Transcript / Navigating the Wage Index: Insights from Industry Experts

Chris Comeaux: 0:00
So, if we can redesign the system and, Judi, I love that you poked on the fact that we've got a looming thing coming, which is the bankruptcy of the Medicare system, and so we're going to have to fix it eventually. Next year is going to be really tough to be a hospital administrator. It gives the vision that we're revolving around the hospital universe and it feels like the solar system is shifting as we speak.

Judi Lund Person: 0:20
Annette and I both talked about this. Rate increase doesn't align at all with reality. It's like it couldn't align less.

Chris Comeaux: 0:27
You can rail against the world, you can rail against gravity, but you're still stuck to the earth. Gravity ruled that situation and there's a couple of situations that we could get so animated and just upset about. It's better to put our energy in what are the problems that we can solve as we go forward. It was the Venn diagram, and I think we're going to have to go back there as a country because we can't, because the other way is not going to work. This is the game that we're playing and these are the rules, and instead of kind of bitching about the rules, let's actually do our best job within it and put our energy on that in a day-to-day basis, because that's what our patients and families deserve.

Annette Kiser: 1:10
Know what's happening, change is going to happen, and we can either be a part of it and help inform it or sit by the wayside and let it happen to us.

Jeff Haffner: 1:16
And now our TCNt alks host, Chris Comeaux.

Chris Comeaux: 1:17
Hello and welcome to TCNtalks. I'm excited today. I'm always excited, but I'm really excited because I just have two giants with me. Giants in terms of just. You know, I get to meet so many incredible people in this podcast, but these are two people I've admired for so long. I just could just pinch myself many years just to think that I've got Judi Lund Person and Annette Kiser on a podcast again. So welcome ladies, it's good to have both of you.

Judi Lund Person: 1:41
It's good to be here

Annette Kiser: 1:43
It is good to be here, thank you.

Chris Comeaux: 1:49
Yep. So, Annette Kiser is the Chief Compliance Officer with TELEIOS. Again, I'm privileged. Not only do I get to have Annette on a podcast, I get to work with her. And then Judi Lund Person is the Principal of Lund Person and Associates, and many of us know that Judi worked for many, many years for NHPCO just truly, two of the most amazing compliance experts in the country. And now I get to call them both friends and get to have them on this podcast and share them with all of you. And, of course, this is an interesting time of the year. I always say that I'm a bit of a geek. I'm always reading stuff, but I have to admit hopefully Annette and Judi will own this they're a bit of a geek when it comes to the wage index.

Annette Kiser: 2:22
Judi's the geek when it comes to the wage index.

Chris Comeaux: 2:24
Good point, absolutely exactly, and I think she'll own it too.

Judi Lund Person: 2:27
Oh I definitely will yes.

Annette Kiser: 2:29
But I use a different G word, and that is guru oh yeah, well said in that, very well cleaned up.

Chris Comeaux: 2:36
She is the guru. So definitely got the two right people to talk about the wage index. It's always an index; it's always an interesting time of the year. So, ladies, shall we just jump in, cause there's a whole lot to talk about. Sure, all right, all right. So, the FYI 2026 final rate increase Wow, 2.6%. I say wow and then also gosh compared to inflation. But it is higher than the proposed rule. So how does CMS determine the amount of the rate increase? And maybe is there anything hospices can do to increase the percentage rate increase? Like, is there anything you can do to advocate? And maybe, final one question I'll add to

that too what about the MedPAC recommendation of no increase? And maybe you guys will kind of take all that and take it from there.

Judi Lund Person: 3:19
Sure. So I think the first thing is the rate increases for hospice and for some other Medicare providers is based on hospital data. So the proposed rule, which was published in the early part of April, had a 2.4 percent rate increase. More quarter of data came in for hospitals and it pushed the rate increase for hospice and for every other provider type that is, in the spring, um, spring season of um payments, um, it pushed it up just slightly. So we are at 2.6 percent, and I think we would all argue that 2.6 is just not very much.

Judi Lund Person: 4:02
Um, and it's certainly to your Chris, is not anywhere close to what we're dealing with inflation. So, as we're thinking about what hospices could do to increase the percentage rate, I'm really sorry to report there is nothing. So that's, I think, the first thing for us to say, and that the statutory requirement for the rate increase is a long, long, long standing and I guess in some ways the statutory requirement for the rate increase is some protection. Maybe is kind of too strong a word perhaps, but it is something where the Congress has said through statute that here is how the calculation should work and here is how that and there will be a rate increase. Over the years I've gotten a lot of questions about MedPAC.

Judi Lund Person: 4:58
Medicare Payment Advisory Commission has a hospice chapter every March and for the last couple of years they have recommended no increase in the rates Now. So when that comes out on March the 15th, then people call and say well, wait a minute, we have a MedPAC recommendation. Does that mean we're not going to get a rate increase this year? No, it means that they are sending a message to the Congress that maybe we should be looking at this a little bit more closely. But it would take a change in the statute in order for a 0% increase to occur. So I think those are all the pieces of this that I think are really important for us to think about, and I wish I could say that a hospice or a group of hospices could change the rate. It is just not possible, I'm sorry to say.

Chris Comeaux: 5:57
Yeah, and maybe this doesn't help any much, because I know trying to run an organization in an inflationary environment wage pressures it's tough. When we look internationally, many of the countries that have different healthcare systems from America, the prices are fixed at a national level, so this is not totally a US-based thing and unfortunately, in healthcare we're not running a restaurant, we're not running just a typical business, you're not Amazon and we can't actually control our revenue. It's one of

the downsides of being part of healthcare. It makes it difficult. But again, it's not only an American thing, I think recently I was reading an article about Japan. Because their baby boomers are ahead of ours and, like you know, minute 1% increases, et cetera. Because their inflationary pressures or volume pressures are even worse than ours, because they're 10 years ahead of ours.

Judi Lund Person: 6:51
Sure

Chris Comeaux: 6:53
Well, Judi and Annette. So every 10 years, CMS uses the census to determine what counties fall into each CBSA the core-based statistical area or rule area and they're using Census Bureau population and journey to work data. Last year, for FY 2025, CMS applied those changes to the Hospice Wage Index. So why do some counties have changes to their CBSA or their rule area and can we do anything about that? It feels like so many people are like I feel like I'm having something done to me. Can we do something about that? Right?

Judi Lund Person: 7:31
So I want to start by using the US Census Bureau term journey to work. I think that is just such an interesting phrase, but it is the Census Bureau's measure of where do people go that live in a county, where do they go to work? So it's commuting patterns, really. And so when you have that and I will take Montgomery County, Maryland, right here in the DC area, as a really good example so Montgomery County, Maryland, is on the other side of the Potomac River from Virginia and it is in the core-based statistical area with Frederick, Maryland.

Judi Lund Person: 8:16
It is not in the Washington DC metropolitan area and for more than 10 years probably 12 to 14 years the Medicare providers in Montgomery County have begged and pleaded and petitioned and gone to Congress and all of that to see if they could move their connection, their assignment of a CBSA to the Washington DC metropolitan area, which is very significantly higher wage index, and nothing worked. Not one single thing worked. No regulatory pressure, no pressure from members of Congress. It is. This is the Census Bureau, this is how it goes, and every 10 years, and so we hoped, I think, as we were working in the last few years with Montgomery County, we hoped that the 2020 census would show a different commuting pattern into DC or into one of the areas, one of the counties that are in the Washington DC metro area. That did not happen. So all of that is a

long-winded way to say that the chances of changing your CBSA are very, very, very, very small.

Chris Comeaux: 9:43
I don't want to say zero, but I think it is as close to zero as really you can get. And if I'm not mistaken, Judi hospitals have a way to like. They can like petition or something. Oh yes, they sure do. But there is no mechanism for that in our world.

Judi Lund Person: 9:56
And hospitals can say well, I have the same pressure as my neighbor next in the adjacent county who is in a metropolitan area and so therefore, I should get that wage index too. Hospitals are the only Medicare provider that has that opportunity and there is no other provider post-acute care or other. You know LTACs or others who have that as an option. So you know, as we think about kind of all the changes that could be possible to the wage index, both for hospice and for, more broadly, for others, you know, I think that certainly should be something we talk about, but I think it's almost. It's been in place for such a long time, and Annette and I were thinking about this the other day that when I still lived in North Carolina, which is now more than 20 years ago, this was a problem in counties adjacent to Charlotte. So, you know it's been around for a really long time and the hospital lobby was a very successful one to get this to work and to keep it in there.

Annette Kiser: 11:07
But it doesn't apply to anyone else. We don't understand the infinite wisdom that happens behind these things, because a hospice adjacent to you know, a hospital in a metropolitan area or a hospice in a metropolitan area has the same expenses, and so if the logic is, the hospitals get to use that, why shouldn't any provider? So I think you're right, Judi. It's just a matter of continuing to fight, and if it were tied just to a certain thing, not to the census or something like that, it would make a difference, and I think even now people aren't as careful about filling out their census forms that come to them as what they used to, and some people don't want to share that information, and so you have to wonder even how accurate some of that census data is.

Judi Lund Person: 11:55
Well then, I want to, I want to throw out another part of this puzzle. So, we're looking at the 2020 current data is the 2020 census. Now we can think back and say what was happening in 2020? Was anybody journeying to work? They were journeying from their kitchen to their home office. So, I am curious about whether that journey to work metric, the commuting metric, really is different because of COVID. So, I mean, it's just interesting to think about all the various pieces of this.

Annette Kiser: 12:31
Well, and what's that going to look like in the 2030 census? Because a lot of people who were journeying no longer journey and they've stayed at home Absolutely, and so it's a very different workplace than what it was previously. So, it'll be interesting, but unfortunately, that's five more years before they even collect that data.

Judi Lund Person: 12:51
Right and 10 more years before we see it in any kind of impact on the wage index values.

Chris Comeaux: 12:57
So these are questions that Annette and Judi are getting all the time, so like they're listening to you guys. And when I said let's do a podcast on the wage index, they said I know exactly what we're going to talk about, because these are questions that they're getting frequently. So, CMS implemented a calculation that would allow up to a 5% decrease in the wage index for a given metropolitan, rural area, but no more. Why was that implemented and why do some wage index values drop? What is that value based on and does it help providers whose wage index value drops in a given year?

Judi Lund Person: 13:31
So, I mean it's actually we should cheer because a 5% maximum decrease in the wage index is a really, really helpful protection. And I know some of the comments that came in on this year's proposed rule. People said, well, 5% is too much. I really want a wage index drop maximum of 2% or 3%. CMS did not go along with that. But what we saw before this 5% maximum adjustment, this 5% maximum adjustment some counties or some CBSAs had wage index values that dropped like 10 or 12% and I could tell you counties around the country for whom that was a horrible, horrible problem. So, CMS has fixed that part of this and the 5% maximum reduction is now permanent and we'll see some adjustments.

Judi Lund Person: 14:28
And the last year and this year both are a little wonky because of the Census Bureau and the changes in the CBSAs and then we have the 5%. But I think it won't feel like if you're the one that got a 5% drop in your wage index, you'll be mad. You're mad, I know, I'm mad too for you, but I think at the same time it's not 10%, it's not what we saw before. This 5% I mean one of them in the Ohio, West Virginia, CBSA 12% and very, very low wage index every single year that it came out. So, I think that's a really good one. And what I think it does for providers is it doesn't give 100% stability because you still have that drop, but it does mean you're not going to be. It's not going to be as catastrophic as we've seen before this happened.

Annette Kiser: 15:29

You can at least budget and know that that's the max, that is going to decrease, yeah.

Chris Comeaux: 15:35
It's so interesting. I'm sitting there processing. I talked to my dad actually before inflation hit, because I don't know we were war gaming scenarios I think that's what it was at one of our visioneering meetings and I just remember as a kid growing up during the whole Carter administration and remembering the long lines of gas and just these crazy inflationary times. And I asked my dad I'm like what did you guys do about wages? And he's like you know, you pretty much froze them because it's all the inflation, or you were trying to keep up with it. And I said, well, what happened on the back end? Did you then take the wages back down once you went up to keep up with the inflation and did you go back down? He said no, you never go back down. And it's like, well, so, processing what you're saying and put myself in the shoes of those hospices I don't know of a market where then you decrease people's wages but yet that's 60, 75% of your total cost. I mean that is a tough way to run an organization.

Judi Lund Person: 16:28
Absolutely.

Annette Kiser: 16:29
That's a great analogy, Chris, yeah.

Chris Comeaux: 16:32
Well, let's talk then about so I know you get a lot of questions about this one. What is up with the labor and non? It wasn't framed in that way. I'm interpreting. But what are the labor and non-labor portions of the rates, and how is that percentage calculated?

Judi Lund Person: 16:46
So, one of the things that I recently spent a good amount of time with a hospice who said well, where does it say where do these percentages come from? Where does it say what the percentage is? And so, what I want to start with is back in 2022, when we were doing some rebasing of the rates, they also rebased the percentage of the total rate that is labor and then the percentage that is non-labor. So, let's just take for an example and you'll see on the slide that we posted for you here that for the routine home care rate, one to 60 days and 61 days plus the wage component is 66% of the rate. Then you see the SIA, also the continuous home care hourly rate, and continuous home care, 75% is wage component.

Judi Lund Person: 17:45

If you start to think about where, what the philosophy is behind this, it's like most of our. What we do with that level of care is human, is people, is staffing, it's not. We don't have buildings, we don't have, and that's when you start then to look at the inpatient respite, which is at 61 percent, and then GIP, which is at 63 percent, that's different because there are there are facility issues in there. So, when you are starting to look at, how do you figure out the rate? The percentages are straight, national and they've been this way for several years. They were adjusted a adjusted in 2022. So then you say, okay, well, how do you figure out what my rate is, what my rate as a hospice is, and that way you can start to see and I was trying to color code it just a little bit so if you look at routine home care, one to 60 days, and you say, okay, the national final rate $230.83 for FY26. 66% of that is the wage component, or that purple box on the slide that you see now is the purple box says $152. And my calculation over many years, where I was never have a rounding error, so it's $152 and 34.8 cents.

Judi Lund Person: 19:17
So, you take that. That is the part that is connected to the wage index. So you take the wage index for a county, times this 152, 348. That's the wage component. And then you add the non-wage component, or the blue column, where it's 34% or $78.482. So that's the wage index value and this is where then we start to say, okay, this 5% reduction is really important, because you are looking at two thirds of your rate being connected to that wage index and so I think that's a piece of this that we wanna always, always keep in mind.

Judi Lund Person: 20:04
So, I'm hopeful that the chart and the calculation gives you a little bit of a sense of you can look at this for yourself. I know TELEIOS has provided rate charts for lots of states where TELEIOS has providers. But you can also figure this for yourself if you look at your wage index and then look at these calculations. So, the formula in the two little gray boxes at the bottom tells you how to make that happen. So, I, you know, I feel like it's not a mystery if you know where all the stuff comes from. And that's probably the first thing is you know you're digging, digging day, and even I, you know, every year, I'm like, okay, did the percentages change? And it's not in a table anywhere. In the final rule it's, it's in narrative and one of the paragraphs on I don't remember what page now, but it it's like, okay, why is this so hard to find? But anyway, once you find it and you know what you're looking for, then you can really make all these calculations.

Chris Comeaux: 21:13
Well, that wonderful chart that you provided, Judi, we're going to actually put that in the show notes in case, because we have listeners that don't actually watch it, but if those who are watching can see it, and then we'll put it in the show notes. And, Judi, not to

chase this rabbit too far. But that labor portion, and then the wage index. The ultimate headwaters of that right is hospital cost reports, and it's like three years trailing. Is that correct? Or is it not three, is it?

Judi Lund Person: 21:37
two. Well, there's some part of it that's two, and then there's some part of it that's four. So it's at least two years and it could be more than three, but I think that is one of the biggest conversations right now. So, if we're thinking about what could we do to well, let me start a different way. So, we've got every provider type in Medicare, so that's not just hospice, not just home health. Every single provider type is dependent on this hospital cost report data. So, when you go down that path, it's like it affects everybody. It affects every single provider that receives Medicare dollars.

Judi Lund Person: 22:22
So MedPAC, in the last couple of years, has come out with a recommendation that says what if we took the wage values and assigned the occupational categories for all employers not just hospitals, but for all employers and what if we used that data to base the wage index values on? So, I love that idea. And there is certainly some activity this fall with a group of hospice leaders who are meeting with CMS and Apt Associates, their contractor, to start to think about changes to the wage index. We say that we get all excited and then we go OK, how long is this going to take? And it is ages and ages and years and years before we can actually make this switch. But I think you know it's there. There is a lot of. I mean, this is old school, when most care was provided in hospitals, so it's a logical thing to use for that. But now most care is provided at home. So how do we adjust the wage index values to really meet the new reality?

Chris Comeaux: 23:40
Yeah, I think you said that incredibly well because it does feel like we're at that sea change. More and more baby boomers are becoming those we're serving and the future of health, healthcare is in the home and so it feels. And you think about the hospital business models are very challenged. It feels like it's challenged everywhere in healthcare. But boy, next year is going to be really tough to be a hospital administrator. And you think they're a service-based business? Yes, they have costs, but their wage component is huge and if you only have so many levers to pull and you've got the Medicaid deducts, all other sorts of interesting payer challenges they're navigating, then you know labor is going to be impacted. So, it's going to be really difficult to be hitched to that wagon going into the future.

Annette Kiser: 24:19

Well, and that's why we have to make sure that we stay engaged and we help our members stay engaged and have a voice. And when someone says let's model a change, then we take that seriously and look at it and see what that would do to our rates and to our bottom line and we share that information so that we are helping inform our models that are being floated around out there right now.

Chris Comeaux: 24:41
Very well said, Annette.

Judi Lund Person: 24:42
Yeah, and you know, Annette, the other piece of it that I think this is the time when, if you will, non-hospital providers need to band together. So this is post-acute care providers of all types, you know, home health, nursing homes, lTACs, long-term acute care hospitals, IRFs or inpatient rehab facilities I'm sorry I'm slipping into my acronyms, but all of I mean we should band together with others who are Medicare providers as well, because I think we will make a lot of headway if we're together and I just I don't want to minimize how important that is. Power in numbers, absolutely.

Chris Comeaux: 25:28
Even I've had people push back on me and like I've tried to get away from using the word post-acute, because it's framed based upon the acute and so it's really care in the home. I've heard pre-acute but then it's still kind of, you know, tied to the. That makes it's. It gives the vision that we're revolving around the hospital universe, and it feels like the solar system is shifting as we speak, right and very, very good.

Judi Lund Person: 25:49
I mean, if we have that visual of everything is centered around the hospital, but now it's not. You know, I think that's a really good visual.

Chris Comeaux: 25:58
Which those are always interesting and tough times. Little Chinese, may you live in interesting times, boy, that's really true for us, absolutely.

Chris Comeaux: 26:06
All right. So, here's another question how do the finalized payment rate adjustments align with or diverge from the needs and realities hospices are facing today, especially in the workforce inflation, the never-ending audits, and then you know, gosh, there's so much that we've talked about recently and a lot of our podcasts related to this. As we've kind of

dug into this. We talked about it in the when the pre wage index came out, so love to hear you guys answer that one couldn't align less.

Judi Lund Person: 26:36
Well, it maybe could if we were getting a decrease rather than an increase or we got nothing. That would be worse, but I think that this is another piece of the outmoded or outdated kind of rate increase process. So, at the same time, then, if we go to current realities, and how can we do things that will make care more efficient, I think that's another piece of this Well and doing a better job of controlling what we have some control over that.

Annette Kiser: 27:41
Hospices need to be thinking about increasing their medication budget as much as 10 percent% and when we think about we got a 2% increase and meds might go up 8, 10%. And then we know supplies and we just think about what happens when you go to the grocery store. Everything's increasing. And so, what can we control and better manage versus what we don't have as much control over? And to some extent we can control even medications from the standpoint of being judicious with our reviews and using those medications that are more cost effective. But it's really thinking smarter and paying attention to how do we manage this better? Absolutely.

Chris Comeaux: 28:26
I love that you said that, Annette, about what you can control. I feel like there's such wisdom for our time. Stephen Covey wrote about this many years ago. He said you can live all of your life. You have one of two walls. On one wall is that which I can control, that which I can problem solve, and ask myself what is the problem to be solved here? The other wall is that which I cannot control. It's a principle, and I know there's, and I love the way Judi has framed a lot of her answers. Some of these are principles.

Chris Comeaux: 28:53
You can rail against the world, you can rail against gravity, but you're still stuck to the earth. I went to dunk a basketball when I was in high school. I could not just float above the earth. Gravity ruled that situation, and there's a couple of situations that we could get so animated and just upset about. It's better to put our energy in what are the problems that we can solve as we go forward. Now, I'm one of those that my mom always said I'd sit there and go why, why, why, why.

Chris Comeaux: 29:21
And so, we had two podcasts this year, one with T.R. Reid, the Healing of America. I think he's got some great wisdom on how we redesign the American healthcare system. I

brought someone who's a little bit more free market thinking, Rita Numerof. We didn't get as much as where I wanted to, which is like, hey, if you were the queen for the day? So, we're going to do a part two and it's basically she's a queen for a day and my theory is that the Venn diagram between both of those podcasts is that's the wisdom, because we're an American country that's always been divided, but we've always had wise people in Washington DC that ruled from the middle.

Chris Comeaux: 29:54
In other words, it was the Venn diagram, and I think we're going to have to go back there as a country, because the other way is not going to work, and there's plenty of illustrations in history where that's the case. So what is the middle? What are the true solutions? So, if we can redesign the system and, Judi, I love that you poked on the fact that we've got a looming thing coming, which is the bankruptcy of the Medicare system, and so we're going to have to fix it eventually so we're going to do some more podcasts trying to at least create some discussion around how do you fix that system In the meantime, this is the game that we're playing and these are the rules, and instead of kind of bitching about the rules, let's actually do our best job within it and put our energy on that in a day-to-day basis, because that's what our patients and families deserve.

Judi Lund Person: 30:39
Couldn't have said it better, Chris.

Chris Comeaux: 30:41
All right, good deal. Well, here's another one Speaking of the rules. Why is there that aggregate cap thing and what does it do? And why do we care? And when the cap amount is announced, what is it that year for?

Annette Kiser: 30:54
It's going to be $35,361.44, which is basically taking the fiscal year 2025 cap amount, increasing it by the 2.6%. So, it's easy to look at that calculation. But the cap came about, you know, way back when, because hospice is supposed to be a cost-effective model. It's not supposed to cost more. So, it's easy to look at that calculation. But the cap came about, you know, way back when, because hospice is supposed to be a cost-effective model. It's not supposed to cost more to provide hospice care than it costs for the more conventional medical care for the same period. And we know from some of the studies that have been published that hospice does save money and they want to make sure it stays there, a way that's going to allow them to have financial gain.

Annette Kiser: 31:47

And we know a lot of focus on profit margins and there are hospices that go over cap. Unfortunately, some do it, you know, knowing that they're going to pay something back, but feel that they make more than is needed. But it really is about keeping hospice as a cost-effective model and it not being a money-making business and there's some shift away from some of that and it's why it's gotten us into some of the concerns around fraud and abuse and that kind of focus and at this point, the cap is what it is. That could change at some point in time, but it is something that we all need to pay attention to.

Dragonfly Health: 32:25

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Judi Lund Person: 33:14

And I'll just add one thing to that, Annette, and this is an aggregate cap. So if you say, oh my gosh, Susie Smith, my patient who was with us for you know, 400 days is going, we got paid way more than what, what this? 35,000 and some changes, but that's why it's the aggregate. So it's like, let's say, you had 100 patients last year or 100 patients and you're applying the cap amount to that, so it's 100 patients times this cap amount gives you the maximum amount of dollars you can get from Medicare for your patients, and if you go over that, then you have to pay the overage back. And I sometimes I just think, starting with a really simple calculation like 100 patients times the cap, and that's how much money I have to spend, and it's like the aggregate. It's not every patient we have to spend this and that's sometimes I think a confusion.

Annette Kiser: 34:17

Well, that's very important to mention that aggregate piece because it makes a big difference. It's not, well, you know, 30,000 left over from that patient, I get to keep it. Well, not if you spend 50,000 for the next patient, right exactly.

Chris Comeaux: 34:31

I've seen. I've seen and I'm thinking about people I've seen go over the cap. I've seen kind of two flavors. I'd like you to push back, and especially you, Judi, because you've seen so many different just pockets throughout the country. Generally, when you're going over the cap, in most cases we've done a lot of discoveries. Those programs are really admitting chronically ill patients, not terminally ill patients, so they're running a chronically

ill program. That's why they're hitting that cap. And so the other type I've seen, though, is more rural programs that they don't have a robust health care system, not a good primary care base, so you may not have the clinical sophistication for that identification. So I don't think they're solely trying to do the wrong thing, but then it's bringing to their attention about the CAP. Does that kind of stratification fit for you, or have you?

Judi Lund Person: 35:16
seen a whole bunch more flavors. Well, I think there are a lot of flavors, but I think, from my perspective, the CAP and its application is 100% connected to your admission policies. So you know for and recertification.

Judi Lund Person: 35:31
That's right. And for all those patients that you say, I think they're eligible, if you're doing a red, yellow, green, they're yellow, they're not green, they're not 100%, but they're not absolutely not ineligible. And then I think we have patients for whom the disease process is slower and so you have a longer stay because the disease process is slower. It just is. It's not a bad or a good, it just is. But I think for that group of hospices that are admitting patients a little bit earlier than maybe others would, or maybe even best practices, I think that's a piece of it.

Judi Lund Person: 36:19
I'm always struck by a conversation I had with a hospice provider several years ago and she was really mad because she had a $6 million cap payback. And so I'm talking to her and I'm trying you know, I'm trying to have this completely no reaction on my face, nothing like that. And she's, she sits up very proudly in her chair and she says well, you know, our average length of stay is 333 days. I'm trying really hard not to react at all and I said okay. So, you know, does your physician look at the face-to-face? Do you do the recertifications? Oh, yes, our physician says that these patients are all eligible and I said okay, so tell me a little bit about the range. And she says well, we have lots of patients who've been on our service for five to seven years. Well, so now you're seeing that. And then she describes her service area is very rural. They're really the only care provider besides the hospital. So, I feel bad. I mean these patients need help. They might not need hospice.

Judi Lund Person: 37:34
So that's kind of where I go, and I remember this woman every day when I talk about the cap.

Chris Comeaux: 37:40

I'm so glad I asked you that. That's actually a great response. All right, so the wage index not only has wage stuff, it has wage adjacent things, and so there are two regulatory changes finalized in the FY 2026 wage index final rule. What are they, and were there some new requirements?

Annette Kiser: 37:57
Well. So we have two pieces to that. One is around admission to hospice care, and one is around the hospice face-to-face encounter, and these are actually good changes that CMS has made. It's not a new requirement. It actually loosens things in both aspects.

Annette Kiser: 38:13
When it comes to admission to hospice care, we've had some misalignment and the regulation at 418.25 says admission to hospice care is only on the recommendation of the medical director or the physician designee, which meant we shouldn't have the IDG physician doing that approval of the admission. And so, what CMS has done is now changing it so that everywhere we have the regulations is going to align to say that the hospice medical director or the physician designee or the physician member of the hospice interdisciplinary group can all do the admission to hospice care and the certification, and that makes everything align. So, we don't have this concern where one person reads one piece and says, well, you let a doctor give approval who shouldn't have. Well, now it's all going to say the same thing. So, hospices don't need to change anything from being more restrictive. If they've been restrictive which a lot of hospices maybe didn't even realize that misalignment was there but if they've been saying, well, we can't have that physician approve admission or be involved, then now they can say, okay, we can, so any hospice physician can do that admission. And then, around the face-to-face, it was a matter of getting things back in alignment again, because just the language and I won't go into the technicalities of it.

Annette Kiser: 39:41
But when it comes to the attestation that the face-to-face visit was made when it was made and needing to have that, CMS has been so prescriptive and you know it has to be here and it has to be above this and that it could be a separate document. It could be part of the certification of terminal illness document. But now CMS is saying that it needs to be documented, but it could actually be part of the clinical visit note. It doesn't have to be a separate standalone identified, as long as it has the components. I will say that this was something that they should have had in like 2011.

Annette Kiser: 40:17
They went way back. I'm not sure what brought that up, but at some point they went way back and they're like, oh, we forgot to put this in there and so hospices that we work with

didn't change. They've been doing it all along. They've had the real clarity around that attestation. I don't see them needing to do anything different now, and it's actually a good thing. So both of these. It's not usual that we can say CMS made a regulatory change and it's all good, but for both of these I think they are good. Would you say anything different, Judi? No, I think they are good. Would you say anything different, Judi?

Judi Lund Person: 40:50
No, I think these are great things and these are small things. These are going to make life easier, but there is nothing big that is a problem here.

Chris Comeaux: 41:01
Okay, what about the hospice quality reporting program? Was there anything related to that?

Annette Kiser: 41:06
Well, there's always hospice quality reporting things as we know. There's this thing called hope that people are having to deal with.

Judi Lund Person: 41:14
I don't know what hope is.

Annette Kiser: 41:15
I know I have said many times if I had a dollar, for every time I've said the word hope, not in response to the tool, but we hope the EMR vendors. We hope that this, we hope that that.

Chris Comeaux: 41:27
We hope it goes away.

Annette Kiser: 41:28
Exactly Well. So, to that point, Chris, CMS has made it clear it is not going away. October 1st 2025 is the confirmed start date for implementing HOPE and if we look at the calendar, today's August 15th and that means we have six weeks Deadline for that and HARP is September 10th. So, hospices have less than a month to do that. And I did actually hear just this morning, and I haven't even had a chance to mention this to Judy that one of the hospices that's in the pilot program for Hope with their EMR, did successfully submit a test case to IKES just today, and so that's good. At this point we don't know how we start getting all the volume going into IKES, but at this point the

hospice was able to submit their hope data, and it worked, and so it's a lot in the next six weeks.

Annette Kiser: 42:21
But from that perspective things are not changing. We're going to continue to have our CAPS satisfaction surveys. We're going to continue to have our hospice visits in the last days of life, which comes from claims-based measures. We're also going to continue to have the Hospice Care Index, and so those pieces are not changing for fiscal year 2026. His Hospice Item Set is rolling into HOPE, and we'll continue then to have that, but CMS will have to collect the data. It's going to be a bit before they report that out there and you know we're there at that perspective and so there's nothing new that's going to happen based on what was in the final rule this year. But there will be things that change and come.

Chris Comeaux: 43:11
Right, gotcha. Well then you can have this good segue Is the threshold change from his to Hope, and what happens if a provider doesn't meet that threshold?

Annette Kiser: 43:20
No, it has not changed. There is still the expectation that a hospice submits 90% of their hope records, 90% of their caps data, and it's imperative, because this is a total change, that everyone is really paying attention and making sure that they're having those successful submissions. And as soon as CMS gives the green light for other people to test, they need to test and make sure your EMR vendor is doing a good job of communicating that to you. And then we need to make sure that we're paying attention to those CMS gives, after every currently HIS to become HOPE, after every submission, the opportunity for a hospice to print a final validation report that says we got it, your data came through, everything's good.

Annette Kiser: 44:12
Hospices that end up in the less than 90% are not always doing a good job with tracking their final validation reports and then they end up in a problem and what happens is if they don't meet their expectation of the 90% submission, then in the applicable year they will get a 4% reduction in their rates and when you think about 4% of what your annual revenue is for Medicare, that is huge and it's so critical to make sure, because hope is so different, it's going to involve a lot more submissions to CMS than what we've been having with HIS. A lot of attention to that has to happen, but it's not changing. Thankfully there's no mention of going higher than 4%, but 4% is significant. We got a 2% 2.6% rate increase. If you get the 4% reduction, you're already still in the red.

Chris Comeaux: 45:09
Absolutely. What should providers be doing to prepare for these future quality performance expectations?

Annette Kiser: 45:16
Well. So, I think it's a matter of you know, really thinking about what they're looking at, being informed, being involved, having a voice and making sure that they're, you know, paying attention to that, monitoring their own data. Don't wait until the provider preview report comes out. There'll be a new provider preview report in the next two weeks. Care Compare the public site, will update in the next two weeks. Those all happen in August, but that data is old. Hospices need to know what is their current reality and they need to be figuring out how to pull that from their EMR, from their claims data, and really tracking what they're doing. And then we're going to have future quality measures around hope. We have to do our symptom follow-up visit within two days for those patients who have symptom impact moderate or severe and CMS will be looking to see did we do the two-day follow-up with that symptom follow-up visit? So hospices need to be paying attention to their own internal data to make sure they're meeting those requirements.

Chris Comeaux: 46:17
All right. Well, all of this is kind of interesting because it tells you how CMS is thinking. So, what do you think this rule tells us about where CMS's maybe long-term view is? What does the final rule tell us about where hospice policy might be heading, and does this tell us anything about maybe like program integrity, survey reform, or even maybe just maybe innovations in care models?

Annette Kiser: 46:41
Right, Judi, I'll let you take that one.

Judi Lund Person: 46:44
It's something I love to think about. It's something I love to think about, so, I think, over the years, when we get the proposed rule. Until two years ago, we had a proposed rule that had a whole section on data trends and that would give you could read it so, and I read it so, so carefully to say what are you saying? What does this mean for our future? Now, two years ago, the data trend chapter went away from the proposed rule and APT put out a hospice monitoring report that is published now each year in April on the CMS website. It's not the same, and so then I want us to think very specifically about this year, because you go, okay, there is not much. You've heard, there's not much in this rule. That is a change. So let's talk about the.

Judi Lund Person: 47:41

Getting everything ready to get posted as a proposed rule in April meant that a lot of this work was done at the end of last year, the beginning of this year, and what happened at the beginning of this year? We had a new, we have a new administration, we have a new Secretary of Health and Human Services, a new CMS administrator, and so from January 20th sometime in February for some of it. We had people who needed to set a new course for the administration, and so there's not much in this one. Now, given that, and now we have these people in place, I think it'll be interesting to see how next year's proposed rule looks. The other thing I think we may depend on kind of reading the tea leaves just by looking at the rulemaking, but there are a lot of other things that CMS can do to communicate what's going on. So, the QSOG and the Quality and Standards Operation Group, I think, is the acronym.

Annette Kiser: 48:49
Quality, Safety and Oversight Group.

Judi Lund Person: 48:51
they changed it a little bit for some reason really off, but it comes from the center for clinical standards and quality, where our survey process is right. Um, there are things we should be watching there. There are things that we should be looking at in terms of changes to the state operations manual. So, there are some other things. There are things that the center for Program Integrity is starting to put out.

Judi Lund Person: 49:14
So it's not just rulemaking, it's really putting your ear to the ground and saying, okay, what is happening in all these different places that we need to pay attention to? I think that's part of the fun in the Judy Limb person world. It really is fun, but for a lot of people it's just trying to figure out where the information is. And then I think, as far as innovation is concerned, the Center for Medicare and Medicaid Innovation, CMMI.

Judi Lund Person: 49:48
There are opportunities for hospices to take a look at some of those innovation models. And if I had to sort of say where I think we should be paying a lot of attention, it's what are the metrics inside some of those Are we looking at in the guide model, what are we looking at in terms of bundling per diem payment or unbundling a payment? What are the things that a hospice could do that really put them in a different place in their community, put them able to serve more people and all of that. So those are, I think, kind of all interesting things, but certainly the new administration will give us plenty to take a look at.

Chris Comeaux: 50:35

At the beginning of this year, we do the top news stories of the month with Cordt Kassner, and we had Mark Cohen kind of carrying over from last year. We coined a term it actually came from someone within TCN, but the predictably unpredictable year. It sounds like that's going to kind of carry over a little bit into next year. Unpredictable year it sounds like that's going to kind of carry over a little bit into next year. But I also hear in that, Judi, that we're going to probably have a sense of which way the windsock is generally blowing, and so do you think that we're going to wake up in April and read the preliminary wage index and be blown away? Or are we going to have some pretty good indications ahead of time? Or is it just?

Judi Lund Person: 51:07

I don't know Well, you know, here is let me just take one example, because I think this definitely could move us into next year's rulemaking and that is the interoperability data kind of stuff that now there's a lot of focus on, a lot of push from Dr Oz, a lot of push from RFK Jr, to really see if we can make data interoperability a goal. Now, how that plays for the hospice community, I mean, I think we could make a few assumptions about it, but I think that's going to be really, really key. The other thing I think that is like just the tip of the iceberg, are some of the RFIs that CMS has been asking for. For instance, in this year's rule we had an RFI on interoperability, but we also had an RFI on nutrition, wellness and the third one, and now that I can't ever remember, but anyway, no comment whatsoever in the final rule about these RFIs. So what does that mean for us? That means that something is cooking but it's not quite ready for prime time.

Judi Lund Person: 52:19

So those are just kind of things I think for us to watch, and I know many of us when we wrote comments on the proposed rule, especially around these kind of new thinking about social determinants of health and you're talking about wellness. With a terminally ill, very, very sick Medicare population, you go. These two things don't fit together. So, what does wellness mean? What does you know? How do we frame that so that we are thinking about the best possible experience for a Medicare beneficiary at the end of life? I don't know how that's all going to come together, but I think that's where we still have to be. I mean, I think this is a place for us to be creative too and not sort of just take, you know, this is maybe it's in that, not on the principle, but on the we can do something about this and we can think about things that are very creative here.

Annette Kiser: 53:16

Well and continue to have a voice. I'm surprised when I read through the comments because CMS in the final rule, CMS says X number of people commented on this and there's so many things where there's only a couple and it's like we needed more of a voice there. Couple, and it's like we needed more of a voice there. Now I recognize that when

the association's comment, CMS counts it as one and they're speaking for a volume, but we still need again back to that comment I made earlier power in numbers and we just need people to be involved and engaged.

Judi Lund Person: 53:46
So, I want to go back to CMS counts it as one, because one of the things I think we should carry into the future as we're looking at kind of changes from the rulemaking process, and that is CMS counts every respondent as one, and so we should all be commenting. It's not just the association, the national association or whatever we can sign on to, whatever letter is going from a national group, but we should all comment as well, because there are some things that are state-specific or provider-specific, and it is a way for us to have all of our voices heard.

Chris Comeaux: 54:27
Well, two thoughts and I want to hear both you ladies' kind of final thoughts about maybe strategic actions given all this. But when I think about the chassis, that is hope. You know, peter Benjamin and I have debated for a while, like you know, what are the true measures of Peter said, here we are 30 years. Do we really know what defines quality? Well, isn't hope going to be the chassis to push what really defines quality potentially, to push what really defines quality potentially? And I love at least some of the general things where, like what matters most that we're asking in there. Which leads me to my second point, Judi, I love that outstanding question. We had a great discussion in the preliminary wage index about those RFIs and that got me thinking.

Chris Comeaux: 55:05
And lo and behold, we did a podcast with the John A Hartford Foundation and the four M's to me are very important.

Chris Comeaux: 55:13
Like that may be the answer to that whole wellness thing, like that's what it means in this world, that's right In the serious illness and end of life which the four M's are, for our listeners to go back and listen to that podcast Mention what matters most mobility and medication. It feels like that's a great framework actually, and what really hit me was the brilliance by which John a Harford came to the four M's. There were some brilliant people around that table and thinking about what matters to the, to those that are aging as we go forward. So, I think that four M's is something we need to keep pushing on, agree, completely good deal. Well, last question to you guys well, given all of this, you know what you think maybe are two, maybe three strategic actions every hospice should take based on this rule, I hesitate to say to stay ahead, but at least keep up. Stay ahead of

where things are going regulatory, financial and clinically wise in 2026 and maybe positioning for beyond.

Annette Kiser: 56:08
Sure. Well, I think it's a lot of what we've already talked about with being engaged, know what's happening. Change is going to happen and we can either be part of it and help inform it or we can sit by the wayside and let it happen to us, and I think we have too many times when we just let things happen to us and we really need to be paying attention, being engaged within tele-ops, within associations within your own community and working with those that you get referrals from, that you have patients who go to for care and really understanding kind of what is going to change and what can we do about it. And back to what I said earlier around, you know in an earlier meeting today, what can we change, what can we impact and you know what do we just have to accept. But there's not a lot that we can't influence in some manner, totally agree.

Judi Lund Person: 57:02
And I think the other piece of it is is that don't be shy. And I would say, don't be shy and don't let caring for patients consume you so much that you kind of shut out all the other stuff that's going on, because there may be some really cool opportunities for something new, something a workflow that might be different. That really really makes a difference. And I'll just share a meeting I was in yesterday afternoon where we were talking about access and what does the data show about access to hospice by various racial and ethnic groups? And the guy who's done the research says you know, in the African-American community it may be that the only hospice care that that African American patient gets is GIP in the hospital and the last two days of life. Don't we want that care to be just as exceptional as the rest of our care when we have a lot longer to provide care to a patient? And it has really stuck with me.

Annette Kiser: 58:12
Right, that's a lot to think about. You do have those where they're admitted in the hospital and they die within hours or days, and that is their sole impression of of hospice.

Judi Lund Person: 58:24
And, and you know, I I also want to just stop and think just for a minute about our own. I mean, now we have so many people that work in hospice that have also had hospice experiences, good and bad, and so when we are thinking about what can we do, it's like we need to also be thinking about what can we do so that more hospice is good, or the experience of hospice is good and not so much bad, and our colleagues who have had

horrible experiences and wonderful experiences and that is, I think, for me, that is a driver that keeps me both awake at night and going every day.

Chris Comeaux: 59:09
I love that and I love that you're both going and are on the job, and thank you for taking the time to, because I know this is always a time of the year of digesting the wage index and you guys just made it very digestible. We're going to include. You included a lot of links whenever we were getting ready for the show, so we're going to include those in the show notes. So, thank you both.

Judi Lund Person: 59:25
Absolutely Great to be with you, Chris

Annette Kiser: 58:30
Thankyou

Chris Comeaux: 59:31
I asked Judi and Annette to pick a quote, and they picked a John Wooden quote. Love John Wooden and it's a great one to end the show with. "Things work out best for those who make the best of how things work out. Thanks for listening to TCNtalks.