Testimony of the Maryland Advisory Council on Serious Illness Care

Re: In Support of House Bill 1251 – Health Facilities and Health Insurance – Palliative Care – Required Access and Coverage (Edna G. Neal Palliative Care Act)

Before the Maryland House Health Committee

Chair Bagnell, Vice Chair Cullison, and Members of the Committee,

Thank you for the opportunity to testify on House Bill 1251, the Edna G. Neal Palliative Care Act. I am Dr. Marian Grant, Chair, writing on behalf of the Maryland Advisory Council on Serious Illness Care. This Council exists statutorily to advise the Assembly and Maryland government on all aspects of care for serious illness including palliative care and this bill is exactly the kind of legislation we are monitoring.

The Advisory Council strongly supports HB 1251 and respectfully recommends several clarifying amendments to ensure successful and equitable implementation.

Support for the bill's purpose

HB 1251 takes an important step toward making high-quality palliative care a standard part of medical care for Marylanders living with serious illness. The bill would require hospitals, nursing homes, hospice care facilities, and other long-term care facilities licensed in the state to provide patients with access to a dedicated palliative care program beginning October 1, 2027. It also ensures that palliative care is offered alongside curative or life-prolonging treatment and not restricted to end-of-life care.

The bill's definition of palliative care appropriately emphasizes relief of symptoms, pain, and stress and the goal of improving quality of life for both patients and their families, regardless of diagnosis or stage of disease. This aligns with national palliative care standards and with the Advisory Council's mission to advance person-centered care.

We particularly support the bill's requirement that, as appropriate, facilities inform patients and families about the availability of palliative care services at the time of diagnosis of a serious illness, during treatment planning, and at hospital admission. This will help address the well-documented under-recognition and under-utilization of palliative care among eligible patients.

On the coverage side, HB 1251 would require insurers, nonprofit health service plans, and health maintenance organizations that provide hospital, medical, or surgical benefits to cover palliative care, including physician and nursing services, counseling and mental health services, pain management and symptom relief, home- and community-based care,

and social work, care coordination, and family support services. The bill prohibits plans from denying palliative care because a patient is continuing curative treatment or limiting coverage to end-of-life care, and it does not allow higher cost-sharing for palliative care than for comparable medical services, with limited exception for high-deductible plans. These are essential protections that align with the bill's health equity goals.

Finally, the bill directs the Maryland Department of Health to adopt minimum standards for the delivery of palliative care, including staffing, training, and quality assurance, and to report annually to the General Assembly on access, utilization, and quality of palliative care services beginning in 2028. This creates an important framework for accountability and continuous improvement.

Recommended amendments and implementation guidance

While we urge the Committee to move HB 1251 forward, we recommend several refinements to make the bill more feasible and more equitable in practice.

1. <u>Clarify acceptable models for facility "access to a dedicated palliative care program."</u>

As drafted, HB 1251 requires each facility to provide patients with access to a dedicated palliative care program but does not specify the models that would satisfy this requirement. There are national guidelines for such programs along with guidance from other states that have expanded palliative care services in their Medicaid programs. We recommend clarifying in statute or in bill language that facilities may meet the requirement through a range of evidence-informed models, such as:

- On-site interdisciplinary teams
- Shared regional or system-level teams
- Tele-palliative partnerships
- Formalized consultation arrangements with specialty palliative programs.

We further recommend directing the Department to provide technical assistance and implementation guidance tailored to different facility types. The Council has the expertise and is available to assist in developing such guidance.

2. <u>Require stakeholder engagement in setting minimum standards and measures.</u>

HB 1251 directs the Department to adopt regulations establishing minimum standards for staffing, training, and quality assurance, and to report on access, utilization, and quality. To ensure these standards are both meaningful and feasible, we recommend that the bill specify that MDH develop regulations and reporting measures in consultation with:

- The Maryland Advisory Council on Serious Illness Care

- The Maryland Departments of Health and Aging
- HSCRC and Medicaid
- Hospitals, nursing homes, hospice and long-term care providers
- Payers and consumer representatives
- Frontline palliative care clinicians and caregivers.

This engagement will help align measures with existing data systems and avoid duplicative reporting while producing actionable information for the General Assembly.

3. <u>Address equity and affordability for Medicaid and high-deductible plan enrollees.</u>

The bill applies directly to commercial insurers, nonprofit health service plans, and HMOs that provide hospital, medical, or surgical benefits, and allows high-deductible health plans to subject palliative care services to the plan deductible. To advance the bill's health equity intent, we recommend:

- Adding report language or a directive for MDH and Medicaid to evaluate and, where appropriate, align Medicaid coverage and payment policies for palliative care with the standards established in HB 1251
- Requesting that the Department and the Maryland Insurance Administration explore strategies, consistent with federal law, to mitigate financial barriers to palliative care for individuals enrolled in high-deductible health plans.

4. <u>Support for workforce and capacity building.</u>

The Advisory Council is keenly aware of the existing shortages of palliative-trained clinicians. While HB 1251 appropriately sets an expectation that facilities provide access to palliative care by October 1, 2027, meeting this requirement will require workforce development and training. We recommend that the Committee consider:

- Adding report language or a planning requirement for MDH, in consultation with the Advisory Council and educational institutions, to develop a statewide palliative care workforce and training strategy
- Using provider-neutral terms such as "health care providers" instead of "doctors" to allow nurse practitioners and physician assistants to also be part of these teams.
- Aligning relevant grant or innovation funds, where available, to support start-up and expansion costs for palliative programs, particularly in under-resourced communities.

Conclusion

In closing, HB 1251 is a significant and needed step toward ensuring that all Marylanders with serious illness have access to high-quality palliative care, regardless of where they receive care or what type of coverage they have. With the clarifications and implementation supports outlined above, the Advisory Council believes this bill can meaningfully improve quality of life, support families and caregivers, and advance health equity across the state.

For these reasons, the Maryland Advisory Council on Serious Illness Care respectfully urges a favorable report on HB 1251, with amendments.

Thank you for your consideration and for your commitment to Marylanders living with serious illness. The Council would be happy to answer any questions.

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