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## **Palliative Care Services Workgroup Meeting**

**June 28, 2023**

### **Meeting Summary**

#### **ATTENDANCE:**

##### **Workgroup Members:**

Dr. Deneen Bowlin, Carefirst  
Cindy Carter, AARP  
Matthew Celentano, League of Life Insurers  
Erin Davis, Maryland Hospital Association  
Amanda DeStefano, Maryland Department of Aging  
Peggy Funk, Hospice & Palliative Care Network of Maryland  
Dr. Chris Kearney, State Advisory Council on Quality Care at End of Life  
Joanna Ruth, Maryland Medicaid

##### **MHCC Staff:**

Ben Steffen  
Linda Cole  
Tracey DeShields  
Dr. Stacy Howes  
Catherine Victorine

##### **Interested Parties/Public:**

Dr. Rachel Adams, Medstar Health  
Nenellia Bronson, SEA Healthcare  
Regina Bodnar, Lifebridge Health, Bridging Life Hospice  
Scott Brown. MyDirectives.com  
Dr. John Dunkle, Adventist Healthcare  
Monica Escalante, Coastal Hospice  
Delegate Ken Kerr, State Delegate  
Louise Knight, Sidney Kimmel Cancer Center, Johns Hopkins  
Dr. Dan Morhaim, Retired Physician and State Delegate  
Shirley Otis-Greene, Collaborative Caring  
Elba Rivas, Adventist Healthcare  
Rebecca Swain-Eng, SEA Healthcare  
Dr. Lakshmi Vaidyanathan, Shore Regional Palliative Care Program  
Kelly Voltran, CMS

## WELCOME AND INTRODUCTIONS:

Ben Steffen welcomed workgroup members and other interested parties, both in the room and online to the hybrid workgroup meeting. Linda Cole checked if there were any updates to the May 23<sup>rd</sup> meeting summary. Dr. Deneen Bowlin offered some comments. Ms. Cole said that a revised meeting summary would be posted.

## UPDATES:

Linda Cole reported to the workgroup that she made a presentation to the June 15<sup>th</sup> Commission meeting. Commissioners had some questions about coordination between primary care providers and palliative care staff. There were also questions about the definition of palliative care. Ben Steffen sent some additional materials after the meeting to further clarify the role of palliative care. Mr. Steffen also mentioned that the Commissioners directed that no specific recommendations be included in the Interim Report. Work will go on during the next few months to revise and finalize recommendations to include in the Final Report.

Ms. Cole then asked Peggy Funk to report on some updates from national meetings on the development of palliative care. Ms. Funk reported that the National Hospice and Palliative Care Organization (NHPCO) held an event in Washington, DC. She discussed proposed legislation (Senate Bill 1845), which would amend title XI of the Social Security Act to provide for the testing of a community-based palliative care model under the Centers for Medicare and Medicaid Innovation (CMMI). This proposed bill has bipartisan support. She also reported that NHPCO is working with the National Opinion Research Center (NORC) to determine the cost of care for this model. Based on preliminary results, NORC found that the model can reduce the average total cost of care by 20% and result in almost \$600 million in savings to Medicare.

Dr. Morhaim also referred the group to an article recently published in JAMA on palliative care that compared place of death from cancer with and without palliative care laws:

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2805786>

Ms. Cole reminded the group that several items were included in the mailing: CAPC's Spotlight on Home-Based Palliative Care; Payment Arrangements for Palliative Care; and Payment Primer for Palliative Care. These will be posted on our website, along with meeting materials.

## REVIEW OF SURVEY DATA:

At the May workgroup meeting, Rebecca Swain-Eng (SEA Healthcare) provided some initial results from the Statewide Palliative Care Survey. She continued the presentation of results at this meeting.

Several key findings include:

- 16 palliative care organizations have been operating 10 years or longer;
- Of 34 respondents, 27 reported having staff who were board-certified; fellowship-trained; or specialty-certified in hospice and palliative care;
- Of 29 responding, 26 organizations offer dedicated palliative care consultation services;
- Most organizations showed an increase in services and consults between 2021 and 2022; hospice was an exception to this trend; this requires further study;
- Most common services: patient and family meetings to support goals of palliative care; pain and symptom management; advance care planning discussions; communication and care coordination;
- Most common diagnoses: cancer; heart disease; dementia; lung disease; stroke;
- Most organizations did not provide pediatric palliative care;
- 20 of 29 respondents said that they offer telehealth palliative care services;

- Palliative care quality measures are standardized metrics and may vary by setting;
- 50% of respondents use Z-codes for billing;
- Majority of respondents use CPT codes for billing for advance care planning.

The complete set of slides will be posted on the Commission's website.

COMMENTS AND QUESTIONS:

Mr. Steffen noted that two thirds of respondents did not provide useable data. Ms. Swain-Eng explained that respondents had to: a) meet the CAPC definition of palliative care; b) be authorized to complete the survey; c) complete the entire survey.

Ms. Funk explained that not all hospices offer a palliative care program, if they restrict admissions to the Medicare hospice requirement of six months or less to live. Monica Escalante explained that Coastal Hospice is able to provide a palliative care program through a partnership with Tidal Health. Regina Bodnar said that she responded (on behalf of Lifebridge and Bridging Life Hospice) by using only palliative care data, not hospice. Dr. Chris Kearney said that the data fairly reflects his 20-year experience with palliative care.

12-STATE SUMMARY:

Ms. Cole mentioned that SEA produced a summary of palliative care efforts in a selected 12 states. The focus includes: legislation; education; funding; quality; and data. She encouraged workgroup members to review these tables in detail and provide any comments or edits to her.

REVIEW OF DRAFT RECOMMENDATIONS:

Ms. Cole then turned to a review of the draft recommendations. She noted that they are draft and for discussion only, since Medicaid and other state agencies have not yet endorsed them.

Comments were offered on the following:

Slide 7: Public and Provide Education:

Ms. Swain-Eng said that other states had done public education campaigns on palliative care. Ms. Funk cautioned that Maryland does not currently have a sufficient number of palliative care providers. The question was also raised as to who would fund such a campaign.

Shirley Otis-Greene said that professional education is also needed and that the state should support the federal Palliative Care and Hospice Education and Training Act (PCHETA).

Dr. Kearney stated that there are several ongoing education efforts that can be supported, rather than duplicating efforts.

Slide 8: Advisory Council on Quality Care at End of Life:

Dr. Kearney said that this group is very anxious to work with the Commission and the industry to move the palliative care efforts forward.

Slide 9-10: Medicaid Waiver:

Mr. Steffen asked how palliative care services would be integrated into a 1915 (c) waiver. Both Hawaii and New Jersey are working on this. There is also a National Academy for State Health Policy (NASHP) guide for funding palliative care under Medicaid.

Cindy Carter pointed out that current Medicaid home and community-based waivers are backed up with long waiting lists.

Mr. Steffen said that any discussions of the Total Cost of Care model would need to involve HSCRC.

Slide 11-14: Medicaid funding options:

Joanna Ruth said that these options would need to be discussed by Medicaid.

Mr. Steffen said that regarding Medicare Managed Care, Aledade acquired IRIS Health, a company specializing in advance care planning. This enhances their ability to provide comprehensive advance care planning to support patients, families, and care teams.

Slide 15: Expansion of Community-Based Palliative Care:

If we encourage expansion of services, there needs to be funding. Ms. Funk suggested that community-based programs be held to certain standards as was done for the Hospital-Based Palliative Care Report.

Slide 16: Workforce Development:

This is needed, but how it would be funded is unclear.

Slide 17: Palliative Care Quality Improvement:

Dr. Kearney said that good quality care costs less and can save money. Ms. Bodnar stated that using palliative care can benefit hospitals, especially using referrals to outpatient palliative care.

Slide 18: Survey Recommendations:

There was also discussion on how to improve the survey process going forward to produce more accurate and extensive results.

Kelly Voltran said that this information is important for CMS to review the data and assess funding options.

NEXT STEPS:

Mr. Steffen indicated that we need to review these recommendations and perhaps condense them. We also need to check with funding partners.

Ms. Cole asked workgroup members to provide comments on the recommendations. A follow-up email requested all comments by July 10<sup>th</sup>.

Ms. Cole said that the Interim Report will be finalized and sent to the legislature. At the next meeting (August 31<sup>st</sup>) the recommendations will be further refined.