SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Bill Monning
Senator Mimi Walters

March 6, 2014

9:30 a.m. or Upon Adjournment of Session

Room 4203, State Capitol

Agenda

(Michelle Baass)

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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4120 Emergency Medical Services Authority

1. Overview

The Emergency Medical Services Authority (EMSA) develops and implements emergency medical services systems (EMS) throughout California and sets standards for the training and scope of practice of various levels of EMS personnel. The EMSA also has responsibility for promoting disaster medical preparedness throughout the state and, when required, managing the state's medical response to major disasters.

Budget Overview. The budget proposes expenditures of about $28.4 million ($6.8 General Fund and $2.7 million federal funds) and 65.2 positions for EMSA. See table below for more information.

Table: EMSA Budget Overview

Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed
General Fund	$6,692,000	$6,771,000	$6,771,000
Federal Trust Fund	1,511,000	2,625,000	2,678,000
Reimbursements	11,276,000	14,801,000	14,801,000
Special Funds	3,351,000	3,972,000	4,132,000
Total Expenditures	**$22,830,000**	**$28,169,000**	**$28,382,000**
Positions	**67.4**	**64.2**	**65.2**

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of EMSA’s programs and budget.

2. Epinephrine Auto Injector Training

Budget Issue. EMSA requests one two-year limited-term position and $135,000 Specialized First Aid Training Approval (SFA) Fund expenditure authority, beginning July 1, 2014, to address the new workload associated with the development and implementation of the Epinephrine Auto Injector training and certification program resulting from the passage of SB 669 (Huff), Chapter 725, Statutes of 2013.

Since training program and certification revenues are not estimated to be collected until July 1, 2015, EMSA is requesting authority for a $135,000 loan from the Emergency Medical Services Personnel (EMSP) Fund for initial costs. Budget bill language to provide for this loan is requested.

EMSA proposes the following timeline to implement this new program:

- January 1, 2014 – June 30, 2014
    - Recruit and hire one position.
- July 1, 2014 – June 30, 2015
    - Convene taskforce to develop training standards and draft regulations.
- July 1, 2015 – June 30, 2016
    - Open and complete rulemaking process through the Office of Administrative Law.
    - Seek approval of the Office of Administrative Law and EMSA.
    - Begin to review and approve training programs and sell certification cards.

Background. The passage of SB 669 authorizes off-duty pre-hospital emergency medical care personnel and lay rescuers to obtain and use an epinephrine auto-injector (Epi-Pen) in emergency situations after receiving certification and training. SB 669 requires EMSA to approve authorized training providers and to establish and approve minimum standards for training and certification on the use and administration of epinephrine auto-injectors as specified by the bill.

SB 669 permits the EMSA to impose a reasonable fee on training providers for the review, approval, and certification of their training programs but does not expect the collection of fees to begin until July 1, 2015. EMSA estimates a training program review cost of $500 per program, with 10 programs to be reviewed throughout the entire state every year. The estimated revenue generated will be $5,000. Estimating an EMSA certification card and sticker cost of $15 per card for 9,000 individuals per year receiving or renewing their training will generate annual estimated revenues of $135,000. According to EMSA, given that there are approximately 80,000 EMTs and EMT-Paramedics currently licensed throughout the State, an estimate of 9,000 individuals who will seek training and renewals of certification every year is a very conservative number, as EMTs and EMT-Paramedics are not the only individuals who may reasonably have the responsibility to care for others. Other individuals throughout the

state may include camp counselors, park and forest rangers, wilderness guides, team coaches, and lifeguards.

California law authorizes school districts to provide epinephrine auto-injectors to trained personnel for the provision of emergency medical aid to students experiencing anaphylactic shock. School personnel first must complete an EMSA-approved training course covering characteristics and method of assessment and treatment of anaphylactic reactions and the use of epinephrine. These laws are consistent with laws adopted across the nation reflecting the understanding that the timely administration of epinephrine is essential to avoiding serious injury or death in cases of anaphylaxis, and that epinephrine auto-injectors, which contain carefully metered doses of this life-saving medication, are safe to administer by properly trained individuals.

Prior to the enactment of SB 669, it was illegal for first responders to possess or carry an epinephrine auto-injector to save lives for anyone suffering anaphylaxis. SB 669 expands the use of epinephrine auto-injectors by authorizing additional qualified personnel who have successfully completed a certified training course to obtain and use them to provide life-saving first aid in the event of anaphylaxis and provides immunity to properly certified individuals from civil liability, except in cases of gross negligence.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal as no concerns have been raised.

Questions. The Subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal and the timeline to implement this new program.

4140 Office of Statewide Health Planning and Development

1. Overview

The Office of Statewide Health Planning and Development (OSHPD) collects and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes. OSHPD also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities.

Budget Overview. The budget proposes expenditures of $145.7 million ($74,000 General Fund) and 479.6 positions for OSHPD.

Table: OSHPD Budget Overview

Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed	BY to CY Change
General Fund	$0	$74,000	$74,000	$0
Federal Trust Fund	1,434,000	1,504,000	1,444,000	-$60,000
Reimbursements	363,000	8,153,000	7,860,000	-$293,000
Mental Health Services Fund	20,957,000	52,350,000	26,291,000	-$26,059,000
Other Special Funds	69,044,000	114,156,000	110,066,000	-$4,090,000
Total Expenditures	**$91,798,000**	**$176,237,000**	**$145,735,000**	**-$30,502,000**
Positions	**445.1**	**476.6**	**479.6**	**-4**

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested OSHPD to respond to the following:

1. Please provide a brief overview of OSHPD's programs and budget.

2. Peer Personnel Support – Investment in Mental Health Wellness Act of 2013

Oversight Issue. A 2013 budget trailer bill, SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, established the Investment in Mental Health Wellness Act of 2013 which invests a total of $206.2 million in mental health wellness. Of this total amount, $2 million (Mental Health Services Act Fund - State Administration) was to provide training in the areas of crisis management, suicide prevention, recovery planning, and targeted case management and to facilitate employment of Peer Support classifications.

OSHPD released the Peer Personnel Support Request for Proposal (RFP) on December 27, 2013, and held two bidders' conferences on January 23, 2014 and February 10, 2014. The final date for proposal submission is March 7, 2014. OSHPD expects to award four contracts.

Generally, the goal of this RFP is to enter into a contract, or contracts, to:

A. Develop and document career pathways for positions employing Peer Personnel that provide entrance to the public mental health system with defined opportunities to advance across healthcare systems (a defined career pathway).

B. Recruit Peer Personnel for participation in the defined career pathway.

C. Establish/Expand educational or training programs for Peer Personnel.

D. Increase the total number of Peer Personnel employed in the public mental health system by recruiting and retaining Peer Personnel in identified entry-level positions.

Subcommittee Staff Comment. This is an informational item. It is requested that OSHPD keep the Subcommittee up-to-date on the implementation of this item.

Questions. The Subcommittee has requested OSHPD to respond to the following:

1. Please provide an overview of this issue and present how this RFP meets the goals outlined in the Investment in Mental Health Wellness Act of 2013.

2. Did OSHPD work with stakeholders to develop this RFP? Please explain.

3. Health Care Reform Health Workforce

Budget Issue. OSHPD requests to make permanent the three limited-term positions responsible for proactive Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA) and Medically Underserved Population (MUP) designation. These positions proactively seek to make these designations to improve access to care in underserved communities.

Additionally, OSHPD requests to make permanent one position responsible for continuing the implementation of the Health Care Reform work plan.

These two requests result in an increase in the California Health Data and Planning Fund (CHDPF) expenditure authority of $355,000 in 2014-15 and ongoing.

Background. OSHPD has traditionally processed HPSA, MUA, and MUP applications in a reactive fashion; community clinics or stakeholders submit their application to OSHPD and staff validates the information in the HPSA, MUA, and MUP applications and makes a recommendation to the federal government.

The 2011-12 budget authorized three positions to perform these designations on a proactive basis. The proactive process allows OSHPD to prepare the aforementioned applications by identifying which areas of the state meet the federal criteria for designation and preparing designation applications on behalf of communities. However, OSHPD was unable to fill these four positions until February 2012. The 2013-14 budget reauthorized these positions through June 2014 on a one-year extension.

According to OSHPD, permanency for these positions is necessitated by the complexity of implementing Affordable Care Act (ACA) healthcare workforce provisions such as upcoming rule changes to the method of shortage designations, increasing demand to designate underserved areas, maximizing federal program and funding opportunities, developing policy recommendations on health workforce issues that promote employer health workforce diversity programs and invest in pipeline efforts, and developing workforce education and training programs that increase the health care workforce in underserved areas.

Additionally, the ACA includes provisions on health workforce. OSHPD has assumed the role of leading the state's efforts to ensure maximum funding for California for healthcare workforce development. This includes applying for grants that expand OSHPD programs , developing new programs and increasing awareness and providing technical assistance to grant applicants. OSHPD has been involved in guiding the implementation of health workforce provisions of the ACA and developed a health care reform implementation work plan. One of the limited-term positions requested to be extended is responsible for continuing the implementation of the healthcare reform work plan.

In the 2012 calendar year, California received almost $1.7 billion in federal, state, local, and private funding for programs in which one of the pre-requisites for participation is a HPSA,

MUA, or MUP designation. Given the myriad of programs whose funding status relies on its designation status, this number will increase considerably. The $1.7 billion represented an increase of nearly $200 million in funds leveraged from the 2011 calendar year. Of the 2013 total, $1.6 billion was awarded to Federally Qualified Health Centers (FQHC), FQHC Look-Alikes, and Rural Health Clinics (RHC). Both FQHC and RHC funds require the sites to be located in either a Primary Care HPSA/MUA/MUP or serve in a MUA/MUP designation.

During 2012-13, the federal government approved 21 new communities as Primary Care HPSAs through the efforts of these three positions, which resulted in an additional 1.7 million Californians benefiting from these designations.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this request. Granting permanency to these positions enables OSHPD to continue to proactively designate shortage areas and secure additional funding for California.

Questions. The Subcommittee has requested OSHPD to respond to the following:

1. Please provide an overview of this proposal.

2. Please highlight the results in California of the proactive designation.

4. Hospital Inpatient Discharge Data Audit

Budget Issue. OSHPD requests two positions, $652,000 in 2014-15, and $636,000 ongoing in California Health Data and Planning Fund authority to conduct periodic audits of hospital discharge data that is related to any report that OSHPD publishes.

OSHPD requests two positions:

1. Research Scientist III –This position would utilize statistical techniques to analyze hospital discharge records to identify the hospitals most likely to have serious coding issues and recommend hospitals to be audited. This position would create, maintain, and update the data mining and analysis system for targeted hospital audits.

2. Associate Governmental Program Analyst – This position would communicate with hospitals, provide training interventions with facilities that have performed poorly on the audits, and provide technical assistance.

As part of this proposal, $400,000 would be used to contract with a vendor to conduct audits of medical records to assess data quality issues onsite at hospitals across the state. This would allow for reabstraction of 4,000 charts annually at 10 hospitals.

Background. OSHPD annually publishes the following 12 medical conditions or procedures:

- Acute Stroke [including hemorrhagic]
- Acute Myocardial Infarction [heart attack including transfers between healthcare facilities]
- Heart Failure
- Gastrointestinal Hemorrhage [intestinal bleeding]
- Hip Fracture
- Pneumonia
- Abdominal Aortic Aneurism Repair [for bulging abdominal aorta]
- Carotid Endarterectomy [surgery on the carotid artery in neck]
- Craniotomy [operation through the skull, including brain surgery]
- Esophageal Resection [removal of all or part of the esophagus]
- Pancreatic Resection [removal of all or part of the pancreas]
- Percutaneous Coronary Intervention (PCI) [non-surgical coronary artery disease treatment, including insertion of a stent]

OSHPD states that funding was not initially requested to fulfill the mandate (Health and Safety Code Section 128745(e)) to create outcome reports because the number of outcome measures OSHPD produced at that time was small, but it has since greatly expanded. Between 2008 and 2010, the number of reports grew 500 percent (from three to 15), making additional resources for data auditing necessary. The need for timely, accurate, and actionable healthcare information has been well documented in legislative mandates, national

healthcare reform efforts, and consumer initiatives as well as by business and healthcare industry representatives and the public health community.

Increasingly, health provider outcomes data are being used in programs that link payers' reimbursement levels with performance, such as the Center for Medicare and Medicaid Service's hospital performance-based incentive programs. OSHPD states that this proposal will support those programs and ensure more accurate reporting of hospital performance in the areas of risk-adjusted mortality, hospital-acquired infections, surgical and medical complications, rates of hospital readmissions, treatment errors, and patient safety incidents.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this request as it is important for reliable data to be used in OSHPD's reports. No issues have been raised with this proposal.

Questions. The Subcommittee has requested OSHPD to respond to the following:

1. Please provide an overview of this proposal.

5. Song-Brown Primary Care Residency

Budget Issue. OSHPD requests the following:

a. $2.84 million per year for three years in California Health Data Planning Fund (CHDPF) expenditure authority to expand its Song-Brown Health Care Workforce Training Program to fund primary care residency programs via the Song-Brown Program. This expansion will increase the number of primary care residents specializing in internal medicine, pediatrics as well as obstetrics and gynecology (OB/GYN).

b. To expand eligibility for Song-Brown residency program funding to teaching health centers. Song-Brown's focus on areas of unmet need (AUN) results in residents' exposure to working with underserved communities, providing culturally competent care and learning to practice in an inter-disciplinary team.

c. One three-year limited-term Staff Services Analyst position and $106,000 in CHDPF spending authority to develop and implement the program. This position would, for example, draft regulations; seek stakeholder feedback; develop key program components such as eligibility criteria; work with OSHPD's e-application vendors to modify the grants management system to include the additional primary care residency programs; develop and implement an outreach and marketing campaign; administer the contract process; collect and maintain program data to prepare progress, final reports, and summaries; and evaluate the outcomes of the expansion program.

The funding source for this proposal will be the CHDPF which will receive a $12 million repayment from a loan to the General Fund in 2014-15.

Statutory changes are needed to implement this proposal. For example, statutory language is necessary to expand the Song-Brown program criteria to include residencies in Teaching Health Centers as the Song-Brown program is currently limited to medical school-based residency programs. Teaching health centers are community-based ambulatory patient care settings (e.g., clinics) that operate a primary care medical residency program.

Background. Song-Brown provides grants to support health professions training institutions that provide clinical training for Family Practice residents, Family Nurse Practitioner, Primary Care Physician Assistant, and Registered Nurse students. Residents and trainees are required to complete training in medically underserved (Health Professional Shortage Areas, Medically Underserved Areas, Medically Underserved Populations, Primary Care Shortage Areas, and Registered Nurse Shortage Areas), underserved communities, lower socio-economic neighborhoods, and/or rural communities.

According to OSHPD, Song-Brown funded programs have led practitioners to be at the forefront of curricula development and clinical care for many contemporary challenges facing California's healthcare system such as homeless, refugee, and immigrant health. Various

studies indicate that residents exposed to underserved areas during clinical training are more likely to remain in those areas after completing their training.

Funding is provided to family practice residency programs via capitation funding. Each training program funded by Song-Brown must meet the accreditation standards set forth by their specific discipline. Song-Brown funds do not replace existing resources but are used to support and augment primary care training. Family practice residency programs are funded in increments of $51,615 per capitation cycle ($17,205 per year for three years). The funding level per capitation cycle has remained the same since the program's inception in 1974 and only covers a portion of a resident's training cost which has been estimated to exceed $150,000 per year.

There are 110 primary care residencies in the state and of these, 44 are family practice programs that currently apply for Song-Brown funds. The remaining 66 residencies include 31 internal medicine, 18 OB/GYN, and 17 pediatric programs. Based on the number of primary care residency programs in California, the $2.84 million would be allocated into an annual 50/25/25 split at a capitation rate of $51,615 per resident for a maximum request of 2 residents per applicant. See below for tables on how these funds are proposed to be used.

Internal Medicine – Projected Outcomes by Fiscal Year

	2014-15	2015-16	2016-17
Requests received	31	31	31
Grants awarded	13	13	13
Residents/students supported	27	27	27
Funds awarded	$1,420,000	$1,420,000	$1,420,000

Obstetrics/Gynecology – Projected Outcomes by Fiscal Year

	2014-15	2015-16	2016-17
Estimate of possible applications	18	18	18
Estimate of possible application awards	6	6	6
Possible residents/students supported	13	13	13
Funds to be awarded	$710,000	$710,000	$710,000

Pediatrics – Projected Outcomes by Fiscal Year

	2014-15	2015-16	2016-17
Estimate of possible applications	17	17	17
Estimate of possible application awards	6	6	6
Possible residents/students supported	13	13	13
Funds to be awarded	$710,000	$710,000	$710,000

In the third year, OSHPD proposes that Song-Brown staff will engage in an extensive review of the expansion program to evaluate outcomes and impact. This will include documenting the number of primary care resident slots funded, exposure to primary care curricula and didactic clinical training in underserved areas, retention of residents in those areas, etc. Based on the evaluation of the program, permanent funding for the expansion program may be considered.

This proposal will be funded by the CHDPF. The CHDPF is supported by annual assessments on California's hospitals and skilled nursing facilities. Health and Safety Code Section 127280(h) provides for a maximum assessment rate of .035 percent of a hospital or skilled nursing facilities annual gross operating expenses. The current assessment rate for hospitals and skilled nursing facilities is .027 percent and .025 percent, respectively. In 2008, the CHDPF made a $12 million loan to the General Fund. This loan is scheduled to be repaid in 2014-15. The loan repayment will provide for the initial 3-year funding for this expansion program. If after evaluation of the first three years, on-going funding is supported, the assessment fee could be raised within the existing statutory limit to provide on-going support for this expansion program.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open to continue discussions with the Administration on this proposal and how the statutory changes would be enacted.

Questions. The Subcommittee has requested OSHPD to respond to the following:

1. Please provide an overview of this proposal.

6. Mental Health Services Act – Unspent Workforce Education Training Funds

Budget Issue. OSHPD requests that $102,000 in unexpended Mental Health Services Act (MHSA) Workforce, Education, and Training (WET) funds be appropriated through 2017-18 for mental health WET Programs.

Background. The 2012 budget transferred the Mental Health Services Act (MHSA) workforce education and training (WET) component to OSHPD (from the eliminated Department of Mental Health). The MHSA WET targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness.

The 2013-14 budget includes the reappropriation of $7.8 million in unexpended WET funds through 2017-18 for WET programs. The $7.8 million included $1.6 million in unexpended WET contract funds from 2010-11 and 2011-12. Since this unspent balance was not from OSHPD appropriations (as it was originally appropriated when the program was at the Department of Mental Health), OSHPD could not request a reappropriation of funds through 2017-18 as it did with all other WET appropriations in SB 68, amending the Budget Act of 2012 (Chapter 21, Statutes of 2012). Thus, OSHPD requested a new appropriation in 2013-14 via a May Revision budget request.

During year-end closing exercises, after the May Revision budget request was submitted to the Legislature, OSHPD received new information regarding unexpended balances for two vendors. As such, those unexpended balances could not be included in the 2013 May Revision proposal. This budget proposal captures those unexpended balances and requests reappropriation.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this request. No issues have been raised with this proposal.

Questions. The Subcommittee has requested OSHPD to respond to the following:

1. Please provide a brief overview of this proposal.

0530 California Health and Human Services Agency (CHHSA)

1. Office of Systems Integration (OSI) – CHHSA Governance

Budget Issue. The California Health and Human Services Agency (CHHSA) requests three permanent positions and $431,000 in reimbursement authority to provide dedicated staffing for the establishment of formalized governance, project assessment, and strategic enterprise architecture functions within the Office of the Agency Information Officer (OAIO).

The Administration states that the requested resources will greatly enhance information technology planning throughout the CHHSA by dedicating resources to prioriting information technology (IT) investments through early assessments and ensuring maximum investment in interoperable, highly adaptive systems that can be leveraged throughout the agency.

One of the requested positions would focus on strategic enterprise architecture and the other two positions would share responsibility for governance and program assessment, with one position taking a management role and the other position taking a staff analyst role. The requested positions would replace the redirected staff used sporadically in the past for these efforts.

CHHSA is also requesting to add provisional budget bill language to Item 0530-001-9745 that is intended to enhance the Office of Systems Integration's (OSI) ability to timely provide requested subject matter expertise on an as-needed basis to departments that have requested technical assistance for information technology projects or have been referred by the CHHSA or the California Department of Technology as having projects that are at-risk. The provisional language exempts augmentations to Reimbursements within this Item from Section 28.50 and requires the Finance Director to provide written notice to the Legislature within 30 days when the increase to Reimbursements exceeds $200,000. Proposed budget bill language:

0530-001-9745--For support of Secretary of California Health and Human Services, payable from the California Health and Human Services Automation Fund ……. 246,655,000
Schedule:
(1) 30-Office of Systems Integration ……. 247,086,000

(2) Reimbursements ……. -431,000

Provisions:
4. Augmentations to reimbursements in this item are exempt from Section 28.50. The Director of Finance shall provide written notification within 30 days to the Joint Legislative Budget Committee describing the nature of these augmentations when the amount received exceeds $200,000.

Background. CHHSA is the largest agency in state government with a total of 13 departments and three offices, with a current active IT project portfolio estimated at $1.8 billion. See table below for a list of these projects.

Table: CHHSA Active IT Project Portfolio Summary (Major Projects)

Department	IT Project Name	Total Cost
DSS/OSI	LEADER Replacement System (LRS)	$472,373,213
DHCS	CA Medicaid Management Information System (CA-MMIS)	$458,591,056
	CalHEERS	$416,332,107
DSS/OSI	Child Welfare Services New System Project (CWS-NS)	$351,800,000
DSH	Personal Duress Alarm System (All facilities: Atascadero (ASH), Coalinga (CSH), Metropolitan (MSH), Patton (PSH)) PDAS	$47,888,223
DHCS	Health Insurance Portability and Accountability (HIPAA) II	$30,777,467
DSH	Automated Staff Scheduling Information Support Tool (ASSIST)	$8,903,016
DSS	County Expense Claim Reporting Information System (CECRIS)	$7,740,594
CDPH	California Immunization Registry (CAIR) 2.0	$6,996,699
DSH	Active Directory Restructuring (AD)	$2,210,380

Acronyms: DSS – Department of Social Services, DHCS – Department of Health Care Services, DSH – Department of State Hospitals, CDPH – California Department of Public Health, OSI – Office of Systems Integration

Historically, the functions peformed by the OAIO have been conducted primarily through staff redirections and work teams derived from various departments. According to agency, this approach has resulted in limited success in ensuring agency-wide coordination of its information technology investments. As technologies continue to emerge toward systems that offer interoperable, multi-departmental opportunities, it is necessary to have full time staff dedicated to coordinating the IT investments at the Agency level.

Office of the Agency Information Officer (OAIO). Legislation enacted in 2007 vested broad responsibilities to improve the governance and strategic planning of IT with an agency Chief Information Officer. The CHHSA's Chief Information Officer was established as the OAIO—an office of the Secretary. It is charged with (1) overseeing the IT portfolio of CHHSA departments, (2) ensuring that all CHHSA departments are in compliance with state IT policy,

and (3) developing an "enterprise architecture"—the organization of IT infrastructure to reflect integration, consolidation, and standardization of requirements. Historically, the OAIO has not had dedicated staff; instead, its functions have been performed primarily through the sporadic redirection of staff from various CHHSA departments.

OSI. OSI—also an office of the Secretary—was established in 2005 to provide—under contract with CHHSA departments—project management, oversight, procurement, and support services to a portfolio of large, complex, and high criticality health and human services IT projects. (Outside CHHSA, departments are responsible for their own project management, unless project management services are contracted out to a third–party vendor.) Although there is collaboration between OAIO and OSI, typically OSI begins its project management role once the strategic planning is competed by OAIO. OSI's funding and staffing is project–specific. Therefore, OSI does not have the ability to redirect staff resources to provide technical assistance to projects not under contract with OSI.

Top Priorities for New Staff. According to the Administration, the top five initial priorities for the requested positions and formalized governance structure are:

1. Create an IT strategic plan for CHHSA and its departments – To ensure development of flexible IT solutions which eliminates silos and fosters interoperability and data sharing.

2. Review IT projects - Identify opportunities for multiple departments with similar IT needs to leverage a single system fostering collaboration and reuse.

3. Prioritize initiatives - Ensure the highest programmatic goals are the focus.

4. Collaborate with departments (once the project concept is approved) – Ensure alignment with project management best practices and CHHSA goals.

5. Review of projects (prior to Feasibility Study Report approval) - Verify that projects are appropriately resourced and if timelines and cost projections are accurate.

LAO Findings and Recommendations. The LAO finds that (1) the OAIO has limited capacity for IT strategic planning, (2) that additional strategic planning could eliminate duplicative projects, improve system interoperability, and lead to enhanced customer services, and (3) additional guidance during the planning phase could improve project success and potential cost savings. Consequently, the LAO supports the concept of the proposal; however, it recommends that the three positions be approved on a three-year limited-term basis and that a status report to the Legislature on the effects of the proposal be required. Additionally, the LAO does not recommend approval of the proposed budget bill provisional language as it finds that the exemption does not address what appears to be delays in the Administration's own internal review processes.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on how to ensure that the resources requested in

this proposal add value and achieve the intended and worthy goals of better agency-wide planning and coordination of IT projects.

Questions. Please respond to the following questions:

1. Please provide a brief overview of this proposal.

2. Please describe the top priorities to be accomplished through this proposal.

3. What is your response to the LAO's finding that the proposed budget bill provisional language does not address what appears to be delays in the Administration's internal review processes for augmentations to OSI's budget?

0530 CHHSA & 4265 Department of Public Health

1. Transfer of Medical Privacy Breach Program to Department of Public Health

Budget Issue. The Administration proposes to combine the authority and resources of two existing programs charged with enforcing medical privacy violations in order to increase efficiency. To do this, the Administration requests to transfer three investigator positions and associated workload and responsibilities from the Health and Human Services Agency California Office of Health Information Integrity (CalOHII) to the Department of Public Health (DPH).

According to the Administration, this proposal would allow current DPH and CalOHII staff to conduct concurrent investigations of violations by health facilities and individuals and eliminate or reduce redundancy and inefficiencies.

This transfer requires statutory changes.

Background. In 2008, legislation was enacted to improve patient privacy laws and their enforcement. The resulting laws established two law enforcement responsibilities as follows:

- ***Department of Public Health.*** Health and Safety Code Section 1280.15 requires health facilities, clinics, hospices, and home health agencies to prevent unlawful or unauthorized access to, and use or disclosure of, a patient's medical information. DPH, after investigation, may assess an administrative penalty of up to $25,000 per patient for a violation of these provisions, and up to $17,500 per patient for each subsequent occurrence. DPH may refer violations of this section to CalOHII for further follow-up enforcement actions.

- ***CalOHII.*** Health and Safety Code Division 109 (Sections 130200 through 130205) established CalOHII to ensure the enforcement of state law mandating the confidentiality of medical information and to impose administrative fines for the unauthorized use of medical information. Upon receipt of a referral from DPH, CalOHII may assess an administrative fine against any person or provider of health care, for any violation of this division. CalOHII may also recommend further action be taken by various agencies or entities to impose administrative fines, civil penalties, or other disciplinary actions against persons or entities that violate state confidentiality of medical information laws.

Since 2009, DPH and CalOHII have established and maintained two distinct enforcement programs, one focusing on medical privacy violations by health facilities and the other focusing on violations by healthcare providers and other individuals. The Licensing and Certification (L&C) Program of DPH is primarily responsible for regulating licensed healthcare facilities and ensuring their compliance to minimum standards of care and patient safety requirements. Since 2009-10, the number of deliberate breaches reported by healthcare facilities has nearly tripled and is expected to further increase**.**

Currently, licensed health facilities, clinics, hospices, and home health agencies report breaches of patients' confidential medical information to the L&C Program. DPH conducts an

investigation into the breach and may assess an administrative penalty for substantiated violations against the reporting entity. When a violation is substantiated, DPH refers the violation to CalOHII for enforcement actions against individuals and other involved entities**.** This requires subsequent visits to the facilities by these investigators, resulting in additional travel time and costs. CalOHII conducts its own investigation after DPH, often requiring interviews with the same individuals questioned by DPH. Furthermore, because CalOHII may only conduct an investigation after the DPH's referral, time lapses occur that often make it difficult for CalOHII to locate and contact individuals including victims, witnesses and subjects of violations. Finally, separate administrative and legal resources are necessary to support both functions. This proposal would improve efficiency by eliminating redundant investigations and related travel, improving timeliness, and by consolidating administrative and legal resources.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

Questions. Please respond to the following questions:

1. Please provide an overview of this proposal.

4265 Department of Public Health

1. Overview

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:

- ✓ Achieve health equities and eliminate health disparities
- ✓ Eliminate preventable disease, disability, injury, and premature death
- ✓ Promote social and physical environments that support good health for all
- ✓ Prepare for, respond to, and recover from emerging public health threats and emergencies
- ✓ Improve the quality of the workforce and workplace

The department comprises seven major program areas. See below for a description of these programmatic areas:

(1) Center for Chronic Disease Prevention and Health Promotion – This center works to prevent and control chronic diseases, such as cancer, cardiovascular diseases, asthma, adverse pregnancy outcomes, and diabetes; to reduce the prevalence of obesity; to provide training programs for the public health workforce; to prevent and control injuries, violence, deaths, and diseases related to behavioral, environmental, and occupational factors; to promote and support safe and healthy environments in all communities and workplaces; and to prevent and treat problem gambling.

(2) Center for Environmental Health – This center works to protect and improve the health of all California residents by ensuring the safety of drinking water, food, drugs, and medical devices; conducting environmental management programs; and overseeing the use of radiation through investigation, inspection, laboratory testing, and regulatory activities.

(3) Center for Family Health – This center works to improve health outcomes and reduce disparities in access to health care for low-income families, including women of reproductive age, pregnant and breastfeeding women, and infants, children, and adolescents and their families.

(4) Center for Health Care Quality – This center regulates the quality of care in approximately 8,000 public and private health facilities, clinics, and agencies throughout the state; licenses Nursing Home Administrators, and certifies Nurse Assistants, Home Health Aids, Hemodialysis Technicians, and other direct care staff.

(5) Center for Infectious Disease – This center works to prevent and control infectious diseases, such as HIV/AIDS, viral hepatitis, influenza and other vaccine preventable illnesses, tuberculosis, emerging infections, and foodborne illnesses.

(6) Center for Health Statistics and Informatics – This center works to improve public health by developing data systems and facilitating the collection, validation, analysis, and dissemination of health information.

(7) Public Health Emergency Preparedness – This program coordinates preparedness and response activities for all public health emergencies, including natural disasters, acts of terrorism, and pandemic diseases. The program plans and supports surge capacity in the medical care and public health systems to meet the needs during emergencies. The program also administers federal and state funds the support DPH emergency preparedness activities.

Summary of Funding for the Department of Public Health. The budget proposes expenditures of $3 billion ($110.6 million General Fund) for the DPH as noted in the Table below and 3,541.4 positions. 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 drinking 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.

The budget includes $683.3 million for state operations and $2.3 billion for local assistance. The budget reflects a net decrease of $472.5 million as compared to the revised 2013-14 budget primarily as a result of transferring the drinking water program to the State Water Resources Control Board. See tables below for more information on the proposed budget.

Table: DPH Budget Overview

Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed	BY to CY Change
General Fund	$129,474,000	$115,182,000	$110,629,000	-$4,553,000
Federal Trust Fund	1,785,473,000	1,888,068,000	1,732,974,000	-$155,094,000
Reimbursements	211,051,000	194,086,000	237,947,000	$43,861,000
Other Special Funds	943,815,000	1,286,301,000	929,615,000	-$356,686,000
Total Expenditures	**$3,069,813,000**	**$3,483,637,000**	**$3,011,165,000**	**-$472,472,000**
Positions	**3493.2**	**3795.7**	**3541.4**	**-254**

Table: DPH Program Funding Summary

Program	2012-13 Actual	2013-14 Projected	2014-15 Proposed
Public Health Emergency Preparedness	$87,891	$98,015	$97,598
Chronic Disease Prevention and Health Promotion	272,326	310,420	294,244
Infectious Diseases	624,053	597,508	592,727
Family Health	1,600,095	1,675,208	1,691,936
Health Statistics and Informatics	23,967	28,154	28,031
County Health Services	13,729	16,685	17,078
Environmental Health	279,559	554,768	83,507
Licensing and Certification	158,836	189,443	192,773
Laboratory Field Services	9,357	13,436	13,271
Administration	27,733	34,158	33,798
Distributed Administration	-27,733	-34,158	-33,798
Total Expenditures (All Programs)	**$3,069,813**	**$3,483,637**	**$3,011,165**

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of DPH's programs and budget.

2. Drinking Water Program Transfer to State Water Resources Control Board

Budget Issue. The Administration proposes to transfer the Drinking Water Program (DWP) from DPH to the State Water Resources Control Board (SWRCB). The budget proposes to shift 291 positions and $202 million ($5 million GF) from DPH to the SWRCB, and includes an additional $1.8 million (General Fund) for one-time funds for technology and facility costs.

The proposal shifts all programs (described below) and combines certain financial assistance programs:

- **Regulatory Program.** The proposal seeks to consolidate all water quality regulation within one state agency. The DWP would be organized as a separate division under the State Water Board. Program regulatory staff would remain in locally-based offices and would not be integrated with the regional water quality control boards. The division would be overseen by a deputy director who would be required to have public health expertise and who would report directly to the executive director. The deputy director would have the authority to grant or deny water system permit applications. These decisions would not be subject to Board review, nor would permit issuance and enforcement be delegated to the regional water boards. The proposal does not include a proposal to extend statutorily-mandated minimum penalties for waste discharge violations to drinking water violations.

- **Maximum Contaminant Level (MCL)-Setting.** MCLs are currently adopted as regulations by DPH. These are the health protective drinking water standards to be met by public water systems. MCLs take into account chemicals' health risks; factors, such as their detectability and treatability; and, costs of treatment. The MCLs would continue to be established through the regular rulemaking process under the Administrative Procedures Act. The deputy director would follow existing rulemaking procedures and the SWRCB would act on the proposed regulations in a public meeting, after which they would be subject to Office of Administrative Law review.

- **Recycled Water.** As a result of this reorganization, the DPH functions related to recycled water would be coordinated through the SWRCB permit process. The Board does not propose to change how these permits are issued, but proposes to seek opportunities for more efficient and effective permitting of recycled water.

- **Emergency Response.** The proposal plans to maintain the existing local emergency response structure of the DWP, including rotating district office duty officers, under the new division. The division would become part of the Cal-EPA Emergency Response Management Committee, which is Cal-EPA's coordinating body that assists in emergencies requiring cross-department or cross-agency solutions. For emergencies affecting water quality, such as sewage or chemical spills, the DWP would coordinate with the Regional Water Boards.

- **Operator Certification.** The SWRCB plans to jointly manage both Operator Certification Programs within the Division of Financial Assistance (already existing at SWRCB). This will allow the DWP to take advantage of the SWRCB's new web-based data management system for wastewater operators and would expand this system to include drinking water operators.

- **Financial Assistance Programs**. The proposal plans for the SWRCB to jointly manage the Clean Water and Drinking Water State Revolving Funds (SRFs) and both bond programs (Propositions 50 and 84) within the Division of Financial Assistance. This proposal will likely require statutory and regulatory changes to harmonize the programs. The division would combine the programs to streamline water quality infrastructure financing, in particular for application assistance for disadvantaged communities.

As a precursor to this proposal, the Administration hosted a series of stakeholder meetings and convened a reorganization task force to solicit feedback on the proposal. The Administration plans to prepare a transition plan in February 2014 that will take into account the efforts to date.

Objectives of Transfer. The Administration intends for the transfer to achieve several objectives. First, it believes consolidating the state's drinking water and water quality programs would result in more integrated water quality management. It considers that consolidating responsibilities for drinking water oversight and regulation with SWRCB's water quality and water rights regulatory activities could allow a single department to address interrelated water issues more comprehensively. For example, there could be a more coordinated focus on the sources of water pollution and their effects on drinking water. In addition, there may be opportunities to coordinate permitting processes for entities that are currently regulated by both DPH and SWRCB.

The Administration also believes this consolidation would improve the state's ability to provide financial assistance to small disadvantaged communities. A SWRCB–administered drinking water program may be more likely to have the expertise and administrative resources required to adequately run the program and get financial assistance out the door in a timely manner. For example, the SWRCB has significant expertise in financial management, including recent experience leveraging their revolving fund to increase the amount of loans the fund is able to offer. This expertise could be extended to Safe Drinking Water State Revolving Fund (SDWSRF).

Finally, the Administration believes the transfer would enhance accountability and transparency on drinking water issues because SWRCB's board structure with regular hearings provides a process for the public and stakeholders to offer comments on proposed rules or other issues. This could improve the ability of the public to hold decision–makers accountable for drinking water outcomes.

Background. DPH administers the federal Safe Drinking Water Act (and the parallel state statute). The DPH's overall programs are involved in a broad range of health-related activities, such as chronic disease prevention, communicable disease control, regulation of

environmental health (including drinking water quality), and inspection of health facilities. The department's drinking water program (DWP) regulates 5,700 public water systems serving more than 15 service connections or 25 people. The department also oversees water-recycling projects, permits water treatment devices; and provides various technical assistance and financial assistance programs for water system operators—including bond and federally-funded programs for infrastructure improvements in public water systems—to meet state and federal safe drinking water standards. The department administers a revolving loan fund for water treatment infrastructure improvements that is funded by the U.S. Environmental Protection Agency (US EPA). The department responds to drinking water emergencies and provides oversight, technical assistance, and training for local water agencies.

The State Water Resources Control Board (SWRCB) and the nine semi-autonomous regional boards, administer the federal Clean Water Act (and the parallel state statute). Specifically, the board regulates the overall quality of the state's waters, including groundwater, to protect the beneficial uses of water by permitting waste discharges into water and enforcing water quality standards. The board administers the state's system of water rights and provides financial assistance to fund wastewater system improvements, underground storage cleanups, and other improvements to water quality. The board also administers a similar revolving loan fund for wastewater infrastructure improvements that is funded by the US EPA.

LAO Findings and Recommendation. The LAO finds that the proposed transfer is likely to improve the effectiveness and efficiency of state water policy. However, it also finds that specific aspects of the transfer that warrant legislative consideration, including: (1) the continuation of some potential enforcement concerns; (2) coordination between SWRCB and DPH in responding to emergencies and protecting public health; and, (3) statutory changes to the administration of Safe Drinking Water State Revolving Fund.

Consequently, the LAO recommends that the Legislature: (1) approve the proposed transfer of DWP to SWRCB; (2) require the Administration to report at budget hearings on the details of the transition plan and progress made by DPH and SWRCB on coordinating implementation of the transfer; and, (3) require reports on the outcomes of the transfer, including its effects on permitting, enforcement, and emergency response.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open in order to continue discussions on this proposal. Additionally, it should be noted that Senate Budget Subcommittee No. 2 (which covers SWRCB) will discuss this issue in more detail at its April 20th Subcommittee hearing.

Questions. The Subcommittee has requested DPH to respond to the following questions.

1. Please provide an overview of this proposal.

2. How has the Administration reached out to and involved public health stakeholders in the development of this proposal? How has the Administration addressed public health stakeholder concerns?

3. Licensing and Certification (L&C) Program

Issue. There are significant concerns regarding the Licensing and Certification (L&C) program's ability to complete its mission to promote the highest quality of medical care in community settings and facilities.

The Governor's budget does nothing to address these concerns and does not put forth a proposal to immediately address the inconsistent and untimely enforcement of federal and state laws regarding the health facilities it licenses.

Background. The Licensing and Certification (L&C) Program 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. L&C contracts with Los Angeles County to license and certify health facilities in Los Angeles County.

L&C Fee Report. Existing statute requires the L&C Program 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 fees are calculated based solely on the statutorily prescribed workload methodology as contained in statute.

The "credits" are applied to offset fees (e.g., hold the fee stable or reduce the fee) for 2014-15 and total $15.3 million. They are as follows:

- $3.8 million credit for miscellaneous revenues for change in ownerships and late fees.
- $11.5 million credit from the program reserve which is applied to each facility type to prevent fees from increasing "on the natural" and placing a cap of 20 percent on fees that would have decreased "on the natural."

***Background on L&C 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).
- 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, as well as useful data on L&C workload associated with the various types of health care facilities, along with a clear description regarding the details of the methodology. This report can be found at:

http://www.cdph.ca.gov/pubsforms/fiscalrep/Documents/LicCertAnnualReport2014.pdf

The DPH Fee Report of February 2014 proposes to generally keep fees at the same level as the current year and to slightly decrease certain fees as shown in the table below.

Table: Proposed Health Facility License Fees

License Fees by Facility Type			
Facility Type	Fee Per Bed or Facility	FY 2013-14 Fee Amounts	FY 2014-15 Proposed Fee Amounts
Acute Psychiatric Hospitals	Bed	$ 266.58	$ 266.58
Adult Day Health Centers	Facility	$ 4,164.92	$ 4,164.92
Alternative Birthing Centers	Facility	$ 2,380.19	$ 2,380.19
Chemical Dependency Recovery Hospitals	Bed	$ 191.27	$ 191.27
Chronic Dialysis Clinics	Facility	$ 2,862.63	$ 2,862.63
Community Clinics	Facility	$ 718.36	$ 718.36
Congregate Living Health Facilities	Bed	$ 312.00	$ 312.00
Correctional Treatment Centers	Bed	$ 573.70	$ 573.70
District Hospitals Less Than 100 Beds	Bed	$ 266.58	$ 266.58
General Acute Care Hospitals	Bed	$ 266.58	$ 266.58
Home Health Agencies	Facility	$ 3,452.38	$ 2,761.90
Hospice Facilities *	Bed	$ 312.00	$ 312.00
Hospices (2-Year License Total)	Facility	$ 3,713.56	$ 2,970.86
ICF - DD Habilitative	Bed	$ 580.40	$ 580.40
ICF - DD Nursing	Bed	$ 580.40	$ 580.40
ICF - Developmentally Disabled	Bed	$ 580.40	$ 580.40
Intermediate Care Facilities	Bed	$ 312.00	$ 312.00
Pediatric Day Health/Respite Care	Bed	$ 150.41	$ 150.41
Psychology Clinics	Facility	$ 1,476.66	$ 1,476.66
Referral Agencies	Facility	$ 3,494.41	$ 2,795.53
Rehab Clinics	Facility	$ 259.35	$ 259.35
Skilled Nursing Facilities	Bed	$ 312.00	$ 312.00
Special Hospitals	Bed	$ 266.58	$ 266.58
Surgical Clinics	Facility	$ 2,487.00	$ 2,487.00

* Pursuant to SB 135 (Hernandez), Chapter 673, Statutes of 2012, a new Hospice Facility licensure category was established. In the first year of licensure, the fee shall be equivalent to the license fee for Congregate Living Health Facilities.

L&C Estimate. In addition to the fee report, the L&C program develops a budget estimate that details all L&C programmatic, fiscal, and workload factors that it uses to develop its budget. The 2014-15 estimated L&C budget is $188.8 million, which is an increase of $1.9 million from the current year. This increase is a result of two budget proposals discussed later in the agenda.

There are about 800 positions in the L&C field operations, these positions conduct and support licensing surveys and complaint investigations.

According to the L&C estimate, updated workload factors show a decrease of overall surveyor workload hours and staffing needs and projects that 70 less L&C field operations staff would be needed. However, L&C notes that it is undergoing a comprehensive program evaluation to improve the reliability of the estimate; consequently, it proposes to maintain the current year level of funding (with the addition of $1.9 million for specific budget proposals).

CMS Concerns with L&C. On June 20, 2012, the federal Centers for Medicare and Medicaid (CMS) sent a letter to DPH expressing its concern with the ability of DPH to meet many of its current Medicaid survey and certification responsibilities. In this letter, CMS states that its analysis of data and ongoing discussions with DPH officials reveal the crucial need for California to take effective leadership, management, and oversight of DPH's regulatory organizational structure, systems, and functions to make sure DPH is able to meet all of its survey and certification responsibilities.

The letter further states that "failure to address the listed concerns and meet CMS' expectations will require CMS to initiate one or more actions that would have a negative effect on DPH's ability to avail itself of federal funds." In this letter, CMS acknowledges that the state's fiscal situation in the last few years, and the resulting hiring freezes and furloughs, has impaired DPH's ability to meet survey and certification responsibilities.

As a result of these concerns, CMS set benchmarks for DPH to attain and is requiring quarterly updates from DPH on its work plans and progress on meeting these benchmarks.

Recent Legislative Oversight Hearings on L&C. Multiple recent legislative oversight hearings by the Assembly Committee on Aging and Long-Term Care, Assembly Committee on Health, Senate Committee on Business, Professions and Economic Development, and Senate Committee on Health and media reports have highlighted significant gaps in state oversight of health facilities and certain professionals that work in these facilities. These gaps include a backlog of complaint investigations against certified nurse assistants and untimely health facility complaint investigations.

Long-Standing Problems with Complaint Investigations. There has been long-standing concerns about L&C's ability to investigate and close complaints in a timely manner. The LAO (in 2006) and the Bureau of State Audits (in 2007) found that L&C had a backlog of complaints and that complaint investigations were not investigated or closed in a timely manner.

These concerns still exist today. See tables below for the number of skilled nursing facility and hospital complaints. At the time of this agenda, the department has been unable to indicate how many reports were investigated in a timely manner (within 10 days per state law for complaints that do not pose imminent danger and 24 hours for those that pose imminent danger) nor a count of how many investigations are currently open.

Table: Skilled Nursing Facility Complaints Summary

Complaints Received per Quarter CY 2012 and 2013		Complaints Investigated and Closed within 60 Days of Investigation in CY 2012 and 2013		Complaints with Departmental Action Taken (deficiency issued) in CY 2012 and 2013	
QUARTERS	TOTAL	QUARTERS	TOTAL	QUARTERS	TOTAL
2012 Q1	1,447	2012 Q1	613	2012 Q1	401
2012 Q2	1,503	2012 Q2	760	2012 Q2	415
2012 Q3	1,534	2012 Q3	771	2012 Q3	365
2012 Q4	1,443	2012 Q4	806	2012 Q4	352
2013 Q1	1,465	2013 Q1	885	2013 Q1	292
2013 Q2	1,386	2013 Q2	993	2013 Q2	278
2013 Q3	1,531	2013 Q3	1,352	2013 Q3	257
2013 Q4 YTD	545	2013 Q4 YTD	404	2013 Q4 YTD	33

NOTE: Numbers in Table 2 and 3 will not add to Table 1 because either a complaint was not completed within 60 days or did not have a deficiency or a combination of both.

Table: Non-Deemed Hospital Complaints Summary

Complaints Received per Quarter CY 2012 and 2013		Complaints Investigated and Closed within 60 Days of Investigation in CY 2012 and 2013		Complaints with Departmental Action Taken (deficiency issued) in CY 2012 and 2013	
QUARTERS	Total	QUARTERS	Total	QUARTERS	Total
2012 Q1	32	2012 Q1	12	2012 Q1	3
2012 Q2	24	2012 Q2	7	2012 Q2	6
2012 Q3	42	2012 Q3	22	2012 Q3	3
2012 Q4	36	2012 Q4	19	2012 Q4	5
2013 Q1	43	2013 Q1	23	2013 Q1	6
2013 Q2	37	2013 Q2	26	2013 Q2	12
2013 Q3	38	2013 Q3	33	2013 Q3	6
2013 Q4 YTD	10	2013 Q4 YTD	1	2013 Q4 YTD	1

NOTE: Numbers in Table 2 and 3 will not add to Table 1 because either a complaint was not completed within 60 days or did not have a deficiency or a combination of both.

Subcommittee Staff Comment and Recommendation—Hold Open. There are major concerns with L&C's ability to meet its mandate to ensure that health facilities and certain individuals who work in these facilities provide quality care in safe environments. Specific concerns include:

- ***L&C Not Meeting CMS Benchmarks.*** As discussed above, DPH must report quarterly to CMS regarding its progress in meeting benchmarks. In its fourth quarter report for 2013 to CMS, DPH did not meet the benchmark to investigate and close 95 percent of hospital and nursing home complaints within 60 days of the investigation. It only closed 64 percent. Subcommittee staff has requested the most recent benchmark report, but it has not been provided.

- ***Unclear if L&C is Enforcing State Laws.*** In addition to conducting *federal* surveys of health facilities, L&C is responsible for enforcing *state* laws regarding health facilities. Generally, these state laws are more stringent than federal requirements. L&C is not able to explain whether or not it is enforcing state laws and has no mechanism to evaluate this workload factor.

- ***Unable to Understand Workload and Staffing Needs.*** The Administration has admitted that its current methodology to assess workload demands and needs is flawed. For this reason, it is proposing no change to its budget even though it estimates that it would need 70 less staff. It notes that it is undertaking an evaluation and making an effort to develop a better timekeeping system and workload forecast.

- ***Credit to Health Facilities vs. Investment in Workforce.*** For the second year in a row, L&C proposes to credit health facilities with over $11 million from the program reserve instead of using these funds to address the problems with this program. L&C fees are to be used to support the work associated with enforcing state laws and requirements. Since it is clear that L&C has not been able to enforce these mandates, it should evaluate how these reserve funds could be used to ensure that laws are enforced.

DPH indicates that it understands these concerns and is in the process of conducting a complete evaluation of its program (see next agenda item for more information). While this evaluation is warranted, the findings and recommendations from this evaluation would not be implemented for at least two more years. Consequently, Subcommittee staff has requested technical assistance from L&C on developing short-term solutions to address the concerns regarding this program on a more immediate basis.

Questions. The Subcommittee has requested the L&C Program to respond to the following:

1. Please provide a brief summary of the L&C budget estimate and health facility fees, including the key credits and adjustments.

2. Please explain what efforts DPH is currently taking to address the concerns with the L&C program.

3. Please explain what steps DPH is taking to monitor its enforcement of state laws.

4. L&C: Program Evaluation Contract

Budget Issue. DPH requests one-time funding of $1.4 million from the Internal Departmental Quality Improvement Account (IDQIA) to further expand the work being conducted by the current contractor related to the Licensing and Certification (L&C) Program Evaluation project.

Background. In a letter dated June 20, 2012, CMS informed DPH that the L&C Program was not adequately meeting the federal survey and certification workload required in accordance with the U. S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) Mission and Priority Document. In addition to laying out benchmark goals in this letter, CMS required DPH to:

> "Conduct a comprehensive assessment of DPH's entire survey and certification operations at not only its headquarters, but also at each of the District Offices and the offices covered by its contractual agreement with Los Angeles County…The assessment must identify concerns, issues, and barriers related to DPH's difficulty in meeting performance expectations."

A previous letter dated May 4, 2012, withheld $1,565,384 from CDPH's 2012 federal grant allocation, pending demonstrated performance improvement.

In order to fulfill the CMS requirement, the L&C Program contracted with an external organizational improvement contractor in 2013-14 to pursue three deliverables: (1) preliminary program assessment, (2) organizational gap analysis, and (3) develop preliminary recommendations. These deliverables are scheduled to be presented to the L&C Program by the current contractor by spring 2014.

According to DHP, the approval of this budget proposal will allow implementation of the preliminary remediation plan proposed by the contractor.

The completion of this project will assist the L&C Program in identifying performance indicators and benchmarks to measure its compliance with state and federal regulations, in terms of both quality and quantity. It will help resolve challenges as follows:

1. Maintain and effectively manage its resources to meet statutory survey and certification responsibilities while successfully accomplishing other CMS workload mandates.
2. Ensure adequate CMS training activities are provided for the effective utilization and adherence to federal survey and enforcement processes.
3. Identify and eliminate barriers preventing the L&C Program from ensuring timely and accurate completion of mandated state and federal workload as outlined in existing state law and regulations.

The current contractor is performing high-level workload assessments and developing six scopes of work for improvements in the following areas: (1) workload assignment and workload management processes; (2) the Time Entry and Activity Management system

(TEAM); (3) allocation of staff and funding resources; (4) best practices; (5) program efficiencies; and (6) quality improvement activities.

Subcommittee Staff Comment and Recommendation—Hold Open. As discussed in the previous agenda item, there is significant concern that L&C is not able to meet federal and state mandates and that a complete program evaluation is warranted. This proposal presents an opportunity to develop a long-term solution to challenges facing L&C. It is recommended to hold this item open as discussions continue on short-term solutions to improve L&C's ability to complete its mandate to ensure individuals are safe and receive quality care in California's health care facilities.

Questions. The Subcommittee has requested L&C respond to the following:

1. Please provide an overview of this proposal.

2. Please provide a high-level overview of some of the preliminary findings from this assessment.

3. As this program evaluation is primarily a result of CMS concern with meeting federal mandates, please explain how DPH plans to utilize the findings to ensure compliance with state mandates as well.

5. L&C: Licensing Standards for Chronic Dialysis Clinics, Rehabilitation Clinics, and Surgical Clinics

Budget Issue. DPH requests one-time special fund (Internal Departmental Quality Improvement Account) expenditure authority of $201,000 to contract with the University of California, Davis (UCD) for an independent research analysis and report that describes the extent to which the federal certification standards are or are not sufficient as a basis for state licensing standards, as required by SB 534 (Hernandez), Chapter 722, Statutes of 2013.

DPH has contacted the Institute for Population Health Improvement at UCD to perform independent research and analysis and produce the required report on the sufficiency of the federal regulations. The analysis and report will consist of: (1) a review of the various certification, accreditation, and other relevant performance standards currently used to evaluate chronic dialysis clinics, surgical clinics, and rehabilitation clinics in other states, comparing requirements of the federal standards with these alternate standards; and (2) a systematic literature review of the peer-reviewed and grey literature on experiences with the implementation of those standards, including identification of areas in need of additional regulatory oversight. The projected cost is $200,000 for the required study.

Background. DPH licenses health care facilities and agencies in California through its Licensing and Certification (L&C) Program. Licensing is a state mandated and controlled function to assure that facilities providing health care services meet standards regarding qualifications and training of staff, the physical layout and condition of facilities, and systems governing the appropriateness and quality of the services provided.

L&C licenses approximately 30 different types of health care facilities including chronic dialysis clinics, rehabilitation clinics, and surgical clinics. L&C is also the state entity designated by the federal CMS to verify that health care facilities meet minimum certification standards to protect patient health and safety and qualify for Medicare and/or Medicaid reimbursement.

L&C develops regulatory standards for health care facilities and conducts periodic on-site inspections and investigations in response to complaints filed by the public. A longstanding policy has been to use federal certification standards to meet licensure requirements. SB 534 authorizes the DPH to continue this practice by formally adopting the federal certification standards for chronic dialysis clinics, surgical clinics, and rehabilitation clinics for a period of four years while the efficacy of the federal standards is evaluated.

Subcommittee Staff Comment and Recommendation—Hold Open. No issues have been raised regarding this proposal; however, it is recommended to hold this item open as discussions continue regarding L&C.

Questions. The Subcommittee has requested L&C respond to the following:

1. Please provide an overview of this proposal.

6. L&C: Oversight on Nursing Home Referrals to Community-Based Services

Oversight Issue. AB 1489 (Committee on Budget), Chapter 631, Statutes of 2012, requires the Department of Health Care Services, in collaboration with DPH, to provide the Legislature an analysis of the appropriate sections of the Minimum Data Set, Section Q and nursing facilities referrals made to designated local contact agencies (LCA) by April 1, 2013. This analysis should also document the LCA's response to referrals from nursing facilities and the outcomes of those referrals.

The Legislature has not yet received this report; it is almost one year overdue.

Background. On October 1, 2010, CMS required certified nursing facilities to begin using a new iteration of the Minimum Data Set (MDS 3.0). MDS is part of the federally mandated process for assessing nursing facility residents upon admission, quarterly, annually, and when there has been a significant change in status. Under Section Q of MDS 3.0, nursing facilities must now ask residents directly if they are "interested in learning about the possibility of returning to the community." If a resident indicates "yes," a facility is required to make the appropriate referrals to state designated local community organizations.

The state's California Community Transitions (CCT) project (funded with a federal Money Follows the Person grant) targets Medi-Cal enrollees with disabilities who have continuously resided in hospitals, nursing facilities, and intermediate care facilities for persons with developmental disabilities for three months or longer. The goal of this program is to offer a menu of social and medically necessary services to assist these individuals to remain in their home or community environments. By providing participants long-term services and supports in their own homes for one full-year after discharge from a health care facility, the state receives an 87 percent federal fund match.

Subcommittee Staff Comment and Recommendation—Hold Open. The Legislature has not yet received this report. Subcommittee staff has continually checked on the status of this report.

Given the state's efforts, with CCT and other initiatives, to provide services in home- and community-based settings, and the opportunity to receive enhanced federal funding for certain nursing home residents who transition to receiving services in the community, it is important to understand how and when nursing homes are making referrals to local agencies.

Questions. The Subcommittee has requested DPH respond to the following:

1. Please provide an overview of this issue.

2. What is the status of the report? When will the Legislature receive this report?

3. How does the Administration ensure that nursing facilities make the appropriate referrals to local contact agencies?

7. Office of AIDS (OA): AIDS Drug Assistance Program (ADAP)

AIDS Drug Assistance Program (ADAP) Update

ADAP is a subsidy program for low- and moderate-income persons living with HIV/AIDS who could not otherwise afford drug therapies. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the ADAP Pharmacy Benefit Manager (PBM).

Comparison of Current Year & Budget Year. The Office of AIDS (OA) estimates that 36,687 people living with HIV/AIDS will receive drug assistance through ADAP in 2014-15. The budget estimates expenditures of $409.6 million which reflects a *net* decrease of $9.4 million as compared to the revised current year. See tables below for more information.

Table: Governor's Estimated ADAP Expenditures for Current Year and Budget Year (dollars in millions)

Fund Source	2013-14 Budget Act	2013-14 Revised	2014-15 Proposed
General Fund	$0	$0	$0
AIDS Drug Rebate Fund	$260.8	$307.2	$259.8
Federal Funds – Ryan White	$79.1	$103.5	$98.7
Reimbursements from Medicaid Waiver (Safety Net Care Pool Funds)	$66.3	$8.3	$51.1
Total	**$406.3**	**$419**	**$409.6**

Table: Estimated ADAP Clients by Coverage Group

	2013-14		2014-15	
Coverage Group	**Clients**	**Percent**	**Clients**	**Percent**
ADAP-only	17,674	48.92%	17,441	47.54%
Medi-Cal	686	1.90%	708	1.93%
Private Insurance	7,714	21.35%	8,163	22.25%
Medicare	10,053	27.83%	10,375	28.28%
Total	36,127	100%	36,687	100%

Major changes from the 2013-14 Budget Act include:

- For 2013-14, an increase in ADAP Drug Rebate Fund expenditure authority of $46.4 million primarily due to the federal requirement to spend rebate funds prior to federal funds.
- For 2013-14, an increase in federal funds of $24.3 million due to additional grant awards.
- For 2013-14, a decrease in the use of reimbursements from the Medicaid Waiver (Safety Net Care Pool Funds) of $58 million due in part to the federal requirement to spend all rebate revenue first.

ADAP Eligibility and Current Cost-Sharing. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the Pharmacy Benefit Manager (PBM). Individuals are eligible for ADAP if they:

- Reside in 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 Californian physician; and,
- Lack private insurance that covers the medications or do not qualify for no-cost Medi-Cal.

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.

ADAP clients with incomes between $45,961 (over 400 percent of poverty) and $50,000 are charged monthly co-pays for their drug coverage which is established annually at the time of enrollment or recertification.

The current cost-sharing formula is based on twice the client's individual income tax liability, minus any health insurance premiums paid by the individual. The final amount due can vary greatly depending on the client's tax deductions, that are used to reach their final income tax liability (based on tax return). This amount is then split into 12 equal monthly payments which are collected at the pharmacy at the time the client picks up their medication.

The client's payment is then credited and the amount the pharmacy bills the ADAP Pharmacy Benefits Manager is adjusted to account for this credit.

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 drug manufacturers through the ADAP Taskforce). Generally, for every dollar of ADAP drug expenditure, the program obtains 65 cents in rebates. This 65 percent level is based on an average of rebate collections (both "mandatory" and "supplemental" rebates).

Federal HRSA Maintenance of Effort (MOE) for Ryan White CARE Act. The federal HRSA requires states to have HIV-related non-HRSA expenditures. California's 2013 HRSA match requirement for 2013-14 funding is $65.3 million. OA will meet the match requirement by using General Fund expenditures from the California Department of Corrections and Rehabilitation, and the University of California's California HIV/AIDS Research Program ($8.753 million), for example.

Impact of Federal Health Care Reform on ADAP. As a result of the federal Affordable Care Act, many ADAP clients have or are projected to transition to Medi-Cal (expansion) or Covered California starting January 1, 2014. See table below for the projected caseload transitions.

Table: Impact of Federal Health Care Reform on ADAP

Transition	2013-14		2014-15	
	Clients	ADAP Savings	Clients	ADAP Savings
Medi-Cal Expansion	5,401	$74 million	9,502	$131 million
Covered California	237	$1.2 million	552	$10 million

ADAP Savings include drug expenditure savings and premium payment savings.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending updated information at May Revise.

Questions. The Subcommittee has requested the Office of AIDS to respond to the following:

1. Please provide an overview of the ADAP budget.

2. Please provide an update on the transition of ADAP clients to Medi-Cal and Covered California.

8. OA: ADAP – Wrap for Out-of-Pocket Medical Expenses

Issue. The Office of AIDS (OA) has a number of programs to help people move into and retain comprehensive health coverage, such as the OA-Health Insurance Premium Payment (OA-HIPP) program. However, it does not have a program to pay for the out-of-pocket medical expenses (copays, coinsurance, and deductibles) associated with comprehensive health coverage for eligible persons with HIV/AIDS.

A program to pay for these out-of-pocket medical expenses could ensure that persons with HIV/AIDS can enroll in and receive comprehensive health coverage and could result in AIDS Drug Assistance Program (ADAP) savings as HIV/AIDS-related medications would be paid for by the primary health coverage (e.g., coverage purchased privately or through Covered California). Fifteen other states have ADAP programs that pay for these out-of-pocket medical expenses.[1]

This is not a proposal from the Administration.

Background. Nationally, ADAPs traditionally have provided access to medications through direct distribution to eligible clients. However, as the health care landscape has changed and more ADAP clients have been able to access public and private insurance coverage, ADAP's activities have also changed. Today, ADAPs are increasingly assisting clients with purchasing insurance, which is more cost-effective for ADAPs than direct provision of medications. Purchasing full insurance coverage also means that clients have access to quality, comprehensive medical care, which can significantly increase retention in care, viral suppression, and, ultimately, decrease rates of HIV transmission.

Currently, the OA-Health Insurance Premium Payment (OA-HIPP) program pays the monthly health insurance premiums for eligible California residents with an HIV/AIDS diagnosis. This program is available to individuals with health insurance who are at risk of losing it, as well as to individuals currently without health insurance who would like to purchase it. The purpose of the OA-HIPP is to get people with HIV comprehensive health coverage because it is better for their health and consequently, save ADAP the costs of covering the drugs (which are more expensive than premiums).

Technical Assistance from DPH. According to DPH, based on ADAP's experience transitioning clients to the Low Income Health Program, OA estimates that between 25 percent and 33 percent of eligible ADAP-only clients would enroll in Covered CA in the first year of implementation of this proposed policy change compared to an estimated 7.2 percent of ADAP-only patients that will enroll in Covered CA in 2015-16 if medical out-of-pocket costs are not covered.

1 National Alliance of State and Territorial AIDS Directors, "Fact Sheet: Insurance Purchasing/Continuation Assistance Provided by ADAPs."

Given these assumptions, OA projects that the cost of paying medical out-of-pocket expenses in this proposal would range from $1.8 to $2.4 million in 2015-16 but would result in a net other fund savings of $6.3 to $9.4 million in 2015-16. These estimates assume the current rebate return rate.

ADAP Special Funds (rebate funds) may be eligible to cover the cost for the Third Party Administrator to operationalize these changes. Also, per federal HRSA requirements, rebate (special) funds would cover the cost of the medical deductibles. If no rebate funds were available, then federal funds could cover these costs – similar to how the state currently pays for ADAP drug costs. The federal Health Resources Services Administration allows ADAP (Ryan White) funds to be used to cover costs associated with a health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain health insurance coverage. Ryan White funds may not be used to pay co-pays or deductibles for inpatient care.

The Administration's estimates assume the payment of medical out-of-pocket expenses would start January 1, 2016. In order to implement this programmatic change, OA would need to develop a request for proposals and enter into a new contract with a third party administrator to pay for premiums and eligible medical out-of-pocket expenses. It is not clear at this time whether additional administrative costs would be incurred for this approach and whether there are other costs to other state programs and departments.

The Administration also notes that this issue is part of a larger discussion of a statewide approach to state-only programs during the implementation of health care reform. There are a number of variables to consider, and its response is based on limited information. Part of the cost depends on how many HIV+ clients have already enrolled in Covered CA compared to how many additional clients would if OA paid the cost of medical expenses. If a relatively low percentage of HIV+ clients have already enrolled, but will now enroll as a result of implementation of this policy proposal, then this proposal would generate savings. However, if a high percentage of HIV+ clients have already enrolled in Covered CA, then this proposal could generate additional costs to the State. The Administration's preliminary data from the first four months of the initial six month Covered California open enrollment period support our estimate in the ADAP November Estimate for the *2014-15 Governor's Budget.*

In order to implement this new program, a statutory change would be needed to clarify that OA has the authority to pay for cost sharing (co-pays) for medical expenses. California Health and Safety Code (HSC) Section 120955(a) authorizes the director to establish and administer a program to provide drug treatments to persons infected with HIV/AIDS. The term drug treatment can be interpreted to mean diagnosis, associated laboratory tests, prescriptions, and follow-up care of a patient. However, the law does not specifically state whether ADAP can pay for medical co-pays (e.g., co-pays for medical office visits, radiologic studies, emergency room visits, inpatient visits, etc.) and deductibles for persons with HIV. HSC 120950(b) also states that the State of California has a compelling interest in ensuring that its citizens infected with the HIV virus have access to drugs used to treat HIV and HIV-related conditions.

The Department was given authority under Health and Safety Code Section 120950(c) to subsidize the cost of these drugs for persons who do not have private health coverage, are not

eligible for Medi-Cal, or cannot afford to purchase the drug privately. Enrolling and maintaining clients in private insurance by paying for cost sharing for medical expenses is a cost effective way for ADAP to subsidize the cost of HIV-related drugs.

Subcommittee Staff Comment and Recommendation—Hold Open. Creating a new ADAP program that covers out-of-pocket medical costs could reduce ADAP expenditures while providing more comprehensive health care coverage to people living with HIV/AIDS.

It is recommended to hold this item open as discussions continue on this proposal.

Questions. The Subcommittee has requested DPH to respond to the following questions.

1. Does the Office of AIDS have any comments on this proposal?

9. OA: Cross Match of ADAP Data with Franchise Tax Board

Budget Issue. The Office of AIDS (OA) proposes to amend statute to provide the State Franchise Tax Board (FTB) with authority to share state tax data with OA. The purpose is for verifying applicant/client income eligibility for OA's federally funded Ryan White HIV/AIDS Program (Ryan White), ADAP.

The proposed trailer bill language:

1. Authorizes DPH to disclose the name and taxpayer identification or social security number to the FTB for the purposes of verifying the adjusted gross income of an applicant or recipient of ADAP.

2. Authorizes FTB to inform DPH of all income information about these individuals.

3. Requires FTB to destroy the information received from DPH after exchanging the data.

Background. OA currently verifies income for Ryan White applicants/clients through a variety of applicant/client-provided documents including: pay stubs, support or self-employment affidavits, bank statements, and/or tax returns. According to OA, often times a client has difficulty providing income documentation. Furthermore, in lieu of providing tax returns, a client may provide pay stubs from only one job, but in fact have a second job that brings their income over the eligibility limit.

FTB has indicated a need for statutory authority in order to provide specified tax data to OA. Currently, FTB is authorized to share tax data with the Department of Social Services (DSS) and Department of Health Care Services (DHCS) for Medi-Cal eligibility determination.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

Questions. The Subcommittee has requested DPH to respond to the following questions.

1. Please provide an overview of this proposal.

2. Please explain how the other departments use this process for their eligibility determination processes.

10. Genetic Disease Screening Program – Prenatal Screening Fee Increase

Budget Issue. DPH proposes total expenditures of $116.9 million (Genetic Disease Testing Fund) for the Genetic Disease Screening Program (GDSP). This reflects a net increase of $8 million (Genetic Disease Testing Fund) as compared to the current-year. This program is fully fee supported. See table below for funding summary.

Table: Genetic Disease Screening Program Funding Summary

	2013-14	2014-15	BY to CY
	Projected	**Proposed**	**Change**
State Operations	$25,157,000	$28,258,000	$3,101,000
Local Assistance	$83,704,000	$88,654,000	$4,950,000
Total	$108,861,000	$116,912,000	$8,051,000

Included in the GDSP budget estimate are the following proposals:

- **Prenatal Screening Program Fee Increase.** DPH proposes to increase the fee in the Prenatal Screening Program by $45 to bring the total fee to $207, effective July 1, 2014. This fee covers a blood test for participating women and follow-up services offered to women with positive screening results. Although participation in the Prenatal Screening Program is voluntary, providers are required to offer screening to all women in California.

  DPH states that the fee increase is necessary to correct for the historic overstatement of caseload and the resulting inadequate fee revenue in recent years to cover costs. Historically, the Prenatal Screening Program has assumed a caseload of approximately 80 percent of the state's births; however, the caseload has been closer to 73 percent of the annual birth rate. DPH states that this fee increase will stabilize the fund over the next three years.

- **Consolidate Regional Screening Laboratories.** DPH proposes to consolidate the number of regional contract screening laboratories from seven laboratories down to five in order to achieve savings through economies of scale. Contract laboratories perform newborn screening and prenatal screening using state-supplied equipment, reagents, methods, and protocols; the labs provide qualified personnel to do the work for DPH. The savings would be realized primarily through a reduction of testing equipment and the related maintenance, operation, and repair expenses. The estimated one-time upfront moving costs in 2014-15 could range from $200,000 to $800,000, depending on the outcome of the competitive bidding process and how many existing Newborn and Prenatal Screening Labs are successful bidders for the newly consolidated regions. DPH anticipates savings of approximately $1.7 million dollars per year, which would occur no sooner than 2015-16.

- **Refine Algorithm for Detecting Positive Case.** DPH is investigating reducing the false positive rate for certain disorders. This would result in a decrease in reference laboratory services, follow-up diagnostic services, and case management and coordination services.

Background—Genetic Disease Testing Program. 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 (PNS) Program provides screening of pregnant women who *consent* to screening for serious birth defects. The current fee paid for this screening is $162. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. This program is expected to screen 371,497 expecting mothers in 2013-14 and 376,249 expecting mothers in 2014-15. DPH estimates that 45 percent of those who receive this screen are in Medi-Cal.

Women who are at high-risk based on the screening test results are referred for follow-up services at state-approved "Prenatal Diagnosis Centers". Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

The Newborn Screening Program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is about $113. Where applicable, this fee is paid by prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees.

The Newborn Screening Program screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis, and many others. Early detection of these conditions can provide for early treatment 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.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open in order to continue discussions on this proposal.

Questions. The Subcommittee has requested DPH to respond to the following questions.

1. Please provide an overview of this item and the components of the PNS fee increase.

2. Please explain what type of access analysis DPH conducted to evaluate if the proposed PNS fee increase would have a negative impact on access to these services.

11. Women, Infant, and Children Program (WIC)

Budget Issue. DPH requests $1.1 billion in federal trust fund and $248 million in WIC Manufacturer Rebate Special Fund for 2013-14 and $1.2 billion in the federal trust fund and $248 million in the WIC Manufacturer Rebate Special Fund for 2014-15.

Table: WIC Local Assistance Expenditures

Fund Source	2013-14 Projected	2014-15 Proposed	BY to CY Change
Federal Trust Fund	$1,144,932,000	$1,154,051,000	$9,119,000
Manufacturer Rebate Funds	248,000,000	248,100,000	$100,000
Total Expenditures	**$1,392,932,000**	**$1,402,151,000**	**$9,219,000**

Declining Caseload. DPH estimates that about 1,434,096 WIC participants will access food vouchers in 2013-14 and 1,427,552 participants in 2014-15.

Actual participation for federal fiscal year 2013 decreased by 2.26 percent from 2012. DPH indicates that it is currently conducting an analysis to understand the reasons behind the decrease in participation and to evaluate if there are geographic or demographic anomalies.

Background on WIC Funding. DPH states that California's share of the national federal grant appropriation has remained at about 17 percent over the last 5 years. Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:

- **Food**. Funds that reimburse WIC authorized grocers for foods purchased by WIC participants. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.
- **Nutrition Services and Administration.** Funds that reimburse local WIC agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition, education, breastfeeding support, and referrals to health and social services, as well as support costs.

  States are to manage the grant, provide client services and nutrition education, and promote and support breastfeeding with NSA Funds. Performance targets are to be met or the federal USDA can reduce funds.

- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with Infant Formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down federal WIC food funds.

Background on WIC Program. WIC is 100 percent federal fund supported. It provides supplemental food and nutrition to low-income women (185 percent of poverty or below) who are pregnant and/or breastfeeding, and for children under age five who are at nutritional risk.

WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

WIC participants are issued paper vouchers by local WIC agencies to purchase approved foods at authorized stores. Examples of foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter, and iron-fortified infant formula.

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

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

Maximum Reimbursement Rate Methodology. The maximum amount that vendors are reimbursed for WIC food is based on the mean price per redeemed food instrument type by peer group with a tolerance for price variances (referred to as MADR). Effective May 25, 2012, the USDA directed CA WIC to remove 1-2 and 3-4 case register WIC vendors from the MADR-determination process and instead set MADR for these vendors at a certain percentage higher than the average redemption value charged by vendors with five or more registers in the same geographic region. The USDA was concerned that California was paying 1-2 and 3-4 cash register stores up to 50 percent higher than prices paid to other vendors.

CA WIC submitted a plan to the USDA to address price competitiveness, MADR methodology, and cost containment. The final step of this plan will be the adoption of regulations regarding revised peer groups and reimbursement rates for authorized stores. DPH anticipates posting the final regulations by April 1, 2014. It is expected that the regulations would then be effective about 60 days later.

WIC Vendor Moratorium. WIC implemented a vendor moratorium in April 2011 so that it could address the backlog in new vendor applications. In April 2012, USDA directed California to maintain the moratorium until the peer group and reimbursement rate regulations (discussed above) are in effect. WIC is in the process of working with the USDA on the process for lifting the moratorium given that it is expected that the regulations would be in effect by June 2014.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as this estimate will be updated in the May Revise.

Additionally, it is recommended that the Subcommittee request that DPH update the Subcommittee on its analysis of the decrease in WIC participation and identify any geographic or demographic factors that impact participation.

Questions. The Subcommittee has requested the DPH to respond to the following:

1. Please provide a brief summary of the WIC budget.

2. Please provide an update on the status of the peer group and reimbursement rate regulations and the lifting of the WIC vendor moratorium.

3. Please comment on why participation in WIC decreased by 2.26 percent from federal fiscal year 2012 to 2013. What steps is DPH doing to evaluate and understand the reason for the decrease in participation?

4. Please provide an update on the appointment of a WIC Division Chief. (The interim Division Chief was appointed in April 2012.)

12. Nutrition Education and Obesity Prevention Branch – Contract Conversion

Budget Issue. DPH's Nutrition Education and Obesity Prevention Branch (NEOPB) requests authority to convert 70 personal service contract positions to 45 state positions. These positions are federally funded by the United States Department of Agriculture (USDA) through a reimbursement contract with the California Department of Social Services (CDSS). This personal services contract expires on September 30, 2014.

According to DPH, the proposed conversion will align this program with the Governor's directive to reduce reliance on external contracts, and comply with civil service mandate in California Constitution and Government Code (GC) Section 19130.

To implement this proposal, NEOPB requests authority to create 45 new state positions, and authority to fund those positions by shifting $4.2 million in 2014-15 and $5.3 million in 2015-16 from Local Assistance to State Operations.

Additionally, DPH proposes to also shift an additional $1.2 million in 2014-15 and $1.6 million in 2015-16 from Local Assistance to State Operations in order to fund 13 research positions which will be contracted through an interagency agreement with a University of California or a California State University. The combined total for the shift from Local Assistance to State Operations is $5.4 million in 2014-15 and $6.9 million in 2015-16.

In total, 70 of the contract positions would be converted to 58 state positions.

Background. California receives the largest portion of national funding ($136 million) from USDA's Nutrition Education and Obesity Prevention grant program also known as the Supplemental Nutrition Assistance Program for Education (SNAP-Ed). NEOPB manages a statewide obesity prevention initiative comprised of local, state, and national partners collectively working toward improving the health status of low-income Californians through increased fruit and vegetable consumption and daily physical activity.

The NEOPB's SNAP-Ed funded program provides nutrition education and obesity prevention services to qualifying residents. Depending on the type of services provided, it reaches between one million and 12 million Californians each year. These public health interventions are crucial in addressing the obesity epidemic in California. The services provided through this program include: education; training; technical assistance; research and evaluation; advertising; promotion; public relations; consumer empowerment; community development; and public and private partnerships.

NEOPB consists of approximately 147 positions, 70 of which are funded through a personal services contract with the Public Health Institute (PHI). The PHI contract was awarded in November 2009 for a five-year term (October 1, 2009 – September 30, 2014) for approximately $20 million per year for a total of $100 million. PHI has been awarded this contract since 1996. The current contract was approved by the Office of Legal Services and

signed by the Department of General Services (DGS) with a provision that another personal services contract of this nature in the future would not be submitted.

Under the existing contract, PHI provides leadership, local capacity building, services for specialized education, and marketing to California's communities. These efforts include special targeted campaigns for children and you in preschool, school, and after-school and community locations. To do this, PHI provides subcontracts and grants to over 50 community agencies, nonprofits, faith-based organizations, small businesses, and small vendors.

Under this proposal, NEOPB would transition into an entirely new model where the majority of funding will be granted to 61 local health departments. Without the conversion of positions, DPH contends that NEOPB cannot support the new model, provide experienced oversight, sustain needed activities, and continue to be a highly successful nutrition education program. If the NEOPB program is unsuccessful under the new model, it may lose future federal funding.

According to DPH, the conversion and addition of staff will result in $12.7 million in annual savings of USDA federal funds, beginning in 2015-16.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as concerns have been raised by the USDA on this proposal. Specifically, the USDA questions whether a conversion to state staff would produce a program benefit that justifies the administrative costs associated with recruiting, hiring, training, and maintaining new state staff. Additionally, USDA cites concerns about whether the allocation of state staff is sustainable given the projected reduction in federal SNAP-Ed funding by 2018. Finally, Subcommittee staff has requested information on how this proposal achieves $12.7 million in annual savings and has not yet received this information.

Questions. The Subcommittee has requested the DPH to respond to the following:

1. Please provide an overview of this proposal and the rational for the proposal.

2. Please provide an update on the department's discussions with the USDA.

3. Please explain how DPH plans to partner with local community organizations to achieve the goals of this program and build trust with hard-to-reach populations.

13. Infant Botulism Treatment and Prevention Program

Budget Issue. DPH requests:

a. An increase in expenditure authority of $3 million in 2014-15 and $951,000 in 2015-16 in the Infant Botulism Prevention and Treatment Fund to use fee revenue accumulated in the BabyBIG®/Infant Botulism Special Fund, to sustain statutorily-mandated production, distribution, regulatory compliance, and other activities for DPH's public service orphan drug BabyBIG® program. (An orphan drug is a treatment for a rare medical condition, typically developed as a matter of public policy because of insufficient profit motive for drug manufacturers.)

b. Authority to convert contract positions and establish two permanent state positions. The conversion of contract positions to state positions would reduce expenditure authority by $46,000 Infant Botulism Treatment and Prevention Fund (IBTP). Positions will provide the full spectrum of administrative services necessary to the Infant Botulism Treatment and Prevention Program which will significantly reduce the burden on highly-skilled medical staff and/or executive management to perform routine administrative duties to ensure business needs of the program are met.

Background. BabyBIG® [Botulism Immune Globulin Intravenous (Human) (BIG-IV)] is the DPH public service orphan drug for the treatment of infant (infectious) botulism. The drug is distributed nationwide to all patients with infant botulism, as required by the federal Orphan Drug Act and California Health & Safety Code (HSC) §123700-123709. The U.S. Food and Drug Administration (FDA) licensed BabyBIG® to CDPH in 2003; the department is the only entity in the world that produces, tests, and distributes BabyBIG® across the state, the country, and internationally. The drug is also a recognized treatment for any domestic bioterrorist attack that uses botulinum toxin as a weapon.

The program was established as a fee-supported program. Parents of children receiving BabyBIG® and/or their health insurers pay a per-use fee of about $45,000. CDPH collects the medication use fee and deposits it into the Infant Botulism Treatment and Prevention Fund to be used for the purpose of producing and distributing BabyBIG®, performing mandated program activities, and other specified activities.

The conversion from contract to civil service staff, under this proposal, will enable the new state staff to provide a full range of fiscal and management oversight over contracts, budgets, and human resource issues. In addition, this conversion will develop and help retain knowledge and skills within state staff.

External contract staff was initially hired to support the fluctuating workload associated with the development, production, and distribution of the infant botulism treatment and to address new regulatory mandates. However, contract staff is ineligible to fully assume routine administrative responsibilities such as contract development and oversight, personnel training, hiring, or

timekeeping. As a result, civil service staff in medical, and/or executive management positions has absorbed routine administrative duties to ensure business needs of the division were met.

Report Due to the Legislature. AB 82 (Committee on Budget), Chapter 23, Statues of 2013, a budget trailer bill, required DPH to submit a report to the Legislature by October 1, 2013 regarding its plans to address the findings and recommendations described in its "Zero-Based Budgeting (ZBB) Review" report concerning the Infant Botulism Treatment and Prevention Program. The Legislature has not yet received this report.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as the Legislature has not yet received the report outlining findings and recommendations on how to improve the Infant Botulism Treatment and Prevention Program. Information in this report is necessary to evaluate these budget proposals.

Questions. The Subcommittee has requested the DPH to respond to the following:

1. Please provide an overview of these proposals.

2. When will the Legislature receive the ZBB report?