

Richard Clarke: Magellan CEO plows ahead with 1-year extension  
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The Guardian Interview

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Three months after he took charge of Maricopa County's behavioral health contractor, Richard Clarke got the results of a blistering court-ordered audit that said his agency was failing to properly treat more than two-thirds of the county's seriously mentally ill.

A few months later came the budget cuts, whacking about \$9 million from Magellan Health Services' bottom line. Shortly after, Clarke told county health officials that Magellan would stop paying for extended court-ordered treatment for certain patients brought to Desert Vista psychiatric hospital, launching a still-simmering contract dispute.

And as the Connecticut-based firm begins the third year of a \$1.5 million state contract to administer behavioral health services to about 80,000 people, the governor has proposed taking nearly half of Magellan's clients -- and about one-fifth of its contract -- and moving them to AHCCCS as part of a court order to reform the system.

Still Clarke and Magellan persist, winning a one-year contract extension last week and preparing for midyear budget cuts that could eliminate the crisis system and all but wipe out care for the mentally ill who don't qualify for Medicaid.

Magellan in August completed transitioning the system's 23 clinics and urgent psychiatric center to provider groups, a key part of the company's contract with the state Department of Health Services.

In an interview with the Guardian last week, Clarke said he wants the community, the Legislature and the governor's office to know about steps the company is taking to improve care for the mentally ill and those struggling with substance abuse. Initiative includes allowing consumers and the public to compare clinics online using more than a dozen indicators, from how many people find work to the level of staff turnover; retraining case managers; lowering caseloads and vacancy rates; combating suicide; and tracking prescribing practices.

Clarke, an avid bicyclist and opera season-ticket holder, said he's not discouraged by Magellan's rocky first two years, impending budget cuts, battles with the county and service providers, and looks forward to the reforms promised under the Arnold v. Sarn class action lawsuit. He's plowing ahead.

Q. Providers are concerned about paying for non-title 19 (serious mentally ill patients) whom they say they don't have the money to care for. How are you negotiating that?

A. There's no question that there are not enough resources to meet the needs of everybody who has a behavioral health need. Dr. (Laura) Nelson stood up in a legislative hearing almost a year ago now and said the system is under-funded statewide

by \$800 million.. So there already isn't enough money... In Maricopa County alone, almost \$17.5 million was cut between '09 and '10 out of the behavioral health system. When you don't have \$17.5 million, you've got to figure out what you provide, what you don't provide and how you resize your system in those areas. And so policy decisions have been made by the department and we've been executing on those as the vendor responsible for this. And what we have attempted to do is share some of that responsibility. So in '09 when we got the first \$9 million of cuts to the system, providers only experienced \$1.5 million of those cuts. We absorbed the entire remainder ourselves...

Q. How did you absorb \$7.5 million here?

A. We took it out of our bottom line... We can generate 4 percent, and we didn't generate it. We lost \$1.7 million our first year... Any company wants to break even at a minimum. Nobody wants to lose. The providers don't want to lose. We don't want to lose.

Q. Are they losing money? This is unclear to me as I talk to providers around the system.

A. I don't believe providers are losing. Last year when the provider system lost \$2.5 million of tobacco tax money, we were told by the department to eliminate services that were being funded by the tobacco tax by \$2.5 million. We didn't think that was the right decision. So what we did was, we eliminated \$2.5 million of tobacco tax money, but we gave \$2.5 million of titled resources to every organization that had tobacco tax money.. Now they had to serve a different population because that money can only be spent on the Medicaid population, but we kept the organizations whole. The organizations lost \$2.5 million, but we moved the money around and they stayed the same. So when you ask, did they lose, it's a complicated question. They lost some funding, but they gained funding in other areas and the overall bottom line of their company stayed the same.

We could save several million dollars if we mandated generic formularies for any medication in which there's a therapeutic equivalent in the generic market. And in a system that we have no money, and you know there's a therapeutically equivalent generic, why would you pay \$1,000 for a brand name when you know there's a generic for \$100?

Q. And you can't make that happen administratively?

A. Right now that requires policy change from the department... people have been unwilling to make that kind of mandate. What they allowed us to do is make that kind of change for non-titled SMI individuals. And we've initiated that already and that's going to save money for the system. But we could save \$6 million maybe if we did the whole population...

Q. Their contract, as I understand it, says they have to take all comers. And that's one of the concerns that they have. That they don't have a limit.

A. No, that's not true. What we asked them to do is, if they going to stop serving somebody, they have to make a request to us as the RBHA that they're going to stop. Intake agencies are a different story and crisis is a different story, because they have to serve everybody. So we're very responsive to that scenario and we have a large system

right now. So if one organization doesn't have enough money to serve individuals, they have to make a decision from their standpoint. Do they want to use their charitable dollars or do they want to use their reserves that they've built over time to serve that individuals?

Q. They're saying that they're out of (reserves). That they're turning people away.

A. Some of the smaller organizations, yes. But the larger organizations, you can pull their (tax-exempt IRS form) 990s up and take a look at all of them. You'll be able to see the reserves that they have. So people have to make those decisions, how they want to spend their money. And if they don't have the ability to do that, I have other organizations that do have the ability to do that... they come to us, we then will refer somebody to another organization. So I believe there's plenty of capacity right now.

Now will there be in January? Probably not, if we have to come up with \$68 million out of the Department of Health Services. The system is going to get resized in very significant ways. And I think we've got to do a whole bunch of things that we should be executing now and not waiting for January. We should examine whether we or not we want to pay 10 days of detention for people awaiting court hearings on court ordered evaluation. Is it better to hire a couple more public defenders at a couple hundred thousand dollars and get a new judge in there and expedite these hearings so you can get it done? Because if we could shorten it from 10 to five days, we could save \$3.4 million as a system. And we wouldn't have to cut that out of somebody else's services. I also think it's a human rights violation to be holding people in a setting because you're waiting for a court hearing to determine whether they should be on court-ordered treatment. Other RBHAs use out-patient court-ordered evaluation and court-ordered treatment. Why aren't we using that?

Q. Why aren't we?

A. It's just the system hasn't operated that way...

Q. Where do things stand right now in terms of your contract negotiations with MIHS (Maricopa Integrated Health System)? They believe that they aren't required to pay for anything beyond the first 72 hours.. You're in a contract dispute, right?

A. We're working on our 2010 contract. I don't see us in any kind of contract dispute. They have concerns about the implementation of the detention period and the decision from a policy standpoint .. not to pay for the detention period or for court-ordered treatment for non-title, non-SMI individuals. We believe we're doing that within the context of the law and within the context of current regulation and policy with the department. They have a slightly different perspective.

They're serving the individuals and we're referring the individuals to them. And we're talking about.. how to shorten detention periods and to convert people. And I'll say what I've said constantly -- 75 percent of all the individuals that come into that system in a non-title status are converted to either SMI, title status or have already Medicare or other insurance available to them. So 75 percent of the total population that we're talking about has a payer source. Maybe not right at the beginning. So we've been working with them to escalate the payer source quickly. We're putting people in their facilities to do the evaluations and get them done quicker. We went eligibility people to the UPC to start the process there so we can get it going before they even get there...

Q. What happens when you've got to cut \$68 million from the Department of Health Services, if that comes to fruition? How can you continue any of this?

A. We have to make decisions about what we provide services for. What I've said, and I said in that legislative hearing shortly after I got here -- this state is faced with a policy decision that needs to be done by the Legislature. And that policy decision is threefold. What's the public's responsibility, for whom is that responsibility to be executed for, and for what range of services? And that has to be answered. And if we don't answer those questions we will be continually wondering how we're serving people. Because there will be no rational approach to resource allocation.

Q. Is the Legislature sort of abdicating its responsibility in that regard?

A. I don't think so. I think that Sen. (Carolyn) Allen and Rep. (Nancy) Barto held those legislative hearings to start getting a handle on that. I think the budget process overtook everybody and I think these are issues we're going to have to grapple with as we move forward. I feel positive in the fact that we have a governor who is so strongly supporting behavioral health care... (The health department's 15 percent scenario) is an approach that cuts services. There are many other things that we can do, like the generic formulary, the detention period. We could narrow the SMI eligibility criteria to match what 90 percent of the other states in the U.S. have so that you don't serve everybody. We could initiate a federal poverty level for behavioral health, which we don't currently have which AHCCCS already uses...

Q. Regarding the proposal that the governor submitted to the court this week, it's not what you would've proposed, as it essentially takes half of your client base and moves it into AHCCCS.

A. It takes about 17 percent of the overall funding. It's a fairly large population, but a fairly low cost population to serve. I want to look at that plan and I want to talk about it more and I know the governor's staff and the department will be engaging in those conversations with us. Integration is a good concept, physical and mental health integration, and there are many ways to do that... I always worry when you decide to take a component of that system and move it under another authority because then you automatically don't have a system of care any longer. And there are difficulties that can accrue because of something like that. Your coordination issues can become difficult because that population still uses our urgent care system, but the health plans would not be responsible for that. It's short on details.. There are issues with individuals who have behavioral health issues don't feel comfortable talking about these issues with their physical health practitioners. So they don't go...

Q. It wouldn't necessarily change who they see and what they see them for.

A. All of that is unclear in terms of their behavioral health care. We have a number of health plans, who would get to make decisions about who they contract with and who they don't contract with. What you see across the country when you carve in is, the health plans then restructure the rates and they try to squeeze the rates and the rates actually get lower for providers. So some providers may not want to take that rate any longer. And then you've got people contracting with multiple entities. You'll have to have a TERROS contract with 10 different people as opposed to one person to deliver a

range of services. All those questions are unanswered yet, but those are the questions that come to mind about the consistency and the continuity of services.