



Palliative Care Services Workgroup Meeting

May 23, 2023

Meeting Summary

ATTENDANCE:

Workgroup Members:

Dr. Deneen Bowlin, Carefirst
Cindy Carter, AARP
Matthew Celentano, League of Life
Erin Davis, Maryland Hospital Association
Dr. Marian Grant, Palliative Care Nurse Practitioner and Consultant
Cathy Hamel, Gilchrist Hospice
Amanda DeStefano, Maryland Department of Aging
Heather Guerieri, Compass Hospice (for Peggy Funk)
Dr. Christopher Kearney, State Advisory Council on Quality Care at End of Life
Kelly Voltran, CMS

MHCC Staff:

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

Interested Parties/Public:

Regina Bodnar
Whit Dunkle
Monica Escalante
Benjamin Goldstein
Sarah Hemming
Louise Knight
Dr. Dan Morhaim
Ted Myerson
Shirley Otis-Greene
Rebecca Swain-Eng
Lisa Tompkins-Brown

WELCOME AND UPDATES:

Ben Steffen welcomed everyone to the fourth meeting of this workgroup. Linda Cole noted that although the workgroup has not met since January, staff have been moving ahead with the palliative care work.

Ms. Cole noted that SEA Healthcare, a health services research and quality improvement consulting firm was awarded the contract to conduct the statewide palliative care survey. They subcontracted with Tenacity Solutions for assistance with quantitative and qualitative data analysis. She noted that the preliminary survey results will be the focus of today's discussion.

In March, we were notified that Maryland was one of six states selected to participate in the State Policy Institute to Improve Care for People with Serious Illness. This group is directed by the National Academy for State Health Policy (NASHP). States will receive technical assistance, sharing palliative care developments, as well as receiving actuarial support to develop models for financing.

In addition, at the request of Leading Age, an organization representing a diverse range of long-term care providers, MHCC staff and workgroup members Peggy Funk and Dr. Marian Grant described the work of this group as well as the development of palliative care in Maryland.

SEA PRESENTATION: PRELIMINARY DATA FROM STATEWIDE SURVEY:

Rebecca Swain-Eng began by describing the process for data collection. The initial survey had to be retooled from a telephone survey to a web-based survey. Beta testing was conducted using volunteers from various healthcare settings.

Since the workgroup had agreed that the survey would be used in four settings, the survey was sent to:

- Hospitals (46)
- Nursing homes (227)
- Hospices (27)
- Home Health Agencies (56)

Reaching the appropriate individuals in each organization was a very complex task, and data collection included multiple follow-up emails and phone calls. The data collection, originally planned for February 22-March 24th, was extended to April 30th to increase response rates.

Ms. Swain-Eng then did a SWOT analysis to review the Strengths, Weaknesses, Opportunities, and Threats gleaned from this process. She also explained that a product of this data collection would be the development of a Palliative Care Provider Directory that would include not only providers who responded to the survey, but also organizations that the research team can confirm have a program by publicly available data. Workgroup members agreed that this would be a useful resource.

Ms. Swain Eng reported an overall response rate of 51%. However, when programs were eliminated if they did not meet the Center to Advance Palliative Care (CAPC) definition, or if they did not complete the entire survey, the responses used in data analysis were 36%. This ranged from 89% for hospices to 45% for nursing homes.

The data presented included: organizational types by region; management of palliative care services; years of providing palliative care services; multi-disciplinary teams composition; program staff roles; certified staff; payers; and billing. For more details, see slides entitled: "Palliative Care Workgroup Meeting MHCC Palliative Care Survey".

Finally, Ms. Swain-Eng provided recommendations for future data collection, including making the survey more focused and briefer; expanding stakeholder engagement to include family providers; evaluate payer types to understand reimbursement policies.

DISCUSSION:

There were some questions from the group to understand the response rates and how the numbers went from 359 surveyed, to 182 respondents to 65 useable surveys. This is further addressed in the slides.

Questions were raised about how staffing questions were formulated. Some were multiple choice (drop down menu) and some were open-ended.

Ben Steffen asked about how value-based care was defined. Lisa Tompkins-Brown responded that there were two questions. One asked if any services were offered under a value-based contracts (yes/no); the other asked the percentage of revenue generated from value-based care. Dr. Grant responded that some hospices have value-based contracts for community care with commercial payers.

Ms. Swain-Eng stated that many programs used contractors to provide palliative care services. For example, Gilchrist provides palliative care for hospitals and nursing homes. Dr. Grant said that palliative care is a unique skill set.

It was noted that most palliative care programs are in urban areas. Other states have used Medicaid benefits to reimburse such care statewide. Heather Guerieri noted that if you pay for palliative care, it will be developed.

Cindy Carter noted that, even in urban areas, there is little to no palliative care provided in the home. If there is reimbursement, this is a way to keep people out of the hospital.

Mr. Steffen asked the payers to discuss their benefits for palliative care. Kelly Voltran, CMS said that the only dedicated benefit is the Medicare hospice benefit. The CMS Innovation Center has funded some models of concurrent care, that is both curative and supportive treatment. It was also mentioned by the workgroup that concurrent care is funded for pediatrics and for Veterans.

Dr. Bowlin, Carefirst said that Carefirst has a pilot with some members in hospitals. . Dr. Chris Kearney said that the previous Carefirst program was a bundled payment program for hospitals and also included care in the community. The current pilot focuses on initiation of palliative care to patients in participating hospitals with continuation of the palliative care into the community.

Matt Celentano said that for commercial insurers it depends on the benefit. He did not have specific data. There is not much value-based care in Maryland; it exists mostly for primary care.

INTERIM REPORT AND RECOMMENDATIONS:

Ms. Cole then reviewed the topics outlined in the legislation that need to be addressed in the Interim Report. She opened discussion on what can be done to address gaps in services, encourage collaboration, address financing, and the other issues outlined.

Dr. Kearney said that the State Advisory Council on Quality Care at End of Life could assist with Advance Care Planning and public education. Dr. Grant cited her work with CTAC (??) which is collaborating with the American Heart Association on palliative care for cardiac patients.

The National Academy for State Health Policy (NASHP) can assist with financial and actuarial analysis. It was mentioned that there are several states that have made progress on Medicaid funding for palliative care, including New Jersey, California, Illinois, Hawaii.

Erin Davis also mentioned work in Arizona to develop community-based palliative care.

Rebecca Swain-Eng mentioned some financial recommendations, including working with policymakers and insurance companies, engaging at the federal level to raise awareness of

palliative care services, identify regulatory barriers, conduct cost-effectiveness studies and other pilot studies.

In terms of gaps in services, Dr. Grant and Ms. Guerieri stated that once funding is established, services will be developed. Dr. Grant cited California where Medicaid coverage is mandated and palliative care services exist in every county. Cathy Weiss asked what licensure system or quality control exists to assure that services provided meet standards. Dr. Grant said she would supply that information.

It was mentioned that there is currently no funding for messaging.

NEXT STEPS:

Ms. Cole mentioned that the group has a short timeframe. She will incorporate comments from today's meeting to develop some themes for draft recommendations. A status report will be presented to the Commission at its June meeting. The workgroup will reconvene on June 28th to review the draft Interim Report. She noted that we have time to refine recommendations prior to the final report, which is due November 1st.