Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator William W. Monning
Senator Jeff Stone

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Upon adjournment of Joint Subcommittee Hearing
State Capitol - Room 4203

PART A

Consultant: Scott Ogus

PUBLIC COMMENT

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4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Overview

Emergency Medical Services Authority - *Three-Year Funding Summary*			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Actual	***Revised***	***Proposed***
0001 – General Fund	$8,482,000	$8,753,000	$8,793,000
0194 – EMS Training Prog. Approval Fund	$208,000	$205,000	$207,000
0312 – EMS Personnel Fund	$2,408,000	$2,106,000	$2,647,000
0890 – Federal Trust Fund	$5,944,000	$6,089,000	$6,216,000
0995 – Reimbursements	$16,894,000	$17,413,000	$17,421,000
3137 – EMT Certifcation Fund	$1,592,000	$1,498,000	$1,503,000
Total Department Funding:	**$35,528,000**	**$36,064,000**	**$36,787,000**
Total Authorized Positions:	**73.4**	**66.9**	**68.9**

Emergency Medical Services Authority - *Comparison to 2016 Budget Act*			
Fund Source	**2016-17**	**2016-17**	**2016-17**
	Appropriation	***Revised***	***Difference***
0001 – General Fund	$8,725,000	$8,753,000	$28,000
0194 – EMS Training Prog. Approval Fund	$200,000	$205,000	$5,000
0312 – EMS Personnel Fund	$2,258,000	$2,106,000	($152,000)
0890 – Federal Trust Fund	$6,035,000	$6,089,000	$54,000
0995 – Reimbursements	$17,355,000	$17,413,000	$58,000
3137 – EMT Certifcation Fund	$1,574,000	$1,498,000	($76,000)
Total Department Funding:	**$36,147,000**	**$36,064,000**	**($83,000)**
Total Authorized Positions:	**66.9**	**66.9**	**-**

Emergency Medical Services Authority - *Comparison 2016-17 (Rev) to 2017-18*			
Fund Source	**2016-17**	**2017-18**	**2017-18**
	Revised	***Proposed***	***Difference***
0001 – General Fund	$8,753,000	$8,793,000	$40,000
0194 – EMS Training Prog. Approval Fund	$205,000	$207,000	$2,000
0312 – EMS Personnel Fund	$2,106,000	$2,647,000	$541,000
0890 – Federal Trust Fund	$6,089,000	$6,216,000	$127,000
0995 – Reimbursements	$17,413,000	$17,421,000	$8,000
3137 – EMT Certifcation Fund	$1,498,000	$1,503,000	$5,000
Total Department Funding:	**$36,064,000**	**$36,787,000**	**$723,000**
Total Authorized Positions:	**66.9**	**68.9**	**2.0**

Background. Prior to 1980, California did not have a central state agency responsible for ensuring the development and coordination of emergency medical services (EMS) and programs statewide. After several years of efforts by EMS stakeholders to establish a state lead agency and centralized resource to oversee emergency and disaster medical services, the Emergency Medical Services System and Prehospital Emergency Care Personnel Act was passed, creating the Emergency Medical Services Authority (EMSA) in the California Health and Human Services Agency. EMSA's mission is to provide quality patient care by administering an effective statewide system of coordinated emergency medical care, injury preventions, and disaster medical response that integrates public health, public safety, and healthcare. EMSA is organized into three program divisions: the Disaster Medical Services Division, the Emergency Medical Services Personnel Division, and the Emergency Medical Services Systems Division.

Disaster Medical Services Division. The Disaster Medical Services Division coordinates California's medical response to major disasters by carrying out EMSA's mandate to provide medical resources to local governments in support of their disaster response efforts. The division coordinates with the Governor's Office of Emergency Services, the Office of Homeland Security, the California National Guard, the Department of Public Health, and other local, state, and federal agencies, private sector hospitals, ambulance companies, and medical supply vendors, to promote and improve disaster preparedness and emergency medical response in California.

EMS Personnel Division. The EMS Personnel Division is responsible for the certification, licensing, and discipline of all active paramedics throughout the state. The division develops and implements regulations that set training standards and the scope of practice for various levels of personnel; sets standards for and approves training programs in pediatric first aid, CPR, and preventive health practices for child day care providers and school bus drivers; and is developing standards for emergency medical dispatcher training, pre-arrival emergency care instructions, and the epinephrine auto-injector training program.

EMS Systems Division. The Systems Division is in charge of developing and implementing EMS systems throughout California, including supporting local Health Information Exchange projects that will allow the state to collect more meaningful data so emergency medical services providers can deliver better patient care. The division oversees system development and implementation by the local EMS agencies, the statewide trauma system, and emergency medical dispatcher and communication standards. It establishes regulations and guidelines for local agencies, reviews and approves local plans to ensure they meet minimum state standards, coordinates injury and illness prevention activities with the Department of Public Health and the Office of Traffic Safety, manages the state's EMS data and quality improvement processes, conducts Ambulance Exclusive Operating Area evaluations, and oversees the operation of California's Poison Control System and EMS for Children programs.

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 mission and programs.

Issue 2: E-Commerce Online Paramedic Licensing Module (eGov)

Budget Issue. EMSA requests expenditure authority from the Emergency Medical Services Personnel Fund of $211,000 in 2017-18 and $71,000 annually thereafter. If approved, these resources would allow EMSA to purchase proprietary software to implement an online paramedic licensing application system.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0312 – EMS Personnel Fund	$-	$211,000
Total Funding Request:	**$-**	**$211,000**

Background. AB 2917 (Torrico), Chapter 274, Statutes of 2008, requires EMSA to establish and maintain a centralized system for monitoring and tracing emergency medical technician (EMT) certification status and paramedic licensure status to be used by certifying entities. In response, EMSA established, My License Office (MLO), a statewide public electronic registry system, which was originally intended to be implemented in two phases: 1) implementation of a centralized EMT electronic registry system to manage paramedic licensure, EMT certification, and paramedic enforcement information that included a web-based, public registry look-up component; and 2) a real-time, self-service online paramedic licensing electronic government (eGov) module option for new, renewing, and reinstating paramedic license applicants.

Due to technical problems related to delays in virtual server procurement and acquisition of a payment processor, the scope of the project was reduced to exclude the implementation of the eGov licensure module. The California Department of Technology created virtual servers to support the MLO system and EMSA purchased credit card payment equipment to process payments received in-person and by mail. However, the real-time, self-service online licensing function was never implemented.

EMSA requests expenditure authority from the Emergency Medical Services Personnel Fund of $211,000 in 2017-18 and $71,000 annually thereafter to purchase proprietary software to implement the online paramedic licensing eGov module originally intended during development of the MLO system. According to EMSA, the MLO eGov module will be located in a cloud-based network environment hosted, administered, and maintained by the current MLO vendor, System Automation. The module will support legible, accurate, and complete data entry by paramedic licensing applicants, reducing the need for staff to support licensing workload. EMSA reports staff time spent processing renewals will be reduced to six minutes, as time previously required to review and upload renewal applicant information and fee payments will be eliminated. According to EMSA, staff will be redirected to address other program services currently underserved within the unit such as increasing the number of random audits of continuing education reported by paramedics during the licensing renewal application review process to ensure compliance with existing paramedic licensing regulations.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: EMT-P Discipline Case Workload

Budget Issue. EMSA requests two positions and expenditure authority from the Emergency Medical Services Personnel Fund of $314,000 in 2017-18 and 2018-19. If approved, these resources would allow EMSA to manage an increase in disciplinary legal caseload related to its oversight of paramedic licensing.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0312 – EMS Personnel Fund	$-	$314,000
Total Funding Request:	**$-**	**$314,000**
Total Positions Requested:	**2.0**	

Background. Under its regulatory authority over paramedic licensing, EMSA may deny, revoke, suspend, or place on probation a paramedic's license if there is evidence of a threat to public health and safety. EMSA's legal counsel is responsible for disciplinary actions under this authority. Currently, EMSA's legal unit consists of one full-time attorney, two retired annuitant attorneys, one retired annuitant staff services analyst, and one student assistant. The full-time attorney provides all legal services to EMSA, which includes: legal advice to the director, review of contracts, legal support for all EMSA divisions, review of local EMS agency solicitations and ambulance exclusive operating areas, public records act request review, subpoena and litigation response, employee discipline, and paramedic enforcement case supervision. The two retired annuitant attorneys prepare paramedic enforcement cases, negotiate settlements, and represent EMSA at administrative hearings at various locations throughout the State. The remaining staff provide administrative support to all three attorneys.

EMSA reports it has experienced an increase in litigation related to local EMS plan appeals and local EMS agency Exclusive Operating Area solicitation reviews. According to EMSA, appeals and reviews of this kind had previously occurred rarely, but have increased in response to adverse findings in EMSA's review processes. As a result of the increase in other litigation responsibilities, EMSA's full-time attorney is unable to devote sufficient time to review and monitor paramedic liensing enforcement cases. This workload is currently being supported exclusively by the retired annuitant attorneys. Because retired annuitants have limited hours per year available to work, these attorneys are insufficient to meet the increased paramedic licensing enforcement caseload, resulting in delayed litigation.

EMSA requests one Attorney I and one Staff Services Analyst, and expenditure authority from the Emergency Medical Services Personnel Fund of $314,000 in 2017-18 and 2018-19 to manage the increased workload related to paramedic licensing enforcement.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Public Health Emergency Preparedness

Budget Issue and Trailer Bill Language Proposal. DPH requests 88.3 positions (76.8 conversion from limited-term and 11.5 new positions) and expenditure authority of $11.8 million federal funds annually. If approved, these resources would allow DPH to continue its public health emergency preparedness activities pursuant to requirements in state and federal law. Accompanying the request is proposed trailer bill language to make technical and clarifying changes to provisions of state law governing the program.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$11,752,000
Total Funding Request:	**$-**	**$11,752,000**
Total Positions Requested:	**88.3**	

Background. DPH responds to numerous public health events on a daily basis. Recent disasters requiring a significant departmental response include the California wildfires of 2003, 2007, 2008 and 2012; Hurricane Katrina in 2005; floods in 2006; extreme heat events in 2006, 2007, 2008, 2013, and 2016; H1N1 in 2009; the tsunami and radiation threat from the Fukushima earthquake in 2011; the 2011 Southern California power outage; the Napa Earthquake; Ebola Virus Disease; Drought, H1N1 Outbreak of 2014; the Valley & Butte Fires in 2015; the June 2016 Heat Event; and the 2016 Zika Virus Outbreak.

With the events of September 11, 2001, and subsequent anthrax attacks, DPH's public health emergency preparedness responsibilities increased significantly to include activities related to countering potential bioterrorism, chemical, nuclear, or radiologic threats. Federal funds to build and maintain capabilities to address these threats are provided to states through the Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP) Cooperative Agreements.

Public Health Emergency Preparedness (PHEP). The PHEP Cooperative Agreement, issued by the Centers for Disease Control and Prevention (CDC), funds state and local health departments to enhance the California public health system's preparedness and response to public health emergencies. DPH allocates 70 percent of this grant to fund local health jurisdictions' (LHJs) preparedness activities and funds state operations with the remaining 30 percent. The PHEP grant is delineated by 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 as follows:

1. Community Preparedness
2. Community Recovery
3. Emergency Operations Coordination
4. Emergency Public Information and Warning
5. Fatality Management
6. Information Sharing
7. Mass Care
8. Medical Countermeasure Dispensing

9. Medical Materiel Management and Distribution
10. Medical Surge
11. Non-Pharmaceutical Interventions
12. Public Health Laboratory Testing
13. Public Health Surveillance and Epidemiologic Investigations
14. Responder Safety and Health
15. Volunteer Management

Hospital Preparedness Program (HPP). The HPP Cooperative Agreement provides federal funding to prepare hospitals, clinics and other health care facilities and emergency medical services systems to respond to disasters. The HPP grant has eight Health Care Preparedness Capabilities with supporting Functions, Resource Elements and Performance Measures that states are required to meet. The Healthcare Preparedness Capabilities are as follows:

1. Healthcare System Preparedness
2. Healthcare System Recovery
3. Emergency Operations Coordination
4. Fatality Management
5. Information Sharing
6. Medical Surge
7. Responder Safety and Health
8. Volunteer Management

Continuation of PHEP and HPP Funded Emergency Preparedness Programs. In 2003, DPH received limited-term positions and resources to build capacity for public health preparedness using PHEP and HPP federal grant funding. There are 76.8 positions remaining from the original request, which have been reauthorized several times since 2003 and expire on July 1, 2017. DPH proposes to convert these positions from limited-term to permanent as the department expects federal grant funding for emergency preparedness programs to continue. In addition, as the post September 11, 2001, emergency preparedness activities have continued, the field of trained and experienced individuals has grown, increasing the ability of DPH to hire state staff with relevant experience in these activities instead of contractors. As a result, DPH is able to convert former contract positions to state positions, which results in cost savings. As qualified civil service classifications are capable of performing the workload, the conversions are also required under state law. The conversion results in an additional resource request of 11.5 permanent positions. The 88.3 positions are located in the following DPH divisions: Emergency Preparedness Office, Center for Infectious Diseases, Center for Environmental Health, Center for Chronic Disease Prevention and Health Promotion, Office of Public Affairs, Office of Compliance, Information Technology Services Division, and the Administration Division.

Trailer Bill Language Proposal. Accompanying the requested extension of resources, DPH proposes trailer bill language to make the following technical and clarifying changes to the provisions of state law governing expenditures of public health emergency preparedness federal funding:

1. Change references for the use of funds from "bioterrorism" to "public health emergency" to be consistent with current uses allowable under federal grants.
2. Clarify initial quarterly payment of grant funds would be made to LHJs upon DPH approval of the application for funding and subsequent payments would be made either quarterly or as

reimbursements upon submission of documentation. According to DPH, this is consistent with current practice.

3. Allow DPH to accept certification from a designee, authorized by the chair of the board of supervisors or mayor, regarding non-supplantation requirements. According to DPH, current law requires the chair of the board or mayor to sign certifications personally.
4. Remove the requirement for LHJs to place federal funds into an interest bearing trust fund account, if exempted from this requirement by federal funding guidance. According to DPH, certain counties have found it difficult and expensive to comply with the trust fund requirement, which is no longer consistent with federal guidance.
5. Require LHJs to remit earned interest in excess of $500 annually to DPH in accordance with federal regulations.
6. Adjust the baseline allocation for emergency preparedness, including pandemic influenza preparedness, in accordance with current appropriations.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 2: Newborn Screening Program (SB 1095)

Budget Issue. DPH requests one position and expenditure authority from the Genetic Disease Testing Fund of $2.69 million ($769,000 state operations and $1.92 million local assistance) in 2017-18 and $137,000 state operations annually thereafter. If approved, these resources would allow the Genetic Disease Screening Program (GDSP) to implement additional newborn screening requirements for genetic diseases required pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0203 – Genetic Disease Testing Fund		
State Operations:	$-	$769,000
Local Assistance:	$-	$1,928,000
Total Funding Request:	**$-**	**$2,689,000**
Total Positions Requested:	**1.0**	

Background. GDSP administers a statewide genetic disorder screening program for pregnant women and newborn babies that is fully supported by fees. When the Newborn Screening (NBS) program within GDSP began in 1980, each newborn was screened for only three disorders. Today, more than 500,000 newborns are screened for 80 disorders annually, resulting in more than 700 diagnoses. According to DPH, California leads the nation in the number of disorders screened and provides the most comprehensive program in terms of quality control, follow-up services, genetic counseling, confirmatory testing, and diagnostic services.

SB 1095 requires the NBS program to expand statewide screening of newborns to include screening for any disease that is detectable in blood samples within two years of the disease being adopted by the federal Recommended Uniform Screening Panel (RUSP). There are two disorders currently on the RUSP that are not on the NBS program panel. Mucopolysaccharidosis type I (MPS-I) and Pompe disease were added to the RUSP in 2016 and 2015, respectively, and will be added to the panel for newborn screening by August 30, 2018.

DPH also plans to couple its primary screening methods with a second-tier, linked test that can improve diagnostic specificity without reducing sensitivity and uses the same blood specimen that was sampled for the original test. The secondary screen measures additional metabolites that either strongly support the presumption of a true positive case or demonstrate the patient does not have the disorder. According to DPH, significant published research supports the public health and cost-saving benefits of adoption of a second-tier testing method to rule out false positive results.

Resources for Implementation of New Screening Protocols Results in Fee Increase. Based on an assessment of laboratory and processing costs, an increase of approximately $10.00 to the current NBS program fee of $130.25 will be required to implement the new testing protocols and provide ongoing funding. Funding from the fee increase will support expenditures associated with processing blood specimens; performing the actual blood screen; testing chemicals, equipment and supplies used to assay results; and arranging for follow-up services for positive cases. Follow-up services may include case

management, diagnostic work-up, confirmatory processing, provider and family education, or informative result mailers.

DPH requests one position and expenditure authority from the fee-supported Genetic Disease Testing Fund of $2.69 million. If approved, $2.25 million would fund one-time costs to develop testing protocols to incorporate MPS-I and Pompe into the NBS program screening panel by August 30, 2018. $139,000 would fund one Research Scientist II to support testing activities. In addition, DPH is requesting a one-time increase of $300,000 in state operations expenditure authority and a transfer of $330,000 in expenditure authority from local assistance to state operations for the purchase of mass spectrometry equipment and support for second-tier testing. The department plans to purchase the equipment in early 2017-18 to begin performing second-tier testing by early 2018.

According to DPH, implementation of second-tier testing would save the NBS program approximately $380,000 per year in local assistance costs related to follow-up services provided in response to a false positive result, beginning in 2018-19.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Genetic Disease Screening Program

Budget Issue. The November 2016 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $132.3 million ($26.5 million state operations and $105.8 million local assistance) in 2016-17, and $136.6 million ($26.8 million state operations and $109.9 million local assistance) in 2017-18.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2016-17	**2017-18**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$26,540,000	$26,767,000	$227,000
Local Assistance:	$105,771,000	$109,857,000	$4,086,000
Total GDSP Expenditures	**$132,311,000**	**$136,624,000**	**$4,313,000**

Background. According to DPH, the Genetic Disease Screening Program (GDSP) performs the following tasks to support its mission:

- Screens newborns and pregnant women for genetic and congenital disorders in a cost-effective and clinically effective manner. The screening programs provide testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.
- Ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance.
- Fosters informed participation in its programs in an ethical manner through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.
- Provides ongoing critical review, testing, and evaluation of existing programs to ensure program objectives and goals are being met.
- Develops programs to adopt new methods and implement new services that further enhance the effectiveness and efficiency of current and future prevention programs.
- Promotes use of high-quality consumer education materials on genetic disorders, screening for birth defects and genetic services.

GDSP operates two primary screening programs: the Newborn Screening program and the Prenatal Screening program. Caseload and expenditures for these programs are reflected in the GDSP Estimate along with operational support costs for the programs.

Newborn Screening (NBS) Program. Newborn screening, recognized nationally as an essential preventive health measure, began in California in 1966 with the testing of infants for phenylketonuria (PKU). In 1980, the program was expanded to include galactosemia, primary congenital hypothyroidism, and included a more comprehensive follow-up system. In 1990, screening for sickle cell disease was added to the screening program, which allows for identification of related non-sickling hemoglobin disorders, including beta-thalassemia major, and Hb E/beta thalassemia. In 1999, the program implemented screening for hemoglobin H and hemoglobin H - Constant Spring disease. In 2005 the screening panel was expanded to include additional metabolic disorders and congenital adrenal

hyperplasia (CAH), and in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

According to DPH, disorders screened for by the program have varying degrees of severity and, if identified early, many can be treated before they cause serious health problems. Between 1980 and 2009, 14,989,863 babies were screened resulting in early identification of the following disorders:

Disorder	Cases
Phenylketonuria (PKU)	1,026
Primary Congenital Hypothyroidism	5802
Galactosemia	191
Sickle Cell Disease and other clinically significant Hemoglobinopathies	2,500
Hemoglobin H Disease	529
Biotinidase Deficiency (BD)	16
Cystic Fibrosis (CF)	242
Congenital Adrenal Hyperplasia (CAH)	114
Metabolic/Fatty Acid Oxidation Disorders	559
TOTAL	**10,979**

The NBS program currently screens infants in California for 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, will be added to the screening panel by August 30, 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), they will be added to the NBS program screening panel within two years. The fee for screening in the NBS program is $130.25.

Caseload Estimate: The budget estimates NBS program caseload of 494,862 in 2016-17, a decrease of 2,221 or 0.4 percent, compared to the 2016 Budget Act. The budget estimates NBS program caseload of 497,973 in 2017-18, an increase of 3,111 or 0.6 percent, compared to the revised 2016-17 estimate. These estimates are based on state projections of an increase in the number of live births. DPH assumes 97.4 percent of births will participate in the NBS program annually.

Prenatal Screening (PNS) Program. The Prenatal Screening (PNS) program provides prenatal screening services and follow-up diagnostic services, where indicated, to all pregnant women in California to detect birth defects during pregnancy. The program offers three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect:

- Sequential Integrated Screening – This screen combines first and second blood test results with nuchal translucency (NT) ultrasound results, which measures the back of a fetus' neck. This measurement helps screen for Down syndrome (trisomy 21).
- Serum Integrated Screening – This screen combines a first trimester blood test screening result with a second trimester blood test screening result.
- Quad Marker Screening - One blood specimen drawn at 15 weeks - 20 weeks of pregnancy (second trimester test).

The PNS program provides pregnant women with a risk assessment for open neural tube defects (NTD), Down syndrome (trisomy 21), trisomy 18 and Smith-Lemli-Opitz Syndrome (SLOS) through one or two blood tests. The screening test indicates risk, but does not diagnose fetal birth defects.

For women with screening results indicating a high risk for a birth defect, the program provides free follow-up diagnostic services at state-approved Prenatal Diagnosis Centers (PDCs). Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation in the screening testing and follow-up services is voluntary and the fee for testing through the PNS program is $221.60.

Caseload Estimate: The budget estimates PNS program caseload of 360,288 in 2016-17, a decrease of 840 or 0.2 percent, compared to the 2016 Budget Act. The budget estimates PNS program caseload of 362,553 in 2017-18, an increase of 2,265 or 0.6 percent, compared to the revised 2016-17 estimate. These estimates are based on state projections of an increase in the number of live births. DPH assumes 70.9 percent of births will participate in the PNS program annually.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the caseload and expenditure changes for the Newborn Screening Program.

2. Please provide a brief overview of the caseload and expenditure changes for the Prenatal Screening Program.

Issue 4: Women, Infants, and Children (WIC) Program

Budget Issue. The November 2016 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.3 billion ($1.1 billion federal funds and $223.4 million WIC manufacturer rebate funds) in 2016-17 and $1.3 billion ($1.1 billion federal funds and $216.4 million WIC manufacturer rebate funds) in 2017-18. The federal fund amounts include state operations costs of $61.4 million in 2016-17 and $63.2 million in 2017-18.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2016-17	**2017-18**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0890 – Federal Trust Fund			
State Operations:	$61,429,000	$63,209,000	$1,780,000
Local Assistance:	$1,035,439,000	$1,057,618,000	$22,179,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$223,377,000	$216,412,000	($6,965,000)
Total WIC Expenditures	**$1,320,245,000**	**$1,337,239,000**	**$16,994,000**

Background. The WIC program provides nutrition services and food assistance for pregnant, breastfeeding, and non-breastfeeding women, infants, and children up to their fifth birthday at or below 185 percent of the federal poverty level. WIC program services include nutrition education, breastfeeding support, assistance with finding health care and other community services, and vouchers for specific nutritious foods that are redeemable at WIC-authorized retail food outlets throughout the state. The WIC program receives federal funds from the United States Department of Agriculture (USDA) under the federal Child Nutrition Act of 1966. Specific uses of WIC Program funds are governed by federal laws and regulations, and DPH must report funds and expenditures monthly.

The WIC program's food expenditures are funded by a combination of federal grants and rebates from manufacturers of infant formula. Federal WIC regulations require that state WIC programs have sole supplier rebate contracts in place with infant formula manufacturers for milk-based and soy-based infant formula. As infant formula is provided to WIC recipients, the program receives a rebate from the manufacturer which is used to fund additional food expenditures. In addition to food expenditures, the program receives federal funds from the Nutrition Services and Administration (NSA) grant, which are used to contract with local agencies for direct services provided to WIC families including intake, eligibility determination, benefit issuance, nutrition education, breastfeeding support, and referrals to health and social services. The NSA grant also funds state operations for administering the WIC program.

Food expenditures are divided into five participant categories, each with special nutrition needs that influence food costs:

- **Pregnant women** are eligible for the WIC program at any point in their pregnancy, and receive supplemental foods high in protein, calcium, iron, vitamin A, and vitamin C to support optimal fetal development.

- **Breastfeeding women** are eligible for benefits up to their infant's first birthday, and receive an enhanced supplemental food package with foods high in protein, calcium, iron, vitamin A, and vitamin C to support caloric needs during breastfeeding.
- **Non-breastfeeding women** are eligible for benefits up to six months after the birth of their infants, and receive a supplemental food package to help in rebuilding nutrient stores, especially iron and calcium, and achieving a healthy weight after delivery.
- **Infants** are eligible until one year of age. The WIC Program promotes breastfeeding as the optimal infant feeding choice due to its many health, nutritional, economical, and emotional benefits to mother and baby. Infants may also receive supplemental foods that are rich in protein, calcium, iron, vitamin A, and vitamin C during this critical period of development.
- **Children** are eligible from age one to up to age five, and receive supplemental foods rich in protein, calcium, iron, vitamin A, and vitamin C. These nutrients have been shown to be lacking in the diets of children who qualify for WIC benefits and are needed to meet nutritional needs during critical periods of development. The food package also provides foods lower in saturated fat to reduce the risk of childhood obesity.

According to the WIC program Estimate, food expenditures by participant category are as follows:

EXPENDITURE COMPARISON (all funds)							
Expenditure Category	2016 Budget Act	SFY 2016-17			SFY 2017-18		
		November Estimate	Change from 2016 Budget Act		November Estimate	Change from 2016 Budget Act	
Pregnant	75,577,000	70,450,000	(5,127,000)	-6.78%	69,259,000	(6,318,000)	-8.36%
Breastfeeding	64,788,000	61,893,000	(2,895,000)	-4.47%	62,542,000	(2,246,000)	-3.47%
Non-Breastfeeding	33,085,000	31,846,000	(1,239,000)	-3.74%	31,545,000	(1,540,000)	-4.65%
Infants	356,215,000	362,555,000	6,340,000	1.78%	361,352,000	5,137,000	1.44%
Children	419,389,000	389,216,000	(30,173,000)	-7.19%	406,033,000	(13,356,000)	-3.18%
Yogurt	10,787,000	10,787,000	-	0.00%	10,787,000	-	0.00%
Cash Value Voucher Increase	3,300,000	3,300,000	-	0.00%	3,300,000	-	0.00%
Reserve	28,894,000	27,902,000	(992,000)	-3.43%	28,345,000	(549,000)	-1.90%
Total Food Expenditures	**992,035,000**	**957,949,000**	**(34,086,000)**	**-3.44%**	**973,163,000**	**(18,872,000)**	**-1.90%**
Food Expenditures Paid from Rebate Funds	*217,085,000*	*223,377,000*	*6,292,000*	*2.90%*	*216,412,000*	*(673,000)*	*-0.31%*
Food Expenditures Paid from Federal Funds	*774,950,000*	*734,572,000*	*(40,378,000)*	*-5.21%*	*756,751,000*	*(18,199,000)*	*-2.35%*
Other Local Assistance Expenditures (Federal NSA)	300,867,000	300,867,000	-	0.00%	300,867,000	-	0.00%
Total Federal Local Assistance Expenditures (Food + NSA)	**1,075,817,000**	**1,035,439,000**	**(40,378,000)**	**-3.75%**	**1,057,618,000**	**(18,199,000)**	**-1.69%**
State Operations (Federal NSA)	61,429,000	61,429,000	-	0.00%	63,209,000	1,780,000	2.90%

The budget assumes 1,170,997 WIC participants in 2016-17, a decrease of 29,708 or 2.5 percent from the assumptions in the 2016 Budget Act. The budget assumes 1,164,043, a decrease of 6,954 or 0.6 percent from the revised 2016-17 caseload estimate.

Food Expenditures Estimate. The budget includes $957.9 million in 2016-17 for WIC program food expenditures, a decrease of $34.1 million or 3.4 percent, compared to the 2016 Budget Act. According to DPH, this decrease is due to lower than projected participation levels. Of these expenditures, federally funded food expenditures are $734.6 million, a decrease of $40.4 million from the 2016 Budget Act, and WIC Manufacturer Rebate Fund food costs are $223.4 million, an increase of $6.3 million from the 2016 Budget Act. According to DPH, rebate funded food costs are increasing by 2.9 percent due to a manufacturer wholesale price increase for infant formula.

The budget includes $973.2 million in 2017-18 for WIC program food expenditures, an increase of $15.2 million or 1.6 percent from the revised 2016-17 food expenditures estimate. According to DPH, these increased costs are due to a 2.9 percent rate of inflation for food. Of these expenditures, federally funded food costs are $756.8 million, an increase of $22.2 million from the revised 2016-17 food expenditure estimate, and WIC Manufacturer Rebate Fund food costs are projected to be $216.4 million, a decrease of $7 million from the revised 2016-17 food expenditure estimate.

Nutrition Services and Administration (NSA) Estimate. The budget includes $300.9 million for other local assistance expenditures for the NSA budget in 2016-17 and 2017-18, which is unchanged from the level assumed in the 2016 Budget Act. The budget also includes $61.4 million for state operations expenditures in 2016-17, also unchanged from the level assumed in the 2016 Budget Act. The budget includes $63.2 million for state operations expenditures in 2017-18, an increase of $1.8 million or 2.9 percent compared to the revised 2016-17 estimate. According to DPH, the increase in 2017-18 is attributed to the $1.8 million increase in expenditures for the eWIC Electronic Benefit Transfer (EBT) and Management Information System (MIS) Project.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the caseload and expenditure changes for the WIC program.

2. Please describe the WIC program's outreach efforts to ensure maximum participation in the program and full use of available federal funds.

3. Please describe how federal WIC allocations are affected by state WIC programs' utilization of federal funds. Is the state at risk of reduction in federal funding allocations due to low participation?