Making the Business Case for Palliative Care

Christopher P. Acevedo

Acevedo Consulting Incorporated
&
Hospice Fundamentals

Session 1

About Acevedo Consulting Incorporated

Acevedo Consulting Incorporated prides itself on not providing cookie-cutter programs, but a quality work product formulated and designed to meet your desired goals. We treat each client as unique, and we tailor our reviews, recommendations, training and action plans accordingly. **One size does not fit all**!

You can rely on us to guide you and your staff through the labyrinth of coding, reimbursement and regulatory compliance issues of the ever-changing and complex health care industry.
We are a client-focused, service-oriented firm specializing in:

- **Appeal Assistance**
- **Chart Audits**
- **Compliance & HIPAA Programs**
- **Credentialing**
- **Education**
- **Quality Payment Programs**

About the Speaker:

Christopher Acevedo
Chief Operating Officer

Christopher P. Acevedo has nearly 20 years of health care experience and is the Chief Operating Officer for Acevedo Consulting. He has a particular expertise in building palliative care programs, chart audits, compliance & education relative to physician documentation and coding. Chris has assisted clients nationwide with these and many other organizational needs and his experience in operational management brings our clients invaluable expertise in the operational aspects of organizations' billing processes and identifying areas for potential improvement. Through the firm, Chris has also served as the Independent Review Organization (IRO) representative for hospices in accordance with their Corporate Integrity Agreements (CIA) with the OIG.

Acevedo Consulting staff serve as a consultants to the NHPCO and AAHPM when physician compliance, billing and coding issues arise. As such Chris has also conducted several educational webinars for the industry, including for state hospice and palliative care organizations.

Christopher is the Heathcare Compliance Officer for Barry University, has served as an instructor at Florida Atlantic University teaching the regulatory compliance modules of FAU's Certificate in Medical Business Management program, and is a member of multiple CMS MAC Provider Outreach and Education Advisory Groups. Additionally, he is the author of the Hospice Physician Service Billing Guide commissioned by the NHPCO.

He is a frequently sought after speaker as he possesses the unique perspective of avoiding risk and liability while optimizing reimbursement in the highly regulated health care industry.

Disclaimer

The information enclosed was current at the time it was presented. Medicare and other payer policies change frequently. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.

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This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and compliance information, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Agenda

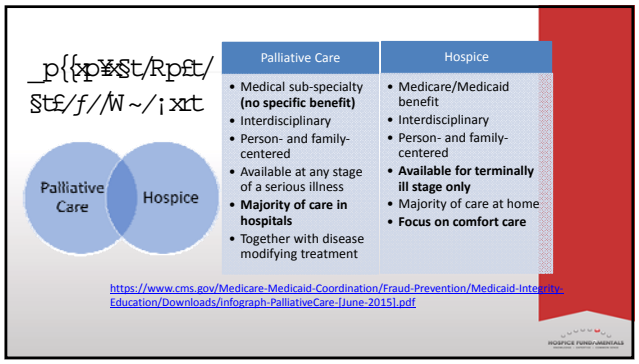
- The Business Case & Your Market
- Business Considerations
- Medicare Part B and Billing Nuances
- Best Practices

Standard Palliative Care Definition

Recognizing the changes to the practice of palliative care in all care settings, the National Consensus Project for Quality Palliative Care defines palliative care as follows:

- Beneficial at any stage of a serious illness, palliative care is an interdisciplinary care delivery system
- designed to anticipate, prevent, and manage physical, psychological, social, and spiritual suffering to optimize quality of life for patients, their families and caregivers.
- Palliative care can be delivered in any care setting through the collaboration of many types of care providers.
- Through early integration into the care plan of seriously ill people, palliative care improves quality of life for both the patient and the family.

National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. https://www. nationalcoalitionhpc.org/ncp.



Start with The Why

- Why are we creating/expanding a PC service?
  - Community need?
  - Defense of territory?
- Why now?
- Do we have core strengths we can leverage?

Elements of the PC Business Case

- Why a palliative care program is needed?
- What the program will look like?
  - Who it will serve?
  - Who will provide the care?
  - What services that will be provided?
- How much the program will cost and the anticipated return on investment?
- What success looks like based on a comprehensive evaluation strategy?
- Established programs may revise the initial or create a new Business Case annually

Background

- The reason you are considering starting a palliative care program:
  - Meet the needs of a patient population
  - Be "first in market" to have a palliative care program
  - Improve timely access to hospice
  - Diversify revenue stream
  - Establish a new partnership through contracting with health systems, ACOs, payors

Potential Partners

- Physician Practices
  - Oncology Practices and Cancer Centers
  - Cardiologists
- Facilities
  - Nursing homes
  - ALFs
  - Hospitals w/ In-patient PC
  - Hospitals with LVAD programs
- Other:
  - ACOs in your service area
  - Medicare Advantage plans
  - Medicaid Managed Care
  - Commercial Insurers
  - Large self-insured employers

Let's Discuss your customers

- Patients
- Families
- Facilities
- Community Physicians
- Hospital Based PC Programs

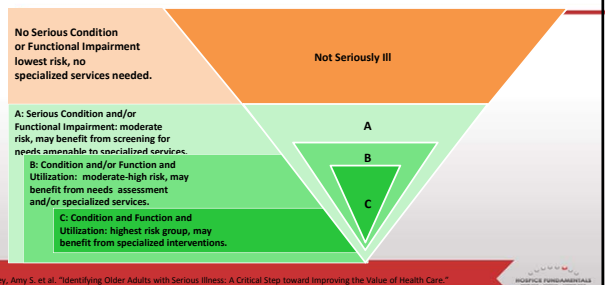
Patients

- How will you identify appropriate patients?
- Trigger based system?
  - Different Triggers for different customers
    - Physicians and facilities have differing needs

Current State: A year in the Life of a Patient

Source:
Johns Hopkins, RWJ 2010 (G Anderson)

Serious Illness



Kelley, Amy S. et al. "Identifying Older Adults with Serious Illness: A Critical Step toward Improving the Value of Health Care." *Health Services Research*52.1 (2017): 113–131. *PMC*. Web. 8 May 2018.et al *Health Services Research* 2016

TARGET POPULATION = HIGH RISK PATIENTS

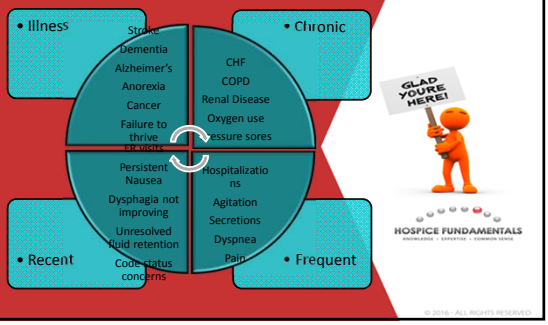
Patients May Have

- Functional limitations
- Multiple chronic conditions
- Dementia
- Serious/advanced illness
- Uncontrolled symptoms
- Recent discharge from hospital
- Caregiver breakdown

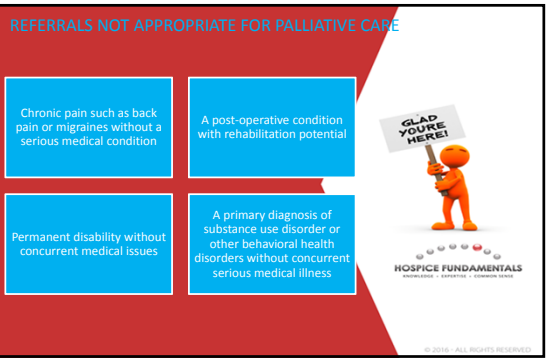
Care May Involve

- Home safety assessment
- Patient and family education
- Medication reconciliation
- What to do in crisis
- Planning care goals
- Home visits
  - Which disciplines?
  - How frequently?
- Telephonic triage and support

Our Palliative Care Patients Have...



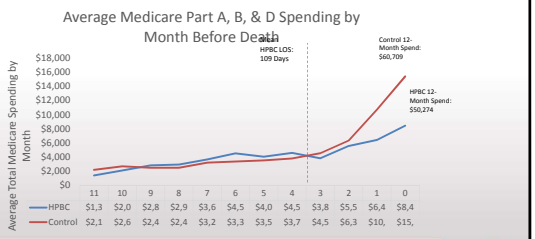
REFERRALS NOT APPROPRIATE FOR PALLIATIVE CARE



Build the Case

- Retroactive analysis of your hospice patients
  - Admissions and ER usage before hospice admission
  - Compare usage post-hospice admit
- Pull out studies of the right diagnoses
  - COPD
  - CHF
  - "High risk survivors", i.e., discharges from hospital

Home Based Palliative Care Saves $$$



Source: Dana Lunhader, MD, PAAHPM, et al., "The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization," *Journal of Palliative Medicine*, August 20, 2016. Note that Medicare Part A spending shown here includes costs from those patients referred to hospice prior to death.

What will the service look like?

- Consult service?
- Co-management model?
- Staff?
  - Physician
  - NPP
  - SW
  - RN/LPN
  - Chaplain
- Service Hours?
- Patient types?
- Service Area/Locations?

Services

- Comprehensive assessment
- Advance Care Planning /Treatment Options/Goals of Care Discussions
- Care Coordination
- Symptom Management
- Medication Management
- Patient/Family Support and Education

Internal Planning

- Response time
  - Staffing considerations
- Expected number of visits per patient per week/month
- LOS expectations
- Case review/IDT to manage ongoing census

PC Triggers

- No Advanced directives or POA in conjunction with one of the other triggers identified on this document.

- **Frequent/Increasing Hospitalizations or ED visits**
- 3 or more admissions in 6 months for the same condition
- Second presentation to ICU/hospital for same condition in 30 days

- **Debility/Failure to Thrive**
- Greater than three chronic conditions in patient over 75 years old w/ any of the following:
- Functional decline
- Weight loss: ≥10% of weight over the last 90 days or (BMI <22)
- Patient/family desire for low-yield therapy
- Pt being considered for PEG placement or nutritional intervention

PC Triggers

- **Cancer**
- Uncontrolled symptoms due to cancer or treatment
- Dx of Metastatic or Locally Advanced Malignancy
- Pt refusing cancer treatment or related therapies
- **Alzheimer's/Dementia**
- Refractory behavioral problems
- Feeding problems – Weight loss: ≥10% of weight over the last 90 days or (BMI <22)
- Caregiver stress – support needed

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- **Alzheimer's/Dementia**
- Refractory behavioral problems
- Feeding problems – Weight loss: ≥10% of weight over the last 90 days or (BMI <22)
- Caregiver stress – support needed
- Increased safety concerns
- Pt being considered for PEG placement
- Increased associated infections:
- Pneumonia/UTIs/Cellulitis/Septic

PC Triggers

- **Heart Disease**
- Stage III or IV heart failure despite optimal medical management
- Pt w/ a desire to discontinue AICD/Patient being considered for LVAD
- Angina refractory to medical or interventional management
- * Symptomatic Bradycardia associated w/ lightheadedness or syncope
- * Symptomatic Tachycardia increased fatigue, chest discomfort and/or lightheadedness
- *Symptomatic Atrial Fibrillation pulse >110 and/or lightheadedness

- **Pulmonary Disease**
- Oxygen-dependent, O2 sats less than 88% on room air
- Weight loss: ≥10% of weight over the last 90 days or (BMI <22)
- Dyspnea with minimal to moderate exertion
- Recurrent Pneumonia
- Other end-stage pulmonary diagnoses:
- Pulmonary fibrosis/Pulmonary hypertension/COPD: O2 sats less than 88% on room air

Details

- What system will be used to document visits/services
- Will current processes be leveraged
  - Intake
  - Ins auth
  - billing

Staffing considerations

- Dedicated to PC or borrowed from Hospice/other?

Productivity Targets for Staffing/Budgeting

- Staff individual productivity
  - Visits/day
  - Time/visit
  - Travel time
  - Admin time
- Consider % of staff time available for appointments vs admin duties
- Can your infrastructure handle productivity tracking and reporting?
- Do your clinicians understand your model and associated goals?

Is your system ready?

- ICD-10 codes (Medical and Behavioral Health)
- Capture evaluation and management codes
- Generate a bill with a CPT code
- Track Key Performance Indicators
  - Referral source
  - Age
  - Diagnosis
  - PC interventions

Back-Office Considerations

- Need to invest in a new or better EMR
- New intake staff to manage palliative patient admissions
- New staff to manage relationship with payer partner
- Extra finance staff for billing and coding staff (or outsourcing service)

Outreach

- Outreach plans based on KPI data
- **Targeted approach based on data and geography w/ volume targets**
- Upto 5 community educational events per month
- Dx specific events coordinated with the DX month (e.g. Cancer awareness month)
- Face to face with Dr.
- Friends of Hospice?
- Tracking w/ Palliative Leadership to forecasted goals

Can You Track Outcomes?

- Internally
  - Advance directive in place
  - Pain and symptom management targets
  - Medication reconciliation
- With help of partner data
  - ED use
  - Hospital admits
  - Referrals and outcomes

What questions do you need answers to?

- What exactly do we do (what, by whom, how much, how often, how?)
- What are our costs per patient, and is that lean/excessive/about right?
- Are we helping patients with their symptoms? With other problems?
- What is the family /caregiver experience like?
- Does our service impact patients' use of healthcare?
- For all of the above, how are we doing compared to others?

Aim for a balance: Metrics Types

Structure	• Describe the program • Ex. Available 24/7
Process	• Describe how care is delivered • Ex. Screenings done at specific points in time
Outcome	• Describe the impact of the program • Ex. Change in pain scores

What are you going to measure?

Top Ten Measures that Matter, but to Whom?

Measurements vs. Performance Indicators

- What is important to a specific stakeholder group?
  - Your team
    - Clinical/Operational/Financial
  - Each clinical partner type
  - Unique payer needs/wants

Key Performance Indicators

- Weekly, monthly & quarterly review of KPI data
  - Referrals
    - By provider
    - By Dx
    - w/ LOS
    - tracking those referrals to receive more upstream
  - Case mix by Dx
    - w/ LOS
  - Discharge Disposition
    - w/ LOS
    - by Dx
    - By Provider
    - Specifically # of Deaths on PC

Key Performance Indicators

- Weekly, monthly & quarterly review of KPI data
  - Avg # of visits per patient
    - By Dx
    - By Provider
    - By Referral Source
  - Avg per visit reimbursement
    - By Dx
    - By Provider
  - # of ACP codes
    - By provider
  - CPT Code Breakdown
    - By Provider

Key Performance Indicators

- Weekly, monthly & quarterly review of KPI data
  - Avg time to consult from referral
  - # of After Hours Calls
  - Visit count by Clinician
  - Total Visit Count (for board reporting)
    - New Pts
    - Established Pts

Best Practices

- Always keep up with and standardize operational measures - volumes, patient characteristics, costs of service, referral sources, etc.
- Always collect vignettes / case studies
- Defer measurement that is not urgent or is too difficult
- Lay the groundwork (registries, EMR) for easing data collection and reporting burden in the future, especially for clinical outcomes
- You do not need to measure everything all the time; measure strategically rather than exhaustively
- What you measure in a given year will be dictated by:
  - The developmental stage of your program
  - The resources at your disposal to gather, analyze, and interpret data
  - Survival (the urgent demands of sponsors and referring providers)

Funding

- Funding sources
  - Mcr
  - Mcd
  - Mcr-Adv
  - Commercial

Palliative Care Staffing Budget/Cost Considerations

Staff	FTEs	1.0 Expense	Total Expense
MD/DO	1.5	$ 250,000.00	$ 375,000.00
RNP	1	$ 140,000.00	$ 140,000.00
SW	0.5	$ 80,000.00	$ 40,000.00
LV	1	$ 90,000.00	$ 90,000.00
CH	0.5	$ 75,000.00	$ -
RN	0.5	$ 65,000.00	$ -
Admin Coordinator	1	$ 60,000.00	$ 60,000.00
Program Director	0.5	$ 125,000.00	$ 62,500.00
Total/	5.5	$ 886,000.00	$ **768,500.00**

Expenses	Annual
Rent	$ 8,500.00
Vacation - TEAM	$ 10,000.00
Consulting - External	$ 8,500.00
TC Outreach	$ 2,400.00
Supplies	$ 500.00
Memberships	$ 7,000.00
Consulting/Professional Fees	$ 8,500.00
Continuing Education	$ 4,367.00
Dues, Licenses & Subscription	$ 6,000.00
Meeting Expense	$ 600.00
Mileage-Non-Patient	$ 1,200.00
Mileage-Patient	$ 3,800.00
Office Supplies	$ 500.00
Misc	$ 18,000.00
Phone	$ 18,000.00
Solar	$ 18,000.00
Sr Auth	$ 18,000.00
Med Mal	$ 6,000.00
	Total $ **138,867.00**
	Total $ **907,367.00**

Proposed Funding w/ 2018 Visits	
Grants	$ 40,000.00
Philanthropy	$ 200,000.00
Fee-for-Visit Funds	$ 72,000.00
Hos Pilot	$ 50,000.00
	$ 362,000.00

2018 Visit Count

annual	548
weekley	11
daily	1

2020 Visit Goal

visit sources	weekly visits
4 clinic days	32
4 facility days	32
2 mesiac days	16
	80
Annual Visits	3,840
Patients	480

Total Expenses	$ 907,367.00	
Shortfall	Annual FFS Visit Shortfall	Weekly FFS Visit Shortfall
$ (545,367.00)	(4,195)	(87.40)

2020 Goal for Visit Revenue

	Weekly Visit Delta	Annual Revenue	Weekly Revenue
	(7)	$ 499,200.00	$ 10,400.00
Program (+/-)		$ (46,167.00)	

Patient Count	
Current	80
Goal	480

So we have decided to move forward…

Now what?

Legal or Regulatory Considerations

Palliative program

- As part of the existing organization

  vs.

- "Newco" as a separate legal entity
- JV with: Local hospital, SNF, HHA?

Are there reasons to create the program within the hospice license?

Legal or Regulatory Considerations

- Legal review
  - Health care counsel
- Any anti-kickback considerations?
- Self referral issues
- Corporate practice of medicine
  - FL's Health Care Clinic Act
- If the organization is not-for-profit, how will structure impact this
  - Especially if the programs remain one legal entity

Legal or Regulatory Considerations

- Medicare
- Medicaid
- Commercial Insurance/MCOs

Separate Entity: The "program" is just a physician practice to them if a separate entity.

Via Hospice License: Payment may be limited as part of the hospice organization.

Know the Payer Specifics

- Which fee schedule applies?
  - Medicare locales
- If the payer is non-Medicare do you have a contract that defines the payment rates?
  - If not contracted, are there out of network benefits?
- Does the non-Medicare payer allow ARNPs or PAs to bill for services directly?
  - Varies greatly by payer

Know the Payer Specifics

- Does the non-Medicare payer recognize consultation codes?
  - Initial Hospital Visit vs. Hospital Consultation fees
- What is the deductible and coinsurance for the non-Medicare patient?
- Is Authorization needed prior to seeing the patient/insured?

Credentialing vs Contracting

- Know the difference!

Medicare Part B Providers and Billing

- The basic providers in palliative care
  - Physicians
  - Non-physician practitioners (NPPs)
    - ARNPs/CNSs
    - Physician Assistants
    - LCSWs
- Covered services are those medically necessary services within the practitioner's scope of practice and Medicare benefit
  - "Physician" services for MDs/DOs/ARNPs/CNSs/PAs
  - Mental health/psychotherapy for LCSWs
    - No case management, placement, etc.
- Credentialing of NPPs
  - Required by Medicare
  - Inquire for other payers

Part B Billing Key Points – Medicare Enrollment

- Palliative Care Practice Enrolls
  - CMS 855B
- Palliative Care Physicians and/or Non-Physician Practitioners Must Enroll
  - CMS 855I
  - CMS 855R
    - PAs do not reassign benefits via an 855R
    - At least one 855R must accompany an 855B

Medicare Part B Key Points

- Enrollment status
  - Participating
    - In Medicare, "participation" means that a provider agrees to always accept assignment of claims for all services you furnish to Medicare beneficiaries. By agreeing to always accept assignment, you agree to always accept Medicare-allowed amounts as payment in full and not to collect more than the Medicare deductible and coinsurance or copayment from the beneficiary
  - Non-Participating
    - Accept assignment or not – case-by-case basis – fees are reduced 5% when you do accept assignment
  - Opt Out
    - Just like it sounds – you have opted out of Medicare and none of your services are payable by Medicare.
      - Only an individual can do this.

Part B Billing Key Points

- Services for professional services are billed on a CMS 1500 form rather than a UB-04
- Medicare pays 80% of the allowed amount after the deductible ($185 in 2019) has been met and the patient is responsible for the remaining 20% which may be billed to the patient's secondary insurance if applicable
  - Patient or secondary insurance pays deductible and/or 20%
- For Medicare services billed under an ARNP's/PA's NPI, there is a 15% reduction in the allowed amount.
  - Part B pays 85% of the 80%

Medicare Physician Fee Schedule (MPFS)

HCPCS CODE	SHORT DESCRIPTION	NON-FACILITY PRICE	FACILITY PRICE	LIMITING CHARGE
99222	Initial hospital care	$139.32	$139.32	$152.51
99223	Initial hospital care	$206.64	$206.64	$225.75
99344	Home visit new patient	$186.12	$186.12	$203.33
99345	Home visit new patient	$226.08	$226.08	$246.99

National allowable amounts, not geographically adjusted.

MPFS

- The Medicare Physician Fee Schedule Lookup can be found at: https://www.cms.gov/apps/physician-fee-schedule/overview.aspx
- For each HCPCS code entered, options include:
  - Pricing by MAC/region
  - Payment policies
  - RVUs

Payment Methods: FFS

- **Fee for Service (FFS)**: Providers are paid for each item or service provided that the 3rd party payer covers
  - May have deductibles, co-pays or co-insurance
  - There is a risk of overutilization

The doctor looks at the toothpick looking thing in the patient's thumb and says "*It's splinter-like in appearance, but I'll need a battery of tests to be sure.*"

Payment Methods: Capitation

- **Capitation:** "PMPM", or, per member per month. The provider is paid a set fee for each month to cover all or a defined subset of services for each individual cared for under that plan.
  - May have "carve outs" or "bill aboves"
  - Provider paid whether the patient is seen or not
  - There is some risk to under-utilize care and treatment

Payment Methods: Bundled

- **Bundled Payments:** Provider is paid a fixed amount for an episode of care (e.g., the total hip replacement surgery itself and all care for the next 90 days).
  - CMS continues to develop new conditions or "episodes" for this model
    - Mostly inpatient driven

You've determined who is paying and the payment methodology, how do you ensure that entity pays for your services?

Coding & Claims Alphabet Soup

- **CPT & HCPCS** Codes
  - ***What*** service was provided
- **ICD-10** Codes
  - ***Why*** the service/item was provided
- **Place of Service** Codes
  - ***Where*** the service/item was provided

Now lets work on getting paid!

- Palliative Care Services
  - E&M
  - ACP
  - CCM
  - TCM
  - Non Face-To-Face Prolonged Services
- Diagnosis Coding
- Alternative Payment Approaches
  - Merit-based Incentive Payment System
  - Advanced Alternate Payment Models

Let's look at the specific palliative "physician" services that can be billed.

Historical Palliative Care Billing Codes

- Initial Hospital 99221-99223
- Subsequent Hospital 99231-99233
- Initial Nursing Facility Assessment 99304-99306
- Subsequent Nursing Facility Care 99307-99310
- New Patient Rest Home (Domiciliary/Rest Home/ALF) 99234-99328
- Established Patient Rest Home 99334-99337
- New Patient Home 99341-99345
- Established Patient Home 99347-99350
- New Patient Office 99201-99205
- Established Patient Office 99212-99215
- Prolonged Services
  - 99354-99355 Outpatient Prolonged Services
  - 99356-99357 Inpatient Prolonged Services
- Consultation Services (non-Medicare)
  - 99241-99245 Outpatient Consultations
  - 99251-99255 Inpatient Consultations

Remaining Process Issues

Homework

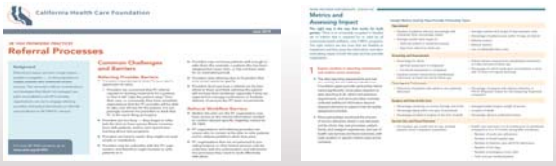
- Dx based triggers
- General patient/program definitions to be created
- Meet with Leadership to discuss Hospice staffing and leadership role
- Set actual budget
  - Work on staffing evolution model
- EMR functionality
  - templates

Homework

- **Staffing model**
  - PC & Hospice as silos or combined staffing to an integrated model?
    - Integrated model preferred
  - Role of The Program Medical Directors (High level leadership)
    - Perhaps a revamp of JDs w/ granular expectations
  - **Combined service needs w/ Clinical Leaders**
  - Visit expectations/daily workload expectation
  - Explore Fellowship options

Free Resources!

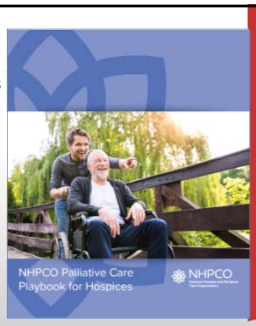
- California Health Care Foundation



NHPCO Resource

Palliative Care Playbook for Hospices

- Chapters:
  - Intro
  - Palliative Care Considerations
  - Regulations, Licensure, and Credentialing
  - Needs Assessment
  - Quality/Data
  - Business Case
  - Budget
  - Staffing
  - Documentation
  - Policies & Procedures
  - Marketing



Documentation and Coding Resource

- https://www.chcf.org/publication/community-based-palliative-care-fee-service-billing-strategies/
- https://www.acevedoconsultinginc.com/publication

Actions of the Prudent Hospice™

- ✓Develop a Business Case / Business Plan and review annually
- ✓Define eligibility, services, accountability, and payment
- ✓Align program to your organization's mission and vision
- ✓Identify and mitigate technology and regulatory risks
- ✓Determine your Return On Investment (ROI) – How will you know you are successful?

Questions????

To Contact Us

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