Transcript / The Need to Know on the 2025 Hospice Wage Index

[00:00:00] **Melody King:**
Welcome to TCN Talks. The goal of our podcast is to provide concise and relevant information for busy Hospice and palliative care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now here's our host, Chris Comeaux.

[00:00:23] **Chris Comeaux:**
Welcome to TCN Talks. I am so excited today. Um, in fact, I'm a little nervous. I have two incredible people today. I have Judi Lund Person and Annette Kiser. Welcome ladies.

[00:00:35] **Judi Lund Person:**
It's so good, good to be with you.

[00:00:37] **Annette Kiser:**
Absolutely. Good morning, Chris.

[00:00:38] **Chris Comeaux:**
Yeah, my gosh. I was actually thinking about when I was getting ready this morning, I'm like, I dreamed about a day I would have Judi Lund Person and Annette Kiser together on a podcast or even in a conversation together. And now this past year, I've actually got to spend, of course, I've got to spend a lot of time with Annette. She was employee number one at Teleios. But now spending time with Judi and now having both of them, it's like, oh my gosh, this is incredible. Um, two incredible dynamos. Well, ladies, before we jump in, I'm actually, I need to, uh, I don't want to call it a retraction, but it's kind of a correction. Um, so we've built a lot of integrity in our podcast and luckily we're the most listened to podcast in the Hospice and powder care space. So recently we released a podcast about the download, the download, the DL on ACOs. And we had Larry Preston, who's the CEO, one of the most successful CEOs in the country.

And I misinterpreted something he said. In fact, I glommed onto it and I said, wait a minute, did I just hear you say that Hospice does not count towards the total cost of care with an ACO? And so the long story short, that was inaccurate. I shouldn't have summarized it that way. And luckily I circled back with Larry.

Luckily, our listeners are listening and like, Hey Chris, that would be awesome. And I'm thinking, yeah, I was thinking it was awesome too. Um, but the reality is, I actually misinterpreted it. Hospice absolutely counts towards the total cost

of care of an ACO. Makes absolute sense if you think about the purpose of an ACO. But there was an interesting pearl. Larry is the CEO of an ACO. Hospice is about 1. 5 percent of the spend. And so there was an interesting Easter egg and it was such a small part. That's why maybe he was like, ah, yeah, it's probably not counting in the total cost of care. He circled back and saw it was a very small part.

So we want to kind of, um, verbalize that retraction and correction. And we appreciate our listeners listening. And circling back so that way we have accurate information now to our show today. Um, you two are so incredible I was on the phone with Judi and she was like I gotta go because the wage index just dropped and I can't wait to jump in i'm like Who says that?

[00:02:40]
Annette Kiser: Right Judi's the only one that gets excited that I know of when the wage index drops other than the fact that leaders want to know what their rate increase is going to be, but Judi wants to dig into the minutiae of it.

[00:02:51]
Chris Comeaux: Which is what's going to

[00:02:52]
Judi Lund Person: It's who I am. I can't help it.

[00:02:54]
Chris Comeaux: Which is what makes both of you so incredible, so before we jump in, I do always want an opportunity for our guests just to connect with our audience. And so Judi, first off, what would you want our audience to know about you?

[00:03:04]
Judi Lund Person: Um, you know, I, I think I've, um, I think I've been in Hospice for such a long time and, um, you know, I often talk about my mother's Hospice experience, and, you know, I was thinking, and Chris, you and I have talked briefly about, um, a neighbor for whom I was one of his caregivers.

He had lung cancer, um, and, um, He was expected to live for three months. He lived for a year. Um, and the Hospice care that he got, the Hospice worker said, Well, it's because you and your other neighbors are taking such good care of him. So, um, I did it as a volunteer. I was not a paid caregiver in any way.

And he was like my second dad. So, a really important person to me.

[00:03:52] **Chris Comeaux:** And every time I interact with you, Judi, I find I always walk away with some Easter egg. And last time we had the podcast, first off, I sat there literally almost in tears because I [00:04:00] realized as you told the story, That you actually changed my life. Um, because I got to be part of four seasons and in some respects, because of who you were and what you did, there was a Four Seasons and, but then the other Easter egg was about the power of volunteerism, like sometimes we're so close to stuff, we forget the power of it. And just as nonprofits. All Hospices have to be able to do volunteers, but as nonprofits who should be part of our superpower.

And that was one of my takeaways in our last last podcast together is, Hmm, I wonder if we take it to a whole nother level, what blessings that might bring our organization. So again, Annette, how about you? What does our audience need to know about you? Other than that, I get to work with one of the most amazing people in the country on a day to day basis, but what would you want the audience to know?

[00:04:44]
Annette Kiser: Thank you, Chris. Well, I want to tag on to the volunteerism. I actually got my start in Hospice as a volunteer nurse. Back in the day before my small community based Hospice was Medicare certified and volunteer nurses could do [00:05:00] most anything and I did most anything back in the day because we were at that point a volunteer organization and didn't have Medicare money coming in and I was on call and I did everything from, you know, symptom management, being by the bedside of someone dying, I even did IVs and wound care as a volunteer nurse.

And had a great experience, and enjoyed that, and It wasn't long, less than a year, until I started working in Hospice, and as they say, the rest is history. And I fully agree with the aspect of volunteers. It is what sets us apart from others. And it can make such a difference in the lives of our patients and families.

And Judi gets into the wage index, I get into the, To the regulations as as well Judi does too, but I dig into the minutiae and I think I'm just one of those rare people uh other than Judi who enjoys reading what CMS has to say in the Federal Register, [00:06:00] but I will say as I've gotten older I had like the pre Federal Register version because it's larger font, more spacing, as opposed to that little tiny print that we get in the final.

[00:06:10]
Chris Comeaux: Um, this morning I have a gentleman mentoring me on some interesting stuff that I'm learning about, we'll just call it economic models, but

he was teaching me the principle of sowing and reaping and Annette, you're just sitting there reflecting, but You probably never in your million years were thinking, I'm gonna make a career out of this thing.

I'm about ready to give, I'm about ready to sew my time. And here you are probably what, 40 years later, which you were 12 at the time, of course. But you both were, you know. Absolutely. We both were right. Soon be 40, I'm about 38 years in . And then just reflecting, like there are a few like nurses, clinicians who came in, social workers.

Now I'm starting to see board members who have been volunteer board members that are now becoming part of senior leadership teams Um, which I think that is pretty cool, too But you guys obviously were the pioneers that way the early trendsetters. Well, all right We want to jump in under our listeners want to hear so this is our favorite time of the year No, we're not talking about Christmas the time of year that the wage index comes out and it's usually chock full of new initiatives requirements And there's usually some easter eggs about things to come.

So, ladies. I just want to hear from you, what, what, what do we need to know about what's in the new wage index?

[00:07:21] **Judi Lund Person:**
Well, let's start with the rates. Everybody wants to start with the rates. So, when I, um, when I cut off my conversation with you to go look at the wage index, um, that's the first thing. Um, so, rate increase of 2.

9%, um, and that's, that's the national rate. So, we can, um, we can kind of hang on to that, but it really doesn't tell the full story. So, In addition to the rate, then we have, um, the wage index values that, um, change every year based on the hospital cost report from two years ago. Um, but this year, and once every ten years, [00:08:00] um, the wage index values and the wage index where counties fall.

Are they rural? Are they urban? Do they change CBSAs? That, that happened this year as well with the U. S. Census from 2020. So, um, there are a lot of providers, um, that, um, had substantial decreases in their rates because of that change in whether the, um, The county is urban or rural, or whether they joined a CBSA, and CBSA, we use that constantly, but it stands for Core Based Statistical Area, and it used to be Metropolitan Area.

So, just, just so we kind of know exactly what that is. Um, but I think what we're seeing this year is, um, a significant number of Hospices where their wage index value, um, dropped significantly. And you might remember that last [00:09:00] year, um, CMS said, we're going to put a cap on the drop in the wage index value so that a Hospice never has to have a drop of more than 5%.

But, um, that being said, um, the, the drops this year in many parts of the country are very, very significant. Um, so, more than anything else, um, very, very important to look at, um, and don't, don't depend on last year, um, but do depend on this year's final wage index to see the Um, what county you're, um, what CBSA your county is in, and then also what's the, what's the wage index value.

And there are a couple of places out there now where the rate, um, calculations are available, but, um, also pay a lot of attention to what am I going to do, how am I going to, um, process claims on the 1st of October, and what does that rate look like.

[00:10:00]
Chris Comeaux: And certainly our listeners could, if anyone listening, reach out to us. We'll be glad to help you with what your specific rates are. We know national organizations put out a great tool. Um, Judi, that was one of the ones you helped when you were at NHPCO. So.

[00:10:13] **Judi Lund Person:**
Absolutely.

[00:10:14] **Chris Comeaux:**
Annette, what's in there that we need to know about?

[00:10:18] **Annette Kiser:**
Well, there's more on the changes to CAP and changes to HOPE and Judi and I'll talk about those in a few minutes. And CMS kind of letting us know, uh, this is not the end. There is more to come. Absolutely. And we can, we can talk a little bit more about that, but, uh, there's going to continue to be changes. And a lot of conversation CMS had in there about aligning with other programs. Organizations, they're really working to get measures around quality, but also the way they look at things, social determinants of health, and move that to how they're doing in the acute world, but also the post-acute care world.

And so a lot [00:11:00] of that alignment, and I think, uh, there's a lot in this year's rule, but it's not the end.

[00:11:07] **Judi Lund Person:**
And maybe I would just add to that, Annette, that, um, I, I know I get this question a lot, where people say, well, Wait a minute, we're talking post, about post-acute care, but Hospice isn't in it. So, Hospice is extra, outside of the post-acute care definition for CMS, and that is inpatient rehab, um, long term care hospitals, nursing homes, and home health.

And so Hospice is separate from that, and when, when the designation first came out, I was still at NHPCO, and I called one of my colleagues at CMS and said, Alright, talk to me. Why, why did Hospice not get included? And their answer really sticks with me, because I think it makes so much sense. Um, for the rest of post-acute care, Medicare beneficiaries are coming and going outside of the various, um, uh, parts of that post-acute care experience.

So sometimes they're in home health, sometimes they're a SNF, sometimes they might be in an LTAC or an IRF, um, inpatient rehab. Um, but once you get to Hospice, um, um, you're not going back and forth anymore. So, it's like, it's a different arrangement. Um, so, it's post-acute care and Hospice. And that's, I mean, I think that's what we continue to see in a lot of the language and a lot of what CMS puts out.

[00:12:31] **Chris Comeaux:**
That's pretty profound. I've never heard that before, Judi. So just mirroring back, um, and I'm not meaning to men, uh, demean, uh, post-acute, whatever you say, but there's almost a contemplated transactional nature. You'll come in, you'll come out, but with Hospice, no, they will walk alongside you through this whole episode of care.

And you only by very small exceptions, would you be interacting really the contemplated is they're going to walk alongside you all the way to the end. That's profound.

[00:12:59] **Judi Lund Person:**
I always think that it's really, really interesting. So just share it with your listeners today, just so that you can kind of say, Oh, I mean, for me it was like, Oh, that makes sense. I get it. Um, and I think it is the walk alongside until the end, or, be one of the places that a Medicare beneficiary might come and go out of. And we certainly have lots of examples of that.

[00:13:23] **Chris Comeaux:**
Yeah. I was going to say, we don't need to chase that rabbit, but you and I, cause you and I did a whole podcast on it.

But when I think about the ugly side of what's going on in Hospice, it's the opposite of that actually, then it's, it's much more transactional. Sorry, the goings get tough. We're going to dump you back into the hospital, et cetera. Yeah. Um, one comment, Judi, when you're talking about the rate, it just, you know, it, um, just need to say it out loud.

Cause I know Hospice are sitting there going Are you kidding me? This is one of the worst inflationary times in our history, and we're getting a deduct at the same time? I mean, I know you can't make sense of that, but that is just hard to make sense of. But it is because [00:14:00] also kind of how the mechanics of the CBSA's work, right?

Because it's really looking at the wake of the ship of hospital cost reports. Is that accurate?

[00:14:08] **Judi Lund Person:**
It is accurate. And, you know, I know Annette and I were talking yesterday that one of the things that is so frustrating to some Um, count to some counties, but certainly to some Hospices as well is you're not necessarily getting the rate that the CBSA that's right next door to you gets.

And so then there's this anger about, well, I only live 30 miles from, you know, let's just say Charlotte, Annette, um, but I only live 30, 30 miles from Charlotte, but yet my county is considered rural or my county is. It's connected to a lower CVSA and having spent years working on that issue with a particular Hospice in Maryland, um, one of the things we learned was the, it's determined by the [00:15:00] census and the primary determinant is a, what they call journey to work.

Um, so it is your, the commuting patterns of the people who live in that county and that's what determines where. That county gets placed in the core base statistical areas. So, you know, another one of those years and years ago. I mean, we, we, um, there's no way to change. that determination from the Census Bureau.

So that's another kind of fun, fun nugget there.

[00:15:34] **Chris Comeaux:**
Just one more question because I don't want to get bogged here around that though, but if hospitals are because of their own financial implications or shedding costs, so they're in a cost reduction mode, does that not ultimately

impact this because then that cost report is going down and then that CBSA is based on that? Is that an accurate? deduction or not?

[00:15:57] **Judi Lund Person:**
It probably is. Um, but I, think it's so complex that it's probably not worth digging into today because we've got plenty of other things to talk about. But I mean, one of the other things for me is, okay, so this 2025 wage index is based on 22 ish cost reports or 23 ish.

Um, and so, post-covid. Does that also impact some of this as well? So, um, I think there is a lot to think about with this and You know, uh, certainly there is many, many people calling for a reform of the wage index system itself, um, but that is going to be years and years and years of, uh, in the making.

[00:16:40] **Chris Comeaux:**
Well, I'll pick your brain on that. We'll do an extended play afterwards for Teleios members who want to pick your brain on that. Well, let's, let's dig in more. What else do we need to know about what's, what's happening here in the wage index?

[00:16:50] **Annette Kiser:**
Well, I want to mention one more thing that will affect rates is Hospice Quality Reporting Program participation.

And those Hospices that are not reporting [00:17:00] HIS, Hospice Item Set, or their CAHPS scores are going to have a 4 percent reduction in their rates, and so that 2. 9 percent is going to go down to a negative 1. 1%, and that's important for organizations to pay attention to.

[00:17:19] **Judi Lund Person:**
And we should say as well that if you reported But you didn't make the 90 percent threshold, you still get the 4 percent reduction.

[00:17:29] **Annette Kiser:**
Good clarification.

[00:17:30] **Chris Comeaux:**
Say that again, that feels important.

[00:17:32] **Judi Lund Person:**
So if, if you report, if you say, well I'm participating in quality reporting, but my, I missed a few, or my percentage is like in the 80s, that doesn't count. So

you have to meet that threshold. 90 percent threshold in order for your participation in quality reporting to count and for you not to get that 4 percent reduction.

[00:17:59] **Chris Comeaux:**
So we're starting to get into some pay for performance.

[00:18:02] **Judi Lund Person:**
Yes we are, actually.

[00:18:04] **Chris Comeaux:**
In this case, kind of pay for tracking. It's not quite performance yet.

[00:18:06] **Judi Lund Person:**
Or pay for participation at the moment.

[00:18:08] **Chris Comeaux:**
Participation, well said. Right,

[00:18:09] **Annette Kiser:**
Participation.

[00:18:10] **Chris Comeaux:**
Um, you alluded to earlier some change in the caps coming as well?

[00:18:15] **Annette Kiser:**
Yes, there are a lot of changes in the CAHPS Hospice Survey and it's going to be significant from the standpoint of the questions, the impact on quality reporting publicly and Hospices are going to really need to pay attention to what's going to happen because the change actually goes into effect for those patients who die in the first quarter. And the, um, we'll begin with the patients who die, actually second quarter April 1, 2025 patients who die then will be subject to that. Now, we have to keep in mind and remember [00:19:00] that the survey goes out about eight weeks or so after the pa, the month in which the patient dies. So it'll be summer of 2025 when we actually see the first administration of that new survey tool.

But we spend a lot of time talking about the survey tool, what's in there, what the questions are, making sure our staff understands so that we can make sure we're having the right communication with our, with our families, they're the ones who fill out the survey, the caregivers, and we've spent a lot of time with them.

talking about what the current tool has and so we're going to have to spend time talking about the new tool and There's not going to be a lot of time to do that to be ready for The conversation with those patients that are going to be you know patients who are potentially dying April 2025 are already on service And so we already have to start thinking about what those new questions are going to be.

[00:19:52] **Chris Comeaux:**
So Annette, if the, oh, I'm sorry, Judi, go ahead.

[00:19:55] **Judi Lund Person:**
No, I was just going to add to that, that, um, the new questions, um, and the survey itself, um, and this is, this, my, my word for this is finally, um, the Hospice CAHPS Survey is coming into the 21st century because it will now be able to be sent by email, um, with a, um, online, um, Survey, um, uh, fill out.

So, um, very, very, of all the things that are exciting about this, this new final rule, that's probably the one that's really going to make a difference, I think, for, for families.

[00:20:33] **Chris Comeaux:**
So, the, so if a patient dies on April the 1st, that will be the, the new survey. So that's the cutover date. And then, Annette, it's no longer 24 questions, it's like, is it 21?

[00:20:44] **Annette Kiser:**
Well, it is, and, but when it comes to public reporting, it's going to vary, because we have what we call substantive changes, and we have the getting Hospice care training is totally being revised. Going from several individual items down to one summary item, and that will not be reported for a period of time, because it is so significant, CMS has to have time to collect the data, ensure everything's accurate.

So we'll actually move to a period of time where we have only seven measures for the STAR rating, as opposed to the current eight, and we've also adding an entirely new set of questions, a new measure around care preferences. And because public recording, reporting requires eight quarters of data, that one is not going to be reported for a while.

CMS will be collecting the data and looking at that. But once the getting Hospice care training kicks back in and care preferences begins, well, actually have nine measures. for the star rating itself. And so, there's going to be a lot,

and I know that a lot of organizations build their operational planning and set goals for the year around caps.

[00:22:00] And how many questions, and so we're going to really have to pay attention to when the shift is, and how that works, and begin to understand what's going to impact Our ratings, what's going to impact our overall scores. There are some changes in some of the other pieces around wording that are not going to cause a problem with when they're reported publicly.

But they're taking out some, um, some wording, making it simpler, they say. They're taking out, um, a question around um, Uh, confusing or contradictory information, but that one is on team communication and it's going to continue to be reported publicly as what they call a non-substantive change. And a lot there that we're going to need to pay attention to and unpack and work with our survey vendors to see when things are going to be ready.

What those reports are going to look like so that we can continue to monitor our own performance and decide. And so what we've done for all these years is going to have to change, I would say, significantly. Would you agree, Judi?

[00:23:03] **Judi Lund Person:**
Oh, absolutely. There's, there's, I think this is all good changes. Um, and the survey.

As it's revised, it will be so much simpler and shorter, but it also will require us to really think carefully about how we're going to talk to patients and families about it and, um, what our processes are, um, as well.

[00:23:24] **Annette Kiser:**
Well, and what we have to keep in mind is because of the lag from when the survey is administered until when it's actually reported publicly, it's going to be the Care Compare Refresh in February, get this, 2028, that's going to be when we first see everything come back and, and everything line up with those nine measures.

But that's going to be our data for quarter two, 2025. Through quarter 1, 2027. And so we're still going to have that year lag of when they end the eight quarters than when they reported publicly. But beginning quarter 2, so April 2025, that's going to be impacting the first Care Compare Refresh with this new survey.

[00:24:08] **Chris Comeaux:**
Talk to me a little bit more about care preferences. This, this sounds exciting.

Like, isn't this really what we're, if I'm interpreting that correctly. Yeah, absolutely. Um, can you just talk more about what do you mean by care preferences? Do we have the questions yet and know what it's going to be getting at?

[00:24:24] **Annette Kiser:**
We do and I need to pull those up, Chris, so we can maybe circle back to that in a minute. Um, it's, it's really trying to get back at where do patients want to get care, what do they want to, want to see.

[00:24:37] **Chris Comeaux:**
I was going to make some conjecture. I like the title of it and, you know, individualized patient care is supposed to be a core of what we do.

And when Judi and I were talking earlier about, and especially her podcast, about some of the, um, not so good things are happening in the Hospice world. This then sounds hopeful, really getting to what matters most to that patient family and putting some measures around it. Um, and we've had Peter Benjamin on this podcast and Peter is pretty vocal about, you know, here we are 30, 40 years later and we still really don't know what defines quality.

This feels core to what we're supposed to be about, which is as Judi was saying, we were contemplated to be different than the rest of the post-acute. So not just walking alongside them, but also finding out what really matters most to them and then working towards. So am I, am I making too much conjecture?

Is that really where this is hopefully going to maybe be taken us?

[00:25:31] **Judi Lund Person:**
Uh, from my perspective, um, I think it is where we're hoping to, to take this and I think part of the frustration both Annette and I have and probably most providers have is that. We want this to be final, we want this to be solid, we want to know what's going on, and it's a little, we've got a few additional questions still going on here.

So, um, when, when you hear that Annette and I are like, well, we're hopeful that that's where it is, that's because we, we want to see the final, final, final. Um, and it's, it, it may be a smidgen delayed here.

[00:26:06] **Chris Comeaux:**
Gotcha, and was that, will that be, obviously it'll have to be sometime before that April is before, when you say the final, final.

[00:26:12] **Judi Lund Person:**
Yes.

[00:26:13] **Annette Kiser:**
Well, we'll have the questions, but I think we have to keep in mind that as CMS does their analysis and starts to begin to look at the data, there could be some things that change. They may find something that they weren't quite expecting, and they could end up with something a little bit different than, the questions should not change, but they may have to do something else when they do their analysis and their case mix.

Some of those kinds of things that they do behind the scene to, to kind of mold the data and get it to where they feel like they're going to be reporting something that's going to be accurate and give the information. Ultimately, this is about the patients and families being able to go out and get information to select a Hospice.

And so CMS will have to look at it and decide if they need to make any changes in how that data is reported.

[00:27:00] **Judi Lund Person:**
We might also want to encourage, um, our listeners to Make sure you participate in the CAHPS Hospice Survey. Um, when we were looking at some of the data and we saw that about 50 percent of Hospices participate in the Hospice CAHPS Survey, um, it's, you know, we're, we're missing the greatest opportunity for a Hospice to, to know what their families think about the care that's being provided.

And I, I think, you know, we, we want to see, um, much more robust participation by Hospice providers and providers. Um, and then we will also want to see the percentage of, People, um, responding to the survey to increase, which is why that email version is going to be so important.

[00:27:43] **Annette Kiser:**
Well, and CMS did in their analysis during their testing, did feel that there would be some increase in participation in the survey.

[00:27:54] **Chris Comeaux:**
Both because of the changes in wording, making it shorter and then giving that online version for a lot of [00:28:00] people that would prefer to do that. Quite often we talk about how. Um, certainly your careers, my careers, we've cared for the greatest generation, but we're now going into caring for the baby

boomers and just use the analogy of how many of us have ordered from Amazon in the last week.

And the first thing you look at is those ratings and reviews on what you order. And so we're going into a time where the people using our services are going to look at that data to make those decisions. And you know, Judi, when you, when you talk about that, shared that in our podcast earlier this year, the 50 percent participate.

It just, it just, yeah, we definitely need that much closer to 100 percent going forward. Does the HQRP then have a bit of a stick related to that, that they have to participate?

[00:28:43] **Judi Lund Person:**
Well, I mean, yes, it has a stick. Yes, it has that 4 percent reduction if you don't participate, but you also have small and new as exclusions.

So you can only claim for one year, but If you are a small provider and you don't have the volume, um, that can be publicly reported, then you, then you are, um, you don't have that requirement for the CAHPS survey. So, I

[00:29:10] **Annette Kiser:**
Well, and as far as the state goes, we've had the 4 percent already in place.

[00:29:14] **Judi Lund Person:**
Right, that's true.

[00:29:14] **Annette Kiser:**
And we still have a lot of Hospices that don't choose to participate.

[00:29:19] **Judi Lund Person:**
Right, I mean, if we are, if we spun that out a little bit more, Annette, I think one of the things we probably will start to look at or start to see is if you don't participate in quality reporting and we don't see an effort, let's say you, you know, you had a change in staff and one month you didn't report, your HIS now hopes.

Um, but, but your threshold, you didn't meet the 90%, that's one thing, but if you don't see any action at all, that's another, and there is some discussion around, um, increasing the 4 percent to a much higher percentage, so, um, you know, also, it is not an optional event, you know, it is a requirement of the

Hospice Quality Reporting Program, so, um, another just piece of this, a puzzle as we're thinking about it.

[00:30:10] **Annette Kiser:**
Let me, one more thing, so I, I want to mention the care preferences questions. So I did find them, so it's, did the Hospice team make an effort to listen to the things that mattered most to you or your family member? And did the Hospice team provide care that respected your family member's wishes? And so back to the core of, of why we do what we do, and focusing on what matters to the patient and the family.

[00:30:33] **Chris Comeaux:**
That just makes me so excited, and I, luckily I was mentored by some amazing nurses, and Um, early in my career, and that was the first thing they taught me, is that you truly learn how to listen. And, cause, it is even a skill set to ask that question, cause so much of the rest of health care, people have never been asked that before.

So even to ask that question, what matters most. Some people don't know. So, the ability to walk alongside them to help them even discover that is a bit of a superpower and a competency to be developed. Well, that's, that's super exciting. Shall we talk about the Hope Tool portion? Is that a good place to go next?

[00:31:10] **Judi Lund Person:** All right, Annette, go for it.

[00:31:13] **Annette Kiser:**
All right. So, the Hope Tool is, is what we've been waiting on for a long time. And it's been in the work for years, but it's finally here, like changes to CAPS, it's finally here. But we really have to think about it's Hospice outcomes and patient evaluation. And it begins October 1, 2025, so we get, in essence, a year.

And it will replace HIS but what everyone needs to understand is HIS is not going away, it's just rolling up into HOPE. And, um, it's going to be significant, and organizations need to pay attention to HOPE. Not only the tool itself but what's going to be involved in clinical processes and administrative processes [00:32:00] because it adds a lot of questions so it's going to take more time to conduct that, but it's not just a one time like our Hospice item set is.

We actually have to administer the HOPE on admission and then we have to do what's called a HOPE update visit between day 6 and 15 and another HOPE update visit between day 16 and 30 and then we can talk in a minute about

another portion of it that's gonna add more visits but they've added more to it and so we talked just very briefly earlier about social determinants of health.

We're now going to be looking at and scoring, putting a number in for what matches the patient's living arrangements. What matches the availability of assistance they have with their care. And so CMS, I think, is starting to look at that. Judi may have some thoughts on what's behind that around the, um, you know, the social determinants of health and where CMS is going with that.

[00:32:58] **Judi Lund Person:**
Well, and we should say that social, the rest of social determinants of health are still kind of. Cooking, if you will, from the CMS perspective. So, we have some interesting feedback, um, and some interesting thoughts from CMS about what will get added, but not this year.

[00:33:17] **Chris Comeaux:**
So October 1st of 25 is when it'll be like they're flipping the switch, so EMR vendors will have to be ready. That's when that kind of clock starts ticking, so if you did an admission on October 1st, you're going to be administering the HULP tool.

[00:33:30] **Annette Kiser:**
Well, and what we, what we hope for the HOPE tool, Chris, is that vendors are going to be ready months in advance because this is such a significant change in the number of questions in the process to get the three visits in if that patient lives for 30 days, that organizations are going to need time to work out those clinical processes.

And what does that look like? Ideally, we should have, the numbers should match up as far as the days, we should have somebody in there in that day 6 to 15 and that day 16 to 30. There should be a nurse in there to do that and it shouldn't be that much of a change but it's going to take a little bit longer because there are more questions.

Initially, there's a lot more around diagnoses. We have to do symptom impact assessments, we have to assess skin conditions, and they're even into pain is a little bit different in that they've added a separate item for neuropathic pain. And it's going to take longer for that to be administered, and then again, when the nurses go in, they're going to have to do that update visit.

And we need the vendors to be ready well in advance. And CMS has said. You know, vendors need to start now with all this around HOPE. Don't wait for all

the final technical specs to come out because CMS feels they've already put enough out for us to get started. A lot of people ask for delays and when it begins because of the amount of time that's going to be involved for the EMR vendors to set that up, but CMS said no.

In essence, we've given you 10 months. We put the rule out early August, and it goes into, well actually you've got Okay. What is it? Fourteen months. Fourteen months. And so there's plenty of time for people to get ready. But it's going to take a lot because it changes visits and it also changes the back end of who's going to be looking through all those records, getting them ready to submit to CMS still within that 30-day time frame after each of those visits take place.

[00:35:28] **Chris Comeaux:**
So, when I sit here and reflect, I mean, where this is probably headed, right, is the outcome of the tool is eventually going to impact reimbursement. Am I going out on a limb on that one?

[00:35:39] **Judi Lund Person:**
No, you're not going out. No, no, no. I think that's exactly where, you know, if we, if we, if we look at HOPE as the Hospice version of OASIS or MDS or any of those things, if this is Setting Hospice up for additional changes, maybe some changes to that value based purchasing, um, kind of discussion that I know we could go into, um, for in, in future years. Not today. Um, but definitely in future years.

[00:36:07] **Chris Comeaux:**
Now, I'm sitting here reflecting too of how to pull that off. And so typically in nursing homes they have a highly skilled person that's called the MDS coordinator that does it. I don't quite know in home health. Some of you, either of you might know. Um, But in Hospice, having a centralized person is going to be almost near impossible.

Um, and so have, so then you think of the challenge of getting this out into the team's hand, as you were pointing out, Annette, you know, the trigger to get out there and get that actually done. Um, if you don't capture the data correctly, how that might bite you in the longterm. Um, wow. Yeah, this is a big deal. This is a really big deal.

[00:36:45] **Annette Kiser:**
Well, and you haven't heard the biggest bang yet.

[00:36:49] **Judi Lund Person:**
Okay, do tell. Go for it.

[00:36:52] **Annette Kiser:**
Absolutely, so now we have, and CMS decided between the proposed rule and the final rule to change it, so we have to think about what that's going to look like. But we have symptom follow up visits, SFVs, say that three times fast.

But these are separate, so on each of the three points of the, of the Hope Tool Administration, If a patient scores moderate or severe on pain and non-pain symptoms, but it's not the symptom severity, it's the impact of the symptoms. So we're looking at how do those symptoms impact a patient's day to day quality of life, their activities.

And if I do a HOPE tool today and that patient scores moderate or severe, An RN or an LPN or an LVN has to be back in the home within two days and it cannot be telehealth. We ask for other disciplines to be able to do that because it's an impact assessment. CMS said no. And so actually making another visit within two days.

And so then when we do our follow up, our first Hospice update, uh, [00:38:00] hope update visit, that same piece kicks in, potentially another visit two days later. And then when we do our third. Potentially another visit. So, there could potentially be six visits within the first 30 or so days depending on the patient's symptoms, how severe they are, how good a job the Hospice does with getting those symptoms managed so that the impact on that patient's life is, is improved.

[00:38:23] **Chris Comeaux:** And you said that could be an RN or an LVN, LPN?

[00:38:25] **Judi Lund Person:** LPN, LVN. Yes.

[00:38:29] **Chris Comeaux:** Judi, were you going to say something else?

[00:38:31] **Judi Lund Person:** No, no, no. That's all.

[00:38:32] **Chris Comeaux:**
Um, so, Annette, after that, so, uh, so, S V, S F V. Did I get that right? Right. That is hard to say quickly.

[00:38:42] **Annette Kiser:**
It is hard. Right.

[00:38:43] **Judi Lund Person:**
It's just horrible.

[00:38:43] **Chris Comeaux:**
And then, so, you've got the first HOPE visit, then 6 to 15 buckets, 16 to 30. Did you, is there other buckets after that?

[00:38:51] **Annette Kiser:**
No, that's it.

[00:38:51] **Chris Comeaux:**
Okay. So, the first 30 days.

[00:38:53] **Annette Kiser:**
Except discharge, there'll be some discharge information.

[00:38:55] **Chris Comeaux:**
Okay. Wow, this is a big deal. What else? And so as we kind of come to wrap up at the end here, what else is in there that they need to know?

[00:39:05] **Annette Kiser:**
Well, we didn't talk, Judi, about the regulatory changes.

[00:39:08] **Judi Lund Person:**
Well, we should. We should. Let's do that. So, um, let's, let's talk just briefly about that. Um, this is one where I, um, am so, in the Judi Lund Person world, I am so excited for these changes. Um, and the, the first one is the change around. Who can certify terminal illness, who can admit to Hospice, and then the section in the COPs 418 102 where, um, what's the role of the medical director.

So, we have language that talks about, uh, that adds physician designee and which also adds the Hospice physician on the interdisciplinary group or IDG. Um, we normally call it the team, but CMS, uh, sticks with the IDG language. Um, and for the first time, [00:40:00] the, um, sections around admission and certification, which are in subpart B, um, B as in boy, not part of the COPs, match what is in the medical director section, um, which is in subpart D, D as in dog.

So, for me, um, and I, I think for probably every Hospice, the idea that a physician member, the interdisciplinary team, a physician designee, or the medical director all have, all of that language is included. And it, it will really help, I think, with confusion. Um, the question I have gotten a lot from

providers is, well, If an NP is the attending physician, can they also be in this, or PA for that matter, but the answer is no.

Um, that the, decision around admission, certification of terminal illness, um, are all the, the responsibility of the M. D. or D. O. Um, that is statutory, it has nothing to, it, it has to do with the regs, but certainly it starts with the statute and that has not changed since 1982. So, um, that's the first one. Um, and then the second one is clarity around, and I'm cheering for this one, Annette and I are both cheering for this one, um, the difference between the election statement, which the patient or their beneficiary or their representative signs, um, and the notice of election, which is what the Hospice admits to CMS to say.

I have a, I have a Medicare beneficiary who has just signed their election statement. Um, and we are, we, we have struggled for such a long time around, um, the language. So, no change in, in the regulation, just clarity around this is, this is what we do with the election statement and then this is what the Hospice does with the, um, notice of election. So, another really, really excellent change.

[00:42:04] **Annette Kiser:**
Good clarification, absolutely.

[00:42:06] **Chris Comeaux:**
Good. Anything else?

[00:42:07] **Annette Kiser:**
No, we have a lot of retraining to do. We do. Everybody from the, even CMS has mixed up the two terms in the past.

[00:42:14] **Judi Lund Person:**
And the MACs as well. So, yeah, we've got work ahead of us on that one.

[00:42:18] **Chris Comeaux:**
Alright, ladies, anything else? Wow, this has been some incredible information. Any final thoughts?

[00:42:25] **Judi Lund Person:**
Um, I, you know, I think, I would just say, I think some, some people will look at this rule and say it's a sleeper. Um, or really the only thing that we care about in here is the hope tool that is finally, my words, um, finally, um, final. Um, but I, I think we need to just like, don't put our heads in the sand.

Um, make sure that we've got, um, we're paying attention to the Hospice cap survey that we're looking at. What implementation of HOPE will do to us, um, and our processes. And then also, because a lot of this is still kind of moving around at CMS, really pay attention to what's ahead, um, in terms of education, resources, and that's one thing that CMS will, um, put out.

So, sorry, I took too much time there.

[00:43:16] **Annette Kiser:**
Right, well, but I echo that Judi. There is, you can't put your head in their sand. There's a lot, it's going to require a lot of internal education of staff, some changes in processes. And we still don't know. CMS hasn't published the final guidance around HOPE to know exactly what it is.

And I'm still not real sure how we're going to submit those, um, symptom follow up visits, how we're going to submit that information. It's not even in the draft guidance.

[00:43:39] **Chris Comeaux:**
Wow. Yeah, no, sleepers an interesting word, but I think this is what many of us have suspected for a long time of this is now laying the tracks for things that we've seen in other parts of health care and a true system of pay for performance, a true system where, um, maybe we really are getting better, more accurate measures of quality.

What matters most to people. So, I'm kind of encouraged but I also get the I won't call it cringe, but this is going to be a lot of hard work Um to be able to do this. So well, thanks to both of you to being on the leading edge of this um, and to our listeners, we always appreciate you and obviously if you want to know more from a Annette and Judi will actually put their contact information in the show notes.

And as we always do, we always leave with a quote, something to make you just think about what we talked about today. And I ran this one both by Judi and Annette is by Kevin Plank. "Trust is earned in drops and it's lost in buckets." Thanks for listening to TCN talks.

[00:44:55] **Jeff Haffner (Ad):**
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