Transcript: Part Two: Hospice Wage Index, the Final Rule, and the Signals CMS Is Sending

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TU Commercial / Chris Comeaux 0:00

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Jeff Haffner 2:11

Welcome to TCNtalks and Anatomy of Leadership we continnue our conversation with Annette Kiser and Judi Lund Person in Part Two Hospice Wage Index, the Final Rule, and the Signals CMS Is Sending for 2027. And now, here's Chris Comeaux.

CMS Oversight And Who It Hits

Chris Comeaux 2:19
So as we go to this next segment, every final rule creates opportunities for some organizations and challenges. And which organization should be paying maybe really particularly close attention to it?

Annette Kiser 2:38
Well, I think that um as Judi and I discussed when we were uh preparing for this, every provider is going to face challenges with this increased oversight. This data is public, CMS has it, it's out there for anyone that wants to go looking for it. And it means that we have to think about, okay, CMS is looking, but who else is looking? You know, we've got the other contractors, and of course, we know that MedPack and the GAO and others are paying attention, but we have to think about how we can respond. And those that are going to succeed are those that look at this as the glass half full moment as opposed to the glass half empty. We've been caught up for a couple of years in a lot of situations where we talk about what's being done to us and why. And we did try to get CMS to make some changes. Not that we don't think transparency and data reporting is important, but we think their metrics are skewed, and we don't have the information, as Judi was explaining, to be able to see where this non-hospice spending is coming from. We can't continue as CMS said Judi said basically in in her editorial comment, stop whining. We have to now stop and look at what we can do. Those organizations that started talking about mandatory addendum and what would we do if it came, they're ready to roll. Others, as I said, haven't even started the conversation. But it's taking that and looking at it as Judi talked about with the data. What does it say? What are your trends over the last two to three years when it comes to those district metrics? Pepper talks about outside Part B spending and part D spending and gives us some a little bit more granular data for our hospice. So they have to take that, they have to look at it. It's got to be across the organization. We can't just say, okay, this is up to compliance and quality to track this. Yes, you can assign someone to monitor it and make sure it's being done, but it's got to come into play with when you're looking at non-hospice spending, you've got to involve your accounts payable team and working with those outside providers to get those invoices in so that hospice can pay and it's not being billed elsewhere. So those that are spending time thinking systemically as opposed to siloed thinking are going to do much better. The organizations that really haven't spent time on this and haven't even tuned in years ago when we started the addendum are gonna struggle. I saw in some commentary in an online group this week where people were talking about the addendum and a nurse said, Well, isn't that the ABN, the Advanced Beneficiary Notice of Non-Coverage? No, very, very different. And then they were like, Well, okay, you know, we have a lot of things we don't pay for, so we're really going to

have to think about this. And so those organizations that really haven't tuned in and don't have a clue what this is now that it's mandatory, are going to be behind the eight ball, so to speak, and they're going to have a tougher time. But we really have to stop and think, okay, we have it, as you've talked about already, Chris and Judi, with the tea leaves. The tea leaves are telling us this. Let's just stop and think. How can we strategically, systemically uh use this information and prepare and position ourselves so that when we get looked at, we're okay. We know that we're gonna be in good shape. We may not be there today, but we're putting things in place with our quality improvement processes to be able to get there.

Mandatory Addendum Documentation Risks

Judi Lund Person 6:03

Yeah, no, I just want to add to that a little bit that um Annette is exactly right, and and maybe we could spend just a little bit of time on the component parts of the addendum now that it is going to be mandatory, and it is the addendum, as Annette reminded me yesterday, um, the addendum is mandatory for things that are unrelated to the terminal MS in related conditions, period. Um, there's a lot of language in the final rule about documentation. So all the times that over the years we have talked about documentation, it is so, so important now. Reminder that decisions about unrelatedness, and Annette, I know you will want to add to this too, are should be done by the physician. And so documentation should show that the physician is the one that made that decision. And you know, I I was talking to a provider the other day, and she said, Well, we did we had made the decision when the addendum first came out that we would do it for everybody. But um, she said, we have, and this is uh thank you, Annette, for helping me. Um we we have a section on the addendum that says it's related but not covered, or related but not indicated. So let's go there. Let's go there for a moment and we say we start to look at what we're hearing from CMS about the addendum as a condition of payment. That means that if a on-medical review, the medical reviewer doesn't see the addendum when after October 1, that um when a claim is is sent in for uh review, the whole stay will not be paid for. It is a condition of payment, period. Now, if it is a condition of payment, the last thing you want is to have things on the addendum, the official addendum form, that say these things are related, but we're not going to pay for them. No, no, no, no, no. So be really, really careful that the addendum is open to scrutiny, open to very serious consequences if something isn't isn't provided. So that doesn't mean we don't cover what's related but not covered or not indicated, that those documents will be in, those that documentation will be in the clinical record, but not on the intended. So just just to be really, really clear on that part of it.

From Volume To Outcomes And Value

Chris Comeaux 8:39
Years now we've been talking about moving from volume to value. As you guys read this rule, how do you see CMS continuing to shift the hospice world towards accountability for quality outcomes in our data?

Judi Lund Person 8:52
Well, so there are a couple of really interesting things, I think, um, here. And one of them is that the patient population we serve. So for other parts of healthcare, they're looking at the CAP survey and it gets the information coming directly from the patient. We're looking at metrics that are outcome-based because the patient is, you know, was started here, improved to here, and we have metrics for that. In hospice, it's a completely different. And so even our CAP survey is family or representative responses about their view of how the hospice care uh that their loved one received was how it was. But it's not it's not coming directly from the patient. But this is another place where I think reading the tea leaves from CMS is really important. So we start with data collection, quality reporting. We both have the CAP survey, and then we also have the HIS and now hope. So it's the beginning of collect the collect the data and collect all that information on all of your patients. And then what will happen? Um, I was just telling Annette that I think what we saw on the home health side is we had oh we had data collection start, we had Oasis, then we had OASIS plus, now, and I I did some research on what is what was the timeline. And for for home health it was about 18 years. Now, when did we start HIS and when did we start some of that um early data collection, standardized data collection work? About 10 years ago. So I think we are starting we are moving in the direction. If you if you read some of the the stuff that's put out on the hospice quality reporting um website, then you also know that they're looking for additional measures. And they're looking not just for process measures, but for outcome measures. Once we get to outcome measures, then we we will have um scoring that will say your outcome was better than uh hospice B, and so you get paid more. Um but I don't I think it'll be a while before that is really settled. But I and I also think that the focus at the moment is on um hospice fraud, waste, and abuse. Um and that may that may push up the or uh speed up the uh value-based purchasing, or it could say we can't do both, so we'll just do fraud, waste, and abuse. So I think both things are possible, but um at this point, that's kind of I think where we are.

Chris Comeaux 11:45
Those are excellent points, Judi. And and probably right, if it took 18 years, but I think about like data and technology, the runway is not gonna be 18 years for us. The cycle's

gonna go quicker, which would mean we're probably in that window. So I guess an excellent point. Um well, let me ask you guys this. You

Margins Workforce Strain And Rate Reality

Chris Comeaux 12:01
know, margins remain under pressure, workforce shortages, inflation's huge, uh, increasing patient complexity, especially as the baby boomers are becoming more and more patients. They have so many comorbidities. So if you look at this year's rule, do you believe CMS understands, adequately recognizes those realities, or are there areas where providers are just going to continue to struggle financially?

Judi Lund Person 12:26
Um, I'll start, but um, Annette, I know you will want to add um as well, but I I think I'll start with um the uh rate increase. The percentage of the rate increase is a statutory percentage. It's not a statutory percentage percentage, but it is linked to the hospital um rates and that sort of thing. So, you know, I I think in some ways it's good to have at least a requirement that the statute says you have to increase the hospice rate. Um and I don't I honestly don't think that CMS really understands the uh financial realities at all. Um and we are um certainly in a place where MedPAC, for instance, is looking at um margins and they publish information in the hospice chapter every uh every March. And I think that's another piece of this where we're looking at margins, we're looking at um, you know, how can a hospice do more and and then do more with with really not a lot of increase in rates. Um and and I and I think that's part of the real frustration. I, I don't think CMS understands kind of what the pressures are. Then we also have all the pressures of you should be paying for more. And so uh the combo is is not uh not a very good one.

Chris Comeaux 14:01
Just it just in your long sigh, it says a whole bunch, Judi. It just really does, because you're exactly right. Just it feels like they're expecting us to just do more and more with less. And most businesses, like inflation is people raising their actual prices because they're but we can't actually. And what were you gonna add?

Cost Reports And Future Payment Reform

Annette Kiser 14:19
Well, I was gonna add, we've talked a lot about data around the utilization and non-hospice spending, but another very important piece of data that I don't think gets enough

attention in hospice is what we report to CMS and our cost reports. Absolutely. If CMS is gonna look at future payment reform, it our cost reports have to accurately reflect what we're doing. They've got to be clean, they've got to be auditable, and I don't think they are based on the information that CMS has used through the years to talk about what it costs to take care of a hospice patient. Not enough information is being being reported, and you've got wide variations with a couple dollars to hundreds or thousands of dollars for the same service being provided. So we really got to look at what's going in our cost reports in addition to what's going on our claims. Yes, SSVI comes from claims data, but that cost report is what's gonna really inform what's gonna happen with payment reform. Right.

Chris Comeaux 15:18
That's so well said.

Judi Lund Person 15:19
I couldn't agree with you more, absolutely.

Chris Comeaux 15:21
Yeah, because the interesting, right? S SVI is a bit of a tail in another way. They um, I had Kim Brand on my podcast, and one of the things we talked about is a chili cook-off. She wasn't cooking chili, she was bringing these technology vendors in of what they could do for CMS. And so CMS is boning up. They have a boatload of data, and then they start digging into that data. And Annette, I don't think they've dug into the cost report data much. I may be wrong about that, but it feels like that that might be a future frontier for them.

Annette Kiser 15:51
Well, I think you're right, Chris, because from a fraud perspective, cost report probably doesn't tell them a lot. It's that claims data that really helps them with the fraud aspect. But again, from payment reform, if they're gonna start looking at paying more for certain diagnosis categories or paying more for certain patients who need certain services, we know they've mentioned uh, you know, things around dialysis and blood transfusions and some of those kinds of things as potential changes in payment. And those kinds of things get reported in cost reports.

Judi Lund Person 16:22
I was just gonna add one uh one small thing, and that is um cost reports could be used, and I've seen some analysis already being done on this that said, What does it cost per day of reaching home care? What's your cost? What do you report on the cost report and what do you get paid? And the differential is what now people are starting to get a lot

more interested in because if it's if you say are a cost for a day of care or uh hospice cost reports um aggregated, say this, that it's pretending don't don't hold me to the number, but say it's $180 a day and you're getting $211 a day, or whatever that number might be. I think that's another place where we have to um pay a great deal of attention. And it's probably worth it to also say um AI and pulling cost report information um out, and lots of people, I bet, are going to be looking at some of that.

Chris Comeaux 17:25
Well

Three To Five Year Hospice Forecast

Chris Comeaux 17:26
said. Well, as we kind of go into our final few questions, I want to ask you a couple futuristic questions. And this year's final rule, uh, it's really a chapter in a much larger story. Where do you think the Medicare hospice benefit is headed over the next, let's say, say three to five years? What should visionary hospice leaders begin preparing for to today, based upon whatever those tales are in that kind of larger story of where things are headed?

Annette Kiser 17:52
Well, Chris, I think it a lot really just reiterating what we've talked about, a lot of increased reliance on data-driven oversight. Know your numbers, know your trends. You know, we have the SSVI, we have Pepper, that takes us through the fiscal year 2025. Well, in six weeks, we're gonna end fiscal year 2026. What does your data show you now that you're not gonna see from CMS for potentially another year? You need to know what it shows now. So that increased reliance on data-driven oversight and really getting good at that. We know that EMRs are not necessarily good at some of those reports, but now that we have outside vendors and we have artificial intelligence, when used well and used correctly, can help do some of that analysis and really start to see more attention to our utilization patterns and non-hospice spending that that Judi spent a good bit of time talking about and really thinking about outcomes. As CMS said, as Judi said, CMS is talking more about outcomes. We've wanted outcomes for years. We looked at outcomes as potentially quality measures and clinical measures. CMS is really looking at some of these other measures around service utilization and dollars, and so I think it's that um increased pressure to demonstrate quality and value, as Judi was talking about with some of those margins.

Judi Lund Person 19:17

You know, I was having a conversation with somebody at CMS yesterday, and um they are reviewing a lot of their, you know, that we're this is in intensely into fraud, waste, and abuse in hospice. And her comment over and over to me is please tell hospices to get back to the basics, to remember what hospice care is, that it is not just a service, it's a program, and it has component parts. And I I've been thinking about that a lot, and thinking, you know, some of even the some of the utilization metrics are back to the basics. Um, and what we pay for and what we should pay for, maybe maybe those two things are different, but also that is part of the design. And I know, you know, all of us would want to say, well, we can revise the hospice benefit in all these ways. What if we did da-da-da-da-da? What if we did blah blah blah? Um, but if we also remember that changes to the Medicare hospice benefit are statutory, and one of the conversations, for instance, yesterday was okay, can we add a requirement that a that a hospice has to have an office? And it's it's one of my passion points. So uh the the comment from the folks at CMS was where can we hook it to the statute? So I think we want to be um really we I think we can be begin to be thoughtful in different ways to say what do we have that if we hook something to uh her words, not mine, hook something to the statute that changes the regulation without having to change the statute, that's a place I think we have some fertile ground. So you know it's it's uh I , I think creativity, stick to it, um, you know, um purpose, uh mission. Um, but for for me, at the end of the day, um the 100% focus is what does that patient and family need? And that's uh I can't I just I can't go beyond that. It's just so, so important.

Annette Kiser 21:39

Well, and to that point, Judi, it is about what patients and families need. And I hear hospices get caught up in you know all the regulations and the documentation and the audits takes away from patients and families, and it does to a point, but that utilization data tells us where we may be missing the mark. Patients aren't getting visits on. The weekends. Patients are being discharged and then coming back in seven days. With non-hospice spending, we have to keep in mind that it's there's a beneficiary cost to that. And so if we keep patients and families at the center of what we're doing and we think about looking at these pieces, that's really what it's about. What do our SSVI scores, our pepper data, and these other metrics show us about the care we're providing to our patients?

Build Systems Now Not Just Compliance

Chris Comeaux 22:26

Well said. Well, let me ask this one because this is a kind of an interesting twist. So leaders spend a lot of energy reacting to regulations, you know, and that you just live in that world. And we always talk about how it's so interesting that wouldn't you wish they

reacted to every initiative like they do to regulations in some cases, or at least the programs we work with, sometimes you almost overcorrect. But exceptional leaders, they anticipate where healthcare is going before the regulations require it. So most of the regulations are lagging type situation. They're trying to get people to play by the rules, et cetera. So as you guys study this rule, what should hospice leaders maybe start building today? Not because CMS is requiring it, but because this is where serious illness should be heading. And you know, we've got the the baby boomers of which both of you are at least in that area. And so there's something that should be built that's gonna care for many of us and our family right now. What should that be?

Judi Lund Person 23:25
Well, you know, you know, for me, as I as I think about many, many, many hospice leaders I know, I think um the ones that are gonna be successful into the future are looking for um innovation. They're looking for things that will make their life easier, they're looking at appropriate and careful use of AI. Um, they're looking at all of the kinds of things that are swirling around, but they're not I I and I think this would be the place that I think we wouldn't see um good leaders that are looking after, looking at bright shiny objects. Oh yes, this is the nice next new best thing, um, but are much more measured and um careful about bringing your whole staff together, showing the leadership that's needed, um, and not doing it all themselves, um, but spreading out the work so that with an idea that we have um at the end of the day a new reality that we we all know where it is and what what can happen with it.

Annette Kiser 24:35
Well, and I think that's that's right, Judi. You know, bringing everybody together, we often see things kind of siloed in organizations and having leaders across clinical compliance, quality, finance, administration, you know, from the CEO down to the the folks in the background working in accounts payable that see some of these issues with non-hospice spending. It's really thinking about the fact that as you said, Chris, we've got the baby boomers, we have shortages of staff, that's not going to change. And how can we how can we take the information and use it to improve our outcomes, improve care for our patients and families? And I will say, and Judi, you you have more conversations with CMS than I do, but I will say that CMS is listening, they're paying attention. Yes, they're doing some bring the hammer down, like with the moratorium on um, you know, new enrollments, but at the same time, they are hearing and they're looking. And it's not just one department of CMS, it's Center for Program Integrity and it's you know the payment folks, it's all the way up to you know, Kim Brandt and Dr. Oz. And so they're paying attention to those things, but we have to give solid information. As Judi said, we we got to stop whining, we have to figure out what we can say to CMS with metrics, with solid information. There has to be data to support it that will help CMS understand what it is

that we need. We know what we need and we spend a lot of time talking about it, but we have to stop reacting, prepare for the future before more changes become mandatory, and be ready for those. And so I really think it's that again, thinking critically, systemically, and looking big picture. Chris, you're great at talking about being visionary, and that's what they've got to do and and really think about those things.

Chris Comeaux 26:25
Okay.

Final Thoughts Relationships And Closing Quote

Chris Comeaux 26:26
Well, ladies, I'd love to hear both of you. What final thoughts do you have? Always love to hear your wisdom. Final thoughts.

Judi Lund Person 26:32
Oh, I this is this is, I think, uh, you know, I thought you were going to ask about what kind of a quote we might have. So, but this is final thought and um um Diane Meyer um discussion around uh palliative care uh even in the early days. If you're not at the table, you're on the menu. And so I think if we are thinking about um how we can position hospice leaders for the future, we want to be at the table. Now, for me, the other thing is we have to build relationships and relationships all over the place. So that is in our communities, within our states, um, whatever relationships we have at the federal level. So that's kind of my thought. Um, being being at the table is the most important thing.

Annette Kiser 27:21
Well, I agree, being at the table is important, and um, we have organizations out there. Judi and I both spend a lot of time working with NPHI, and um they're doing a good job of getting us in front of CMS and different departments so that we can work on some things. And so I do think um, you know, being at the table, but just be attuned, reach out to use your resources so that you can it, you're not in it alone. Others are going through these things as well. And so just really stop and think about where where do you want to be in that three to five years? And um, what do we want our patients and families ultimately to get from our hospices?

Chris Comeaux 27:59
Well, well said. Well, ladies, I'm so glad you were still at this. You both have so many years of knowledge and perspective. And so just getting your perspective every time a new wage index comes out. It is, you know, the regulation just feels like it's getting tougher

and tougher. And usually I'm a bit of a student of business cycles. When you're in that business cycle, those are the times, the eraser or their seasons when you need the most innovation because the regulation just keeps kind of making it harder and harder and harder. And sometimes the innovation is how do you innovate what is better? Um, like you know, innovations within hospice, but then how do you innovate maybe further upstream? People use the term disruptive innovation, substitution competitions. It feels like we've got to be doing both during this season because hospice is just gonna get tougher and tougher just by itself.

Judi Lund Person 28:50
Wow, absolutely.

Chris Comeaux 28:52
Wow. Well, thank you. Well, to our listeners, we thank you. At the end of each episode, we always share a quote, a visual. The idea is to create a brain bookmark, a thought prodder about our podcast subject, the further you're learning, your thought, and your growth. And we're hoping that sticks like a brain tattoo. Be sure to subscribe to TCN Talks, the Anatomy of Leadership. We don't want you to miss an episode. If you're interested in the book, Anatomy of Leadership, we always have a link to that. You know, it's easy for us to rail against the world and be frustrated by things. Let's be the change that we wish to see in the world. So thanks for listening to TCN Talks The Anatomy of Leadership. And here's our Brain Bookmark to close today's show.

Jeff Haffner 29:28
"The leader who is forever in the learning mode is the most likely to succeed." by Dr. Lee Thayer