CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
1115 WAIVER RENEWAL
SAFETY NET FINANCING EXPERT STAKEHOLDER WORKGROUP
Meeting Summary
Tuesday, December 9, 2014
Sacramento Convention Center, 1400 J Street, Sacramento, Room 203
10:00am – 2:00pm

Members Attending:
Matt Absher, Private Essential Access Community Hospitals; Kelly Brooks Lindsey, California State Association of Counties; Bruce Butler, University of California Office of the President; Michelle Cabrera, SEIU; Sherreta Lane, District Hospital Leadership Forum; Rich Rubenstein, California Association of Public Hospitals and Health Systems; Diane Ung, Foley Lardner; Allan Wecker, Los Angeles County Department of Health Services; Anthony Wright, Health Access;

Members Attending by Phone: Elizabeth Landsberg, Western Center on Law and Poverty; Efrat Eilat, DHCS

Members Not Attending: Molly Brassil, County Behavioral Health Directors Association of California; Sandra Naylor Goodwin, California Institute for Behavioral Health Solutions

Others Attending: Mari Cantwell, DHCS; Wendy Soe, DHCS; John Mendoza, DHCS; Pilar Williams, DHCS; Bobbie Wunsch, Pacific Health Consulting Group; Rafael Gomez, Pacific Health Consulting Group

12 Members of the public attended the meeting.

Overview of 1115 Waivers, DHCS Goals for Workgroup
Wendy Soe, Department of Health Care Services

Presentation Slides are available at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Safety-Net-Financing.aspx

Following introductions of workgroup members, DHCS staff Wendy Soe provided an overview of 1115 Medicaid Waivers and reviewed the 2015 1115 Waiver Renewal goals and objectives, timeline and the eight renewal concepts. The current waiver expires October 2015. She also noted that a one-page description of waiver renewal authority will be posted on the waiver renewal web site today.

Questions/Comments from Members:
Matt Absher, PEACH: What is the timeline for a baseline for the budget neutrality calculation?
Wendy Soe and Mari Cantwell, DHCS: We will be submitting the waiver renewal application in March 2015 with the budget neutrality calculation. DHCS will share an initial calculation of budget neutrality number at a one day shared savings meeting on January 30th at the DHCS Auditorium.

DSH AND SNCP: Today and Future Perspectives
Mari Cantwell, Department of Health Care Services
Presentation Slides are available at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Safety-Net-Financing.aspx

Mari Cantwell, DHCS, provided background on the definition of Disproportionate Share Hospital (DSH), eligibility criteria and prior calculations. Every state receives a DSH allotment, calculated by the federal government. Hospitals are determined to be DSH eligible based on the level of care they provide to Medicaid and the uninsured. She described the history of DSH payment methodologies and inter-governmental transfers (IGTs) and the history of the Safety Net Care Pool first established in the 2005 1115 waiver. She clarified that the SNCP is eligible for hospital and non-hospital costs, whereas DSH is just for hospital services. There is a reduction of funding in the SNCP based on a formula for undocumented as these costs are not allowed. She discussed future considerations for DSH/SNCP, including the impact of ACA and Medicaid expansion on funding amounts and methodology. She also discussed CMS parameters for the formulas. CMS may be looking to move away from uncompensated care pools in future waivers.

Questions/Comments from Members:
Diane Ung, Foley Lardner: These [per presentation slide deck as DSH eligibility criteria] are the minimum requirements for DSH eligibility under federal law. The state requirements could be more expansive.

Diane Ung, Foley Lardner: The designated public hospitals continue to put up the non-public share of DSH payments.

Anthony Wright, Health Access: How does this compare to what other states do?
Cantwell, DHCS: The idea of the "DSH swap" for private hospitals is California specific. Other states have different ways of allocating their DSH funding.
Diane Ung, Foley Lardner: There is wide variation in terms of funding and allocations because of different needs in other states.

Anthony Wright, Health Access: Is this [the SNCP] where the Coverage Initiative funding in the 2005-10 comes from? What are the current amount? What is the definition of non-hospital costs?
Cantwell, DHCS: Yes, the SNCP was the federal funding source for the Coverage Initiative in the 2005-2010 waiver. In Bridge to Reform Waiver (2010-2015) $400 million goes to the state and $236 million goes to the public hospitals from the Safety Net Care Pool. Hospital costs are any costs incurred on the hospital license, including clinics. Physician costs, even in the hospital, are not considered hospital costs. Ancillary services provided in the hospital setting are hospital costs. Any services provided in settings not licensed under the hospital are non-hospital costs (such as a freestanding clinic separately licensed from the hospital).

Diane Ung, Foley Lardner: Certified Public Expenditures are identified through the complex claiming protocol.

Anthony Wright, Health Access: Can counties without public hospital systems participate in the SNCP? He How is the undocumented reduction factor is calculated and whether it will go up or down post-ACA?
Cantwell, DHCS: Counties without public hospitals do not receive SNCP. In terms of the undocumented rate, the reduction factor was originally negotiated for Family PACT and later re-negotiated.

Anthony Wright, Health Access: Do the changes in the demographic of the uninsured post-ACA mean the federal government would want to renegotiate in the future? Is there an audit or other mechanism for verifying the costs due to undocumented?
Cantwell, DHCS: It is possible the federal government would want to re-negotiate the reduction factor post-ACA, but at this time that is an unknown. We do not specifically track the costs of the uninsured who are undocumented, the costs of all uninsured are collected and are audited.
Diane Ung, Foley Lardner: It is the expenditures for providing the care that are being recognized and reimbursed.

Rich Rubenstein, CA Association of Public Hospitals: Another future consideration is that DSH funding is limited to hospital expenditures which is an inhibiting factor to public hospitals as they look to strengthen their health systems.

Elizabeth Landsberg, Western Center on Law and Poverty: Can you talk more about the consequences of growth in Medi-Cal Managed Care on funding?

Cantwell, DHCS: Yes, public hospitals utilize IGTs to fund some components managed care capitation rates. Rates to managed care plans are set through actuarial rates in a range. CA currently pays closer to the lower bound of the range. Public entities can fund increases to the upper bound if they were willing to put up the matching funding. The other major way that hospitals participate in funding managed care is the Seniors and Persons with Disabilities (SPDs) expansion. SB 208 gave public hospitals the option to fund the base part of the capitation tied to inpatient hospitalization, then the State would include in the capitation rate development payment to those hospitals at. From a federal point of view, it appears that there is a "long fall" being made by public hospitals because they count both the federal and non-federal share financed by the public hospitals. What CMS requires today in public hospital claiming is that the "long fall" counts against hospital claiming limits in DSH. If a public hospital had $500 uncompensated costs and then on the Medicaid side, when you count both the federal and nonfederal share, they had a $100 long fall, they only can claim $400 and have a loss of $100. Overall, it is a loss of $1.75 for every $1 excluded from claimed funding due to the OBRA limits and the CA provision that OBRA for public hospitals is set at 175% of uncompensated costs. That is the impact of the move to Medi-Cal Managed Care. It makes it complicated when we claim for DSH. We want to have SNCP and DHS for uncompensated care and managed care considered separately.

Rich Rubenstein, CA Association of Public Hospitals: For the expansion population, when there is a non-federal share due, the public hospitals will be self-funding that.

Sherreta Lane, District Hospital Leadership Forum: For SPDs in managed care, the designated public hospitals provide the non-federal share and get a federal match to costs?
Cantwell, DHCS: Essentially, yes. The goal is to try to mimic what happens in fee for service when claiming was under a CPE methodology in managed care, so there is no general fund cost to the state, which is not easy.

Diane Ung, Foley Lardner: Prior to these rate range payments, there was at least one county funding the non-federal share. For the rate range payments other than the SPDs, there is an additional IGT made by the participating public hospitals to help with the administration of that. It is not really a 50% match.
Cantwell, DHCS: In 2011, the state instituted a 20% administrative fee on rate range IGTs due to the degree they were supplemental.

Matt Absher, Private Essential Access Community Hospitals: The funding for PEACH is different than those for Designated Public Hospitals, but we do use the DSH funding to cover the uncompensated care costs for the uninsured and the Medicaid population. It sounds like the direction we are moving is using the DSH allotment and the SNCP in a different way. Will California still try to claim the full DSH allotment and just spend it a different way?
Cantwell, DHCS: Yes this is the case.

Michelle Cabrera, SEIU: Other recent state waivers have included Designated State Health Plan (DSHPs) and wondered what the relationship between CMS is and DSHPs in these post ACA waivers (e.g. Massachusetts)?
C*antwell, DHCS:* DSHP allows specific state programs, mostly those funding services for uninsured, but also programs such as work force, to allow state expenditures to be claimable under the SNCP. CMS is not focused on uncompensated care pools but in other states they have allowed other types of DSHPs, such as workforce, that are more time-limited and not for the life of the waivers.

DHCS Proposal for Safety Net Financing: DSH/SNCP in the 1115 Waiver Renewal
M*ari Cantwell, Department of Health Care Services*
Presentation Slides are available at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Safety-Net-Financing.aspx

Mari Cantwell, DHCS discussed the key drivers of DSH/SNCP reform, goals, desired outcomes and draft concepts for the DSH/SNCP. She provided an overview of the draft concept for the future DSH/SNCP funding. This included establishing a statewide pool of funding for the remaining uninsured that combined federal DSH funding for DPHs and some level of federal SNCP funding based on final years of the current waiver. It also proposes establishing individual pools of funding for remaining uninsured for each DPH from the overall pool. Additional

components included quarterly county payments and use of IGTs as source of non-federal share, requirements to provide services to uninsured at specified levels with documentation and establishing a required amount and types of services that take into account the make-up of remaining uninsured. The new arrangement could incentivize care coordination, reduced inpatient utilization and increased primary care. We want to include quality and outcome metrics to incentivize primary care. There would be some risk to funding for DPHs that did not meet service requirements.

Questions/Comments from Members:
Allan Wecker, Los Angeles County Department of Health Services: Two issues affecting triple aim goals. The first is a tremendous unfunded liabilities that will result in significant increased costs to fund the pensions. The way the counties do it is to ask each department to make up their share. Over the next few years, county health systems will see a tremendous increase in costs to fund pensions. Secondly, the biggest cost for counties is labor and there is a competitive market that will lead to increased compensation. These create big concerns because they expect to see increased costs. We are concerned about the reductions.
Cantwell, DHCS: Fair enough. The goal is to drive down unnecessary emergency room or the costly care.
Allan Wecker, Los Angeles County Department of Health Services: Could we also look at productivity and shifts from ER to urgent care, things we have control over?

Matt Absher, Private Essential Access Community Hospitals: PEACH hospitals do provide a lot of services to limited-scope Medi-Cal patients. As much as we try to connect them to primary care, and not use the emergency room, it does not always happen. It is important to retain that Medi-Cal payment.
Cantwell, DHCS: Yes, there are no plans to change that.

Michelle Cabrera, SEIU: How is DHCS thinking about calculating the number of uninsured?
Cantwell, DHCS: That is a challenge we will need to figure out. It is complicated by the number of individuals on partial coverage.

Anthony Wright, Health Access: Given the CMS aversion to safety net care pools, why do we think this approach is a more viable approach – why would one pool be more viable than two pools? You are signaling that the status quo won't fly in the future.
Cantwell, DHCS: We don't not know how CMS will see the SNCP component. This concept isn't really about making it more likely CMS will approve this. DHCS does not believe it is appropriate that Designated Public Hospitals are penalized on the managed care side even though they are providing a lot of uncompensated care. That is one of the issues here, as well as DSH funding is limited to hospital services. There are not necessarily the right incentives to provide the right types of services. A part of the overall construct, that CMS shares, is that we want to talk about the financing of health care as a system and not cost-based and volume-based. There are structural reasons and delivery system transformation reasons to try to combine them.

Michelle Cabrera, SEIU: What are the lessons learned from the LIHP experience to help design this?
Cantwell, DHCS: We saw in the LIHP program what we are talking about here - a reduction in ER utilization over time (after accounting for pent up demand). This is the kind of thing that we are trying to drive here; to incentivize care that treats the whole person and coordinates care.

Sherreta Lane, District Hospitals: Can we assume that the proposal ensures that amounts of funding would be consistent over the life of the waiver, given the Medi-Cal DSH cuts?
Cantwell, DHCS: We would not be saved from DSH cuts. Funding will decrease. DHCS would hope that the components that are not DSH would stay the same.

Rich Rubenstein, California Association of Public Hospitals and Health Systems: We should also think about what other types of costs that could be claimable, such as telephone calls. By putting these in the waiver, this would allow those flexible services that improve care efficiency to be included.
Cantwell, DHCS: Yes, we are seeking that kind of flexibility – telephone calls, non-claimable providers, e-consults. There are essentially two payment buckets that are both volume and cost based, as well as various limitations on what can be claimed in each bucket that don't promote integration of care. It is really about trying to better rationalize the funding of care to the remaining uninsured and improve care.

Anthony Wright, Health Access: Is DHCS seeking that counties can choose to participate or that all public hospitals would have to move together – or could counties have some variation in what they do. What's the variability between the public hospitals in different counties?
Cantwell, DHCS: My perspective right now is that this would be an all-in approach because otherwise it would be too complicated. But there could be flexibility in how a county chooses to provide care to the uninsured, whether through a coverage-like program or other ways.

Diane Ung, Foley Lardner: The DSH rules and formulas for cuts that are published do appear to penalize those states that have narrowly focused DSH payments to hospitals with highest rates of Medi-Cal beneficiaries – not sure if these rules will hold. We think one of the benefits of restructuring the program this way is that it is more apparent we are targeted the remaining uninsured and that may help as CMS is rethinking the DSH funding reductions.
Cantwell, DHCS: Yes, one of the elements that has to be considered by CMS is how targeted the funding is to the uninsured.

Anthony Wright, Health Access: Are the DSH funding reductions a zero sum reduction across states?
Cantwell, DHCS: Yes, this one of the big challenges, particularly since California has the second largest DSH allocation in the country. It is hard to see how California would not end up taking a large cut.

Bobbie Wunsch facilitated solicited participant feedback and comment on key questions.

Question 1: What are your thoughts about the county allocations?

Allan Wecker, Los Angeles County Department of Health Services: We need to look at ALL the funding, not just SNCP/DSH but also DSRIP, then look at all the funding and then look at the needs of the different counties. Through CAPH, you need the counties to get together, have a discussion that looks at current needs and financing - everything we have and what the needs are. I don't think there can be a formula, but more of a discussion and negotiation.
Wendy Soe, DHCS: CMS let us know that they want to see the state and local needs assessed.
Cantwell, DHCS: I agree to a degree. In looking at the 2005 waiver from the outside it did not make sense to those outside the process. It was done for some good reasons but it was not very understandable or particularly rationale. In 2010, we did look at the whole picture and local situation and we did move somewhat toward a more rational and clearer approach. While I agree that at the end of the day we as a whole picture have a stable safety net and understand the impacts, it is also important to look at each components separately and think about what we are trying to accomplish with each piece first before we look at them together. What are the goals we are trying to accomplish and how do the pieces fit together.

Allan Wecker, Los Angeles County Department of Health Services, In LA one of the things we liked in the last waiver was having a good idea of what the amounts are. It is very difficult to go to our governing body and have a huge range in funding. We like the idea of knowing what the amounts are over the five years. What we would like to see is more of an amount certain so each public hospital can know what they need to do to bring in the funding.
Cantwell, DHCS: That is what we are thinking about – trying to establish a general idea

Rich Rubenstein, California Association of Public Hospitals and Health Systems: We are about 11 months post-ACA and can look at the data to get a better idea of the allocation. But it is just 11 months and there will be variation and change over time so there should be some flexibility layered in to allow different systems to take advantage of funding.

Diane Ung, Foley Lardner: Potentially, there could be a layering approach as we progress into the waiver. We should leave that open to development of different factors at the federal level that we will need to take into account.

Kelly Brooks Lindsey, CA State Association of Counties: I like the concept that there would be certain knowns and that if you did certain activities you would be able to claim that match. That is easier to explain to boards and get support. On a pragmatic level you do want some flexibility and the devil is in the details at that point.

Allan Wecker, Los Angeles County Department of Health Services: One of the key things in selling this to CMS is that it's not just payment reform but it's also simplification. It has gotten to the point where it has gotten too complicated. We have to simplify the rules in terms of how we get paid.

Anthony Wright, Health Access: We are very supportive of the goals but it's a little like shadow-boxing. We are trying to anticipate what CMS wants to see. One of my questions is that different counties have different standards in terms of who they serve on income and documentation status, so how would this be different in LA vs. Riverside, etc. I do see some importance in allowing some flexibility but having some standards in how we get there. What would we do outside of the 12 counties we are discussing here? What is the likelihood CMS will go for this?
Cantwell, DHCS: Overall CMS shares our goals. We haven't spoken in detail with them about this concept but of the many concepts we have, I think this is one that would be somewhat easier to get through.

Question 2: What are your initial thoughts on the appropriate metrics?

Rich Rubenstein, California Association of Public Hospitals and Health Systems: We have talked about the importance of it being complementary with DSRIP. The metrics could include unnecessary ER usage given we have experience with LIHP.

Michele Cabrera, SEIU: In those counties that do not provide coverage-like programs (like LA), how will people will be informed that there is a program for them and that they can access primary/preventive services? And doing that in a way that is not as expensive and can be counted in the overall metrics.
Cantwell, DHCS: One thing that we need to walk a line on is that this is not coverage – and that is for some specific reasons. But, it is important to communicate that individuals can access services available to them so we can redirect care from the ER. I think it is important that we demonstrate that services are being provided. What is the population and can you really define it? People who are uninsured or partially uninsured. What is the baseline data and how do you use it to set metrics for the level of services that should be provided to claim full funding?

Michele Cabrera, SEIU: Since there are so many people are in Medi-Cal managed care, can you look at those individuals that are NOT enrolled as the target population?
Cantwell, DHCS: Another thing to keep in mind is that this won't always be the same people.

Allan Wecker, Los Angeles County Department of Health Services: This could be viewed as an extension of My Health LA. It is essentially primary care at the clinics and when patients move into the hospital system, it's DSH. What this is moving towards is folding in the primary care access points into the funding.

Cantwell, DHCS: Counties already provide services differently to different populations. Is there a way to think about this so that it could incentivize more services? What we don't want to see is that those counties that only provide emergency services are incentivized to not provide more services. We don't have to standardize what is provided but we need to be sure we have the right metrics and understand what utilization we are incentivizing and how it could affect the allocation. What is the data that we have, what is the data that we need? How do you start

thinking about where the uninsured are, who the uninsured are, what services are provided today and how we want to change that service?

Rich Rubenstein, California Association of Public Hospitals and Health Systems: We agree and we are starting to look at our data. The problem is that given that the ACA is 11 months old, there is a lag and old data may not be that useful. It's important to look at the data trends but there are some limitations. Some of the challenges are that we do have a changing group of people to serve so even if you do a good job in moving them from the ER to primary care, the people you serve are always changing. Another challenge is that some of the counties are so big geographically that it's difficult to reach people - there has to be this county by county approach in terms of the expectations while trying to standardize how funds are allocated.

Cantwell, DHCS: I agree we have to acknowledge how big some of the counties are. In terms of the data, we did have the LIHP in the counties. In a sense we had Medi-Cal expansion population enrolled in LIHP before the true expansion in ACA. We didn't have the hospital presumptive eligibility and not as many people enrolled but the data would be informative.

Rich Rubenstein, California Association of Public Hospitals and Health Systems: Yes, it could be informative but there is limited value.

Cantwell, DHCS: I was speaking about looking at the data of those not enrolled at all. If they were eligible for LIHP, I think that the counties made every effort to get them enrolled. Looking at the completely un-enrolled population during the LIHP period of time may be helpful.

Michelle Cabrera, SEIU: If we don't have anything to compare this to, it does become managing re-admissions for people who don't have coverage. How do we link people to coverage and keep them from going to the ER at all.
Cantwell, DHCS: Some people get into the system through the ER and then get into primary care so it prevents future visits to the hospital. The turn over makes it hard to think about continuity and you are always taking care of different people.

Rich Rubenstein, California Association of Public Hospitals and Health Systems: Part of this will depend on what ability we have to design the program to include efficient services like e-consult.

Matt Absher, Private Essential Access Community Hospitals: Some of these counties are huge geographically. One of the good results from the LIHP is that there were some protocols of what to do if these patients showed up at our hospitals and how to connect them with the county to get enrolled. I think that could be important with this remaining population.

Anthony Wright, Health Access: I appreciate the need for flexibility but in that balance I would put a weight toward some standardization. We want to be very supportive to encourage counties to do preventive programs and if there is a way that this program can incentivize those counties that don't to do it and to widening eligibility criteria, then that would be a benefit. I do

wonder if there is some part of the metric that is not just an enrollment based program because of the opportunity to cover the under-insured (e.g. pregnancy only) with some services that they don't have access to. We want to structure a way so that all counties are included and some standards across the counties.

Cantwell, DHCS: Connecting to the AB85 piece, the calculation of this is all uninsured. It supports the idea that a county could shift the population it serves that is not true in "article 13 counties".
Anthony Wright, Health Access: I was under the impression they can't shift eligibility to new populations previously uninsured.
Cantwell, DHCS: There is a cost cap but it is an aggregate cost, not a per person calculation.
Rich Rubenstein, California Association of Public Hospitals and Health Systems: In the aggregate, if you put in lots of measures to transform, that increase your costs in a given year and do not flow through the formula, that needs to be looked at.

Bobbie Wunsch, Pacific Health Consulting Group: How do you think CMS will characterize the remaining uninsured?
Cantwell, DHCS: I am not sure. They share our goals. DSH funding is something that is available and claimable; it is not a new or different cost. There are some issues of precedent, but we've done that many times. I think it's a good direction to go in and consistent with health reform.

Michele Cabrera, SEIU: Rich has mentioned mechanisms to improve efficiency like phone and e-consults. How is that similar and/or folded into the PPS reform pilot?
Rich Rubenstein, California Association of Public Hospitals and Health Systems: This is very similar and there should be some synergies. The clinics participating in the PPS pilot serve the same people who will served in this program.

Question 3: How might the DSH/SNCP concept integrate behavioral health to a greater degree?

Cantwell, DHCS: We know that counties provide behavioral health services to the uninsured today from the cost data. I think the question is do we actually include requirements and metrics related to behavioral health? What is available to be provided varies by county and there are some data limitations. I think it is something we should look at this to see what are we even talking about and how does that change as a result of expansion and how do we want it to further change as part of this program.

Rich Rubenstein, California Association of Public Hospitals and Health Systems: We need to look at it in the context of the whole waiver of where there may be other areas there can be funding for behavioral health where we can address that. Since there is going to be reduced DSH funding here, I think we need to be careful about what requirements we put here and whether we include it here.

Kelly Brooks Lindsey, California State Association of Counties: There has probably been some change over time over the depth and breadth of behavioral health services provided to the

uninsured. Counties are trying to do as much as possible to secure a match for county mental health clients. I'm not sure how much is going on in the counties with the uninsured. SMI requirements are "to the extent that resources are available" so it is not the same mandate as section 17000.

Cantwell, DHCS: We have the cost information for the mental health uninsured for those who did include it – many but not all counties.

Diane Ung, Foley Lardner: Currently in Medi-Cal, are counties able to get reimbursement at cost through the CPE mechanism?
Cantwell, DHCS: yes.

Allan Wecker, Los Angeles County Department of Health Services: Our biggest issue is in the ER in both public and private hospitals and it is becoming problematic. So is there something you could do related to incentive payments? Right now we have physical and mental health in different departments. So, if you could develop some incentives to encourage us to work together and keep people out of the ER that could be helpful. The same thing with access, where can we turn this into incentive payments to get the right thing done.
Cantwell, DHCS: This is being thought about for both DSRIP and Incentive workgroups.

Matt Absher, Private Essential Access Community Hospitals: On the private side we talked to a private hospital yesterday and one third to one half of the ER are folks with mental health issues.

Sherreta Lane, District Hospital Leadership Forum: Even our very smallest members, this is a big issue.

Bruce Butler, University of California Office of the President: One of the big issue is just the fragmentation of the social service network. Nurses carry binders of social service resources to help them with patients outside of the ER.

Kelly Brooks Lindsey, California State Association of Counties: In the Workforce Workgroup, is the lack of psychiatrists and other mental health providers is being discussed?
Yes.

Michele Cabrera, *SEIU:* I think for DSH, which is about the uninsured it is good to include this as a topic to be addressed. I know there is a movement to team-based care and we want people working at the top of their scope. We need to look across the waiver for incentives.

Cantwell, DHCS: We need to discuss private and non-designated public hospital DSH funding. DHCS does not have a proposal to modify the current funding but would be interested in talking about modifications if the workgroup is interested.

Matt Absher, Private Essential Access Community Hospitals: We are supportive of maintaining the program the way it is set up right now. Obviously, we are in a different place than the public hospitals in terms of participating in the waiver. A benefit of keeping it the way it is right now is that it gives the hospitals an ability to plan from a budget standpoint and to understand what the funding will be.

Sherreta Lane, District Hospital Leadership Forum: This is intriguing and in line with what district hospitals are struggling with. How to provide better care not just services. Unfortunately, we get a very small amount of money via DSH and so I am not sure how to make this work financially. I don't want to close the door and am happy to continue to think through.

Cantwell: We were open to uncompensated care funding and it is a possibility, but we were pursuing before was four times the money now under consideration. It is worth thinking about this because I think it will hard to have a plain uncompensated care pool under the current construct being proposed.

Sherreta Lane, District Hospital Leadership Forum: I don't think we are thinking of a plain, pre-2015 uncompensated care pool. Some of the work outlined and the discussion from CAPH is intriguing.

Rich Rubenstein, California Association of Public Hospitals and Health Systems: As you were alluding to earlier about mental health services and ER services, if you wanted to achieve some sort of countywide impact on this problem, this could be an opportunity to connect the two.

Cantwell, DHCS: Our team will think critically about data, what they have now, what they collect from public hospitals and counties, and look at other sources in terms of who are the remaining uninsured, whether partially or fully uninsured.

Public Comment

There was no public comment.

Next Steps and Next Meeting #2 (January 12, 2015)
DHCS and Bobbie Wunsch

Bobbie Wunsch reviewed next steps. Besides from assembling some data, are there other issues or topics that the workgroup would like to make sure are addressed

Anthony Wright, Health Access: Is this is the right group to leverage additional funding to expand access to the uninsured, both due to the president's order on immigration forcing the question about how to provide care and expanded coverage?

Future Workgroup Meetings:

- January 12, 2015 – USC State Capitol Center, Room E, 1800 I Street, Sacramento

- January 29, 2015 – DHCS Training Rooms A, B, C, 1500 Capitol Avenue, Sacramento