asthma.

TRIGGER PROPOSAL

Included in the package of “trigger” proposals, the Governor has proposed shifting all \$1.2 million in remaining Proposition 99 funds in the AAPI to backfill General Fund dollars in Medi-Cal, for General Fund savings of \$1.2 million. This would eliminate the AAPI.

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ISSUE 7: OFFICE OF AIDS PROGRAMS – GOVERNOR’S 2009 VETO
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In the 2009 May Revise, the Governor proposed elimination of most General Fund support for Office of AIDS programs. The Legislature rejected this proposal and instead agreed to much more modest reductions as follows:

AIDS Drug Assistance Program (\$.5 million); Therapeutic Monitoring (\$.7 million); Education and Prevention (\$2.2 million); Counseling and Testing (\$0); Early Intervention (\$0); Home & Community Based Care (\$.5 million); Surveillance & Epidemiologic Studies (\$1 million); Housing (\$.1 million); and state operations (\$3.4 million).

Nevertheless, the Governor subsequently vetoed all remaining \$52.1 million in General Fund support for these programs (excluding ADAP and Epidemiological Studies/Surveillance), per the table below.

Table: Office of AIDS Budget Detail
(Dollars in Millions)

PROGRAM NAME	2008-2009			2009-2010		
	GF	FF	TOTAL	GF	FF	TOTAL
Education & Prevention	\$24.6	\$6.4	\$31	\$0	\$6.4	\$6.4
HIV Counseling & Testing	\$8.2	\$2.5	\$10.7	\$0	\$2.5	\$2.5
Epidemiological Studies/Surveillance	\$8.6	\$1.5	\$10.2	\$7.6	\$1.5	\$9.2
Early Intervention	\$7.4	\$6.9	\$14.4	\$0	\$6.9	\$6.9
Therapeutic Monitoring	\$8	\$0	\$8	\$0	\$0	\$0
AIDS Drug Assistance Program	\$96.3	\$88.4	\$356.3	\$70.8	\$92.9	\$414
Housing	\$1.1	\$3.5	\$4.6	\$0	\$3.5	\$3.5
Home & Community Based Care	\$6.3	\$5.4	\$11.7	\$0	\$5.4	\$5.4

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ISSUE 8: ADAP ESTIMATE**Budget Issues**

The DPH proposes total expenditures of \$462.1 million (\$158.3 million General Fund, \$210.9 million ADAP Rebate Fund, and \$92.9 million Federal Funds) for ADAP. This reflects a *net* increase of \$42.2 million (increase of \$87.5 million General Fund and a *decrease* of \$45.2 million ADAP Rebate Fund).

Background

The AIDS Drug Assistance Program (ADAP) was established in 1987 to help ensure that HIV-positive uninsured and underinsured individuals have access to drug therapies.

Beginning in 1997, California contracted with a pharmacy benefit manager (PBM) to centralize the purchase and distribution of drugs under ADAP. Presently, there are over 200 ADAP enrollment sites and over 4,000 pharmacies available to clients located throughout the state.

The state provides reimbursement for drug therapies listed on the ADAP formulary (over 180 drugs). The formulary includes antiretrovirals (about 30), opportunistic infection drugs, hypolipidemics, anti-depressants, vaccines, analgesics, and antibiotics. Since the AIDS virus can quickly mutate in response to a single drug, medical protocol calls for inclusion of at least three different anti-viral drugs for patients.

ADAP is a subsidy program for low and moderate income persons with HIV/AIDS. Under the program, eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor (i.e., the pharmacy benefit manager). Individuals are eligible for ADAP if they:

- Are a resident of California;
- Are HIV-infected;
- Are 18 years of age or older;
- Have an adjusted federal income that does not exceed \$50,000;
- Have a valid prescription from a licensed CA physician; and
- Lack private insurance that covers the medications or do not qualify for no-cost Medi-Cal.

ADAP clients with incomes between \$43,320 (400 percent of poverty as of April 1, 2009) and \$50,000 are charged monthly co-pays for their drug coverage. A typical client's copayment obligation is calculated using the client's taxable income from a tax return. The client's copayment is the lesser of (1) twice their annual state income tax liability, less funds expended by the person for health insurance premiums, or (2) the cost of the drugs.

Summary of ADAP Caseload

The ADAP is the payer of last resort. Individuals who have private health insurance, are eligible for Medi-Cal, or are eligible for Medicare, must access these services first, before the ADAP will provide services. The following chart provides a summary of estimated ADAP client enrollment.

ADAP Clients by Coverage Group (2010-11)		
Coverage Group	Clients	Percent
ADAP-Only	22,006	59.2
Medi-Cal	454	1.2
Private	6,084	16.4
Medicare	8,602	23.2
TOTAL	37,146	100%

The ADAP is a core State program. Without ADAP assistance to obtain HIV/AIDS drugs, individuals would be forced to: 1) postpone treatment until disabled and Medi-Cal eligible; or 2) spend down their assets to qualify, increasing expenditures under Medi-Cal. According to the Administration, typically 50 percent of Medi-Cal costs are borne by the state, whereas only 30 percent of ADAP costs are borne by the state.

Studies consistently show that early intervention and treatment adherence with HIV/AIDS-related drugs prolongs life, minimizes related consequences of more serious illnesses, reduces more costly treatments, and increases an HIV-infected person's health and productivity.

The Table below provides a detailed summary of each ADAP component.

Detailed Comparison of ADAP Adjustments as proposed in January			
ADAP Local Assistance Components	2009-10 Revised January	Budget Year 201-11	Difference
Basic Prescription Costs	\$405,297,000	\$456,950,000	\$51,653,000
Eliminate Services to Jails	0	-\$10,889,000	-\$10,889,000
Subtotal of Prescription Costs	\$405,297,000	\$446,061,000	\$40,764,000
Basic Pharmacy Benefit Manager	\$12,966,000	\$14,782,000	\$1,816,000
Administrative Reduction from 2009 (PBM)	-\$500,000	-\$500,000	--
Eliminate Services to Jails	0	-348,000	-\$348,000
Subtotal PBM Operations	\$12,466,000	\$13,934,000	\$1,468,000
TOTAL Drug Expenditures	\$417,763,000	\$459,995,000	\$42,232,000
Local Health Officers: Administration of Enrollment & Eligibility	\$1,000,000	\$1,000,000	--
Medicare Part D Premiums	\$1,000,000	\$1,000,000	--
Tropism Assay (for clinical indication)	\$133,000	\$133,000	--
TOTAL Support and Administration	\$2,133,000	\$2,133,000	--
TOTAL EXPENDITURES	\$419,896,000	\$462,128,000	\$42,232,000
General Fund	\$70,849,000	\$158,311,000	\$87,462,000
Drug Rebate Funds	\$256,120,000	\$210,890,000	-\$45,230,000
Federal Funds	\$92,927,000	\$92,927,000	--

The following budget issues affect ADAP:

Prescription Expenditure Increase

The basic prescription expenditure is estimated to increase by \$51.6 million (total funds), prior to the Administration's proposed adjustment for elimination of funding to certain counties for incarcerated individuals. The ADAP states that about 88 percent of drug expenditures are for antiretroviral drugs.

The Office of AIDS states there are two key reasons for the increases in prescription drug expenditures. First, drug costs are increasing, including anti-retrovirals. Second, caseload has also increased from 35,611 clients in 2008 to about 37,146 clients for 2010-11 (estimated in January), or an increase of 1,535 people over about an 18-month period. The May Revision will provide an update on estimated drug expenditures and client caseload.

Reduction of \$11.2 million to Discontinue ADAP in Jails

This issue was heard by the Subcommittee during Special Session (February 11th hearing), and is discussed in more detail in the next issue in this agenda.

ADAP Rebate Fund

Drug rebates constitute a significant part of the annual ADAP budget. This special fund captures all drug rebates associated with ADAP, including *both* mandatory (required by federal Medicaid law) and voluntary supplemental rebates (additional rebates negotiated with 14 drug manufacturers through ADAP Taskforce). Generally, for every dollar of ADAP drug expenditure, the program obtains 46 cents in rebates. This 46 percent level is based on an average of rebate collections (both "mandatory" and "supplemental" rebates).

It should be noted the federal Patient Protection and Affordable Care Act, signed by President Obama in March, makes changes to the federal mandatory Medicaid rebate calculation which may impact ADAP. Specifically, the federal Medicaid rebate calculation was increased for both brand name drugs (from 15.1 percent to 23 percent of "average manufacturer price"), and generic drugs (from 11 percent to 13 percent), effective as of January 1, 2010 (retroactive). The Office of AIDS notes they are seeking additional information regarding the increased rebates under Medicaid to discern how ADAP may be affected. In addition, California and several other large States negotiate additional supplemental rebates from manufacturers of anti-retroviral drugs through the ADAP Taskforce. The ADAP Taskforce will be meeting in early May to encourage manufacturers of antiretroviral drugs to implement price freezes and encourage additional supplemental rebates.

The Office of AIDS will update the ADAP Rebate Fund projections at May Revision, including addressing the potential for increased rebates due to the new federal Patient Protection and Affordable Care Act, as well as discussions regarding supplemental rebates. If ADAP Rebate Fund revenue is increased, General Fund support may be offset.

Medicare Part D and "True-Out-Of-Pocket (TrOOP)"

California's ADAP interacts with the federal Medicare Part D drug benefit, implemented in 2006. The income level and assets of federal Medicare Part D enrollees determines the level of prescription assistance they receive under the federal program. The ADAP is the payer of last resort and serves as a *wrap-around* for enrolled clients because it is cost-beneficial to the State.

A Medicare Part D enrollee's TrOOP spending— a person's prescription payment obligation during the Medicare Part D coverage gap, or "donut hole"—determines how one advances

through the various Part D coverage levels. This rule typically leads to ADAP clients (who are also in Medicare Part D) remaining “stuck” in the Part D coverage gap, and thus shifting more to ADAP coverage for this period.

The new federal Patient Protection and Affordable Care Act allows for ADAP expenditures to count towards a person’s “TrOOP” effective as of January 1, 2011. As such, federal Medicare Part D coverage will provide more support, and ADAP will experience savings from this action.

The Office of AIDS states the May Revision will reflect an adjustment for this good federal news, and that a small amount of General Fund savings is likely (possibly \$1 million to \$2 million or so).

Update on Ryan White HIV/AIDS Federal Funding

In April, the federal HRSA informed the DPH of California’s award of federal Ryan White HIV/AIDS grant funds. The table below provides a summary.

California’s Award of Federal Ryan White HIV/AIDS grant funds			
Component	Purpose	Federal Amount	Increase
AIDS Drug Assistance	ADAP—drug expenditures	\$98,809,000	\$4,705,000
Base	HIV Care	\$34,685,000	\$692,000
Minority AIDS Initiative	Local Health Jurisdictions	\$936,000	\$207,000
Emerging Communities	HIV Care	\$175,000	\$10,000
TOTAL		\$134,605,000	\$5,614,000

As noted in the table, the ADAP is to receive an increase of \$4.7 million (federal funds) for 2010-11. The Office of AIDS will account for this change at the May Revision.

Office of AIDS Request for Application for Pharmacy Benefit Manager

On March 26, the Office of AIDS released a Request for Proposals (RFP) to provide pharmacy services and claims processing for the ADAP. The existing PBM contract will be expiring on June 30, 2010.

The contract term in the RFP would provide for a 3-year term, with an option of two one-year extensions. According to the RFP, the notice of intent to award is to be made by May 20, 2010. The Office of AIDS has modified some of the administration overhead provisions and anticipates some savings from these actions.

Proposed Use of ADAP as “Certified Public Expenditure (CPE) in 1115 Waiver

The DHCS proposes to utilize State CPE from the ADAP, along with other programs, to draw federal funds under the existing Hospital Financing Waiver in the Medi-Cal Program.

For the DHCS to claim CPE, there needs to be clarity that these funds are not otherwise being used to match other federal funds (cannot use funds to match federal dollars multiple times). However, the ADAP does recognize a portion of their expenditures for federal purposes in order to obtain federal Ryan White CARE Act funds.

According to the DHCS, the amount of CPE being counted from ADAP is a maximum of \$144 million. Of this amount, the DHCS states they will be recognizing \$65 million for 7 months (i.e., existing Hospital Finance Waiver amendment from February 1, 2010 to August 30, 2010). The DHCS states they have accounted for all maintenance of effort (MOE) requirements with the Ryan White CARE Act, as well as with the federal HRSA.

The DHCS states that there would be no impact to ADAP and that no changes to ADAP systems would be needed.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the Office of AIDS to provide an overview of the ADAP program, its budget estimate, and any other issues related to ADAP that the Legislature should be aware of.

Subcommittee Action Here

The Senate Budget Subcommittee adopted the following placeholder trailer bill language regarding the use of ADAP as a certified public expenditure in the event it is identified to be used for this purpose under a DHCS federal Waiver. (This issue is presently pending in a Waiver amendment to the Hospital Financing Waiver.) The adopted language is as follows:

“In the event State expenditures for the AIDS Drug Assistance Program (ADAP) are identified by California to be used as a certified public expenditure for the purpose of obtaining federal financial participation under the State’s Medi-Cal Program for any purpose, including federal demonstration waivers, the Department of Health Care Services and the Department of Public Health shall ensure the integrity of the ADAP in meeting its maintenance of effort requirements to receive federal funds, and to obtain all ADAP drug rebates to support the ADAP. The Department of Health Care Services and the Department of Public Health shall keep the policy and fiscal committees of the Legislature informed of any potential concerns that may arise in the event the ADAP is used as a state certified expenditure as noted.”

ISSUE 9: AIDS DRUG ASSISTANCE PROGRAM – COUNTY JAILS**Budget Issue**

The Governor proposes legislation to amend Section 120955 of Health & Safety Code regarding ADAP which would make an inmate residing in a city or county jail ineligible to receive HIV/AIDS medications under ADAP effective July 1, 2010. The Administration states that \$9.5 million (General Fund) would be saved from taking this action and would be invested within the ADAP to assist in meeting state expenditures in 2010-11. The Administration states that local health jurisdictions are legally responsible for inmate care in jails. The DPH also estimates that the total increased cost to 36 counties to be approximately \$11 million.

Background

ADAP contracts with a Pharmacy Benefit Manager (PBM) which reimburses pharmacies for dispensed medications. ADAP began serving inmates in county jails in 1994 due to the increasing fiscal impact on local health jurisdictions in meeting their mandate to provide medical services to their incarcerated populations. The ADAP's PBM contracts with either the in-house county jail pharmacy, or with the county's pharmacy service provider, to provide reimbursement for medications. Thirty-six counties receive reimbursement for medications from ADAP to serve individuals in 44 jails. About 2,027 incarcerated individuals would be affected by this proposal. Existing statutes in both the Government and Penal Codes state the responsibility of local governments to provide medical care to inmates in local jails.

This proposal can be viewed as a cost shift from the state to counties, as compared to a reduction in services. The DPH did an extensive analysis of the feasibility of allowing counties to purchase the drugs through the state's ADAP program and found: 1) it would result in minimal savings; 2) substantial administrative work would be required; and 3) it likely would be a violation of federal law.

The Office of AIDS notes that five counties—San Francisco, Santa Clara, San Diego, Contra Costa and Los Angeles— support their own jail programs. Santa Clara County is able to access 340b federal pricing through their county hospital (Valley Medical Center). Perhaps other counties can establish relationships through their Local Health Jurisdictions to access this low-cost pricing via hospitals or applicable clinics.

Subcommittee Action

ISSUE 10: GENETIC DISEASE TESTING PROGRAM - PRENATAL AND NEWBORN PROGRAMS
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Budget Issue

The DPH proposes total expenditures of \$95.2 million (Genetic Disease Testing Fund) for local assistance. This reflects a net increase of \$472,000 (Genetic Disease Testing Fund) as compared to the current-year. This program is fully fee-supported. The proposed expenditures for each of the programs are outlined below.

GENETIC DISEASE TESTING PROGRAM EXPENDITURES		
Program & Component	Total for 2010-11	Adjustment Over Current Year
Prenatal Screening:		
Contract Laboratories	\$5,090,000	\$0
Technology Support	\$13,146,000	\$165,000
Systems Development, Equipment & Testing	\$6,485,000	\$0
Follow-up Costs	\$6,110,000	\$1,132,000
Prenatal Diagnostic Centers	\$17,426,000	-\$765,000
Result Reporting & Fee Collection	\$1,310,000	\$0
TOTAL	\$49,567,000	\$532,000
Newborn Screening:		
Contract Laboratories	\$7,429,000	\$0
Technology Support	\$23,497,000	\$47,000
Systems Development, Equipment & Testing	\$4,222,000	\$0
Follow-up Costs	\$5,834,000	-\$193,000
Newborn Diagnostic Centers	\$3,366,000	\$86,000
Result Reporting & Fee Collection	\$1,290,000	\$0
TOTAL	\$45,638,000	-\$60,000
TOTAL for Genetic Disease Testing Program	\$95,205,000	\$472,000

As noted in the Table above, the Prenatal Screening Program reflects net increased costs of \$532,000 (Genetic Disease Testing Fund). The DPH states most of these increased expenditures are attributable to costs associated with providing additional testing, follow-up, and diagnostic services associated with the "First Trimester" test expansion implemented in 2009. With the addition of the First Trimester test, women will be able to receive screening services in both trimesters (traditionally it has occurred only in the second trimester).

Expenditures for the Newborn Screening Program remain relatively stable and reflect no new policy issues.

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*** screens pregnant women who consent to screening for serious birth defects. The fee paid for this screening is \$162 dollars. 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*** screens all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is \$103 dollars. 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 76 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 which mitigates more severe health problems. Informational material is provided to parents, hospitals and other health care entities regarding the program and the relevant conditions and referral information is provided where applicable.

Repayment of Previous General Fund Loan

The Genetic Disease Testing Fund received two loans from the General Fund in past years in order to maintain solvency. The outstanding principle balance is \$4.24 million (General Fund). A loan repayment of \$3 million is reflected for 2009, and another payment of \$1.2 million is reflected in 2010-11.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to provide an overview of the Genetic Disease Testing Program and its proposed budget.

ISSUE 11: VALLEY FEVER AUGMENTATION**Budget Issue**

The DPH proposes to expend \$1 million (General Fund) in 2010-11 for Valley Fever research and related activities. This is a proposed continuation of a one-time only appropriation made in 2009-10.

Existing law provides for the DPH to contract with the Valley Fever Vaccine Project, a nonprofit organization, to distribute grants from funds appropriated by the Legislature for Valley Fever research to develop a vaccine. The Legislature has provided one-time appropriations in various fiscal years, including the following:

- \$700,000 in 1997-98
- \$3 million in 1998-99
- \$500,000 in 2001-02
- \$350,000 in 2002-03
- \$750,000 in 2003-04
- \$1 million in 2009-2010

Background

Valley Fever is an illness that usually affects the lungs. It is caused by a fungus called *Coccidioides*. *Coccidioides* lives in the dirt. The spores become airborne when the uncultivated soil is disturbed and then they are inhaled. It is found in portions of the Sacramento Valley, all of the San Joaquin Valley, desert regions and southern portions of California, much of the Southwest, Northern Mexico and some areas of Central America.

About 150,000 infections occur each year in the United States, although over 60 percent of these infections do not produce symptoms. For some, it may feel like a cold or the flu. For those who become sick, pneumonia-like symptoms, requiring medication and bed rest, can result. For those severely affected, meningitis can result. Valley Fever is diagnosed through an antibody blood test or culture.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to describe this proposal and provide California-specific morbidity and mortality statistics for Valley Fever.

Subcommittee Action Here

ISSUE 12: AMBULATORY SURGICAL CENTERS LICENSING***Ambulatory Surgical Centers***

Ambulatory Surgical Centers (ASCs) are health care facilities that specialize in providing surgery, pain management and certain diagnostic (e.g., colonoscopy) services in an outpatient setting. Since the first ASC was established in 1970, many procedures that used to be performed exclusively in hospitals began taking place in ASCs such as knee, shoulder, eye, spine, and other surgeries. Most ASCs are certified by Medicare and accredited by one of the major health care accrediting organizations. Stand-alone ASCs rarely have a single owner and most involve at least some physician ownership. Physician partners who perform surgeries in the center will often own at least some part of the facility, but ownership percentages vary considerably. Some ASCs are entirely physician-owned and some have a development or management company that owns a percentage of a center. According to a 2008 article in *Health Affairs*, in 2003, there were an estimated 3,800 ASCs operational nationally, with more than 40% owned by physicians and another 40% in joint physician-hospital or physician-corporate ventures. From 2000 to 2006, the number of ASCs grew by 55%.

Medicare Certification

The federal Centers for Medicare and Medicaid Services (CMS) develops Conditions of Participation and Conditions for Coverage that are minimum standards a health care organization must meet in order to participate in the Medicare and Medicaid programs. Certification as a surgical clinic is limited to any distinct entity that operates exclusively for purposes of providing surgical services to patients not requiring hospitalization. A surgical clinic may be either hospital-operated or independent. However, it must be physically and administratively distinct from other operations of the hospital and be able to identify its costs separately from other hospital costs.

According to CMS, covered procedures performed in certified ASCs are those that generally do not exceed 90 minutes in length and do not require more than four hours recovery or convalescent time. The surgical clinic may not perform a surgical procedure on a Medicare beneficiary when, before surgery, an overnight hospital stay is anticipated. Anticipated extended care in a non-hospital health care setting as a result of a particular procedure is not a covered surgical clinic procedure for Medicare beneficiaries.

Board of Pharmacy Licensure Requirement

Under existing law, the surgical clinic, outpatient setting, or ASC is required to comply with all applicable laws and regulations enforced by DPH and the Board of Pharmacy, relating to drug distribution, in order to ensure that inventories, security procedures, training, protocol development, recordkeeping, packaging, labeling, dispensing, and patient consultation are carried out in a manner that is consistent with the promotion and protection of the health and safety of the public.

Capen V. Shewry

In 2007, a California appellate court ruled that ASCs owned, in whole or in part, by physicians, would no longer be eligible for licensure by DPH. As a result, DPH ceased licensure activities of ASCs owned by physicians, although it continued to perform Medicare certification for those facilities. Prior to the Capen v. Shewry ruling, DPH interpreted the exemption from licensure in law for physician-owned clinics to mean that each licensed health practitioner at the clinic had to have at least some share in the ownership (or leasehold) and operation of the clinic. DPH interpreted the law in this way to ensure that a practitioner at the clinic could not disclaim

responsibility for its operation should a problem arise. Although following Capen v. Shewry, DPH is not renewing or granting any licenses to a surgical clinic with any degree of physician ownership, it continues to certify these centers for Medicare purposes.

Current law allows the Board to issue pharmacy permits to state licensed individuals or entities. Because physician-owned ASCs are now deemed “unlicensed” by the state, the authority of the Board to issue permits may be unclear. Currently, the Board is issuing permits through the Drug Enforcement Agency (DEA) number of the medical directors of these clinics, but is re-evaluating its authority to do so. This process imposes substantial demand and liability on the medical director; and should the board cease to issue permits at all, each physician-owned ASC would have to completely redesign how medications are procured and distributed to patients, with each physician having to use their individual DEA number to order drugs for their patients.

Given that patients come to ASCs for a wide range of surgeries as well as diagnostic procedures, the prescription products in jeopardy are a large and complex variety of intravenous drugs used for general anesthesia, sedation and recovery room care, as well as, emergency drugs to manage a variety of potential medical emergencies, ranging from cardiovascular instability and cardiac arrest, to anaphylactic shock, pulmonary decompensation, and life threatening reactions to general anesthesia. The potential impact of the loss of pharmacy permits to the medical directors of these clinics is substantial to California’s healthcare delivery system, as most clinics and their surgeons cannot be expected to operate their own “individual” pharmacy and continue to provide the high quality, low cost care to patients. As a result, many patients would not be able to obtain surgery at these centers and would be required to receive care at higher cost locations.

Substantial legislation has been pursued in an effort to resolve the problems created by this lack of licensure, including the following:

- a) AB 832 (Jones) of 2009 would have required DPH to convene a workgroup to develop recommendations regarding the oversight of ASCs to address issues raised in Capen v. Shewry. AB 832 died on Suspense in Assembly Appropriations Committee.
- b) AB 1574 (Plescia) of 2008 would have required the Board to inspect outpatient settings and ASCs within 120 days of issuing a clinic license and then at least annually thereafter. AB 1574 was vetoed by Governor Schwarzenegger who stated that the bill failed to address the larger issue concerning the Capen v. Shewry ruling.
- c) AB 2122 (Plescia) of 2008 would have required surgical clinics to meet prescribed licensing requirements and standards, including compliance with Medicare conditions of participation, and also contained provisions nearly identical to those proposed in AB 1574. AB 2122 died in Assembly Appropriations Committee.
- d) AB 543 (Plescia) of 2007 also would have required surgical clinics to meet specified operating and staffing standards, to limit surgical procedures, as specified, and to develop and implement policies and procedures consistent with Medicare conditions of participation, including interpretive guidelines. AB 543 was vetoed by Governor Schwarzenegger who stated that the bill did not establish appropriate time limits for performing surgery under general anesthesia, inappropriately restricted administrative flexibility, and created fiscal pressure during ongoing budget challenges.

- e) AB 2308 (Plescia) of 2006 would have required the Department of Health Services (now DPH) to convene a workgroup to develop licensure criteria to protect patients receiving care in surgical clinics, and to submit workgroup conclusions and recommendations to the appropriate policy committees of the Legislature no later than March 1, 2007. AB 2308 also would have revised existing law to replace the term "licensed surgical clinic" with "ambulatory surgical centers" or "ASCs." AB 2308 was vetoed by Governor Schwarzenegger, who stated that the bill did not establish clear licensing standards for surgical clinics.

Currently, AB 2292 (Lowenthal) permits the Board of Pharmacy to grant a limited license to a clinic that is certified as an ASC for participation in the Medicare program or accredited as an outpatient setting to allow them to purchase drugs at wholesale for administration or dispensing to clinic patients for pain and nausea under the direction of a physician. AB 2292 also allows the Board to conduct inspections of these clinics at any time in order to determine whether a clinic is operating in compliance with the law.

STAFF COMMENTS & QUESTIONS

The Subcommittee has asked the DPH to provide an overview of the history of ASC licensure and what policy solutions the Governor would support.

DPH SPRING FINANCE LETTERS & BUDGET CHANGE PROPOSALS

ISSUE 1: AB 32 POSITION REQUEST (SFL)

Budget Issue

The DPH is requesting budget authority and funding (\$299,000 in 2010-11 special funds) for 3 positions to provide expertise and assistance in the implementation of AB 32. The funding for these positions will be a direct appropriation from the California Environmental Protection Agency (Cal/EPA), Air Resources Board (ARB) AB 32 administrative fees. The 3 positions will be redirected from within DPH, therefore no new positions are being requested.

Background

AB 32 (Nuñez, Pavley, Chapter 488, Statutes of 2006), the Global Warming Solutions Act of 2006, sets a greenhouse gas emissions reduction goal into law – to reach 1990 emission levels by 2020. Under Executive Order, the Governor directed the Cal/EPA to coordinate multi-agency efforts to meet the AB 32 goal and created the Climate Action Team (CAT) for this purpose. Recently, the Cal/EPA invited the DPH Director to participate in the CAT, and to create a CAT Public Health Work Group in order to provide public health input into the AB 32 implementation process, as well as other public health issues related to climate change. This Work Group has met over the past year and has developed a work plan for public health activities. This proposal seeks to fund the activities within the work plan that pertain specifically to AB 32.

The AB 32 Administrative fee will be levied against industries responsible for producing greenhouse gas emissions, and, according to the DPH, will begin in 2010. Cal/EPA is in support of this proposal.

STAFF COMMENTS & QUESTIONS

The Subcommittee has asked the DPH to provide an overview of the proposal and answer the following question:

When will the AB 32 administrative fee begin being levied?

Subcommittee Action Here

ISSUE 2: ARRA GRANT FOR ENVIRONMENTAL CHANGE AND TOBACCO CESSATION (SFL)**Budget Issue**

Through a Spring Finance Letter, the DPH is requesting expenditure authority to receive \$4.7 million in American Recovery and Reinvestment Act of 2009 (ARRA) federal funds, through the federal Centers for Disease Control and Prevention (CDC). This is a supplement or continuation of a grant that the state first received in April of 2009, called: "Healthy Communities, Tobacco Control, Diabetes Prevention and Control, and Behavioral Risk Factor Surveillance System."

The time period for the grant began February 4, 2010 and ends February 3, 2012. No state match is required and a Section 28 letter was submitted on March 3, 2010 to request current year budget authority. Five positions to support this program were administratively established on April 1, 2010, and the positions were redirected from within the department.

Background

This grant includes the following two components:

Component I: "Statewide Policy and Environmental Change (Nutrition, Physical Activity, and Tobacco)" (\$2.2 million)

This funding will enable the DPH to expand its core activities to improve nutrition, increase physical activity, decrease overweight/obesity, and decrease smoking and exposure to secondhand smoke. Specifically, the DPH will seek to:

1. Reduce the consumption of sugar-sweetened electrolyte beverages ("sports drinks") – health education activities to advance policy changes that address the sale of sugar-sweetened beverages in public schools, and utilize media strategies to counter unhealthy drink choices. (\$733,334)
2. Foster safe and equitable access to school facilities during non-school hours for physical activity – work with stakeholders to enable schools to be open during non-school hours, including mini-grants to low-resource communities which will serve as pilot sites. (\$733,334)
3. Reduce secondhand smoke by requiring 100 percent tobacco-free school campuses and worksites – the CDC requires states that are not designated by the CDC as 100 percent smoke-free to work through statewide policy and environmental change objectives to increase workplace secondhand smoke protection. The CDC's definition of a 100 percent smoke-free state is one that does not include exemptions such as ventilation or partial smoking areas in enclosed spaces. California's laws include exemptions and therefore the state does not meet the CDC definition. (\$733,334)

Component III: "Tobacco Cessation through Quitlines and Media" (\$2.5 million)

The goals of this component include:

1. Increase the number of tobacco users who receive proactive cessation counseling by 11,000 over 24 months (22,632 tobacco users were counseled in 2009);
2. Expand promotion of the California Smokers' Helpline statewide through mass media, health care provider outreach, and a digital advertising campaign targeting young adults, military, and college students;
3. Conduct a free nicotine replacement therapy pilot project; and
4. Increase the capacity, and expand evaluation, of Helpline.

STAFF COMMENTS & QUESTIONS

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

Subcommittee Action Here

ISSUE 3: UMBILICAL CORD BLOOD BANKING (SFL)**Budget Issue**

The DPH requests an increase of \$471,000 (one-time federal grant funds) to support the collection and storage of publicly donated and ethnically diverse umbilical cord blood in California for use in transplantation. These grant funds are provided through a Congressional Special Initiative grant award and can only be used for this purpose. This is one-time funding and is to be expended in 2010-11.

Of the total federal grant amount, \$120,000 would be used to engage a contractor to: 1) develop a "Request for Proposal" for the cord blood bank; 2) oversee all implementation and evaluation activities; and 3) monitor the contract with the established cord blood bank.

The \$120,000 amount is the maximum the federal grant allows for this purpose. According to the DPH, this contractor will consult with the federal Health Resources and Services Administration (HRSA) on the following:

- Developing cord blood collection protocols;
- Assisting with reviewing the contract bids;
- Implementing the contract agreement with the selected cord blood bank;
- Overseeing and managing the grant activities;
- Serving as the subject matter expert for the DPH;
- Providing status reports to HRSA as required; and
- Developing and implementing the grant performance evaluation.

The remaining amount of \$351,240 would be used to contract with a selected cord blood bank to collect, process, and store the cord blood from minority populations to diversify the national inventory of umbilical cord blood stem cell units that are available for transplantation.

The DPH states that the cord blood bank's collection and storage fee is a one-time fee inclusive of long-term storage. This is consistent with existing federal requirements. The DPH states that given the high cost associated with cord blood banking, the grant award will only enable collecting a limited number of cord blood units by the selected cord blood bank.

Summary of State and Federal Law

AB 34 (Portantino, Chapter 516, Statutes of 2007) established the Umbilical Cord Blood Collection Program for the purpose of collecting and storing umbilical cord blood for use in research and to add genetically diverse cord blood units to the national inventory. It requires, among other things, that any funds available for these purposes to be deposited into the Umbilical Cord Blood Collection Program Fund. The current AB 52, also authored by Portantino, seeks to provide a detailed structure for implementation of the Umbilical Cord Blood Collection Program.

The federal Stem Cell Therapeutic and Research Act of 2005 established a national umbilical cord blood network and authorized funding to collect and maintain cord blood stem cells for the treatment of patients and for research. As of 2009, there are nine banks contracted by HRSA to collect cord blood for the national inventory. This includes StemCyte, Incorporated located in Arcadia, California.

STAFF COMMENTS & QUESTIONS

As described above, Assemblymember Portantino has authored substantial legislation in this area, including AB 34 in 2007 and AB 52 this year. Therefore, the Assemblymember has taken a keen interest in this BCP and has expressed concerns to Subcommittee staff about some of the details included in the BCP narrative submitted by the DPH. Of most significance, the Assemblymember and his staff have raised the following concerns:

- 1) The DPH proposes to engage a contractor for one full year on a full-time basis, at a cost of \$120,000. Assemblymember Portantino states that standard contracts already exist for entities that collect cord blood in compliance with federal guidelines, and therefore this workload can be completed in 6 months, rather than a full-year, at half the cost.
- 2) The DPH proposes to contract with an "umbilical cord blood bank" for these purposes. Assemblymember Portantino states that the term "bank" is an inappropriately narrow term that will disqualify other types of "entities" that are equally qualified, such as the University of California.
- 3) The DPH proposal is silent on the role of the selected "bank" (or entity) in making cord blood samples that do not have sufficient cell dose for transplantation available for research. Assemblymember Portantino believes that it is critical to the future of cord blood research that the state do all that it can to encourage or even require, when possible, that cord blood units that cannot be used for transplantation be provided for research purposes.

Assemblymember Portantino has been in discussions with the DPH about his concerns; the DPH has explained that the specifics of the BCP have been dictated by HRSA requirements. To some degree, this may be reflective of the way the DPH is interpreting the HRSA requirements. The DPH has agreed to submit questions to HRSA to clarify these issues and states that they agree with the goal of making unusable cord blood samples available for research if it can be done without violating the HRSA requirements of this grant.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to provide an overview of this proposal and respond to Assemblymember Portantino's concerns, including any update on new clarifications from HRSA.

Subcommittee Action Here

ISSUE 4: REDUCTIONS FROM BREAST CANCER FUND ACCOUNTS (CD-06, CD-07)**Budget Issue**

The Administration requests decreased expenditure authority of \$393,000 in the Breast Cancer Research Account, and of \$5,212,000 (\$4,075,000 in local assistance and \$1,137,000 in state support) from the Breast Cancer Control Account.

Background

As described earlier in the agenda under Issue #4 on the Every Woman Counts Program, AB 478, the Cigarette Tax Increase: Breast Cancer Act of 1993, was enacted adding a 2 cent per cigarette pack tax to the existing taxes. The Breast Cancer Fund was established to receive revenue from this 2-cent tax and it is divided evenly between two sub-funds:

- The Breast Cancer Research Account (BCRA) – This fund receives 50 percent of the revenue, of which 90 percent funds University of California tobacco-related research and 10 percent funds the California Cancer Registry (CCR) – a collection of breast cancer-related data and epidemiological research by the DPH.
- The Breast Cancer Control Account (BCCA) – This fund receives 50 percent of the revenue, all of which is statutorily directed to fund the Every Woman Counts Program.

Tobacco taxes in general are a declining revenue source. Consequently, these two proposals reflect an anticipated decline in revenue in the Breast Cancer Fund. The BCRA reduction of \$393,000 is proposed to be reduced from funding for the CCR, not to UC research.

California Cancer Registry

According to the DPH, the CCR is "award winning" and one of the leading cancer registries in the world. CCR data helps identify where disparities exist and to identify disproportionately-affected populations, critical for prioritizing prevention strategies, early detection programs and cancer research. CCR data is also used to evaluate the effectiveness of cancer control programs.

University of California Tobacco Research

While there may be a vast array of tobacco-related research being done throughout the state, country and world, UC's research is unique in that it focuses specifically on California-specific aspects of tobacco-related diseases.

Every Woman Counts Program

As described in detail under Issue #4 specifically on this program, the EWC program provides breast and cervical cancer screenings to uninsured and under-insured women, not covered by Medi-Cal, up to 200 percent FPL.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH or the DOF to answer the following questions:

1. If the Administration anticipates reduced revenues in the Breast Cancer Fund, what is the reason that the two sub-funds are not reduced in equal amounts?
2. Is there no proposed reduction to funding for UC research or is that reflected in the UC budget documents?

Subcommittee Action Here

ISSUE 5: WOMEN, INFANTS, AND CHILDREN (WIC) PROGRAM (FH-01)**Budget Issues**

The DPH is requesting an increase of \$590,000 (federal funds) to support 14 State positions (all permanent, except for one) to address increased WIC participation, accommodate new workload requirements as directed in federal regulations, and to manage the expansion of the WIC Breastfeeding Peer Counselor Program. Eight of these positions are presently funded from a temporary help blanket (federal funds).

The DPH states increased federal funds through the federal American Recovery and Reinvestment Act (ARRA) of 2009, signed by President Obama, and USDA rules regarding WIC food packages, published in 2007, have added new workload for WIC. WIC is also experiencing expansion of the Breastfeeding Peer Counseling Program to include more local WIC agencies. They contend that growth in the number of participants and authorized vendors (such as groceries stores) is expected to continue.

Of the total 14 requested positions, nine are requested to address issues regarding overall WIC Program growth. These positions and key functions are as follows:

- Staff Services and Governmental Program Analysts (7). These positions will be employed to conduct the following key functions: 1) provide support to local WIC Agencies through contract management, training and on-site technical assistance to assess operations and quality, and recommend improvements; 2) authorize additional vendors to increase WIC participant access to stores that redeem WIC checks; 3) coordinate and deliver training classes on program, nutrition, and vendor requirements; 4) review and recommend action on WIC food instruments rejected for payment by the State Treasurer's Office and work with affected vendors; 5) develop and maintain a centralized system for tracking all federal reporting deliverables and responses to the USDA and conduct any necessary follow-up regarding technical reviews; 6) provide technical assistance to vendors (over 4,700 now); and 7) conduct policy reviews as directed.
- Health Program Specialist I (1). This position will review, analyze and update program performance measures and outcomes to ensure compliance with federal and state laws and regulations.
- Office Technician (1). This position will provide support functions for various aspects of the training program.
- The remaining five requested positions will be used for compliance with federal regulation and to expand the Breastfeeding Peer Support Program. A total of five Public Health Nutrition Consultants, including supervisory, will address issues regarding food package policy, implementation of recent federal regulations, breastfeeding policy development and expansion of the Peer Support Program. An Associate Governmental Program Analyst will provide other administrative support functions related to federal deliverables.

WIC Funding

WIC is funded with federal grants and WIC manufacturer rebate funds such as from baby formula, juice and cereal. As noted in the Table below, California has been receiving increased federal funding for the program. The table below provides a summary of WIC Program funding for the past three years.

WIC PROGRAM FUNDING			
FUND	2008-09	2009-10	2010-11
Local Assistance			
Federal Grant for Food	\$766,691,000	\$805,025,000	\$805,025,000
Federal Grant for Admin.	\$269,219,000	\$282,846,000	\$282,846,000
WIC Manufacturer Rebate Fund	\$281,214,000	\$329,901,000	\$329,901,000
Total Local Assistance	\$1,317,124,000	\$1,417,772,000	\$1,417,772,000
Total State Operations (Federal Grant)			
	\$40,440,000	\$48,170,000	\$52,296,000
WIC PROGRAM TOTAL	\$1,357,564,000	\$1,465,942,000	\$1,470,068,000

It should be noted that the DPH does not provide the Legislature with an estimate package for the WIC Program. As such, fiscal detail is not readily discernable.

Background

WIC is a federally funded program for low-income women who are pregnant or breastfeeding and for children under age five who are at nutritional risk. WIC's objective is to provide nutritious foods, nutrition education, breastfeeding promotion and education, and referrals to health and social services programs.

The DPH has contracts with 82 local WIC agencies to provide nutrition education, referrals to health and social services and food checks to purchase nutritious food. In California, about 1.440 million WIC participants receive food checks each month. WIC offers over 200 different types of food checks, including checks for milk, eggs, cheese, cereal, and infant formula, that vary based on the needs of the individual participants. There are presently over 4,700 WIC authorized vendors.

WIC's Breastfeeding Peer Counseling Program

The federal USDA provides an annual grant to California for this program which is used to develop and operate breastfeeding peer counseling programs serving 37,500 pregnant and breastfeeding WIC participants. While in operation for only three years, California WIC agencies have succeeded in increasing the percentage of infants fed exclusively with breast milk. However, more work needs to be done as illustrated by the following statistics:

- Only 54 percent of the mothers participating in the WIC Program initiate breastfeeding as compared to 75 percent of all California mothers; and
- Only 21 percent of mothers participating in the WIC Program are breastfeeding their infants at six months of age as compared to 42 percent of all California mothers.

The costs savings of breastfeeding include reductions in illness in infants and their associated medical visits and time lost from work by parents. There is also evidence that lack of extended breastfeeding contributes to overweight and obesity later in life. According to WIC, California could avoid \$476 million a year in health care costs and lost wages if just 50 percent of mothers breastfed exclusively for six months.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to provide an overview of the WIC program and proposed budget.

Subcommittee Action Here

Consistent with the Senate, it is recommended to adopt placeholder trailer bill language to require the DPH to submit an estimate package on the WIC Program to the Legislature, as is done with most large programs the State operates. The proposed language is as follows:

“By no later than January 10 and May 14 of each year, the State Department of Public Health shall provide the fiscal committees of the Legislature with an estimate package for the Women, Infant, and Children Supplemental Nutrition (WIC) Program. This estimate package shall include all significant assumptions underlying the estimate for the WIC’s current-year and budget-year proposals, and shall contain concise information identifying applicable estimate components, such as caseload, policy changes, federal fund information, manufacturer rebate information, State positions and organization charts, and other assumptions necessary to support the estimate.”

ISSUE 6: NEW SAFETY REQUIREMENTS FOR PUBLIC SWIMMING POOLS AND SPAS (EH-AB 1020)**Budget Issue**

The DPH requests an increase of \$402,000 (Recreational Health Fund) to support two State positions (three-year limited-term) and a contract of \$151,000 to develop educational materials related to public swimming pools and spas as directed in AB 1020 (Emmerson and Ma, Chapter 267, Statutes of 2009).

Through this new program, the DPH will participate in training personnel to enforce the state pool and spa law, and participate in educating pool owners, construction companies, service companies, and the general public about the dangers of drowning and entrapment.

The State staff—two Staff Environmental Scientists—would conduct various activities, including the following:

- Work with various stakeholders to develop guidance on the definition of unblockable drains in state and federal law.
- Work with various organizations on recommended practices and standards to prevent entrapment. Adopt specified standards as appropriate.
- Interact with national testing organizations and manufacturers on approval of performance standards and testing protocol for pool operators and Local Health Jurisdictions.
- Work with Local Health Jurisdictions and pool and spa organizations to assist with development of forms and public notification of the new law and its compliance dates.
- Develop compliance options for pool contractors and owners of public pools and spas.
- Provide technical assistance to Local Health Jurisdictions and the pool and spa industry to eliminate public health and safety hazards related to equipment design, use, and operation.
- Respond to public inquiries on safe and healthy swimming and bathing activities.
- Conduct investigations of entrapment incidents and determine if additional public education is needed or new physical entrapment measures are needed.

The DPH intends to contract with a public safety organization to develop educational materials, technical bulletins, public service announcements, and a training program. The consultant will also be involved to evaluate anti-entrapment devices and provide training on the enforcement of the new standards to local government.

AB 1020 (Emmerson, Ma, Chapter 267, Statutes of 2009)

This enabling legislation, based on federal law enacted in 2007, contains the following key provisions:

- Requires all newly constructed and existing public swimming pools to be equipped with: 1) at least two main drains per pump; and 2) one or more anti-entrapment devices or systems as specified.
- Requires DPH to train personnel to enforce the law.
- Requires DPH to educate the public about these requirements and about drowning prevention.
- Requires DPH to issue a form for use by an owner of a public swimming pool to indicate compliance.
- Creates a \$6 annual fee on public swimming pool owners for the DPH to defray costs for carrying out specified requirements.

There are about 80,000 public pools in California. The \$6 fee on permitted recreational water venues (public pools and spas) is anticipated to generate about \$480,000 in revenues. Local health departments will collect the fee and may retain up to \$1 of the fee to cover their administrative costs of collecting the fee. The remaining amount will be expended on the program as noted. The fee is scheduled to sunset on January 1, 2014.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to summarize this proposal.

Subcommittee Action Here

ISSUE 7: INFANT BOTULISM (BABYBIG) (ID-02)**Budget Issue**

The DPH is requesting an increase of \$3.8 million (Infant Botulism Funds) in 2010-11 to begin the several year process to manufacture the next lot of BabyBig. The next lot will be needed in about four to five years.

The DPH states that programmatic efforts required to make the next lot of BabyBig will include: 1) moving the freeze-drying and vialing from Cangene to a replacement federal FDA approved contractor; 2) developing a new toxoid to boost the plasma donors to replace the present 40 year-old and now degraded toxoid; 3) obtaining and reporting to the federal FDA on the stability and potency testing results from the current lot production; 4) continuing the development of faster diagnostics to enable more efficient and accurate use of BabyBig; and 5) fulfilling the statutory mandate to identify sudden infant death cases that result from infant botulism poisoning.

The \$3.8 million appropriation would be used for the following consultant and professional services:

- Public Health Foundation Enterprises at \$990,000. This contract is for technical and logistical support.
- Emergent BioSolutions, Incorporated at \$825,000. This is for new toxoid development.
- Cato Research, Limited at \$550,000. This is for regulatory services oversight and project oversight.
- Cato Research, Limited at \$279,672. This is for regulatory activities associated with vial transfer.
- Cato Research, Limited at \$150,000. This is for deliverables associated with regulatory support.
- Battelle Memorial Institute at \$400,000. This is for potency testing.
- Los Alamos National Laboratories at \$325,000. This is for new assay development.
- Unknown Contractor at \$200,000. This will be for a new freeze-drying facility.
- Baxter Healthcare Corporation at \$70,990. This is for stability testing.
- FFF Enterprises at \$39,438. This is for distribution.

Background

The DPH has an “orphan drug” license from the federal FDA for the Botulism Immune Globulin Intravenous (BabyBIG) which is the only antidote available for infant botulism in the world for infants. The licensure was provided by the federal FDA in 2003 but prior to that, the DHS provided the drug for many years. BabyBIG is made by harvesting and bottling special antibodies from the blood plasma of volunteer donors.

Without treatment, affected infants spend weeks to months in the hospital, much of that time in intensive care. About 100 cases occur in the United States per year. More than one-third of the cases occur in California. In California, BabyBig saves Medi-Cal about \$1.5 million annually. BabyBig is distributed nationwide.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to summarize this proposal and an estimate of future on-going costs associated with BabyBIG.

Subcommittee Action Here

ISSUE 8: LICENSING AND CERTIFICATION – LICENSING FEE

The Licensing and Certification (L&C) Division develops and enforces State licensure standards, conducts inspections to assure compliance with federal standards for facility participation in Medicare and/or Medi-Cal, and responds to complaints against providers licensed by the DPH.

In 2006, the L&C Program began a transition to migrate from General Fund support to a fee-based program, coupled with applicable federal funding. Only State departments that operate long-term care facilities are appropriated General Fund support for the purpose of licensing and certification activities. Existing statute provides the framework for calculating the annual licensing and certification fees for each of the various health care facilities.

Existing statute requires the L&C Division to annually publish a Health Facility License Fee Report (DPH Fee Report) by February of each year. The purpose of this annual DPH Fee Report is to provide data on how the fees are calculated and what adjustments are proposed for the upcoming fiscal year.

The DPH Fee Report utilizes the requirements of existing statute for the fee calculations, and makes certain “credit” adjustments. The DPH notes that these “credits” are most likely one-time only and that when fees are calculated based solely on the statutorily prescribed workload methodology as contained in statute, there may be significant increases to fees in the near future.

The “credits” are applied to offset fees for 2010-11 and total \$14.7 million. They are as follows:

- \$8.5 million credit in savings resulting from 2009-2010 employee furloughs.
- \$4.2 million credit for miscellaneous revenues for change in ownerships and late fees collected in 2008-09.
- \$2 million credit for 2008-09 for internal program savings.

The fees also must take into consideration various incremental cost adjustments for 2010-11, including budget change proposals (to be discussed individually in this Agenda, below), employee retirement and worker’s compensation, facility space for field offices and related aspects.

Budget Issues

The baseline incremental changes result in increased costs of \$3.6 million and are as follows:

- Adjustment of pro-rata as directed by the Department of Finance for a net increase of \$2.1 million.
- Reallocation of DPH overhead expenditures of \$1.4 million.
- Adjustment of \$134,000 for employee compensation and retirement.
- Adjustment of \$64,000 for lease revenue debt service for staff located at the Richmond Laboratory complex.

The DPH Fee Report of February 2010 proposes a slight reduction to fees which results from application of the “credits,” primarily from the State employee furloughs, as referenced.

Fee Methodology

Licensing fee rates are structured on a per “facility” or “bed” classification and are collected on an initial license application, an annual license renewal, and change of ownership. The fees are placed into a special fund — the Licensing and Certification Special Fund.

The fee rates are based on the following activities:

- Combines information on projected workload hours for various mandated activities by specific facility type (such as skilled nursing home, community-based clinic, or hospital). The DPH notes that workload data from 2008-09 is used to calculate rates for 2009-2010.
- Calculates the State workload rate percentage of each facility type to the total State workload.
- Allocates the baseline budget costs by facility type based on the State workload percentages.
- Determines the total proposed special fund budget cost comprised of baseline, incremental cost adjustments, and credits.
- Divides the proposed special fund cost per facility type by the total number of facilities within the facility type or by the total number of beds to determine a per facility or per bed licensing fee.

The DPH Fee Report provides considerable detail regarding these calculations, data on L&C workload associated with the various types of health care facilities, and details on the methodology.

Licensing & Certification Division Total Resources

The L&C Division is supported by licensing and certification fee revenue as noted above, as well as various federal funds, and certain reimbursements. For additional detail, please see the table below.

Funding Sources for L&C Division	2009-10	2010-11	Difference
L&C Fees Paid by Facilities	\$73,993,000	\$86,523,000	\$12,530,000
Federal Funds	\$60,677,000	\$56,526,000	-\$4,151,000
Transfers from other State Departments	\$8,005,000	\$8,005,000	--
Reimbursement from the DHCS for federal certification, Nurses Aide Training and related items	\$3,439,000	\$3,292,000	-\$147,000
State Citation Penalties Account	\$2,149,000	\$2,149,000	--
Internal Quality Improvement Account		\$818,000	\$818,000
Nursing Home Administrator Program	\$326,000	\$445,000	\$119,000
Federal Bioterrorism Funds	\$217,000	\$217,000	--
General Fund	\$221,000	0	-\$221,000
TOTAL FUNDS	\$149,027,000	\$157,975,000	\$8,948,000

STAFF COMMENTS & QUESTIONS

As discussed in the DPH Fee Report, certain “credits” are being applied which reduce the fees paid by the various health care facilities. The DPH furloughing of staff for a reduction (credit) of \$8.5 million is the most significant reason why fees are being temporarily reduced. However, the affect on L&C Division performance measures for completing required survey work and enforcing quality assurance measures are not readily known. Fees may need to be adjusted at the May Revision or subsequent date to reflect any changes that may be forthcoming regarding employee furloughs or other State employee changes.

The Subcommittee has requested the L&C Division to respond to the following questions:

1. Please provide a brief summary of the L&C Fees, including the key credits and adjustments.
2. How have the existing furloughs affected the L&C Division workload, survey requirements, and quality assurance follow-up?

Subcommittee Action Here

Consistent with the Senate, it is recommended to adopt placeholder trailer bill language to require the DPH to provide the fiscal committees of the Legislature with an L&C Division estimate package by no later than January 10 and May 14 of each year. Presently the L&C Division does not provide this level of fiscal detail to the Legislature. It is the understanding of Subcommittee staff that the DPH has been working on the development of such a fiscal estimate package.

**ISSUE 9: LICENSING AND CERTIFICATION—QUALITY IMPROVEMENT
ACTIVITIES (HQ-05)****Budget Issue**

The L&C Division requests one-time expenditure authority of \$800,000 for contracts for quality improvement activities to initiate a “High-Risk Operating Room Department Safety Collaborative” (Collaborative). This Collaborative would focus on assisting hospitals to reduce or eliminate surgical adverse events related to retention of a foreign object, which is the second most frequent preventable adverse event.

Senate Bill 541 (Alquist, Chapter 605, Statutes of 2008), among other things, increased certain penalties assessed against hospitals for adverse actions and required these funds to be placed into a special fund to be expended, upon appropriation by the Legislature, to support internal departmental quality improvement activities.

The DPH states that the use of a Collaborative is a new major approach for rapidly improving the quality and efficiency of health care. It focuses on a single technical area and seeks to rapidly spread existing knowledge or best practices related to that technical topic.

California Hospitals will enroll into this Collaborative so that their medical staff can receive training sessions on best practices that are proven to reduce the incidence of retention of foreign objects during surgery. Participant hospitals will establish their baseline for this adverse event and set quarterly goals for including new reduction strategies and methods to reduce event rates.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to provide a summary of the proposal and anticipated timing of the contracts and outcomes.

Subcommittee Action Here

<p>ISSUE 10: LICENSING AND CERTIFICATION—HEALTH FACILITY REPORTING (CALHEART) (HQ-03)</p>
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Budget Issue

The DPH is requesting an increase of \$721,000 (\$703,000 L&C Fund and \$18,000 Internal Department Quality Improvement Account) for 1.5 positions (limited-term), an interagency agreement, and a contract to develop, implement and maintain the California Healthcare and Event Reporting Tool (CalHEART) web-based portal.

The purpose of CalHEART would be to address reporting needs as contained in State statute. Specifically, Senate Bill 1301 (Alquist, Chapter 657, Statutes of 2006), and Senate Bill 1058 (Alquist, Chapter 296, Statutes of 2008), both require health facilities to report to the DPH regarding certain adverse events (occurring in hospitals) and certain bacterial infection incidences (occurring in health facilities).

Presently, these reporting requirements are met by facilities providing the information to the L&C Division by telephone, fax or mail. There is concern this manual process discourages the timely reporting and may delay the L&C Division's ability to investigate incidences in a timely manner.

The 1.5 positions include a half-time Data Processing Manager III (two-year limited-term to June 30, 2012), and one Staff Programmer Analyst (one-year limited-term from January 2011 to December 2012). These positions would work with the contractor and the Office of the Chief Information Officer (interagency agreement at \$140,000) to implement the web-based portal.

The DPH would procure a contractor from the California Multiple Award Schedule (CMAS) qualified information technology vendor list to develop the web portal beginning July 1, 2010. A total of \$431,000 has been identified for this purpose.

The DPH has provided the following preliminary timetable for this project:

MAJOR MILESTONES	ESTIMATED COMPLETION DATE
Feasibility Study Report (required)	July 2009
Project Approval	July 2010
Complete Requirements Analysis	January 2011
Complete System Design	February 2011
Complete System Development	July 2011
Testing and User Acceptance	August 2011
System Live	September 2011

<p>STAFF COMMENTS & QUESTIONS</p>
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The Subcommittee has requested the DPH to provide a brief description of the budget request and project.

Subcommittee Action Here

ISSUE 11: LABORATORY FIELD SERVICES — CLINICAL LABORATORY INSPECTIONS (HQ SB 744)**Budget Issue**

The DPH is requesting an increase of \$3.4 million (Clinical Laboratory Improvement Fund) to support 35.5 permanent State positions to implement Senate Bill 744 (Strickland, Chapter 201, Statutes of 2009) regarding inspections of clinical laboratories and to address concerns identified in a Bureau of State Audits investigation in 2008. The budget request also includes \$250,000 (Clinical Laboratory Improvement Fund) for equipment, including moveable storage units and an electronic scanner.

Background

Among other things, SB 744 increased the fee structure based on the volume of testing for licensed laboratories and increased fees for registered laboratories and certified phlebotomists. This new revenue is to be used to enable the DPH's Laboratory Field Services to conduct required biennial inspections, complaint investigations, proficiency testing oversight, enforcement for non-compliance, and phlebotomy certifications.

The DPH states that many of the existing Laboratory Field Services activities have either been minimally performed or not conducted at all due to understaffing and under-funding of the program. A Bureau of State Audit investigation also identified many deficiencies in the program which SB 744 was intended to address.

The DPH notes that 70 percent of diagnoses are based upon laboratory tests. Laboratory mistakes lead to misdiagnoses and inappropriate follow-up treatment. As such, inspections and oversight of laboratories is vital to public health and safety. The number of clinical laboratories continues to increase and there are about 19,500 presently in California, and another 600 outside the State performing testing on California residents.

The 35.5 positions and core functions are described below. The DPH will utilize two existing field offices for this additional staff — one in Los Angeles and the other in Richmond.

- Examiner III, Section Chief (1). This position manages the Los Angeles Office and staff.
- Examiner II, Program Managers (4). These positions shall coordinate initial onsite inspections, biennial inspections, out-of-state licensure, and complaint investigations.
- Examiner I (9). These positions shall conduct initial onsite inspections of the new laboratories, and follow up with biennial inspections of newly licensed laboratories. These positions will be shared between Los Angeles and Richmond field offices.
- Examiner I (7). These positions shall conduct biennial inspections of licensed laboratories, including selected laboratories licensed outside of California. These positions will be shared between field offices.
- Examiner I (1). This position shall review and approve phlebotomy training programs in Richmond.
- Program Technicians II (10). These positions shall be assigned to support licensing and registration activities.

- Program Technicians II (3). These positions shall be assigned to review and process phlebotomy renewals and applications.
- Staff Counsel (half-time). This half-time position shall coordinate enforcement actions for non-compliance including failure to comply with inspections, proficiency testing failures, employment of unlicensed persons to perform testing, phlebotomy competency, and operating without a license after being noticed.

The DPH states that with this new staff in place, they will be able to: 1) assure that licensed laboratories are inspected every two years as mandated by law by 2012-13; 2) begin to investigate complaints in a more timely manner; 3) process phlebotomy applications and renewals timely; and, 4) approve phlebotomy training programs as required.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to provide a brief summary of the budget request and timing of implementation for all activities.

Subcommittee Action Here

DRINKING WATER PROGRAM

The DPH has statutory authority to administer California's public Drinking Water Program. The program provides for ongoing surveillance and inspection of public water systems, issues operational permits to the systems, ensures water quality monitoring is conducted and takes enforcement actions when violations occur. They oversee the activities of about 8,000 public water systems (including both small and large water systems) that serve more than 34 million Californians.

The DPH is also designated by the federal Environmental Protection Agency (EPA) as the primacy agency responsible for the administration of the federal Safe Drinking Water Act for California.

California's total need for water system infrastructure improvements is in excess of \$39 billion, as reported through a needs-assessment conducted in 2007. The majority of public water systems are not able to finance necessary improvements on their own and require State and federal assistance.

There are three budget issues regarding the Drinking Water Program. These include receipt of federal funds, expenditure of State bond funds, and the need for State staff to manage various water projects. These issues are discussed below.

ISSUE 12: SAFE DRINKING WATER: REVENUE BONDS AND STAFF REQUEST**Request for State Staff** (BCP EH-03)

Under the Safe Drinking Water program, the DPH is requesting, for 2010-11, an increase of 24.5 (two-year limited term) positions to: 1) continue support of the Safe Drinking Water Program; 2) implement the U.S. EPA Groundwater Rule and State 2 Disinfectant and Disinfectant By-Products Rule; and 3) redirect State staff from Proposition 84 bond functions and integrate them into the global Safe Drinking Water Program.

10.5 limited-term positions within the Safe Drinking Water Program are proposed to be extended for another two-years (from June 30, 2010 to June 30, 2012). These positions have been provided by the Legislature on a two-year limited-term basis since 1999.

14 limited-term positions established July 1, 2009, pursuant to SB X2 1 (Perata), Statutes of 2008, are proposed to be integrated into the Safe Drinking Water Program from Proposition 84 bond functions. These positions would be used to: 1) implement the federal US EPA Groundwater Rule and Stage 2 Disinfectant and Disinfection By-products Rule; and 2) provide technical assistance and administrative support for the increase in projects due to additional federal grants under the Safe Drinking Water Program.

A total of \$3 million (various special water funds) is requested for the 24.5 limited-term positions. These positions are as follows:

- Sanitary Engineers—various levels (13)
- Environmental Scientists—various levels (4)
- Accounting, Analysts, and Clerical support (6.4)
- Staff Counsel IV (1)

Key activities of staff include: 1) review pre-applications and supporting information from public water grant applicants and rank projects; 2) conduct full engineering review of applications; 3) review construction bids for compliance and project costs; 4) conduct midpoint construction inspections; 5) review and approve invoices for payment; 6) assist in program management; 7) develop program financial reports; 8) develop contracts and monitoring performance procedures; 9) conduct activities associated with water capacity development; and, 10) provide training and technical assistance on all aspects of the program.

The DPH currently has 45 permanent positions funded under the Safe Drinking Water Program. In addition, the program has 10.5 limited-term positions which expire as of June 30, 2010.

Background

Enacted in 1997, under the Safe Drinking Water Revolving Fund Program, California receives federal funds to finance low-interest loans and grants for public water system infrastructure improvements.

In order to draw down these federal capitalization grants, the State must provide a 20 percent match. Further, the State must submit an annual "Intended Use Plan" which describes California's plan for utilizing the program funding.

The program is comprised of five set-aside funds, as well as a loan fund. The set asides are as follows:

- Drinking water source protection (15 percent);
- Technical assistance to small water systems (up to 2 percent);
- Water system reliability/capacity development (2 percent);
- State water system program management activities (up to 10 percent); and,
- Administrative costs (up to 4 percent).

California will be receiving increased federal grant funds due to a change in the federal allocation, and from increased Congressional funding (H.R. 2996).

With respect to the 20 percent State match, General Fund support was used for a period of time, then a portion of Proposition 13 bonds (until fully expended), then a portion of Proposition 50 bonds, and now a portion of Proposition 84 bonds.

It should also be noted that a portion of the State match has been obtained from local matches (cash) provided by Large Water systems to allow them to access some federal funds. In 2008, a total of \$2.3 million was provided through a local match, and in 2009, a total of \$6.1 million was provided.

The DPH states that Proposition 84 bond funds will be available to serve as a portion of the 20 percent match until 2011-12. Then, additional State sources will be needed—such as other bond funds, local matches, or General Fund support.

The Table below provides a summary of the federal capitalization grants and State match.

SAFE DRINKING WATER STATE REVOLVING FUND PROGRAM			
State Fiscal Year	20% State Match	Federal Fund Amt.	Total Amt.
Current Year	\$13.3 million (\$7.2 million Prop 84) (\$6.1 million local – Large Water)	\$66.4 million	\$79.7 million
2010-11	\$25.4 million (Proposition 84)	\$126.9 million	\$152.3 million
2011-12	\$13.3 million (Proposition 84) \$12.1 million (unidentified)	\$126.9 million	\$152.3 million
2012-13	\$25.4 million (unidentified)	\$126.9 million	\$152.3 million
2013-14	\$25.4 million (unidentified)	\$126.9 million	\$152.3 million
2014-15	\$25.4 million (unidentified)	\$126.9 million	\$152.3 million

Authority to Sell Revenue Bonds (SFL EH-01)

The DPH has proposed trailer bill language for statutory authority to sell revenue bonds to provide the required 20 percent State match to access federal funds under the Safe Drinking Water Program.

Specifically the DPH is requesting an increase of \$110,000 (Safe Drinking Water—Administration Account) to hire a consultant to provide assistance to the DPH for the sale of revenue bonds. The revenue stream would be obtained through water rate adjustments over several years. Considerably more detail is needed in order to discern how the revenue bond sales would be structured, and thus the DPH is seeking an appropriation for a consultant.

The DPH notes several States — New York, Massachusetts, Arizona, Maine, Colorado, Nevada, Ohio and Connecticut — that currently use a revenue bond approach.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to respond to the following questions:

1. Please provide a brief summary of the Safe Drinking Water Program.
2. Please describe both the trailer bill request and the 24.5 limited-term positions.

Subcommittee Action Here

**ISSUE 13: DRINKING WATER: REAPPROPRIATION OF PROPOSITION 84 BONDS
(SB X2 1) (SFL EH SB X2 1))**

The DPH is requesting a five-year reappropriation of \$100.4 million (special funds) pursuant to SBX2 1. However, the DPH states that due to sluggish bond sales, they have not been allocated sufficient bond proceeds to utilize the appropriation. Specifically, the DOF directed the DPH to suspend authorizing any new grants or obligations for bond projects in 2008.

Proposition 84, of 2006, provided the DPH with up to \$300 million in bond authority for water projects. A spending plan was approved for this in 2007. As noted above, a portion of Proposition 84 bonds (total of \$45.7 million) is expended under the Safe Drinking Water Program for the State's 20 percent match to receive federal funds, and the remaining amount being available for various water projects. SBX2 1 (Perata, Chapter, Statutes of 2008) modified the spending plan to increase the appropriation in 2008-09 and 2009-2010 (until June 30, 2010) for certain projects.

The DPH did receive some bond proceeds in March 2009, November 2009, and March 2010 and has recently restarted the program. But the impact of the freeze on operations means the DPH cannot meet the encumbrance timeframes specified in SBX2 1.

Further, the DPH notes that, depending on bond sales, full encumbrance is not expected to occur until 2013-14. Therefore, the DPH proposes to reappropriate funds to extend its available budget authority as shown in the table below (last two-columns).

PROPOSAL FOR REAPPROPRIATION OF SB X2 1 STATUTES OF 2008 (FOR PROP 84)				
Fiscal Year	SB X2 1 Appropriation (State Operations)	SB X2 1 Appropriation (Local Assistance)	Proposed Reappropriation (State Operations)	Proposed Reappropriation (Local Assistance)
2007-08				
2008-09	\$327,000	0	\$9,994	0
2009-10	\$1,717,000	\$98,356,000	\$1,500,000	\$18,898,787
2010-11		0		\$50,313,006
2011-12		0		\$10,000,000
2012-13		0		\$10,000,000
2013-14		0		\$9,678,213
TOTAL	\$2,044,000	\$98,356,000	\$1,509,994	\$98,890,006

Authority for other Proposition 84 bond funds (i.e., those not related to SB X2 1) are not affected by this DPH proposal. The appropriation amounts for the remaining Proposition 84 bonds are shown in the table below.

Existing Proposition 84 Appropriation (non-SB X2 1) = \$134.3 million		
Fiscal Year	Proposition 84 (non-SB X2 1) (State Operations)	Proposition 84 (non-SB X2 1) (Local Assistance)
2007-08	\$414,000	
2008-09	\$1,467,421	\$113,500
2009-10	\$2,152,000	0
2010-11	\$2,154,000	0
2011-12	\$2,154,000	\$32,154,997
2012-13	\$2,154,000	\$28,854,997
2013-14	\$1,638,616	\$29,793,250
2014-15	\$1,500,000	\$29,793,250
TOTAL	\$13,634,037	\$120,709,994

A key concern of the entire program is the receipt of Proposition 84 bond proceeds to commence with projects. As shown in the table below, the DPH has projects identified in various stages that total \$194.4 million presently, including an expected "shovel ready" (in two to six months) amount of about \$16.2 million. Yet, proceeds from bond sales for Proposition 84 are very sluggish and presently cash on hand is only about \$21.1 million.

The DPH states that March 2010 bond proceeds may increase the \$21.1 million (cash on hand), but it is unclear how the March proceeds of \$159 million will be split between Proposition 84 program needs and Proposition 50 program needs. The DPH notes that the Department of Water Resources decides the actual split between programs.

PROPOSITION 84 PROJECT OBLIGATIONS COMPARED TO BOND PROCEEDS AVAILABLE	
Description of Funding Obligation	Proposition 84 Need
Contract Agreements with Water Systems – 15	\$16.9 million
Letters of Commitment – 12	\$12.2 million
Applications in Process – 6	\$124.3 million
New Applications Received – 7	\$40 million
Emergency Grants – 20	\$1 million
TOTAL	\$194.4 million

SBX2 1, (Perata, Chapter, Statutes of 2008)

The purpose of this legislation is to require the integration of flood protection and water systems to achieve multiple public benefits and to make a portion of the funds authorized by Proposition 84 of 2006 immediately available to the DPH and Department of Water Resources. Additionally, it requires the DPH to give the highest priority to water systems that serve disadvantaged and severely disadvantaged communities in the funding for small water system infrastructure improvements. The DPH was provided 14 limited-term positions (expire as of June 30, 2010) for various aspects of the enabling legislation. These positions are proposed to be extended and will be integrated with the DPH's overall Safe Drinking Water Program (as referenced in the agenda item above).

Proposition 84, Safe Drinking Water & Water Quality Projects (2006)

This act contains several provisions that pertain to the Department of Public Health (DPH). It should be noted that 3.5 percent (annually) of the bond funds are to be used to service the bond costs, and up to 5 percent (annually) can be used for DPH state support expenditures. The remaining amounts are to be used for local assistance. A summary of the provisions for which the local assistance funds can be used is as follows:

\$10 million for Emergency Grants. Section 75021 of the proposition provides funds for grants and direct expenditures to fund emergency and urgent actions to ensure that safe drinking water supplies are available. Eligible project criteria includes, but is not limited to: 1) providing alternate water supplies including bottled water where necessary; 2) improvements to existing water systems necessary to prevent contamination or provide other sources of safe drinking water; 3) establishing connections to an adjacent water system; and 4) design, purchase, installation and initial operation costs for water treatment equipment and systems. Grants and expenditures shall not exceed \$250,000 per project.

\$180 million for Small Community Drinking Water. Under Section 75022 of the proposition, grants for small community drinking water system infrastructure improvements and related actions to meet safe drinking water standards will be available. Statutory authority requires that priority be given to projects that address chemical and nitrate contaminants, other health hazards, and by whether the community is disadvantaged or severely disadvantaged. Eligible recipients include public agencies, schools, and incorporated mutual water companies that serve disadvantaged communities. Grants may be made for the purpose of financing feasibility studies and to meet the eligibility requirements for a construction grant. Construction grants are limited to \$5 million per project and not more than 25 percent of the grant can be awarded in advance of actual expenditures. Up to \$5 million of funds from this section can be made available for technical assistance to eligible communities.

\$50 million for Safe Drinking Water State Revolving Fund Program. As discussed above, Proposition 50 implementation, the Safe Drinking Water State Revolving Fund Program, enables California to provide a 20 percent state match to draw down federal capitalization funds. Once the Proposition 50 bond funds are exhausted for this purpose, the Proposition 84 bond funds will be used. This conforms to Section 75023 of the proposition.

\$60 million Regarding Ground Water. Section 75025 provides for grants and loans to prevent or reduce contamination of groundwater that serves as a source of drinking water. Statutory language requires the DPH to require repayment for costs that are subsequently recovered from parties responsible for the contamination. Language in the proposition also provides that the Legislature may enact additional legislation on this provision as necessary.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to respond to the following questions:

1. Please provide an update regarding Proposition 84 bonds, including funds affected by SBX2 1.
2. Specifically, what is presently being done to provide assistance to disadvantaged communities?

Subcommittee Action Here

ISSUE 14: DRINKING WATER: PROPOSITION 50 BONDS AND STATE STAFF (EH-01)**Budget Issue**

The DPH is requesting an increase of \$1.8 million (Proposition 50 Funds) to extend 15.5 positions for another two-years (June 30, 2010 to June 30, 2012). These positions were first authorized in 2003 and are supported by the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 (Proposition 50).

The positions are primarily engineering classifications, along with related environmental scientist classifications and administrative support. The DPH states these positions are necessary to meet workload needs for key activities as follows:

- Review technical “pre-applications” for Proposition 50 funding and rank proposals.
- Create a project priority list based on the priority ranking of the projects.
- Evaluate full project applications and prepare extensive technical report documents for each project.
- Review and evaluate the plans and specifications for each project and conduct construction inspections and a final inspection of each project.
- Review proposal for reduction or removal of drinking water contaminants and participate in demonstration projects such as ultraviolet treatment processes.
- Review and comment on draft environmental documents prepared for drinking water projects.
- Conduct final project inspection and certify completion.
- Conduct program fiscal management and administration.

The Proposition 50 Plan is maintained by the State’s Resources Agency. The DPH updates its portion of the Plan twice a year to reflect bond cash flow by updating project status information. The DPH states they have updated their Plan to reflect a longer disbursement period for local assistance funds, and part of this is due to sluggish bond sales.

Proposition 50, Statutes of 2002 & Chapters Applicable to the DPH

Proposition 50 of 2002 provides funds to a consortium of state agencies and departments to address a wide continuum of water quality issues. The DPH anticipates receiving up to \$485 million over the course of this bond measure for water projects. Of this amount, \$89 million has been expended towards the State’s 20 percent match requirement under the Safe Drinking Water Program. The remaining amount is for various water projects as specified in the following key chapters of the proposition.

Chapter 3 — Water Security (\$50 million). Proposition 50 provides a total of \$50 million for functions pertaining to water security, including the following:

- 1) monitoring and early warning systems; 2) fencing; 3) protective structures;
- 4) contamination treatment facilities; 5) emergency interconnections;
- 6) communications systems; and 7) other projects designed to prevent damage to water treatment, distribution and supply facilities.

Chapter 4 — Safe Drinking Water (\$435 million total for DHS). Proposition 50 provides \$435 million to the DHS for expenditure for grants and loans for infrastructure improvements and related actions to meet safe drinking water standards. A portion of these funds will be used as the State's match to access federal capitalization grants.

With respect to the other projects, the Proposition states that the funds can be used for the following types of projects: 1) grants to small community drinking water systems to upgrade monitoring, treatment or distribution infrastructure; 2) grants to finance development and demonstration of new technologies and related facilities for water contaminant removal and treatment; 3) grants for community water quality; 4) grants for drinking water source protection; 5) grants for drinking water source protection; 6) grants for treatment facilities necessary to meet disinfectant by-product safe drinking water standards; and, 7) loans pursuant to the Safe Drinking Water State Revolving Fund (i.e., whereby the state draws down 80 percent federal match). In addition, it is required that not less than 60 percent of the Chapter 4 funds be available for grants to Southern California water agencies to assist in meeting the state's commitment to reduce Colorado River water use.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to respond to the following questions:

1. Please provide an update regarding Proposition 50 bonds.
2. Please provide a brief summary of the budget request.

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ISSUE 15: RADIATION PROTECTION PROGRAM (EH-02)**Budget Issues**

The DPH is requesting a total of 13 two-year limited-term staff (to June 30, 2012) to address two issues regarding the Radiation Protection Program.

First, nine Associate Health Physicist positions (two-year limited-term) are proposed to increase the number of radiation machine inspections conducted. Presently, the DPH must register and inspect about 13,000 X-ray machines, including medical diagnostic, therapy accelerators, research machines and others. However, presently they are only able to inspect about 10,000 machines using 33 Health Physicists (about 300 inspections per position). These inspections are required by State statute and are intended to:

- Reduce the potential for excessive radiation exposure to individuals from medical and industrial sources;
- Reduce the number of unqualified individuals using radiation machines;
- Provide education to assist users to understand and comply with radiation protection standards; and,
- Respond and investigate complaints and perform enforcement activities aimed at prosecuting those facilities and operators in violation of laws and regulations.

The DPH states that with the additional nine Associate Health Physicist positions, they will be able to address the need for the additional 3,000 inspections.

Second, four positions (two-year limited-term) are requested to monitor radioactive materials per existing State statute (Section 115070 of Health and Safety Code) and as required by the federal Nuclear Regulatory Commission (NRC). The requested positions include two Associate Health Physicists and two Office Technician positions. Specifically, the Associate Health Physicists would do the following:

- Annually inspect 80 to 120 additional radioactive materials licensees;
- Perform verification of licensee's employees background and communication procedures and policies;
- Inspect locations of increased controls materials, logs of materials receipt, transfer and disposal, licensee radiation detection equipment, and maintenance and calibration records; and,
- Annually perform over 50 escalated enforcement activities to ensure that noncompliant facilities and unauthorized operators are identified and stopped from illegal activities.

The requested two Office Technicians would be used for various data collection activities, including maintaining tracking system documents.

Further, the DPH proposes a technical reduction of \$2.275 million (Radiation Control Fund) for the current-year, and a net reduction of \$1.3 million (Radiation Control Fund) for 2010-11.

The current-year reduction reflects adjustments for one-time expenditures related to equipment purposes and training requirements. The \$1.6 million cost of the requested 13 positions are accounted for within the net reduction for 2010-11.

Background on Radiation Control Program

The purpose of this program is to protect public health and safety by decreasing excessive and unnecessary exposure to radiation, and reducing the release of radioactive material into the environment. This is accomplished through: 1) licensing users of radioactive material, including medical, academic and industrial facilities; 2) registration of radiation producing machines; 3) certification of individuals using radiation sources; 4) inspection of facilities using radiation sources; and, 5) conducting enforcement actions.

California, along with 33 other States, has an agreement with the federal NRC by which the federal government does not have regulatory authority over certain types of radioactive material. Instead, the State has the authority for oversight but the NRC conducts performance evaluations as part of its function. This State-Federal relationship is known as "Agreement State Program." Therefore, the Radiation Control Program licenses and inspects users of radioactive materials that are subject to both federal and State law.

The federal NRC has instituted additional controls including a National Source Tracking System Program in which the DPH must participate. This program tracks the location of radioactive materials, and adds an additional layer of security and workload to the DPH.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DPH to provide a brief summary of the Radiation Protection Program and the budget request.

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4260 DEPARTMENT OF HEALTH CARE SERVICES

FAMILY HEALTH PROGRAMS – GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)

The DHCS proposes total expenditures of \$83 million (\$49.8 million General Fund, \$4 million Blood Factor Rebate, \$1.2 million Enrollment Fees, and \$28 million Federal Funds) for the GHPP.

This reflects a net increase of \$6.3 million (increase of \$12.7 million General Fund, decrease of \$6.9 million Federal Funds, and increase of \$502,000 in Enrollment Fees) as compared to 2009-2010.

The DHCS states that expenditures for individuals with Hemophilia continue to increase, primarily due to the cost of blood factor products. The DHCS utilizes two mechanisms to manage blood factor product expenditures, including a rebate program (both federal rebate and State supplemental rebates), and a soon to be implemented program with pharmacy providers.

The DHCS states that the collection of blood factor rebates is progressing but that three blood product manufacturers have not *yet* signed State supplemental rebate contracts. The DHCS states that at least \$5.3 million has been collected from the federal rebates for 2009-2010, and that \$1.044 million has been collected from the State supplemental portion. These rebates are used to offset General Fund support.

The DHCS increased enrollment fees under the program as of July 1, 2009. A total of about \$1.2 million in GHPP enrollment fees is estimated to be collected which reflects an increase of \$502,000 over last year. These enrollment fees are also used to offset General Fund support. The table below reflects the DHCS base expenditures for specified diseases.

BASE EXPENDITURE ASSUMPTIONS FOR SPECIFIED DISEASES 2010-11			
Diagnosis	Average GHPP-Only Caseload	Average Annual Cost Per Case	Total Program Expenditure
Hemophilia	437	\$172,300	\$75,302,000
Cystic Fibrosis	427	\$19,300	\$8,238,000
Sickle Cell	308	\$4,400	\$1,355,000
Huntington's	157	\$1,000	\$160,000
Metabolic	109	\$600	\$63,000
TOTAL	1,438	\$59,200	\$85,118,000

ISSUE 1: GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)

The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions. Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially ineligible for the CCS Program. GHPP clients with adjusted gross incomes above 200 percent of poverty pay enrollment fees and treatment costs based on a sliding fee scale based on family size and income.

STAFF COMMENTS & QUESTIONS

The GHPP is a core health care program that provides medically necessary treatment to individuals with specified, often life-threatening, conditions who have often not had access to health care coverage. Often health care coverage has been denied due to their pre-existing condition.

The DHCS will be providing an update on caseload and expenditures at the May Revision. It is recommended to encourage the DHCS to assertively seek participation in the supplemental rebate program by all blood factor product manufacturers.

The Subcommittee has requested the DHCS to provide:

1. An overview of the GHPP and proposed budget.
2. An update regarding implementation of the blood factor contracting program.
3. A description of how the GHPP might be affected by federal health care reform.

DHCS BUDGET CHANGE PROPOSALS

ISSUE 1: PHYSICIAN ADMINISTERED DRUGS REIMBURSEMENT POLICY (SFL)

Budget Issue

The DHCS requests funding for one two-year limited term Pharmaceutical Consultant II Specialist position, at a cost of \$169,000 TF (\$44,000 GF, and \$125,000 FF), to develop and maintain reimbursement policy for Physician Administered Drugs. The DHCS will redirect an existing position for this purpose. This workload results from a change in the reimbursement policy contained in the 2010-11 budget, which resulted from a federal lawsuit. The DHCS states that without this additional position, the DHCS will not be able to make the required change to reimbursement policy and therefore will not be able to achieve the anticipated \$26.3 million TF (\$13.17 million GF) in annual savings.

Background

Historically, the Medi-Cal program has calculated reimbursement policy for pharmacies using Average Wholesale Price (AWP), minus 17 percent. However, as a result of a federal lawsuit settlement against First Data Bank, the information supplier of AWP, AWP will no longer be published as of October 2011, and therefore the DHCS must change this reimbursement methodology.

Therefore, the DHCS is proposing legislation to change physician reimbursement to the Medi-Cal pharmacy rate of reimbursement or the Medicare rate unless federal law requires a higher reimbursement level.

STAFF COMMENTS & QUESTIONS

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

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ISSUE 2: CA-MMIS REPLACEMENT**Budget Issue**

The DHCS is requesting approval of funding and 35 new or extended positions in order to create a qualified team of people to manage, oversee, and ensure the success of the replacement of the California Medicaid Management Information System (CA-MMIS). The DHCS is requesting these positions on a three-year limited term basis in order to evaluate workload over the three years to determine if the positions are needed for a longer period of time. These positions require an augmentation of \$585,000 General Fund, and draw \$3,706,000 in Federal Funds in 2010-11, and approximately the same amounts in 2011-12.

Background

The CA-MMIS processes millions of payment claims every year to Medi-Cal providers, including physicians, pharmacies, and hospitals. Since 1987, CA-MMIS has been operated through an approximately \$189 million per year contract with Electronic Data Systems (EDS – recently purchased by Hewlett Packard) as the State's fiscal intermediary. The EDS contract is due to end in 2011 and therefore the DHCS undertook a competitive procurement process to secure a new contract, releasing the RFP in December, 2008. Three bids were received and the State awarded the contract to ACS, recently signing the contract which began May 3rd.

The CA-MMIS is an extremely complex system and, according to the DHCS, as well as a report by Eclipse Solutions, it's a system that is outdated and unable to continue meeting the needs of the Medi-Cal program into the future. Among many other goals, the new system is expected to comply with new federal CMS requirements, reduce costs, increase efficiencies, improve beneficiary quality of care, and increase provider participation.

The DHCS is proposing 35 positions to oversee the transition from EDS to ACS. Of the 35, 24 are new limited term positions, 6 are existing limited-term positions to be extended, and 5 are existing limited-term positions that are to be extended and reclassified. The DHCS states that the establishment of this functional organization is consistent with the recommended OCIO governance for the oversight of large projects.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DHCS to provide an overview of this procurement process and specifically of this proposal.

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ISSUE 3: HOSPITAL PROVIDER RATE STABILIZATION & QUALITY ASSURANCE FEE PROGRAM**Budget Issues**

In order to begin implementing the Hospital Provider Rate Stabilization & Quality Assurance Fee Program, created by AB 1383 (Jones, Chapter 627, Statutes of 2009), for 2010-11, the DHCS requests a total of 14 State staff (two-year limited-term), and no contract funds, for an expenditure of \$1.3 million (\$463,000 Private Hospital Supplemental Fund, \$163,000 Hospital Quality Assurance Revenue Fund, and \$709,000 federal funds). The State staff includes the following positions:

1. Staff Legal Counsel (2);
2. Associate Governmental Program Analysts (4);
3. Associate Management Auditors (3);
4. Associate and Trainee Accounting Analysts (4); and,
5. Office Support (1).

Utilizing an appropriation provided in the legislation, the DHCS has \$1.1 million (\$537,000 Private Hospital Supplemental Fund from the Hospital Finance Waiver and \$566,000 federal funds) available in the current-year to commence with implementation. These funds are to support 3.5 State staff and to contract with two consulting firms (Covington and Burling, and Mercer) for their expertise with hospital financing issues.

The DHCS states the workload for these staff includes the following key items:

- Participate in Medi-Cal Program changes (i.e., State Plan Amendments) that require negotiations with the federal CMS and resolve ongoing legal issues related to these changes;
- Collect data to develop total QAF amounts imposed on each hospital and to determine different types of payments to each hospital.
- Develop certification forms, fee notices, and prepare payment letters for hospitals.
- Develop a QAF collection database and prepare relevant collection processes and paperwork.
- Perform full-scope audits to reconcile the enhanced payments to Managed Care Plans.
- Calculate and certify the Managed Care payments as actuarially sound pursuant to federal regulations.
- Develop accounting procedures for processing new hospital payment invoices and implement a new federal claiming process.

Background

AB 1383, Statutes of 2009, authorized the implementation of a Quality Assurance Fee (QAF) on General Acute Hospitals for the period of April 2009 through December 2010. Implementation of the QAF requires federal CMS approval which is pending. The Governor's January budget proposes to appropriate these revenues within the Medi-Cal Program. There are three budget issues regarding implementation of the QAF.

First, the federal CMS is in the process of evaluating California's model for implementing the QAF. The DHCS must obtain federal CMS approval for several aspects of QAF implementation, including:

- An amendment to the existing Hospital Financing Waiver for the QAF to be applied to participating hospitals;
- The overall QAF fee design and model;
- Distribution of the payments to hospitals; and,
- Method of payment to be made to Medi-Cal Managed Care Plans and County Mental Health Plans for the pass-through to hospitals.

Second, based on estimates as of January 2010, the DHCS anticipates the QAF to generate almost \$3.6 billion in revenues across three fiscal years as shown in the table below. The QAF will be deposited into the Hospital Quality Assurance Revenue Fund, where they are available for expenditure until January 1, 2013.

Total Estimated Revenues from Hospital Quality Assurance Fees	
Fiscal Year and Time Frame	Estimated Quality Assurance Fees (Dollars in Thousands)
2008-09 (April 2009 to June 2009) *	\$513,920
2009-10 (July 2009 to June 2010)	\$2,055,680
2010-11 (July 2010 to December 2010)	\$1,028,000
TOTAL Estimated Fees (April 2009 to December 2010)	\$3,597,600

*These funds will be reflected in the 2009-2010 state fiscal year.

Third, the table below reflects total estimated payments, including federal funds (61.59 percent for ARRA where applicable), to be made by fiscal year as contained in the January budget for Medi-Cal, including State support for implementation.

Total Estimated Payments by Fiscal Year (as proposed by the DHCS)			
AB 1383 Uses	2009-10 (April 2009- June 2010)	2010-11	Total Amount (7 Quarters)
Direct Grants to Public Hospitals	\$387,500	\$155,000	\$542,500
Hospital Payments-- includes Private and Non-Designated Hospitals, Managed Care Plans and Mental Health Plans	\$4,636,380	\$1,854,050	\$6,490,930
Children's Health (off-sets General Fund)		\$560,000	\$560,000
DHCS Staff & Administrative Request	\$1,103	\$1,335	\$2,438
TOTAL Estimated Payments	\$5,024,983	\$2,570,885	\$7,595,868

Each of the proposed expenditures from Table 2 is described below:

Direct State Grants to Public Hospitals

As contained in statute, Public Hospitals are to receive direct grants in support of health care expenditures in an aggregate amount of \$310 million (federal fiscal year). Public hospitals include both those operated by Counties and by the University of California system. These grants are not considered Medi-Cal payments and cannot be matched with federal funds. This is because these hospitals are now paid at the maximum amount that qualifies for federal matching funds under the existing Hospital Financing Waiver.

Hospital Payments

This reference broadly covers several areas:

1. Private hospitals (those paying the fee) will receive supplemental Medi-Cal payments for inpatient and outpatient hospital and subacute care services. These supplemental payments are in addition to existing Medi-Cal per diem payments. Most of the payments will be made in this area.
2. The DHCS will increase Medi-Cal payment rates to Managed Care Plans (Plans) and require them to “pass-through” all of these funds to hospitals. The Plans will receive funds for those hospitals located in their service region as well as funds for hospitals in neighboring counties where there is no Medi-Cal Managed Care. The Plans will then pay supplemental payments to these hospitals as directed by the DHCS. The amount a hospital will receive will be based on the number of total Medi-Cal Managed Care days it provides.
3. The DHCS will provide payments to County Mental Health Plans to “pass-through” to hospitals providing Acute Psychiatric Services. This is a supplemental payment made in a similar manner as done with the Managed Care Plans.
4. Non-designated hospitals (District Hospitals) will also receive supplemental Medi-Cal payments for inpatient services. Reimbursement rates for these hospitals are on a per diem basis and are lower than those for private hospitals since non-designated hospitals are not paying the QAF.

Children’s Health

AB 1383 provided for \$320 million annually for health care coverage of children. The \$560 million represents seven quarters of QAF collection which corresponds to the statute. As proposed in the Governor’s budget, the \$560 million serves as an offset to General Fund support in the Medi-Cal Program for providing services to children. The clear intent of AB 1383, with regard to this provision, was to protect and expand health services for children, rather than to replace General Fund dollars. The Governor’s proposed use of these funds likely reflects the severity of the state’s fiscal crisis, though is not consistent with the Legislature’s intent with this legislation.

The Fee

The enabling legislation specifies a three-tier QAF structure which is intended to maximize the number of hospitals that benefit from it and minimize the number of hospitals that do not, while still meeting federal requirements. Certain categories of hospitals, such as designated public, small and rural, most specialty care and long-term care, are exempt from paying the fee. The fees in statute are as follows:

- \$27.25 for every inpatient day of patients enrolled in a Managed Care Plan, *excluding* Medi-Cal;
- \$233.46 for every inpatient day of patients covered by Fee-for-Service, *excluding* Medi-Cal; and,
- \$293.00 for every inpatient day of patients *covered* by Medi-Cal, whether Managed Care or Fee-for-Service.

The DHCS may alter the specified QAF amount slightly in order to obtain federal CMS approval. As such, the fee structure may be altered. Fees are to be computed starting on the effective

date of the bill and to continue through December 31, 2010 (i.e., corresponds to existing expiration date of the federal ARRA -- FMAP amount 61.59 percent).

Use of Fees and Taxes

Taxes and fees assessed on health care providers have become a key component of Medicaid financing in 43 of 50 States. In addition to hospitals, California currently applies provider fees on certain Nursing Facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD), and has also extended an existing State gross premium tax on insurance to Medi-Cal Managed Care Plans (AB 1422, Statutes of 2009). These revenues, coupled with federal matching funds (including enhanced ARRA funds), have been used to increase Medi-Cal reimbursement to providers, to finance quality improvement efforts, and to maintain or expand health care coverage. Federal law restricts the use of provider taxes and fees, and all Medicaid applications require federal CMS approval.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DHCS to provide a brief overview of the structure for this Quality Assurance Fee (QAF) and an update regarding progress being made with the federal CMS.

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ISSUE 4: DRA CITIZENSHIP REQUIREMENTS**Budget Issue**

The DHCS proposes to extend four limited-term positions for two-years to: 1) continue implementation of the federal Deficit Reduction Act of 2005 (DRA) citizenship and identity verification, and the transfer of asset rules for Medi-Cal eligibility determination; and 2) implement new Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 requirements regarding citizenship and identify.

The four positions — two Governmental Program Analysts and two Staff Counsels — were established July 1, 2007 and will expire as of June 30, 2010. An increase of \$435,000 (\$218,000 General Fund) is requested to maintain the positions for another two-years (June 30, 2012).

Background

The DRA of 2005 changed eligibility requirements by requiring that any person who declares to be a citizen or national of the U.S. must provide acceptable documentation of citizenship and identity, unless they are in an exempt group. In addition to citizenship and identity requirements, the DRA also mandated changes to Medi-Cal's treatment of assets for eligibility determination purposes. SB 483 (Kuehl, Chapter 379, Statutes of 2008) enacted these changes.

The CHRIPA amends the DRA to provide that applicants that declare U.S. citizenship or declare to be a U.S. national must receive full-scope Medi-Cal while they are obtaining citizenship documents if they are otherwise eligible. In addition, as of January 1, 2010, CHIRPA gives the State the option to use electronic verification of a Medi-Cal enrollee's name, Social Security number and citizenship status by the federal Social Security Administration as an alternative means of complying with the DRA.

The Medi-Cal Eligibility branch has a total of 111 positions with eight vacancies as of February 1, 2010. The DHCS noted that one of the Governmental Program Analyst positions being requested in this proposal is presently vacant.

Further, though implementation has required much work by the DHCS, counties and advocacy groups believe a considerable amount of the work has been completed. The DHCS has implemented a process using vital records that provides for citizenship verification for Medi-Cal enrollees born in California, and has issued several "All County Letters" to provide direction.

STAFF COMMENTS & QUESTIONS

The Subcommittee requests the DHCS to respond to the following questions:

1. Please provide an update on key actions taken to implement the DRA requirements of 2005.
2. Please provide a brief summary of the budget request and need for the positions.

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ISSUE 5: EXPANSION OF FQHC & RHC AUDIT POSITIONS**Budget Issue**

The DHCS is requesting an increase of \$787,000 (\$393,000 General Fund) to support 7 new State positions (two-year limited-term) to conduct field audits of Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) which are associated with payment changes.

The DHCS states these additional positions are needed to address workload needs associated with reimbursing these providers using the Prospective Payment System (PPS) and the number of FQHC/RHC providers which has increased from about 400 in 2001 to over 900 in 2010. Presently the DHCS has six auditors that work on these activities.

Specifically, the DHCS states the requested seven positions would do the following:

- Health Program Auditors III (4 positions). These positions would augment current staff and do the following: 1) Conduct tentative settlements subsequent to cost report acceptance procedures; 2) Monitor differential rates and propose changes as necessary; 3) Conduct field audits and desk reviews for the FQHC/RHC providers, including annual reconciliations, change in scope of service requests, and initial rate setting audits; and 4) Participate in administrative hearings and appeals.
- Health Program Auditors IV (2 positions). These positions would augment current staff and do the following: 1) Conduct enrollment functions not currently done by the DHCS Provider Enrollment Division; 2) Develop regulations, policies and procedures for continued improvement to audit and review protocols; 3) Provide training and technical assistance to providers and other stakeholder groups; 4) Attend formal appeals as an expert witness or subject matter expert; and 5) Conduct the more complex field and desk audits.
- Health Program Audit Manager (1 position). This position provides supervision and conducts more complex tasks related to the above work.

The DHCS states that final audits are completed on about one-third of all FQHC/RHC providers each fiscal year. They contend that if more staff is provided and more audits are conducted a savings of \$2.7 million (\$1.3 million General Fund) will be obtained. This savings is included in the Governor's January budget for Medi-Cal.

The Fiscal Audits Branch of the DHCS, who is requesting these positions, has a total of 297 staff in several field offices throughout California. As of April 1, 2010, they had 15 overall vacancies.

Background

FQHC/RHC providers are reimbursed by Medi-Cal using a prospective payment rate (PPS) as required by federal law and enabling state legislation. Among other things, PPS requires that FQHC/RHC providers receive their reimbursement on a per visit basis according to their cost report and for all additional qualifying State programs the FQHC/RHC provides, including "wrap-around payment" (such as Medi-Cal Managed Care, and other services/programs).

The DHCS must analyze and review rate-setting or rate-changing cost reports or any request for reconciliation to validate and verify the costs and services, and if necessary, make audit

adjustments to the report. The DHCS calculates the difference between each clinic's final PPS rate and the expenditures already reimbursed (interim rate, Managed Care Plans and Medicare) in order to prepare a final settlement with the clinic.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DHCS to provide an overview of this budget request.

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ISSUE 6: LOCAL EDUCATIONAL AGENCY MEDI-CAL BILLING OPTION**Budget Issue**

The DHCS is requesting an increase of \$1.6 million (\$819,000 from local entities and \$819,000 Federal Funds) to support 14 new State positions (two-year limited-term) to perform financial oversight requirements of the “Local Educational Agency” (LEA) billing option provided under the Medi-Cal Program.

The DHCS states that two positions within the Fiscal Audits Branch are presently conducting audits of LEA billing option information but due to workload increases, these additional 14 positions are needed.

Full implementation of the LEA billing option was delayed by the DHCS for almost two-years due to claims and billing problems with the Medi-Cal Fiscal Intermediary (Electronic Data Systems). Because of these technical problems as well as the need to conduct more audits, the federal CMS has deferred \$85 million in federal payments for the LEA billing option. The DHCS states that two-years worth of “Cost and Reimbursement Comparison Schedule” forms must be reviewed and validated by the DHCS before federal payment can be obtained.

In addition, the DHCS would utilize the positions to provide training and to improve existing procedures. The requested staff is as follows:

- Ten Health Program Auditor III positions;
- Two Health Program Auditor IV positions; and,
- Two Health Program Audit Manager positions.

As California’s lead state agency for the Medicaid Program (Medi-Cal), the DHCS is required to perform financial oversight responsibilities for the LEA billing option to ensure that federal Medicaid funds are being appropriately expended. The DHCS states that if these positions are not provided, the LEA billing option may be in jeopardy and it is very likely the \$85 million in deferred federal funds would not be obtained.

Background

There are 485 LEA providers participating in the LEA billion option. The LEA billing option provides the federal share of reimbursement for health assessment and treatment for Medi-Cal eligible children and family members within the school environment.

The billing option program provides early and periodic screening, diagnosis, and treatment services such as physical therapy, occupational therapy, speech and audiology, physician and nursing services, and school health aid services.

STAFF COMMENTS & QUESTIONS

The LEAs are at risk of losing the \$85 million in reimbursement if action is not immediately taken.

The Subcommittee has requested DHCS to provide a summary of the budget request and the need for these positions.

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ISSUE 7: TARGETED CASE MANAGEMENT PROGRAM**Budget Issue**

The DHCS is requesting 8 two-year limited-term positions to comply with the Centers for Medicare and Medicaid Services (CMS) request that the DHCS take corrective actions to resolve Targeted Case Management (TCM) claims. The CMS has deferred (delayed providing reimbursements) payments to California every year since 2002-03, totaling \$37.2 million.

Background

The TCM program provides comprehensive case management services to Medi-Cal beneficiaries in six targeted populations. The program has been plagued with accounting deficiencies, in the eyes of the CMS, per the following:

- In 2002-03, CMS placed TCM claims for programs with CPE components on deferral pending the DHCS taking corrective actions;
- In 2005-06, CMS determined that the DHCS was out of compliance with Federal Medicaid regulation that related to the payment of claims;
- In 2007-08 and 2008-09, the DHCS audited TCM cost reports and found at least one CPE funding problem in each cost report totaling \$2.9 million. Since CPE problems were found, the DHCS is required to audit the 2004-05 years forward until the CPE problems are resolved by the Local Government Agencies (LGAs). Currently, 14 audits are in progress.
- On February 25, 2009, the CMS sent a deferral letter to DHCS requiring reconciliations of the TCM Cost Reports to ensure:
 1. Payments do not exceed actual costs; and,
 2. Funds from the LGAs comply with and are certified as representing expenditures eligible for Federal Financial Participation.

STAFF COMMENTS & QUESTIONS

The Subcommittee has asked the DHCS to:

1. Provide an overview of the TCM program and the on-going fiscal problems associated with it;
2. Explain how the TCM program works and who benefits from it; and,
3. Explain how these 8 new positions will finally resolve the concerns of CMS.

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ISSUE 8: SKILLED MEDICAL – REQUEST FOR BACKFILL DUE TO FEDERAL DISALLOWANCE**Budget Issue**

The DHCS is requesting an increase of \$634,000 (General Fund) for the DHCS' Medical Review Branch to backfill for the loss of federal funds related to nurses, physicians and pharmacists due to a federal disallowance.

The DHCS states the federal Centers for Medicare and Medicaid Services (CMS) has disallowed their claim to obtain an enhanced federal match (25 percent to 75 percent) for certain medical related staff—nurses, physicians and pharmacists.

In their review, the federal CMS deemed that much of the work conducted by the Medical Review Branch was administrative and not a professional medical service.

Therefore, they agreed to only provide California its baseline federal match of 50 percent to 50 percent (General Fund to federal funds).

Therefore, the DHCS is requesting the General Fund augmentation in order to continue existing support within the Medical Review Branch. Without this backfill, the DHCS contends six positions may have to be eliminated.

Based on April 1, 2010 information, the Medical Review Branch has 714 positions, including support positions. Of these positions, 639 are filled, leaving 75 positions vacant. As such, the branch should be able to identify on-going savings to adjust for the \$634,000 over time.

STAFF COMMENTS & QUESTIONS

The Subcommittee has requested the DHCS to provide a summary of the budget request.

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HOSPITAL FINANCING 1115 WAIVER – OVERVIEW DISCUSSION

As a result of federal policy changes, California was required to completely change its method in which Safety-Net Hospitals (about 146 hospitals) are financed under the Medi-Cal Program. The Administration negotiated a five-year federal Waiver with the federal CMS which was completed as of September 1, 2005 and expires as of *August 30, 2010*. This Waiver is to provide over \$2 billion in annual reimbursement to hospitals.

The federal requirements for this Hospital Finance Waiver are contained in the “*Special Terms and Conditions*” document which serves as a contract between California and the federal CMS. Senate Bill 1100 (Perata and Ducheny, Chapter 560, Statutes of 2005), provides the state statutory framework for implementing it.

Under this Waiver, Public Hospitals certify their health care expenditures (referred to as “Certified Public Expenditures” or CPE) in order to obtain federal funds, and Private Hospitals solely on the state’s General Fund to obtain their federal funds. In addition, Public Hospitals use Intergovernmental Transfers (IGT’s) on a limited basis to obtain federal matching funds.

The framework of the Waiver is quite complex and consists of several funding mechanisms, including the Health Care Support Fund (i.e., Safety Net Care Pool), Stabilization Funding, Disproportionate Share Hospital (DSH) payments, replacement DSH and replacement Graduate Medical Education payments, Physician Services, Distressed Hospital Fund, and Medi-Cal per diem and cost-based payments.

Pending Comprehensive 1115 Medi-Cal Waiver

With the existing Hospital Financing Waiver scheduled to sunset as of August 2010, trailer bill legislation — AB 4X 6, Statutes of 2009 — was adopted to commence with the framework for a new, more comprehensive Waiver for California. The goals of this new Waiver are:

- Strengthening California’s health care safety net;
- Reducing the number of uninsured individuals;
- Optimizing opportunities to increase federal financial participation;
- Promoting long-term, efficient and effective use of State and local funds;
- Improving health care quality and outcomes; and,
- Promoting home and community-based care.

The statute also directs for the Waiver to provide Medi-Cal enrollees with access to better coordinated and integrated care to improve outcomes and help slow the long-term growth in program costs. Among other things, it provides for the more comprehensive enrollment of individuals into specified organized delivery systems, such as managed care, enhanced primary care case management, or a medical home model.

The DHCS has developed a concept paper for the Waiver and is convening extensive workgroups to engage diverse stakeholders in crafting a framework for this Waiver.

Considerable work needs to be done over the next several months, including the development of an implementation plan. This plan is to be provided to the fiscal and policy committees of the Legislature prior to implementation of the Waiver, and at least 60-days prior to an appropriation by the Legislature for this purpose.

STAFF COMMENTS & QUESTIONS

The Subcommittee has asked the DHCS to provide an overview of the current 1115 Waiver, the process for developing the proposed new 1115 Waiver, and the Administration's goals for the content of the new Waiver.