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Palliative Care Services Workgroup Meeting
November 14, 2022
Meeting Summary

ATTENDANCE:

Workgroup Members:

Dr. Deneen Bowlin, CareFirst
Cindy Carter, AARP
Matthew Celentano, League of Life
Erin Davis, Maryland Hospital Association
Amanda DiStefano, Maryland Department of Aging
Peggy Funk, Hospice & Palliative Care Network of Maryland
Dr. Marian Grant, Palliative Care Nurse Practitioner and Consultant
Catherine Hamel, Gilchrist Hospice
Scott Hanel, Accentcare
Dr. Christopher Kearney, State Advisory Council on Quality Care at End of Life
Cindy Massuda, CMS
Joanna Ruth, Medicaid
Kelly Voltran, CMS

MHCC Staff:

Ben Steffen
Linda Cole
Tracey DeShields
Stacy Howes
Zoram Kaul
Catherine Victorine
Cathy Weiss

Interested Parties/Public:

Rachel Adams, MedStar
Scott Brown, My Directives
Allison Ciborowski, Leading Age
Dr. Donald D'Aquila, University of Maryland Clinical Pharmacy Specialist
Dr. Ethan Goldstein, MedStar Good Samaritan Hospital
Ted Myerson, Nursing home general interest
Kathryn Walker, MedStar

WELCOME AND INTRODUCTIONS:

Ben Steffen welcomed all participants to the second meeting of the Palliative Care Services Workgroup. He introduced staff and workgroup members in the conference room and asked participants on zoom to introduce themselves.

Linda Cole asked the workgroup members if there were any comments or corrections on the meeting summary sent for the September 21st meeting. There were no comments.

UPDATES BY PAYERS:

Ms. Cole then stated that she had followed up with payer representatives, asking them to prepare information for this meeting on how palliative care is reimbursed.

Kelly Voltran, representing CMS stated that Medicare has a hospice benefit, but no separate palliative care benefit. Mr. Steffen pointed out that hospice requires a patient to forego curative treatment, while palliative care does not.

Cathy Hamel, Gilchrist Hospice, said that certain palliative care treatments are covered under the hospice per diem. She also said providers (physicians and nurse practitioners) bill Medicare Part B for palliative care consults. She said that advance care planning is covered under Medicare. She added that concurrent care (both hospice and curative care), which was covered by the Centers for Medicare and Medicaid Services Innovation Center (CMMI) under grants was successful, but not continued. Dr. Marian Grant said that the CMMI model of concurrent care was established, but the entrance requirements for patients were so stringent that there were insufficient patients, and therefore it was discontinued.

Joanna Ruth, representing Maryland Medicaid, said that Medicaid funding is similar to Medicare. Some covered services may be considered palliative care, but there is no specific benefit. Cathy Hamel stated that Medicaid will cover concurrent care for pediatric patients. Ms. Ruth said that she will follow up to see if Medicaid has any plans to cover palliative care in the future.

Dr. Deneen Bowlin, representing CareFirst said that there is no separate benefit for palliative care. Hospice and palliative care are covered under employer contracts. Medicare Advantage covers some palliative care services under contract with Aspire. Dr. Chris Kearney asked if CareFirst had previously had a commercial benefit for palliative care. He believed it was concurrent care for younger populations when Tim Cox was working at CareFirst.

Dr. Grant clarified that hospice is palliative care at the end of life, but earlier palliative care is not hospice. We need to come up with creative solutions to financing issues.

Mr. Steffen said that the MHCC has found that advance care planning is not used much by primary care physicians. He noted that palliative care seems to be a contract-by-contract option and asked if it was a pricey option.

Matt Celentano, representing League of Life, said that insurance carriers whom he contacted struggled to reply. Most have some hospice/palliative care benefit, but it is usually treated as the same thing. He offered that if the group can come up with some CPT codes, he could check to see which services are covered.

Dr. D'Aquila said that the Veterans Administration (VA) is very well versed in providing concurrent care. He asked if that may be a model to consider. Dr. Grant said that the VA has a comprehensive

program, but it is an integrated system, unlike the rest of the healthcare system, so results cannot be generalized.

Dr. D'Aquila said that Medicare Advantage has low use in Maryland. He asked if the Health Services Cost Review Commission (HSCRC) covers services under "serious illness programs." Mr. Steffen said that the HSCRC application to CMMI to allow HSCRC to establish lower hospital rates for Maryland Medicare Advantage plans had been rejected. Maryland is currently considering one-time funding support to Medicare Advantage plans, while a long-term plan is developed.

Mr. Steffen said that HSCRC is planning for the next stage of the Total Cost of Care (TCOC) expansion. Workgroups will be formed to identify opportunities for greater alignment with the TCOC model among various health care providers that are not directly linked to TCOC. One workgroup will focus on post-acute care payment and quality initiatives.

Ms. Cole summarized this discussion of payment for palliative care that the current situation seems to indicate very few, if any, specific palliative care benefits. This information, along with the survey, will help to describe the current situation. Future discussions will help the workgroup to develop recommendations about expansion of palliative care benefits.

REVIEW OF DRAFT SURVEY:

Ms. Cole continued with the review of the draft palliative care survey. She pointed out that this draft survey had been mailed in advance for review by workgroup members. She received detailed comments from Dr. Grant but expected full participation by workgroup members.

Dr. Kearney asked what definition of palliative care was to be used for the survey. Ms. Cole referred him to the discussion at the first meeting of the workgroup and the selection of the definition developed by the Center to Advance Palliative Care (CAPC) as follows:

Palliative care is specialized medical care for people living with serious illness.

This type of care is focused on providing relief from the symptoms and stress of the illness.

The goal is to improve quality of life for both the patient and family.

Palliative care is provided by a specially-trained team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support.

Palliative care is based on the needs of the patient, not on the patient's prognosis.

It is appropriate at any age and at any stage of a serious illness, and it can be provided along with curative treatment.

The survey, which will be sent by email to identified staff at the provider programs and facilities will be followed up by telephone surveys so that the interviewer can probe for detailed responses.

Representatives (such as MHA, HFAM, Hospice & Palliative Care Network) will be asked to advise on the best person/department to contact for the survey.

Ms. Cole said that we are interested only in formal programs that meet the palliative care definition above. For those programs that offer palliative care under contract (e.g., nursing homes that contract with hospices), we will identify the program and with whom they contract. That would identify the site of care without duplicating the count of providers.

There were recommendations to modify question 5 to address hospital programs and contracts. There were wording suggestions for question 7(f) to modify community setting options. Some suggestions

were made to include a general statement of possible losses on question 8. For question 9, recommendations included adding measures such as reduction in hospital readmissions and use of emergency departments.

Dr. Kearney asked a general question about the length of the survey and level of detail. Ms. Cole responded that the legislative directive is quite broad. She also stated that the basic survey (modified by staff and the workgroup) has been used in other states, including three times in Colorado and twice in Maine. Dr. Kearney asked if additional data is available from CAPC or the Palliative Care Collaborative. Ms. Cole summarized some of the limitations of the data collected by CAPC, including a greater focus on hospital and not community-based palliative care.

Ms. Cole reviewed the sites recommended for the survey: licensed general hospitals; licensed nursing homes; licensed hospices; licensed home health agencies; other identified community providers as identified in the survey. There were no additional comments on this.

The modified survey will be included in the mailing to the workgroup.

OTHER ISSUES:

Scott Brown asked if Maryland Order for Life-Sustaining Treatment (MOLST) forms were identified could that be used to document registries. Mr. Steffen replied that this is addressed by other MHCC initiatives on advance directives.

Cindy Carter asked if there will be a survey of caregivers in the community. Peggy Funk added that it would be good to get the perspective of caregivers. Ms. Cole responded that this survey is directed to licensed facilities in Maryland, but another approach could be considered for caregivers.

There was mention of the importance of telehealth. Ms. Cole pointed out that this is included in the survey.

NEXT STEPS:

Mr. Steffen thanked everyone for their participation. Ms. Cole said that the next workgroup meeting is scheduled for January 9, 2023. Ms. Cole said that she will keep the group updated on the process of getting out the bid board for the survey. The agenda for that meeting will also address “improving and expanding palliative care” as well as further discussion on financing, including what exists now and what is needed in the future.