PROVIDER ADVISORY COMMITTEE
FUNDING UTILIZATION WORKGROUP
DATE: June 7, 2022

BACKGROUND

At a Department of Public Health (DPH), Substance Abuse Prevention and Control (SAPC) All-Provider Meeting held in 2021, SAPC staff presented Residential Bed Utilization claims data, citing the underutilization of contracted beds. The Provider Advisory Committee (PAC) suggested that the data used may not be an accurate assessment, and in December of 2021, formed the Funding Utilization Workgroup to explore the issue further. With support from SAPC, the following goals were set for the Funding Utilization Workgroup:

1. Learn strategies to decrease the discrepancies between SAPC claims data and agency claims submissions;
2. Understand the various funding sources available through SAPC, as well as other non-profit, private or public options, and opportunities that can be used to pay for residential beds; Learn provider obstacles to utilizing secondary funding sources
3. Learn different provider methods for communicating helpful updates about data input and funding sources to frontline staff; and

WORKGROUP MEMBERS

Shelly Wood – Workgroup Co-Chair
Grandview Foundation

Christina Gonzalez – Workgroup Co-Chair
Principles, Inc.
(dba Impact Drug and Alcohol Treatment Center)

Kathy Watt – PAC Co-Chair
Van Ness House

Cory Brosch
Phoenix House California

Jason Carrasco
Didi Hirsch Mental Health Services

Brandon Fernandez
Cri-Help, Inc./I-ADARP, Inc.

Junie Gonzalez
Fred Brown Recovery Services, Inc.

Jonathan Higgins
The Beacon House Association

Elan Javanfard
Didi Hirsch Mental Health Services

Claudia Murrillo
House of Hope Foundation, Inc

Denise Shook
Behavioral Health Services

William Tarkanian
Los Angeles Centers for Alcohol and Drug Abuse

MEETINGS

The committee met virtually from 9:00 a.m. – 10:30 a.m. on the following dates:

January 6, 2022
February 4, 2022
March 10, 2022
April 7, 2022
May 5, 2022

GOAL ONE: STRATEGIES TO IMPROVE THE DISCREPANCIES BETWEEN SAPC CLAIMS DATA AND AGENCY CLAIMS SUBMISSIONS

CHALLENGE: STATE/COUNTY DENIALS

One of the biggest challenges the workgroup discussed concerned county and state denials, and how this directly affects data. Patients are admitted, treatment is provided, billing denied, and data does not reflect the fact that patients, in fact, received services.

Several challenges regarding denials were identified and seemed common amongst participants. They include the following:

- Accepting Inter-County Transfers not being funded post 30-days.
- COVID-19 related delays and increased expenses
- Lack of in-house resources
- The impact denials have on Provider budgets

We polled committee members to see what percentage of services were provided in 2018-2019, where payment was denied for various reasons, and was not recoupable. Percentages ranged from 5% - 7.5%.

PROVIDER ACTIONS

- Often denials are based on in-house mistakes. To mitigate this the following was suggested:
    - Quality control check at admission stage (i.e. verify with SAGE DOB)
    - If denial is due to DOB, collaborate with other Providers to problem solve in an effort to see if they have additional information that may be useful when re-billing
    - Involve staff who made the error to re-bill and better understand process
- Designate scholarship beds into budget to off-set denials.
- Print out AEVS and Aid Code when sending billing as backup documentation

ASK – SAPC (RECOMMENDATIONS)

- Provide an all-provider training on billing process from start to finish, so staff better understand intricacies of the process
- Provide Contact sheet with defined roles of SAPC billing staff so that staff understands who to contact for follow-up questions

- Streamline denial process, specific to out-of-county-denials, assign one SAPC staff for Providers to contact with issues/concerns to help recoup or rebill if able to
- Provide training on how to interpret various reports from SAPC
- Explain why certain changes are being made so that Provider better understands big picture (i.e. Why out-of-county transfers were reduced from 60-days to 30-days for payment?)

CHALLENGE: RETENTION OF STAFF

The workgroup also discussed the impact that the pandemic has had on retaining qualified staff and the financial impact this has had on budgets. SUD healthcare providers are having to compete with other agencies who are able to offer higher pay/benefits, causing instability with staffing patterns.

Additionally, the increased credentialing requirements is causing additional challenges, including delays when new hires are able to provide service and contribute to revenue.

PROVIDER ACTIONS

- Provide bi-annual bonuses to staff based on performance
- Reduce expenses to be better able to increase staff compensation
- Diversify Program to attract staff who may have a special interest or specialty
    - Pregnancy programs, LGBQT, In-custody (Criminal Justice), 290 (Registered Sex Offender) Programming, Young Adults (18-25) programs
- Hybrid programs that support part-time schedule and working from home
    - Staff able to document at home, for example
    - May result in need for less office space
- Empower management to develop and be responsible for their own budgets, creating an environment where staff are more invested in revenue and expenses, making them more responsible for financial oversight of their department

ASK-SAPC (RECOMMENDATIONS)

- Provide annual training to Providers, reviewing changes made to contract that will impact budgets.
- Connect Cost-Report to Budget, making it easier to review budgets and spend revenue appropriately

CHALLENGE: INCREASED EXPENSES

The committee spent a lot of time discussing Payment Reform and the financial impact the pandemic has had on providing treatment. Several things have contributed to increased expenses, which directly relates to the underutilization of beds. Percentage increase for expenses ranged from 8%-18%.

These include the following:

SUPPLIES

Products, food and merchandise were limited; stores were not accessible. Early in the pandemic, providers were all facing rations, often having to pay premium prices just to get toiletries and required COVID-19 supplies (i.e., masks, gowns, sanitizers, gloves, disposable kitchen supplies such as plates, utensils, etc.). Additionally, many providers restricted patients from bringing in personal clothing, unless it was washed by staff, in case it was infected, thus requiring the purchase of intake/quarantine clothing.

TRANSPORTATION
In an effort to avoid public transportation, in hopes of mitigating the risk of exposure to the virus, Providers were paying for rideshare service (such as Uber) rides for patients who were required to attend important appointments.

CLEANING CREWS
Professional cleaning crews were hired to help sanitize work spaces.

COVID-19 PROTOCOL REQUIREMENTS
Countless hours were spent by Management in an effort to revamp operations and adhere to the constant changes in COVID-19 regulations.

VIRTUAL REQUIREMENTS
Increased costs associated to supporting staff working from home (i.e., additional computers, Zoom lines, supplies, etc.)

OVERTIME AND STAFF SHORTAGES
Following COVID-19 requirements, staff who showed symptoms were sent home to quarantine for up to 14-days at a time, countless hours of sick-time were used throughout the pandemic and staff were working in various roles to support 24-hour treatment.

Staff missed work due to childcare issues, and while some providers allowed staff to work from home when possible, this took a toll on the staff who remained working in the facility.

Staff received paid time off to get vaccinated and to recuperate after the vaccination, if warranted.

Providers have experienced an increase in cost as staff retention rates and turnover of employees has increased. Increased demands on overworked employees as coworkers quarantine/isolated was commonplace.

CENSUS FLUCTUATION
Due to quarantine/isolation requirements, it's been difficult to maintain a consistent census. This continues to be a challenge. Patients often left treatment early, finding quarantine/isolation to be too much, resulting in early discharge. Other providers had logistical restrictions due to the lack of rooms and contaminating new quarantined patients. Other providers were required to keep rooms empty incase patients needed to be isolated.

PROVIDER ACTIONS
- Continue to share resources and purchase in bulk, to reduce costs
- Continue to quarantine all intakes regardless of vaccination status, to reduce chance of facility being locked-down.
- Require all vaccine exempt employees to work remotely, having no contact with facility
- Weekly test all staff/patients

ASK-SAPC (RECOMMENDATIONS)
- Request SAPC to explore Payment Reform (Augmentation vs. Cost Settlement)
- Extend Cost Based billing through end of pandemic, or at least until COVID-19 protocols lifted for health care workers

- Request SAPC to explore other ways to determine Quality of Care.

GOAL TWO: Understand the various funding sources and opportunities that can be used to pay for residential beds; identify provider obstacles to utilizing secondary funding sources.

SAPC Providers have opportunities to collaborate with each other on different projects and to work together to identify prospective funding sources. Additionally, there are ample opportunities for SAPC Providers to collaborate with other agencies, helping to leverage resources and improve practices.

For example, L.A. CADA recently received a large grant by collaborating with the LA Mission, addressing their increased need to provide additional housing. Grandview Foundation collaborates with the Flintridge Foundation who provides job training. The Beacon House shared how their thrift shops and catering business not only provide employability opportunities for their patients, but raises unrestricted funds to off-set expenses, helping to diversify their revenue streams.

There are lots of funding opportunities to access, including municipalities, private/public foundations, corporations, fundraising efforts and entrepreneurial projects.

PROVIDER ACTIONS

- A sub-committee was established to explore collaborations and identify prospective funding sources
- Develop a database of prospective grants
- Providers collaborate with each other to establish annual fundraisers

ASK – SAPC (RECOMMENDATIONS)

- SAPC to set up Bulletin to explain steps in identifying and accessing secondary funding sources
- SAPC to act with more intentionality to support Providers willing to collaborate
- SAPC to create a mechanism by which like-minded agencies can collaborate on projects, programs or with regard to specialized populations and providers are incentivized to do so
- SAPC to create services funded through SAPC that require collaboration (i.e., Homeless Outreach w/ Harm Reduction emphasis that includes a provider that is certified to do syringe exchange with a provider that does client engagement and navigation services)
- Offer Letters of Support to agencies seeking third-party grants which specifically involve collaboration between SAPC providers
- Reduce the emphasis on geography and increase emphasis on collaboration between agencies that are uniquely adept at working with special populations (LGBTQ+, Pregnant Women, Re-Entry)
- Allow SAPC contracted agencies to act as “fiscal sponsors” for smaller, non-SAPC contracted providers to encourage expansion of services and increased access
- Providers to have additional opportunities to collaborate directly, for example, SAPC could procure leases for programs in underserved areas to allow for providers to run programs from those sites and take over the leases to also encourage expansion of services and increased access to services;
- Collaborate with DMH: Incentivize co-location of DMH and SAPC funded-programs;
- Incentivize agencies with Master Agreements with both DPH SAPC and DMH;
- Incentive co-location at DHS sites (SUD units) operated by CBOs

MISCELLANEOUS

Committee members also explored the possibility of setting up a Benefits Network for LA County SAPC Providers. Committee members reached out to their respective insurance brokers to see what was possible, in hopes of reducing costs by banding together to secure required insurance (i.e., D&O, Property, Health, etc.). To do this, it would require establishing an Association of providers. It was further determined that rates are based on use, and due to COVID-19 related circumstances (i.e. lack of access to health care the past two years and people now attending to preventative or neglected healthcare needs) that the rates would not accurately result in savings.

SUMMARY

Several things were realized by meeting the past six months; all agree that it was time well spent. It gave us an opportunity to share challenges and work together in an effort to mitigate those challenges moving forward. Simple things like holding monthly activities to distract from the stress of being essential workers helped retain and acknowledge overworked staff, positively affecting our ability to stay vigilant in bringing patients in to receive much needed treatment (adding to bed utilization).

We realized some easy fixes to help mitigate denials and recoup funds. We recognized that there are multiple funding sources, agencies and foundations who want to support the work that we do and we've identified partnerships that were not recognized before. We discussed the need to consider entrepreneurial ventures that would add to both program goals and diversification of funding goals. Finally, we were reminded that we truly are "in this together" and collectively we continue to make a difference in the lives of our patients and in each other.