State Advisory Council on Quality Care at the End of Life

Minutes from the March 4, 2024 Meeting

Meeting time and place: March 4, 2024, 10:00 a.m., via video conference.

Council members present: Christopher Kearney; Paul Ballard (Attorney General's designee); Jane Markley; Peggy Funk; Gail Mansell; Sara Hufstader; Steve Glazer; Tiffany Callender Erbelding.

Others present: Dan Morhaim; Jeff Zucker; Kathrine Ware; Stacy Howes; Joanne Ogaitis; Nancy Denebeim; Marian Grant; Karren Pope-Onwukwe; Alexandra Baldi; Tammy Turner; Brendan Green.

Chairman Christopher Kearney opened the meeting. The January 29, 2024 minutes were approved.

Paul Ballard reported that House Bill 461, which bill would change the name of the Council to the "State Advisory Council on Serious Illness Care," passed the House of Delegates by a vote of 136-1 and had moved over to the Senate. He did not think the bill had yet been set in for a hearing before the Senate Finance Committee. Peggy Funk was told that the bill's chances of success were looking very good, and that no opposition was anticipated. Members of the Council thanked Gail Mansell for her excellent testimony on behalf of the Council in support of the bill and for appearing in person to testify at the House Committee. Gail Mansell said Delegate Joseline Pena-Melnyk, Chair of the House Health and Governmental Operations Committee, had thanked the Council members for all the work they do.

Peggy Funk updated the Council on the Palliative Care workgroup. The Council had drafted a letter to the General Assembly thanking them for their support of HB 378 that had created the workgroup. The Maryland Health Care Commission prepared a very nice report that was submitted on November 19, 2023. The Council sent the letter to keep in the consciousness of legislators the recommendations made by the workgroup in the report. Christopher Kearney said it was safe to say that there would be no legislation in the 2024 session based on the report issued in November but hopefully there may be legislation introduced in the 2025 legislative session. Peggy Funk strongly recommended that at the end of the 2024 session, the Council start planning and strategizing regarding what the Council may want to do in 2025. If the Council has conversations regarding such a bill very early on, a bill could then be pre-filed for the 2025 legislative session. She suggested that the Council put such an effort on the agenda for the Council's next meeting. Christopher Kearney agreed.

Marian Grant discussed Maryland's participation in the National Academy of State Health Policy's Serious Illness Institute. Maryland and 5 other states are working with the Institute to share information across states and figure out how to expand palliative care within those states. The focus to date on the state level has been Medicaid expansion because Medicaid, unlike Medicare, is within the control of the states. States can perhaps require all payors to offer a palliative care benefit, but it has been proven easier (but not logistically easier) to seek to add a palliative care benefit to a state's Medicaid program. California has done this, Hawaii is in the

process of doing this, New Jersey has passed a bill that says that the state has to do it within a couple of years. Maryland is among several states that are moving ahead with this effort.

In addition to being able to talk with other states about their experiences, Marian Grant said Maryland gets the benefit of free financial analysis as part of being in the Institute. She, Christopher Kearney, Ben Steffen from the Maryland Health Care Commission, and a representative from the Medicaid Program, were able to take Maryland's data and give it to the financial analysts to take a look at how many people might be involved and what the financials might be if there were a palliative care benefit in Maryland. Looking at 2022 data, there are 1.25 million Marylanders enrolled in Medicaid. Using financial assumptions similar to other states they have examined, the financial analysts estimated that about 260,000 of these 1.25 million Marylanders (14 %) could be considered to have a serious illness. They then took a look at that group of 260,000 people for 2022 and examined how many hospitalizations and emergency room visits they had. These costs amounted to 2.4 billion dollars in 2022. She said that everyone knows that palliative care can help people to not have to be in an emergency room or in the hospital. The first round of financial analysis estimated that a palliative care benefit for this group of people could save a gross amount of approximately one billion dollars per year. That figure doesn't include the cost of a Medicaid palliative care benefit, which is the next bit of analysis being done. The Institute's financial analysts will hopefully share those numbers with Maryland in the next couple of weeks after the Council's meeting. It is probably hundreds of millions of dollars that the State could save with a palliative care benefit, but she does not know how much. The bottom line is that there will certainly be savings for Maryland if a Medicaid palliative care benefit was enacted into law.

Christopher Kearney asked Marian Grant to describe how the Serious Illness Institute defines seriously ill patients as they engage in their assessment. Marian Grant said that these are people with end-stage illness, including how many people have heart failure, COPD, dementia, cancer, etc. She said it isn't just somebody with controlled diabetes, for example. It is someone who has a higher proportion of needs. She said there are all sorts of statistical ways they can sort out these groups using Medicaid and Medicare claims data. She said it is the same methodology that was used in Hawaii to support their Medicaid expansion effort, and no one has questioned the numbers used to support that effort. She said the numbers states have been generating using this analysis strategy are holding up.

Jeff Zucker asked Dan Morhaim, based on his experience as a Delegate in the Maryland House of Delegates, whether this methodology would work to convince the General Assembly. Marian Grant said this would not be presented to the Maryland legislature. Jeff Zucker said that people will attack numbers, so he was curious regarding what Dan Morhaim thought. Dan Morhaim said if you show savings, it is always good, and the question is how you present the information to the policy makers. Marian Grant reiterated that Maryland is not the first state, but is instead probably the fourth or fifth state to do this. Not only is the methodology the same, but NASHP is going to help by informing Maryland how other states have used that strategy with their Medicaid people, and their key stakeholders. Marian Grant thought they will hopefully not have a hard time explaining and debating the numbers if they are based on the same methodology that other states are using. Peggy Funk said this is just the first tranche of data because what NASHP has done is to identify the target population, which is really helpful. She

said the second tranche of data is going to identify what the palliative care team would look like, like who you would include and what the cost would be per patient. They need that information as well because there are some decisions that will definitely need to be made as to how the program is rolled out.

Christopher Kearney said there have been conversations among Council members and others about forming a coalition to help move this project forward because Maryland, like all the other states who have done this, have large numbers of stakeholders who get involved to make these things possible. To succeed, this project has to have broad support. So, there has been some discussion about who the possible stakeholders might be that would be helpful partners in this project. The Secretaries of Aging and Health would both be good partners and to that end the Council has either scheduled and or has been granted meetings with both Department of Aging Secretary Roques and Department of Health Secretary Scott. The Council was reporting to Secretary Roques about the Council's activities, including this topic of creating a Medicaid palliative care benefit. Secretary Roques was pretty positive about it, and even though she does not control the Medicaid program, her support would be helpful. Marian Grant said that the Council is very fortunate that these two Secretaries are the key players in the State of Maryland because they are both knowledgeable about, and supportive of, palliative care. Secretary Roques saw how a palliative care benefit would help and she had ideas about how the Department of Aging could help support an effort to create this benefit. She was very positive and supportive and would be open to talking with the Council further about the issue when the Council has final numbers from the financial analysis being conducted by NASHP.

Christopher Kearney said that Council members had met with Secretary Scott during the week before the Council meeting to report the activities of the Council to her and this topic of a possible palliative care benefit was central to what was discussed. Marian Grant reported that the Secretary said two or three times in the meeting that she loved palliative care and was working to find a way to include palliative care in the Medicaid benefit. Marian Grant said that Secretary Scott had previously worked for a payor and thus understands how important these services are and that Secretary Scott is trying to think of ways it could be done in Maryland. Unfortunately, the State of Maryland is in a serious budget shortfall regarding Medicaid spending. In 2023 Governor Moore added benefits to the Medicaid program such as maternal heath, substance abuse treatment, and antiviolence benefits. Unfortunately, now the State is in a budget deficit situation and Secretary Scott said the State is struggling to find a way to pay for these new benefits, let alone adding additional benefits. Because of a math error, the Medicaid program has to find an additional 120 million dollars just to meet its existing obligations. So, Secretary Scott cannot entertain expanding the Medicaid program to include a palliative care benefit in the foreseeable future even though she loves palliative care, and she thinks such a benefit would be a great thing. Nevertheless, Marian Grant believes that NASHP's financial analysis will still be beneficial to this effort to expand palliative care because it will show the potential cost savings from creating a palliative care benefit. She said she would send the methodology being used by NASHP to Paul Ballard that he could then share with the Council.

Marian Grant said the good news is that Maryland is a unique state with the total cost of care model. Secretary Scott said CMS is proposing the AHEAD model to replace the Medicare waiver that currently allows Maryland to use the total cost of care model. The AHEAD model is

also a total cost of care model that CMS is offering to states and Maryland was going to apply for that AHEAD model very soon. Maryland will know later in 2024 whether its application will be accepted. So, a palliative care benefit could be included in the total cost of care model as part of efforts to reduce the total cost of care in accordance with the requirements of that model. And that is how payors are justifying palliative care benefits, that is, as a way to reduce the total cost of care. Secretary Scott is working on how to include palliative care benefits in the total cost of care model. Because Maryland's application is likely to be accepted by CMS, Marian Grant recommended that the Council educate itself about the AHEAD model, which is based in part on Maryland's total cost of care model, because this may be the way to establish a palliative care benefit. Secretary Scott invited Council representatives to meet with her again in June, 2024. If the Maryland Department of Health's effort to create a palliative care benefit as part of the AHEAD model are successful, this benefit would not be established until 2026 or 2027, so it is important for the Council to take the long view.

Christopher Kearney said that the meeting with Secretary Scott did shift their thinking regarding how the palliative care benefit would be established. Secretary Scott said the AHEAD application will be due late in the Spring of 2024. He thought that she had said it would take 18 months after the Department's application was filed before the Department would hear back from CMS. He commented that the Council is very fortunate to have Secretary Scott's support because her sophistication with palliative care and end-of-life issues is very high and she is very approachable and very easy to talk with and is very frank. She is a great partner in this effort. And he thinks that she also thinks the Council is a great partner and that the Council is a very useful group. She was supportive of the idea that was floated to her of the Council helping to form a broad coalition of stakeholders to support the creation of a palliative care benefit. After meeting with her, because of the budget shortfall, they learned that although it may take longer to obtain the benefit than they thought, that there is still a path forward to create it.

Peggy Funk said that Secretary Scott is a really good partner, and that Secretary Scott does try to stay positive. Peggy Funk learned the State has a shortfall in the Medicaid program of 236 million dollars because of a budgeting error. The Medicaid program has to cover a 115-million-dollar gap this year. And then next year another 150-million-dollar gap. So, Secretary Scott was really clear that there will be no Medicaid expansion for this project. Secretary Scott's other point was that even if the palliative care benefit did save the State of Maryland a half-billion dollars, you still have to be able to front the money to be able to get those savings. Still, Peggy Funk thought the Council should not be discouraged. Secretary Scott said that it was very, very important that we move forward with palliative care. Peggy Funk thought that it was just important to look at how to do it within the confines of the State budget. Whether that is through the new AHEAD program or maybe through an innovation program through the Health Services Cost Review Commission. HSCRC used to have a program where you could write what your project is, submit it, and if you could prove a savings, the HSCRC could approve it because Maryland has the Medicaid waiver. She suggested that maybe the Council should investigate whether pursuing that option through the HSCRC is still possible. She thought there would be bumps in the road along the way but eventually the palliative care benefit would happen.

Marian Grant said that this effort is an arduous undertaking, and the Council does not have a structure and thus can only play a limited role in this effort. The Council needs to figure

out if there is foundational funding in the State of Maryland that might not have been there in the past, and whether over the next few months it might be worth taking the NASHP information and recommendations from the palliative care workgroup and setting up meetings with the key health systems, with the hospital association, with the cancer society, with AARP, with all of these organizations to start sharing this information and to tell them that the Council anticipates that one way or another that there is going to be movement in the State of Maryland in the next couple of years, and that they are the key players and that the Council wants their input. Because things are not going to move quickly because of the Medicaid program's budget shortfall, the Council has months or a year to do this outreach to key stakeholders in preparation for eventually establishing a palliative care benefit.

Dan Morhaim talked about his op/ed published in the Baltimore Sun recently about emergency room wait times. He wasn't able to fit the math into the op/ed but said that if every hospital's CEO who is making over a million dollars per year was instead only making a million dollars a year, the Maryland's hospitals would have about 60 or 70 million dollars made available to address ER wait times, to fund a palliative care benefit, or to fund any number of other programs. In fact, if their salaries were reduced to about 500,000 dollars a year there would be over 10 million dollars per year available to solve some of these problems. So, there is plenty of money in healthcare, it just isn't going towards things like a palliative care benefit. He noted that these salaries are public information and the HSCRC has it on their website. He also noted that the CEO's pensions are two thirds of these colossal sums of money paid in salaries. In Chat, Jeff Zucker agreed with Dan Morhaim that the money is there in healthcare but not allocated as many would wish.

Marian Grant said the Council has had great success with the Moore administration. The Council met with the Secretaries of Aging and Health both last year and this year to report to them in accordance with the Council's statutory mission, and this enables the Council to meet with the Secretaries to inform them of the Council's activities, including their efforts to advocate for the creation of a palliative care benefit. The Secretaries have been very receptive to the Council's efforts, and they have already heard back from Secretary Scott's office about scheduling another meeting for June because Secretary Scott asked for the meeting. Thus, the Council should be able to have meetings with these Secretaries regularly as needed. And the Secretaries appreciate that the Council is doing this work. Jeff Zucker congratulated people for meeting with these leaders to increase their awareness of the Council's commitment to important issues such as palliative care.

Gail Mansell thanked all the persons involved with the Council regarding all their efforts to increase the availability of palliative care and thought the Council's name change to the State Advisory Council on Serious Illness Care might help to broaden the scope of the Council's work. Christopher Kearney noted that Secretary Scott thought the name change for the Council was a good idea because the existing name is limiting, and people are turned off by the name referring to the end of life.

Christopher Kearney talked in general about the Council's possible future structure. He said that when the Council was created in 2002 it was very forward-thinking and novel among states. Over the years he thought the Council had been useful but there may have been some

languishing of activity at times. In recent times, he has been a little concerned that the Council is a bit of an orphan that is not part of any agency, although the Maryland Office of the Attorney General's staff support has been helpful. And this support from the Attorney General's Office exists because of Jack Schwartz, Paul Ballard's predecessor back when Joe Curran was Attorney General. Christopher Kearney does not think this is the most natural fit. Paul Ballard pointed out in their discussions that the original bill language to create the Council had the Maryland Department of Health as the agency designated to provide support and technical assistance to the Council but was later amended to have the Attorney General's Office and the Maryland Department of Aging jointly provide this assistance. With that history in mind, Christopher Kearney suggested to Secretary Scott that the Council might work better if it was instead supported by the Maryland Department of Health. He said the Council is mainly a volunteer operation which makes it hard to sustain the Council and keep things going without some kind of paid staff. For example, the project of forming a coalition to advocate for a palliative care benefit would require paid staff to succeed. California's coalition had paid staff when it created its palliative care benefit. But if the Council were to be transferred into the Maryland Department of Health, that would require legislation.

Christopher Kearney asked Paul Ballard if he had anything to add. Paul Ballard said the issue is of more academic interest to him because he can't speak for the Attorney General at this time on that particular idea. But he did find it interesting to discover that when the Council was created, the original bill language had the Maryland Department of Health providing the staff support and technical assistance but was later amended to have the Attorney General's Office and the Department of Aging jointly provide staff support and technical assistance. He speculated that perhaps the Department of Health did not want to take on this duty and the Attorney General and the Department of Aging agreed to step in. Speaking from a purely academic standpoint, he acknowledged the staff support and technical assistance provided by the Health Department would seem to be a more natural fit but also acknowledged it is nice that the Council is independent and not beholden to any one agency. The tradeoff is that no agency is fighting on behalf of the Council. He believed it was something for the Council to consider going forward because he was not certain how much of a role the Attorney General's Office would continue to play regarding the Council's work going forward.

Given the work being done by the Cancer Collaborative within the Maryland Department of Health regarding advance care planning, Paul Ballard thought that perhaps the Maryland Department of Health might have the motivation to bring the Council into the Department. He said that it always depends on the priorities of each Secretary and each successive change of administration. But there is a danger that the Council will start to tread water if there is not a mission the Council is trying to accomplish. He said how amazed he was at the talent that has been assembled on the Council and he thought it would be a shame to squander that talent and not have it used in a very positive way moving forward to aid the citizens of Maryland. But the way the Council is structured as an advisory group limits what it can do. He thought this might be a time to think about where the Council goes from here and the Council was certainly groundbreaking when Jack Schwartz had the idea to create the Council. There are other states that have since created similar entities. Paul Ballard said the Council's name change better reflects the current focus on palliative care rather than on end-of-life care, which as Jack

Schwartz acknowledged at recent Council meeting, was more the focus than on palliative care when the Council was originally created in 2002. If the Council wanted to move within the Maryland Department of Health, the Council would have to present that idea to all interested people and get legislation enacted.

Marian Grant said because the Council has a little more time because they are not rushing to try to expand Medicaid to include a palliative care benefit, the steering committee (made up of her, Peggy Funk, Christopher Kearney, Cathy Hamel of Gilchrist, and Louise Knight of Johns Hopkins) could explore this transfer of functions as one of the many topics they are examining. After considering whether there is funding, they could consider what kind of structure would be beneficial, and how changing the home of the Council would fit into their goal of expanding palliative care, advance care planning, and hospice care in Maryland. Such recommendations could then be implemented legislatively in the 2025 session. Peggy Funk said that the Council should be very careful before making any changes and she doesn't have any opinion at this time. She said the Council should be cognizant of any unintended consequences, and it would be good to know what those unintended consequences might be before the Council decides to move so as to avoid any potential negative consequences that would hamper the Council's mission. Gail Mansell said she really values Jack Schwartz's input on this and would really like to hear what he has to say. Paul Ballard said he could contact Jack Schwartz about the issue. In Chat, Kathrine Ware volunteered to serve on any task force that might be formed to study the issue.

Christopher Kearney acknowledged that this topic is still just exploratory and there are no well-formed proposals yet. He said that ways to make the Council more effective have been on his mind lately. He acknowledged what Paul Ballard and Peggy Funk have said, that is, that you have to be careful what you ask for. He suggested this should be an agenda item for a future Council meeting where the Council could have the opportunity for a little more formal presentation of the pros and cons of the Council moving within the Maryland Department of Health. Of interest to him was the fact that Secretary Scott was open to the idea. So, there is an opportunity to have a discussion within the Department of Health to see how that move might be mutually beneficial for the citizens of Maryland to make the Council's work more effective.

Christopher Kearney next moved on to the end-of-life care in prisons workgroup update and asked Marian Grant to update the Council on the workgroup's activities. Marian Grant said the workgroup is interested in the quality of end-of-life care given in Maryland's prisons. She reported that the contract with the for-profit vendor to provide health care in Maryland's prisons ended on December 31, 2023. The Council's workgroup tried assiduously to insert itself into the process for the new contract proposal. The Council offered its help numerous times but was kindly rebuffed. The Council made suggestions nonetheless and apparently Secretary Scott also made suggestions, and Marian Grant was not sure any of those suggestions got into the final request for proposals (RFP). The new contract was supposed to be awarded on January 1, 2024. The RFP was issued in November so needless to say a new contract was not awarded by January 1, 2024. The current contract had been extended through March 31, 2024. Any information regarding who would be awarded the new contract was not available at that time.

Marian Grant was given an article in the Baltimore Banner by a reporter who told her that the Baltimore Banner is reporting on the current contractor, Corizon, which declared bankruptcy

and then rebranded itself as YesCare. In Texas, they separated the two organizations, that is, Corizon and YesCare, so that YesCare has none of the liabilities (which apparently were large) for Corizon. United States Senator Elizabeth Warren and other states that contract with this company are objecting to this, saying this company should not be able to get away with having no liabilities simply by splitting itself into two legal entities and declaring bankruptcy. That is relevant for Maryland because this fact should weigh heavily on whether they should grant the contract to YesCare. A court ruling is pending, and things could get complicated. Regardless, there are not a lot of good organizations capable of providing billion-dollar healthcare services contracts for incarcerated individuals, which unique ability is unfortunately concentrated in the for-profit world. So, the workgroup is waiting to see what happens with the contract award or whether a contract extension will be granted if a contract is not ready to be awarded.

Jeff Zucker said Marian Grant's comment that the private equity world appears to have taken over the delivery of healthcare to prisons concerns a topic larger than Maryland. Senator Warren's comments speak to the larger issue of unregulated financing having changed the dynamics of the delivery of healthcare services through for-profit and nonprofit hospitals. The fact there is not a nonprofit opportunity to deliver a billion dollars' worth of health care in the State of Maryland (which has massive nonprofit health organizations that benefit from State nonprofit status) seems like an opportunity for discussion of whether these nonprofits as a consortium could take over this contract during the extension period so that the State doesn't reward bad behavior on the part of the contractor by giving them a contract extension.

Dan Morhaim liked Jeff Zucker's idea for a nonprofit consortium to take over during any extension of the current contract. Dan Morhaim said that is what California did through their Department of Health. He posted the following link in Chat: https://cchcs.ca.gov/#:~:text=California%20Correctional%20Health%20Care%20Services%20(CCHCS). California provided these services through their state government, although one has to keep in mind the massive size of California's population and economy which makes it comparable to a nation-State. He also posted this from an article about salaries: https://www.beckerspayer.com/payer/50-things-to-know-about-unitedhealth-group.html?origin=BHRSUN&utm_source=BHRSUN&utm_medium=email&utm_content=newsletter&oly_enc_id=3013B3483078A2X. And he said there was also an article published in the Journal of the Medical Association in which a study found that safety factors are measurably down in for-profit hospitals. This is because for-profit hospitals start cutting staff and discharging people who can't pay, etc… He said it takes an unusual person who wants to work in a prison system. Not many people want to work in a prison system. So, you are going to get a lot of second and third-tier doctors and others who can't get employment elsewhere. California solved this problem by paying doctors more and thus attracting higher quality physicians to work in its prison system that the State operated internally, which is what Maryland prisons should do. But the for-profit companies are always going to have these problems in the prison systems.

While Jeff Zucker agreed with Dan Morhaim regarding the larger issue of for-profit healthcare service organizations, he recommended that the leaders of Maryland break the issue into addressing the short-term crisis of not rewarding bad behavior by extending the contract with a company already in bankruptcy that has had numerous allegations made against it regarding the poor quality of healthcare it has provided. He instead recommended having a

consortium of nonprofit healthcare providers provide these services. Marian Grant said that there is no way anyone other than the current vendor could handle the work required during an extension of the contract. It is just too big a prison system to bring in new people who have never run a prison health system. She said that the new contract to be awarded in 2024 will end in 2029, and thus there is an opportunity for people in the State of Maryland to try to gather together a group and see if that group could persuade Johns Hopkins, Medstar, or the University of Maryland health care system, all of which health care systems are already operating in Maryland, to convince one of those systems to take over the prison healthcare system, which they could do if they were given the right resources from the State of Maryland. Marian Grant recommended that the Council just continue to monitor the situation.

Christopher Kearney what California's experience was like with having the State take over this function. Dan Morhaim said it has only been in place for a couple of years, and thus he didn't know. He said that would require some research, but he speculated it couldn't be much worse than the services that were provided by the private contractor. Christopher Kearney also asked people if they knew what Maryland's experience had been like before using this current contractor. Marian Grant said they had bad experiences with the previous for-profit vendor, and they were dropped in favor of the current vendor when the contract was issued 5 years previously. Dan Morhaim and she agreed that structurally there will never be a good for-profit vendor in this arena. Christopher Kearney did mention the issue to Secretary Scott at their meeting. The Council has also raised the issue with other involved agencies.

Paul Ballard gave a legislative update. He said that the aid-in-dying legislation failed to get through either of the relevant committees, and so never was voted on by either house of the General Assembly. Based on news reports, they just did not have enough votes to pass the legislation. Other than the bill changing the Council's name, he didn't notice any legislation relevant to the Council's mission. He noted that the Council should thank Delegate Ashanti Martinez for his work getting the Council name change bill passed through both houses of the General Assembly.

Paul Ballard informed the Council of his pending retirement in July, 2024, and said he was grateful for the great experience of working with the Council. Christopher Kearney thanked Paul Ballard for his calm and careful work to keep the Council moving in the right direction.

There being no further business, Christopher Kearney adjourned the meeting.