Transcript: **Hospice Wage Index, the Final Rule, and the Signals CMS Is Sending | Part One**

Leadership Open And Guest Intros

Melody King 0:00
Everything rises and falls on leadership. The ability to lead well is fueled by living your cause and purpose. This podcast will equip you with the tools to do just that. Live and lead with cause and purpose. And now, author of the book, The Anatomy of Leadership, and our host, Chris Comeaux.

Chris Comeaux 0:23
Hello and welcome. I'm so excited today. I have two special guests with me. I've got Annette Kiser, the Chief Compliance Officer with Teleios Collaborative Network. Welcome, Annette.

Annette Kiser 0:33
Hi, Chris. Good morning. Great to be here.

Chris Comeaux 0:36
And then we got Judi Lund Person, who's a principal with Lund Person and Associates. Welcome back, Judi. Oh, thanks. It's good to be here. Anytime I get to hang out with both of you ladies, is a wonderful thing. Now I can't imagine we have a listener who doesn't know who you are, but just in case, let me introduce you both. So first, Annette, she's a chief compliance officer at TCN. She has more than 40 years of healthcare experience. She's recognized for her regulatory compliance expertise in the hospice community. She holds a master's degree in nursing administration, nationally certified as a nurse executive in healthcare compliance. NEP began her career as a nurse volunteer in 1986. She was 12 years old then, before moving into full-time hospice nursing leadership roles. Her experience includes more than two decades with community-based nonprofit hospices and more than six years supporting hospice and powered care providers through two state associations with a focus on quality compliance, clinical care, and public policy. And then Annette joined TCN in 2017, where she's partnered with hospice and powered care leaders nationwide to strengthen their compliance practices, help them respond surveys, audits, and navigate the wonderful complexities of regulatory challenges. Away from work, Annette enjoys spending time with her husband Ron, their daughter Taylor, and her

new son-in-law, Anthony, and their two grandkiddies, Jasper and Onyx. Annette, anything I'll leave out you want to add?

Annette Kiser 1:56
No, that was more than enough, Chris. Thank you.

Chris Comeaux 1:59
Awesome. And congratulations on the new son-in-law. That's actually a really cool addition. So, Judi, she's the principal of the newly established One Person Associates. It's not new now, but it's been new for a little while. Right. That does hospice consulting. Judi has, for 21 years, she served as the vice president of regulatory compliance of the National Hospice and Palliative Care Organization, where she served as the key contact with CMS and also other federal agencies helping to ensure that NHBCO's voice was heard with policymakers. She is known for translating complex regulations into plain English. She has a lot of superpowers. I definitely think that's a superpower for hospice providers and providing resources for regulatory compliance. Prior to joining NHBCO, Judy served for 22 years as a presidency of the Carolina Center for Hospice and Life Care, where she provided support and resources for hospice providers and then of life care coalitions in the Carolinas. Early in her career, Judi was part of a small group of advocates that worked for the passage of the Medicare Hospice Benefit in Congress, which we're all blessed by. Think about if it wasn't for Judi, I'm not sure we'd even be here having this podcast today. That advocacy work resulted in the addition of hospice to Medicare in 1982 with the original hospice conditions of participation published in 1983. And so, Judi always liked to tell you thank you, because in many respects, you're one of our matriarchs.

Judi Lund Person 3:34
It's a big deal, of course.

Chris Comeaux 3:36
I don't know if anyone else is like, oh my God, it just came out and I'm gonna spend all weekend reading it. I'm like, who are you? But you're two amazing, talented ladies, and I'm so glad I get to have a conversation with you about this. Are you guys ready to jump in?

Judi Lund Person 3:50
Let's go. We're

Reading The Tea Leaves In CMS

Judi Lund Person 3:51
ready.

Chris Comeaux 3:51
All right, so I just did a wonderful tell there of what we're gonna be talking about, the wage index. So, the final 2027 hospice wage index and final rule is now out. You know, as I've maybe matured in my career, I always believe that the wage index is more than a payment rule. It really gives us some interesting insight to how CMS is thinking about things, their strategic thinking. So, beyond the reimbursement updates, what signal is CMS sending about where they want hospice care to evolve over the next several years?

Judi Lund Person 4:20
So, you know I, I um always look at the uh final rule, the even the proposed rule, but the final rule in particular, as a way to read the tea leaves. And um, I know I am like nerdy in that way, if you will. Um, but so this is this year is no different. So, I pulled out a few things that I thought would be really um interesting examples. But I think for anybody who wants to know what CMS is doing, um, a close read, um even if you spend you know two or three different sessions reading parts of it, of the CMS commentary and the CMS responses to comments from comment letters is very, very helpful. So here are a couple. So, as we know, and we'll talk about a lot more, the um uh hospice election statement addendum is mandatory effective October 1, 2026. And so, one of the things um CMS was responding to is comments about the addendum, and you know, obviously their comment, which you'll hear in just a second, is because a lot of commenters said the form was confusing and burdensome and so on and so forth. So here is what CMS said. CMS said the addendum must include a clinical explanation in language that the patient or representative can understand of why the drug, item, or service is unrelated. And then the translation to that, this is a tea, this is one of those tea leaf things. The translation to that is stop whining and get this implemented. Um, and I I also um thought about experiences in my um career, especially at NHBCO, where we would go, we would talk to CMS, or we would go to CMS. And I remember one time somebody was we were at in Baltimore and somebody was walking me um out the door, and I said, you know, thank you so much for you know including blah blah blah, whatever it was. And her she looked at me and she said, well, Judi, we've been telling you this for five years. So, it's about time you got it together. That's the same kind of category of this. So, stop whining, get this, um, get this accomplished. Another example, and um this is like seriously nerdy, so we'll go there for just a second. But we've had a lot of commentary about what to do about unrelated drug services and treatments. And CMS over the years has said, you know, the words you should be using in your election statement are unusual and exceptional. So we've argued with CMS and with the MAX about this issue over some time and said, you know, sometimes people use the word rare because it's more understandable to the patient and

their family. So this year, what do we have? Um here's the CMS uh sentence. Unrelated items, services, and drugs should be exceptional, rare, and unusual. And all of a sudden, now we have it in CMS language. And so, we can now use this. Um, and a hospice can use this language and say, you can no longer deny my election statement form as being invalid because I've used the word rare. It may seem like a really small thing, but it is not. And so another kind of read the tea leaves, CMS is starting to get um what's going on here. And then I just add a third thing, and I I think for all of us who who really believe in high quality hospice care, this is when it's hard, um, I think. So we've we know that there's a lot of um focus on hospice fraud, waste, and abuse. And so, one of the things that CMS puts in the report about why we are focused on this is the things that hospices they have they have reports from advocates, they have reports from families that hospices did not provide. Look at this list or listen to this list wheelchairs, hospital beds, oxygen, oxygen supplies, wound care supplies, incontinence supplies, catheters, needles, and common palliative drugs. And so, this is another one where reading the tea leaves is because CMS is seeing this, we have we have a responsibility to really dig in and make sure that this gets corrected. So just a couple of examples I think that are interesting and um certainly give us some roadmaps for the for the future.

CEO Must Knows Addendum And Telehealth

Chris Comeaux 9:15
Well, Annette, any tea leaves you want to read?

Annette Kiser 9:19
Well, I'll just tag on to what Judi was saying about um you know what it's hospices not paying for things they should be. CMS pointed out in the um commentary that Medicare payments just for non-hospice part A and B, that doesn't include part D uh medications, but just for part A and B, that um that increased 160% from 2020 to 2024. And in 2024, the non-hospice spending for parts A and B was um over $2 billion.

Judi Lund Person 9:55
Billion with the B.

Annette Kiser 9:56
So, two billion dollars. Right. Billion with the B. And the important piece that hospices don't often think about is patients have cost sharing for parts A and B. Anybody with Medicare and goes to the doctor, the hospital, they got to pay their part. Hospice patients had five hundred and ten million dollars in cost sharing for parts A and B services billed to Medicare just in 2024. $510 million in cost sharing. And so that's really where it gets

important. And Judi mentioned the addendum, and that's about transparency for patients as to what they are going to be expected to cover that's unrelated to that terminal illness and related conditions. But it's a lot of money, and when you stop and think about that, that's a big reason why it's getting CMS attention.

Chris Comeaux 10:47
Wow. Well, love how you guys just jumped in. Let me ask it this way: um, if a hospice CEO only had five minutes to understand this rule, what are the three most important takeaways?

Annette Kiser 10:58
Well, I would say the addendum, Judi said it, October 1, and today is August 14th. We have six weeks to be ready for this. And I talked to a hospice just yesterday, and they haven't even had a meeting yet to think about how they're going to implement it. Um, others started back in in April when the proposed rule came out. So they need to understand the addendum and make sure someone is assigned to be the project leader in their organization to get that going because it's significant. Every Medicare patient has to get the addendum within the first five days of election of the benefit. And I'll have a little caveat because of a conversation I had earlier today with the hospice. It's at election of the benefit. If a patient turns 65 later, if you have to discharge them and readmit because you miss the face-to-face, you get to do a new addendum because it's based on the election of the Medicare benefit. So, CEOs need to make sure someone has in has been tasked with being responsible for getting everyone together to make that process happen. And then Judi's going to talk more about this in a few minutes, but the the SSVI, the Service and Spending Variation Index, is huge. CMS did not make changes to that. They updated the data a little bit, but basically it's there. Hospices get those scores based on their utilization statistics and based on their non-hospice spending. And so CEOs need to make sure there are multiple people looking at those metrics through a quality improvement lens, not just this, you know, this data. CMS focused on those hospices, and there are only 69 of them that had a score of 13 or greater as being above the 99th percentile. But what Judy and I talked about is over time, less hospices are gonna have a score of 13, so the threshold's gonna lower. And so any hospice that has any points in that score really needs to pay attention. So, CEOs need to make sure multiple people are tracking and they know how to track. And Judi's gonna talk a little bit more about that. And then just a couple little things unrelated to the addendum and the SS VI and the wage index is all physicians, all hospice physicians can now write discharge orders. It used to be just the medical director. I have a feeling that hospices have been using others, but now it's official that any hospice physician can write that discharge order. We are going to have the G-code that should be coming out soon that beginning January 1, 2027, hospices have to put that code on their claims if they do a face-to-face visit by telehealth.

CMS wants to know how much telehealth is being used. And then I would just encourage at some point, make time, as Judi said, it'll take a couple sessions, but sit down and read what CMS had to say about the request for information comments they got back regarding medical aid and dying, regarding palliative care and hospice payment reform. It gives some good insight into what CMS is thinking.

Chris Comeaux 13:59
Yeah, I just want to put an exclamation point on that. Annette, you're the one who taught me that those RFIs are their tells as well, um tea leaves as well, of like what they're thinking about going forward. So that's fascinating. That made palliative care and then other payment reform. And then I want to ask you, Annette, but Judi, you could comment as well. Is the G code and telehealth a bit of a tell, also? Um, or don't read anything into it. I mean, I could understand why they'd want at least had a way to segment that data, but do you think it's a tell in any way, shape, or form?

Annette Kiser 14:30
Well, I think it might be just a little bit because there is some concern that telehealth is being used, and there are so many concerns about eligibility determinations. And if it's telehealth, it is harder, um, depending on the patient, to make some of those assessments. What my word of encouragement is if you are feeling pretty confident that patient's eligible, telehealth, telehealth is okay. I would encourage to have a nurse in the home to help ask questions, turn the patient, you know, um answer some of those questions for the provider. But if that patient is is a little less clear, some of those patients that that decline more slowly, an in-person visit may be good. And I think if we want to be able to help CMS understand there's a role for it, having that code lets them know we are needing to use it. But as we all know with anything, it could come a time when they look and see, oh, this hospice does 100% of their visits by telehealth. And that that could be some concern.

SSVI Scores Utilization Versus Spending

Chris Comeaux 15:30
Well, let's talk more about the SSVI. Like, we need one more acronym, right? Well, my wife, my wife is listening to me in a Zoom call and she's like, do you guys have like your own language? I'm like, Yeah, we do. It's a bunch of acronyms.

Annette Kiser 15:43
And just when you think you understand it, they're going to add a new one. Right.

Chris Comeaux 15:46
Absolutely. So, what first step should a hospice take now that they can actually see their own SSVI data?

Judi Lund Person 15:55
Well, let's kind of um pull it apart just a little bit as we start and um also kind of think about um what's in that what's in that SSVI report. And if you downloaded it from the CMS website, it is 6,200 rows of data, but it includes every single hospice in the country. So, it's all public data, it all comes on the utilization side, it all comes from claims data on the non-hospice spending side, it comes from non-hospice providers and links it to the enrolled hospice beneficiary. So, I think that in itself is daunting. Um, all of a sudden you can see all this information about yourself, your own agency, but you can also look at others in your state, your competitors, any of that kind of thing. So, the the whole issue with SSVI is um uh let's start with utilization metrics. Um, the utilization metrics are things that are pretty commonly already known. So, things like um, did you provide any GIP or continuous home care? If no, you get a point of one. Maybe and maybe we should stop there and talk about the point system. So, on the utilization metrics, there are eight points, and you get a point if you hit a threshold that's specified for this year, but for this year only, kind of to an point, this will change over time. But um, when we are looking at a um utilization metric, so that's one point, but there are eight of them, and things like um what uh percentage of your census was in a nursing home or a skilled nursing facility? If your percentage of nursing home residents who have hospice is greater than 40 percent, you get a point. Um, they're looking at um nursing minutes, they're looking at visits done on the weekends, they're looking at that score for HVLDL. And if you are at a certain threshold, and this threshold is specified in the final rule, but also um many of us who've been talking about this try are trying as hard as we can to turn it into plain English a little bit more. Um, but I I think you know these are these are not big surprise metrics. Um percentage of hospices who or percentage of patients who have a live discharge, uh percentage of patients who have a length of say greater than 180 days, that that sort of thing. What we're seeing in the data, um as Annette said, this utilization metrics, eight points, and then non-hospice spending eight points, um, is I think not so concerning on the utilization side. Um, but certainly as we move to the non-hospice spending side, um, when the proposed rule came out, we said we looked at the non-hospice spending and it is eight categories by the amount of the spend. So, you get one point if your non-hospice spending in FY25, the year we are looking at data-wise, is sixty-five hundred dollars or more. One point. Now it has no it doesn't matter at all if you had 20 patients that year or if you had 6,000 patients that year. If you had non-hospice spending of $6,500 rounded number, um, then you get a point. And so, all I bet you, all of us um who wrote comments on the proposed rule said this is not right, this is unfair, this is does not take into account

the size of the hospice. Um, but the non-hospice spending metrics were finalized as proposed.

Annette Kiser 20:06
If I could jump in, Judi, the bigger concern for me is the those who get a score of eight, if you have more than $515,000 rounded, you get a score of eight. So, a hospice that has an average daily census of $500 and has more than $500,000 is going to get the same score as a hospice that has an average daily census of $50,000. Well, you would expect that a larger hospice has more non-hospice spending. Right. CMS did not change that metric, and so there are hospices that all of us work with that may have a score of eight or seven or six because of the size, and some of that non-hospice spending is legitimate, such as part B attending physician visits, but CMS didn't extract those things, and so it's important to understand how that scoring comes.

Judi Lund Person 20:58
So I, I think then there's a second issue with the non-hospice spending part of this, and that is do we even know when um non-hospice spending is occurring? And that I think is uh I think the bigger issue, and this is what a hospice should be looking at is where can I find, especially part B, because that's going to be a lot of it. Um, part D, I think, is maybe more of a black hole, but um, on the part B side, um, where can I find data that is patient-specific, beneficiary specific? And you begin to put together what spending what occurred. I will use an example of a provider I talked to recently who said my non hospice spending was $1.6 million. I serve 2,000 patients a year. And I have no idea where that spending came from because. We have never had information that gives us insight into who billed for what patient. And the only way we're going to really correct this is to have that information. So, you know, I think now we're beginning to look at what vendors have Part B claims data that is patient specific. And that's uh, you know, if I if I in on my list of things a hospice should do immediately is figure out where you can get that information because this is the only way you're going to be able to correct the non-hospice spend. Now, uh I will do maybe an editorial comment as well, which is as we talk to CMS about the SSVI, about the non-hospice spending. I remember one conversation I had with somebody at CMS, and I said, well, you're aware, of course, that most hospices have no idea where this spending came from. And her response was, oh no, that's not true. Um, we we know that hospices are pushing uh claims or pushing services over to the Part B side so that Part B will pay and the hospice doesn't have to pay. And after steam came out of my ears, after I was like, okay, take a breath, Judi, don't really damage this relationship. Um, I said, no, I don't believe that's completely true. It may, you may be seeing that from some providers, but the vast majority of providers have no idea where this non-hospice spending is occurring. So, but on the on the uh short list of things to do is pull this non-hospice spending data apart. See what you can get in terms of patient level, beneficiary

level matched with your hospice enrollment data so that you can reach out to whoever it is that's billing. Now, the other comment I would make, um also uh editorial comment is Annette and I both worked on this, um, that for years we worked on trying to convince CMS to put some flags in the claims processing system. That if you were a hospital, an outpatient clinic, a doctor's office, a whatever, there would be a block on filing the claim until the hospice was contacted, until you figured out whether the claim should be filed or whether the hospice should pay. That part of um claims processing has never been fully implemented. And so that's the other piece we have is we have to do the digging. And I guess my own passion about this is that is the only way we're gonna solve this non-hospice spending. And that is right. I mean, we are looking at huge, huge, huge volume here. So they're very habit.

Chris Comeaux 25:03
Would that be hard for them to do, Judi? It seems like it'd be fairly simple for them to just put like a flag if that part A has been elected, that it would just flag the system and they couldn't put that bill through. It should be, it should be easy.

Judi Lund Person 25:14
Now, when you look at the data, um the percentage of the total that was part A has gone down significantly over the five-year period. Well, part B has just expanded. So it it should be easy. But and maybe once they have the um moving the claims processing system to the cloud and some of those things are accomplished, maybe that'll be an easier, easier lift.

Annette Kiser 25:42
Do you think that'll be in our lifetime, Judi? I don't know.

Chris Comeaux 25:47
Was when Annette had originally shared the first round of reports, I wasn't wound care like the tops on that list. Did I misremember that?

Judi Lund Person 25:55
Yes, it was actually um skin substitutes um were a huge part of the reason that the um non-hospice spending has grown so much. Skin substitutes for Medicare in general is a huge issue. Never mind the hospice part of it, which was also huge. Um, but one of the things, again, that reading the tea leaves, um the CMS commentary on it was to say, yes, we have addressed wound uh care specialists, we can have addressed um skin substitutes, but that does not negate the um responsibility of the hospice to pay for wound care when

it's related to the terminal illness. So, I mean, yes, we've got all of these things, and and certainly a lot more conversation needs to be had with CMS.

Chris Comeaux 26:46
And the I was thinking about interjecting this when we were talking. So obviously, more points is not good. This is like dominoes and golf. You want a lower score as possible.

Annette Kiser 26:55
Absolutely. You can have a zero, it's it's great. I don't expect zero because again, some of that spending, non-hospice spending is legitimate. Right. So, a hospice may have a score of one, two, three. It's the six, sevens, and eights that that we need to be more concerned about as long as CMS continues to use the spending categories that they are.

Chris Comeaux 27:16
And Judi, so it's weighted about 50-50, 50% utilization, and then 50% non-hospice spending. So it's kind of like a weighted average based on those two categories.

Judi Lund Person 27:25
Right. It's weighted on the number of points. Um, but because the non-hospice spending has no connection to census, uh, it's it's weirdly weighted on the non-hospice spending side, unfortunately.

Chris Comeaux 27:39
Yeah, okay. Wow. And SSVI stands for because once we get the acronym, we totally forget what it stood for originally. Service and spending variation index. Okay, perfect. So, what first steps would you guys recommend a hospice should take now, now that they can see their SSVI data?

Judi Lund Person 27:56
Um, for me, it is um you can see both FY24 SSVI data and 2025. Now you also have the PEPPR, and so you are looking at two years of SSVI, soon to be no, and but we won't have 26 data until next year. Um, and then three years of PEPPR. And uh for me, I think you are uh, you know, a hospice is going to be looking at all the trends. You were you were saying, okay, how did I do in 24, even on the utilization metrics? Did I improve in FY25? Did my number of metrics, did that lower score happen in 25 compared to 24? That would be one thing. Then I think some of these are overlapped with pepper. Um, and so I I have been begging the pepper contractor to release information on percentage of hospices who have downloaded their pepper or percentage of hospices by state. And neither one has happened so far, but it's it's really it. But I think that's the other thing is take a look at your pepper and say which one, and maybe Annette and I between us will

figure out some alignment to say this this uh metric in the pepper matches this metric in SSVI. Start to really look at that, peel it apart, look at every single metric. And I guess um my only other comment would be uh review early and often. Um we've got a lot of really, really great metrics. Um you know, you will learn, I think. I think all of us will learn something about the hospice that we work for, the hospice that we love working for. So um, and opportunities, definitely opportunities for quality improvement.

Who This Rule Helps And Hurts

Chris Comeaux 29:52

Well, well, I think you two have done a good job of kind of laying the okay, so this is what's in the wage index. So, as we go to this next segment, every final rule creates opportunities for some organizations and challenges. Um Which type of hospices do you think are positioned to succeed under this year's rule? And which organizations should be paying maybe really particularly close attention to it?

Jeff Haffner 30:17

Don't miss part two of this episode coming this Friday.