Advancing Health Equity – One State at a Time

"Expanding Access to Care & Health Equity for People with Serious Illness Through State Medicaid Palliative Care Benefits"

Speakers:

- Sandra Clark, MPH, Director of Population Health, TFA Analytics
- Peggy Funk, CAE, Executive Director, Hospice & Palliative Care Network of Maryland
- Senator Angela McKnight, New Jersey State Senate
- Jamie Teuteberg, MS, Director of Health Aging Initiatives, WA State Health Care Authority




C+TAC

Advancing Health Equity One State at a Time:

Expanding Access to Care & Health Equity for People with Serious Illness Through State Medicaid Palliative Care Benefits

October 21, 2024

2:50pm – 4:05pm Breakout Session

Agenda

2:50 pm: Opening Remarks by Sandra Clark, MPH, TFA Analytics

3:00 pm: Video Presentation by Judy Mohr-Peterson, PhD, HI Med-QUEST Administrator

3:05 pm: Presentation by Peggy Funk, CAE, Executive Director Hospice & Palliative Care Network of Maryland

3:20 pm: Presentation by Senator Angela McKnight, NJ Senate

3:35 pm: Presentation by Jamie Teuteberg, MS, WA State Health Care Authority

3:50 pm: Audience Q&A

Why is now the time for focusing on advancing access to palliative care benefits?

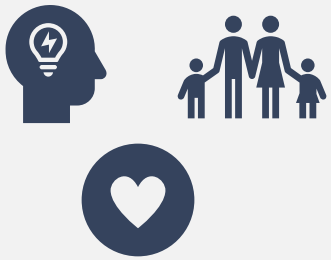
We Must Meet the Demands of Current Healthcare Reality

1. Medical innovations have increased access to new medications, treatments, devices, and procedures that prolong life, treat (and sometimes cure) diseases, and improve quality of life even in the face of new diseases.
2. Some illnesses previously considered life-threatening are now being classified as chronic diseases, including cancers, heart failure, and neurological conditions.
3. Infectious diseases have become largely managed through vaccines, therapies, and other preventive measures, leaving more attention to be paid on those with chronic conditions and sudden events.
4. COVID accelerated the adoption of new technologies to sustain connectivity, deliver new interventions, and protect health and well-being.
5. COVID taught the public about risk: how to assess personal health risk, and how to take precautions when identifying someone as being in a high-risk category.
6. Medical crises lead to financial, social, psychological, and existential crises. Healthcare is no longer medical care.

People with Serious Illness Need Comprehensive Care

Individuals with serious illness, need extra support from multi-disciplinary team that bridges all **care settings, geographies, and cultures.**

Individuals with serious illness, need **whole-person and person-centered approach** that includes **emotional, social/family, spiritual, cultural, and intellectual** aspects of care.



Individuals with serious illness, and their caregivers need the **right care**, at the **right time**; from the **right person**; at the **right place**.

State Approaches to Increasing Health Equity during Serious Illness

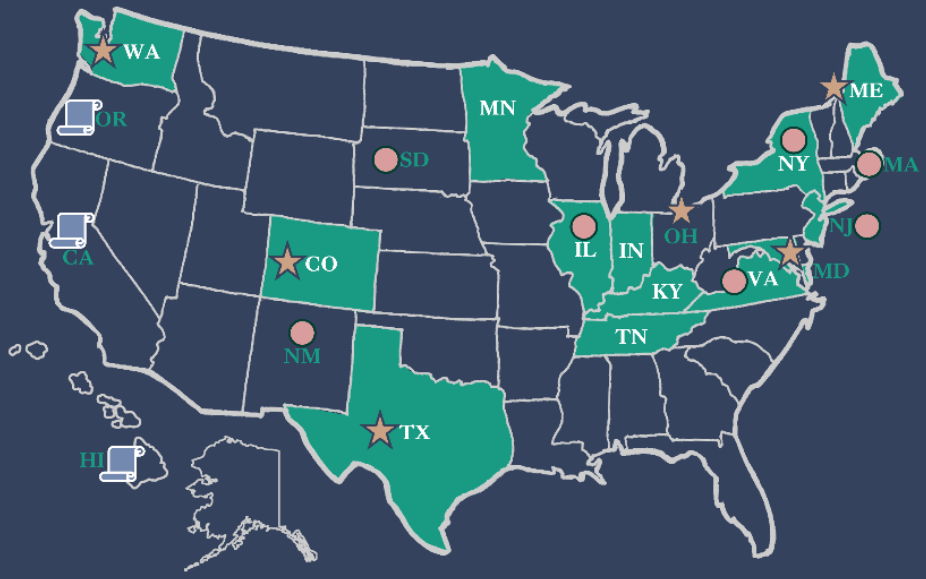
State Medicaid Expansion of Palliative Care Services

Medicaid agencies have a mission to deliver a set of **defined benefits, policies, and payment methodologies** that allow the program to support **increased access to high-quality services for people with serious illness, especially in their homes.** The American Rescue Plan Act (ARPA) reinforced this mission through a federal match to expand such services across the state.

- **Palliative Care Services:** 22 states have advanced legislation to expand Medicaid benefits to include reimbursement for community-based palliative care services
- **Home and Community-Based Services:** Waiver expansions for serious illness, home-based care, social determinants of health, substance use treatment, and behavioral health services
- **EPSDT:** Includes coverage for children to access concurrent hospice services. Must still meet hospice eligibility criteria.
- **Dual Alignment Program:** Managed care plan alignment of dual eligible beneficiaries to ensure access and affordability. Currently, Medicare – Medicaid reimbursement coverage split is 80% Medicaid, 20% Medicare, on average. Hospice benefit is covered by Medicare for duals.
- **Other Programs and Services:** State Master Plans on Aging; Program All Inclusive for the Elderly (PACE); Health Homes

States Advancing Palliative Care Benefits: Legislative and Budgetary Initiatives (Oct 2024)

The lack of coordinated palliative care in the community leaves a gap in care for people with a serious illness that should be closed with **policy recommendations** that requires an **interdisciplinary team** and a **payment model** that supports all aspects of palliative care.



Legend

TEAL States: PC council named in law, with budget authority

States in NASHP serious illness institute

States that have at least initiated action all the way up to actively pursuing PC policy

CA SB1004 (2015), HI State Plan Amendment (2023); OR HB 2981 (2022)

Why Develop a Palliative Care Benefit?

People with Serious Illness have consistent goals:

- Control pain and symptoms
- Achieve a sense of control
- Relieve burden on family
- More time at home

Medicaid Agencies and States have consistent goals when implementing Palliative Care Services:

- Improve health equity for individuals with serious illnesses;
- Improve access to high-quality serious illness care throughout the state;
- Improve the quality of life for patients and for their families;
- Decrease symptom burden for patients; and
- Decrease avoidable utilization and spending.

Medicaid: Filling a Gap with Palliative Care Services

As part of a comprehensive review of services, we found that:

1. There is no palliative care "benefit" available in any setting.
2. Palliative Care Services are being delivered in 68% of all hospitals with over 100 beds, most through an interdisciplinary team. These are reimbursed through the DRG payment
3. Palliative Care Consultations are required as part of the prior authorization for certain invasive procedures (e.g., LVAD)
4. Some palliative care assessments and consultations are available in the clinic or at home today, but these services are billed "a la carte", and often to not include an interdisciplinary team that can support a person's holistic needs longitudinally. Access is subject to workforce availability and provider competency, with no current network adequacy requirements.
5. The only time PC is part of a coordinated benefit is through hospice care, which focuses on managing comfort at the end of life rather than supporting people with serious illness who continue to pursue treatment.
6. Concurrent care services for hospice are available for children under EPSDT, but access is limited due to the need to meet 6-month prognosis requirements.

This lack of coordinated palliative care in the community leaves a **gap in care** for people with a serious illness that should be closed with a coordinated benefit that **requires an interdisciplinary team and a payment model that supports all aspects of palliative care**.

Decisions Needed to Develop a Benefit

1. Define palliative care services
2. Identify gaps in coverage/services
3. Determine what services need to be covered and how
4. Determine the policy route to take
5. Identify the population in need
6. Setting a baseline based on experience
7. Determine how many people might access services
8. Determine the cost of the services offered
9. Determine if the costs can cover services delivered and how much the state can afford
10. Understand the value of delivering the benefit
11. Determine the impact on the premium and if there is budget neutrality/cost savings

Potential Policy Routes to Take

States can develop a palliative care benefit through many routes

Major Route	Requirements	Benefits	Drawbacks
Waivers: • **1915c (HCBS)** • **1115 (Demonstrations)** • **D-SNP Alignment**	• Waiver must be filed annually • Rates must be developed and published	Pathway less clear for what federal justification needs to be made	Must be filed yearly, making benefit more likely to be reversed
Legislation	• Must find a champion in state legislature • Must clearly define services in partnership with MCOs and Department of Health	Does not require CMCS approval; Does not require a budget to be attached	Not formally filed May not have budget attached, or budget may vary by legislature
State Plan Amendment (1905(a) Social Security Act)	• Formally filed as a permanent benefit • Rates must be developed and published • Must prove that the benefit does not create material changes to the fee schedule or to the nature of care delivery	Faster, with a more clearly defined process	Permanent, with additional feasibility testing and regulatory review needed Must prove statewideness
Integrated into existing programs • **Health Homes** • **Value-Based Purchasing** • **MLTSS**	• Must clearly define services in partnership with MCOs and Department of Health • Must prove that the benefit does not create material changes to the fee schedule or to the nature of care delivery	Faster Does not require a budget to be attached	Requires more stakeholder education and awareness

Improving Health Equity through Increased Representation

Stakeholder feedback is needed to ensure that the benefit designed meets the needs of people with serious illness in the state and their caregivers. Community stakeholders and clinical leaders are crucial to **ensuring access and representation in the local community**.

What needs to be collected:

- Determining who would be most appropriate for services
- Determining provider capacity, competencies, and training needed to deliver services
- Understanding the "ideal" care model
- Understanding the up-front capital investment needed to deliver services and ongoing costs, including staffing, administration, and other infrastructure
- Setting expectations for outcomes from services, including quality and reporting
- Identifying additional needs to support equity and access, including public engagement, provider education and training, and consumer protections

Panelist Presentations

Expanding Access to Care & Health Equity for People with Serious Illness Through State Medicaid Palliative Care Benefits – The Maryland Experience

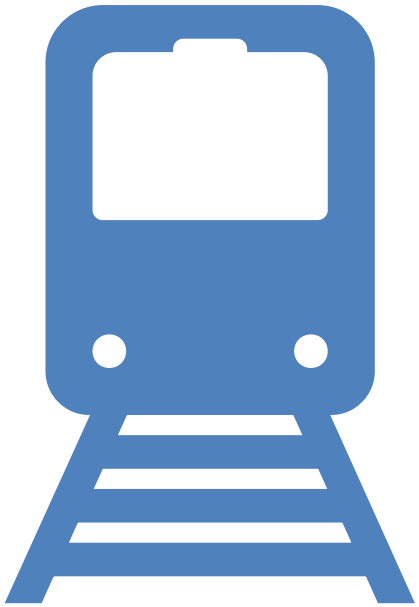
October 16, 2024

Hospice & Palliative Care Network
OF MARYLAND

Peggy Funk, CAE
Executive Director

Today's Discussion

- **Background/State Overview**
- **Why pursue a PC Benefit?**
- **Our Goals for a PC Benefit**
- **Opportunities & Challenges Along the Way**
- **What's next**



Background – Maryland's PC Journey!

Key Legislation

2013 – HB 581 - Establishment of Palliative Care Programs in Hospitals

- Hospitals with 50 or more beds must provide PC services.
- Some performed well; others struggled
- **Challenge**: Where do patients go for PC services after discharge, or even if they just receive a PCP referral for PC?

2022 – HB378 – Palliative Care Services – Maryland Health Care Commission Workgroup Study

- Modeled after Hawaii's early legislation to study PC
- Initiated by HPCNM to address the lack of Community-based PC
- No opposition; passed its first year

2023 – Maryland Accepted into the National Association of State Policy (NASHP) Serious Illness Institute

State Team Consists of:

- MD Health Care Commission (Lead)
- MD Medicaid
- Hospice & Palliative Care Network of Maryland
- Health Policy Consultant for C-TAC

Two- year program that will conclude in March 2025 with the objective of creating a Community-Based Palliative Care Benefit for the State of Maryland.

Includes assistance with financial analysis to support the financial case for a PC benefit.

Why Pursue a PC Benefit?

- Patients and families with a serious illness need access to high quality care at home which research has demonstrated is often **unavailable in communities of color, along with communities that are economically disadvantaged**

- Many community-based palliative care programs in Maryland are currently being operated by Hospice Providers in various models-- stand-alone, at home with telehealth, and with hospital-system partners. These operations are funded primarily through philanthropy and grants. **This is not sustainable**.

Why Pursue a PC Benefit? Cont.

Research through the NASHP Serious Illness Institute shows that with the implementation of a PC Benefit:

- Inpatient admissions are reduced by 50%
- Emergency Department Utilization is reduced by 10%
- The increase in average length of a hospice stay is increased by 50%

Our Goals for Community-Based PC in MD

- Improve health equity and access to care for patients with serious illness – *Patients & Families First!*
- To work with our key stakeholders to design a community-based benefit that is accessible to all, comprehensive, and sustainable
- Ensure that providers are adequately compensated for their services – goes to the issue of sustainability

Challenges & Opportunities

CHALLENGES/OPPORTUNITIES

Challenges

- Funding – MD Medicaid – **large budget shortfall**
- Workforce – If a PC benefit was turned on today, **would there be enough providers?**
- Education – Lack of understanding of PC among the general population **and in some cases clinicians and government leaders**

Opportunities

- Recent legislation and the NASHP project has **reinvigorated interest** in forming a Maryland Serious Illness Coalition and partnerships with key stakeholders.
- Ongoing meetings with our Secretary of Health who has a good understanding how a **palliative care benefit will support health care disparities initiatives.**
- We now have the benefit of **learning from other states**.

Next Steps?

Pathways to a PC Benefit

We continue to work on this effort with our partners. We have identified three potential pathways to implement a PC Benefit

1. State Plan Amendment
2. Working with private insurers (about 19% of the market in Maryland)
3. Continue to work with Medicaid on a benefit expansion.

Thank you!

Washington State Palliative Care

Jamie Teuteberg

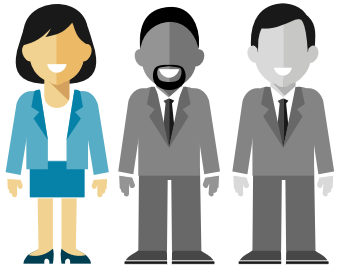
Director of Healthy Aging Initiatives

Washington State Health Care Authority

Washington State Health Care Authority

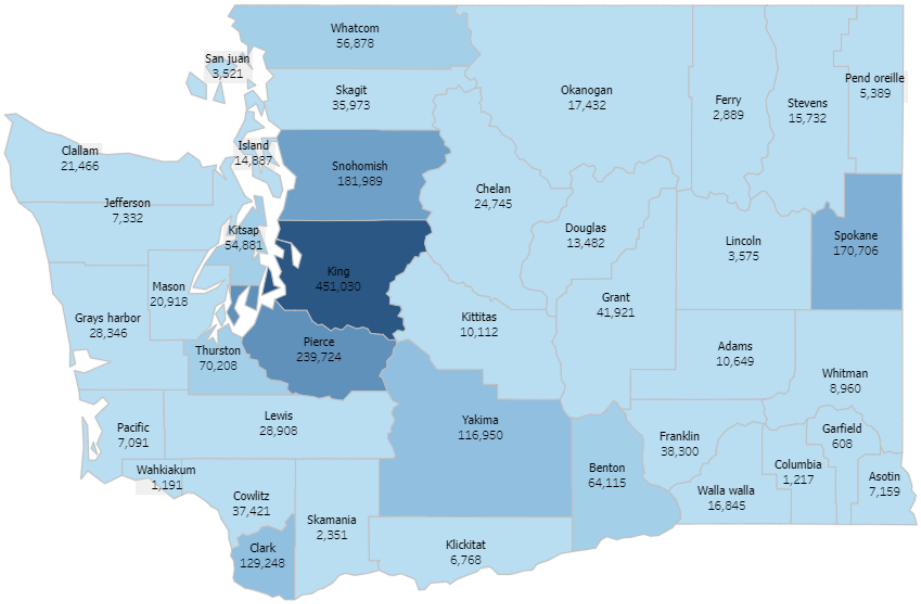
The state's largest health care purchaser

We purchase care for 1 in 3 non-Medicare Washington residents.



- We purchase health care for more than 2.5 million Washington residents through:
  - Apple Health (Medicaid)
  - The Public Employees Benefits Board (PEBB) Program
  - The School Employees Benefits Board (SEBB) Program

Apple Health enrollment (August 2024)



- Total clients: 1,973,057
- Child managed care: 810,454
- Child fee-for-service: 55,075
- Adult managed care: 847,439
- Adult fee-for-service: 260,089

Source: Apple Health client eligibility map
https://www.hca.wa.gov/about-hca/client-eligibility-data-dashboard

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Managed care and fee-for-service

- Managed care
  - Delivery system organized to manage cost, utilization, and quality.
  - Contracted arrangements between HCA and managed care organizations (MCOs) that accept a set per member, per month (capitation) payment
- Coverage without a managed care plan (fee-for-service)
  - HCA pays providers directly for each service they provide
  - Does not lend itself to care coordination and disease management
  - Value added services that MCOs offer

Road to Palliative Care – at a glance

Legislative Action

WA Palliative Care Reimbursements Project Report

Fully Insured Palliative Care

Existing Benefits

Hospice

Pediatric Palliative Care

Adult Palliative Care

Learning Opportunities

NASHP Learning Collaborative

CAPC

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COMMUNITY BASED PALLIATIVE CARE
NASHP LEARNING COLLABORATIVE
CAPC
DATA

Stakeholders

- Internal
- External
  - State based and local professional societies
  - Providers in rural and/or underserved areas
  - Community based palliative care providers

Current Coverage

- Advance Care Planning
- End of Life Counseling
- Comprehensive Assessment & Care Planning (dementia)
- Health Homes
- Home Health
- Evaluation & Mgmt

Future state vision

- Initial Assessment
- Goals of Care
- Pain/Symptom management
- Care Coordination
- Advance Care Planning
- After Hours support
- Caregiver support
- Grief Counseling
- Reassessment

Current Coverage

- Physicians
- Advanced Practice Providers

Team Based

- Medical Director
- Advanced Practice Provider
- Nursing (RN & LPN)
- Social Work
- Case Manager
- Grief Counselor

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Current Coverage

- Fee for Service – fragmented services

Future state vision

- Nurse driven
- Includes dual eligible population
- Tiered approach

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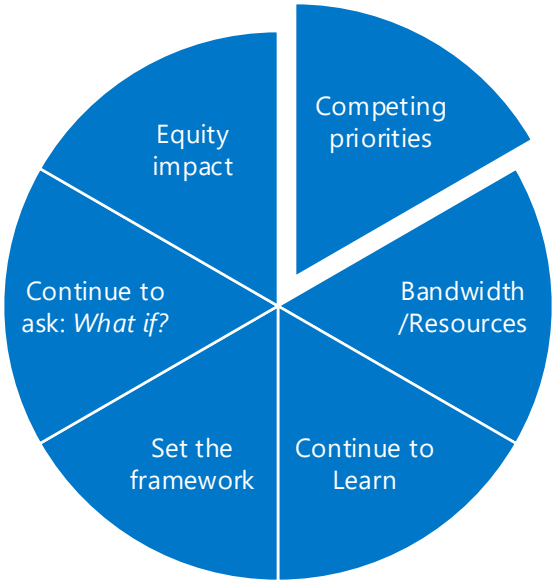
Challenges and Opportunities



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Know your why!

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Thank you!

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