Why Do Psychiatric Clinic Costs Vary by 1030%:
A Review of the Efficiency of Freestanding Clinics

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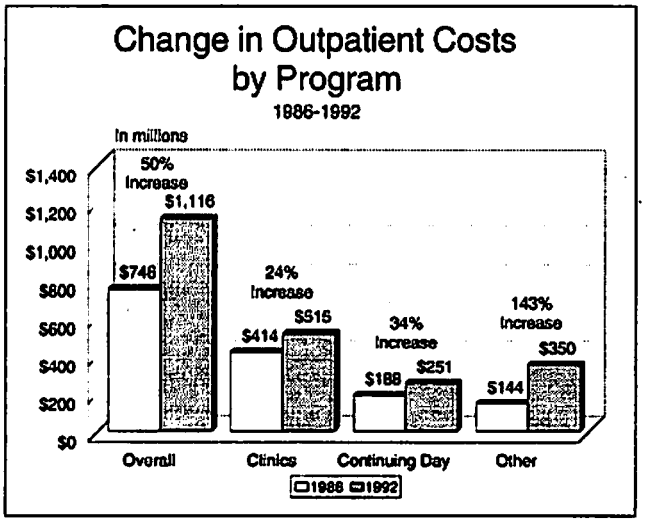
NYS COMMISSION
ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

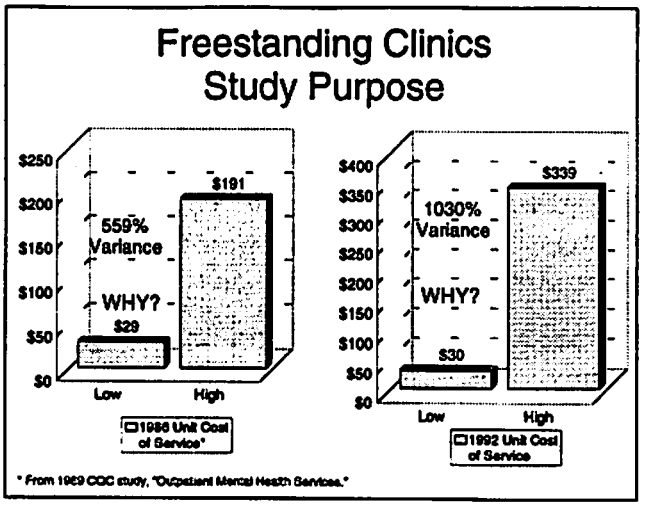
Executive Summary

In 1989, in response to a request from the State Legislature, the Commission conducted a study of outpatient mental health services which concluded that, despite an investment of three-quarters of a billion dollars annually, there was little accountability for the services being provided.[1] The Commission found wide variations in the actual per unit cost of providing similar outpatient services.

In this follow-up study, the Commission attempted to determine the reasons for the wide variations in the cost of clinic services, which are the largest category of outpatient programs, accounting for the expenditure of $515 million of the total $1.1 billion spent on outpatient mental health services in 1992. In the interval since our prior study, the cost of the clinic program had grown by 24%, or some $100 million.



This study examined the costs of 188 clinics operated by voluntary agencies (144) or county governments (44) which accounted for 42% ($217 million) of the $515 million spent in 1992. The ***variation*** in the cost of a unit of service of these clinics had almost doubled from 559% in 1986 to 1030% in 1992.



Findings

The Commission found that four factors substantially explained the wide variations in the cost of services.

1. Method of Payment for Clinicians' Services

   Clinic operators using a primarily salaried work force had over double the unit costs of those using contract clinicians, who were paid only for the services they actually delivered (Report pp. 10-11).

2. Clinician Productivity

   Programs where clinicians averaged one to two units of service per clinician had unit costs 185% ***higher*** than programs where clinicians produced over five units of service per day (Report pp. 11-12).

3. Hours of Operation

   Clinics that were open 40 hours per week or less had average unit costs 58% ***higher*** than those open over 60 hours, apparently because longer hours permit scheduling clinicians to work peak hours on nights

[1] *Outpatient Mental Health Services*, July 1989.

and weekends which are more convenient for some patients (Report pp. 12-13).

4. No Show Rate

   Clinics that had a higher rate of patients who did not keep scheduled appointments had higher average unit of service costs than those with low rates of "no shows" (Report pp. 13-14). However, less than a third of the providers kept track of their "no show" rates.

As important as it is to note the relationships between provider practices and their costs, it is equally important to note expected relationships which do ***not*** exist.

- The study found ***no*** correlation between the severity of mental disability of the patients served by clinic programs and the unit cost of service (Report pp. 14-15).
- Examples were found of both county-operated and voluntary agency-operated programs, regardless of whether they employed contract clinicians or salaried employees, that were equally efficient in providing services, suggesting that auspice of service alone is not a significant factor in cost efficiency (Report pp. 19-20).
- Finally, given the state policy since 1991 to provide a Medicaid payment supplement of up to $83.20 to the base Medicaid fee to clinics in the Comprehensive Outpatient Program (COPs) which have agreed to improve clinic service access to seriously and persistently mentally ill adults and seriously emotionally disturbed children, one would expect COPs programs to be serving more such patients. However, the Commission found that non-COPs programs were serving a ***higher*** percentage of such patients (47%) than COPs providers (42%) who were receiving these subsidy payments (Report pp. 1, 4-5, 15).

It is clear from this study that the management practices of clinic programs substantially affect their cost-effectiveness, and in turn affect the expenditure of public funds for these services. Yet, there has historically been no state oversight or scrutiny of these practices to encourage or require greater accountability.

The Commission recommends that the State Office of Mental Health, which licenses these clinic programs:

- require programs whose unit of service costs significantly exceed the statewide average to implement cost reduction efforts including tracking clinician productivity and setting performance standards, and reducing client "no show" rates;
- gradually reduce governmental subsidies to inefficient clinic providers; and
- form a task force with counties and voluntary providers to reduce paperwork and increase computerization.

A draft of the Commission's report has been reviewed by the Office of Mental Health and a response from the Commissioner is appended to this report.

The findings, conclusions and recommendations reflect the unanimous opinions of the members of the Commission.

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Chapter I
Introduction

Background for Study

In 1989, in response to a request from the State Legislature (Chapter 50, Laws of 1988), the Commission completed a study of mental health outpatient services including: clinics, continuing treatment programs, day treatment programs and other outpatient services. The legislative request stemmed from its concern that, although the State of New York spent more per capita than any other state on these services, its system did not seem to be responding to the needs of the state's most seriously mentally ill residents.

The Commission's July 1989 report to the Legislature entitled *Outpatient Mental Health Services* found that, despite the state's sizable investment of three-quarters of a billion dollars annually on mental health outpatient services and more than 950 licensed programs, there was little scrutiny of program cost-efficiency, service priorities or effectiveness. There were virtually no performance standards for the various outpatient program types, no clearly defined priority population to be served, and wide variations in the actual per unit cost of providing similar outpatient services of from 545 to 2,000 percent.

The study also found that, while eligibility for federal Medicaid/Medicare reimbursement significantly influenced New York's reliance on clinically-oriented outpatient programs, federal funds played only a modest role (13%) in their financing. Meanwhile, the availability of close to one-quarter billion dollars in deficit funding from the state and local governments had the perverse effect of removing provider incentives for limiting costs. Inefficient providers were frequently rewarded with higher levels of reimbursement than more efficient providers.

The Office of Mental Health (OMH) agreed that the outpatient mental health system had not been responsive to the needs of the seriously and persistently mentally ill and acknowledged that accountability for performance of the outpatient system had been lacking. It supported the Commission's recommendation for improved information systems to track fiscal performance and agreed to evaluate the continued use of deficit financing of non-state programs.

OMH responded by requiring all outpatient providers to file standardized Consolidated Fiscal Reports (CFRs) which are certified by independent accountants to assure the uniformity and accuracy of reported program revenues, expenditures, and service units. CFRs provide OMH with baseline unit cost data which could be used for informed planning and fiscal decision-making.

OMH also established Comprehensive Outpatient Programs (COPs) to furnish outpatient providers with supplemental payments under Medicaid for providing priority service access to adults with serious and persistent mental illness (SPMI) and children with serious emotional disturbance (SED). COPs also substantially reduced reliance on state/local deficit financing by shifting costs to Medicaid which provides 50 percent federal matching funds.

Despite OMH's commitment to improving its local program performance monitoring systems and reducing deficit financing, no systemic effort has been undertaken to assess the efficiency and effectiveness of the outpatient system as noted in the Commission's 1989 report. Instead of financial incentives to limit costs, unit cost variations have widened as high cost providers have continued to be rewarded through subsidy payments for their underlying inefficiencies. Moreover, New York's fee-for-service approach actually encourages agencies to provide more services, regardless of need, quality, or service outcomes.

However, while these underlying inefficiencies remain unaddressed, an analysis of outpatient costs from 1986 (baseline data used in the Commission's 1989 study) to 1992 indicates a significant growth in expenditures of about 50%, rising from $746 million to over $1.1 billion (Figure 1). Clinic programs continue as the largest single segment of the mental health outpatient services system with costs increasing by 24% from $414 million in 1986 to $515 million in 1992 (Figure 2).

Looking at 1992 clinic expenditures by provider auspice reveals that freestanding mental health clinics[2] account for 42% of overall clinic expenditures, hospital-based clinics 40%, and state-operated clinics the remaining

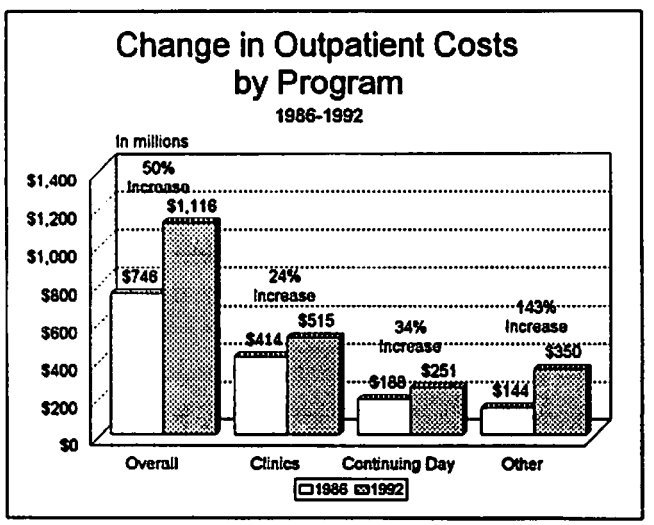


Figure 1

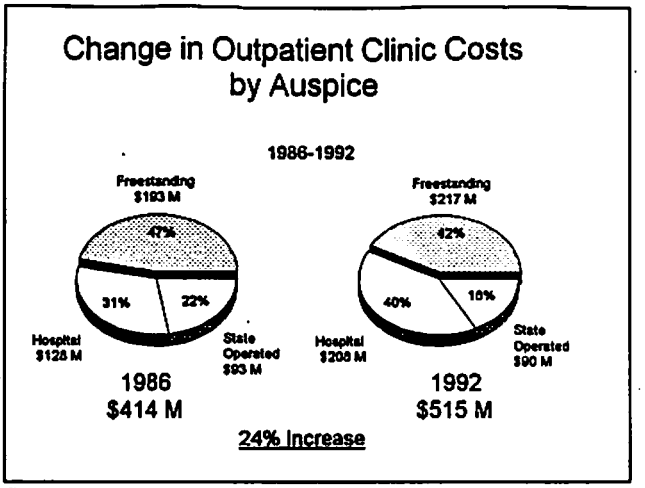


Figure 2

18%. Thus, by focusing on the $217 million freestanding clinic portion of outpatient services, this study examines a vast and costly segment of the state's public mental health outpatient system. It also examines and tries to determine why the variation in "weighted" cost per unit of service for therapy sessions at freestanding clinics has widened from 559% in 1986 to 1,030% in 1992 (Figure 3).

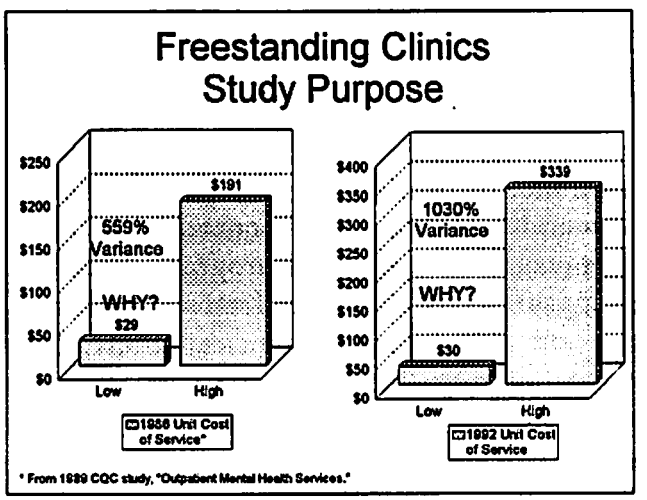


Figure 3

By examining the costs and services of freestanding clinics operated by county and voluntary agencies during 1992, this study takes a necessary first step toward identifying the underlying factors contributing to the high cost of the state's outpatient services. It analyzes whether the differences in cost are because of the disability level of recipients served or other controllable operational factors. What

[2] Clinics not co-located with general hospitals or psychiatric centers.

it does not do is assess outcome or recovery, results which at the outset of this study OMH and Commission staff agreed would be difficult to measure because of the lack of methods for determining the effectiveness of care. OMH supported the Commission's cost efficiency focus which could help it restructure the financing of outpatient mental health services.

Objectives and Methodology

The Commission's primary study objectives were to determine the reasons for ever-widening variations in voluntary and county clinic unit costs and to identify the key factors driving clinic costs. The information sources used to make these assessments were the 1992[3] CFRs and a Commission survey completed by clinic programs that were in operation during 1992.

In conducting this study, the Commission:

- Met with OMH executive staff to discuss clinic operations, cost, and productivity issues.
- Conducted four clinic provider pilot visits to identify key cost efficiency issues and obtain survey design input.
- Correlated provider survey data collected with OMH's computerized CFR information, and analyzed the data and performed statistical analyses to isolate factors impacting on clinic operating costs.
- Reviewed CFRs and financial statements for outlier clinics[4] to obtain a better understanding of the factors causing wide cost variations.
- Visited 11 clinics statewide to further clarify the underlying reasons for the variations in unit costs.

Hospital-Based Clinics

In planning this study, the Commission intended to conduct a second stage evaluation of the relative unit costs of clinics operated by state psychiatric and general (Article 28) hospitals. These clinics generally have higher average unit costs than freestanding county and voluntary-operated clinics largely attributable to the "step down" of hospital and/or state overhead costs.

[3] July 1, 1991 - June 30, 1992 for New York City providers and calendar year 1992 for the rest of the state. This time period was selected because it was the only year for which OMH had a validated CFR data base available at the onset of the Commission's study in mid-1994.

[4] A clinic provider incurring a unit of service cost 50% below or 50% above the mean unit cost of service for all freestanding clinic providers.

Chapter II
Clinic Provider Profile

Clinic Services and Reimbursement

OMH-licensed freestanding psychiatric clinics furnish outpatient treatment services to both chronic and non-chronic mentally ill adults and/or children to reduce symptoms, improve their functioning and provide ongoing support. Upon entry into a clinic program, a person's treatment needs are assessed and a treatment plan is developed. Clinics principally address treatment needs through individual verbal therapy sessions, most often conducted by social workers or psychologists, which typically last from 30 minutes to one hour. In those instances where recipients require medication during the course of treatment, psychiatrists periodically furnish 30 minutes of medication therapy. A clinic program may also provide case management, crisis intervention and clinical support services.

Review of 1992 revenue at clinics showed an increased dependence on Medicaid (54%) and lessening dependence on state/local deficit financing (22%) since the Commission's 1989 study when Medicaid revenue was only about 25% and there was heavy reliance on state/local funding (Figure 4). It also revealed that clinic revenue by funding source shifted away from state to the federal government i.e., federal (29%), state (25%), and localities (21%)[5] (Figure 5).

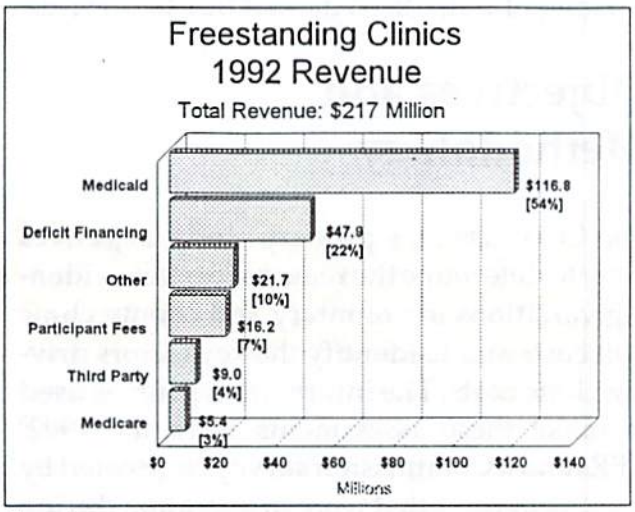


Figure 4

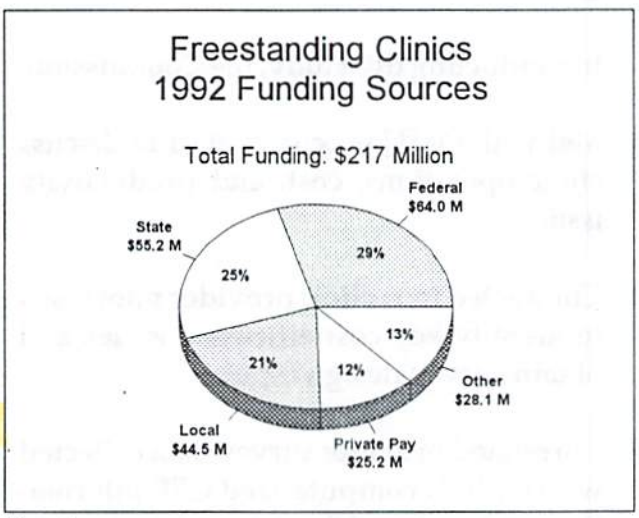


Figure 5

Much of this shift was accomplished by adding a COPs supplement to the base Medicaid fee. Providers receive a base fee ranging from $53 to $60 for each full Medicaid clinic visit, depending on location. COPs providers agreeing to meet OMH requirements for fur-

[5] Comparable percentages for all outpatient services in the 1989 *Outpatient Mental Health Services* study were: federal (13%), state (54%), and localities (18%). Discrete data was not available for freestanding clinics, but it is likely that such percentages mirror the aggregate outpatient data.

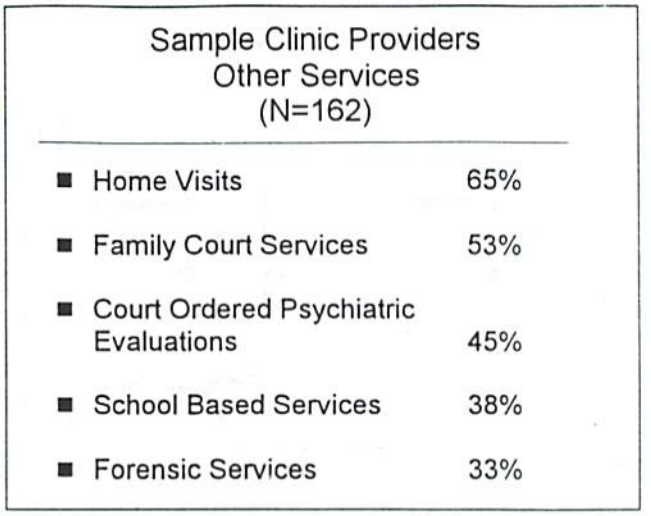
nishing priority service access to SPMI adults and SED children are eligible to receive COPs supplements of up to $83.20 per visit. The COPs add-on is agency-specific and adjusted annually based on a formula which combines historical and current Medicaid units provided with each agency's base year fiscal deficit. Despite COPs supplementation, clinics with too high a unit cost or too few base Medicaid units continue to require significant infusions of state/local deficit financing.

Other Services

Survey responses revealed that many clinics also furnished other recipient services including: home visits, family court services, court-ordered psychiatric evaluations, school-based services, and forensic treatment (Figure 6). During field visits, providers stated that they received insufficient or no state reimbursement for furnishing these costly and time-consuming services which contributed to their clinic program deficits. Forty-eight percent of the respondents indicated there was a significant fiscal impact associated with providing these other services; 42% said the fiscal impact was negligible (Figure 7).[6] Nevertheless, the average unit cost was found to be *lower* ($89.35) for those clinics claiming these services greatly increased their costs than for those reporting a negligible fiscal impact ($101.36) (Figure 8). Since this differential impact on unit costs was not in the direction expected, it appears that the amount of these other services is modest, perhaps reflecting the absence of direct public financing for them.

Clinic Provider Overview

In 1992, there were 188 voluntary/county clinic providers in New York State serving the mentally ill. Over three-quarters were operated by voluntary agencies and about one-fourth by counties (Figure 9). Similarly, voluntary providers accounted for 80% and counties



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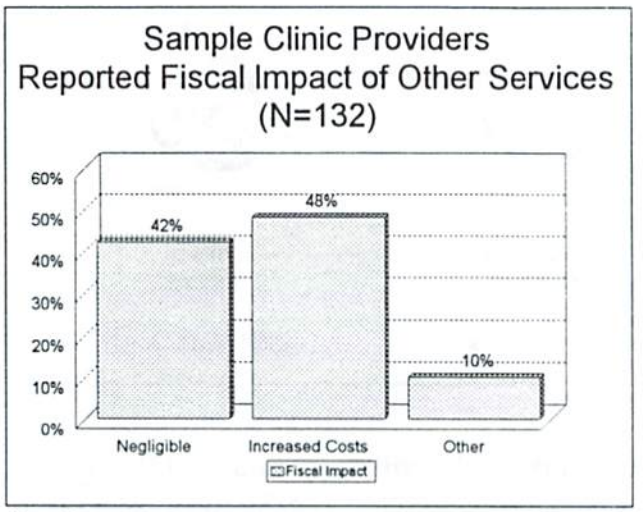

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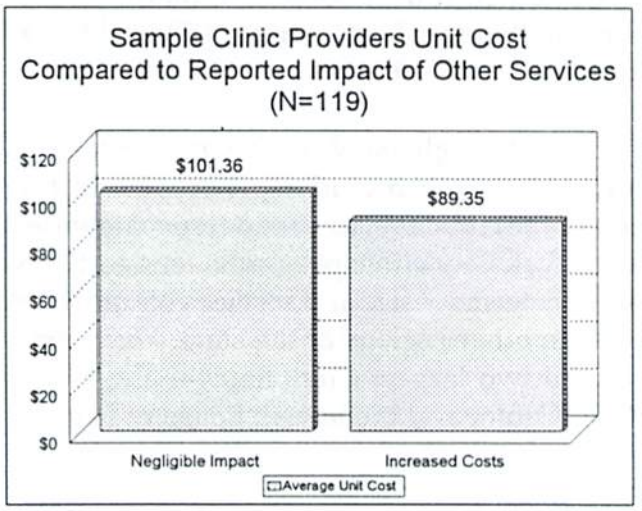
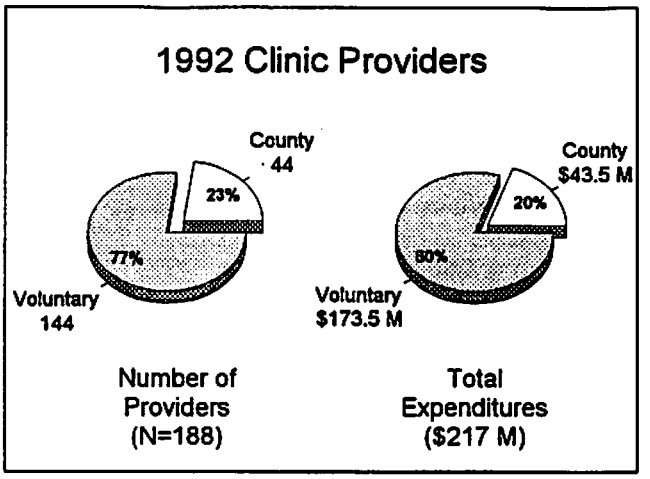


Figure 8

[6] Since providers did not furnish responses to all survey questions, the "N" value in some of the report figures is less than the 162 total survey responses received.



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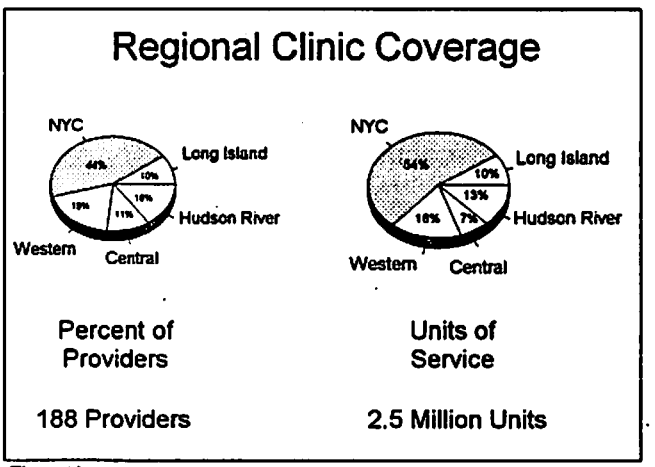


Figure 10

20% of the $217 million in total 1992 program costs. Nearly half (44%) of the clinic operators were concentrated in the New York City Region, while the remainder (56%) were located in the other four regions: Western (19%), Hudson River (16%), Central (11%), and Long Island (10%) (Figure 10).

Even though New York City contained only 44% of the providers, it accounted for 54% of the clinic services rendered statewide. New York City clinic programs tended to be larger in terms of size and service volume than those in other regions of the state. For example, the two largest City clinics--New Hope Guild Center and the Jewish Board of Family

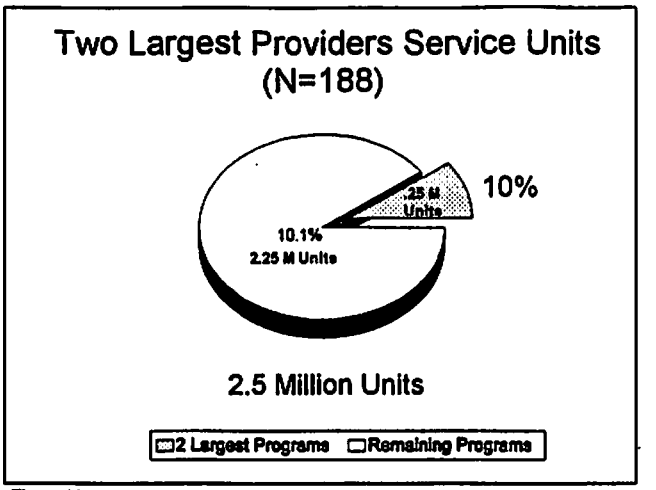


Figure 11

and Children's Services--generated a combined 10% of the 2.5 million service units provided statewide in 1992 (Figure 11).

Expenditures by Category

As shown in Figure 12, when direct care personal service (39%), fringe benefits (8%), and contract clinician costs (8%)[7] are combined, they account for the majority of clinic expenditures at 55%. Additional payroll and related costs are included in the program (18%) and agency (14%) overhead categories for supervisory and administrative personnel. Expenditures having a less significant impact on

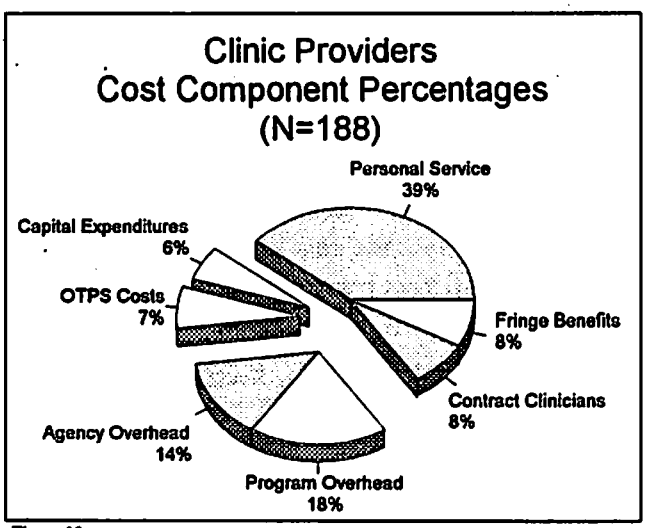


Figure 12

[7] Contract clinicians are generally paid for completed sessions rather than through a fixed salary. As such, there is a strong incentive for these clinicians to be productive by assuring that their work schedules are full, recipients keep scheduled appointments, and duration of sessions and paper work are "efficiently" performed.

total clinic costs are other than personal service (adjusted to exclude contract clinician costs) (7%) and capital expenditures (6%). Thus, with these heavy personnel costs it should not be surprising, as found in the following two chapters, that therapist practices (e.g., clinician productivity, use of contract clinicians) will be significant contributing factors to clinic performance and cost.

Weighted Service Units and Costs

For performance measurement and accountability purposes, OMH requires providers in completing their CFRs to assign weights to units of service provided based on type and/or duration. These weights are classified as: full[8] (1.0), brief (0.5), and group (0.35) visits (Figure 13). Using OMH's CFR data base, the Commission determined that 2.5 million weighted clinic units of service were generated in 1992 by voluntary (2.1 million or 84%) and county (.4 million or 16%) providers (Figure 14). For a sample of providers, the Commission analyzed their discrete service data and found that almost 90% of the weighted units were for full visits, while the remaining 10% were equally divided between group and brief visits.

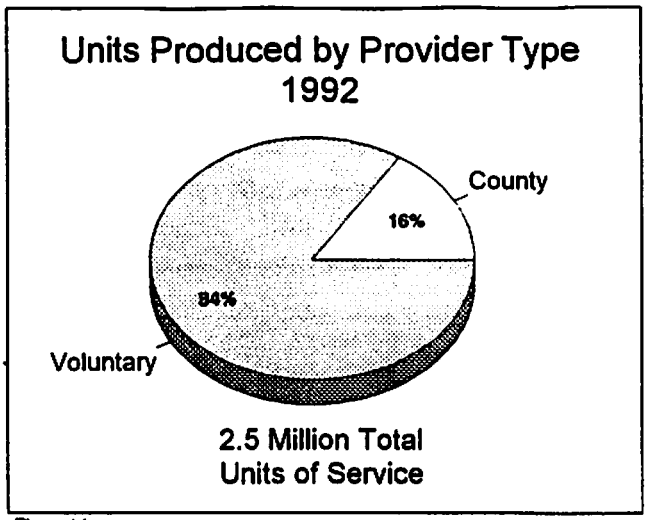
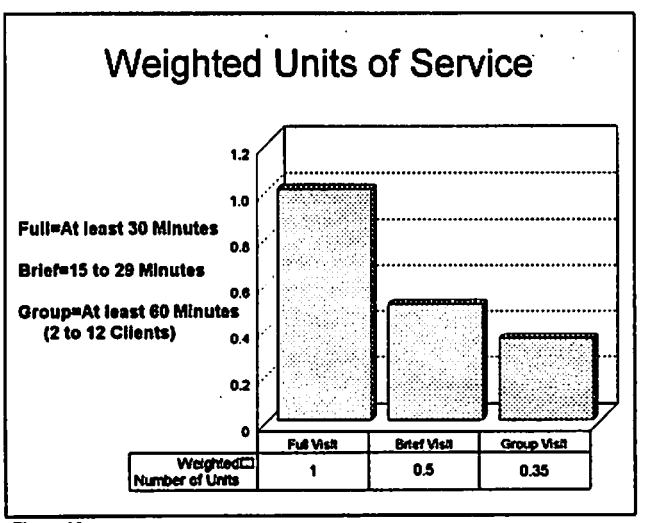


Figure 14

After correcting for provider CFR reporting errors, the Commission used OMH's methodology for calculating unit cost by dividing *each* provider's 1992 total clinic treatment costs by the number of weighted units produced. A statewide arithmetic average of these individual provider unit costs was then calculated to be $96.26[9]. Using this method, the average voluntary provider unit cost was computed to be slightly lower at $94.49 than county clinics at $102.04 (Figure 15). This can be attributed to the fact that county clinics are slightly less productive and tend to pay their clinic employees higher wages and fringe benefits than the voluntary agencies.



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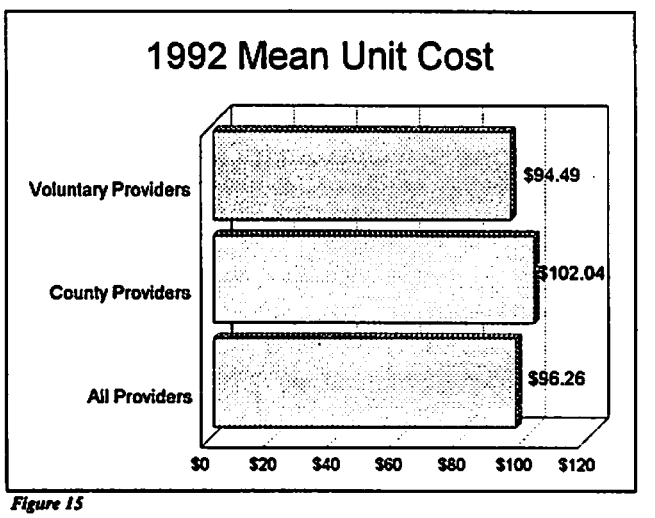

Figure 15

[8] Full clinic visits represent a variety of face-to-face interactions between the patient and therapist lasting at least 30 minutes, including: regular, home, crisis, pre-admission, and collateral (with or without the patient) sessions.

[9] The "aggregate" average unit cost for all clinic programs at $86.80 ($217 million + 2.5 million units) is approximately $9 lower than the $96.26 arithmetic provider average. This study uses OMH's provider-specific method because it correlates with the Commission's study focus on individual provider unit costs. Moreover,

Figure 16 shows the distribution of unit costs for county and voluntary providers. Although the majority (52%) of provider unit costs cluster in the $51 to $100 range, there are a substantial number (39%) with unit costs over $100 for therapy sessions generally lasting 30 minutes to one hour. Only 9% of the clinic providers have unit costs under $50.

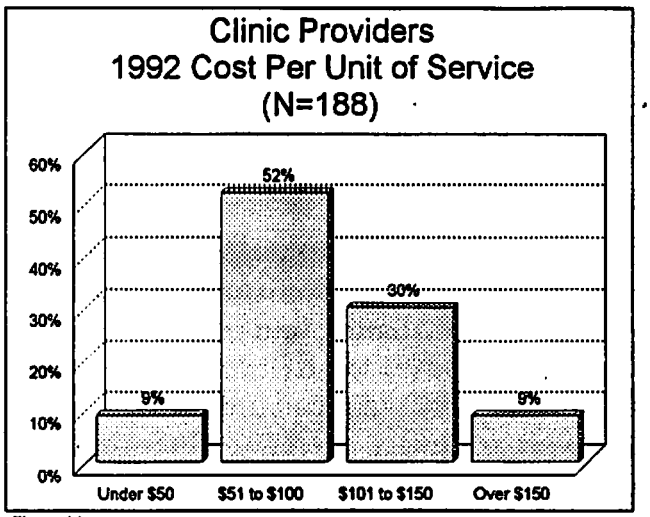

Figure 16

The average unit cost by OMH region ranged from a low of $78.09 in the Central Region to a high of $108.74 in the Long Island Region (Figure 17). The Central Region's average unit costs were less because clinic payroll and occupancy costs tend to be lower in this largely rural area of the state. Long Island's average unit cost was much higher due to its concentration of more costly, low service volume providers. The relationship between unit cost and certain program and productivity determinants is discussed in Chapter III, Clinic Survey Results.

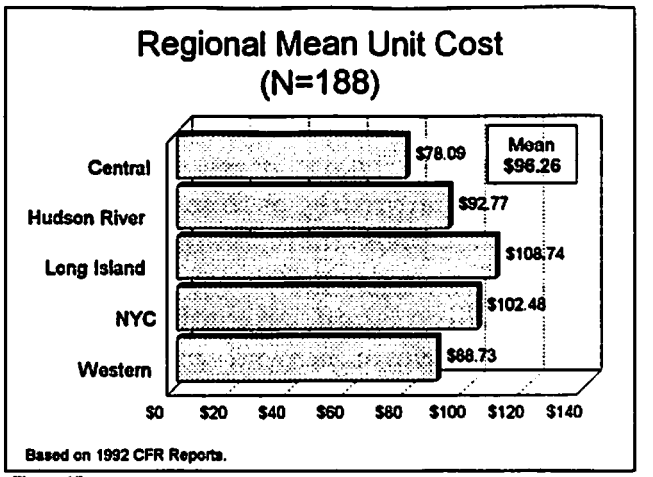

Figure 17

Chapter III
Clinic Survey Results

Clinic Provider Survey

To further assess clinic practices and their impact on operating costs, the Commission--with input from OMH officials and clinic providers--designed a provider survey to gather descriptive data to supplement the cost and unit of service data obtained from operator CFRs. The draft survey was pilot tested with several clinic providers to assure its accuracy and completeness. After revision, the final survey document was sent to the 188 county/voluntary providers operating clinic programs during 1992. (See Figure 18 for a listing of the major survey data points utilized.)

Survey Data Utilized

- Types of Clients Served
- Clinic Site Profile
- Clinic Operating Hours
- Other Clinic Services
- Recipient No-Show Rate, Actions to Control
- Clinicians: Payment Method and Productivity
- Clinic Changes Desired

Figure 18

Survey responses were received from 162[10] of the 188 clinic providers in nearly the same proportion as the population by provider type (Figure 19). Additionally, the mix of survey respondents by region matched the population (Figure 20). The returns mirror the universe of voluntary/county clinic providers at the 95% confidence level.

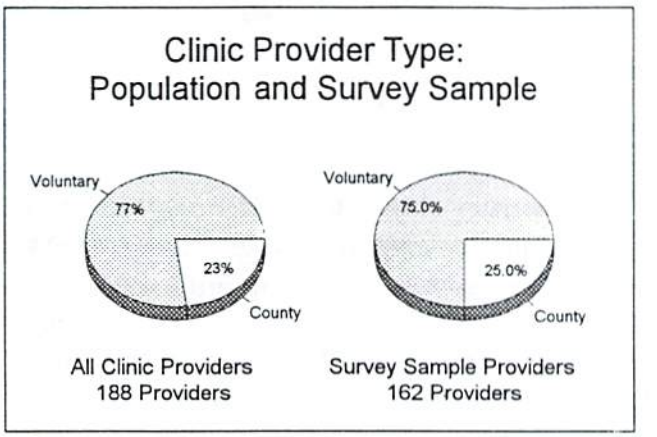

Figure 19

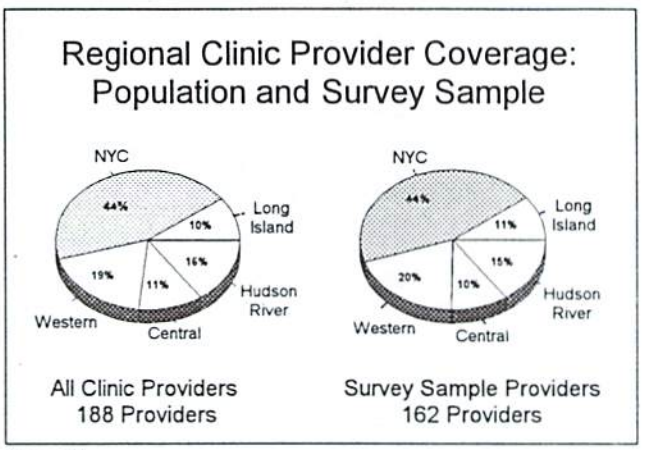

Figure 20

Provider Sites, Recipients and Expenditures

The survey data reveal that the respondents operated a total of 485 clinic sites[11] in 1992. Nearly one-half of the 162 clinic programs operated a single site; by comparison, 19% of the providers operated five or more sites (Figure 21).

[10] Includes survey responses from the ten largest New York City providers in terms of service units. These providers accounted for 25% of the units provided statewide in 1992.

[11] Includes licensed clinic and adjunct satellite locations.

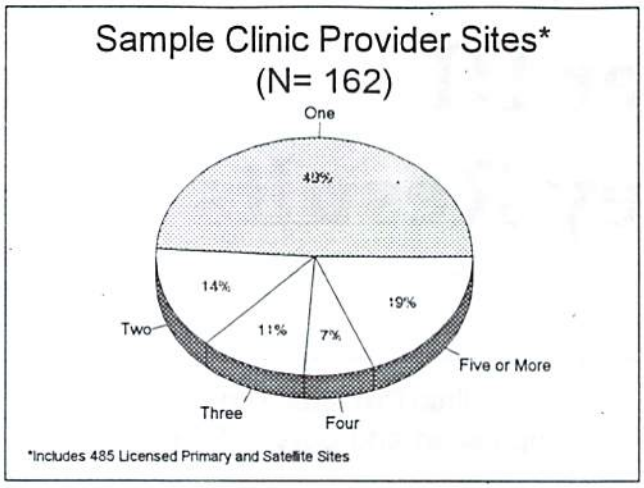

Figure 21

The survey shows too that most providers operate smaller size clinic programs--with 50% of operators serving 750 recipients or less and 27% serving 751 to 1,500 individuals. Larger providers serving over 1,500 recipients constituted the remaining 23% (Figure 22).

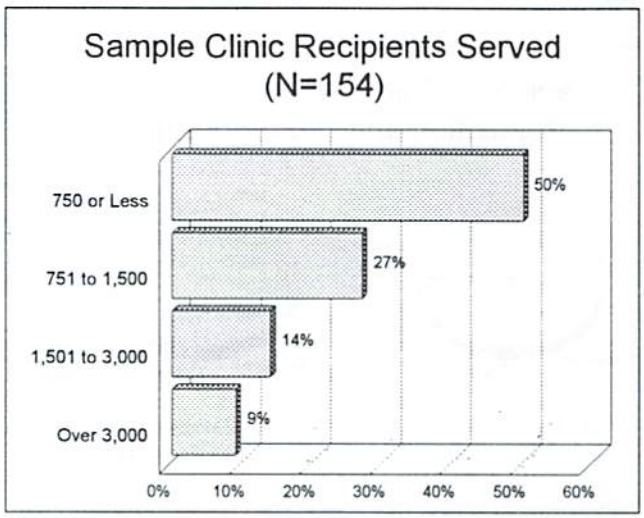

Figure 22

Total expenditures provide further perspective on the scale of provider clinic operations. As reflected in Figure 23, the average sized clinic expended $1,220,225 in 1992. Sixty percent of clinic providers incurred operating costs totaling $1 million or less, while 22% expended over $1 million to $2 million. Only 9% had total costs of over $3 million.

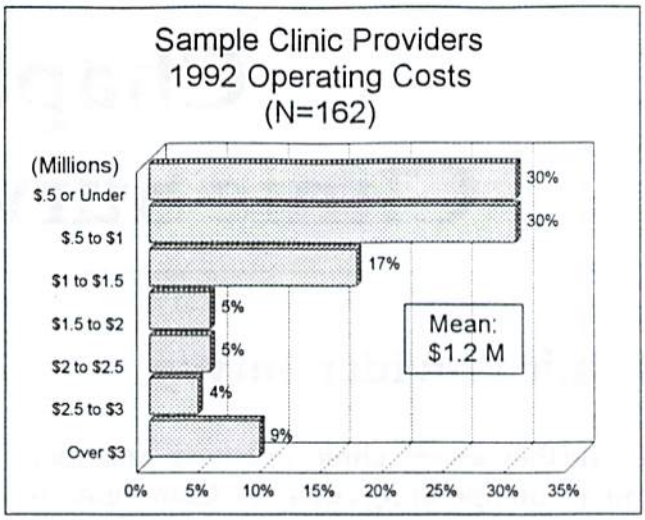

Figure 23

Factors Impacting Cost

While clinic operating costs tended to cluster as outlined above, the Commission found that clinician unit of service production often varied widely for providers within the same cost ranges. In analyzing the wide variance in unit cost, the Commission focused on the following five factors which were identified in consultation with OMH and providers as potentially impacting cost:

- Clinician payment method
- Daily clinician unit of service output
- Hours of operation
- Recipient no-show rate
- Percentage of chronic (SPMI & SED) individuals served

Clinician Payment Method

The Commission found that providers paid their clinicians on either a salary or contract basis. In general, contract clinicians were less costly than salaried therapists. They received

no fringe benefits and were usually paid only for completed therapy sessions. Since they do not get paid for recipient "no-shows," there is a strong financial incentive for contract therapists to assure that individuals attend their scheduled sessions. Consequently, average unit costs tend to be lower at agencies where contract therapists were used.

Analysis of 1992 provider-reported clinician payment methods revealed that 78% of the clinicians were salaried and 22% on contract (Figure 24). By provider type, county-run clinics employed more salaried clinicians (86%) than the voluntary providers (75%). The difference is reflective of a small group (14%) of voluntary providers employing 75% or more contract clinicians, while no counties reported this high a proportion of non-salaried workers (Figure 25).

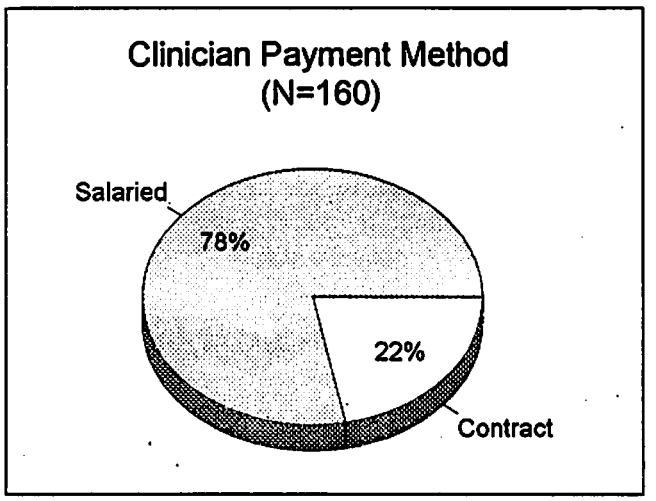

Figure 24

When the Commission analyzed the relationship of clinician payment methods to unit cost, it found that operators using a primarily salaried work force had over double the unit cost ($106.68) of those using primarily contract clinicians ($51.90) (Figure 26). However, as noted in Chapter IV, site visit results revealed that despite the overall cost advantage of using contract clinicians there were some very cost-efficient providers that employed

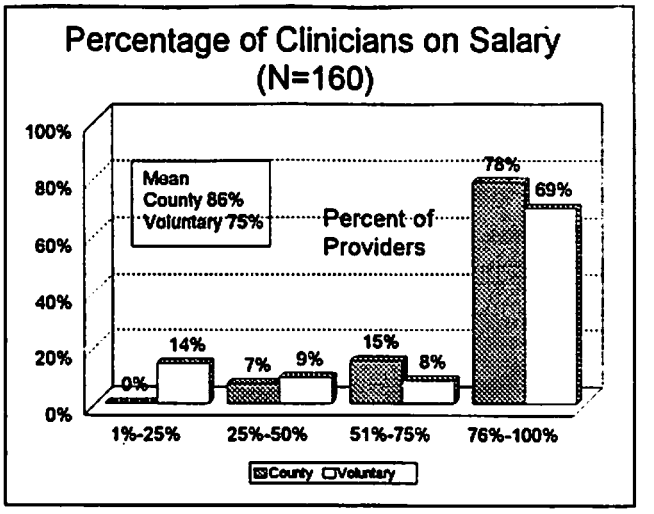

Figure 25

salaried clinicians. Moreover, while using contract clinicians can facilitate clinic cost reduction objectives, they are less likely to furnish the comprehensive array of treatment and support services which persons with serious mental illness require to adequately function in the community.

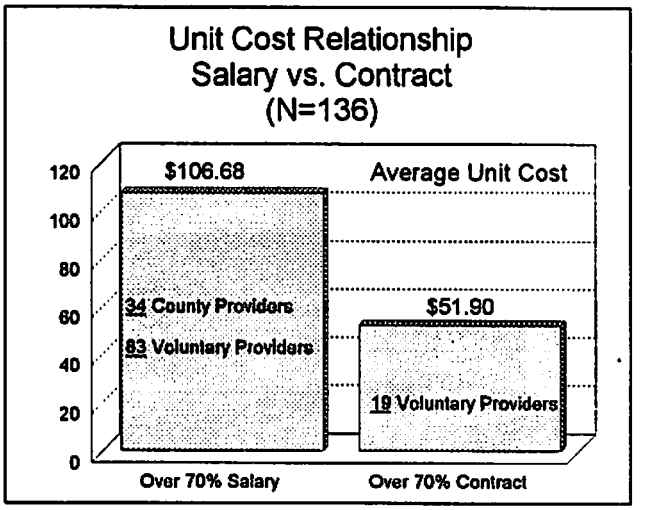

Figure 26

Daily Clinician Unit Output

To assess clinician productivity and its influence on provider unit cost, the Commission developed a standardized formula for calculating daily clinician output. Using data from the CFR, the Commission recomputed clini-

cian Full Time Equivalents (FTEs) to include both salaried and contract therapists based on a 37 1/2 hour, 48 week work year, totaling 1,800 labor hours. The resulting total FTE figure was divided into the provider's total weighted units of service recorded on the CFR to compute an annual average clinician unit of service production figure. It was converted to a daily measure by dividing annual clinician production by 240 yearly work days. (See Figure 27 for an example).

Computation of Clinician's Average Daily Unit of Service Output

Average Daily Unit of Service Output =

(A) Compute Full Time Equivalent (FTE)
Total Annual Clinician Hours/1,800 Hours
(48 weeks x 37 1/2 hrs/week)

(B) Compute Yearly Average Clinician Units of Service Produced:
Divide Yearly Weighted Units Produced by FTE (A)

(C) Compute Daily Unit of Service Output
Yearly Average Units of Service divided by 240 (48 weeks x 5 days/week)

Reported: Total Clinician Hours 9,000
Weighted Units Produced 4,800

9,000 Hours/1,800 = 5 (FTE)
4,800 Weighted Units/5 (FTE) = 960

960 Annual Units/240 (Work Days) = 4 Daily Units

Figure 27

The resultant analysis of this output measure showed that the vast majority of clinicians provided 5 or less units of service per day in 1992, with the average for county and voluntary-run agencies being around 4 units (Figure 28). Since a regular clinic visit usually lasts from 30 minutes to an hour, the Commission calculated that the average therapist was only generating 2 to 4 hours of direct consumer service during a 7 1/2 hour work day.

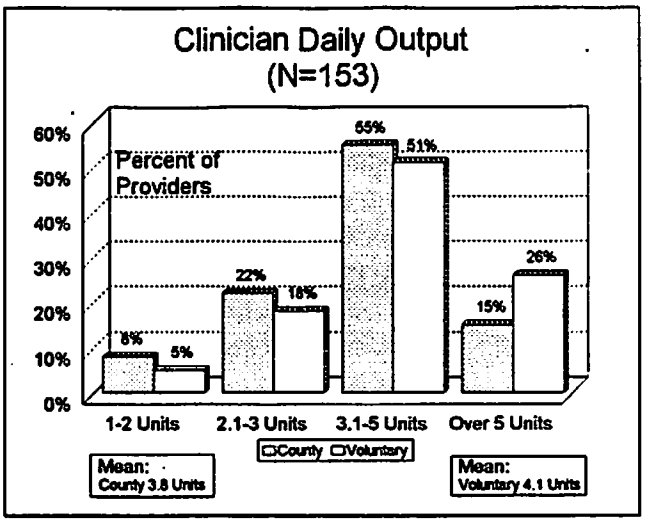

Figure 28

When this output measure was assessed in conjunction with unit cost, the Commission found as expected that the more units produced per clinician the lower the overall unit cost (Figure 29). For instance, very productive programs averaged over five units per clinician and had a unit cost of only $60.25, while those producing a very low output of one to two units per clinician had a 185% higher unit cost of $171.62.

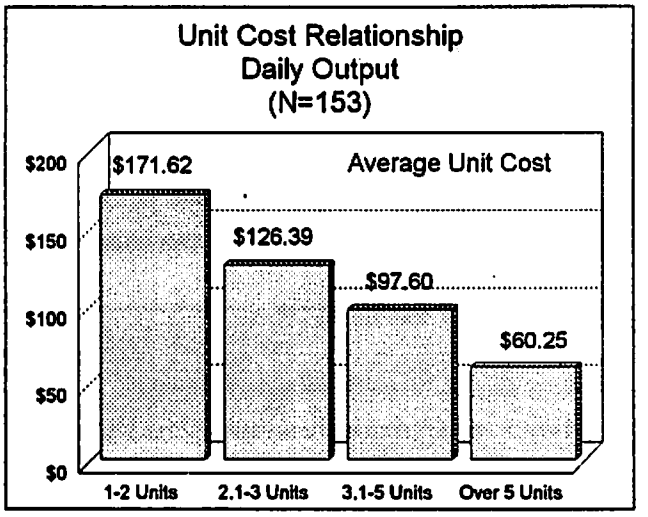

Figure 29

Total Hours of Operation

The clinic survey collected data on the day, evening, and weekend hours when each provider's primary clinic was open. The Commis-

sion's summary analysis showed that only 35% of voluntary clinics were open 50 hours or less, whereas 70% of county clinics were open 50 hours or less per week (Figure 30). This reflects the tendency of county clinics to emphasize a more standard work week.

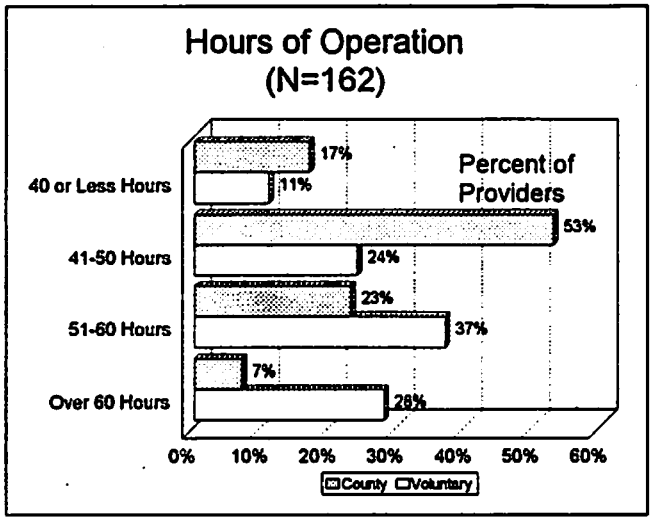

Figure 30

While it might be expected that keeping a clinic open longer would cost more, the Commission found the opposite to be the case; i.e., providers open over 60 hours had an average unit cost of $73.55, while those open 40 hours or less cost $116.23 (Figure 31). An apparent reason for this relationship is that clinics operating longer hours are able to more efficiently schedule therapists to work the peak night and weekend hours when more consumers are available to be seen.

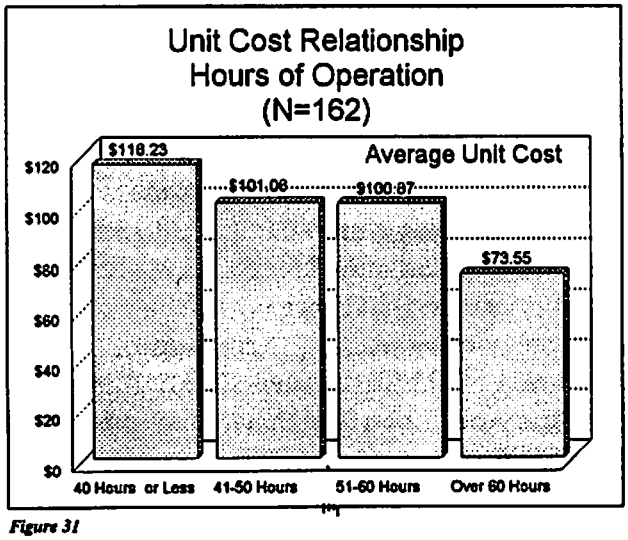

Figure 31

Recipient No-Show Rate

A "no-show" occurs when a recipient misses a scheduled therapy session without notifying the clinician beforehand. This creates unexpected gaps in clinician schedules which often significantly reduces their productivity. This also leads to increased costs of rendering clinic services in this predominantly salaried industry because operators must absorb personnel costs associated with these missed appointments.

Review of overall 1992 recipient no-show rates for clinic providers showed they ranged from less than 10% to over 30% with no significant difference between the rates reported by county and voluntary providers (Figure 32).

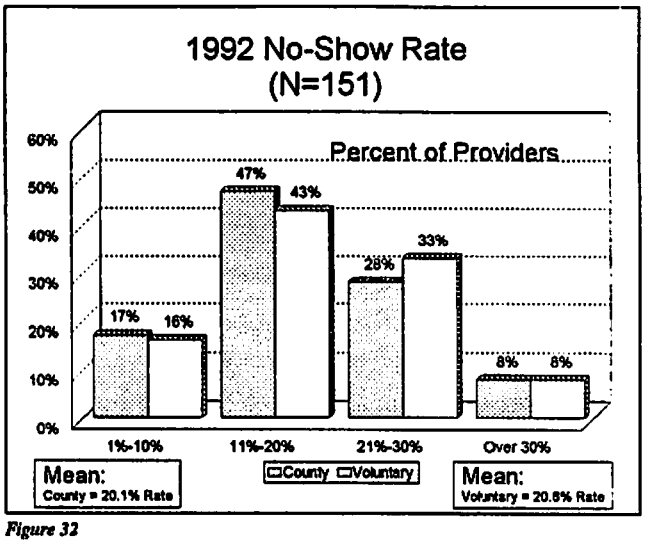

Figure 32

Unfortunately, only 31% of provider respondents knew their actual 1992 no-show rates (Figure 33). Most providers (62%) estimated their rates, while nearly 7% had no idea at all. The primary reason for this data deficiency appears to be that OMH does not require providers to collect this important information. Nevertheless, based on those operators knowing their actual 1992 no-show rates, there appears to be a direct relationship between this factor and unit cost (Figure 34). Unit cost gradually rises as no-show rates increase.

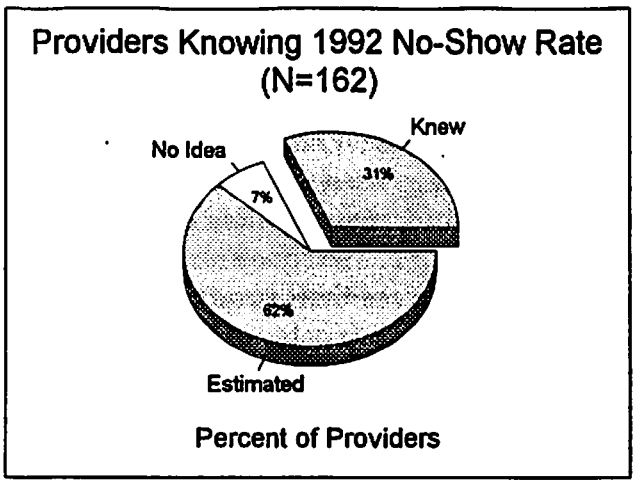

Figure 33

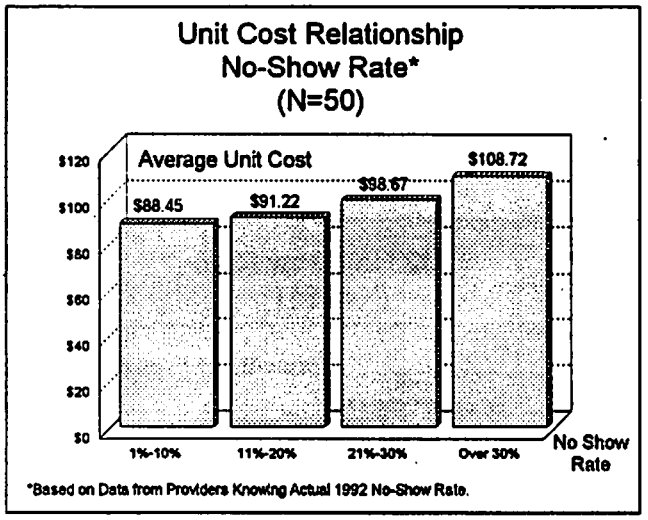

Figure 34

Despite a general lack of formal no-show tracking systems, it seems that providers recognize the importance of controlling no-show rates since survey respondents indicated that a majority send follow-up letters and/or make telephone calls after missed appointments. Another 25% take the preventive step of making reminder phone calls before clinic appointments. Unless providers track and control actual no-show rates, they will have difficulty improving clinician productivity.

Mix of Recipients Served

The Commission's analysis of the ages of 1992 recipients disclosed that clinics on average treated three adults (age 18 or over) for every child (under age 18) (Figure 35). A further breakdown of these individuals by diagnosis status revealed: 56% non-chronic, 31% SPMI adults, and 13% SED children (Figure 36).

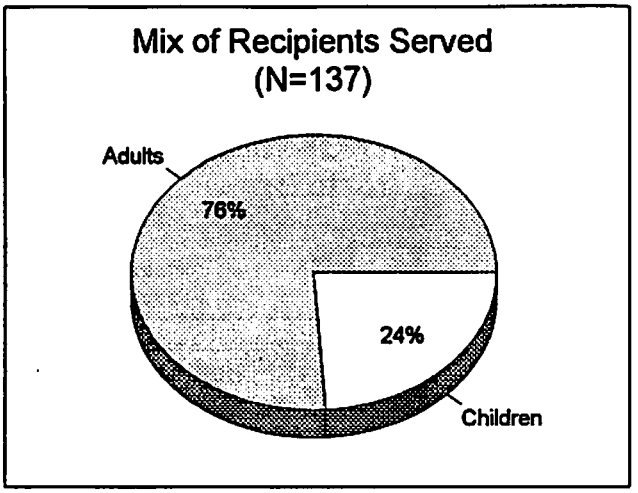

Figure 35

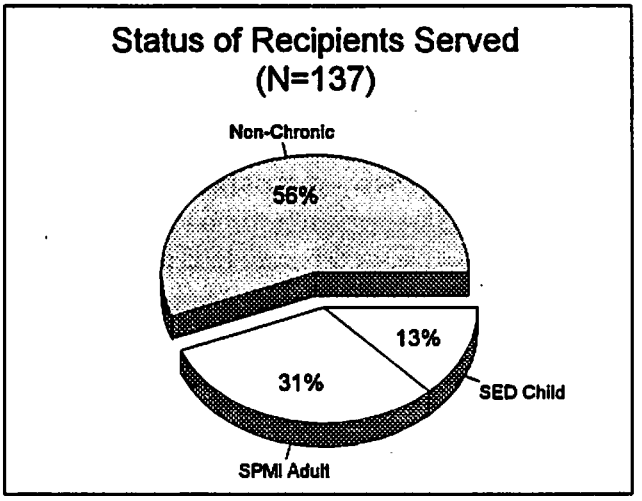

Figure 36

County clinics served on average significantly fewer SPMI adults and SED children recipients than did voluntary clinics (Figure 37). This is likely due to the absence of local government-operated clinic programs in New York City where 53% of the consumers have an SPMI/SED diagnosis compared to 39% for the rest of the state. Although it might logically be expected that there would be a strong correlation between the percentage of SPMI adults and SED children served and unit cost, this study did not find this to be the case (Figure 38).

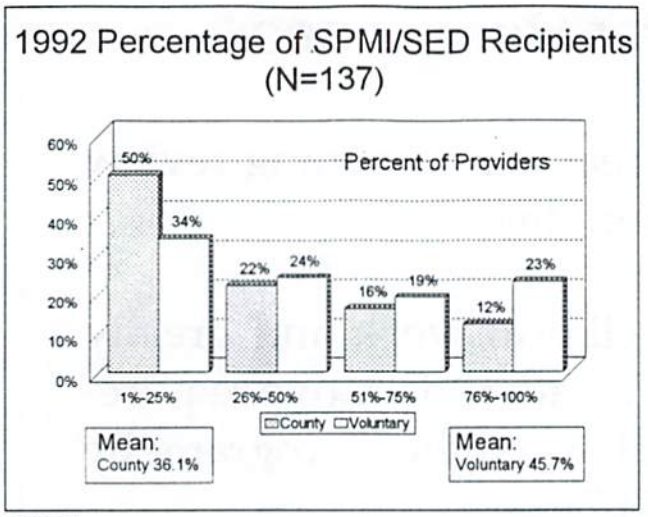

Figure 37

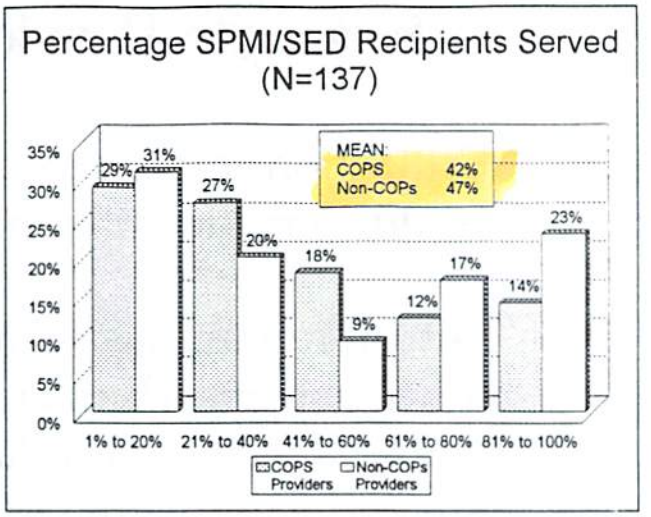

Figure 39

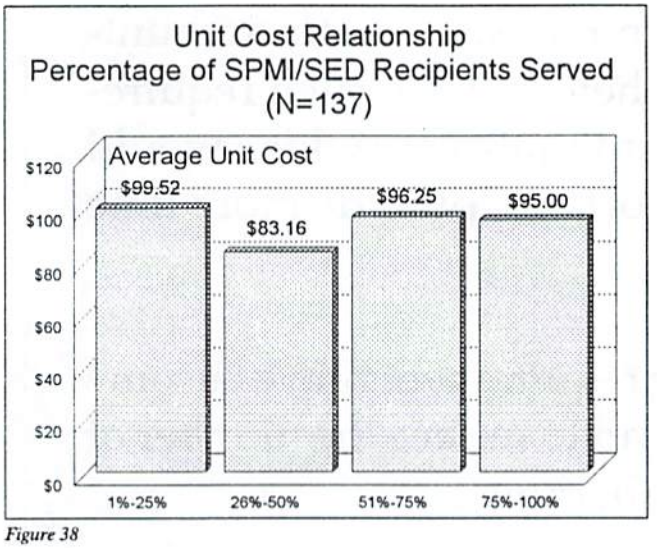

Figure 38

As previously indicated, OMH furnishes through the Medicaid system up to an $83.20 supplement to the base $53 to $60 Medicaid fee to providers that have entered into COPs agreements to improve clinic service access to SPMI adults and SED children. Therefore, the Commission expected to find differences in the average percentages of SPMI/SED recipients being served by COPs and non-COPs clinics. However, the Commission found that non-COPs providers were serving a higher percentage of SPMI/SED individuals (47%) than COPs providers (42%) who were receiving these subsidy payments (Figure 39).

Clinic Suggested Changes

The Commission's survey also asked operators to recommend clinic program changes to OMH. Some 39% of respondents urged a cut in general paperwork, including less frequent updates of treatment plans (every six months instead of every three months) and the elimination of redundant OMH and county reporting requirements. Another 37% called for a general increase in clinic funding levels. About 20% of providers recommended streamlining or eliminating the Consolidated Fiscal Report. (Examples of provider responses are listed in Figure 40.)

Example Provider Responses

- "Utilization review and treatment planning review should coincide with one another."
- "Put more emphasis on clinical work and greatly reduce paperwork and other administrative requirements related to redundant oversight of programs by both OMH and NYCDMH."
- "All funding entities have increased their accountability trails. It would be helpful if all such requirements were incorporated into software which would increase our ability to report and provide more time for services."
- "The client recordkeeping requirements have become so significant that we've had to reduce the number of sessions required by our therapists."
- "Recordkeeping should be streamlined. Treatment plans every three months take away from direct client contact and is not valuable in any way. There are too many picky details required in paperwork that are also not valuable to the clients."
- "Regulation and the increased bureaucracy mean that we must absorb their cumulative costs in ways which detract from our ability to provide direct services."

Figure 40

Chapter IV
Agency Specific Cost Analysis

Analysis Approach

As part of this study, an in-depth review of clinic providers identified as having a very high or low unit cost was undertaken. The Commission believed that studying providers at the extremes of the unit cost distribution would provide further understanding and substantiation of the factors causing wide cost variations.

Using OMH-suggested parameters the Commission identified high and low cost "outliers"[12] as being those clinic providers which had incurred a 1992 unit cost over $144 or below $48. Using these criteria, there were 14 low cost outliers with an average unit cost of $38.98 and 20 high cost ones with an average unit cost of $194.92 (Figure 41).

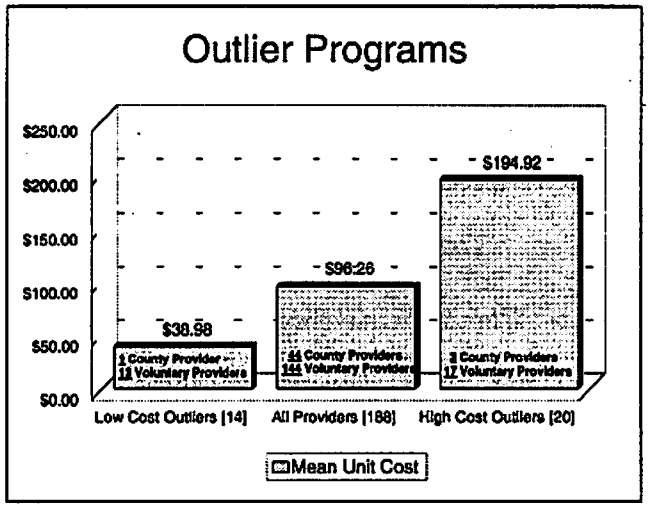

Figure 41

An analysis was then conducted of these providers by comparing the following:

- average total service units produced,
- average total program costs,
- average clinician's daily service units, and
- average total hours of operation.

To further look behind the cost and productivity statistics and obtain a better sense of high and low cost clinics' operating practices, the Commission also conducted field visits to 11 providers, including six outliers. The unit costs at the providers visited ranged from $38 to $232 (Figure 42). Prior to each visit, the Commission analyzed agency CFRs, financial statements, and survey responses. Interview questions were then prepared to address agency specific issues, such as: clinic unit cost, clinician output, staffing practices, computerization, impact of managed care, and duration of therapy sessions. (See Figure 43 for selected field visit comparison results).

Profile of Field Visit Providers

	Region	Unit Cost	Total Cost	Total Units	Clinician's Avg. Daily Units	Clinician's Payment Method	Average Service Duration	% SPMI/SED	Total Operating Hours
High Cost Providers:									
	NYC	$232	$1.8 Million	6,457	1.7	Salary	45 Min	99%	55 Hrs
	Western	$187	$.6 Million	3,051	1.9	Salary	1 Hour	22%	47 Hrs
	NYC	$156	$3.7 Million	21,57	3.6	Salary	45 Min	37%	43 Hrs
Low Cost Providers:									
	Western	$70	$.7 Million	4,079	1.9	Salary	55 Min	23%	52 Hrs
	NYC	$60	$6.7 Million	33,56	5.3	Salary	38 Min	42%	79 Hrs
	NYC	$56	$7.9 Million	101,869	4.8	Contract	30 Min	60%	79 Hrs
	NYC	$51	$1.3 Million	19,63	5.8	Contract	45 Min	38%	72 Hrs
	Western	$49	$2.0 Million	21,222	4.6	Salary	53 Min	97%	59 Hrs
	NYC	$47	$1.0 Million	17,43	9.9	Contract	35 Min	N/A	64 Hrs
	Hudson River	$44	$.4 Million	3,993	5.9	Salary	1 Hour	22%	49 Hrs
	NYC	$38	$1.3 Million	12,93	7.3	Contract	45 Min	0%	66 Hrs

Figure 42

[12] *See, supra,* discussion at p. 3, footnote 3.

Field Visits: Selected Clinic Comparisons

Upstate County Clinic [Salary]

High Clinician Productivity: **5.9 Service Units/Day**

- Well-paid, low-turnover clinical staff
- Microcomputer network used for scheduling, clinician notes, billing, and statistics
- Close service coordination with local social service agencie reduces no-shows
- Clinic administrators work closely with therapists and carry own caseload

Streamlined clinic management with low administrative support costs

Unit Cost $44 **Units Produced: 3,993**

⇔

Upstate County Clinic [Salary]

Low Clinician Productivity: **1.9 Service Units/Day**

- High use of clinician staff for forensic services
- Focus on clinician team approach
- Main clinic in remote location
- Minimal computerization. Use off-site county mainframe for billing and statistics only

Heavy use of costly psychiatrists

Unit Cost $187 **Units Produced: 3,051**

Upstate Children's Clinic [Salary]

High Clinician Productivity: **4.6 Service Units/Day**

- Staff scheduled to handle peak evening and weekend hours
- Community and school-based sites make service provision convenient and efficient

Able to retain good staff at relatively low average salary and fringe benefits

Clinic staff work closely with fiscal staff to balance cost and service

Relatively high service volume

Unit Cost $49 **Units Produced: 21,222**

⇔

Downstate Children's Clinic [Salary]

Low Clinician Productivity: **1.7 Service Units/Day**

- Direct clinic services primarily provided only in the afternoon with no extended hours
- Unionized clinicians work 6 1/2 hour day
- Much clinician time spent on support rather than direct treatment services

High union wages and fringe benefits

Unit Cost $232 **Units Produced: 6,457**

Downstate Clinic [Contract]

High Clinician Productivity: **5.8 Service Units/Day**

- Extended hours for recipient convenience
- Extensive use of low-cost contract clinicians

Low administrative salaries with good board oversight

Unit Cost $51 **Units Produced: 19,635**

⇔

Downstate Clinic [Salary]

Low Clinician Productivity: **3.6 Service Units/Day**

- Limited extended hours and inefficient clinician scheduling
- Low utilization of remote MICA clinic site
- Unionized clinicians work 6 1/2 hour day

High management salaries and fringe benefits

High union wages and fringe benefits

Unit Cost $156 **Units Produced: 21,571**

Figure 43

Units and Costs

To place the subgroups of low and high cost providers into perspective, total clinic costs were compared to units produced (Figure 44). It was found that the high cost operators, while producing on average 43% fewer units, spent an average of 146% more to operate their clinic programs than the low cost providers.

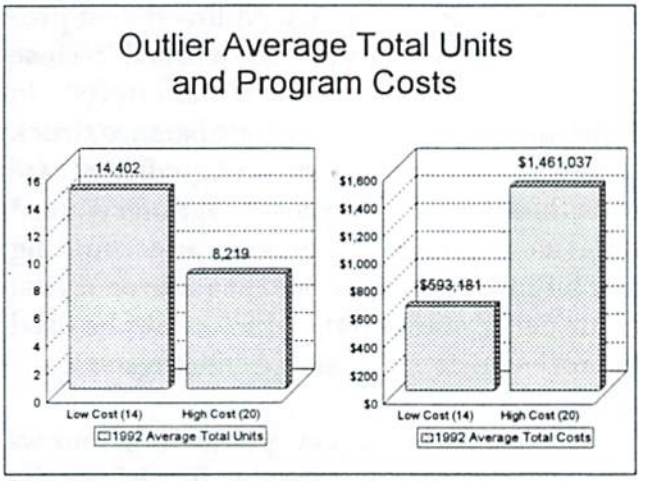

Figure 44

OMH regulations (14 NYCRR 588.6) require full clinic visits to be at least 30 minutes duration. While a few of the agencies visited seemed to have set the average length of their recipient visits to coincide with this minimum standard, most agencies visited furnished longer clinic sessions, ranging from 45 minutes to one hour. Looking for a possible explanation for this variance, the Commission compared the percentage of SPMI/SED individuals served and the mean service duration for these providers. No apparent relationship was found between the two. For example, one large clinic in New York City with 60 percent SPMI/SED recipients furnished 30 minute sessions while another New York City provider with no SPMI/SED recipients conducted 45 minute therapy sessions. At another large agency which operated two clinics, SPMI adults and SED children were routinely scheduled for 30 minutes sessions while non-chronic recipients were scheduled for 45 minutes.

The Commission also examined average clinician daily units of service produced and found that the low cost providers' daily output of 5.38 units was over double that of the high cost providers at 2.53 units (Figure 45). These data reinforce the link between productivity and overall unit cost found with the survey population in Chapter III. Interestingly, while most of the higher unit production operations employed contract clinicians, some salaried clinics achieved comparable results.

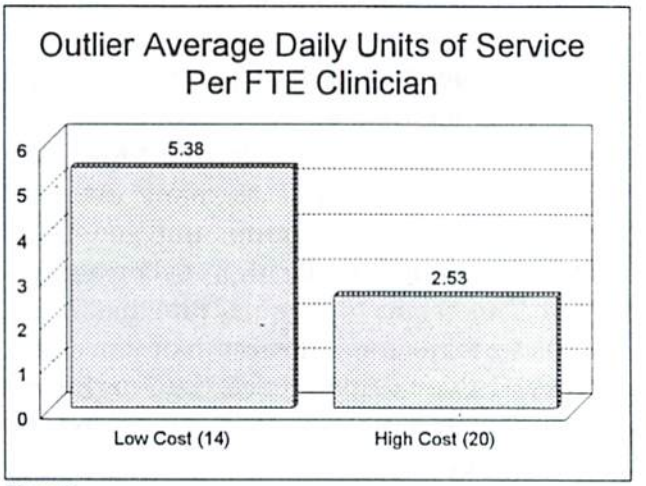

Figure 45

Through site visits to cost-efficient salaried clinics, the Commission found close monitoring of therapists' unit output. Some clinic managers attentive to output maintained a small recipient case load themselves. This practice seemed to create a collegial climate among administrators and clinicians which fostered high staff morale and productivity.

In contrast, one clinic with low productivity emphasized a Total Quality Management (TQM) approach. Management placed heavy reliance on higher cost psychiatrists for recipient evaluations. Also, all clinicians met for about five hours each week to discuss their clinic cases, further diminishing the time available for direct recipient services.

Another low productivity clinic serving New York City children, which scheduled its salaried clinicians to work a 6 1/2 hour work day, further reduced direct clinic service time by scheduling nearly all children's clinic sessions for the afternoon. A similar children's clinic in the City which was facing budgetary problems greatly increased clinician productivity by restructuring clinician workdays to coincide with student availability based on school schedules. Part-time staff were hired to meet peak winter and spring workloads.

Hours of Operation

Bolstering another Chapter III finding, low cost outliers were open on average 15 more hours per week than high cost outliers (Figure 46). A more detailed breakdown of these programs' weekly hours revealed that low cost outliers were open twice as many evening hours as high cost programs and generally had weekend hours while high cost providers did not. This seems to demonstrate that being responsive to recipient desires to obtain clinic services at their convenience (i.e., nights or weekends) has a positive impact on provider cost efficiency.

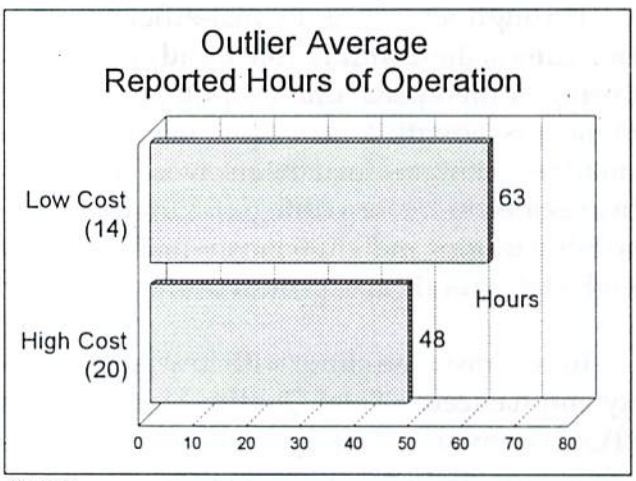

Figure 46

Other Cost Factors

Through field visits it also seemed clear that lean management structure and computerization helped improve clinic cost efficiency. Management at most low cost clinics was streamlined and closely monitored by an active board of directors. Executive compensation also tended to be lower at less expensive clinics. Management layering was kept to a minimum and, as discussed, these individuals maintained a hands-on-approach by conducting therapy sessions. At lower cost programs clinic manager(s) also worked in close partnership with fiscal administrator(s). In short, there was an appropriate balance struck between cost containment and quality of care considerations. Higher cost programs viewed fiscal management as primarily an accounting and billing function instead of a source of vital clinic performance data which could be used to more effectively manage clinic resources.

During clinic survey phone call follow-ups, many clinics had trouble furnishing the Commission with basic data on the characteristics of their client populations, no show rates, clinician productivity, and annual units of service generated. Commission staff conclude that much of this difficulty stems from a lack of computerization beyond the basic billing process at many providers. In fact, it appears that many clinic operators still fail to recognize the value of networked microcomputers as a relatively cheap and effective clinic management and productivity enhancement tool. However, OMH has acknowledged the potential role that computers could play in reducing clinic costs by funding several clinic computerization demonstration projects; but the results of these efforts have not yet been disseminated.

Site visits also revealed that private vendors have already developed affordable microcomputer software which automates most aspects of clinic operations including: clinic scheduling, billing, tracking of therapist productivity, treatment planning, and case note preparation. Wider implementation of these systems by clinic operators could lead to significant cost savings by obviating the need for some clinic provider support personnel and minimizing the amount of time spent by clinicians on paperwork. These systems could additionally furnish data on clinic program performance to support management's monitoring of clinician productivity.

Chapter V
Future Directions in Clinic Service Delivery and Funding

Managed Care Impact Upon Clinics

During the course of the Commission's study, managed care had just begun to emerge in New York State's clinic program through some employer-funded managed care plans and several county Medicaid managed care demonstration projects operating under state and local Department of Social Services auspices. Both managed care approaches were designed to prevent unnecessary recipient use of expensive hospital emergency psychiatric services and inpatient psychiatric care. Typically, clinics provide services to the enrollees of these plans for a reduced fee with an annual cap on the number of recipient visits (typical cap was 10 to 15 visits per year - compared to 40 visits utilization cap under Medicaid fee-for-service). Clinics were also subjected to new managed care utilization review and other paperwork requirements.

Clinic survey data showed that by the summer of 1994 59% of providers reported managed care participation. However, where plan participation existed, it was usually limited to only one or two privately funded managed care programs covering only a small percentage of the clinic provider's recipients. Even though these plans only covered a small percentage of clinic recipients, most providers seemed to recognize the inevitability of the future widespread implementation of managed care programs for mental health.

Provider concerns about managed care were reflected in their survey responses or identified during field visits. They seemed most troubled about the lack of uniformity among managed care firms regarding the nature and scope of required consumer paperwork for treatment planning and utilization review purposes. Operators were also encountering difficulties obtaining waivers on recipient visit caps even though additional mental health treatment was required. Other providers were apprehensive about possible revenue shortfalls caused by these visit caps and being excluded from managed care provider networks. Some county clinics were concerned about unreimbursed services for crisis visits by patients refused timely treatment by managed care firms.

Integrated Delivery System

As part of the *1996-97 Executive Budget* proposals, a budget bill was introduced calling for the creation of an Integrated Delivery System (IDS) which would radically restructure how community mental health services are funded and administered in New York State. The IDS bill would combine into one block grant over 70 different funding streams underwriting community mental health services and turn administrative control over to the counties and New York City. State spending on these services is projected to be cut by $200 million annually, reflecting potential savings that could be achieved as counties assumed

the role of "gatekeeper" over costly hospital inpatient psychiatric stays and the quantity, type and duration of outpatient mental health treatment.

The yearly IDS block grant allocation would represent the state's entire obligation to fund community mental health services within a given county. In return for local control, counties would no longer be required to continue their previous mental health spending patterns and would have wide discretion to decide which types of outpatient services would be funded at the local level. For instance, a county could reduce clinic program funding and shift monies to psychosocial clubs, continuing day treatment, housing or work assistance programs. By removing categorical funding and program requirements counties would have greater flexibility in structuring community mental health.

The legislation makes clear that consumers would not have a right or entitlement to receive publicly funded mental health services. This provision would support the county's new role as the sole "gatekeeper" within the community mental health system which decides which outpatient services, if any, will be furnished to recipients.

OMH's role in the local mental health service delivery system would be restricted to: acting as an IDS funding conduit, approving county IDS plans, analyzing quarterly county IDS expenditure reports, and certifying provider programs.

The overall success of the IDS initiative is linked to a federal government proposal to increase the state's control over how Medicaid funds are spent and the State Legislature's adoption of these reforms.

Clinic Program Implications

Although the full implications of managed care and IDS for New York State's clinic program have not yet emerged, it is clear that clinic providers will have to become much more efficient to survive in this new stringent cost conscious environment. As this study points out, many efficiencies are possible through improvements in the way clinics are managed and increasing clinician output. There are, of course, other efficiencies in quantity, type and duration of clinic services that are being addressed through the above more global initiatives.

The Commission does, however, know from this study that there is significant room for clinic program savings. In the aggregate, if unit costs are held to 140% of the mean or $134.72 ($96.26 x 140%) overall clinic costs could be reduced by $7 million based on 1992 spending and unit of service data. Similarly, $11 million could be saved if costs are held to 125% of the mean or $120.33 ($96.26 x 125%) and $19 million at 110% of the mean or $105.59 ($96.26 x 110%). While in 1992 a large portion of these savings could be expected to occur .n state/local deficit financing which is the payor of last resort for high cost clinics, it is expected that the greatest savings today of clinic revenue would come from Medicaid, as the state has increasingly relied on COPs supplements to fund rising program costs.

Nevertheless, while the Commission believes that much of the savings are achievable through operational changes (e.g., greater clinician productivity, use of part-time or contract clinicians based on recipient availability, downsized administrative structure, computerized service/billing systems, reduced no-show rates and extended operating hours), it

realizes that such decisions need to be made on a clinic-specific basis.

Notwithstanding these potential cost reductions through increased efficiency, the "service effectiveness" of seemingly "efficient" programs should be closely examined. The Commission noted one clinic where its cost per unit was $60. Yet, the clinic operator readily admitted that recipients were routinely scheduled for therapy sessions each week to achieve its revenue maximization objectives. Another "efficient" provider located close by had an average cost of $51 per visit but did not appear to be inflating its unit volume by providing clients with unneeded services.

Thus, in achieving clinic savings the focus should start with high cost programs where the potential payoff from instituting efficiency measures is apparent.

Recommendations

1. OMH should require clinics whose unit of service cost significantly exceeds the statewide average to develop and implement cost reduction plans. These plans should include: tracking clinician productivity and setting performance standards; measuring and reducing client no-show rates; streamlining operations; and increasing clinic fiscal/program management coordination.

2. In support of the first recommendation, the governmental subsidies furnished to inefficient clinic providers should be gradually reduced either through implementation of the IDS/managed care approach or by OMH reductions in deficit funding and/or COPs supplements.

3. OMH should form a task force with counties and providers to reduce clinic paperwork and increase computerization. Topics should include: standardization of governmental and managed care reporting requirements; reexamining the frequency of treatment planning, and increasing computerization of clinic operations and record-keeping.

Appendices

Glossary

CFR	Consolidated Fiscal Report is a single standardized annual fiscal document reporting costs, revenues, and units of service required to be filed by all organizations which receive funding from New York State or local governments for the provision of mental hygiene services.
COPs	Comprehensive Outpatient Programs provide supplemental reimbursement under the medical assistance program for providers which grant priority service access to the most seriously mentally ill individuals.
FTE	Full Time Equivalent is a standardized method for converting part-time to full-time staff for reporting purposes.
IDS	Integrated Delivery System is a *1996-97 Executive Budget* proposal to consolidate funding for services to mentally ill recipients into a single block grant to be administered by the counties and New York City.
NYCDMH	New York City Department of Mental Health, Mental Retardation, and Alcoholism Services
OMH	New York State Office of Mental Health
OTPS	Other Than Personal Services is a standardized cost category used for reporting non-salaried costs including: contractual services, travel, supplies, and equipment.
SED	Seriously Emotionally Disturbed children are individuals under 18 years of age who are in psychiatric crisis or have a mental illness diagnosis whose severity and duration results in substantial functional disability.
SPMI	Severely and Persistently Mentally Ill adults are individuals 18 years of age or older who are in psychiatric crisis or have a mental illness diagnosis whose severity and duration results in substantial functional disability.

NEW YORK STATE
OFFICE OF MENTAL HEALTH 44 Holland Avenue, Albany, New York 12229

James L. Stone, MSW, Commissioner

May 14, 1996

Mr. Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
One Commerce Plaza, Suite 1002
Albany, NY 12210

Dear Mr. Sundram:

Pursuant to your written request dated March 22, 1996, please find delineated below responses to the Commission's report: **A Cost-Efficiency Review of Freestanding Psychiatric Clinics in New York State.**

Recommendation:

1. The Office of Mental Health (OMH) should require clinics whose unit of service cost significantly exceeds the statewide average to develop and implement cost reduction plans. These plans should include: tracking clinician productivity and setting performance standards; measuring and reducing client no-show rates; streamlining operations; and increasing clinic fiscal/program management coordination.

OMH Response:

OMH concurs with the Commission that each of the management actions identified are key efficiency practices which should routinely be considered by providers. There are, however, some considerations against a new OMH initiative to require efficiency plans:

- As the report concludes, managed care initiatives for medicaid eligible persons with mental illness will force new efficiencies in the provider community. The proposed managed care approaches to mental health services have spurred intense discussion among providers relative to changes needed for them to continue to provide mental health services in this new environment. Indeed, the increasingly competitive nature of the reimbursement environment has already resulted in new strategic planning initiatives within many agencies.

- In the current fee-for-service environment, reductions in unit of service costs based on efficiencies, can be identified. However, since medicaid remains an entitlement service, programs can admit new medicaid eligible individuals thereby reducing any statewide savings potential. The federal waiver would allow OMH to capitate funds to providers and avoid incurring additional expenditures.

- OMH continues to provide regulatory relief to providers of outpatient services. These are designed to provide needed flexibility which will enable providers to better manage their services and costs as programs move to a more flexible, outcome oriented managed care environment.

In summary, we believe that in view of the impending managed care changes, the CQC's report is useful and should be distributed to the outpatient provider community but not tied to new planning or reporting requirements.

Recommendation:

2. In support of the first recommendation, the governmental subsidies furnished to inefficient clinic providers should be gradually reduced either through implementation of the IDS/managed care approach or by OMH reductions in deficit funding and/or COPs supplements.

OMH Response:

The 1996-97 OMH Aid to Localities Contingency Executive Budget includes a cost containment initiative which would cap gross cost per unit of service for clinic and continuing day treatment programs (CDT) to ensure acceptable levels of operating efficiencies. This cap would be implemented by disallowing costs significantly in excess of the calculated statewide average for these two programs, thereby rewarding efficiency.

Recommendation:

3. OMH should form a task force with counties and providers to reduce clinic paperwork and increase computerization. Topics should include: standardization of governmental and managed care reporting requirements; reexamining the frequency of treatment planning, and increasing computerization of clinic operations and record-keeping.

OMH Response:

OMH agrees with the Commission's recommendation to reduce clinic paperwork and increase computerization and has been diligent in its efforts over the past two years to assist providers in these areas. OMH has developed the following software packages and distributed them without cost to all licensed programs:

- Consolidated Fiscal reports;
- The LS-3 Reporting System for local services;
- The Incident Reporting System;
- The Community Support System Registry; and,
- The Psychiatric Rehabilitation Reporting System.

OMH recently reexamined the frequency of treatment planning review requirements for clinics and reduced them significantly. We also reduced the record-keeping requirements for these programs and streamlined the structure of the outpatient Uniform Case Record to further support enhanced clinic efficiency.

OMH is committed to working with providers and counties toward the goals of increased efficiency and to the provision of more effective services.

I appreciate the opportunity to provide comments on this draft report.

Sincerely,

James L. Stone

James L. Stone
Commissioner