

State of Maine Palliative Care Advisory Committee

July 21, 2016

Present: Dr. Jim VanKirk, Dennis Fitzgibbons, Greg Burns, Kandyce Powell, Dr. Lauren Michalakes, Dr. Kaowole Bankole, Scott Taggersell- Harvard Pilgrim, Hilary Schneider-ASCAN, Kristin Ossenfort- Anthem, Maggie Moree- Aetna, Eliza Eager, Sam Sneft- MaineCare. Stephanie Nadeau- MaineCare, David Sorenson

Topic	Discussion	Follow-up
Welcome	Welcome by Dr. VanKirk	
Introductions	Introductions by all in the room.	
Payor presentation	<p>Harvard Pilgrim (HPHC): Scott Taggersell Scott disclosed he was not a subject matter expert but here to present for HP. They are performing activities on the palliative care front throughout New England. Medical directors meet on a regular basis to discuss hospice and palliative care services.</p> <p>Coverage: Services are eligible state wide. More rural towns may not have the depth of service capability for patients due to lack of providers. Kandyce asked what the number of patients in Jackman and other rural areas in Maine. Scott did not have the numbers at this time, but he is able to obtain. Northwest Maine has less PCP coverage. Most of the business is Bangor south.</p> <p>Core benefits: Hospice is a multidisciplinary approach. The goal is to involve the primary care physician and specialists into the hospice component of the benefit structure. The patient does not always have to be terminally ill (i.e. 6 months or less prognosis.) If care is palliative, it will focus on symptom control. For hospice benefit: the disease is not curable, death is expected in 6 months, reauthorization occurs at 180 day intervals. The lead provider determines ongoing eligibility (the physician signs the plan of care.)</p> <p>Benefits: <u>Levels of care provided:</u> home routine care, respite care 5 days every 3 months max 14 calendar days per year, acute inpatient care if medically necessary, up to 4 hours of home health aide services per day, continuous in home care 8-24 hours. The number of hours do not need to be consecutive in 24 hour periods; the physician determines the appropriate level of care.</p> <p><u>Services:</u> Home Health Aides, Nursing, Physician services, Occupational Therapy, Physical Therapy, Speech Therapy, Respiratory Therapy, Respite, Volunteer, Bereavement, Symptom Management, Counseling, Non self-administered medication, Durable Medical Equipment,</p> <p><u>Out of pocket costs:</u> Pre-authorization is required for the benefit. There are deductibles and co-payments with cost sharing plans depending on the employer. There is a max out of</p>	<p>Scott will obtain number of patients served in the more rural areas of Maine (i.e. Jackman)</p>

	<p>pocket expense amount that varies plan to plan. There is no cap on services or amount spent in the benefit.</p> <p>Service providers: Stand alone or ancillary contracts are available. A hospital system may utilize a single signature contract (all facilities under hospital license). Some providers may not want to contract with the payor due to reimbursement rates. They may do letter of agreement for cases if there is not another contracted agency in the area to provide services.</p> <p>2 new CPT codes: 99.497 and 99.498 physicians to bill for advanced directives and form completion.</p> <p>Case management is provided. Their care management model is nationally recognized; it is a telephonic program. All staff are employed and trained by Harvard Pilgrim. The program is based on diagnosis. Some diagnoses are easier than others to identify for palliative case management. The care managers reach out to the identified population. If the consumer is not receptive, they wait for consumer to reach out to them. Physicians can ask for case management. They would like to have more physicians utilize the program.</p> <p>Palliative care is treated as the transition between dx and treatment and outcome. The care manager will work with patient, PCP, specialist, and care team. They will identify one person as a point person for communication, usually the primary care giver.</p> <p>Pilot Study: Harvard Pilgrim would like to be included in a pilot study if to occur. They do have experience with rural areas.</p> <p>HPHC perspective: They are a non profit organization. Reimbursement for palliative care makes sense and they would like to broaden the palliative care component of their benefits offered.</p> <p>Aetna: Maggie Moree: Overview: Benefit structure is largely the same. They are a national company for insurance. In Maine, the market covers small and large group coverage. There is limited participation in the self-insured and market place venues. The majority of the business is Bangor south. There are some self insured consumers on Canadian border. Rurality remains a challenge no matter what state you are in.</p>	<p>Kandyce asked if there were published findings on dual care being delivered at the same time. Maggie can obtain</p>
--	---	--

	<p>Care management: Ruth Macintosh developed the continuum of care management for compassionate care for the company. She sits on the national quality committee as well. Care management model focuses on chronic conditions and end of life conditions. They attempt to contact the consumer through the use of a social worker for enrollment when they are identified by their conditions. Engagement is challenging; Aetna is not always seen as the first line of service to the consumer that can provide care and resources. When they receive referrals, the consumer has reached the breaking point and needs assistance. Members can help spread the word of how the services helped. Palliative care is covered as part of the treatment plan.</p> <p>Reimbursement: Aetna covers palliative care. There have been some denials due to computer generated system. Cases are reviewed individually if necessary. They have participated in models throughout the US. The difficulty is to engage society about what (palliative) care goals are due culture of curative medicine. Consumers can be in active treatment and still receive hospice benefit. Hospice is part of the routine coverage. Their models do not direct models of care.</p> <p>Pilot: Willing to work with committee with initiatives going forward.</p> <p>Anthem Blue Cross: Kristine Ossenfort</p> <p>Coverage: Their coverage is similar to above carriers. All of Maine is in the service area for small and large market group. The grandfathered plans in existence are being phased out by 2017.</p> <p>Case Management: Case management is not provided with in-hospital hospice. It is offered to all home services.</p> <p>Pilot projects: Participation in a pilot would depend on what is being proposed and what is under consideration.</p> <p>Under the Affordable Care Act, insurance companies are required to submit proposed reimbursement rates approximately 18 months in advance for approval. Adequate advanced time for pilot introduction, 18 month to 2 year period for implementation.</p> <p>California is piloting a program utilizing a 3rd party vendor to identify members that could benefit from hospice/palliative care. The 3rd party vendor is contacting this population on the</p>	<p>the article for the committee.</p> <p>Dr. Michalakes shared the results from the compassionate care study done with Intermed and Aetna Medicare advantage. There were positive results from the study. Aetna reached out to the physician for palliative care. The study did phase out after 2-3 patients. Other government rules came in towards the end of the initiative and over ruled with other care models.</p> <p>Kandyce asked if Aetna knew anything about carving in hospice in the Medicare Advantage program. It is conversation at this point with bill introduction. Maggie will f/u with it.</p>
--	--	---

	<p>company's behalf (facilitation). They are careful to ensure the member does not feel the insurance company does not want to pay for care. There have been successes, but they are proceeding with caution.</p> <p>Discussion: Discussion was held around educating members of what services are provided with the benefits. Payors will not have a discussion about the treatments that are appropriate or not with consumers. Discussion was held about Americans wanting access now and not wanting to pay much for it. Maggie is not aware of regulations that do not allow carriers to showcase or educate about benefits available. It is difficult to introduce the policy beginning with end of life options. They are often not accessed until the disease has progressed. Consumers should be educated to call the carrier about benefits.</p> <p>MaineCare: Stephanie Nadeau, Sam Senft</p> <p>Coverage: Coverage is state wide. It is the Medicaid entitlement program and is funded with federal and state funding. General eligibility guidelines were distributed that included hospice services, other palliative services and case management services. Hospice services are covered and align with Medicare. Treatment must be waived to receive hospice services.</p> <p>Expenditures: 3 million dollars was spent on hospice care for 469 individuals fiscal year 2015. The most common diagnoses were lung and colon cancer, dementia and COPD. It is hard to separate palliative care due to consumers who are still actively seeking treatment. Claims data is utilized to obtain the information as that is the only data available at this time for use. The costs associated were believed to be much larger. They look at the use of the V66.7. with pain and chronic condition management. MaineCare does reimburse for transportation with palliative and hospice care and includes homemaking services.</p> <p>Case management: Case management is focused on mental illness, HIV and developmental issues. In hospice case management is provided through a social worker. Palliative care is not a separate item in home care.</p>	<p>The Senate has a bill with a care planning act. Senator Collins is co-sponsoring. Allows people to have opportunity to have goals of care conversation. Kandyce will send out a copy of the bill. More robust then companion bill on the House of Representatives side.</p> <p>It was recommended to reach out to providers to engage them in conversations about care options.</p>
--	---	--

<p>Pain Management and Addiction and the need for Palliative Care</p>	<p>MaineCare had large initiatives around value based purchasing. Health and behavioral health homes for physical/behavioral health care are examples of this. An Accountable Care initiative with a large state agency for MaineCare participants is underway.</p> <p>Pilot: MaineCare may be willing to participate, but may not want to change the structure that is in place today due to broad scope of services available at this time. They would like to avoid more regulatory structure around palliative care that prevents access. Consideration should be given as to how the participants view a call from the state about what care they should have.</p> <p>Kandyce asked to how to expedite MaineCare enrollment for patients who are at end of life to avoid dying without coverage. Stephanie is willing to have the conversation. The conversation needs to be had with all facilities due to hospitals and LTC agencies have patients in great need as well. Caution needs to be taken around prioritizing applicants. They are willing to help with the education around the MaineCare application process. There may be some overlap with individuals needing the care.</p> <p>Kandyce is working with VA system to expedite turn around for veterans.</p> <p>Dennis shared challenges with consumers who are struggling with pain control issues have needs for care and treatments and the fear of being cut off.</p> <p>American Cancer Society Cancer Action Network Hilary Schneider shared comments about stigma related to pain management and addiction. Palliative care may have a role in helping with weaning of pain medications when necessary. Research shows that provider relationships are correlated with likelihood of addiction. Pain is one reason that cancer patients end up in the emergency department on the weekend. The American Cancer Society advocates for early intervention and goals of care. Would it be possible to incorporate goals of care discussions as part of Medicare wellness visits? The goals could be reviewed annually while people are well and not ill. The messenger is important as to who is delivering the information. She discussed the fear of sharing information with insurers and employers. Consumers trust physicians, nurses and agencies like the American cancer society. Market and communications research has led to reframing the issue of palliative care is not about dying but about living life to its fullest. Important to frame about living. Family involvement is critical. Hilary shared a personal story stressing the importance of including family members and care managers in education around the end of life and securing appropriate care at end of life.</p>	<p>Not all agencies are using the V code for billing. Needs standardized use to help gather accurate data.</p> <p>Kandyce shared the initiative on Critical Care at the End of Life looking at if aggressive</p>
---	--	--

<p>Physician Palliative Care Education</p>	<p>It is important to try to capture all information in survey research. Not all information is quantitative. It is important to capture the qualitative data as well.</p> <p>Hilary shared that anecdotally she has met volunteers who decide to forgo treatment for a period of time if cancer is not progressing and is incurable in order to maintain or improve quality of life. Understanding options for treatment and its impact on quality of life can be important to these decisions.</p> <p>Dr. Michalakes shared that it could be more. Dr. VanKirk stated he did not receive training. The younger physicians are receiving training that physicians 30 years ago did not receive. University of New England and Vermont are sending residents to Eastern Maine Medical Center for palliative care training because training is not available in Vermont.</p> <p>Dr. VanKirk shared his experience as a new physician having end of life discussions. The question was posed: How do we prompt the PCP to have end of life discussions with the patients?</p> <p>Kandyce shared the SUPPORT study in 1995 by Robert Wood Johnson Foundation that examined at how people died in hospitals. Elements examined included how many people died in ICU, had pain managed and had advanced care planning. Despite the information, the practices in the facilities did not change how people die. Communication, education and training did improve after the study. Education in medical schools was implemented.</p> <p>Scott asked if the council had researched models in other countries. He shared an experience that his brother had in England knowing that the healthcare funding and expenditures are different.</p> <p>Dr. Michalakes shared Scott's example tied back to reimbursement and they may have more of a social model.</p> <p>Maggie shared that unfamiliarity in executing advanced directives and the lack of exposure of people who are dying creates barriers in palliative care discussions. Dr. Michalakes spoke about comprehensive care directives. It is not black and white in the real world. There is a lack of clarity in the health care dialogue as to when to implement appropriate care. It goes back to active discussions between the family, patient and physician. There is data available to support appropriate decision making.</p>	<p>technology is appropriate at end of life. It is looking at providing adequate information to make an informed decision.</p>
--	---	--

<p>Palliative care discussion and teams</p>	<p>Kandyce shared the lack of reimbursement of spending time with patients and families may inhibit the time for professionals to gather important information for adequate care planning. A critical part of palliative care is preparing them for what to expect with an illness.</p> <p>Hilary shared further on the importance of palliative care and identifying who can be reimbursed for delivering palliative care and in what setting(s). She shared another example of a respiratory therapist taking the time to educate her on the care of her son with asthma. The therapist helped to prepare for care at home more so that the physician by stressing the importance of what to expect and having more time to sit down with family. It changed her life to be able to care for her loved one.</p>	
<p>Insurance Billing Codes</p>	<p>Dr. Michalakes stressed the importance of providing care as team with insurance companies to be cost effective and provide solid care. Patients with largest costs and greatest need should be a priority. Well functioning teams are vital to positively impact patient outcomes.</p> <p>Sam asked for information on the physician billing codes. The code for the first 30 minutes 99.479. The additional time after that is 99.498. Dr. Michalakes stated she is not sure if the reimbursement for the 99.498 covers the costs that are actually incurred. They are attempting to find the codes that best represent their time.</p>	
<p>Telemonitoring</p>	<p>Scott asked what more can insurance carriers do to make the system more efficient. Dr. Michalakes referred to the study at the southern part of the state. It was pro active in seeing ill and costly patients. Scott stressed the importance of identifying conditions prior to development (i.e. diabetes). Dr. Michalakes discussed the importance of having insurance companies ask for a palliative care consult for a patient with appropriate diagnosis.</p> <p>Dr. VanKirk shared we are tasked with addressing the lack of providers in areas without services. He asked the payors if they are going to bring telehealth into serving remote areas. Some are already doing so.</p> <p>MaineCare has just expanded the telehealth and telemonitoring services. Final regulation was adopted in the last month. MaineCare will pay for telemedicine if clinically appropriate using the GP modifier. The modifier does not change the payment but allows for tracking and allows home health agencies to use telemonitoring of vital signs and video capability.</p>	

<p>What would payers like for follow up from the council?</p>	<p>Rural areas do not have the broadband coverage, limiting accessibility. Anthem and Aetna are mandated to cover for telehealth. The two medical boards just closed comments around telemedicine visits. Harvard Pilgrim has home monitoring type service. It is eligible for members, need to have primary care physician for referral with HMO/PPO model. The definitions of telemonitoring and telemedicine are not interchangeable. They are two separate services.</p> <p>It was asked if telemedicine was being used in hospice. It is being used in the southern part of the state and around the nation. The technologies are more advanced than reimbursement. There is data that supports the use of telemedicine but it is not easily accessed.</p> <p>Kandyce asked what the payors would like to for follow up from the committee.</p> <p>Maggie shared she would like what the research shows about timely conversations around palliative care. The public is receptive to marking phrases. “What do you want for your care from your doctor or health care experience?” to help address the societal fear of dying. Maine Hospice Council has been working with VA medical center. In the early 2000s, a mandate was issued that all veterans who were appropriate would receive hospice care. The VA has emerged as a leader in end of life care and taking care of their own. Their reimbursement system is easy to work with. The patient can received chemo and palliative care.</p> <p>Maggie spoke of the perceptions that home is easier or less costly for hospice and palliative care, but that may not always be true. She asked to consider the environment and if the families are able to care for at home safely and for less cost. Consumers should be asked where they want to die, including long term care facilities as one of the options.</p> <p>Scott would like to obtain minutes from this meeting to share with the palliative programs in their companies. He asked the council: How do you see yourselves working the HP system? What meetings would you like to attend/participate? Harvard Pilgrim has a network news coming out that he would share with the council. Kandyce shared she would like to meet on a regular basis with the payors to discuss palliative care issues, pilot ideas and solicit their ideas and concerns.</p>	
---	--	--

David Sorenson	<p>David shared that he came to listen to the meeting and hear the comments. He asked for a summary of discussions from today's meeting. Dr. VanKirk summarized the session for him:</p> <ul style="list-style-type: none"> *Access to providers *Limited resources in rural areas *Lack of broadband *Ways to work together to provide better outreach to population sooner *Improve palliative care outreach and services while saving costs and maintaining patient satisfaction *Any ideas to increase the number of providers: <ul style="list-style-type: none"> *Use of telemedicine – the use is catching on slowly <p>Kandyce explained the use of hospice in the prison system. Discussion was held related to the review of opioid regulations. He stated palliative care, hospice and end of life patients are an exception law. David would like to have input into future changes to prescribing under this law. Definition of palliative care encompasses patients who require symptom management for quality of life. He is looking for assistance with having a more comprehensive definition of palliative care.</p>	Email minutes to David to keep the governor informed
Absent payor follow up	<p>There are 2 more payors from whom the council would like a presentation: Community Health Options and Cigna. The last 30 minutes of the next meeting will be open for the payors to discuss services. The two absent payors will be requested to send information to the council for review prior to the next meeting.</p> <p>Should discussion with the payors should be ongoing? The energy the payors bring to the discussions is important. They will be invited on a regular basis throughout the year.</p>	Include 30 minutes for payor presentations at the end of the next meeting.
Next meeting	October 20, 2016 8:00am-4:30pm	Respectfully Submitted Alicia Mooney RN, MSN