

 IHPCO Home

As the voice of Illinois hospice providers, the Illinois Hospice & Palliative Care Organization (IL-HPCO) appreciates the opportunity to participate in the process of developing coordinated care for Illinois Medicaid recipients. As outlined in the June 2011, Coordinated Care Program Key Policy Issues, there are many technical aspects to consider. The questions outlined are difficult to answer in a healthcare environment that is in a tremendous state of flux and uncertainty. Providers, including Illinois hospices, are currently having difficulty in keeping up with increasing regulations and scrutiny while financially sustaining operations. IL-HPCO does not have insight in answering the global policy questions that were posed; however we do have a vast body of knowledge as to how coordinated care is provided to individuals who have a terminal illness. The Hospice Benefit currently contains the majority of characteristics that are addressed in the memo, specifically:

- Hospice providers are reimbursed a capitated per diem rate and assume the financial risk for care received that is greater than the reimbursement rate.
- Care is provided and coordinated across all settings- personal home, nursing home, assisted living environment, hospital. Coordinated care in hospitals and nursing homes is through contractual arrangements, with hospices case managing care of hospice patients at all levels.
- Hospice provides the majority of care through specifically trained employees of the hospice- physicians, nurses, hospice aides, chaplains, social workers, and volunteers.
- In addition to services of the interdisciplinary team listed above, covered services also include medications, supplies, and durable medical equipment related to the terminal illness.
- Hospice is not limited by diagnosis or age, but rather based on prognosis.
- Benefits to Medicare Part A and Medicaid are waived when hospice is elected and the services are related to the terminal illness.
- Quality measures are under development by the National Quality Forum for national reporting. Currently, many hospice providers collect patient/family satisfaction data to work at improving outcomes.
- Increasingly, hospice providers are implementing electronic medical records; some have been electronic for over a decade. Since there are not any standardized or mandated forms, hospice medical records may vary from hospice to hospice. There is no common exchange for records with other providers.

In order for Illinois Medicaid to capitalize on this extensive coordinated hospice care, patients need to be referred when there is a life limiting prognosis and stay on hospice care. A research study, published in the Journal of Clinical Oncology, examined the impact of disenrolling hospice patients. Researchers at the Mount Sinai School of Medicine found that:

- 34% of patients who disenrolled were admitted to an ER in comparison with only 3% of hospice patients.
- 40% of disenrolled patients were admitted to the hospital in contrast to 1.6% of hospice patients.
- 10% of disenrolled patients died in the hospital compared to only 0.2% of hospice patients.
- Cost of care for patients with cancer who disenrolled was nearly five times higher than for patient who remained in hospice.

In summary, the Medicare/Medicaid Hospice Benefit is an existing model of care that includes all the components that are being considered in the development of the Coordinated Care Program. The number of Medicaid recipients who receive hospice care could be increased if Medicaid reimbursed for care provided to individuals with a year prognosis as included in the Illinois Hospice licensure requirements. It is difficult for a younger population to admit that their life expectancy is short and physicians are reluctant to have the discussions. The end result is that the individual receives aggressive care that does not improve quality of life. Likewise, as in the model created by Aetna, individuals can receive curative care while concurrently receiving hospice. This alleviates the stigma of “giving up” and allows for more realistic discussions regarding treatment decisions. Both of these modifications to the existing Medicaid Hospice Benefit could increase the number of patients served.