

POLITICO CALIFORNIA PRO

Q&A SERIES WITH

XAVIER BECERRA, BRIAN KELLY
& JENNIFER KENT



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Q&A WITH:

XAVIER BECERRA



California's Attorney General, Xavier Becerra, sat down with POLITICO California Pro's ANGELA HART for an interview in our California Pro Q&A series with the state's top policy leaders.

In his first two years in office, California Attorney General Xavier Becerra focused his power on filing lawsuits against the Trump administration related to Obamacare, immigrant protections and California's energy and environmental regulations. He's also taken action on a range of consumer issues, including a lawsuit against Sutter Health that alleges the health care network has engaged in unfair practices that undermine competition.

After winning election in 2018, Becerra waded into legislative fights in the state Capitol. On health care, Becerra is sponsoring a "pay-for-delay" bill authored by Assemblyman Jim Wood (D-Santa Rosa) that seeks to end private settlements between brand-name and generic drug manufacturers that keep lower-cost medications off the market.

In an interview with POLITICO focused on health care issues, Becerra hinted at forthcoming action on the broad issue of consolidation in the industry. Major health care legal battles are expected to intensify in Becerra's third year in office, and chief among them is the battle with the Trump administration over the constitutionality of Obamacare.

Becerra has also formed a health care "strike team" of lawyers and policy experts specializing in state and federal health care issues. The idea is to ensure the office is equipped to act offensively and defensively. It is the only such team in the California Department of Justice. Of California's 47 lawsuits against the Trump administration, six are focused solely on health care.

By ANGELA HART 03/22/2019

WHAT IS YOUR CONCERN ABOUT CONSOLIDATION? HOW DOES THE SUTTER LAWSUIT FIT INTO THAT?

What we're seeing is consolidation that's leading to higher costs, which essentially means that the consolidation isn't extracting efficiency, it's extracting more money out of the pockets of patients. And so here in Northern California, you and I are likely paying higher prices for our insurance, or for our cost coverage if you don't have insurance, than if we were living in Los Angeles with the same ailment or condition.

It shouldn't be that you're paying more simply because you live in a different area, if you're getting the same kind of treatment.

We did a lot of work, a lot of research, looked at this case for quite some time and when we jumped in it's because we were convinced we had enough evidence to show that the consolidating activities engaged in by Sutter were leading to higher costs for people — not necessarily the efficiency and coordination that everyone had been hoping for, but just higher costs.

They were figuring out how to game the system.

We may be heading towards trial later this year. There's been a lot of work done in preparing for trial in this case.

SUTTER REFUTES THE ALLEGATIONS. HOW STRONG IS CALIFORNIA'S CASE?

These are always tough cases because they're going to throw everything including the kitchen sink at you, with an army of attorneys. And so you don't become the biggest system in the area, and this is a pretty big area, without doing a whole bunch of stuff that let

you become a big Goliath.

We think we've prepared well enough. We think we're in pretty good shape. We may not be David, but we think we're in pretty good shape. We take action when we think we're ready and I think my team's ready.

COULD THE LAWSUIT AND ITS POTENTIAL OUTCOME DETER CONSOLIDATION AND PRICE SETTING BEYOND SUTTER?

I feel pretty confident that it will.

Once we prove that these anti-competitive activities are not only harming consumers and patients, but that we could put them to the test in front of a court and win, the price that these providers — these health systems — will pay will dissuade them from engaging in some of these practices. It will become more expensive to try to become anti-competitive [rather] than trying to be collaborative with your health care partners and sister organizations.

You need to be able to know that you're going down the path of health care and that all the way through the system, you're the primary concern, not profit.

SO THIS COULD HAVE A RIPPLE EFFECT ACROSS SYSTEMS?

This will definitely have ripples.

LARGE-SCALE CONSOLIDATION HAS ALREADY HAPPENED. COULD CALIFORNIA BREAK UP SOME OF THESE LARGER CHAINS?

Well, anytime you can show anti-competitive behavior, you have the legal right to pursue that, because there are laws in this country and in this state that say you cannot engage in practices that intentionally are out there to remove competition — anti-trust laws. So you can't go out there and just engage in collusive activity or anti-competitive activity and think that's a business model that you can use.

We could try to pursue actions against those that are violating our anti-trust laws — those who are making the state's different business sectors less competitive because the ultimate result is our consumers — in this case of health care, our patients — are the ones who pay the price and get harmed.

I UNDERSTAND YOUR OFFICE IS WORKING WITH ASSEMBLYMAN JIM WOOD TO ADDRESS HOSPITAL CONSOLIDATION.

We're working on any number of matters, but like an investigation, unless we're out there talking publicly about it, it's ... what you know is what you know. I can't say much about what we're doing on any number of fronts. I will tell you noncompetitive activities like consolidation is something that the Department of Justice will continue to examine very closely because we have a job to try to enforce the laws and protect people in California.

SOME BELIEVE YOU ARE MORE ACTIVE IN THIS AREA THAN YOUR PREDECESSOR. WHAT'S DRIVING THAT?

There's no doubt that my 24 years in Congress informs a lot of what I do now as attorney general.

I often tell my legal teams, we're going to win as many battles not so much in a court of law but in a court of public opinion. So we should be prepared to engage at the policy level, at the legislative level and just with the public on these various fights we're going to have to protect consumers and patients.

When we took on the Trump administration and those seeking to terminate the Affordable Care Act, we did it because some of us had a good understanding about the Affordable Care Act, having worked on it Washington, DC.

When we took swift action to protect birth control for women under the Affordable Care Act, we did it because we had a clear understanding of what had been constructed under the Affordable Care Act to give women access to equal medical services, including reproductive services.

And so, we've been able to act swiftly and pretty successfully so far in some of these areas because it helped to have the underpinnings of having worked in Congress on most of these issues, including these health care issues, while I was there. And No. 2 — Sean McCluskie was my health point-person and he's now the No. 2 in the Department of Justice.

So it helps. I've got a double-barrel shotgun when it comes to expertise on health care on the policy side, let alone a legal team that's

really good as well. We're well armed on this matter. That's why we were able to establish a health care strike force. We saw so many areas on health care where there was need to go at it and have a defined group of attorneys who can work it.

It's not a big team, but it's a dedicated team and then it can pull in folks from some of the other sections to help — consumer and anti-trust. Before we were just pulling folks in the sections to come together but it was clear there was a need to deal specifically with health care and only health care.

YOU ARE ALSO BEHIND LEGISLATION TO END PAY-FOR-DELAY AGREEMENTS THAT KEEP LOWER-COST GENERICS OFF THE MARKET.

Having the strike force helps because you now have people who are zeroing in just on health care. Folks have known for a long time that these collusive agreements have been taking place for quite some time.

Most of the studies will tell you that it's driving up the cost of pharmaceutical medications substantially. Most of the cost is ending up in the pocket of the patients who need these important medicines, and so when we felt we had enough information we decided to strike on the policy side, to try to change the way these agreements work.

We think that if we can tackle it that way, it will make it easier to tackle it in court. But hopefully it'll diminish the number of these that are arrived at between these pharmaceutical companies.

You see the prices of medicines go up dramatically and you don't have any choice, you're stuck. You're hostage. And if it's hostage to someone who is just trying to make a big profit, it just doesn't seem right.

In this case, when a brand-name drug company is simply trying to keep a similar generic drug from coming on the market because it does the same thing for a cheaper price, the only people who lose are the folks who need the drug. That should not be the business model — to keep prices artificially higher than it costs you to manufacture them, because you can make more money at the expense of the people who desperately need them. That just doesn't seem like the right kind of model most Americans would agree is a good way to do business.

And so it just seems right to try to bring these out more into the open and make them harder to use.

WHAT FUTURE HEALTH CARE ACTION WILL WE SEE FROM THE CALIFORNIA DEPARTMENT OF JUSTICE?

The Affordable Care Act case is going to start revving up in court.

We're beginning to see some of these cases like our Sutter Health case coming to trial. You'll hear very soon the committee process on our pay-for-delay bill, so a lot of these things are going to start coming to a head, which is good.

We are also working on any number of other things. Opioids is one of them. We're involved in a multi-state, multi-jurisdictional effort to address the opioid crisis. That's moving. I'm not sure I can tell you where it'll end up, but it's big. It's big.

Most of the states, we are all part of an effort investigating the opioid manufacturers — Purdue [Pharma] being the front-and-center company on this and their practices. What they did, how they did it, why they did it. We've also roped in the distributors because what we've found is that it looks in many cases like opioids were being dumped into certain communities in vastly greater quantities than makes any logical sense.

The places that are getting hit the hardest are often times rural or low-income white communities and what we're finding is, it seemed like there was an actual method to what was being done.

These are very addictive drugs, to the point where you spiral to even more dangerous pharmaceuticals from there, which ultimately leads a lot of these folks to OD. Your need, your chemical need, increases so it becomes tougher and tougher for you to feel like you're OK. This is an investigation involving just about every state. It's also not just the states, we've got probably hundreds if not thousands of cities and counties and other jurisdictions — the tribes are in it as well, individual plaintiffs, organizations.

IF CALIFORNIA HAD THE WAIVERS IT NEEDED, COULD IT CREATE ITS OWN SINGLE-PAYER SYSTEM?

I have no doubt that we could. You're just changing the underpinnings of the health care

system some. You still have doctors, you still have hospitals, you still have all the providers. The mechanism for financing changes, so it's no longer your employer essentially reducing your wage or your salary some because he or she is providing you with health care benefits.

So rather than paying for your health care through your paycheck, through a deduction for health care from your wages, or rather than it coming from Medicaid or Medicare, which you pay for through your taxes anyhow, you would more directly see that you would pay for that care from a tax that you would have.

So whether you call the money your employer doesn't pay you so your employer can afford to offer you health care — whether you consider that a health care tax or not — it works the same way.

But the beauty of single-payer is rather than having an employer do it — who then takes some money off the top of what you could have otherwise been paid because they've got to pay for their administration of this health care plan for you, and then you get an insurer through the plan who then takes some money off of the top to pay for its administration of your health care plan, and then you get to the hospitals and doctors and other providers who shave a little bit to offer you care — under a single-payer system you get rid of all those middlemen. And you're dealing only with your provider.

WOULD YOU SUPPORT THE STATE'S QUEST TO DO THIS IF IT DECIDES TO?

When I got elected to the state Assembly [in 1989], I became a sponsor and supporter of single-payer. So almost 30 years later, I'm a supporter of single payer.

WHAT ABOUT THE TAX INCREASES NEEDED? HOW DO YOU MESSAGE THAT?

Those taxes, you're already paying those taxes. It's just, they're not called taxes, they're called an employer deduction from your paycheck. You're already paying them it's just the label is different.

Nothing is free.

When you get your health care through your employer, it's not free. You're foregoing higher wages or salary to get those benefits.

Your employer isn't just being gracious for offering you health care. No, your employer is not paying you as much in salary so that your employer can then go out and contract with these health care plans to offer you a plan. So it's simply the same thing, except rather than having to go through your employer or some private insurance company to do this, the federal government or the state government is saying forget about all that stuff.

Get rid of all those middlemen. There's the field of doctors and hospitals that are out there — you'll be able to access them. It's like Medicare. Medicare, you can see pretty much any doctor you want. That's why the way some people are signaling single-payer is "Medicare for All." I was a sponsor of Medicare for all back when I first got to Congress in 1993. John Conyers of Michigan was the lead sponsor.

SOME PEOPLE THINK IT'S PIE-IN-THE-SKY.

Do you like pie? I love pie.

Q&A WITH: BRIAN KELLY



California's High-Speed Rail Authority CEO, Brian Kelly, sat down with POLITICO California Pro's DEBRA KAHN for an interview in our California Pro Q&A series with the state's top policy leaders.

Brian Kelly is a longtime veteran of California transportation policy debates, but his latest job — overseeing the state's contentious high-speed rail project — may be his toughest yet.

Kelly, who became CEO of the High-Speed Rail Authority in January 2018, was previously secretary of the state Transportation Agency, where he helped pass 2017's gas tax increase. Prior to that, he advised four consecutive Senate president pro tems: Darrell Steinberg, Don Perata, John Burton and Bill Lockyer.

In an interview with POLITICO, Kelly said he's advising Gov. Gavin Newsom to start service as soon as possible on a 171-mile stretch between Merced and Bakersfield — an approach that Newsom touted in his State of the State speech. A project update report that's due to be delivered to lawmakers May 1 will lay out the rationale for that particular leg to be completed first.

Kelly, who had the flu last September and subsequent complications that resulted in a collapsed trachea and a tracheotomy, has been delivering remarks at the agency's board meetings through an intermediary. He is expected to regain his full voice next month with another surgery to reconstruct his trachea.

By DEBRA KAHN 04/22/2019

WHAT IS THE STATUS OF HIGH-SPEED RAIL UNDER NEWSOM, AS YOU UNDERSTAND IT?

As muddled as the interpretation may have been, the governor has committed to the project and moving forward on the project.

I think what's different is he has a focus on making sure that we move forward within our means, like understanding what's a reasonable estimate of what we have and what we can do with that. Ever since day one on this project, when the voters approved the bond in 2008, they gave us \$9 billion for a project that was then estimated to cost \$45 billion. Twenty percent of what you need. Today we have about 30 percent of what we need.

You can't do it all at once if you don't have all the resources. I think what the governor's saying is, let's get something going, let's get trains on the ground, let's have Californians experience this and then let's work to expand it as we go forward.

To me it's very pragmatic. It's what you do with massive transportation projects, and so we're in a little bit of a reorientation, but I think it's good and healthy.

THIS PROJECT UPDATE REPORT WAS UNDERWAY BEFORE NEWSOM TOOK OFFICE. HOW MUCH ROOM IS THERE TO MAKE CHANGES ACCORDING TO WHAT HE WANTS?

A lot. Because the vision for the project is not changed. It's no different than what the voters said to do in 2008.

However, in my opinion — in my humble opinion — for too long, we've taken limited resources and promised a lot around the state, but we got to get our eyes on getting trains on the ground so that high-speed rail is not an abstract concept, but a real service people can touch, feel, ride, experience.

So what I think the governor is saying is, let's move toward that where we can with our resources, and then let's do the work we need to do to be ready to expand when more money is available.

As I said earlier, we've never had all the money we need to do the whole system. So

you do it in building blocks. It's exactly how BART was built in the Bay Area. They started with the three-county sales tax and in 1972 they opened service from the East Bay to San Francisco. But today, it connects to the airports. It's going to San Jose. It's going deeper into the Tri-Valley, deeper into the East Bay. In '72 they had 4.6 million riders. Last year they had 126 million, but they didn't do it all at one time. They built it over 40 years.

NEWSOM'S STATE OF THE STATE SPEECH — DID HE JUST PUT HIS FOOT IN IT? WAS THAT NOT A CALCULATED DECISION?

I think the difficulty is you're using a seminal speech to say that you're reorienting a project. I think some were eager to run with, 'He's doing something different than Jerry Brown,' and they wanted to run with that.

My view is, if you look at the entire text of what he said, I think he was clear that we're still doing environmental [permitting] everywhere. We're still doing our bookend investments. We're going to try to get something operating sooner.

I know how it was interpreted, but in my view, the big change is a focus on getting trains on the ground and getting that going as we move. The commitment to do the whole thing is still there, but there's a reality check that we need more revenue. And I think he tried to express that in three or four sentences.

HE SAID, "THERE'S NOT A PATH, I WISH THERE WERE."

Yes, but he also said, 'Here's all the things we're going to do.' When he says there's not a path, it's true. We don't have all the money in hand right now. But we're going to do all the work in preconstruction to see if we can get it going and then we're going to have to find more money.

WHAT'S ACTUALLY CHANGING?

What I think is changing is that rather than continue to move money all around the state and do, you know, a little here and a little there and a little here, there's a keener focus on getting the assets we are already building in the Central Valley, putting those to use and not letting them sit there and gain weeds and tumbleweeds and decay.

The vision has not changed. There's an

expression here of the reality of how much money we have. We do not have enough to do the whole vision.

We have enough to get trains going, show people how it works and get all the preconstruction work done everywhere else, and then go find more money. I'd rather go find more money after we've delivered something in the Valley and we can perform and then work the issue.

What we're saying is, let's make that interim service longer — Merced to Bakersfield — and let's put it to use. So I don't view it as very controversial, I view it as a better interim route than had been discussed before and one to get trains on the ground in California as soon as we can.

YOUR COO SAID RECENTLY THAT THE FEDERAL GOVERNMENT HAS STOPPED DOING WORK ON ENVIRONMENTAL PERMITTING. HOW MUCH HAS THAT BEEN AFFECTING THINGS?

We asked for what's called NEPA [National Environmental Policy Act] assignment, where they let the state do the federal work. That application was sent to them in June of '18. There's been no reaction and we've been tugging at them for a while. No answer. Then, in about August, they notified us that they were told from above to sort of pull back a little bit until the NEPA assignment question was settled on how they were going to review our environmental documents, and so it's been harmful, but they have pulled back since that time on being active participants in our process.

BUT THE RELATIONSHIP WITH THE FEDERAL GOVERNMENT DETERIORATED FURTHER AS A RESULT OF NEWSOM'S STATE OF THE STATE SPEECH.

I've got to say something about that. They were on a path that was not functional for some time. I mean, we've been asking about NEPA delegation for six months, now, eight months. And then the issue on doing the environmental doc, they told us, 'Well, until we settle NEPA, we're not sure what our review role is.' But what that's meant to us on the ground is we're having to move forward on this state-only stuff and then wait for them on the federal, and they're not moving.

WHAT PRACTICAL EFFECT HAS THAT HAD?

We did the state CEQA document for our Bakersfield Locally Generated Alternative from Fresno to Bakersfield. Ours is done. Theirs isn't. They have not done the federal part of it but we've completed the state part. If there was NEPA assignment, they'd both be done. You can't get to construction without that.

We have an agreement with them to get the environmental work done by 2022. They are putting up obstacles to make that happen. Now we're going to move forward. We're going to get our work done on the state side, but they gotta engage. If they don't, you'll have to deal with them in a different way, but we're going to do our work. And we're going to leave it on the federal side to do their work. Now if this relationship was functional, we would have an agreement and have this solved, and that's what I said to [Federal Railroad Administrator Ronald] Batory. Rather than taking money away, let's figure out how to restore a functional relationship here.

WHAT DO YOU THINK IS THE MOST LIKELY SOURCE OF ADDITIONAL FUNDS AND WHEN IS THE SOONEST ANYONE WOULD BE INCENTIVIZED TO PRODUCE THEM?

When I think about how policymakers look at this, I'm not eager to go ask them for more money until I show more delivery, and I understand that. That's why in our business plan, and again in the project update report, our focus is getting the work in the valley going, and getting it done and getting our environmental work done everywhere.

[If] the FRA wants to sit on their hands, they can. We're going to do our part and deliver it. Then we'll talk about more money. But I think you'll see in the project update report, we have enough money under a reasonable assumption of cap and trade just until 2030, which is where it is in the law today, to get something significant done. That's what we're going to talk about in the PUR.

ARE YOU WORRIED THAT LAWMAKERS WILL TAKE AWAY THE 25 PERCENT OF CAP AND TRADE PROCEEDS THAT THE PROJECT CURRENTLY RECEIVES?

No. Because I think the Legislature has had a very good sense that we have to get a lot

of greenhouse gas emission benefits out of transportation and you're not going to do that until you start building transportation projects that can help, and an electrified rail system with renewable energy as its source is the way you do that.

You can't keep building highways and add cars and think you're going to help on greenhouse gas. So I think both the mobility benefits, the environmental and the economic benefits of this project are exactly what cap and trade is for. I think a lot of them know that. But again, I got to deliver. If I'm not delivering, everything's at stake. My job is to deliver what we say we're going to do.

HOW CAN WE HAVE HIGH-SPEED RAIL WHEN WE DON'T EVEN HAVE DECENT AMTRAK SERVICE?

The reason I care so much about this project is just what you talked about. Amtrak or Metrolink — they will never deliver what passengers really want as long as they are sharing the track with the freights.

Our great benefit is that we are grade-separated and we can move without that conflict, and it makes a big difference when you're a passenger and it's one of the reasons I really want to do this. Show the mobility benefit, have people experience that.

Something that transformed me in 2013

when I was a secretary: I went to Spain, and I traveled on high-speed rail. I was sold, totally sold, and thought, why are we not doing this in California? Spain, the topography, reminds me of California. So when you're on this train and you're rolling through it, you're kind of like, 'This really should be ours.'

So look, it's tough. This project has been a political football from day one and a financially constrained football from day one, which makes it hard. What I'm really trying to do is narrow and shrink a little bit the first operating part so that we can manage that, deliver that. Then talk about expansion. And I have enough money to do it. That's where we are.

Q&A WITH: JENNIFER KENT



California's Department of Health Care Services Director, Jennifer Kent, sat down with POLITICO California Pro's ANGELA HART for an interview in our California Pro Q&A series with the state's top policy leaders.

Department of Health Care Services Director Jennifer Kent oversees California's largest state agency, which provides health care benefits for 13.2 million low-income people — a third of California's population.

Since becoming director in 2015, Kent has spearheaded the expansion of Medi-Cal under Obamacare and has tested the boundaries of what a state Medicaid program can do. She is responsible for leading California's "Whole Person Care" pilot program, which invests in mental health care, drug treatment and homeless services. Federal Medi-Cal waivers are also up for renewal, and Kent tells POLITICO that the Medicaid 2020 application to the Trump administration could seek to make the Whole Person Care program permanent across California.

Under Kent, the department is also working on Gov. Gavin Newsom's bulk pharmaceuticals purchasing plan, which he hopes will lower prescription drug costs across public and private sectors. Prior to leading DHCS, Kent was executive director for the Local Health Plans of California, a trade association that represents health plans serving Medi-Cal beneficiaries. Before that, she worked for a private health care consulting firm and has served in previous roles at DHCS and the state Health and Human Services Agency under former Gov. Arnold Schwarzenegger, steering legislative affairs work. She got her start in Sacramento as a lobbyist for the California Optometric Association.

WHAT COULD CALIFORNIA DO IF ITS FEDERAL WAIVERS ARE APPROVED?

We have multiple waivers in the department for Medicaid, probably seven or eight, but there are two big ones.

There's our Section 1115 waiver, our Medi-Cal 2020 waiver. It expires on Dec. 31, 2020, and it's a demonstration waiver. Demonstration waivers are five years in duration, and the simplest way to explain what they are is essentially state Medicaid programs will go to the federal government and say we want to do something — we want to demonstrate something to you, and in doing that demonstration, we promise to save money, improve outcomes or do something different.

In exchange for that, the federal government agrees to waive certain aspects of the Social Security Act. So you're waiving certain pieces of the federal law to demonstrate that something is better in the state's efforts.

There are complicated financial calculations that are made, but you'll do a budget saying, without the waiver my costs are trending up, and under the demonstration, my costs will go down. This room that's created between the "with-waiver" and "without-waiver" budget line is the amount of money that you get to spend as a state to do something different.

We've had several 1115 waivers dating back to 1995 — public hospital waivers. And then they transformed, really, with the start of our early implementation of the Affordable Care Act.

ESSENTIALLY IT FREES UP A POT OF MONEY FOR INNOVATION?

Yes. Our waivers have always been a longstanding funding source for public hospitals. So we have done a lot of work around the safety net.

In the previous waiver, the idea was that there was a pot of money, significant money, like billions of dollars for the public hospitals. Over the course of five years, they were transforming themselves into entities that can compete in a world in which everyone had coverage.

These public hospital systems — there's 19 in the state — have been allowed to take that money and transform themselves and

create outpatient networks, improve their hospital quality. The idea was, and the pitch to the federal government was, these public hospitals have always been the safety-net for the uninsured. Now that we are basically insuring people and providing them coverage, these hospitals have to transform themselves to be able to compete against all of the other hospitals and providers in the state.

Those hospitals are continuing to do greater and greater quality programs. They have to hit certain quality metrics that we have designed, and if they do, they get targeted amounts of money. If they don't, they don't get the money.

WHAT ELSE DOES THE CURRENT WAIVER HELP FUND?

There's also a significant amount of money for what's known as the dental transformation initiative. When I started here in 2015, our dental program was not doing well. Utilization of services, especially in children, was not at what was considered an acceptable level. It was below 50 percent, for a lot of reasons. Providers said you're not paying enough, parents said they didn't know it was available and it's hard to get an appointment. So we did a variety of things to improve the dental program.

The dental transformation initiative is \$750 million over the course of the five-year waiver that we are pumping into local dental pilot projects, continuity of care and basically baseline provider incentives if you increase the number of Medicaid patients that you're seeing in your practice.

Also under our waiver is the global payment program, also at public hospitals and dealing with the remaining uninsured — mostly undocumented. Hospitals have a financial incentive to put people's heads in beds. That's how you get your money, right? You don't get money if you're outpatient and getting treated in the community.

We have flipped the model to the public hospitals and said under the waiver, we will do this very complicated point system in which you get more points for providing outpatient care to the remaining uninsured rather than inpatient.

Another big component of the waiver is "Whole Person Care."

WHAT'S THE IDEA THERE?

That started off as an idea and a concept in San Diego County called Project 25. They looked at their top 25 users of the 911 system and they were like, who are these people? Everybody knew them. The jails knew them, the emergency room knew them, the police, community organizations — everybody knew them. So basically San Diego said let's wrap these people with as much social services as we can to try to reduce their impact on the system overall.

It was drug and alcohol counseling and housing assistance and case management and if they had jail or bail issues, they helped clear those out. If they had children that were in foster care, they were working to unify families. They went as big as they could go in providing this comprehensive suite of services.

Say someone costing the county \$150,000. They've now provided pretty extensive services to that person, but with this approach, they've dropped their costs down to \$80,000 and that's with full services being provided to them.

So we took that concept and said to the counties, when we go to the federal government with this idea, this is what we'd like to do as a waiver concept.

That's how Whole Person Care came. We have 25 pilot counties. It's across California, but it's not all 58 counties. Counties had to apply to us to be a Whole Person Care pilot.

In total it's \$300 million a year for five years and it started in 2015.

CAN THEY PROVIDE RENTAL ASSISTANCE?

They can do supportive housing. They cannot pay for rent.

Gov. Newsom in his budget this year proposed \$100 million for Whole Person Care housing pools. That will go towards rent. We're going to put it out to any of the Whole Person Care pilots that have housing programs now.

ARE THERE ANY PLACES THAT ARE DOING IT THE BEST?

Placer County has knocked it out of the park,

and Los Angeles has done a ton.

Both have done the right thing. They have hired people to go out into the community and work with these populations, in the streets, developing a relationship, talking them into services, making sure they get to appointments. Getting them directed into services and if they bounce out then they go back and try to get them back in.

They're recognizing that the people sitting in jail are most likely the same people that are outside but for the week that they're in. When they get discharged from jail they'll go immediately back into homeless status, they commit a crime, and then they're back in jail. So they're working with their incarcerated population to say, what do you need? Do you have a drug and alcohol problem? Do you have a mental health issue? They're treating it in the jail, or they've created sobering centers.

HOW COMMON IS THIS APPROACH?

We were first in the country to do that.

We got the first housing type of waiver, and the last part that we're proud about in this existing 1115 waiver is our drug Medi-Cal organized delivery system. Again, first in the country on this.

Medicaid beneficiaries have never had a full spectrum services for substance use disorder, ranging from voluntary inpatient detox all the way down to outpatient sobering services, so these counties have opted in and have to provide a mandated set of benefits ranging from residential treatment all the way down, including medication-assisted treatment, case management and intensive outpatient therapy.

THERE'S A BIG PUSH RIGHT NOW, IN THE LEGISLATURE AND BY THE GOVERNOR, TO BETTER INTEGRATE BEHAVIORAL AND PHYSICAL HEALTH. WHAT IN YOUR MIND DOES INTEGRATION MEAN?

It's different for different people.

WOULD IT REQUIRE LEGISLATION?

It would need a constitutional amendment.

We in the state have had two significant financing arrangements with the counties — 1991 realignment and 2011 realignment.

Realignment essentially means the state and the counties sit down and say, we're

going to require you to do things statutorily and in exchange we're going to give you a dedicated tax revenue source to do that. So if you were going to do an integration at the state level, the counties still get the money from a constitutional standpoint, so you have to change the constitution if you're going to change the responsibility.

I always like to make sure people understand that, because it's not as simple as saying, oh sure, we'll take responsibility back for those.

The counties would love it if we took the drug and alcohol responsibility back but they get to keep the money. But if you don't change the constitution, you can't really do it from a financial standpoint.

Right now there's a nice collision of two waivers coming due that the same time, in 2020, and so what I like to tell people is it's up to us to figure out as much as possible, how do we align county mental health services with the rest of the Medi-Cal managed care program and figure out how to make the financing work.

WHAT IS INTEGRATION FROM YOUR PERSPECTIVE?

In my mind integration means that each of your providers recognizes both your physical and mental health issues.

Some people think of integration as being co-location, meaning your mental health provider and your physical health provider are in a shared space so when you walk into your doctor's door you get both providers at the same time. That is some people's concept of what integration means and I don't think that's practical in a state of 40-plus million people.

Too often, people are left struggling to figure it out on their own. So when I think about integration, it's building a recognition in a provider community that they have to acknowledge people's behavioral health issues and then they have to have a solution to offer that person.

That takes a lot of time and effort. It takes a lot of collaboration and it takes a lot of silo destruction.

DOES THAT MEAN MORE PEOPLE?

Yeah, doctors, nurses, social workers.

Sometimes I also think that we rely on physicians to do some of the things that a

really good case worker or social worker could do, as an extender of that physician's capability.

Sometimes that's a dollar issue too. Some of the discussion around here and elsewhere is how do you build that and make it a successful business model such that you can have better patient satisfaction and better patient outcomes.

Some of the incentive payments that we're talking about doing in the budget all goes to helping physician offices at the ground level do a better job of managing for outcomes, as opposed to managing for volume.

It's a very distinct shift in how you treat physicians, because you're essentially telling them, you're going to take a lower volume in patients but you're going to make up the difference because we're going to pay you more because you're going to get better outcomes from the patients you do see.

That's hard for people to see, but it's essentially what we're rolling out.

We're proposing it as part of the value-based purchasing initiative. That's the shift that we're going to try.

It's a significant amount of money — it's \$180 million a year for at least three to five years. That's matched. It draws down federal money, so that \$180 million could be \$360 million.

HOW MUCH MORE MONEY WOULD PROVIDERS GET FOR THE VALUE-BASED PURCHASING SHIFT?

They will get a payment that we haven't figured out yet. It'll come in four different categories — early childhood, pre-natal and post-partum, chronic disease management and behavioral health integration. Once we get broad buy-in from stakeholders on the measures, we'll back into payments as to what that looks like.

SOME BILLS IN THE LEGISLATURE SEEK TO IMPROVE QUALITY IN MEDI-CAL. IS THERE ROOM FOR IMPROVEMENT?

There's always room for improvement.

I also am of the mindset that if everything's a priority, then nothing's a priority. So part of the careful balance we have as a state department running a big program is we have to be mindful of how we prioritize work for our

contracting plans. I can't go to them and say make it all perfect.

WILL THE WHOLE CARE PROGRAM GET BIGGER?

Depending on how it goes, our next phase after this waiver is over is do we take that statewide, and say to counties you should all be doing this.

It's one of those things — people are more likely to make something more successful if they come to the decision themselves, so we try also not to force things on people and say this is a great idea and you're going to do it. That doesn't always lead to the best outcomes.

A lot of what we do is we gauge when you use a carrot versus a stick.

Some of what we're doing with the plans right now is a little bit more stick. We're threatening them with sanctions and corrective action plans.

We're going to basically whack you if you don't do your existing job that you are contractually expected to do now. But you balance those relationships out.

WHAT IS THE DEPARTMENT'S ROLE IN THE GOVERNOR'S DRUG PURCHASING PLAN?

We, as a state program, are saying we're going to pull all pharmacy responsibility and money out of the managed care plans, and we're going to return the benefit back to fee-for-service for all beneficiaries in Medi-Cal. So you as a Medi-Cal beneficiary, instead of getting your drugs authorized and paid for by your plan, we will be doing it at the state level.

Part of the governor's proposal was I'm going to consolidate my leverage and negotiating power and instead of negotiating and getting rebates for 2 million people, I'm going to negotiate and get rebates for 13 million people.

Manufacturers, day one after that executive order was out, they were like jangling up our

pharmacy people like, hey, whatcha doing? We want to come by and talk about your rebate program.

So part of it is consolidating your negotiating power. I've got 24 plans, each with their own pharmacy benefit manager and each with their own ability to negotiate, so we will take it all back. January 2021 is when we're going to effectuate that.

The second reason that we're doing it is to standardize the benefit. So across 24 plans, four different managed care models, there are dozens if not hundreds of exceptions in each of our contracts with each of our plans.

I got so many different patchwork-y things and so part of our issue is, in order to do things like Whole Person Care going forward, we have got to standardize the benefit across all of our different managed care plans across all of our different models because we have to be able to set rates in a way that we're confident that the rate reflects what the plan is doing based on the contract.

The second body of work on the executive order is think big thoughts. Go out, come back with some great ideas and recommendations for the governor to consider that lower health care costs and pharmacy costs not only for Medi-Cal but across the state altogether.

I HEARD THERE HAVE BEEN CONVERSATIONS GOING ON ABOUT WORKING WITH OREGON AND WASHINGTON. WHAT'S HAPPENING THERE?

They have wanted to. Their leadership in those states have said they we want to join our Medicaid programs with your Medicaid program and let's just buy all together.

And we're like, you combined as two Medicaid programs are a million people.

We're 13 million.

So the purchasing and negotiation for us doesn't get us anything.

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