SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

March 14, 2013

Upon Adjournment of Joint Legislative Budget Committee Hearing

Room 4203, State Capitol
(John L. Burton Hearing Room)

(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.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

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 EMS Authority 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 $28 million ($6.8 General Fund and $2.6 million federal funds) and 64.3 positions for EMSA. See table below for more information.

Table: EMSA Budget Overview

Fund Source	2011-12 Actual	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
General Fund	$6,644,000	$6,695,000	$6,757,000	$62,000	.9%
Federal Trust Fund	1,401,000	2,554,000	2,605,000	51,000	2%
Reimbursements	13,313,000	14,714,000	14,749,000	35,000	.2%
Special Funds	3,072,000	3,477,000	3,919,000	442,000	13%
Total Expenditures	**$24,430,000**	**$27,440,000**	**$28,030,000**	**$590,000**	**2%**
Positions	**65.7**	**64.3**	**64.3**	0	**0%**

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. Please provide an update on the impact of the federal sequestration on EMSA programs. What programs may be impacted?

2. Paramedic Licensing and Enforcement Program Workload

Budget Issue. EMSA requests an increase in Emergency Medical Services Personnel (EMSP) Fund expenditures of $270,000 to (1) improve paramedic application processing time, (2) pay for the additional expenses associated with the acceptance of electronic payments during the paramedic licensing process and increased travel expenses associated with the monitoring of paramedics on probation, and (3) streamline the investigatory process.

EMSA proposes to redirect two positions (a Management Services Technician and an Office Technician) from other programs to the Paramedic Licensing Program to address the workload associated with this proposal. As a result, there would be an overall increase of EMSA budget authority of only $136,000.

Background. EMSA's Paramedic Licensing Program is a fee supported program that processes paramedic applications, issues licenses, and provides technical assistance to the state's 19,000 paramedics. The fee revenue is deposited into the Emergency Medical Services Personnel (EMSP) Fund.

This request is for the following three purposes:

1. ***Decrease Paramedic Application Processing Time.*** Currently, it takes EMSA 45 days to process a licensing application, from the time the application is received until the application is evaluated, and 4-6 weeks for licensure renewal applications (or longer if information is missing). The 2010-11 budget approved of a staffing augmentation that resulted in an average processing time for new and renewal licensure applications of one hour, decreased a backlog of applications, and ensured that random audits of continuing education (CE) credits reported by paramedics were continued. In 2011-12, due to the budget crisis, staffing was reduced, resulting in an increase in application processing time to 1.76 hours, the discontinuation of the random audits of CEs, and a new backlog of applications.

   EMSA expects these two new positions to decrease the processing time from 1.76 hours to 1.19 hours per application.

2. ***Accept Electronic Payments for Paramedic Licensing Process.*** Government Code Section 6163(a)(1) requires all state agencies to accept payments via credit cards or other types of electronic payments. This BCP will enable the EMSA to institute a credit card payment system for individuals to pay new and renewal licensure application fees. According to the EMSA, this will bring the program into compliance with the Government Code, enhance customer convenience, achieve operational efficiencies, expedite the availability of the funds, and increase collection rates for payments.

3. ***Streamline and Improve Paramedic Investigative and Enforcement Efforts.*** The EMSA proposes to streamline and improve the investigation processing time of its Special Investigators (SIs). According to the EMSA, SIs function as probation monitors

while in the field, conducting interviews with probationers and gathering documents directly from law enforcement, courts, and district attorneys. As a result of budgetary reductions at all levels of government, it takes longer for the Paramedic Enforcement Program to receive documentary evidence from courts and law enforcement agencies necessary to complete the investigative process. To help streamline this process, under this proposal, SIs would now go directly to law enforcement agencies to retrieve necessary documentary evidence; thereby, reducing the overall case processing time. According to EMSA, this will extend the length and cost of travel, but will improve due process, increase the effectiveness of interviews and collection of physical evidence and improve probation monitoring.

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

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

1. Please provide an overview of this budget proposal.

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 $122.7 million ($74,000 General Fund and $1.3 million federal funds) and 471.6 positions for OSHPD.

Table: OSHPD Budget Overview

Fund Source	2011-12 Actual	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
General Fund	$0	$74,000	$74,000	$0	0%
Federal Trust Fund	4,425,000	1,648,000	1,290,000	-$358,000	-22%
Reimbursements	348,000	993,000	931,000	-$62,000	-6%
Special Funds	92,663,000	133,795,000	120,391,000	-$13,404,000	-10%
Total Expenditures	**$97,436,000**	**$136,510,000**	**$122,686,000**	**-$13,824,000**	**-10%**
Positions	**415.5**	**475.2**	**471.6**	-4	-1%

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. Are any OSHPD programs impacted by the federal sequestration?

2. Mental Health Services Act Workforce and Education Training – Five-Year Plan

Budget Issue. OSHPD requests $196,000 Mental Health Services Act Fund (Proposition 63) to contract with an independent evaluator to develop and carry out a needs assessment that will inform its required Five-Year Workforce Education and Training Plan. (This is a one-time request.)

Background on WET Five Year Plan. 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.

AB 1467, a 2012 budget trailer bill, requires OSHPD to develop a Five-Year WET Plan. The Five-Year Plan must be informed by an evaluation of the relative efficacy of current state-level WET strategies and must include objectives to establish, expand, and/or promote the following: high school, university and post-secondary education pathways; scholarships, loan forgiveness and stipends for current and prospective public mental health system employees; regional partnerships; psychiatric residency programs; staff training curriculum; and the employment of consumers and family members in the public mental health system.

The Five-Year Plan must be developed pursuant to a stakeholder process and be approved by the California Mental Health Planning Council. To fulfill these requirements, OSHPD proposes to carry out a needs assessment to determine the efficacy of the current state-level WET programs, present the outcomes of the needs assessment to key public mental health stakeholders, engage stakeholders in the development of a new Five-Year Plan, and draft a new Five-Year Workforce Education and Training Plan.

The current Five-Year WET Plan is effective until April 1, 2013 and will serve as a baseline.

Update on Transfer of MHSA WET Program to OSHPD in 2012. Since the transfer of the WET Program on July 1, 2012, OSHPD has engaged in the following activities:

- Created an advisory committee comprised of stakeholders to advise OSHPD on MHSA WET programs.
    - At the January meeting, OSHPD received initial feedback on the draft Five-Year Plan Vision, Values, and Mission. Meeting minutes and materials are available on the Foundation website at www.oshpd.ca.gov/HPEF/wet.
    - OSHPD developed the WET Five-Year Plan Advisory Sub-Committee to focus on the Five-Year Plan. The Sub-Committee held their first meeting on February 27, 2013 and provided feedback on the stakeholder engagement process, needs assessment scope of work, and draft Five-Year Plan Vision, Values, & Mission.

- In March, the Foundation will be starting the focus groups and community forums. A total of 14 are planned and specific locations are still to be decided.

- Begun a stakeholder engagement process to develop the Five-Year Plan due April 2014

- Issued two Psychiatric Residency Request for Proposals (RFP). The second RFP was issued and posted on February 1, 2013. The Psychiatric Residency Program trains psychiatric residents in the public mental health system.

- Finalized awards for the 2012-13 Mental Health Loan Assumption Program Cycle. 1,823 applications were received, over 1,300 applications reviewed and 1,109 were awarded.

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

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

1. Please provide an overview of this budget proposal.

2. Please provide an update on the transition of the MHSA WET component to OSPHD.

4260 Department of Health Care Services & 4800 California Health Benefit Exchange

1. CalHEERS Overview

Background. As required by the Affordable Care Act (ACA), states must establish a health insurance exchange or use a federally established exchange. California's Health Benefit Exchange (Covered California) was established by AB 1602 (Perez, Statutes of 2010) and SB 900 (Alquist, Statutes of 2010).

The Exchange is an independent state agency that is required to facilitate the purchase of qualified health plans by individuals and small employers no later than January 1, 2014. The California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) is the Exchange's enrollment system to purchase qualified health plans. The ACA requires coordination between Exchanges, Medicaid (Medi-Cal in California), and Children's Health Insurance Programs to ensure a seamless, integrated process for individuals seeking health care coverage under an Exchange.

In addition, the ACA requires the establishment of a single statewide web portal for Medicaid applicants. This portal can include referrals to the human services programs (e.g., CalWORKs and CalFresh). The ACA's provisions will significantly impact the three Statewide Automated Welfare Systems (SAWS)—LEADER, CalWIN, and C-IV—that currently determine eligibility for CalWORKs, CalFresh, and Medi-Cal.

The CalHEERS Project is jointly sponsored by the Exchange and the Department of Health Care Services (DHCS). The CalHEERS Project has acquired Accenture, LLP as a prime vendor to develop the CalHEERS solution that will support the implementation of a statewide healthcare exchange.

The primary business objective of CalHEERS is to provide a 'one-stop shop' to determine eligibility for California's entire health coverage program offered by the Exchange, Department of Health Care Services (DHCS), and the Managed Risk Medical Insurance Board.

The federally mandated implementation date of January 2014 requires a very aggressive schedule and increases the risks for a project of this size and impact to citizens.

CalHEERS has an Independent Validation and Verification (IV&V) contract with an outside entity. The IV&V assesses adherence to established IT project standards and provides recommendations on project improvements to the CalHEERS oversight agencies. Additionally, it provides a monthly assessment report that objectively illustrates the strengths and weaknesses of the project.

Project Schedule Delays Related to Medi-Cal. At the February 26, 2013 Exchange meeting, two delays to the CalHEERS project schedule were noted: (1) the interface between CalHEERS and the SAWS systems would be delayed from October 1, 2013 until January 1,

2014 and (2) the Medi-Cal health plan selection process in CalHEERS would be delayed until the spring of 2014.

These delays have fiscal and programmatic impact on county eligibility processing, as county workers will be required to double-enter data in both CalHEERS and SAWS for persons applying for Medi-Cal and other human services programs (e.g., CalFresh).

Additionally, county staff will now need to be trained to use CalHEERS to complete the Medi-Cal MAGI (Modified Adjusted Gross Income) eligibility processing since the interface between CalHEERS (with the MAGI rules) and SAWS will not be ready in October.

Contingency Plans. According to Covered California and DHCS, contingency plans have been created to address a variety of situations in which one or more portions of CalHEERS and/or the share eligibility service via interfaces to SAWS, MEDS, the federal Hub, and other state interfaces are not ready for Go-Live.

In addition to those plans, the CalHEERS Project anticipates creating temporary alternative procedures (either manual or automated) to ensure services are delivered if the system changes cannot be implemented when needed. For example, a County Eligibility and Enrollment Workgroup is developing business process flows and identifying training needs to manage MAGI Medi-Cal enrollment through counties during the open enrollment period until the CalHEERS-SAWS interface is operational, tentatively planned for December, 2013.

Subcommittee Staff Comment. CalHEERS' timely implementation is critical to the success of California's implementation of the ACA. It is important to remember that that the primary business objective of CalHEERS is to determine eligibility for California's **entire** health coverage program offered both by Medi-Cal and the Exchange.

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

1. Please provide an overview of the CalHEERS Project.

2. Please provide a status update on CalHEERS deliverables and the project timeline.

3. **Decision Criteria.** It appears that the project sponsors could have competing interests in ensuring that the functionality most relevant to their programs is implemented timely (i.e., Covered California's priority is health coverage offered under the Exchange and DHCS's priority is Medi-Cal).

   What criteria are used to make decisions about project schedule changes? How was this criteria applied to make the decision to delay the SAWS interfaces and the Medi-Cal health plan selection?

4. **High Risk for Interface Delays.** According to the IV&V January 2013 report, there is a high level of risk for interface designs. The IV&V report indicates that interface designs lack the level of detail necessary to develop a technical design which could result in

schedule delays. According to the project timeline, the interface with MEDS is scheduled for October 2013. Is there any potential risk of delay for this interface? What would be the impact of a delay in this interface?

5. How does/will the CalHEERS project work with affected stakeholders in developing contingency plans?

0530 Health and Human Services Agency – Office of Systems Integration

1. CalHEERS

Budget Issue. The Governor's budget requests an increase in Office of Systems Integration (OSI) reimbursement authority in the amount of $115,356,396. The increase in reimbursement authority is requested for OSI to provide project management services for the design, development, implementation and operation/maintenance for the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) Project. These costs will be reimbursed by Covered California (California's Health Benefit Exchange), the Department of Health Care Services (DHCS), and the Managed Risk Medical Insurance Board (MRMIB).

CalHEERS Total Project Costs, 2013-14

Entity	Cost	Federal Funds	General Fund
OSI	$115,356,396	$112,220,039	$3,136,357
Non-OSI	$23,482,317	$22,869,474	$612,843
Total	$138,838,713	$135,089,513	$3,749,200

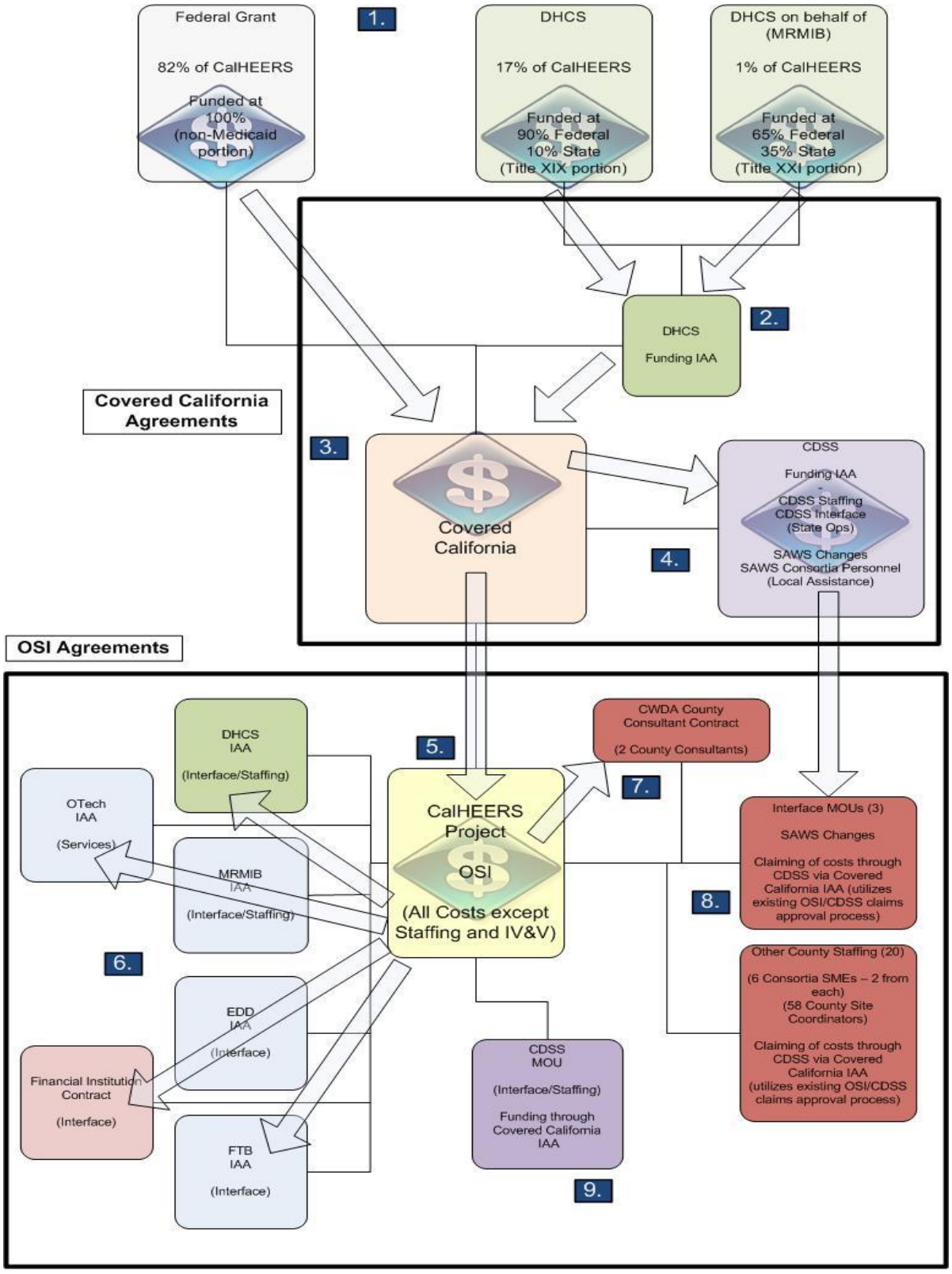
CalHEERS Funding Sources (See table on next page for diagram on how funds flow to OSI.)

Entity	Exchange Grant (82%)	Title XIX (DHCS) (17%)		Title XXI (MRMIB) (1%)		Total Funds
	100% Federal	Federal	General Fund	Federal	General Fund	
OSI	$94,592,245	$16,877,978	$2,732,610	$749,817	$403,747	$115,356,396
Non-OSI	$19,255,500	$3,461,339	$530,654	$152,635	$82,188	$23,482,317
Total	$113,847,745	$20,339,317	$3,263,264	$902,452	$485,935	$138,838,713

CalHEERS Budget Summary - OSI

	2012-13	2013-14
Development and Implementation	**$146,233,875**	**$85,099,492**
State / Program Partner Personnel	$7,665,880	$6,794,514
Systems Integration Services	$123,556,996	$67,267,027
Interface Development	$5,506,078	$2,850,588
Project Management and Technical Support Services	$4,198,422	$3,249,697
OTech Services	$3,300,000	$3,600,000
CalHEERS Consultants	$2,006,499	$1,337,666
Operations and Maintenance	**$0**	**$30,256,904**
State / Program Partner Personnel	$0	$308,016
Systems Integration Services	$0	$27,156,988
Interface Development	$0	$1,715,334
Project Management and Technical Support Services	$0	$1,076,566
OTech Services	$0	$0
Total OSI Costs	**$146,233,875**	**$115,356,396**

Diagram 1 – CalHEERS Proposed Funding



Background. OSI has been chosen by the Exchange to provide project management services during the design, development and implementation and system stabilization of the CalHEERS solution to help meet the federally mandated timelines and requirements. In order to provide adequate project management for the CalHEERS Project, OSI requires reimbursement from the Exchange for the costs associated with these project management services in 2013-14.

LAO Findings and Recommendation. The LAO recommends approval of this proposal. It finds that approval of this proposal facilitates the need to complete the project by January 1, 2014, and provides the required project management services to mitigate project risk. It also finds that the CalHEERS project creates an opportunity to learn lessons about the advantages and disadvantages of a streamlined approach to IT project management processes.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding OSI's role in the CalHEERS project. It is recommended to approve this request to ensure continued development and management of the CalHEERS project.

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

1. Please provide a brief summary of the proposal.

4260 Department of Health Care Services

1. Assessment of Administration's Estimates for ACA Medi-Cal Simplification & Comparison to LAO & CalSIM

This item provides an overview of the Administration's recently released cost estimate for the Medi-Cal simplification provisions of the Affordable Care Act (ACA) (the "mandatory" expansion of Medi-Cal), an assessment of this cost estimate, and a comparison of this estimate with projections from the LAO and UC Berkeley Center for Labor Research and Education's CalSIM model.

Background. The ACA requires a Medicaid (Medi-Cal in California) expansion to currently eligible populations through eligibility and enrollment simplifications. Currently, Medicaid eligibility is based on several factors, including linkage to a specific coverage group, income eligibility (including allowable deductions), assets, residency status, and citizenship status. Childless adults currently are not eligible for Medi-Cal unless they are disabled or aged.

Major changes include the following:

- Establishing a new standard for determining income eligibility, based on Modified Adjusted Gross Income (MAGI), consistent with the standard used to determine eligibility for premium tax credits.

- Eliminating the asset test for individuals whose eligibility determination is based on MAGI.

- Conducting an "ex parte" review when making a redetermination of eligibility. Redeterminations must be made based on available information with a primary reliance on electronic data.

Due to a number of factors, including the requirement that most individuals obtain coverage (individual mandate), Medi-Cal enrollment and eligibility simplifications, and marketing and outreach activities conducted by California's Health Benefit Exchange (Covered California), it is anticipated that Medi-Cal enrollment will increase.

The Governor convened an extraordinary session that began on January 28, 2013, to consider and act upon legislation necessary to implement the ACA. SBX1 1 (Hernandez and Steinberg) and ABX1 1 (Perez) have been introduced to implement the ACA's Medi-Cal simplification provisions discussed above and the state-based expansion of Medi-Cal to low-income adults with incomes up to 138 percent of the federal poverty level (FPL). These bills are identical as the Legislature is working collaboratively on these vehicles.

Budget Proposal and Revised Estimate. The 2013-14 Governor's January Budget includes $350 million General Fund as a placeholder for the costs of the increase in Medi-Cal caseload

as a result of the above described changes. The Administration refers to this as the mandatory expansion of Medi-Cal under the ACA.

In February, the Administration provided a revised and more detailed estimate for the mandatory expansion. Now, the Administration estimates that the General Fund costs of the mandatory expansion will be $188.7 million in 2013-14, $659.6 million in 2014-15, and $729.1 million in 2015-16, when costs are fully phased in.

DHCS's Major Premise – Disenrollments will be Drastically Reduced. The Administration's estimate is premised on the notion that the redetermination simplification provisions of the ACA will dramatically reduce the disenrollment rate and; consequently, individuals will retain coverage at a higher rate. It finds that 525,601 individuals, who would have been disenrolled will retain coverage.

The Administration classified individuals who discontinue enrollment into three categories of leavers and assumes a certain rate of retention for each of these categories:

(1) Short-term leavers – Individuals who disenroll from Medi-Cal and return within one to six months are considered "short-term" leavers. The Administration assumes that 100 percent of these individuals will retain continuous coverage. (265,508 individuals)

(2) Longer-term leavers – Individuals who disenroll from Medi-Cal and return within seven to 12 months are considered "longer-term" leavers. The Administration assumes that 75 percent of these individuals will retain continuous coverage. (126,508 individuals)

(3) Non-returners - Individuals who disenroll from Medi-Cal and return within 13 to 18 months are considered "non-returners." The Administration assumes that 40 percent of these individuals will retain continuous coverage. (133,435 individuals)

The total base caseload is also adjusted by 33 percent to attempt to capture currently eligible but unenrolled individuals, given that marketing and outreach activities conducted by Covered California and the requirement that most individuals obtain health coverage are likely to result in additional enrollment among this population. (200,506 individuals)

Finally, the Administration assumes that about 82,000 children in families with incomes up to 150 percent of the federal poverty level (FPL) who are eligible for Healthy Families, but not enrolled would enroll into Medi-Cal.

Based on these assumptions, the estimate projects that Medi-Cal enrollment would increase by a total of about 809,000. This increase in caseload would be fully phased in by September 2014, or just nine months after these ACA provisions are effective.

Table: Summary of Administration's Caseload Estimate

Category of Individual	Number
Individuals who would have discontinued, but retain Medi-Cal coverage	525,601
Eligible individuals, but never enrolled	200,506
Eligible children with incomes under 150, but not enrolled	81,994
Total Estimated Increase within Nine Months	808,101

LAO Findings and Estimate. The following table below shows the LAO's range of estimated costs for these additional enrollees under three different scenarios. The LAO finds that the moderate-cost scenario is most likely. Under this scenario, it estimates that the General Fund costs associated with this population would be $104 million in 2013-14, about $290 million in 2014-15, and $359 million in 2015-16. Under the moderate scenario, the LAO estimates that average monthly enrollment will increase by 154,016 in 2013-14 and 410,447 in 2014-15.

Table: LAO's Estimated Annual Medi-Cal Costs for Mandatory Expansion

Range of Estimated Annual Medi-Cal Costs for Health Care Services to Currently Eligible but Unenrolled Population Under the ACA[a]

(In Millions)

	Low-Cost Assumptions			Moderate-Cost Assumptions			High-Cost Assumptions		
State Fiscal Year	Total Cost	Federal Funds[b]	State Funds	Total Cost	Federal Funds[b]	State Funds	Total Cost	Federal Funds[b]	State Funds
2013-14	$65	$35	$30	$222	$118	$104	$540	$286	$254
2014-15	180	98	83	618	328	290	1,517	804	714
2015-16	222	120	102	765	407	359	1,897	1,005	893
2016-17	245	145	101	849	482	367	2,127	1,198	929
2017-18	259	157	103	901	522	379	2,279	1,309	970
2018-19	274	165	109	958	554	404	2,447	1,404	1,043
2019-20	289	174	115	1,015	587	429	2,620	1,501	1,119
2020-21	305	184	122	1,080	623	457	2,814	1,610	1,204
2021-22	323	194	129	1,150	663	487	3,027	1,731	1,297
2022-23	341	205	136	1,222	703	518	3,248	1,855	1,393

Key Assumptions

Eligible population in 2014	2.4 million	2.5 million	3.1 million
Average take-up rates[c]	8%	20%	33%
Annual average cost per new enrollee in 2014	$1,169	$1,440	$1,694

[a] Estimates do not include administrative costs, such as additional costs for eligibility determinations.

[b] Applicable federal matching rate depends on whether the enrollee is currently eligible for the Medicaid matching rate or currently eligible for the Children's Health Insurance Program matching rate.

[c] The "take-up rate" is the percent of eligible individuals who actually enroll. Estimates assume take-up is complete by July 1, 2016.

ACA = Patient Protection and Affordable Care Act.

The LAO finds that the short– and long–term costs from additional enrollment among the currently eligible Medi-Cal population under the ACA are subject to uncertainty. Some of the major areas of uncertainty include: (1) the size of the eligible, but not enrolled population, (2) the percent of the eligible population that will enroll (take–up rate), and (3) the cost of providing services to each additional enrollee.

CalSIM. In addition to the Administration and LAO's estimates, under the CalSIM model, which was created by the UCLA Center for Health Policy and Research and UC Berkeley Labor Center for Labor Research and Education, it is estimated that the total General Fund costs associated with this population would be between $143 million and $378 million in 2014, between $125 million and $380 million in 2016, and between $134 million and $407 million in 2019.

It should be noted that the CalSIM model is being used by California's Health Benefit Exchange to produce enrollment estimates and the California Health Benefits Review Program (CHBRP) to simulate and project the effects of the ACA in California. (CHBRP provides the Legislature with independent analysis of proposed legislation related to health insurance benefits. Policy makers consult CHBRP reports for guidance on issues of health benefits policy design.)

Estimate Comparison Chart. The chart below presents a high-level overview of these various estimates. It should be noted that for the purpose of creating this chart, certain generalizations were made for ease of comparison (e.g., the CalSIM estimates are based on a calendar year; whereas, the Administration's and LAO's estimates are based on the state fiscal year).

Table: Already Eligible/Mandatory Medi-Cal Expansion Estimates

	DHCS	LAO Moderate	CalSIM Base	CalSIM Enhanced	Comments
Medical inflation	5%	5.1% Medicaid/ 4.2% CHIP*	2.30%	2.30%	*LAO's medical inflation is an average annual rate over their 10-year forecast period
Caseload growth rate	3%	1%	0.07%	0.07%	This rate is compounded annually.
Take-up rate	N/A	20%	10%	40%	*DHCS did not estimate the total currently eligible but not enrolled, so does not have an estimated take-up rate. *LAO's take-up rate is average of 30% for Medi-Cal and 10% for HFP.
Full take-up achieved	Sept. 2014	July 2016	2018	2016	
Total number eligible but not enrolled	N/A	2.5 million	2.5 million	2.5 million	*DHCS did not estimate the total currently eligible but not enrolled.
Average monthly enrolled into Medi-Cal (Caseload)					
2013-14	239,283	154,016	200,000	440,000	
2014-15	814,960	410,447			
2015-16	858,000	488,218	230,000	490,000	
2016-17	883,000	519,251			
2018-19	965,000	529,688	240,000	510,000	
Medi-Cal Per Member Per Month (PMPM)					
2013-14	$136	$125	$135	$150	
2014-15	$143	$131	$138	$153	
2015-16	$150	$136	$141	$157	
Healthy Families Program (HFP) PMPM					
2013-14	$93	$104	$129	$129	
2014-15	$98	$109	$132	$132	
2015-16	$103	$113	$135	$135	
General Fund costs					
2013-14	$188,436,000	$103,844,679	$143,000,000	$378,000,000	
2014-15	$661,461,000	$289,528,711			
2015-16	$732,111,000	$358,553,824	$125,000,000	$380,000,000	
2016-17	$797,364,000	$367,000,000			
2018-19	$1,057,892,000	$404,000,000	$134,000,000	$407,000,000	

*CHIP is the Children's Health Insurance Program (formerly the Healthy Families Program and now the Targeted Low-Income Children's Program under Medi-Cal).

Administration's Estimate Built on Questionable Assumptions. Stakeholders, including Senate staff, the LAO, and researchers, have raised various concerns about the Administration's estimate.

The Administration's methodology is different from other estimates and most of its key assumptions are generally informed by DHCS's "best thinking" on what it believes will happen with the simplification provisions and outreach. In contrast, the LAO and CalSIM estimates are based on rigorous published research.

It is recognized that all estimates are approximations for what is expected to occur and that many of these variables are subject to significant uncertainty, but clarity, consistency, and transparency of assumptions and methodology provides more assurance and comfort with estimates. As discussed below, the Administration has not been able to provide supporting documentation for many of its assumptions.

The Administration's questionable assumptions include:

- **Caseload Too High.** The biggest concern with the Administration's estimate is its projected enrollment. The Administration's estimated caseload is substantially larger than any of the other estimates and it has not provided any basis for this estimate.

  It argues that this estimate is built on the premise that there will be a significant reduction in disenrollments at annual redetermination and generally points to prior Medi-Cal simplification efforts that occurred in the early 2000's as support for this assumption.

  However, it has not provided any details or data to support these assumptions. Specifically, it has not provided rationale regarding the retention rates (of 100 percent, 75 percent, and 40 percent for the different categories of persons who are discontinued) of persons who are discontinued at the annual redetermination process.

  Additionally, it has not provided any data to support that an additional 33 percent of its base estimate are eligible, but not enrolled.

- **Take-Up Rate Questionable.** The Administration's estimate for when all persons who are eligible, but not enrolled, would enroll in Medi-Cal is considerably more ambitious than the other estimates. The Administration projects that all individuals who are eligible but not enrolled would enroll by September 2014. This is almost two years earlier than other estimates.

  This estimate also assumes that all redeterminations occur in nine months instead of 12. Under changes that are implemented at the redetermination process, the process necessitates at least 12 months to complete given that redeterminations happen in each of the 12 months of a year.

This estimate assumes that a year's worth of annual redeterminations occur between January and September 2014 and provides no explanation on how it plans to complete this expedited redetermination process.

- **Estimate Does Not Account for Natural Attrition.** The Administration's estimate does not account for the natural attrition of people leaving the program (because they have moved out of state or have a change in employment, for example). Its estimate assumes that almost all individuals will remain on the program because of the redetermination simplification provisions.

- **Caseload Growth Rate Too High.** The Administration expects caseload to grow at 3 percent annually. This growth rate is high and does not reflect the declining unemployment rate which should sharply reduce caseload growth. Additionally, DHCS's projected caseload growth for Medi-Cal in 2013-14 is about 1 percent absent the growth from the Healthy Families transition to Medi-Cal. It is unclear why this estimate assumes a greater growth rate than what was projected in the November 2012 estimate.

- **Medical Cost Inflation Too High.** The Administration's medical cost inflation appears high for many reasons, including:

    - It double counts caseload growth. The Administration's medical cost inflation rate is the past 10-year average in change of spending for Medi-Cal. This average is based on Base spending which includes caseload growth. If the past 10-year average is reduced by the average 10-year caseload growth rate, then the medical cost inflation factor would be about 2 percent.

    - It takes into account the increases in federal supplemental spending a result of the Medi-Cal hospital financing waiver and hospital quality assurance fee, for example. These supplemental federal funds do not impact the General Fund and should not be used to determine a medical cost inflation rate for the General Fund.

    - The medical cost inflation rate is over one percent higher than the rate projected by research conducted on behalf of DHCS for the "optional" Medi-Cal expansion under ACA. Under this estimate, the average of the most recent three years of estimates used in pricing of Medi-Cal managed care capitation rates is 4.25 percent. It is recognized that DHCS generally funds at the lower end of this average which is anywhere between 3.25 percent and 3.75 percent.

Enrollment of This Population May Reduce Costs in the Long-Term. The Administration acknowledges that individuals that are eligible but unenrolled are likely healthier and could reduce the overall cost of care. However, since DHCS cannot develop its actuarially-based rates on this assumption (because it does not have utilization data for this population), it recognizes that in the long-term, overall costs may be reduced as a result of this healthier population.

Subcommittee Staff Comment and Recommendation—Hold Open. The Administration's estimates are unclear, inconsistent, and based on its "best thinking" rather than transparent data or research; this does not provide a comfortable level of confidence in their numbers.

It is recommended to hold this item open to continue more in depth discussions regarding these assumptions. Staff looks forward to a more comprehensive assessment of the Administration's estimates using the LAO forecast and CalSIM model.

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

1. Please provide an overview of the Administration's estimate.

2. Please provide the basis for the assumptions used to develop this estimate.

3. Please comment specifically on the research and data used to justify the caseload estimates.

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

(1) Center for Chronic Disease Prevention and Health Promotion
(2) Center for Environmental Health
(3) Center for Family Health
(4) Center for Health Care Quality
(5) Center for Infectious Disease

Summary of Funding for the Department of Public Health. The budget proposes expenditures of $3.4 billion ($114.5 million General Fund) for the DPH as noted in the Table below and 3,777.5 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.

Of the amount appropriated, about $698.3 million is for state operations and $2.7 billion is for local assistance. The budget for 2013-14 reflects a net decrease of $104 million as compared to the revised 2012-13 budget.

Department of Public Health

Summary of Expenditures (dollars in thousands)	**2013-14**
Public Health Emergency Preparedness	**$97,831**
Public and Environmental Health	**$3,137,923**
Chronic Disease Prevention and Health Promotion	309,629
Infectious Disease	613,286
Family Health	1,815,824
Health Information and Strategic Planning	27,196
County Health Services	17,390
Environmental Health	354,598
Licensing and Certification Program	**$200,704**
Licensing and Certification of Facilities	186,902
Laboratory Field Services	13,802
Total Program Expenditures	**$3,436,458**
Funding Sources	
General Fund	$114,499
Federal Funds	$2,014,499
Genetic Disease Testing Fund	$115,734
Licensing and Certification Fund	$88,637
WIC Manufacturer Rebate Fund	$255,000
AIDS Drug Assistance Program Rebate Fund	$265,075
Water Security, Clean Drinking Water, Beach Protection Fund	$26,018
Safe Drinking Water Account of 2006	$50,312
Childhood Lead Poisoning Prevention Fund	$22,714
Radiation Control Fund	$22,549
Food Safety Fund	$7,761
Reimbursements	$266,396
Other Special Funds (numerous)	$187,264
Total Funds	**$3,436,458**

Subcommittee Staff Comment. This is an informational item.

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

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

2. Please provide an update on the impact of the federal sequestration on DPH programs. What programs may be impacted?

2. Environmental & Occupational Disease Control Contract Conversion to State Staff

Budget Issue. DPH's Division of Environmental and Occupational Disease Control (DEODC) requests to convert 11 contract positions into full-time permanent state positions in order to eliminate reliance on contracting for essential program services. These positions include: three full-time equivalent (FTE) information technology (IT) contract positions in the Division Office for IT support; two positions in the Occupational Lead Poisoning Prevention Program (OLPPP) for investigatory and research activities; and six positions in the Environmental Health Investigations Branch (EHIB) to support the Asthma Prevention and Environmental Health Programs.

The conversion of contract positions to state positions would save $48,000 in annual costs. In addition, according to DPH, this conversion to state staff will align these programs with the Governor's directive to reduce reliance on external contracts, and will comply with Government Code (GC) Section Code 19130. It will also develop/enhance state institutional capacity, rather than leaving expertise to external consultants, and help retain knowledge and skills within state staff.

Background. Historically, DEODC has hired contractors to perform various state functions for its programs. The following DEODC contracts are affected by this proposal:

- **DEODC IT.** Since the creation of DPH (in 2007), DEODC has contracted out for essential IT support, which includes Local Area Network (LAN) and Wide Area Network (WAN) administration; Response and Surveillance System for Childhood Lead Exposures (RASSCLE) project support; desktop/end user support; operational recovery planning; information security; etc. IT services are provided to over 350 workstations and maintain 19 servers. Because DEODC has insufficient position authority for civil service employees to carry out IT support functions, DEODC has contracted out for these functions.

- **Occupational Lead Poising Prevention Program (OLPPP).** OLPPP was established by legislation in 1991 as a statewide program to provide public health services to prevent and reduce lead poisoning in California workers and their children who may be exposed to lead from the workplace. Since 1991, OLPPP has contracted for staff to carry out program responsibilities because it did not have sufficient position authority to carry out its mandates.

- **Asthma Prevention Program, Disease Cluster, and Environmental Health Programs.** This program encompasses asthma disease surveillance (including periodic public reports on asthma prevalence, hospitalizations, mortality and other data), support for asthma research in California, implementation of school-based asthma programs, and other public health approaches to address asthma. These functions are carried out in part by contract staff, under this proposal, the major portion of these asthma reduction programs would be conducted by state staff.

Other contract staff provide assistance with DPH's responses to disease clusters and environmental health responses. Under this proposal, these activities would be performed by state staff.

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

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

1. Please provide an overview of this budget proposal.

3. Export Document Program

Budget Issue. DPH requests $287,000 and 3.0 full time permanent positions for the Export Document Program to meet statutorily mandated activities to respond to each request for issuance of an export document within five working days of receipt of the request.

Background. The Food and Drug Branch (FDB) at DPH ensures the safety of foods, drugs, medical devices, and cosmetics through the inspection, regulation, and education of food, drug, and cosmetic and medical device manufacturers.

Health and Safety (H&S) Code Sections 110190-110240 require FDB to issue export documents to California processors of food, drugs, medical devices, and cosmetics. H&S Code Section 110220 (d) requires FDB to respond to each request for issuance of an export certificate within five days of receipt.

FDB considers two primary factors in determining whether an export document should be issued. First, the system of manufacture and quality control used to produce the products must be adequate; this is determined during FDB's inspections of manufacturers, distributors, and wholesalers. Second, the products must be properly labeled; this is determined by a review of product labeling at the time the export document is requested.

California processors of food, drugs, medical devices, and cosmetics have advised FDB that an increasing number of foreign countries now require the export certification documents before products can be imported from California. These documents certify that the manufacturer and its products meet DPH requirements, and it does not object to the sale of the products in California or the shipment to other countries. FDB understands that exporters need these documents quickly to avoid shipping delays and unnecessary storage costs.

Within the last three years, FDB has seen a 38 percent increase in the number of export document applications that include requests to have the certificates notarized. Requests that include multiple product labels, labeling and advertising, special wording, and notary requirements require labor intensive processing, specialized review, and result in additional review time needed to complete the export documents. Applications such as these contribute to the current eight week review timeframe.

The demand for export documents requested by the California processors of food, drugs, medical devices, and cosmetics and the associated workload has increased significantly from 1,731 application requests for certificates in 2001 to approximately 9,500 in 2012. According to DPH, the current staffing level of 1.5 positions and their classification level do not provide adequate staffing resources to meet the increased demand for export certificates.

The Export Document Program Fund has collected annual fee revenue in excess of $300,000 for the past three years. The current Fund Condition Statement projects a reserve of $2.0 million at the end of 2012-13. The increased demand for export certificates over the past several years has created this reserve.

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

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

1. Please provide an overview of this budget proposal.

4. Stop Tobacco Access to Kids Enforcement (STAKE) Act

Budget Issue. The budget requests $129,000 from the Sale of Tobacco to Minors Account and 1.0 permanent position (a staff counsel) to implement the provisions of AB 1301 (Hill, Statutes of 2012) which increases tobacco control efforts in California and requires DPH to notify the Board of Equalization (BOE) of a third, fourth, or fifth STAKE Act violation committed by the same retailer within a five-year period.

Background. The goal of the STAKE Act is to reduce the illegal sale of tobacco products to minors. The California Tobacco Control Program (CTCP) was established as a result of the passage of Proposition 99, the Tobacco Tax and Health Protection Act of 1988. CTCP is responsible for supporting a statewide tobacco control program that includes conducting a statewide media campaign, conducting evaluation and surveillance activities, and conducting community outreach, policy, and cessation activities. Since 1995, DPH has administered the STAKE Act Program.

DPH expects that retailers throughout the state will appeal STAKE violations more frequently because multiple violations will now lead to disciplinary action on the retailer's BOE license and consequently have an adverse effect on their revenues due to the suspension of tobacco sales. This expected increase in the number of appeals for STAKE Act violations will result in an increased workload and DPH will incur increased costs to litigate these appeals through administrative hearings.

An appeal requires DPH legal staff to review the facts of the case, prepare, and litigate the case in an administrative hearing in front of an administrative law judge (ALJ). The ALJ would issue a proposed decision in which DPH has 100 days to adopt the decision as final. When the Department adopts a decision as final, the Food and Drug Branch receives a copy and the decision would trigger the 60-day period to notify BOE. DPH is requesting one additional staff counsel to handle the anticipated increased number of appeals.

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

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

1. Please provide an overview of this budget proposal.

5. Emergency Preparedness - Extension of Limited-Term Positions

Budget Issue. DPH requests an extension of 76.8 limited-term positions for a four year period to align with the federal grant period (from 2012-13 through 2016-17) and associated funding authority of $9.4 million to support public health emergency preparedness responsibilities.

These positions are a continuation of limited-term positions originally established in 2003-04 and reestablished as limited-term positions every two years since then. These limited-term positions are scheduled to expire on June 30, 2013. The positions are located in several organizations throughout DPH, including but not limited to the Emergency Preparedness Office, the Center for Infectious Diseases, the Center for Environmental Health, the Center for Chronic Disease Prevention and Health Promotion, the Office of Public Affairs and the Administration Division.

All proposed positions are dedicated to working on public health and healthcare emergency preparedness activities. These activities include:

- Ensuring medical surge capacity to care for a massive influx of patients
- Coordinating the receipt and distribution of medical countermeasures (Strategic National Stockpile)
- Conducting laboratory testing
- Disease surveillance and epidemiology
- Monitoring drinking water and food safety
- Radiologic/Nuclear Power Plant safety
- Environmental health
- Maintaining emergency operations coordination/Duty Officer Program
- First responder and health care worker health and safety
- Providing public information in preparation for and response to a disaster
- Ensuring emergency communications
- Tracking hospital bed and resource availability
- Pre-hospital care, triage and patient transportation
- Developing systems to register and activate licensed health care professionals to volunteer during disasters
- Decontaminating patients
- Educating and training healthcare workers
- Supporting fatality management and evacuation plans

Background. DPH receives federal funds to support public health emergency preparedness responsibilities through the following grant awards:

- **Public Health Emergency Preparedness Cooperative Agreement (PHEP)**
  The PHEP Cooperative Agreement funds State and local health departments to enhance the California public health system's preparedness and response to public health emergencies. Based on Health and Safety Code Sections 101315-101319, DPH

allocates 70 percent of this grant to fund local health department preparedness activities and funds State operations within the remaining 30 percent.

The PHEP grant has delineated 15 Public Health Preparedness Capabilities with supporting Functions, Resource Elements and Performance Measures that State health departments must meet. These Public Health Preparedness Capabilities are outlined in Attachment A. The Functions required by these Capabilities include ongoing public health emergency preparedness workload to prepare for and manage DPH's response to public health emergencies such as planning response procedures; conducting laboratory testing; providing public information in preparation for and response to a disaster; coordinating surveillance and epidemiology in response to emergencies; ensuring electronic communications during emergencies; operating the Joint Emergency Operations Center (JEOC) shared by DPH, the Emergency Medical Services Authority and the Department of Health Care Services in response to emergencies; training DPH and local health department staff in preparedness activities; managing emergency supplies of pharmaceuticals; oversight of local health department preparedness; and coordination of public health and medical care response capabilities.

- **HPP Cooperative Agreement (HPP)**
  The HPP Cooperative Agreement provides funding to prepare hospitals, clinics and other health care facilities and emergency medical services systems to respond to disasters. This includes the need to ensure the health care system has the capacity to surge as needed in an emergency and to safely evacuate health care facilities when necessary. During these disasters, health care systems must convert operations quickly from their current patient capacity to surge capacity, the maximum patient load a health care system can handle, or to evacuate patients from the facility to another location that can provide the necessary level of care.

  The HPP grant has eight Healthcare Preparedness Capabilities with supporting Functions, Resource Elements and Performance Measures that States are required to meet. These Capabilities include, but are not limited to, increasing the ability of health care systems to provide needed beds; engaging with other responders through interoperable communication systems; tracking bed and resource availability using electronic systems; developing systems to register licensed health care professionals who volunteer to assist during emergency response; protecting health care workers with proper equipment; decontaminating patients establishing and enabling partnerships of healthcare organizations; educating and training health care workers; enhancing fatality management and health care system evacuation/shelter in place plans; and coordinating regional exercises. The Healthcare Preparedness Capabilities are delineated in Attachment B.

Federal funds have been reduced from $98.1 million in 2004-5 to $75.63 million in 2012-13; a reduction of 22.9 percent. Under these reductions, DPH has prioritized the retention of staff for public health and medical preparedness activities.

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

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

1. Please provide an overview of this budget proposal.

6. Office of Health Equity Update

Background. The Governor's 2012 budget proposed the creation of a new Office of Health Equity (OHE) at DPH. The OHE would be created by consolidating the following entities:

- Office of Multicultural Health at DPH
- Office of Women's Health at the Department of Health Care Services (DHCS)
- Office of Multicultural Services at the Department of Mental Health (this department was eliminated in 2012)
- Health in All Policies Task Force at DPH
- Healthy Places Team at DPH

Concerns were raised by various stakeholders during last year's budget process finding that the Administration's proposed trailer bill language was vague and provided no metrics to hold this new office accountable for improving health equities. Additionally, stakeholders were concerned that with the elimination of the existing offices, there would be a loss of focus on women's issues, for example. As a result, Legislative staff and stakeholders worked together to strengthen the administration's proposal. This modified proposal was approved by the Legislature and included in AB 1467 (a 2012 budget trailer bill).

AB 1467 established OHE to align state resources, decision making and programs to accomplish all of the following:

1) Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities;

2) Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health;

3) Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services; and

4) Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.

OHE is comprised of three units: Community Development and Engagement Unit (CDEU); Policy Unit (PU); and Health Research and Statistics Unit (HRSU). Currently OHE consists of fourteen positions; seven of which are filled. Additional contract positions will be added to the OHE based on recent grant funding opportunities.

Deputy Director. AB 1467 created an OHE Deputy Director, who is appointed by the Governor and is subject to confirmation by the Senate. The Deputy Director of OHE will report to the DPH Director and work closely with the Director of the Department of Health Care Services (DHCS) to ensure compliance with the requirements of the office's strategic plans, policies, and implementation activities.

A Deputy Director has not yet been appointed. DPH is in the process of conducting interviews.

Advisory Committee. The law requires that an advisory committee be established within OHE to provide input and recommendations on issues related to eliminating mental and health disparities and achieving health equity amongst California's vulnerable population groups.

The committee will participate in four meetings per year and make recommendations on a broad range of health and mental health related issues that address the diversity of multicultural communities in California as a whole. AB 1467 requires that the advisory committee meet by October 1, 2013.

DPH has received 109 applications from persons interested in participating in this committee and is in the process of creating a grid to ensure that all perspectives are represented on the committee. DPH anticipates that the advisory committee will be composed of 20 to 30 members.

Strategic Plan. OHE is also required to develop a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities with collaboration of external and internal stakeholders. The strategies and recommendations developed will take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan will establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. OHE will seek input from the public on the plan through an inclusive public stakeholder process.

The first report is due by July 01, 2013. DPH indicates that it is unlikely that it will meet this deadline.

Collaboration with Department of Health Care Services. AB 1467 requires that an interagency agreement be established to outline the process by which DPH and DHCS will jointly work to advance the mission of the office, including responsibilities, scope of work, and necessary resources.

OHE is in the process of establishing this interagency agreement.

OHE Budget. See following table for a summary of OHE's budget.

Table: Office of Health Equity's Budget Summary

Fund	2012-13	2013-14
General Fund	$337,745	$340,037
Air Pollution Control Fund	$322,930	$111,320
Cigarette and Tobacco Surtax Fund, Unallocated Account	$220,439	$228,759
Federal Trust Fund	$352,205	$465,977
Mental Health Services Fund	$17,342,117	$17,352,000
Cost of Implementation Account, Air Pollution Control Fund	$0	$212,087
Total	**$18,575,436**	**$18,710,180**

California Reducing Disparities Project (CRDP). One of OHE's responsibilities is the CRDP. The CRDP is a statewide policy initiative (funded with Mental Health Services Act Funds—Proposition 63) to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities in the public mental health system.

The project focuses on five populations: African-American; Latino; Native American; Asian and Pacific Islander; and Lesbian, Gay, Bisexual, Transgender, and Questioning individuals. These groups are required to establish Strategic Planning Workgroups (SPWs) that will produce population-specific reports that will form the basis of a statewide comprehensive strategic plan on reducing disparities.

All of the five population reports have been approved and posted on the DPH website. Recommendations from these reports will be incorporated into a comprehensive draft strategic plan. Once finalized, the California Reducing Disparities (CRD) Strategic Plan will be used as a guide to identify new service delivery approaches from multicultural communities using community-defined evidence to improve outcomes and reduce disparities. Furthermore, the Strategic Plan will serve as a blueprint to implement these strategies at the local level.

According to the December 2012 update on the OHE, a 30-day public review and comment period of the CRDP Strategic Plan would commence in December, 2012. However, this public review period has not yet begun because the CRDP Strategic Plan is still under internal department review. DPH hopes to have the draft available for public comment at the end of March. The delay in review and approval of this plan could delay Phase II of CRDP.

Subcommittee Staff Comment—Hold Open. This office was created almost nine months ago; however, it appears that DPH has not made progress on any major responsibilities. These delays interrupt the momentum of projects, such as the CRDP, that improve access to care for disadvantaged communities. It does not appear that this issue has been a high priority for the Administration. Health equity is an extremely important topic and the design of this office was intended to produce outcome-oriented solutions to address disparities.

It is recommended to hold this item open and have DPH report at a future subcommittee hearing on any progress it has made on key OHE responsibilities.

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

1. Please provide an update on OHE activities including an update on hiring the Deputy Director, selecting the Advisory Committee, completing an Interagency Agreement with DHCS, and completing the Strategic Plan.

2. Please discuss the activities that OHE and DHCS on which plan to collaborate.

3. Is the Office of Health Equity a priority for DPH? Please explain.

7. Licensing and Certification (L&C) Program Update

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.

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 2013-14 and total $15.1 million. They are as follows:

- $3.5 million credit for miscellaneous revenues for change in ownerships and late fees.
- $11.6 million credit from the program reserve (which is largely a result of vacancies due to the state's hiring freeze).

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/LicCertAnnualReport2013.pdf

The DPH Fee Report of February 2013 proposes slight changes to fees as shown in the table below.

Table: Proposed Licensing and Certification Fee Schedule (February 2013)

License Fees by Facility Type			
Facility Type	Fee Per Bed or Facility	FY 2012-13 Fee Amounts	FY 2013-14 Proposed Fee Amounts
Alternative Birthing Centers	Facility	$ 2,975.24	$ 2,380.19
Adult Day Health Centers	Facility	$ 4,164.92	$ 4,164.92
Chronic Dialysis Clinics	Facility	$ 3,578.29	$ 2,862.63
Chemical Dependency Recovery Hospitals	Bed	$ 191.27	$ 191.27
Community Clinics	Facility	$ 718.36	$ 718.36
Correctional Treatment Centers	Bed	$ 573.70	$ 573.70
Home Health Agencies	Facility	$ 4,315.47	$ 3,452.38
Hospices (2-Year License Total)	Facility	$ 4,641.96	$ 3,713.56
Hospice Facilities *	Bed	$ 312.00	$ 312.00
Pediatric Day Health/Respite Care	Bed	$ 188.01	$ 150.41
Psychology Clinics	Facility	$ 1,476.66	$ 1,476.66
Referral Agencies	Facility	$ 4,368.01	$ 3,494.41
Rehab Clinics	Facility	$ 259.35	$ 259.35
Surgical Clinics	Facility	$ 2,487.00	$ 2,487.00
Acute Psychiatric Hospitals	Bed	$ 266.58	$ 266.58
District Hospitals Less Than 100 Beds	Bed	$ 266.58	$ 266.58
General Acute Care Hospitals	Bed	$ 266.58	$ 266.58
Special Hospitals	Bed	$ 266.58	$ 266.58
Congregate Living Health Facilities	Bed	$ 312.00	$ 312.00
Intermediate Care Facilities (ICF)	Bed	$ 312.00	$ 312.00
Skilled Nursing Facilities	Bed	$ 312.00	$ 312.00
ICF - Developmentally Disabled (DD)	Bed	$ 580.40	$ 580.40
ICF - DD Habilitative	Bed	$ 580.40	$ 580.40
ICF - DD Nursing	Bed	$ 580.40	$ 580.40

* Pursuant to SB 135 (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 Congregate Living Health Facilities.

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. In its July 2012 report to CMS, DPH reported that it met 30 of the 33 benchmarks for that quarter. In its September 2012 report to CMS, DPH reported that it met 38 of the 41 benchmarks for that quarter. DPH indicates that it still faces challenges in (1) meeting the 10-day timeframe to forward to certain non-compliances to the CMS regional office and (2) closing complaints within 60-days and was unable to meet benchmarks related to these challenges.

Insufficient Staff to Address Workload. According to the L&C 2012 November Estimate, in order for L&C to meet 100 percent of its mandated workload, an additional 122 positions are needed in the field. However, the Administration has no proposal to increase staff to ensure that mandated work be performed or to improve the state's ability to meet all of the CMS benchmarks discussed above.

In the past, there has been a reluctance to add L&C positions because it has been difficult to fill Health Facility Evaluator Nurses (HFEN) positions and; consequently, these classifications had a high vacancy rate. (HFENs conduct health facility surveys and respond to complaints.)

However, in its December 2012 report to the Subcommittee, L&C noted that the HFEN vacancy rate was 4 percent (which is generally considered a very low vacancy rate). Consequently, it appears that there is genuinely a need for additional HFENs to perform L&C activities.

Subcommittee Staff Comment and Recommendation—Hold Open. As discussed above, L&C proposes to use fund reserves to decrease L&C fees and is not requesting any additional staff to meet its mandated workload. Given CMS' concern, it is unclear why the reserve funds are not being used to address workload needs. It is recommended to hold this item open in order to continue these discussions.

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

1. Please provide a brief summary of the L&C Fees, including the key credits and adjustments.

2. Please provide an update on CMS' concerns and the steps DPH has taken to meet CMS benchmarks.

3. Please explain how L&C determined that an additional 122 positions would be needed to meet workload requirements.

4. Please provide an update on the status of regulations on hospital administrative penalties and hospital fair pricing.

8. L&C - STAR Staffing Audit Section

Budget Issue. DPH requests an increase of $200,000 in reimbursement authority (from the Department of Health Care Services) to perform increased workload regarding the auditing of required nursing hours per patient day for free-standing skilled nursing facilities (SNFs).

To complete this workload, two Associate Governmental Program Analyst positions and one Office Technician from the Staffing Audit Section will be used to create three Staff Counsel positions in the Office of Legal Services. (The requested increased reimbursement authority is the salary differential of these positions.)

Background. Health and Safety Code Section 1276.5 requires L&C to assess administrative penalties when a SNF fails to meet the nursing hours per patient day requirements. When a penalty is assessed, the facility may file an appeal. DPH anticipates receiving 50 appeals per year. The positions requested under this proposal would conduct quality assurance of this process and work on appeals.

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

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

1. Please provide a brief summary of this proposal.

9. L&C - Healthcare Associated Infection Public Reporting

Budget Issue. DPH request an increase of $1.2 million from the Internal Departmental Quality Improvement Account (IDQIA) for the next two years to continue eight contract positions in the Health Associated Infections (HAI) Program's Infection Preventionist (IP) Liaison Unit.

Background. SB 739 (2006), SB 158 (2008), and SB 1058 (2008) created the HAI program at DPH. This program's mission is to improve the quality of care in California hospitals through the prevention of healthcare associated infections. This is achieved through the public reporting of infection rates and prevention measures and working with stakeholders to enhance infection prevention activities in hospitals.

The primary objectives of the IP team are to ensure use of HAI data for the prevention of infections. They perform all outreach to hospitals in the form of onsite visits, phone consultations, education/coaching to use data to reduce HAI, data validation and support. Hospitals may request assistance and/or are contacted by the locally-assigned liaison for high rates of infections or poor data quality. The HAI program also provides monthly regional conference calls, all educational offerings, and all outreach projects (i.e. prevention collaborative projects, data validation projects, "data for action" site visits).

These positions were supported from September 2009 – July 2013 by a federal grant.

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

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

1. Please provide a brief summary of this proposal.

10. 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 37,167 people living with HIV/AIDS will receive drug assistance through ADAP in 2013-14, a decrease of 3,297 clients over the current year. The budget estimates expenditures of $435.7 million which reflects a *net* decrease of $32.9 million as compared to the revised current year.

Table: Governor's Estimated ADAP Expenditures for Current Year and Budget Year

Fund Source	Revised Current Year	Proposed Budget Year	Difference
General Fund	$16.875 million	$0.00	-$16.225 million
AIDS Drug Rebate Fund	$308.683 million	$264.158 million	-$44.525 million
Federal Funds – Ryan White	$125.876 million	$105.179 million	-$20.697 million
Reimbursements from Medicaid Waiver	$17.15 million	$66.339 million	$49.189 million
Total	**$468.584 million**	**$435.679 million**	**-$32.908 million**

New and Revised Assumptions. The ADAP budget includes a new assumption that the federal mandate to conduct six-month ADAP client eligibility re-certification results in increased workload and associate costs for the ADAP Pharmacy Benefits Manager. These additional costs are $778,539 in 2012-13 and $671,484 in 2013-14.

Additionally, the ADAP budget reflects revised assumptions regarding the shift of ADAP clients to the Low-Income Health Programs (LIHP) including (1) the additional delay in ADAP clients shifting to LIHP due to additional grace periods for LIHP application processing, and (2) changes to the LIHP implementation dates in counties.

ADAP Funding Sources. OA attempts to minimize the need for General Fund support by maximizing the use of special funds and federal funds. Consequently, the 2013-14 proposed budget includes no General Fund as a result of decreased ADAP expenditures and the availability of Safety Net Care Pool Funds (Reimbursements from the 1115 Medicaid Wavier).

Federal funds (Safety Net Care Pool Funds) are available from the state's 1115 Medicaid Waiver administered by the Department of Health Care Services. These funds are not restricted and therefore may be used for expenditures not allowable under the Ryan White Payer of Last Resort federal provision. Thus, in 2013-14, DPH will use these funds to cover the

costs associated with clients eligible for other public assistance programs, including Medi-Cal and LIHP. (The Ryan White Payer of Last Resort federal provision requires that Ryan White federal funds or AIDS Drug Rebate Funds can only be used to pay for services if there is no other payer source.)

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 CA 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 deduction, 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 60 cents in rebates. This 60 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 provide expenditures of at least one half of parts of the federal HRSA grant award. The 2012 HRSA Ryan White Part B HIV Care Grant amount is $151.2 million. Three parts of the grant (Minority AIDS Initiative, ADAP Supplemental, and Part A Transfer Funds, totaling $10.0 million) do not have a match requirement. The remaining parts

of the grant (Formula, ADAP Earmark and Emerging Community funds, totaling $141.2 million) do have a state match requirement, making the state match $70.6 million for 2012-13.

Additionally, HRSA requires grantees to maintain HIV-related expenditures at a level that is not less than the prior fiscal year. California's MOE target, based on 2010-11 expenditures, is $502.5 million.

LIHP Transition. During last year's Subcommittee #3 hearings, concerns were raised that OA's oversight and engagement in the transition of ADAP clients to LIHP was inadequate. Consequently, AB 1467, a 2012 budget trailer bill, required OA to provide guidance on the LIHP transition and to consult with stakeholders regarding the transition of ADAP clients to LIHPs. Stakeholder advisory calls occur every two weeks.

Additionally, given the uncertainty regarding the rate at which ADAP clients may transition to LIHP, AB 1467 required DPH to report to the Legislature by October 1, 2012, if any of the projections or assumptions used to develop the ADAP budget for 2012-13 may result in a potential shortfall or inability of ADAP to provide services to eligible ADAP clients. On October 1, 2012, DPH notified the Legislature that it would be able to provide services to eligible ADAP clients and did not face any projected shortfall.

ADAP and Health Care Reform. The ADAP estimate identifies changes under the Affordable Care Act (Medi-Cal expansion and health coverage provided through the California Health Benefit Exchange) as potential future fiscal issues effecting ADAP. The Administration indicates that it will present its assessment of these impacts in the May Revise.

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 LIHP and the department's efforts to ensure that there are no interruptions in care or services.

3. Please provide DPH's initial thoughts on how ADAP may be impacted by implementation of the Affordable Care Act in California.

11. Proposition 50

Budget Issue. The DPH requests the following:

- A $22 million local assistance appropriation in Proposition 50, Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002.
- Budget Bill Language to revert, effective June 30, 2013, all unspent Proposition 50 funds ($63.3 million) from the 2009-10 appropriations.
- Provisional Budget Bill Language that authorizes DPH to increase its Proposition 50 expenditure authority above the requested $22 million appropriation upon approval from the Department of Finance (DOF).

Background. DPH has statutory authority to administer a regulatory program to ensure California public drinking water supplies meet all applicable federal and state drinking water standards. DPH's Drinking Water Program (DWP) has regulated and permitted public water systems (PWS) since 1915.

DWP provides ongoing surveillance and inspection of PWS, issues operational permits to the systems, ensures water quality monitoring is conducted, and takes enforcement actions when violations occur. The program oversees the activities of approximately 8,000 PWS that serve more than 34 million Californians. In addition, DPH is designated by the U. S. Environmental Protection Agency (EPA) as the primary agency responsible for administering the federal Safe Drinking Water Act (SDWA) in California.

In 2002, California voters approved Proposition 50, a $3.44 billion water bond measure known as the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002. Proposition 50 provides funds to a consortium of state agencies and departments to address a wide continuum of water quality issues. The DPH anticipates receiving up to $485 million over the course of this bond measure for water projects, as follows:

Chapter 3—Water Security ($50 million). Proposition 50 provides a total of $50 million for functions pertaining to water security, including the following: (1) monitoring and early warning systems, (2) fencing, (3) protective structures, (4) contamination treatment facilities, (5) emergency interconnections, (6) communications systems, (7) other projects designed to prevent damage to water treatment, distribution, and supply facilities**.**

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

With respect to the other projects, the Proposition states that the funds can be used for the following types of projects: (1) grants to small community drinking water systems to upgrade monitoring, treatment, or distribution infrastructure; (2) grants to finance development and demonstration of new technologies and related facilities for water contaminant removal and treatment; (3) grants for community water quality; (4) grants for

drinking water source protection; (5) grants for drinking water source protection; (6) grants for treatment facilities necessary to meet disinfectant by-product safe drinking water standards; and (7) loans pursuant to the Safe Drinking Water State Revolving Fund (i.e., whereby the state draws down an 80 percent federal match). In addition, it is required that not less than 60 percent of the Chapter 4 funds be available for grants to Southern California water agencies to assist in meeting the state's commitment to reduce Colorado River water use.

Of the $485 million outlined in the bond measure, $353.8 million was made available for commitment to new water projects after accounting for bond costs ($16.975 million), state administration costs ($24.250 million), and the state match for the State Revolving Fund ($90 million).

The department has committed $293.5 million to projects and $60.3 million remains available to be committed. DPH has received project applications for $73.7 million.

LAO Findings and Recommendation. The LAO recommends that the Legislature reject the Administration's proposed provisional budget bill language that would allow DOF to increase expenditure authority above the requested $22 million. The LAO finds that the Administration should request the level of funding it believes necessary to fund shovel–ready projects in 2013–14. Historically, this is how funding to implement Proposition 50 has been appropriated.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to:

- **Approve** the $22 million local assistance appropriation in Proposition 50, Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002.
- **Approve** the Budget Bill Language to revert, effective June 30, 2013, all unspent Proposition 50 funds ($91.5 million) from prior appropriations through 2009-10.
- **Reject** the Provisional Budget Bill Language that authorizes DPH to increase its Proposition 50 expenditure authority above the requested $22 million appropriation upon approval from the Department of Finance (DOF). Staff concurs with the LAO's finding and recommendation that this provisional language should be rejected as DPH should request the level of expenditure authority necessary for 2013-14.

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

1. Please provide an update regarding Proposition 50 bonds.

2. Please provide a brief summary of the budget request.

3. Please discuss what steps the drinking water program has taken to improve its ability to more quickly fund projects.

12. Proposition 84

Budget Issue. DPH requests the following:

- A $48 million local assistance appropriation for Proposition 84, Safe Drinking Water, Water Quality and Supply, Flood Control, River and Coastal Protection Act of 2006.
- Provisional Budget Bill Language is also requested that authorizes DPH to increase its Proposition 84 expenditure authority above this $48 million appropriation upon approval from the Department of Finance (DOF).

Background. On November 6, 2006, California voters passed Proposition 84, a $5.4 billion water bond measure, known as the Safe Drinking Water, Water Quality and Supply, Flood Control, River and Coastal Protection Bond Act of 2006. Under the provisions of Proposition 84, DPH is responsible for administering three grant programs under Chapter 2 "Safe Drinking Water and Water Quality Projects" with approximately $300 million in grants for public water systems. The Proposition 84 funds are designated in the Public Resources Code as follows:

- Section 75021(a) provides $10 million to DPH for grants and direct expenditures to fund emergency and urgent actions to ensure that safe drinking water supplies are available to all Californians.
- Section 75022 provides $180 million to DPH for grants to small community drinking water systems for infrastructure improvements and related actions to meet safe drinking water standards with priority given to address chemical and nitrate contaminants. It also allows DPH to expend up to $5 million of the funds for technical assistance to eligible communities.
- Section 75023 provides $50 million to DPH to provide the 20 percent state match to access the federal capitalization grant for public water system infrastructure improvements. These funds are deposited into the Safe Drinking Water State Revolving Fund (SDWSRF) account (Section 116760.30 of the Health and Safety Code) and are available for loans and grants to public water systems to meet safe drinking water standards.
- Section 75025 provides $60 million to DPH for the purpose of loans and grants for projects to prevent or reduce contamination of groundwater that serves as a source of drinking water.

Proposition 84 provided $300 million to DPH to address contaminated drinking water, of which $219 million is available for projects (after bond costs and administration is considered). Of this, $124 million remains to be committed. According to DPH, there are expectations from stakeholders and the Administration that DPH will need to commit all the remaining funds in order to address contaminated water as quickly as possible. DPH is expecting to have all funds encumber into funding agreements by June 30, 2015.

In order to carry out the program, DPH requests new appropriation authority to align appropriations with planned expenditures. DPH indicates that it will spend the money at a different pace than originally anticipated. In part, this is due to actions in 2008 – the bond freeze and the excess appropriation authority DPH awarded through SBX2 1. The bond freeze prohibited the department from issuing funding agreements for 18 months; then DPH had to ramp up again. Although a BCP was approved to stretch the appropriation over five years, this was not enough time for DPH to expend the funds. As a result, the appropriation authority is out of alignment with planned expenditures.

DPH anticipates the ability to expend more than the $48 million requested for 2013-14 and is requesting Provisional Budget Bill Language that will allow DPH to increase its Proposition 84 expenditure authority above this $48 million appropriation upon approval from the Department of Finance.

LAO Findings and Recommendation. The LAO recommends that the Legislature reject the Administration's proposed provisional budget bill language that would allow DOF to increase expenditure authority above the requested $48 million. The LAO finds that the Administration should request the level of funding it believes necessary to fund shovel–ready projects in 2013–14. Historically, this is how funding to implement Proposition 84 has been appropriated.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to:

- **Approve** the $48 million local assistance appropriation for Proposition 84, Safe Drinking Water, Water Quality and Supply, Flood Control, River and Coastal Protection Act of 2006.
- **Reject** the Provisional Budget Bill Language that authorizes DPH to increase its Proposition 84 expenditure authority above this $48 million appropriation upon approval from DOF. Staff concurs with the LAO's finding and recommendation that this provisional language should be rejected as DPH should request the level of expenditure authority necessary for 2013-14.

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

1. Please provide an update regarding Proposition 84 bonds.

2. Please provide a brief summary of the budget request.

3. Please discuss what steps the drinking water program has taken to improve its ability to more quickly fund projects.

13. Recycled Water Program

Budget Issue. The DPH requests 3.0 one-year limited-term positions and $700,000 in reimbursement authority with the State Water Resources Control Board (SWRCB) to develop and adopt water recycling criteria for indirect potable reuse of recycled water through ground water recharge and surface water augmentation. The proposal also includes convening of an expert panel to review and make a finding on the criteria for the indirect potable reuse using surface water augmentation. (SWRCB has submitted a corresponding budget request.)

Background. California water supplies are increasingly limited due to changes in weather patterns, population growth, and other factors. Recycled water is wastewater which has been treated and is suitable for various uses. Depending on the degree of treatment, recycled water may be suitable for many uses, including: domestic uses, such as tap water; agricultural uses, such as irrigation; recreational uses, such as swimming pools; or industrial uses, such as water used for cooling in manufacturing processes.

Senate Bill (SB) 918 (Pavley, Statutes of 2010) seeks to expand the use of a recycled water as a water resource. Recycled water is wastewater that has been treated to meet standards determined to be appropriate, based on the beneficial use of the recycled water and the potential human exposure. Increased use of recycled water would expand the availability of existing potable water supplies, would improve water system reliability in the event of ongoing drought or other water shortages, could provide an economic benefit to communities by decreasing the need for importation of more expensive water supplies, and by allowing communities to expand their water supplies to accommodate the expected growth of the state.

SB 918 requires:

- DPH to develop and adopt criteria (regulations) for indirect potable water reuse, as follows:
    - For groundwater recharge by December 31, 2013; and
    - For surface water augmentation by December 31, 2016, after the expert panel makes a finding that the criteria are adequately protective of public health.
- DPH to investigate and report to the Legislature by December 31, 2016, on the feasibility of developing regulations for direct potable reuse. A draft report must be available for public review by June 30, 2016, with a minimum 45-day public review and comment period.
- DPH to convene an expert panel to advise them. The bill describes the professional composition of the panel. The panel would:
    - Review the draft criteria for surface water augmentation, and must make a finding that the criteria is adequately protective of public health before DPH may adopt the criteria.
    - Advise DPH on the investigation of the feasibility of developing criteria for direct potable reuse.
- DPH to convene an advisory group comprised of representatives of water and wastewater agencies, local public health officers, environmental organizations, environmental justice organizations, public health nongovernmental organizations, and

the business community to advise DPH regarding the development of uniform water recycling criteria for direct potable reuse.

DPH, in consultation with SWRCB, to submit written reports to the Legislature as part of the annual budget process from 2011 – 2016 on the progress of developing and adopting the criteria for surface water augmentation and the feasibility investigation.

SB 918 authorizes the SWRCB to provide funding from the Waste Discharge Permit Fund to assist DPH with the requirements of SB 918. DPH has met with SWRCB, which has indicated that the annual amount available in this fund varies based on penalties collected. SWRCB has informed DPH that $1.4 million is available starting July 1, 2012 to begin the implementation of SB 918.

According to DPH, the funding available from SWRCB is insufficient to fund all the requirements of the statute. If additional funding is identified at a future time, DPH will submit another BCP to request the additional appropriation authority necessary to complete the mandates of SB 918.

The 2012 Budget Act appropriated $700,000 in expenditure authority to the SWRCB from the Waste Discharge Permit Fund to begin a contract wth DPH to implement provisions of SB 918. DPH and SWRCB are still working on an interagency agreement for these efforts.

LAO Findings and Recommendation. The LAO recommends approval of this proposal on a workload basis to meet the requirements of SB 918. However, the LAO recommends that DPH report at budget hearings on which competing statutory priorities are delaying implementation of SB 918. This information will allow the Legislature to assess whether DPH's prioritization of workload reflects the Legislature's priorities. The LAO also recommends the Legislature require DPH to report at budget hearings on the additional resources that would be necessary to fully meet the statutory requirements of SB 918.

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

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

1. Please provide a brief summary of this proposal.

2. What activities of SB 918 will not be funded under this request?

3. What are the additional resources that would be necessary to fully meet the statutory requirements of SB 918?

14. Women, Infant, and Children Program

Budget Issue. DPH requests an increase of $35.5 million in federal funds and $2 million in WIC Manufacturer Rebate Funds for the WIC program. This requested increase in expenditure authority is a result of the expectation that the WIC participant levels will increase by 1.32 percent and an increase in food costs of 2.56 percent. Additionally, manufacturer rebates are anticipated to increase by 4.2 percent based on the anticipated increase in participation and the increased per-can rebate received under the infant formula rebate contract.

Table: WIC Expenditures

Fund Source	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
Federal Trust Fund	$1,236,175,000	$1,271,641,000	$35,466,000	3%
Special Funds	253,000,000	255,000,000	$2,000,000	1%
Total Expenditures	**$1,489,175,000**	**$1,526,641,000**	**$37,466,000**	**3%**

DPH states that about 1,507,914 WIC participants will access food vouchers in 2013-14. An estimated $65.50 is the monthly average participant cost for food.

Of the total federal grant amount, $990.6 million is for Base Food and $355.4 million is for Nutrition Services and Administration. The $255 million in Manufacturer Rebate Funds must be expended on food.

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

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

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

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, 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 USDA to address price competitiveness, MADR methodology and cost containment on October 3, 2012 and anticipates a decision from USDA shortly.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open the impact of USDA's decision on MADR will impact the May Revise estimates.

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 Maximum Reimbursement Rate Methodology.