



**AUGUST 2021**

**Minnesota Serious Illness  
Action Network**

**Palliative Care Virtual Summit:  
Practice, Policy, and Payment**



MINNESOTA NETWORK OF  
HOSPICE & PALLIATIVE CARE



## Executive Summary

Over one hundred participants, representing providers, legislators, state agencies, health plans, and advocates, joined together for the second Serious Illness Action Network virtual summit held August 13, 2021, co-convened by the Minnesota Network of Hospice and Palliative Care and Stratis Health.

The summit had three core goals:

1. Discuss payment challenges and opportunities related to palliative care for providers and payers.
2. Describe the current state of palliative care payments in Minnesota.
3. Agree on, and commit to, actionable ways to move palliative care payments forward in Minnesota.

*With **ACTION** in mind, key questions that guided the summit included:*

- 1. What are the **next steps** necessary to advance palliative care in Minnesota?*
- 2. What are you willing to **commit to** in order to move palliative care payment initiatives forward?*

Participants heard presentations from state and national palliative care payment experts and participated in facilitated small group discussions designed to elicit participant's ideas on the best way forward.

The summit ended with a panel discussion with two state elected policymakers, the Minnesota Department of Human Services (Minnesota's Medicaid agency), and a private non-profit health system and insurer -- State Senator Karin Housley, State Representative Liz Reyer, Gretchen Ulbee from the Minnesota Department of Human Services, and Patrick Courneya, Chief Health Plan Medical Officer at HealthPartners.

**The panel, joined by the two national presenters, identified** that getting an **accurate definition of palliative care into state statute** is one of the critical first steps in advancing palliative care in Minnesota. Having an accurate definition will **help communicate the distinction between hospice care and palliative care**, a differentiation which can pave the way to palliative care payment.

**The panel discussion also led to support for creating a task force** that would work with the state to advance payment strategies. This task force would help **determine payment model(s) which are sustainable over time**, develop **a plan to pilot to test the payment model(s)**, and as part of the process, **identify payment model attributes or approaches that may be counterproductive or have unintended consequences**.

## HIGHLIGHTS FROM PRESENTATIONS AND PANEL DISCUSSION

### ***POLICY AND PAYMENT RECOMMENDATIONS FROM THE MINNESOTA PALLIATIVE CARE ADVISORY COUNCIL (PCAC)*** by Jessica Hausauer, PhD, Chair

The Minnesota Palliative Care Advisory Council was established in 2017 through MN Statute 144.059. The Council has three core responsibilities:

- Assess access to palliative care.
- Identify barriers to palliative care.
- Make recommendations for legislative action.

The Council is required to file an annual report with the appropriate legislative body by February 15<sup>th</sup>.

The Council considers a lack of workforce as a key barrier to palliative care. At the current time there is 1 palliative care physician for every 808 eligible patients; absent any policy changes there will be 1 for every 1,380 by the year 2038 (Kamal et al 2019).

The Council recognizes that palliative care payments are a necessary component to expanding palliative care in Minnesota. Payment recommendations from the Council's 2020 and 2021 annual reports include:

- Ensure that palliative care benefits offered by private and public payers are **comprehensive** and **support the full interdisciplinary team** [includes physician, nurse, social work, spiritual care].
- **Reduce variations** in coverage and payment requirements across payers that make it challenging to develop and deliver serious illness care.
- Provide **adequate** reimbursement and regulatory **incentives** for increasing utilization of **advance care planning**.
- Implement **regulatory and reimbursement flexibilities** to structure services that better meet the needs of serious ill patients.

*Additional information about the Council and the annual reports can be accessed [here](#).*

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### ***PAYMENT DESIGN AND CHANGES NEEDED TO GROW RURAL PALLIATIVE CARE*** by Karla Weng, MPH, CPHQ, Stratis Health

Approximately twenty-two percent of the state's 5.7 million residents live in rural areas. Rural residents tend to be older, sicker, and poorer, disproportionately needing palliative care services. During late 2018, Stratis Health, as part of a decade-long effort to help rural programs expand palliative care services, held roundtable discussions with existing programs in Minnesota and surrounding states regarding payment.

Their findings highlighted how critical palliative care payments are for rural providers. **Current payment approaches** for use by rural providers to offer palliative care services include:

- Billing and traditional reimbursement.

- Grants and philanthropy.
- Value-based contracting.

Of note, grant funding is typically awarded to start a program, but is not the same as financing, and is not sustainable as few grants support on-going operating costs.

**Emerging opportunities** include working with Medicaid, Medicare Advantage plans, and private payers to develop consistent palliative care reimbursement or benefit options within the state. There is also the potential for participation in the Community Health Access and Rural Transformation (CHART) model through the Center for Medicare and Medicaid Innovation (CMMI).

Even for rural health care organizations whose managed care contracts allow for billing for palliative care services, reimbursement is **challenging** because there may only be **two or three patients per payer**, leading some providers to consider not billing due to **administrative hurdles**.

*The Stratis Health report Sustainability Strategies for Community-based Palliative Care: A Blueprint for Supporting Rural Palliative Care Services can be accessed [here](#).*

**BEST PRACTICES IN PALLIATIVE CARE PAYMENT AND ACCESS** presented by Allison Silvers, MBA, Vice-President, Payment & Policy, Center to Advance Palliative Care (CAPC)

Since 2015, CAPC has been collecting ideas and approaches from diverse payers including Medicare Advantage Plans, Medicaid Managed Care, commercial insurers, integrated payer-providers, and full risk providers.

The following key lessons learned emerged from CAPC's research:

- It's critical to **identify the 'right population'** for palliative care.
- **Identify the payment model** that best supports the service needed by each population.
- **Payment models may serve different purposes and goals**, e.g., fee for service works well for assessments and consultations.

**Payment models should be variable.** Using a gas burner as an illustration, payments should be able to 'dial up' for higher intensity care, and 'dial down' for lower intensity care.

**Standard payment models** currently in use across the country for palliative care services include:

- **Fee-for-service**, typically used for assessment and consultation.
- **Episodic payments**, typically for 30-, 45- or 60-day periods; recertify if additional services needed.
- Monthly bundled, **per member per month**, is a 'go to' payment model for many payers.
- **Tiered bundled**, may become the next popular option. High, medium, and low depending on patient needs.

Financial incentives from health plans, state Medicaid agencies, and accountable care organizations in general seek to influence provider behaviors whether clinician, hospital, specialty care, or palliative care. Incentives should be based on quality measures including:

- **Access** to care.
- Patient **satisfaction**.

- **Advance care planning.**
- **Clinical quality.**

**The goal for payments is consistency across payers.**

Additional payment information from CAPC's Better Care Playbook can be found [here](#).

## **ONE STATE'S APPROACH: IMPROVING QUALITY THROUGH A SUSTAINABLE COMMUNITY BASED PALLIATIVE CARE PROGRAM** presented by Torrie Fields, MPH, CEO, Votive Health

It took Hawaii **twenty-two years** to fully develop their palliative care benefit. Torrie Fields, CEO of Votive Health, shared Hawaii's experience.

Palliative care shows **high customer satisfaction** but sees **low adoption when people are unfamiliar** with the services available, or that palliative care is covered by insurance.

Palliative care is in line with what patients want, namely **improving health equity** for individuals with serious illnesses, **improving access to high-quality serious illness care**, and **improving quality of life** for the patients and their families.

**Key decisions** Hawaii used to develop their benefit included:

1. Determine the **policy route** to take [what is the process to create the cost and business case for creating a state Medicaid benefit for these services].
2. Identify the **population in need**.
3. Setting a **baseline** based on past experience.
4. Determine **how many people** might access services.
5. Determine the **cost of the services offered**.
6. Determine if the **costs can cover services delivered** and **how much the state can afford**.

Questions to determine **impact on cost and savings** included:

### **COST** Assumptions

- **What population** will be covered?
- **Who will benefit** most from services?
- **How many people** will access care?
- How **long will people be receiving care**?
- How **will other services be impacted**?

### **SAVINGS** Assumptions

- **What is being avoided** by delivering this care?
- **What services will be accessed sooner** because of this care?

Specialty providers and hospital care teams may have little interaction with palliative care teams outside of the hospital and as a result may be unfamiliar with community-based palliative care.

Community engagement is critical to ensure those with the most need understand, access, and are satisfied with the services.

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## **SMALL GROUP DISCUSSIONS**

Summit attendees participated in two small group discussions between presentations. Themes emerging from the small group discussions included:

- There is **tension** between what is **best for the patients** and **what is sustainable for the health system**.
- Patients, especially pediatric patients, **must choose between palliative care and private duty, e.g., a night nurse**. Cannot have both as it is considered **double billing**. Families will frequently choose the night nurse.
- **Identify the right population and associated trigger points** (eligibility) and **ensure continuity of care across all settings**, including a live discharge from hospice. **Don't let patients and families get lost in the system**.
- **Ensure consistency across all payers, including private and government**. For example, there are **differences in Minnesota between MinnesotaCare, Medical Assistance, and Minnesota's State Employee Plan**, as well as **differences between private payers** regarding benefits and payments.
- There is support for a **task force** with at least **one member having actuarial experience** and sense of what the provider will experience from a cost perspective.
- There is support for a **pilot program** to examine **what works, what doesn't work**, and what are the **best quality measures**.

**Panel discussion** with **State Senator Karin Housley, Gretchen Ulbee**, Manager of Special Needs Purchasing with MN Department of Human Services, **Patrick Courneya**, Chief Health Plan Medical Officer, HealthPartners, and **State Representative Liz Reyer**.

The goal of the panel discussion was to help **move toward actions steps regarding palliative care and sustainability**. Panelist were asked three questions:

1. What are the **next steps** that need to happen to advance palliative care in MN?
2. Is there anything that you can **commit to** leaving today's session?
3. Where do **your interests** lie?

**The panel identified** that getting an **accurate definition of palliative care into statute** as one of the critical first steps in advancing palliative care in Minnesota. Having an accurate definition will **help communicate the distinction between hospice care and palliative care**. Both Representative Reyer and Senator Housley expressed support for this effort during the 2022 legislative session.

**The panel discussion also led to support for creating a task force** that would work with the state to advance payment strategies. This task force would help **determine payment model(s) which are sustainable over time**, develop a **plan to pilot to test the payment model(s)**, and as part of the process, **identify payment model attributes** or approaches that may be **counterproductive or have unintended consequences**.

## NEXT STEPS

The presentations and group discussions were rich and deep resulting in a wealth of information, ideas, and concepts. With the focus on **ACTION**, the immediate **next steps** identified were:

1. **Submit** Minnesota's **definition** of palliative care **to state legislators** during the 2022 legislative session.
2. **Create a task force**/coalition to identify and **advance palliative care payment initiatives**.
3. **Create a Minnesota specific payment pilot study**.

## ADDITIONAL RESOURCES:

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**Session 1: Policy and Payment Recommendations from the Minnesota Palliative Care Advisory Council**, Jessica Hausauer, PhD, Chair

[Palliative Care Advisory Council 2021 Legislative Report](#)

[Palliative Care Advisory Council 2020 Legislative Report](#)

[Palliative Care Advisory Council 2019 Legislative Report](#)

[Palliative Care Advisory Council 2018 Legislative Report](#)

**Session 2: Payment Design and Changes Needed to Grow Rural Palliative Care** presented by Karla Weng, MPH, CPHQ, Stratis Health

[Stratis Health Sustainability Strategies for Community-based Palliative Care](#)

[Rural Palliative Care Toolkit \(stratishealth.org\)](#)

[Policy and Regulatory Considerations to Address Urgent Needs During the Pandemic: Recommendations from Minnesota's Serious Illness Action Network - Stratis Health](#)

[Serious-Illness-Action-Network August-2020-Forum Summary Final.pdf \(stratishealth.org\)](#)

**Session 3: Best Practices in Palliative Care Payment and Access** presented by Allison Silvers, MBA, Vice-President, Payment & Policy, Center to Advance Palliative Care (CAPC)

<https://bettercareplaybook.org/blog/2020/8/driving-improvements-hospital-care-through-palliative-care-quality-incentives>

[Build a Portfolio Not a Garden; Michael E. Chernew, PhD](#)