Transcript of interview with DHHS Secretary Aldona Wos (AW), Carol Steckel (CS), April 10. Press officer Ricky Diaz (RD) sitting in on the conversation.

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RH: Thanks again for the opportunity, I know you folks are busy, we have about 45 min.?

RD: I think, I'll confirm that.

RH: so we'll just jump right into things, rather than going through all of the niceties

AW: we like niceties because we don't have enough of them

RH: right. We all are so busy. So one of the thoughts I had was you folks are talking a lot about reducing costs and providing better outcomes. And Carol I think in one of the HHS committee meetings you spoke quite positively about mid-level providers practicing to the level of their licensure. So folks have talked to me, and the data have showed that using those mid-levels can produce savings and expand access to care. I know there are a couple of bills making their way through committee, have you folks talk to legislators about scope of practice in the context of providing access to care, providing quality, I mean, things like midwives and nurse practitioners

AW: you're asking a specific question and we almost live at the legislature between one of us, both of us, all of us, in the department obviously you are seeing us there all of the time. I have not, it has not come up in any discussion that I have been in on, that's in response to your direct question.

CS: and I haven't either, for me specifically the licensure of mid levels, for them to work out and all of that and what we were talking about, and what I was specifically talking about there was within the current licensure laws they have a very valuable role in the healthcare continuum. But I come up for one, not necessarily interested in getting into a licensure issue...

RH: I know that there is a midwife still, I note the nurse practitioners would like to do a bill, **2:30** I know that there is the CRNA bill, I'm just curious if you've been asked for input on this issue.

AW: I have not

CS: No, I have not

RH: that was easy... so jumping right into Medicaid. Looking at numbers from the Kaiser Family Foundation, North Carolina Medicaid has the lowest year over year growth of any state in the country, and also, based on what you said in committee Carol **3:00** about Arizona's admin costs, I did a recalculation of those data and found when you adjust for Arizona's admin costs being more like 13% rather than 1.7 as cited in the Medicaid audit, the North Carolina

admin costs pretty much come in line with what other states are spending.
And then I did a per beneficiary calculation and found that North Carolina is actually in the middle of the pack. And I think this is been one of the arguments for making the statement that North Carolina Medicaid is broken. So, if admin is not as large an issue, or as big an expenditure, what are specific examples that you have that show that North Carolina Medicaid is broken?

AW: I suppose we can start with one thing last year we were informed **4:00** that we were $450 million over budget, so no matter what industry, no matter what you are doing you may not be able to peg it exactly on the dime, but at the end of the day that's a pretty big spread. $450 million over budget, just in last year's budget? So we're doing something not right, in order to have that much money **4:30** that's over budget

RH: Is that a function of being over budget or is that a function of having the budget budgeted to tightly?

AW: I'm sure it's both of the end of the day and it's such a large amount of money, it seems to repeat that there is such a large spread between what it was supposed to be and what is. So that is one example, you can say it's certainly not perfect as one option. But I think the way that weI can't speak for the governor... **5:00** but the way we look at the broken concept, is it working properly? Adequately? For whoever is using the system and who is using the system, and I think in general, it's the stakeholders, you've got the patient, or the client, where the recipientwhichever is the proper term. So the person is not happy because they cannot get what they need when they want it, especially when it comes to mental health, **5:30** it's really an issue. It's a very confused process, very convoluted, where you could help, who you get it from, how do you get it, who provides it, who pays for it, this kind of stuff. So, one is the fact that from the consumer's point of view, , the patient, the recipient, they don't think it's perfect, they are not happy, because it's too confusing, sometimes they don't have an ability to get the rate care that they actually need due to how the system is structured, and who else is not happy to make it an unbroken system? The healthcare community has enormous hurdles right now. The healthcare community, the providers, the fact thatthe complexity of the IT system to pull all this off for them is a major hurdle. The complexity of, duplication of, **6:30** sometime services duplication, administrative complexities, the hurdles that we have legislated people into, all of us inclusive, between the state government, the federal governmentwe work in... not a clear path to the easiest goal. We make it pretty, complicated. So the provider community is not happy.
And then who is not happy, certainly the legislature is not happy as a stakeholder because they have, in the end have to figure out **7:00** how to create money for this, because this does have to be paid for. And then the taxpayer is not happy because their taxes keep going up from year, to year, to year because the budget is going in a certain direction. So it truly is broken from that perspective because we are not where we could be as a state. Perhaps not get everybody to be as happy as they can and be perfect but at least be better off than we are. So the concept of broken is probably a correct **7:30** word, you know, we can pick another word but it is broken. You are supposed to be able towe wish, or our goal is that if you are a patient you ought to be able to get the care that you need at the time that you needed from the person that needs to give you the care and it needs to be a sustainable financial model, because it's not just to get at this year or next year in a budgetary cycle and then in 3 years it falls apart. 8:00 it's got to be sustainable financially.

RH: I think part of the reason why the broken word has stuck with me is because the fact that, well, for one thing, doing a lump some or overarching thingoh, $400 million, oh maybe it wasn't $400 million! I know that Sec. Cansler before he left he talked about the fact that they were budgeting too tight, and he used the example of **8:30** I know my house mortgage is $2000 and if you only give me $1800 to pay it then I'm going to be over budget every time I pay it. So I think part of it has to do with the political language used around it in that when you say there is this huge $400 million overage and there's no context provided, what it does is gins up opposition by taxpayers.

AW: well I think unfortunately it's a extremely complex issue **9:00** and there's not enough time by anybody to put anything in context. So, everything depends on context, so the gist is that it's not a matter of, (turns to CS) now correct me because you are the subject expertit is a budget, etc.we think gamewe request X, you give Y, and the outcome is Z. But you have to be able to, when you run an organization, to be able to say **9:30** if this is all we are getting we have to be able to get it plus or minus... in that zone. We can produce this product within this zone. And I think that it requires multiple things. If the legislature says you only have this much, that's all you're going to get! I mean at the end of the day, maybe you'll get a little but more...

RH: There is the issue that it is an entitlement program...so if you have a lot of...

CS: well, let me talk about broken to, because we will start at the national level there is not an Medicaid director or a governor who will tell you that the Medicaid program in and of itself is not broken.

RH: And I've been speaking to them, I don't think they said the word broken but they've all said things like need improvements

all talking at once...

CS: it is very much a program that was designed when it was designed in the late 60s early 70s, and think about the healthcare system at that time **10:30** if we went into the hospital we either died or went home. We did not have chronic I don't mean to be crude about it but that's what happened. He didn't have chronic illnesses, you didn't have hypertension, you didn't have diabetes like you do now, so the system was designed around in patient, the physician visit, the inpatient visit. So now fast-forward into the environment that we have. Where it shouldn't be there skilled nursing facilities, it should be hospitals that are driving the train but the system is still designed by **11:00** that early 70s model, and in addition, if you look at all of the waivers, why do we do waivers? Because the model is based on fee-for-service which isvery few entities are paying that, in the private sector, much less in Medicaid programs. So you start at the national level and it is broken. Then you start winnowing down to what do you mean by its broken here. Not only do we**11:30** I'll be so glad when I don't have to refer to the state auditor's report, but just the management and the trust factor, and why was the budget under budgeted because no one in the Gen. assemblyand I wasn't here but I don't know for a fact, but I have been told that they could trust the administration, they didn't trust the department. So the secretary and I have been doing a lot of work to try to rebuild that and to make sure that when we give estimates that we understand where it's coming from. You are

exactly right, it's an entitlement program. **12:00** if the economy goes south again, we are going to see it go up and we will be over budget.

RH: and you and I have talked about reserves which have finally been budgeted in.
AW: which were...

CS: but the point here is you have to have a trust relationship between any legislative body and the department. So that those type of scenarios don't happen again. And then it's a matterthen you look at is it broken and the secretary did it much more eloquently, but just by handing someone a Medicaid card doesn't **12:30** guarantee that 1, they're healthier and 2, that they even have access to care. So we have got a lot of work to do on every level of that broken system and I think it's fair to say it's a broken system. So how do we work itI mean, the federal rules are what they are and they are probably not going to change for the near future. But then how do we make our system work within that system.

AW: **13:00** and I think it is important to go back and explain what we are attempting and what we're attempting to run the department and what we're attempting to with the partnership for a healthy North Carolina. Traditionally, there has not been that trust factor between the Department of Health and Human Services, and look, there are some people who work here who are absolutely the most passionate, smartest, hard-working people that you can imagine. **13:30** Who will... Do everything humanly possible to advocate and make sure that we are protecting the most vulnerable. that's just the nature of people who gravitate towards this, versus going into a different department. But saying that, there is not been a history of the trust factor that the product that has come out of DHHS, is a usable product. **14:00** Whether it is the accuracy of the number, whether it is the accuracy of the report, the timeliness of the report, whatever it is. So the legislature, after having X number of years of having that type of relationship, does what they do best, and they do best by trying to make the best possible decision at a given point in time, to the best of the citizens of North Carolina and creating the law.

RH: and I think the real rancor though is more a political issue, because we have had a Republican legislature **14:30** the past 2 years it was a Republican legislature and the Democratic governor. So I think that the levelI mean, everyone that I speak to at the legislature talks about that that level of partisanship has been ratcheted up to an unprecedented level in the General Assembly. And even Lanier Cansler's parting words I don't know if anyone has ever told you about this, but he made a very impassioned farewell to DHHS oversight and he talked about the fact that **15:00** the partisanship that existed at that time, as he was leaving, was serving no one well.

AW: Well I think politics, politics, but also trust. If you are asked legislatively to submit a report by June 1, I come from the outside, I don't come from politics that means to me legally, I need to submit a report by July 1. That's my interpretation. Well, that's not what has happened traditionally, **15:30** whether it's last 2 years or previously, is at July 1, is it August 1, is it a year later, 6 months later? Okay. That environment of lack of accountability, lack of following rules and regulations, lack of... creating a situation wherefiscal research constantly is asking for things, these guys are either constantly missing the deadlines are not getting their numbers right, they are reacting by making more rules, more regulations, **16:00** putting a backlog on more and more work, and asking for moreand it said unsustainable internal interplay between

department and Legislature and the executive branch. So when we came in it was a priority for me, to do whatever was humanly possible in restructuring the department to give credibility to what we say. So number one was get the report in on time. And I had to ask before it's due, but get the report in on time and this stuff in the reportanswer the question, they had a question, answer the question. Take away the fluff, take away the adjectives, don't start with how smart and wonderful we are at HHS and we know what we're doing. Answer the question, and speak to each other. Because did you really need that report you are asking us to do? You know what our reports look like it's not a matter of just hitting print off of someone's computer. We have to go through multiple zones to coordinate the information, get data from multiple places, **17:00** for us it's a lot of work to create a report. Do you really need that information? Because I don't think it's usable for you. Tell me what you really need and I'll get it to you. But don't ask me for everything because you are not going to use it anyway and for us to give it to you anyway is pretty problematic. So I am trying to instill a culture of where what someone needs, get it to them what they need and trying in the other way to have a culture of what do you need so that you are not asking us for stuff you are not going to use anyway. **17:30** and allowing a working relationship. And I think we have done a pretty good job in this last 4 months of where the legislature is actually kind of surprised because they will call up here, they call Carol appeared they have a question they get an answer, they are kind of like, oh my gosh we just inundated with a whole bunch of reports June 1 and they were like, ohthey are kind of surprised that we are actually producing a product **18:00** that is usable for them based on what they are requesting. And in return we're asking them to allow us to work. Don't ask us for stuff just for the sport of asking or because you don't think we are giving you whatever, whatever.

RH: will that flies in the face of the response that I got from some legislators about your Medicaid plan because by their account they had not been given any foreknowledge, maybe 24 hours notice of what your plan was.

AW: that's notthat's not, well I don't think that's valid. We don't have a plan we have a frameworkI don't think that's a fair assessment, I think since the governor came into office and I think since we came into office we've been speaking about the need toof change, and I think that's exactly the direction that the governor has mandated all the agencies that we're unfolding, which ever project
Yesterday I was out east with Sec. Shanahan **19:00** on this safer school forums that we are unfolding, and that initiative with the governorthat's what the governor had asked, that we figure out what's wrong, we figure out how to solve it, we move it forward, we act on what is in front of us and I think when it comes to Medicaid I think that was the biggest gripe of the legislature is I know you are new on the block Mme. Secretary, **19:30** lovely to see you, but what about the money? So they really, we have been working with them very aggressively on every aspect that we can to figure out how to be more accountable, how to improve on whatever product we have, how to be more reliable with them with Medicaid…

CS: and the day after the governor's announcement, we were on their doorstep actually beforesoI guess in a way I almost want to say what are we apologizing for? Because we did in RFI that brought everyone to a virtual table that in a way if we had spent 6 months to a year bringing everyone into a physical table we would not have gotten the quality we got. It was very productive, and a very good use of both the people who responded and our time to give the candidness and the quality of the proposals **20:30** and then we absorbed them, we

compiled them together and built on the system that North Carolina has and took it to another level and then created another framework and immediately gave it to the legislature, the governor presented it and we have been out beating the bushes, soliciting input,

AW: oh my goodness…

CS: what's do we have to apologize for? How much more inclusive could we be?

AW: and actually we were very inclusive from the very beginning. I mean it was because of the need, which I realize very **21:00** quickly from my experience in working with the federal government that a lot of times in agencies or associations, people don't speak to each other, they really don't speak to each other, they don't get into a room together and powwow about whatever they can actually agree on or mutual goal or whateverand so in the very beginning Ricky this is before you came, I had asked to bring at the senior staff members we invited them here to come, we had a whole forum from the Legislature. We had people from Senator Burr's office in DC I called there to have them come down and be a part of that. We had folks from fiscal research,we hadin the very beginning of January when I started this, this is even before you came on Carol. Just toyou guys gotta speak to each other. This is what we want to do, get on board, we want to pile through this and move forward. **22:00** So this process through January's when we were creating it, they were very much…

Now, does it mean that all 200 or 300 elected public officialsbut certainly there were staff

RH: I'm talking about people like who were the chairs of HHS committees, expressing their dismay that reallyand I want to move on to Community Care of North Carolina because I think others, and myself included, have noted the irony that sees CCNC was receiving a national award**22:30** while the governor

AW: and it should…

RH: I don'tAnd others as wellDon't really see where CCNC really fits into this new scheme. I think extensively you have private managed care coming in to run Medicaid whereas right now you have a homegrown, not-for-profit, Dr. run system where savings revert back to the state.

CS: well…
AW: there are several things**23:00**

RH: they are not profit taking

AW: well, that's not true either. Wait, waitThere are several things that you said that are not really correct so we will go through specifically each one and I think it's important that we dissect it actually today at one of our meetings we had 30 of the people from CCNC today, and we had the doctor day today, we are on a road toWe have office hours, so, so from big industries to small industriesbut there are several things that you mentioned and so let's untangle **23:30** each of them as we go forward.
The CCNC model for the state is, as we all know, it's an excellent model, the other states are envious that we have pulled it off, homegrownNorth Carolinaso I think they should've gotten in

the award from Senator Burr.

RH: so how are they going to fit?

AW: I said thatBut they are not perfect

RH: I don't think they would say they're perfect either

AW: and they don't. And so they are an evolution just like we are just like everyone is because healthcare evolves through the years, centuries, we have filed, it's a nonstatic process. So by building on to what they are doing, expanding what they are doing we are able to increase the efficiency and be effective in providing the right care at the right time for the right person at the right cost. And so they, just like everybody else, was included in the RFI and they, just like everybody else, is included and our transition cycle. We just left the meeting just before we came downstairs to youand they, like everyone else, we are hoping and counting on it that they will submit an RFP once that gets structured. **25:00** So, we are not excluding them under any stretch of the imagination we have been inclusive of them and everybodyevery body. My goodness, we have been hooting and hollering please come and speak to us…

RH: they don't have the capitalization to be functioning as like a private managed care…

CS: why not?

RH: I don't know, do they have the reserve? **25:30**

CS: but they are, there are ways that you can do that, I mean look at the technology that they have built, look at the staff that they have built, so why not make that leap and that's one of the thing that we're talking to everyone about, what do the risk reserves need to be? What do the bonds need to be for protecting the citizens of the plan goes out of business or goes out of state. So all of that is part and parcel. But there is nothing **26:00** in our plan that doesn't build on the success of CCNC, but the one concept that we feel very strongly about is that you have to have competition. We would not be serving the citizens of North Carolina well if we vested every bit of the Medicaid program into CCNC. And I like Allen (Dobson, head of CCNC), and I think they've done a fantastic job

RH: you called it state-of-the-art

CS: it is
AW: it is.

CS: it is, for the time that it was founded. Now we need to step up **26:30** and we need to move farther. We need to challenge all of us, we need to challenge the Medicaid program, and we need to challenge them and the only way you're going to make that happen and make it happen in the long term is to have a competitive marketplace.

AW: because at the end of the day Let's look at it another way, let's pretend that you excluded people. You didn't allow people to compete for this, the skill in that avenueIntellectual discussion that you are suggesting**27:00** The state makes a decision that we are only going to

exclude everyone else we're just going to go with this model that we have right now. And so, we know from experience from just life and other states that when a state decides to have no competition, they are limiting their options. Because all of a sudden, it's life unfolds and business you could be held hostage as a state by lack of competition in any industry by the fact that now we have cost overruns, and now you have to renegotiate your contract **27:30** because the contract time is up and now we have to have an increase in cost because of this, and this, when you have no competition you have taken away the ability for the states to have any flexibility. So, the concept of having one is something that I don't think that consumers would agree with. Consumers like choice. Most of us in the United States like an option **28:00** that I would like to go to this doctor, I would like to take this insurance company, I would like to buy this car or that food, we like choices. And so the whole thing with healthcare is that people want choices, they don't want lack of choice. And so, allowing everyone to come to the table and asking everyone to please come to the table and requesting that please, many people come up with innovative ideas of how to structure it so that **28:30** you can come to the table is what our intent is. Our intentour intent is to offer as many options as possible within a sustainable business model that we can.

RH: it makes me think of 2 questions, one is that North Carolina has attempted managed-care before, and part of the problem was that it didn't have the networks, particularly in the rural areas, so it begs the question of how could an outside entity come in and establish some of those networks? And that's a question that's out there and I don't think any of us can answer it yet. But the other question is more pertinent for me is a slightly different topicwe have spent hundreds of millions of dollars on an MMIS system and this is part of what I was getting at last week when I asked the question about transparency, being able toWhen you have for profit businesses coming in there's going to be an issue with their having proprietary data and having proprietary systems for things like billing. How are you going toYou spend all this money on MMIS, how are you going to do their billing?

CS: can I ask you a questionhow did for-profit outside companies become such a dirty word? I just find that interesting in North Carolina

RH: well who else is it?

CS: wellbutIt's such a negative

RH: well, just for profit, not outside, just for profit.

CS: we have Eli Lilly here, we have Glaxo here, we have Walgreens, Walmart, and we recruit companies to come in, and this is an intellectual argument and I'm taking away from your time, but I would love to sit down because to me it's such a foreign concept that ...
AW: to America, right?
CS: rightI don't understand this
AW: it is a foreign concept to America what created our country is competition, **30:30** and innovation

RH: But I think we also created the not-for-profit marketplace in this country, we have a very lively not-for-profit marketplace and you talked about…
AW: that's not not-for-profit

CS: oh...
RH: You also talked about living through managed care in the 90s which I did too as a provider and you see for-profit, managed care companies come in, the first contract, it looks good, right? Because they got the contract they bid low.
This just happened in Oklahoma **31:00** they come back after the first contract is over and they say we need an increase
AW: exactly, exactly
RH: and then what happens, your UR (utilization review) becomes tougher, you've got more people having denial of services or, like you said they manage doctors out of business by cutting reimbursement.

AW: in the 80s they did. That's one of the reasons why having one, one entity, doesn't matter what the entity is, it does not serve the public of North Carolina well. So the concept of having one, versus an option, and also there's stuff that we can't predict **31:30** when you have an option when feels you have someplace to go but be realistic hereWe came in 20-something, the concept of MCO world started here in North Carolina and now we're down to 10 (mental health MCOs). There's life, there's business on all of this that people fail for many, many reasons. Not only by wanting to do bad I mean people fail because they didn't create the goods necessary to succeed. So going to the concept of why more than one, the concept of opening up to everyone we will see where it ends up. It's not an open process that we will have many because the business model of the state, we have a given population, we have a different geography, and only X amount can be sustained, so that's why that concept of the 3-ish, you know the concept...

RH: isn't it a federal requirement to have at least two?

CS: it depends on what kind of waivers you get. Generally that's their preference.

AW: So that's the concept of not one. And then there's the concept of for-profit, that's more of a getting back to This is more of a philosophical discussion, I guess, more than an interview, you know, if a for profit, a not for profit, and a nonprofit can produce the same result, (throws up hands) okay.

RH: OK. I'm just
CS: but also
AW: you know what I meanI see nothing that **33:00** and especially in a free market economy, in a right to work state, why would you exclude people? To me the conceptual part, why would you…

RH: it's not about exclusion is just about looking at the experiences of other states
AW: and that's what we're doing, that's exactly what we're doing, the whole focus is that looking at the experience of other states for the last 30 years in different models

RH: because the history of managed care is littered with failures
AW: correct.
CS: that's exactly right.
AW: correct, correct, correct.

CS: one of the things that kind of clicked today with me is that what we're looking to do could not be done in any other state with out the work that CCNC has done, in the managed care. But if any state can make this happen and you could see their brains starting to click aroundwhat if we lower all of the barriers that you now have because they don't provide all of the services for a patient **34:00**
RH: they don't provide the services for mental health.
CS: they still have to pull in the mental health, they still have to pull in, they don't do long-term care at all, what if we lowered all of those barriers and empowered them to do it they are very good at throughout the continuathat is what we're looking at doing and they could probably only be done here. So, when everyone saysWhat are we going to look like, we are going to look like North Carolina

RH: as you said if you see one Medicaid system you've seen one Medicaid system.
CS: right. But we have got such strengths to build on here and I mean 86% participation in the Medicaid program we do not want to lose that. The CCNC program. The (mental health) managed care entities, the one thing that I haven't heard or we haven't heard is any real bad concerns about quality of care, there may be one off stories that their quality of care is good, we took them out of their core competency by saying you've got to become a financial institution and pay bills, well that's not what they're good at. **35:00** so let's return them to what they're good at and that will be a powerful tool for the CCE's. So we're learning fromand Mike Fogarty (Oklahoma Medicaid head) and I go back a long, long way so I am very familiar with what happened in Oklahoma, in Connecticut and other states. We've got to learn from those and we've got to learn from the early scorched earth methodologies of managed care and look at how we create an environment that allows **35:30** for there to be competition and choice for our recipients but also empowers the networks to be creative and innovative around that person. That can be done here in North Carolina.

RH: You talk about lowering the barriers for CCNC then, how then, does this, how do you roll this mental health system, which... when you talk about broken I will not argue with you and North Carolina mental health is broken in oh-so many ways. (everyone laughs) I've made a career in writing about the mental health system in North Carolina. So how do you dodo you say to these entities like Cardinal innovations, "Thanks, OK. We're gonna do something else!" Or do they become the statewide, you know, mental health.. .how does this go?

CS: this is what's exciting about it. I tend to play all these games about: if I were a Cardinal person **36:30** if I were a CCE person, if I were provider, what would I do? And how would I've figure out how to take over the world? It's just my nature, I'm sorry. <laughs>

RH: well I had a conversation with Jim Verdier, he used to be in Indiana, he's now at Mathematica, and he said, "Oh, my old friend Carol Steckel is there, what is she doing?" And I said, " I think Carol has come here to create the perfect Medicaid system as the capstone to her career, that's what I see you trying to do."

CS: Exactly. And here's the thing about Cardinal and other MCOs, **37:00** and we're meeting with the MCOs to walk throughbecause again the quality of careand this is the story I gave them and particularly the smaller ones,
RH: like Coastal…
CS: again, we have taken you off of your core competencies, so let us take that back and

what do you have to offer to a CCE. Oh my, you have put together 100 different providers that provide behavioral health. You have put together an emergency response system, if I am a CCE **37:30** and I can pay you to continue to manage that, and pay your providers, I have now got 100 providers in a system that works. I will figure out how to do the payment part of it and I will figure out how to do that.

RH: So the risk part of that would be somewhat stripped away from them…
CS: it dependsIt depends
RH: I mean, obviously, they'll still have risk but they won't be doing the billing
CS: it depends on how they negotiate now, and back to Cardinal, what if Cardinal can put together a statewide network marrying physical and mental health together, and they become, they do an RFP. And that's exactly it. And it's all about how this CCE's got to, they've got to comply with our requirements for a network. So if they know that they've got these hundred providers, they may not do a financial risk, they may do a shared savings program. Or they may do a withhold and **38:30** earn back methodology. You may have all sorts of different methodologies going on depending on what the provider network is and what they are trying to accomplish. But that is the power of that CCE network. But it's also the power of groups that exist today, whether you are a large individual practice, whether you are a CCNC network, or whether you are an MCO network. Is your value added to that CCE becomes you are negotiating tool.

AW; and I think the issue is that right now we have **39:00** we have a state full of excellent and clever stuff and then mediocre staff and the not so good stuff. So we are trying to create something that's more uniform as the end product. So we're staying focused…

RH: in terms of provision of care, quality of care

AW: if we all stay focused on what do we want. To achieve that we can all agree on, all of us across the board. We want to have healthier people, and to be able to sustain that in some way. Right? So if we all stay focused on that how do we get to that goal? So, if we all learn from mistakes past, and try not to repeat them, that's the 1st thing, don't re-create the same mistakes, so that's number 1. So let's pretend that we are all trying not to make the same mistakes. And we will never create something that isand we know that if we continue doing what we're doing we cannot sustain that in this state and we all kind of know that in some sort of way. If we just continue on the same path **40:00**

RH: I don't think anyone would say that the program does not need improvement…

AW: rightand so how do we create something, or what do we create in order to achieve that goal that we are all talking about, healthy people in North Carolina and be able to pay for it, and sustain it for a long period of time. And that's what we're getting from everyone all this information. We didn't create something, and then are now telling everyone this is what we are going to implement and we're not trying to sell that. We could've gone down that path **40:30** but we probably would've made a lot of mistakes. So we are going on a path that here is the goal that we're pretty convinced that everybody agrees on. Bring everyone to the table, we have created our matrix, so the RFI allowed us to create that frame, the frame of the house is the building of the matrix because it seems that those three **41:00** parts of it, most people were concerned aboutthe person as a whole, the mental and the physical, duplication and

administrative staff, hurdles, and the hurdles of IT. So fine, we've got these 3 things. How do we now take IT, take administrative hurdles and take the whole person concept, so we have this. Had we approach each one, fix it, change it, tweak it, whatever you want to do and then put the all the other thousands of ideas that are coming from other people and concerns, put it into the matrix to get to this (moves water bottle to the middle of the table). And we have a clarity and some of them **41:30** a lot of clarity, we have medium clarity and some of them and we're working through and we will be meeting lots of assistance from experts, not just our brilliance, subject experts we are now trying to find through the United States to come in to guide us, legal experts, contractual experts, all sorts of experts tothat are really specific subject matter experts to what we're looking for in order to create the right stuff. **42:00** but we have prettya pathway already for the IT staff for better, for worse, NC Tracks is truly, almost there. The reality is since January that was likeI came in where I came in. So when I came in and I saw, I kind of know what happens there and there is no option just get it over the finish line.
RH: just get it done
AW: just get it done. And then we can go back and say we need a little bit more this, a little bit morebut just getthisdone. And we are going to get this done, we are going to push it over July 1 and we are going to pull it over to July 2 and by January we will be kind of okay. So that part, the payment concept and the new NC Tracks, actually since 2008, they made that name change, which is astonishing to me that since 2008 were also calling it MMIS. But anyway, the NC Tracks offers now an opportunity to deal with the multiple stuff that originally was notso now we're equipped to handle if company A in all these zones and all these are applying things differently, this will allow us to do that.
RH: and give you analytics
CS: yes, yes.

AW: so that's concept of the payment stuff is plus or minus, we are on in and path of that. And we are also on the payment model part and also on the IT part, the eligibility part, of who is actually eligible
RH: which is NC FAST
AW: what we are on that path, and that we are pretty firm and solid on and we are getting to that October 1 and we will probably get that it adhering and aligning with the federal government on that date and we are moving along on that. So we've got that IT stuff that was already started and we just, improved it and put the force of under the microscope since January 1 of moving it with all of the resources that we have and all of the expertise that we got from the outside to get it done. So that is the IT staff. So then we've got, the second part is the whole person, the person as a whole, and the duplication and the administrative hurdles, will that's what you're trying, that's exactly what we're trying to do, I mean, how can you possibly practice medicine these days? I mean it is just…
RH: it's difficult
AW: yesmy hat off to everybody. So we're trying to figure out how to create, take away hurdles as opposed to creating new hurdles. How to streamline things. How to make things lessand what do I mean by that? What these care entities**44:30** we want to create something that is that base that every single one of them has to do. Everyone in the state who is a healthcare provider or patient, the government, everyone knows what's expected. Align yourself here. Nonnegotiable. Nowhere's the goal. Whatever you do between this, okay. Now you can figure out with creativity and innovation do more of this or less of this or do it this way, do it that way, go for it. **45:00** As long as you get to this, we are all fine. And I don't have to micromanage you

because that's how we get into trouble. Why do we have issues and Medicaid because everything is scripted. Everything is scripted! Why are we in a difficult structural situation inside of HHS because everything is scripted. I meanFrom the Legislature trying to help us, guide us, oversee us, manager us, we are **over**-regulated. **45:30** when you are over regulated you can't work.

RH: let's interesting you talk about thatyou have been in the state for a while, Carol you have not, you know we had an attempt of being not quite so scripted in the mental health system in community support.
AW: yes.
RH: there are some creative business folks out there who took advantage of an opportunity between here and there.
AW: but you have tobut at the end of the day
RH: I think that's why Medicaid ends up being so scripted. **46:00**
AW: Right. Right. And we agreeBut if you look at it from a different point of view, and of course we are not all angels if God made us all angels we would not meet the legal system. I understand that. But being the devil's advocate on the other side of it, it does appear at times that laws do not prevent bad people with bad intentions from doing bad things. But there are situations and appearance we are laws prevent good people with good intentions from being creative to accomplish good things. And that's balance between that is what we are trying to strike. And encouraging people to think with all good intentions of this, what are the downside of creating this law. Now. What's the upside and what's the downside of it? And take away maybe some of the stuff where what you get, that the up and down are not balanced. **47:00** Where you're preventing this much bad (holds hand down low), from doing this much good happening (holds hand up high), because of a law. So, the opening up of an ability within guidelines and a framework and some kind of accountability system to allow people to get to a goal

CS: and that's for the measurement of outcomes and what we define as outcomes **47:30** what do we define as metrics that we are going to start watching very closely.

RH: not just process measures but outcome measures.

CS: no, in Louisiana we called it the brochure mentality. I am successful because I did 100 brochures and had 3 meetings. Well did anybody... did anybody quit smoking, did anybody lose weight. No. I don't know, was the answer. I don't know. So how do we move from that to well, we had 5 people lose 20 pounds, and get off their hypertension medication. Or we made sure that everybody in our pool had their eye exam and the foot exam annually at least. And we lowered their A1C scores by 2% each year. So that is owing to be the critical component for making sure, that and there will be financial measures and all of that. We're going to have a very responsive trigger point of both quality and financial management to make sure, **48:30** and a very quick action item, action scenario, so that someone doesn't languish in a system where it's stumbling along and it's not doing what it needs to do for folks.

RH: and one just one last question, looking at political relationships, I know that you raised money for the governor. Did you folks raise money from anyone in the managed care industry?

AW: you mean personally did I?
RH: yes
AW: no.

RH: do you know if the governor did?
RD: I don't have that
RH: I was curious about that.

RH: Okay for nowis our time up.
RD: yes it is
RH: That's what I figured, but I have 2 more questions but…

AW: And Rose, if you need very specific subject , short answers just scoot it over to Ricky, because Ricky will get it to one of us who can find something specific because the problem is that this is really complicated. And so, when folks with good intentionswith really good intentions try stuff people inventWe will be able to find who what where, not everything but maybe we can be of some assistance in some stuff. If you feed it through Ricky Ricky may be able to between <interference> Be able to come up with some stuff.

RH: one other thing is when are we going to be able to see the RFIs. Now I know that there are redacted versions for people who have proprietaryInformation. Again, it's that whole what's the squishy part therewhen are we going to be able to see those?

AW: what did we already release, we released the names?
RD: the list.
AW: I think the only things that were excluded from the list so far were from legal counsel just a few individuals, people would send us suggestionsunless he really presses on that let's leave well enough alone. We're trying to do the right thing and why bring them into this. So we didn't release that to you and we are right now making sure that we adhere to all of the laws that are necessary for us to adhere to. And I think that that's presently behind 2 doors from us right now.

RH: so I know that in the RFI it did say that entities that wanted to protect some information were toso you do have redacted versions
AW: and we certainly will not release this becausewe're trying to follow the law from all sides because that is our goal. Everything is so that we are in line with following law. So the if we have the redacted versions that that is one aspect and the unredacted that's another aspect.

CS: But soon.
RH: Soon. OK.
CS: Soon.
AW: literally, literally

RD: our one legal counsel…
AW: just remember Rose, 18,000 people, we have one...
RH: attorney
RD: who is here 24 hours a day, sometimes.
AW: I don't know how else to impress on everybody, dear legislature, you have authorized

only one…

RH: that begs to me the question of admin, going back to them and saying we need …

AW: and we are in a process of that, I think the governor is now resolving that for us.
RH: and if you made a big deal over the fact that the admin is broken then how can you go back to them and say we need more admin?
AW: no no no no no. Update about the legal staff, we have one in-house counsel who is paid by DHHS but obviously we have a lot of legal cases as you knowso our legal agreement is that who works with us are from the Department of Justice attorneys.

RH: gotcha
CS: we have 25 DOJ attorneys working on Medicaid issues
AW: so some days we have between 40 and 60 that we pay for and there are more efficient ways of doing that.

RH: Okay thank you so much...