Developing a Pediatric Palliative Care Program: Finance

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2 Main Objectives

* Describe two components of healthcare reform that support a business model for pediatric palliative care (PPC)

* Identify current and potential sources of revenue and reimbursement to support a PPC program
What makes funding a PPC program difficult?

- Financial barriers
- Enrolling into “Hospice” often not applicable
- Resource allocation
Financial Barriers

- Reimbursement
  - PPC outcomes not favorable in Fee-for-service environment

- Not an efficient, procedure-driven, money making enterprise
  - Our “procedure” is often the family meeting
  - Time and decision making might be our major offerings

- Current system forces choices between services
  - Emphasis on duplication of services
“Hospice” concept - why often not applicable in pediatrics?

* Unrealistic to think parents will be able to abandon aggressive therapy
  * “leave no stone unturned”
  * Exception, not the rule – rare family will fall into “classic hospice patient”
    * Horse already needs to be out of the barn
  * Pediatric care is (!) more expensive
    * But the cost is often offset by true QoL

* => 2010: Concurrent Care
Volume & staffing requirements inpatient

* Annual Pediatric Hospitalizations
  * Year 1: Consults: 1% of annual hospitalization
  * Year 2: 2%
  * Year 3: 3%
  * Target: 4-5%

* Pediatric Staffing
  * 1.2 FTE (MD / NP) per 50-75 consults/year (plus 1.2 FTE SW/chaplain/admin. etc.)
Objective 1

Describe two components of healthcare reform that support a business model for pediatric palliative care
I. Concurrent Care for Children

* March 23, 2010: Patient Protection and Affordable Care Act (PPACA)

* Section 2302 (page 202), termed “Concurrent Care for Children” Requirement (CCCR)

* http://www.nhpco.org/resources/concurrent-care-children
Concurrent Care for Children Requirement (CCCR)

* Applies to children:
  * covered by Medicaid and Children’s Health Insurance Program (CHIP)
  * With a 6 month prognosis and eligible for hospice services
  * Also applies to children covered under umbrella programs, such as Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, the child health component of Medicaid
What Concurrent Care for Children Is...

* When child elects hospice care under Medicaid or CHIP:
  
  * **Does not waive** the child’s right to be provided with, or to have payment made for, services that are related to the treatment of the child’s condition, for which a diagnosis of terminal illness has been made.

  * Services covered and **paid for separately** from those provided under the child’s hospice benefit
* A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to this treatment of the child’s condition for which a diagnosis of terminal illness has been made

* Retroactive to March 23, 2010
Example: California

* CA: 2013: 7 hospice agencies in 13/58 counties

* 2011-2012: 166 kids on concurrent care CA Children’s Hospice & Palliative Care Coalition
What Concurrent Care for Children Is Not...

- Does not remove major barriers to providing more expansive PPC services
  - Child must be within last 6 months of life (If disease follows its normal course/progression)
  - Limited to existing Medicaid hospice and other Medicaid services
- Does not indicate:
  - Who determines what is curative or palliative
  - How the services should be billed
  - How to handle children who have or are awaiting waiver services
Free Toolkit Available

* Concurrent Care for Children Implementation Toolkit
  * Free download: www.nhpco.org/pediatrics
How about ACOs?

Let’s get started...
II. PPC as a Strategy in an ACO Model

- "Super-utilizers": 1 percent of patients consume 21 percent of all healthcare spending in US: $1.3 trillion in 2010

- Fee for Service -> Accountable Care Organization / Bundled Billing
- PPC key health system strategy in re-aligning healthcare delivery
- Population health management includes seriously ill children (highest risk and highest cost)
What is a Pediatric ACO?

* Providers who work together, alongside families, to provide and coordinate services for individuals under 21 years of age; and collectively take accountability for improving the lives of these children
ACO Goal Outcomes

* In adults and pediatrics:
  * Decreased institutional utilization
  * ED visits
  * Readmission (?) – controversial
  * Hospitalizations – occurrences and LOS
* Increased home care utilization
* Increased value (V= quality x safety / costs)
Authority for ACO Programs

- PPACA Sec. 2706: Pediatric Accountable Care Organization Demonstration Project

- O.R.C. 5111.161: Recognition of Pediatric Accountable Care Organizations
Specific Pediatric ACO Objectives

- Improve health outcomes
- Incentivize more appropriate care
- Assign high risk families and children a primary support team that will coordinate services across traditional boundaries
- Smoother transitions
- Create a single care plan for high risk families and children
- Track performance measures

* ... isn’t that PPC...?
To be recognized as an ACO, programs must:

* Explain how you will be accountable for care, share data, and collaborate with managed care providers and community-based organizations such as schools and social services.

* Have collaborative agreements with Primary Care Medical Homes, Pediatric Specialists (esp behavioral health), Community Pharmacies, Dentists.

* Explain what region of the State you will be covering.

* Demonstrate performance measures in place and being tracked

* Certain types of pediatric ACOs will be required to agree to a state’s performance measures
Pediatric ACO Mandatory Elements for performance

- Education
- Social
- Mental Health
- Physical Health
- Transparency
- Community Leadership
- Consumer Trust
Payment per member/month

- Insurance companies: already paying for adult home PC
- Now first payers in peds is paying per member/month
- Example: The Center of Hospice & Palliative Care www.HospiceBuffalo.com
- Thanks to Melanie Marien, MS, RPAC
PPC: ACO is the light at the end of the tunnel...?

- In the new environment, payers are new natural allies!
Objective 2

Identify current and potential sources of revenue and reimbursement to support a pediatric palliative care program.
A. Direct Reimbursement / Fee for service (FFS)
Professional Billing and Coding

- **ICD-9: diagnostic codes (soon to be ICD-10)**
  - Think beyond the primary diagnosis
  - Signs/symptoms, psychosocial concerns
  - BILL on TIME!

- **Current Procedural Terminology (CPT) codes**
  - Outpatient
  - Inpatient
  - Home-based
  - Prolonged service
Some payers...

* Like Regence Blue-Cross/Blue-Shield (6 US states) MI, SC
  * reimburse for RN/SW working under MD with NPI
  * Incident 2 billing (nurses reimbursed under MD)
  * Torrie Fileds, MPH Cambia Health Solutions, Portland OR
Professional Billing and Coding

* Existing codes are somewhat poorly reimbursed, even the well-established ones

* Peds in adult hospitals using adult MA codes

* Many codes are not paid for at all
  * Prolonged service (but some are!)
  * Telephone calls (some telehealth is)
  * Care plan management (currently changing)
  * Team conferences
Hospice benefit

* Restrictions of the hospice benefit
  * Per diem is not enough: average $142.91 in 2010, $176/day 2013 (CA)
  * Private insurance caps rapidly exceeded
  * Palliative Care Waiver (CA): Expressive Art included (not in Hospice)
* Non-ideal reimbursement for time and non-medical services
  * Most of the interdisciplinary team members cannot bill
How do we do this better?

- Billing -> checklist
- Working with business development to interact with discharge
- Document time spent in the medical record
  - Be specific about complexity necessary to justify time
- Bill for symptoms whenever possible – symptoms that someone else isn’t managing
- Learn your payer mix
- Temporarily, “consultations” paid better than new patients
  - Not in Medicare; Medicaid likely soon to follow
B. Philanthropy
Philanthropy

* Clinical reimbursement will not be enough
* Philanthropic support is a VALID income stream and can become a stable source of funding for innovation and expansion
* Need to ensure that you can raise money for your program separately from your institution/organization, if possible
* Philanthropy = Investment from donor, often expecting program sustainability
Grants

* Great for start-up costs / momentum
* Need to show sustainability
* Attractive if show collaboration among different agencies, systems, etc.
Grants

- National/regional – ONLY if you have support infrastructure
- Memorial bequests
- Local granting agencies or community foundations
- Employee Foundations from hospitals, corporations/businesses
- Private local funders
- FAMILIES
Caveats

- Close collaboration with Grants and Development/Foundation staff
- Can be fairly time-consuming – and then they are due again
- Avoid funding positions/people if possible, and go for program extras that will require less for ongoing maintenance
  - Ex: database construction
C. Direct Support
Direct Hospital Support

- In-kind support
- Alignment with hospital mission
- Community Benefit
- Resource sharing
Why should they do that...?

* Recognition
* Halo Effect: Increase in market share
* Decrease in complications / earlier discharge = higher patient turnover
* Reduced liability for iatrogenic harm
* Increased staff / patient / parent satisfaction
  * HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey
* Reduced staff turnover (> $60-100K training 1 ICU RN)
* “Never Events” NOT reimbursed (PPC patients over represented) --> home care
Direct Hospital Support

PALLIATIVE CARE IS STANDARD OF PRACTICE IN U.S. NEWS HONOR ROLL Children’s HOSPITALS

100% of the U.S. News 2014 – 2015 Honor Roll Children’s Hospitals Have Palliative Care Teams

- Ann and Robert H. Lurie Children's Hospital of Chicago
- Boston Children's Hospital
- Children’s Hospital Colorado, Aurora
- Children's Hospital Los Angeles
- Children's Hospital of Philadelphia
- Children's Hospital of Pittsburgh of UPMC
- Cincinnati Children's Hospital Medical Center
- Johns Hopkins Children's Center, Baltimore
- Nationwide Children's Hospital, Columbus, Ohio
- Texas Children's Hospital, Houston
Value = \( Q \times S / C \)

- An early palliative care intervention (even from the point of diagnosis) = appropriate and beneficial treatments, increased quality of life and may in fact lead to prolonged (!) life.

- RCT, n=151; adult cancer patients receiving palliative care early in their illness lived longer (11.6 months vs. 8.9 months, \( P=0.02 \)), with better quality of life, including decreased depression

- Results underscore the need for palliative care early in a serious illness

- This appears to refute the notion that palliative care means giving up

- Patients received palliative care alongside their curative treatment.

- Although this is only one study, it is an exciting one & results are not surprising: PC clinicians regularly see these outcomes in practice - even in pediatric patients.
Pediatric Palliative Care & Cost Savings?


* Children’s Hospitals and Clinics of Minnesota, Dept. Pain Medicine, Palliative Care & Integrative Medicine: 425 children 1-21 years: Home-based PPC or hospice services 2000-2010

* Compare pediatric hospital resource utilization before and after enrollment

* Non-cancer patients: LOS decrease 38 days, decrease hospital charges $275,000 / patient
Barking up the cost saving tree...?
We are here, where do we go...?

* Current world: FEE FOR SERVICE
  * The more you do, the more you get paid
  * The more you have done to you, the more you or your insurance company have to pay
  * DRGs: Prospective payment

* What’s here or will be soon
  * Value-based care or Pay-for-performance (P4P)
  * Accountable Care (ACO)
  * Shared savings or risk models (SSAs)
  * Patient-Centered Medical Homes (PCMH)
  * Population health
  * Global payment/capitation
  * Bundled, episode-based or episode-of-care payments
So.... How do we overcome these barriers?

* PPC program sustainability depends (approximately) in 2014/2015 on:
  * Professional billing revenue (1/3)
  * Philanthropy/grants (1/3)
  * Direct support (1/3)
* But, things are A-Changin’...
  * ACO
  * Payers
How do you bring this all together?
Wrapping It Up...

* Healthcare reform supports a business model for pediatric palliative care

* Successful PPC programs get funded:
  * Professional billing revenue
  * Philanthropy / grants
  * Direct support
Further Training

Education in Palliative & End-of-life Care [EPEC]: Become an EPEC-Pediatrics Trainer | Phoenix, AZ | May 4-5, 2015

8th Annual Pediatric Pain Master Class | Minneapolis, MN | June 20-26, 2015