2005 FEDERAL AND STATE LEGISLATIVE REPORT

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
OFFICE OF POLICY AND PLANNING

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I. INTRODUCTION

A. LEGISLATIVE ADVOCACY AND THE STRATEGIC PLAN

Under goal four of the Department of Public Health's revised Strategic Plan, the Department is directed to engage in local, State and federal advocacy efforts in order to ensure that health policy changes are consistent with Department priorities. The Department's advocacy activities are coordinated in the Office of Policy and Planning which, through legislative analysis, participation in statewide coalitions and collaboration with community partners and colleagues from other counties, reviews and analyzes health-related legislation for the Department and the City. The Department works closely with the Mayor's Office of Public Policy and Finance to impact those policies that will affect the health of San Franciscans. As set forth in the Strategic Plan, the Department's advocacy strategies are to:

- Engage in local, State and federal advocacy efforts through the Mayor's Office;
- Advocate for State and federal legislative changes addressing programmatic issues; and
- Coordinate with the State on licensing and regulatory matters.

B. THE CITY'S FEDERAL LEGISLATIVE PROCESS

The Department works with the Mayor's Office of Public Policy and Finance, and also directly with the City's federal lobbyist to impact federal legislation and appropriations. The Department relies heavily on the City's federal lobbyist to communicate the Department's positions in the most timely and effective manner. The Department also works in coalition with organizations such as the National Association of Public Hospitals and Health Systems, the Public Health Pharmacy Coalition, the Communities Advocating Emergency AIDS Relief (CAEAR) Coalition and others to impact federal policy. By its participation in these coalitions, the Department ensures that the City's interests are well represented at the federal level. Because responsibility for health care falls largely to states rather than the federal government, the majority of the Department's advocacy activities are focused at the State level.

C. THE CITY'S STATE LEGISLATIVE PROCESS

Pursuant to City policy, the Department of Public Health, like all other City departments, does not take positions on State legislation; that is, the Department does not itself support or oppose State legislation. Rather, the Department makes recommendations to the Mayor's Office of Public Policy and Finance and the Mayor's State Legislative Committee for City positions on health-related legislation. The Mayor's Office approves City positions on legislation in one of two ways: (1) by approving at the beginning of each legislative session the Department's State Legislative Plan, which outlines the Department's recommendations on issues likely to arise in the upcoming year; or (2) through a hearing before the State Legislative Committee for those issues that are not addressed in the State Legislative Plan.

Because the Mayor's Office responds to a large number of such requests coming from all City departments, the Department ensures that the bills it recommends for City positions are those where the impact of the City's position is maximized. In many other instances, worthy bills are supported by statewide coalitions of which the Department is a member. The Department is an active member of the County Health Executives Association of California, the California Conference of Local Health Officers, the Health Officers Association of California, the California Association of Public Hospitals and Health Systems, the California State Association of Counties and the California Healthcare Association, to name a few. By its participation in these coalitions, the Department ensures that the City is represented in coalition positions. As another example, the Department may not recommend a City position on legislation that is clearly not moving within the Legislature. Though these issues may be important, the City's efforts would not be best spent on inactive legislation.

II. FEDERAL LEGISLATIVE SUMMARY

A. OVERVIEW OF THE LEGISLATIVE SESSION

The 109th Congress convened in January 2005 to begin the first session of the two-year Congressional cycle. With Republicans retaining the White House in the November 2004 election and slightly expanding their majorities in both the House and Senate, President Bush and Republican leaders in Congress appeared to have built momentum for their agenda heading into 2005. Disagreements related to health care access for the uninsured, Medicare prescription drug coverage, medical malpractice reform and stem cell research played a prominent role in the 2004 campaign, but it was debate about entitlement cuts and reigning in the ballooning deficit that dominated the Congressional health agenda this year.

Though slightly smaller than the record $412 billion federal budget deficit reached in 2004, the $317 billion deficit for 2005 was the third highest in the history of the Country. The bleak fiscal outlook guaranteed another highly partisan budget process, with the Republican majority arguing for spending cuts to alleviate the deficit and the Democratic minority arguing against further tax cuts and against programmatic cuts they believe are harmful. In his Fiscal Year 2006 budget, which was released in February 2005, President Bush proposed cutting $45 billion from Medicaid and $931 million from discretionary health programs. The Republican majorities in the House and Senate eventually passed a Congressional budget resolution in April that called for $35 billion in cuts to entitlement programs, including Medicaid, over the next five years. The battle to enact those cuts continued through the rest of the year.

Intense debate over progress in the Iraq war and its escalating cost, as well as the need to respond to the devastating impact of Hurricane Katrina, pushed many other items off of the agenda as the year progressed, including a proposed overhaul of Social Security, changes to the tax code, medical malpractice reform and other legislation Republicans had emphasized at the beginning of 2005.

B. FEDERAL BUDGET

In response to the rising federal deficit, President Bush proposed significant spending cuts in his Fiscal Year 2006 budget. Specifically, the Bush budget cut $71 billion over the next ten years from mandatory entitlement programs, including a proposed $45 billion Medicaid cut, and over

$10 billion from non-homeland security domestic programs in 2006. Offsetting these proposed savings, however, were $1.4 trillion in additional tax cuts proposed over the next ten years.

The president's budget serves as a blueprint for the Congressional budget resolution, which dictates how much funding goes to discretionary programs funded through the appropriations process as well as any mandatory spending cuts or tax cuts that will receive reconciliation protections. Reconciliation protections are an important tool for the majority party because they prevent a filibuster in the Senate, meaning that spending cuts or tax cuts with reconciliation protections can pass with 51 votes rather than the 60 votes needed to overcome a filibuster.

The Congressional budget resolution was passed in April and included reconciliation protections for over $35 billion in entitlement cuts, as well as $70 billion in new tax cuts, over the next five years. Although the House and Senate agree to overall numbers, each chamber has discretion over how they divide up the proposed cuts. As a result, there were significant differences to resolve between the package of entitlement cuts proposed by the House and that proposed by the Senate, especially in terms of health.

The House proposal cut $9 billion from Medicaid while the Senate cut only $4.3 billion. The bulk of the House cuts came from allowing states to increase cost sharing for beneficiaries, while the Senate avoided increases in beneficiary costs and instead achieved savings through changes in Medicaid prescription drug pricing and elimination of a $10 billion fund to encourage private plans to participate in Medicare. The Senate bill also included a provision to prevent a scheduled 4.4 percent cut in Medicare reimbursement for physicians.

Congress spent much of the summer and fall trying to work out a compromise between these two approaches. The compromise bill that emerged included $5 billion in net cuts to Medicaid. However, this figure takes into account additional Medicaid spending for victims of Hurricane Katrina, a new option for parents of disabled children that allows them to buy into Medicaid and the cost of a few other new provisions. Once these additions are taken out, gross cuts in services to existing Medicaid beneficiaries total $11 billion over five years and $42 billion over the next ten years.

Most of the Medicaid cuts in the final bill come from giving states the option to increase beneficiary cost sharing. Whether or not the California Legislature will agree to increased cost sharing is a question mark. Numerous studies show that increases in co-payments and premiums lead low-income Medicaid patients to forgo needed health services or, in some cases, fail to enroll in Medicaid at all. This means that patients with illnesses that could have been prevented or treated on an outpatient basis wait until they are very sick and require costly emergency room and/or inpatient care. At San Francisco General Hospital, 45 percent of our inpatient and 34 percent of our outpatient patients are on Medi-Cal (California's Medicaid program). Another 21 percent of our inpatient and 36 percent of our outpatient patients are uninsured, some of whom may be eligible for Medicaid. Increased cost sharing will make it more difficult to get everyone eligible for Medicaid enrolled.

Also included is language preventing seniors with home equity over $500,000 from becoming eligible for long-term care services under Medicaid. States have the option of raising that amount to $750,000. Under current law primary residence is exempted from assets when determining eligibility for these services if there is a reasonable chance that the senior may

eventually be able to return to their home. This proposed change would be indexed to the Consumer Price Index (CPI), but the median home price in San Francisco is already $750,000 and rising much faster than the CPI.

Finally, under current law Medicaid looks back three years to see if a beneficiary has transferred any assets to a family member or friend in order to qualify for nursing home coverage. The reconciliation bill extends that look back period to five years. Although there is no way to calculate how many people will be captured in the new five year window, and preventing more affluent individuals from sheltering assets that could be used to pay for their long-term care is a laudable goal, the way the language is written non-affluent individuals who make modest gifts to relatives (to help with things like college tuition or medical bills) or contributions to charities, and then several years later experience an unexpected decline in their health that necessitates long-term care, could be penalized.

Although the budget resolution included reconciliation protections for $70 billion in tax cuts, the House and Senate were not able to reach agreement on a tax cut package in 2005. Republican leaders have said that they will attempt to move a tax cut bill when Congress reconvenes in late January 2006.

C. APPROPRIATIONS

On December 22nd, Congress passed the Fiscal Year 2006 Labor-Health and Human Services-Education Appropriations bill. The bill includes $459.5 billion in mandatory spending for entitlement programs and $142.5 billion in discretionary spending, a slight 0.1 percent decrease below Fiscal Year 2005. Overall discretionary funding for the Department of Health and Human Services, however, was cut by nearly $1 billion. Congress passed an additional 1 percent across the board discretionary spending cut for all of the appropriations bills before adjourning, cutting funds in the Labor-HHS-Education bill by an additional $1.4 billion.

As in years past, the Department worked with San Francisco Representative Nancy Pelosi to secure set-asides or "earmark" funding for DPH priorities in the Fiscal Year 2006 federal appropriations bills.

In the Labor-HHS-Education bill, DPH submitted requests for earmarks related to HIV/AIDS services and supportive housing, but the House and Senate struck a deal to eliminate all earmarks from the final conference report, so neither of our requests were included. This was the first time in over a decade that no earmarks were included in this particular appropriations bill. Given this, it is now hard to determine whether or not there will be any earmarks in next year's Labor-HHS-Education Appropriations bill.

In the Commerce-Justice-Science Appropriations bill, however, which passed Congress and was signed into law on November 22nd, Representative Pelosi secured an $800,000 earmark for DPH to expand transitional services to inmates recently released from jail. These funds will be used to provide case management and supportive housing coupled with onsite behavioral health services for ex-offenders as they re-enter into the community.

This funding is the result of the hard work and continued support of House Democratic Leader Nancy Pelosi. The Department is grateful for her continued assistance, particularly during this time of fiscal uncertainty when the need is most critical.

D. RYAN WHITE CARE ACT REAUTHORIZATION

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act represents the largest source of federal funds specifically designated to provide services to people infected with HIV. San Francisco received over $28 million directly from the CARE Act this year for primary care and support services that help people living with HIV/AIDS learn about, access and adhere to medical care. Additional funds are awarded to the State and directly to community-based organizations. The federal legislation authorizing this important program expired on September 30th. Neither the House nor the Senate introduced legislation to reauthorize the program in 2005. However, it is not unusual for reauthorizations to be enacted after a program's authorization has expired, and operation of CARE Act funded programs will not be impacted. Negotiations are underway and legislation is expected to be introduced early in 2006.

In July, the Bush Administration released a set of principles for the reauthorization that severely threaten CARE Act funding in San Francisco and throughout the State. Specifically, the principles propose elimination of the "hold harmless" protection, a change that would cost San Francisco over $7 million each year, and propose excluding cases from cities when calculating the amount of funding that goes to states, which would cause California's award to drop from $31 million to $11 million. The Administration also proposes a shift from allocation of CARE Act funds based on AIDS reporting to allocation based on HIV reporting beginning in 2007, but refuses to accept HIV reporting data from California and twelve other states (including the District of Columbia) that use non-name based HIV reporting systems. Finally, the Administration proposes a severity of need for core services index that would be used to determine future allocations, and is suggesting criteria for the index that would allocate fewer resources to jurisdictions with strong commitments to HIV/AIDS treatment and care in their state and local budgets.

The extent to which the Bush Administration principles will be incorporated into reauthorization legislation that moves through the House and Senate is unclear at this point. The nine California cities that receive CARE Act funding are working together in opposition to elimination of the hold harmless and other proposals harmful to California.

E. IMPLEMENTATION OF THE MEDICARE PRESCRIPTION DRUG BENEFIT

Enrollment in the new Medicare prescription drug benefit, enacted by Congress in 2003, began in November 2005, with coverage starting on January 1, 2006. Enrollment is open until May 2006, after which beneficiaries will be charged a late enrollment penalty. The benefit, also referred to as "Part D", established a variety of private prescription drug plans (PDPs) approved by the federal Centers for Medicare and Medicaid Services (CMS) from which Medicare beneficiaries may select their coverage. Premiums, deductibles and prescription co-pays will depend on patient income and the plan selected.

The majority of Medicare patients in San Francisco's public health system (approximately 25,000) are "dual eligible" patients who qualify for both Medicare and Medicaid. Prior to

implementation of the new benefit, these individuals received prescription drugs through Medi-Cal. As of January 1st, however, dual eligibles must choose a PDP to continue receiving prescription drug coverage. This is a concern because while Medi-Cal had a comprehensive formulary, different PDPs cover different drugs and a beneficiary could end up in a plan that doesn't cover all the drugs prescribed by their doctor. Medi-Cal also had no cost sharing. Under Part D, the federal government designates specific plans in which dual eligibles will not be required to pay premiums, but they will have a small co-pay for the first time. This could be a significant hardship for this very low-income population, especially considering that many have multiple prescriptions to fill. Federal officials approved 58 plans in California, and 10 of these PDPs have been designated for dual eligibles. Dual eligible patients were auto-enrolled into a PDP by CMS if they did not self-select a plan by December 31, 2005.

A smaller group of patients in our public health system (approximately 2000) currently receive benefits from Medicare only. DPH will continue to allow these individuals to access prescription drugs through the Community Health Network's sliding scale program until the Part D enrollment period ends on May 15th. After that date, Medicare only beneficiaries must enroll in a PDP in order to continue receiving prescription drug coverage. The Department will notify this population of the required change prior to the May deadline.

Another concern that DPH is monitoring relates to HIV-positive individuals who receive prescription drug coverage through the AIDS Drug Assistance Program (ADAP). Many Californians living with HIV/AIDS who have incomes over the Medi-Cal limit, but do not have access to health insurance, are able to receive coverage through Medi-Cal by paying a "share of cost". Prior to the implementation of the new drug benefit ADAP covered the "share of cost", but can no longer do so under the new law.

F. LOOKING AHEAD

Looking ahead to the second session of the 109th Congress, which convenes in January 2006, additional spending cuts and unfinished business from 2005 loom large. Legislation to place limits on medical malpractice litigation as well as legislation to remove limits on embryonic stem cell research both passed the House during the first session, but stalled in the Senate. In his last budget, President Bush proposed tax credits of $1000 for low-income individuals and $3000 for low-income families to purchase health insurance in the non-group market, as well as tax deductions for those who purchase high deductible health plans linked to Health Savings Accounts. Democrats criticized these approaches saying they would do little to reduce the number of uninsured Americans and would largely benefit younger, healthier people. Instead, they proposed a package of bills to reduce the number of uninsured Americans, including legislation to expand Medicaid and the Children's Health Insurance Program to cover parents of children already covered under those programs, legislation to allow people ages 55 to 64 to buy into the Medicare program and legislation to give tax credits to small businesses providing health coverage to their employees. Both sides are expected to pursue similar approaches in 2006. In addition, the Ryan White CARE Act, which provides federal funding for HIV/AIDS care and treatment, expired in September 2005 and must be renewed by Congress in 2006.

In response to the record federal deficits of the past few years, President Bush has pledged to cut the annual deficit in half by 2009. Without significant tax increases, unlikely in the current political environment, it will be difficult to meet this goal without enacting additional cuts to

both entitlement and discretionary programs. The President's Fiscal Year 2007 budget request will be submitted to Congress in February. The House and Senate Budget Committees will then have until April 15 to hold budget hearings, mark up a Budget Resolution and resolve differences between the House and Senate Resolutions. It is not unusual, however, for Congress to miss the April 15th target.

Finally, depending on the response to the newly implemented Medicare prescription drug benefit program, efforts to change aspects of that law may become a priority for both parties heading into the 2006 Congressional elections.

III. STATE LEGISLATIVE SUMMARY

A. OVERVIEW OF THE LEGISLATIVE SESSION

The Legislature began the first year of its two year 2005-06 legislative session in January 2005. Relations between the State's Republican Governor and Democratic Legislature became increasingly strained as the year progressed, particularly in response to the $45 million special election called by the Governor Schwarzenegger to consider a series of ballot initiatives. The Democratic majority was particularly opposed to Proposition 76, which would have shifted budgetary power away from the Legislature and to the Governor, and Proposition 77, which would have taken Congressional redistricting power away from the Legislature. When the special election was held on November 8th, all of the Governor's initiatives were soundly defeated.

Shortfalls in the State budget continued, but were not as severe as the past few years. The final budget agreement passed easily as the looming special election shifted the focus of lawmakers from policy to politics.

The partisan nature of this year's legislative session is reflected in the small number of bills that became law. During the first year of the session, lawmakers introduced almost 2900 bills and sent 961 of those to the Governor's desk. After setting new records for a first-year Governor in 2004 for the fewest bills signed (75 percent) and the most bills vetoed (25 percent), only 729 bills (76 percent) were signed into law in 2005 and 232 bills (24 percent) were vetoed. Bills that were not acted upon in the first year of the session are carried over and may be considered in 2006.

B. STATE BUDGET

When Governor Schwarzenegger proposed his Fiscal Year 2005-06 budget in January the State was facing a deficit of $8.6 billion. The budget outlook, however, improved during the course of the year and the shortfall had decreased to $4.9 billion by the time the budget was signed into law on July 11, 2005. The final budget was balanced through a combination of spending cuts, higher than anticipated revenues and some previously agreed to borrowing.

The Governor's proposal to require, for the first time, that some Medi-Cal beneficiaries pay monthly premiums was dropped, but the budget does generate $23 million in savings by capping dental benefits for adults in Medi-Cal at $1800 per calendar year. The cap does not impact federally mandated dental services such as emergency dental care, dentures and complex oral

surgeries. Also dropped was a proposal to reduce State contributions to wages for In-Home Supportive Services workers, who serve seniors and people with disabilities, to the minimum wage.

The final budget did include $5.9 million in State funds to increase enrollment of children in the Healthy Families and Medi-Cal programs, and $10.6 million to expand nursing education programs at community colleges and within the CSU system.

The budget also includes some good news for Californians living with HIV/AIDS. Funding for the State's AIDS Drug Assistance Program (ADAP) was increased by $34.1 million to $268.3 million, and the budget restores $5.6 million for HIV/AIDS education and prevention programs that was cut in the Fiscal Year 2002-03 budget. Under the budget agreement, ADAP will also be able to cover the deductibles and co-payments that thousands of Californians with HIV and AIDS must pay in order to receive coverage through the new Medicare prescription drug benefit.

C. MEDI-CAL HOSPITAL FINANCING WAIVER

In January 2004, Governor Schwarzenegger announced his intention to pursue a Section 1115 Medicaid Demonstration Waiver to redesign the Medi-Cal program as part of his budget proposal for Fiscal Year 2004-05. The Administration began to provide details in the Fiscal Year 2005-06 budget proposal released in January 2005, and the State spent most of the year negotiating a waiver that significantly alters the way California's safety net hospitals will be reimbursed by Medi-Cal for the next five years. Governor Schwarzenegger signed legislation (SB 1100) implementing the Medi-Cal hospital financing waiver in October.

Although the first year of the waiver does include increased funds for safety net hospitals, the waiver freezes funding for public hospitals for the next four years and shifts the risk and responsibility for supporting them from the State to the counties. As a result, public hospitals will no longer be able to rely on the State General Fund for assistance, and San Francisco General Hospital will be entirely dependent on how much the County is willing and able to spend. Statewide, frozen funding amounts to a cut given rising health care costs and the increasing number of uninsured Californians. SB 1100 does include "hold harmless" language that ensures no public hospitals will receive less under the waiver than the amount they received in Fiscal Year 2004-05.

Prior to the waiver, counties with public hospitals used intergovernmental transfers (IGTs) to generate required matching funds. The State then forwarded those funds to the federal government to draw down Medicaid reimbursement. Due to the federal government's desire to decrease use of IGTs, the waiver requires public hospitals to instead rely entirely on certified public expenditures or "CPEs" to draw down federal funds. CPEs are based on the costs public hospitals actually incur in providing care to eligible populations. However, whether the costs that the federal Centers for Medicare and Medicaid Services (CMS) will reimburse are sufficient to provide the amount of funding hospitals need is questionable.

Throughout negotiations between the State and the federal government it was unclear how CMS officials would determine what counts as a "certified public expenditure". The information that the Schwarzenegger Administration has provided on the waiver deal still does not clarify this important aspect or the appeals process that public hospitals will have access to when disputes

arise. The list of expenditures that can be counted must reflect the true operating costs of public hospitals. The lack of a clear set of parameters for what will and will not count as a "certified public expenditure" puts public hospitals at great risk because federal officials have a significant incentive to ratchet these allowable costs down in order to reduce federal spending. The timeframe for a clear definition of allowable CPEs remains unclear.

Also unclear are the details of a new "coverage initiative" included in the waiver. The waiver designates $540 million in years three, four and five of the waiver to expand health coverage Statewide, but gives no details regarding how those funds will be used. The waiver requires the State to submit a proposal to the federal government by January 31, 2006.

The City and County of San Francisco is supporting an innovative proposal for the coverage initiative put forward by the California Association of Public Hospitals, the Urban Counties Caucus and the Local Health Plans of California. Their proposal is designed to reach uninsured adults between the ages of 18 and 64, including the parents of children covered by Medi-Cal and Healthy Families. Public hospitals, like San Francisco General Hospital, will be the source of certified public expenditures necessary to draw down federal funds and this proposal appropriately emphasizes the importance of structuring the initiative in a way that will benefit those hospitals.

Mayor Newson has written to the Governor to urge flexibility in the coverage initiative so that counties have the opportunity to tailor programs to address the specific needs of the uninsured in their communities, including the ability to target sub-populations. In San Francisco, for example, we currently fund coverage for young adults exclusively through the City General Fund because no State, federal or foundation funds exist to support coverage for individuals between the ages of 19 and 24. Our hope is that the coverage initiative will provide assistance for this successful expansion, which was implemented in January 2005 and has already enrolled over 1600 young people, while giving us the flexibility to create a new plan for uninsured San Franciscans over the age of 24.

Finally, $360 million of the federal funds provided under the waiver during the first two years are contingent on implementation of a new requirement that all aged, blind and disabled Medi-Cal beneficiaries join a managed care plan. A similar proposal from the Schwarzenegger Administration was rejected by the Legislature in May, and the need to pass SB 1100 before the Legislature adjourned in September did not leave enough time for a compromise to be negotiated. The failure to include this provision in the bill means the State will forfeit $90 million of the funds available during the first year of the waiver. Without these funds, the waiver does not provide sufficient resources to meet the needs of safety net hospitals, and Assembly Member Wilma Chan and Senator Denise Ducheny have submitted a letter to Governor Schwarzenegger requesting that the Administration work with federal officials to renegotiate the timeline for the managed care expansion.

Questions related to certified public expenditures, the proposed coverage initiative, expansion of managed care and other aspects of the negotiated waiver agreement ensure that this issue will be revisited in the 2006 legislative session. The Department has been and will continue to be actively engaged with its hospital partners and the San Francisco delegation in the Legislature on this critical issue.

D. PROPOSITION 63

In November 2004 voters approved Proposition 63, the Mental Health Services Act. State officials estimate that the new 1 percent tax created by this initiative, which will be levied on individual incomes exceeding $1 million per year, could generate up to $750 million annually.

Each county was given planning funds and directed to submit a proposal for the use of these new funds. During the first three years each county is supposed to spend 10 percent of funds on capital improvements and infrastructure, and 55 percent on direct services. After the first three years the proportion going to direct services will rise to 75 percent.

Mayor Newsom appointed a 42 member Behavioral Health Innovations Task Force to draft an expenditure plan. The Task Force met seven times from May to August 2005 at locations throughout San Francisco to gather input and identify priorities for use of these new funds. In addition to the tri-weekly Task Force meetings, eleven planning sub-committees also met six times to focus on planning for specific populations and services. Consumers of mental health services, family members of individuals with mental illness, providers and other County departments all participated in this process.

In June, the State Department of Mental Health (DMH) released allocations under the Act for the portion of funding that would support expansion of clinical services. San Francisco's award of $5,332,900 was far less than anticipated.

The existing State allocation formula partially bases awards on population rather than proportional need. Given the City's relatively small population and high mental health caseload, this hurts San Francisco. The formula also fails to adequately incorporate either San Francisco's high cost of living or the large number of people who come to San Francisco for services not provided in their original places of residence, and assumes that counties like San Francisco that have invested significant resources in mental health services have low unmet need.

The Department has made our delegation in the Legislature aware of these concerns and has met with both the DMH Director and members of the Mental Health Services Oversight and Accountability Commission, which was established by Proposition 63. The formula is unfortunately locked in for three years, but the Commission has encouraged DMH to instead review it after one year. In addition, DMH has discussed creating a $35 million set-aside fund that counties could compete for based on demonstrations of need. Although DMH has not provided any guidelines yet for distribution of the set-aside, DPH has drafted a proposal to treat an additional 2000 patients using supplemental funds.

E. STATE MEDICAL CANNABIS CARD PROGRAM

The State announced plans in February 2005 to begin issuing identification cards to individuals eligible to use medical cannabis under Proposition 215. This Statewide card replaces the local DPH card program which has been registering medical cannabis patients since 2000.

Beginning as a four county pilot, with Statewide expansion starting in August, State and local authorities are now prohibited from seizing cannabis from cardholders or prosecuting them. A 24 hour, toll-free number is available for officials to verify that identification cards are authentic. The program was originally authorized in late 2003 by a law sponsored by former State Senator John Vasconcellos, but money for implementation was not available until this year.

In July, the California Department of Health Services suspended implementation in response to the June 6th U.S. Supreme Court ruling that the federal government has jurisdiction to enforce the Controlled Substances Act against persons growing cannabis for personal medical use. The card program was quickly reinstated after the California Attorney General's office clarified that operators of the program will not be at risk for federal prosecution. However, the Attorney General's office did recommend that card recipients be notified that information collected for the card could be subpoenaed by federal prosecutors and used as evidence against patients.

On November 1, 2005, the San Francisco Board of Supervisors passed Resolution 051777 to delay implementation of the program until patients, advocates and City and State Legislators have sufficient time to petition the State Department of Health Services (DHS) to modify the program to better protect the anonymity of patients and caregivers, and to inform physicians of their new obligations under the program.

The Department delayed implementation of the State card program until January 2006 and wrote to DHS to convey these concerns, emphasizing that San Francisco had worked within the parameters of Proposition 215 to implement a medical cannabis identification card program that verifies the patient's identity and the recommendation of their physician that they qualify as medical cannabis users under Proposition 215 while keeping no information identifying patients or caregivers.

Applications for the new card program are now being accepted at San Francisco General Hospital, and DPH has worked out a process that complies with all State regulations while still protecting confidentiality by returning all identifying documents after a card is issued.

F. SUMMARY OF SELECTED HEALTH-RELATED BILLS ENACTED IN 2005

Following is the health-related legislation enacted in 2005, the first year of the two-year legislative session.

AB 228 (Koretz) Signed CCSF Support

Organ Transplants for Patients with HIV: Prohibits a health care service plan and a health insurer from denying coverage for the costs of organ or tissue transplantation services on the basis that the enrollee, subscriber, insured or policyholder is infected with HIV.

> ***Impact:*** *Some insurers refuse to cover the costs associated with transplants for patients with HIV infection due to a perceived short lifespan and concern about the effects of immunosuppressive medications used to prevent transplant rejection. However, there is a growing body of medical literature documenting positive outcomes for HIV-positive patients receiving transplants. Transplants can be crucial for the approximately one-third of people living with HIV who are co-infected with Hepatitis C, which can lead to fatal liver disease. Some HIV-positive individuals also experience liver or kidney failure*

as a result of medication toxicities. AB 228 clearly establishes that otherwise suitable transplant candidates can not be denied based on their HIV status.

AB 547 (Berg) Signed CCSF Support

Needle Exchange Programs: Authorizes cities, counties or cities and counties to have a clean needle and syringe exchange program without the need for bi-weekly declarations of a local emergency.

Impact: *San Francisco has an estimated 17,100 injection drug users (IDUs) and access to needle exchange is vital. It is estimated that nearly 20 percent of San Francisco's IDUs are infected with HIV and 90 percent are infected with Hepatitis C. Limited access to sterile syringes contributes to the transmission of these infections among IDUs, their sex partners and their children. Though obtaining bi-weekly Board of Supervisors approval has not been an issue in San Francisco, this is unfortunately not the case in other jurisdictions. The City of San Diego, for example, had their program shut down when a majority of the Board did not renew the emergency declaration. Requiring localities to renew public emergencies creates an unstable and unreliable system of services, which puts all communities – with and without established needle exchange programs – at increased risk for transmission of HIV and Hepatitis C.*

AB 1586 (Koretz) Signed CCSF Support

Insurance Non-Discrimination for Transgender People: Adds additional language to existing anti-discrimination provisions under the Health and Safety Code and the Insurance Code to clarify that State law prohibits insurance companies and health care service plans from discriminating on the basis of gender, including transgender status, in the creation or maintenance of service contracts or the provision of benefits or coverage.

Impact: *This legislation clarifies that transgender people also are protected under the existing prohibition on discrimination based on sex in the Insurance and Health & Safety Codes. AB 1586 uses clarifying language that has already been applied to discrimination in housing and employment to ensure that insurance companies and health care service plans understand their legal obligation to refrain from discriminating against transgender people.*

SB 536 (Bowen) Signed CCSF Watch

Clean Up of Illegal Methamphetamine Sites: Requires the Department of Toxic Substances Control to develop sampling and analytical methods for the collection of methamphetamine residue and to adopt health-based target remediation standards for methamphetamine. Requires development of investigation and clean-up procedures for remediation of illegal methamphetamine manufacturing sites.

Impact: *Many houses and apartment buildings are being contaminated by substances used for methamphetamine manufacturing or that are byproducts of methamphetamine lab production. Contamination from these substances poses a significant health risk to neighbors and future occupants of these contaminated homes. While State and local agencies were authorized to require a property owner to clean up this contamination prior to passage of this bill, there were no enforceable remediation standards that had to be met.*

SB 708 (Speier) Signed CCSF Watch

Participation of Private Non-Profit Hospitals in the 340B Program: Requires the Department of Health Services (DHS) to develop a standard contract for use in an agreement entered into by DHS and a private not-for-profit hospital that elects to participate in the federal

Section 340B drug discount program. The hospital entering the contract must agree to continue its historic commitment to the provision of charity care, as reported to the Office of Statewide Health Planning and Development.

> ***Impact:*** *Private hospitals must contract with a state or local government to provide health care services to low-income individuals who are not entitled to benefits under Medicare or Medicaid in order to qualify for discounts under the 340B program. This bill simplifies the contracting process for those hospitals while encouraging them to increase the amount of charity care they provide to indigent and uninsured patients.*

SB 941 (Alquist) Signed CHEAC Watch

Emergency Care for the Uninsured: Places limits on administrative costs, makes changes to certain aspects of reimbursement and establishes new reporting requirements for two sources of funds targeted to emergency care for the uninsured.

> ***Impact:*** *Provides clarity and adds consistency to the health code sections that govern funds used to reimburse emergency and on-call physicians for treating uninsured patients.*

G. SUMMARY OF SELECTED HEALTH-RELATED BILLS THAT FAILED IN 2005

AB 417 (Aghazarian) Vetoed CADPAAC Oppose

Flavored Malt Beverages: Would have modified the definition of beer under the Alcoholic Beverage Control Act to include any alcoholic beverage that qualifies as a malt beverage under the Federal Alcohol Administration Act. Would have classified flavored malt beverages, which may consist of up to 49 percent distilled alcohol rather than fermented alcohol, as beer. Beer is taxed at a much lower rate than distilled spirits.

> ***Veto Message:*** *This bill would codify current law and practice to treat flavored malt beverages as a malt beverage product consistent with federal standards of identity, which 49 of the 50 states follow.*
>
> *I am taking this action to allow a full discussion of the issues surrounding flavored malt beverages, not to suggest that the State's regulatory administration of flavored malt beverages is flawed. It was amended late in the session and only had one full hearing with short notice. I encourage all interested parties, particularly health professionals, law enforcement and the producers of flavored malt beverages, to use this opportunity for public debate and serious consideration of the policy issues surrounding this beverage.*

AB 624 (Montanez) Vetoed CCSF Watch

Simultaneous Enrollment in Child Health Programs: Would have required the State to deem any child who meets the income eligibility requirements for the Child Health and Disability Prevention Program to have met the income documentation requirements, and to give the option of simultaneous enrollment, for the Healthy Families and Medi-Cal programs. Currently, there are approximately 429,000 uninsured children in California who are eligible for either Medi-Cal or Healthy Families, and studies show that complexities in the application process for public programs are a factor in preventing children from enrolling.

> ***Veto Message:*** *I am returning Assembly Bill 624 without my signature.*

I believe that children should be insured but this bill fails to address a critical question: How to pay for it? At a time when California has a $7.5 billion structural deficit, this bill would cost the state almost 200 million dollars once implemented without providing a funding source or offering comprehensive children's health reform.

As written, AB 624 grants a child presumptive Medi-Cal eligibility until county eligibility workers and HFP make a final determination of the child's eligibility for the programs.

This could effectively result in extending indefinitely the current two-month presumptive eligibility period for the Children's Health Disability and Prevention (CHDP) Gateway program. Not only would this generate an undetermined increase in CHDP Gateway costs due to an anticipated increase in enrollment in temporary Medi-Cal, it would discourage a final eligibility determination for and enrollment in comprehensive health coverage programs. In addition, the bill would place a greater responsibility on the counties to follow up on Medi-Cal eligibility and would result in a substantial increase in workload.

Finally, this bill does not allow enough time for the Department of Health Services, the Managed Risk Medical Insurance Board and the counties to plan and implement all the aspects of the CHDP Gateway application modification.

I have continually stated my interest in providing health coverage to low-income uninsured California children. Consistent with that interest, I have made expanding children's health coverage a top priority in a challenging fiscal time by protecting eligibility for Medi-Cal and the Healthy Families Program (HFP), funding an additional 126,000 children in HFP, and reinstituting community-based certified application assistance to help reach the estimated 428,000 children who are eligible for public programs but not yet enrolled. More broadly, my budget included a $1 billion increase in funding for health care services for over 7 million low-income Californians already eligible for public programs.

Providing access to affordable health coverage for California children has been and will continue to be an important priority for me and my Administration. While progress has been made over the past year in expanding coverage, more needs to be done. My Administration is committed to working with the Legislature and stakeholders to find a comprehensive solution to this critical priority for California, but we must do so in a manner that the State of California can afford, is funded, and that effectively targets new investments in proven strategies to provide coverage to California children.

AB 772 (Chan) Vetoed CCSF Watch

Healthy Kids Insurance Program: Would have created the Healthy Kids Insurance Program, which would have consisted of the portion of the Medi-Cal program that covers children and the Healthy Families Program. AB 772 also would have accelerated the process for determining eligibility for the program by authorizing administering agencies to rely on eligibility determinations made by other public assistance programs, including reduced price school lunch programs, WIC and the Food Stamps Program.

Veto Message: *I am returning Assembly Bill 772 without my signature. I believe that children should be insured but this bill fails to address a critical question: How to pay for it? This bill would cost the state almost a half billion dollars a year without providing a funding source at a time when California has a $7.5 billion structural deficit. I have continually stated my interest in providing health coverage to low-income uninsured California children. Consistent with that interest, I have made expanding children's health coverage a top priority in a challenging fiscal*

time by protecting eligibility for Medi-Cal and the Healthy Families Program (HFP), funding an additional 126,000 children in HFP, and reinstituting community-based certified application assistance to help reach the estimated 428,000 children who are eligible for public programs but not yet enrolled. More broadly, my budget included a $1 billion increase in funding for health care services for over 7 million low-income Californians already eligible for public programs. While I share the goal of insuring children in California, I have concerns with certain aspects of the roadmap provided in this legislation and for that reason I am unable to sign AB 772. The measure relies solely on the expansion of state programs as the means to increase health coverage for uninsured children. The measure includes strategies that need to be further analyzed for their relative effect on enrollment, cost effectiveness, and program integrity, and evaluated to ensure that they won't divert resources to administrative processes and investments for already enrolled children. As an example, AB 772 would eliminate documentation and verification requirements for purposes of determining eligibility, despite evidence in other states regarding error rates associated with this approach, the potential for federal disallowances and susceptibility to fraud. Additionally, AB 772 fails to include a funding source for a program that once fully implemented is expected to cost in excess of $820 million dollars ($444 million General Fund) annually. Providing access to affordable health coverage for California children has been and will continue to be an important priority for me and my Administration. While progress has been made over the past year in expanding coverage, more needs to be done. My Administration is committed to working with the Legislature and stakeholders to find a solution to this critical priority for California that can be enacted next year, but we must do so in a manner that the State of California can afford, is funded, and that effectively targets new investments in proven strategies to provide coverage to California children.

AB 1736 (Levine) Vetoed CCSF Support

Chronic Care Model: Would have required the Department of Health Services to conduct a demonstration project to study the Chronic Care Model, a method of care delivery designed to improve disease management. Under the Chronic Care Model, caregivers work collaboratively to treat patients on a proactive basis, rather than simply focusing on acute illness. The model also encourages patients to become active participants in their treatment, thereby reducing acute episodes and fostering productive interactions with caregivers. Research shows that providers using the Chronic Care Model improve clinical outcomes and save money.

Health care providers using these innovative and effective approaches for treating patients with diabetes and asthma would have been reimbursed as part of the pilot project established by AB 1736. The bill also included an evaluation of the pilot to study health outcome improvements and savings from the Chronic Care Model. San Francisco General Hospital's Family Health Center is among a group of public hospital clinics that have implemented this innovative approach to care delivery.

Veto Message: *I share the author and sponsor's interest in testing the efficacy of different treatment models for Medi-Cal beneficiaries. However, this bill is duplicative of current Department of Health Services (DHS) efforts and would impose significant costs on the program. DHS is currently developing a disease management program utilizing a Primary Care Case Manager (PCCM) model, which will be implemented in a select number of fee-for-service counties (both urban and rural) and will test the efficacy of a disease management benefit to eligible Medi-Cal beneficiaries with several specific targeted diseases. The chronic care model proposed in AB 1736 is a different model for chronic disease management and would significantly increase costs because the Department would have to expand the scope of service for federally qualified health centers and rural health centers. In addition to increasing costs in the clinic model, it would be difficult to obtain necessary data for the needed evaluation because*

the bundled rate used for reimbursement of clinics does not show the individual services provided.

AB 1768 (Leno) Vetoed CCSF Support

Trauma Recovery Center: Would have provided continued, short-term funding for the San Francisco Trauma Recovery Center (TRC). This $1.3 Million allocation would not have come from the General Fund, but rather from surplus monies in the State of California Victim Compensation Program.

In four years of existence, the TRC has proven itself to be a highly accountable and cost-effective program. The TRC has helped victims deal with the devastating aftermath of interpersonal violence and return to economic and social productivity by providing a range of mental health services. In addition, the TRC has increased victims' cooperation with law enforcement so that perpetrators of crime can be brought to justice.

Veto Message: *The Victims Restitution Fund was established to assist all victims of crime by providing reimbursement for out of pocket expenses for costs related to the crime. I support protecting this fund so government can ensure victims do not face economic hardship after suffering at the hands of a criminal. Making a special appropriation out of this fund for a service provider, even for a program as successful as the Trauma Recovery Center at San Francisco, would endanger our ability to ensure these funds will be available to all victims throughout the State.*

In addition, using funds in the manner contemplated by this bill will compromise federal reimbursement funds to California because they are not being spent on direct victim reimbursement.

H. LOOKING AHEAD

The second year of the Legislature's two-year session began on January 1, 2006. The State's non-partisan Legislative Analyst, Elizabeth Hill, is forecasting a better budget outlook than in recent years. Although a $4 billion deficit is projected for the 2006-07 budget year, extra revenue and savings from spending cuts included in the current budget will generate $5.2 billion to offset the shortfall. Despite this good news, multi-billion dollar deficits continue to be projected for many years.

Senate President pro tem Don Perata has indicated that health will be among the top priorities for Democrats in the Legislature in 2006, and emphasized the need for a general obligation bond to help hospitals meet the State's seismic safety standards. San Francisco General Hospital must be rebuilt to meet these standards and resources to comply with this unfunded mandate, as well as an extension of the current 2013 deadline for the rebuild, are vital priorities for the Department. Governor Schwarzenegger has also spoken recently about making a "huge" investment in infrastructure, but has not provided details. He has said that he will not support tax increases to cover the costs, but is looking at options such as user fees or assessments that do not involve borrowing money.

Mayor Newsom has identified development of legislation that requires the State Department of Health Services to request a Medi-Cal waiver to allow reimbursement for assisted living services, including supportive housing, as another priority. Reimbursement for these services

would create less costly community-based options for individuals currently being served at Laguna Honda Hospital and those at-risk for entering Laguna Honda. Such a waiver would also increase reimbursement options for the Direct Access to Housing Program.

The Department will also continue to pursue a bill (AB 631) sponsored by the City that would create a program for the operation and regulation, including licensure, of mobile narcotic treatment programs. The Department currently utilizes specially equipped vans to provide mobile methadone maintenance treatment for approximately 150 persons in treatment for heroin addiction. However, while methadone treatment provided to Medi-Cal beneficiaries in a clinic setting is reimbursable under Medi-Cal, the same services provided to beneficiaries in the van are not. Approximately 21 percent of our mobile clients are Medi-Cal beneficiaries, but DPH assumes the full cost of their treatment. Medi-Cal denies these claims because the methadone van is operating as a temporary pilot project without formal State licensure. AB 631 will not only remedy this issue in San Francisco, but also expand access to methadone maintenance treatment Statewide. This bill has passed the Assembly and the Senate Health Committee, but is awaiting consideration in the Senate Appropriations Committee.

As mentioned above, the Department will also closely monitor development of the new "coverage initiative" included in the recently implemented Medi-Cal hospital financing waiver to ensure that it helps the City offset costs associated with indigent care, and will continue to push for a fairer distribution of Proposition 63 resources.

IV. STATE LEGISLATIVE PLAN FOR 2006

As discussed above, the Department relies heavily on its State Legislative Plan to guide the City's positions on health-related legislation at the State level. The State Legislative Plan was approved by the Health Commission and submitted to the Mayor's Office for approval at the beginning of the two-year Legislative Session in January 2005. Appendix A, attached, is a copy of the State Legislative Plan for the Department for 2005-06.