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Integrating physical health: What were the costs to behavioral health care clinics?

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ABSTRACT

Objective: To inform providers and policy-makers about the potential costs of providing physical health care in mental health clinics.
Methods: Cost data were collected through interviews with 22 behavioral health clinics participating in New York State Office of Mental Health's health monitoring and health physicals programs. The interview data was combined with financial reporting data provided to the state to identify per interaction costs for two levels of physical health services: health monitoring and health monitoring plus health physicals.
Results: This study gives detailed information on the costs of clinics' health integration programs, including per interaction costs related to direct service, charting and administration, and total care coordination. Average direct costs per client interaction were 3 times higher for health physicals than for health monitoring.
Conclusions: Costs of integrating physical care services are not trivial to mental health clinics, and may pose a barrier to widespread adoption. Provision of limited health monitoring services is less expensive for clinics, but generates proportionally large non-clinical costs than health physicals. The relative health impact of this more limited approach is an important area for future study. Also, shifting reimbursement to include health care coordination time may improve program sustainability.

1. Introduction

Adults with serious mental illness (SMI) suffer disproportionately from physical health conditions, such as diabetes and hypertension, for which they often receive low quality care [1–4]. In recent years, efforts have been made to integrate treatment for these conditions into specialty mental health clinics, the clinical settings through which many adults with SMI access the health care system [5,6]. Provision of primary care services to adults with serious mental illness in specialty mental health clinics has been found in randomized controlled trials to improve quality of physical health care [7,8]. The Substance Abuse and Mental Health Services Agency (SAMHSA) supports mental health clinic based primary care services through its Primary Behavioral Health Care Integration (PBHCI) grants, which have been awarded to over 160 mental health clinics across the country since 2009 [6,9,10]. However, the financial sustainability of integrated care models, particularly for clinics that do not have dedicated external grant funds, remains a challenge [11–13]. Information on the costs of providing these services is essential for clinics considering adding primary care to their scope of practice and for Medicaid and other state and federal payers and policy makers interested in designing payment systems to support these services.

While a number of studies have examined the costs of integrating behavioral health care into primary care clinics [14,15], such as the Advancing Care Together program [16], little is known about costs of integration of physical health care services into behavioral health clinics. The one study which has examined costs of providing medical management of physical health conditions in a single behavioral health clinic found that the costs were unsustainable without higher enrollments in Medicaid [13]. No studies have examined component costs to multiple clinics for providing these services and how these vary by the level of services provided by clinics. In addition, existing data systems at the majority of clinics are limited to services that were billed to payers, but many physical care services were never billed. Thus, interviews with the clinic staff are the only source of comprehensive information about the workload associated with physical health programs

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in behavioral health focused settings.

In 2010 the New York State Office of Mental Health (OMH) introduced regulations designed to promote physical health care in mental health clinics by allowing reimbursement for limited services through Medicaid [17]. This study uses detailed cost interviews with a sample of the clinics that enrolled in that program to examine the incremental costs to clinics of providing different types of physical health services. The data are used to identify and compare the major cost components associated with different levels of care that can be provided in mental health clinics, including direct patient interaction, charting, and care coordination costs. Results from the New York experience can inform decision-making by clinics as well as state and federal policy makers.

2. Methods

2.1. Health services programs in mental health clinics

In 2010 NYSOMH introduced new regulations designed to promote physical health care in mental health clinics by allowing reimbursement through Medicaid. Specialty mental health clinics had the opportunity to enroll in two levels of integrated health services, health monitoring and health physicals [18]. OMH defined health monitoring (HM) as the ongoing assessment of specific health indicators associated with increased risk of medical illness and early death, including but not limited to blood pressure, body mass index, smoking, activity or exercise level. HM services can be provided by an RN, LPN, physician, nurse practitioner, or physician's assistant. OMH guidance defines health physicals (HP) as a comprehensive physical evaluation including age and gender appropriate history, examination, and appropriate laboratory or diagnostic tests. Only physicians, nurse practitioners, and physician's assistants are eligible to bill for HP services under this program. HP can only be billed once annually, but HM can be billed on a frequent basis. The vast majority of clinics that enrolled chose to implement HM only (177 clinics) or for both HM and HP (111 clinics), effectively creating two groups of clinics, with lower (HM only), and higher (HM and HP) levels of integrated physical health care.

2.2. Clinic sample

Clinics were selected for the cost interview based on their enrollment in either the HM only or HM and HP program and an established record of providing HM and/or HP services as evidenced by Medicaid claims and encounters in OMH data warehouse. Clinics were also selected to represent a diversity of geographic locations across the state, and clinic affiliations (hospital-affiliated, government, or free-standing). Research methods were approved by RAND's Human Subjects Protection Committee.

2.3. Data sources

Data on costs of providing physical health care services were collected through interviews with clinic staff. Supplementary information was drawn from certified financial reports submitted annually by clinics to the NYS Department of Health and the Patient Characteristics Survey, a bi-annual census of mental health clinics conducted by the NYS OMH [18].

2.3.1. Interviews

Telephone interviews were conducted in collaboration with the Office of Mental Health, by a cost analyst and a research assistant with clinic directors, leadership and health and billing staff between April 2015 and November 2016. The interviews followed a structured interview guide that was adapted to the purposes of this study from the Treatment Cost Activity Tool (TCAT) [11] and the TCAT-Lite [19], both of which were originally designed to collect costs on substance use treatment. The instrument was redesigned to assess the incremental costs to the clinics associated with provision of physical health services, i.e. costs incurred through the provision of these specific services over and above the cost of operating as a mental health clinic.

Prior to each interview, respondents were given a cost template in spreadsheet form. The cost template was then filled in during the course of the interview. Answers to questions requiring more detailed examination of administrative records were provided to the research team by clinic staff by follow-up email or phone calls. The interview form is available from the authors.

2.3.2. Financial reports

NYS requires mental health clinics to submit Certified Public Accountant certified financial reports on an annual basis through the Consolidated Fiscal Reporting System (CFRS). Information on clinic budgets, client population, staffing and staff costs were obtained from the 2015 fiscal year reports.

2.3.3. Clinic census

Data on clinic characteristics were drawn from the 2015 Patient Characteristics Survey (PCS) [20]. The PCS is conducted every other year and collects information on caseloads over a one week period for all mental health clinics in NYS.

2.4. Types of health services

Physical health services were defined to include HM and HP, as described above, as well as care coordination for management of physical conditions. Care coordination related to physical health care included communication with internal and external providers regarding treatment planning, health status, or referrals.

2.5. Analysis by cost components and service type

All cost estimates were measured in 2015 dollars. To reflect the diversity of care provision across clinics in our sample, we generated average and median costs by cost component and service type. Costs were divided into clinician costs and overhead:

2.5.1. Cost of physical care clinician effort

A bottom up approach was taken to estimating the costs of paying staff to provide care, based on the time required to deliver HM or HP services, including time spent on direct patient services as well as clinician time spent on administration and charting per interaction.

Clinic interview data was used to identify the types of clinical staff used to provide HM and HP services at each clinic. Clinic CFR data was used to determine the annualized cost of these staff, and an average cost per minute was calculated for the HM and HP clinicians. A mean time per HM or HP interaction was calculated from clinic interview data. When more than one type of clinician provided services, we developed a weighted mean for the cost of their time. The average cost of clinician time per interaction was calculated by multiplying the mean cost of the clinicians' time per minute (from the CFR) by the mean time spent by the clinicians on direct patient care, and on administrative and charting (from the clinic interviews) for HM and HP services.

Clinics also reported on the type of staff and total time spent weekly on physical health related care coordination. Information on costs of different staff types was drawn from the CFR, and was used to calculate the average annual cost of providing health related care coordination.

2.5.2. Facilities and administrative overhead

Two types of overhead costs, facilities and administrative personnel, were calculated by allocating total overhead costs as reported in the CFR. The total annual non-personnel facility cost from the CFR was divided by total annual clinical staff FTEs to create a facility cost per clinical FTE, and a facility cost per clinical staff hour. The facility cost