Texas Association for Home Care & Hospice
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Winter Conference
Wednesday, February 18, 2026
10:15am-11:30am

1b. Hospice Revenue Cycle Management

Presented by:

Melinda A. Gaboury, COS-C, Chief Executive Officer,

Healthcare Provider Solutions

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Hospice Revenue Cycle Management

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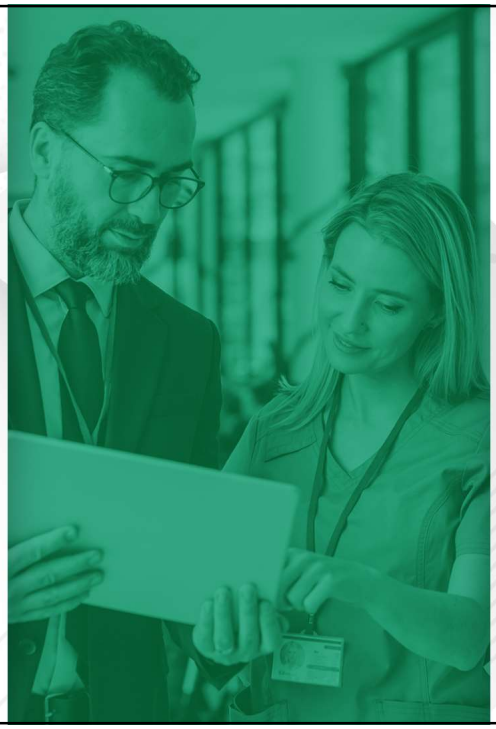

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Melinda A. Gaboury, COS-C
Chief Executive Officer

Melinda A. Gaboury, with more than 35 years in home care, has over 24 years of executive speaking and educating experience, including extensive day to day interaction with home care and hospice professionals. She routinely conducts Home Care and Hospice Reimbursement Workshops and speaks at state association meetings throughout the country. Melinda has profound experience in Medicare PDGM training, billing, collections, case-mix calculations, chart reviews and due diligence. UPIC, RA, ADR & TPE appeals with all Medicare MACs have become the forefront of Melinda's current impact on the industry. She is currently serving as Chair of the Alliance/HHFMA Advisory Board and Work Group and is serving on the board of the Home Care Association of Florida and the Tennessee Association for Home Care. Melinda is also the author of the Home Health OASIS Guide to OASIS-E2 and Home Health Billing Answers, 2025.

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Hospice 2026 Final Rule Recap

- Released to Federal Register on August 1, 2025
- Payment update net 2.6%
- Hospice Cap Update
- Admission Clarification regarding physician certification
- Face to Face Attestation Clarification
- HOPE Implementation

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2026 FINAL Payment Rates

Code	Description	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2025 Hospice Payment Update	Final FY 2025 Payment Rates	FY 2026 Final Payment Rates
651	Routine Home Care (days 1-60)	1.0005	1.0011	1.026	$224.62	**$230.83**
651	Routine Home Care (days 61+)	1.0001	1.0022	1.026	$176.92	**$181.94**
652	Continuous Home Care Full Rate = 24 hours of care	N/A	1.0082	1.026	$1,618.59 ($67.44/hour)	**$1,674.29 ($69.76/hour)**
655	Inpatient Respite Care	N/A	1.0004	1.026	$518.78	**$532.48**
656	General Inpatient Care	N/A	0.9995	1.026	$1,170.04	**$1,199.86**

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2026 FINAL Payment Rates – NON HQRP COMPLIANT

Code	Description	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2025 Hospice Payment Update	Final FY 2025 Payment Rates	FY 2026 Final Payment Rates
651	Routine Home Care (days 1-60)	1.0005	1.0011	0.986	$224.62	**$221.83**
651	Routine Home Care (days 61+)	1.0001	1.0022	0.986	$176.92	**$174.84**
652	Continuous Home Care Full Rate = 24 hours of care	N/A	1.0082	0.986	$1,618.59 ($67.44/hour)	**$1,609.02 ($67.04/hour)**
655	Inpatient Respite Care	N/A	1.0004	0.986	$518.78	**$511.72**
656	General Inpatient Care	N/A	0.9995	0.986	$1,170.04	**$1,153.08**

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HQRP Reporting Requirements

Reporting Year for HIS/HOPE and Data Collection Year for CAHPS data (calendar year)	Annual Payment Update Impacts Payment for the FY	Reference Year for CAHPS Size Exemption (CAHPS only)
CY 2023	**FY 2025 APU**	**CY 2022**
CY 2024	**FY 2026 APU**	**CY 2023**
CY 2025	**FY 2027 APU**	**CY 2024**
CY 2026	**FY 2028 APU**	**CY 2025**

If the requirements are not met the agency will incur a 4% payment reduction in the APU.

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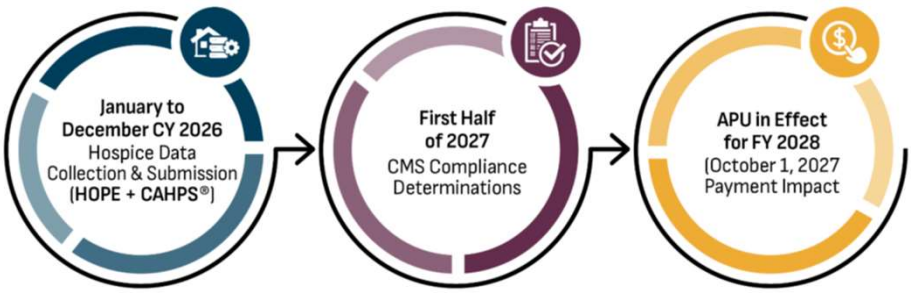
2026 Hospice Final Rule - HQRP

Failure to least 90% of HOPE records to CMD per the 30-day deadline will be subject to a 4% APU reduction starting FY 2028.



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HOPE Compliance and Impact

- Beginning October 1, 2025, HOPE replaces the HIS. HOPE has the same data submission requirements as the HIS:
  - HOPE data submission deadline is 30 days from the target date.
  - 90 percent of all HOPE assessments must be submitted within 30 days of the target date.

HOPE Records From	Submission Threshold	Reporting Year
Calendar Year 2026 and beyond	90%	Fiscal Year 2028 and beyond

- **Hospice Timeliness Compliance Threshold Report gives agency information ongoing about 90% compliance.**

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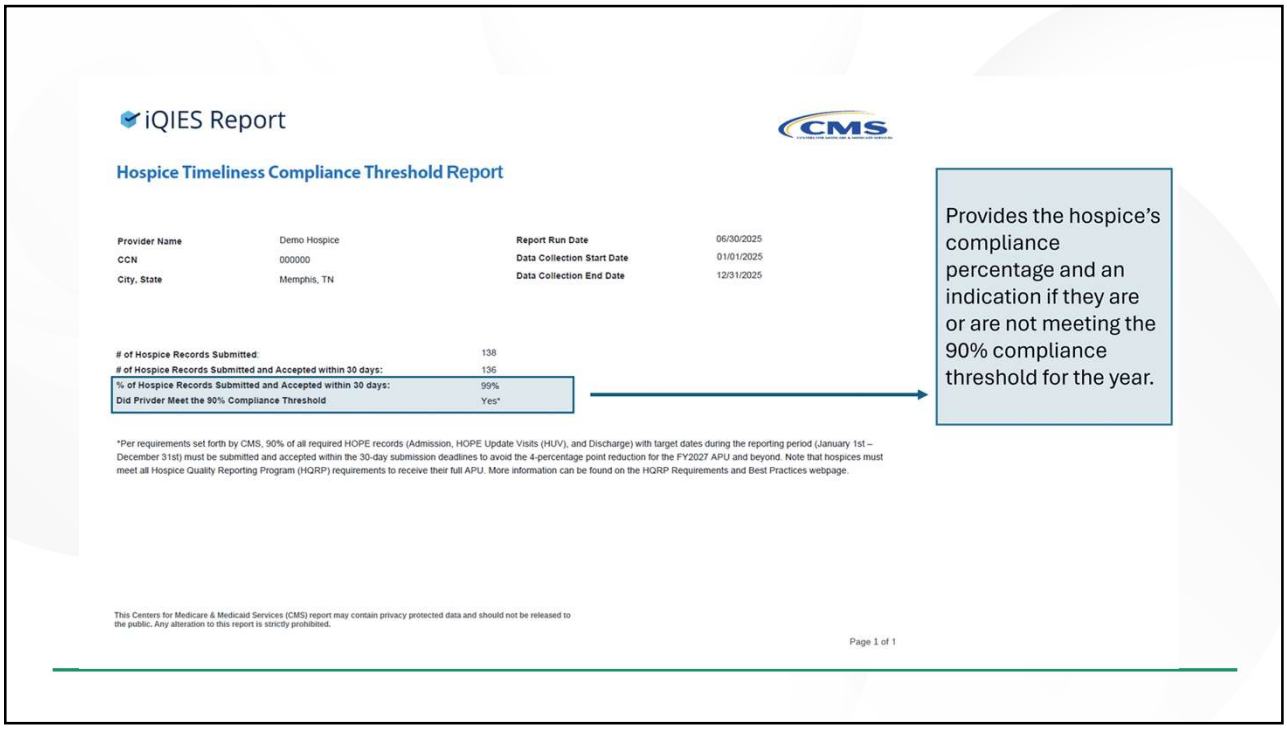

iQIES Report

CMS

Hospice Timeliness Compliance Threshold Report

Provider Name	Demo Hospice	**Report Run Date**	06/30/2025
CCN	000000	**Data Collection Start Date**	01/01/2025
City, State	Memphis, TN	**Data Collection End Date**	12/31/2025

# of Hospice Records Submitted:	138
# of Hospice Records Submitted and Accepted within 30 days:	136
% of Hospice Records Submitted and Accepted within 30 days:	99%
Did Privder Meet the 90% Compliance Threshold	Yes*

*Per requirements set forth by CMS, 90% of all required HOPE records (Admission, HOPE Update Visits (HUV), and Discharge) with target dates during the reporting period (January 1st – December 31st) must be submitted and accepted within the 30-day submission deadlines to avoid the 4-percentage point reduction for the FY2027 APU and beyond. Note that hospices must meet all Hospice Quality Reporting Program (HQRP) requirements to receive their full APU. More information can be found on the HQRP Requirements and Best Practices webpage.

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Provides the hospice's compliance percentage and an indication if they are or are not meeting the 90% compliance threshold for the year.

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Payment/Wage Index

- Estimated net impact of the policies in this rule is approximately $750 million in increased revenue to hospices in FY 2026.
- The FY 2026 hospice wage index will continue to include the hospice floor as well as the 5 percent cap on wage index decreases. For FY 2026, the 5 percent cap on wage index decreases will continue to be calculated at the county level as well. While some counties that required a transition code for FY 2025 will continue to use the same transition code for FY 2026, other counties that required a transition code in FY 2025 will no longer require a transition code in FY 2026. For these counties, the FY 2026 wage index of the CBSA or rural area that they are designated into has a wage index higher than 95 percent of their previous FY's wage index. Therefore, these counties will use the CBSA or rural county code of the area they were redesignated into based on OMB Bulletin No. 23-01.

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Wage Index

2026 Hospice Payment Rule

- **https://www.federalregister.gov/documents/2025/04/30/2025-06317/medicare-program-fy-2026-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting**

Hospice 2026 Wage Index

- https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-wage-index

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Labor Share

	Labor Share	Non-Labor Share
Routine Home Care	66.0 Percent	34.0 Percent
Continuous Home Care	75.2 Percent	24.8 Percent
Inpatient Respite Care	61.0 Percent	39.0 Percent
General Inpatient Care	63.5 Percent	36.5 Percent

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Calculated Rates

2025 Hospice Payment Rates For TN [redacted]

County/CBSA Area	CBSA Code	Wage Index	Routine Home Care (per day) Days 1-60	Routine Home Care (per day) Days 61 and beyond	Cont Home Care (per hour)	Inpt Respite Care (per day)	Gen Inpt Care (per day)
Nashville-Davidson--Murfreesboro--Franklin	34980	0.9359	215.12	169.44	64.19	498.49	1122.41

224.62 0.66 148.25 0.9359 138.75

224.62 0.34 76.37 76.37

215.12

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Finalized Change – Admission to Hospice

After consideration of public comments, we are finalizing our proposal to add the text "or the physician member of the hospice interdisciplinary group" to § 418.25(a) and (b) to indicate that, in addition to the medical director or physician designee, the physician member of the hospice IDG may also determine admission to hospice care.

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Face-to-Face Attestation

- Therefore, we are finalizing a revision to the regulation text at § 418.22(b)(4) to state, the physician or nurse practitioner who performs the face-to-face encounter with the patient described in paragraph (a)(4) must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation must include the physician's or nurse practitioner's signature and the date it was signed. The attestation could be a separate and distinct section of, or an addendum to, the recertification or the signed and dated face-to-face clinical note itself, as long as said clinical note indicates the face-to-face encounter occurred, and includes the clinical findings of the face-to-face encounter, the date of the visit, the signature of the physician or nurse practitioner who conducted the face-to-face encounter, and the date of the signature. If the attestation of the nurse practitioner or a non-certifying hospice physician is a separate and distinct section of, or an addendum to, the recertification, the attestation shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

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Telehealth Face-to-Face

- Telehealth visits allowed to meet the **Face-to-Face (F2F)** requirement for all patients
- This visit would be conducted by allowed physician or NP (PA not allowed)
- These visits are NOT reported on the claim.
- F2F via telehealth is extended through **December 31, 2027** after which CMS expects telehealth services to be summarily limited to follow-up contact with patients and would not expect to see provision of hospice services furnished via telecommunications systems
- Telehealth system utilized must be HIPAA Compliant

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Clarifications

Sec 6209: Extension of Certain Telehealth Flexibilities:

1. For home health providers, it extends provisions removing geographic requirements and expanding originating sites through December 31, 2027. This allows the required face-to-face visit (F2F) to be performed via telehealth
2. For hospice providers, it extends the hospice F2F telehealth flexibility through December 31, 2027; however, telehealth is NOT permitted, beginning January 31, 2026, if:
   - the individual receiving hospice is located in an area subject to a CMS moratorium on enrollment of hospice programs;
   - the individual is receiving hospice care from a provider subject to the Provisional Period of Enhanced Oversight (PPEO); or
   - the encounter is performed by a hospice physician or nurse practitioner who is not enrolled in Medicare and is not an opt-out physician or practitioner.
3. For hospice providers, requires CMS to create a claims modifier or code to indicate if a F2F encounter was conducted via telehealth starting January 1, 2027.

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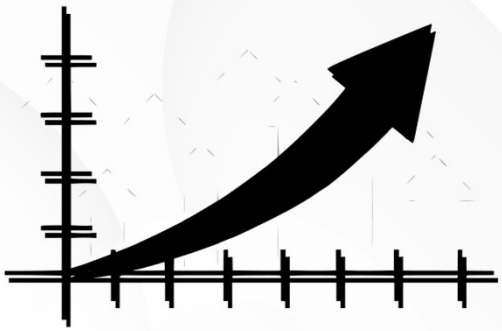
Final Hospice Cap 2026

- Hospice payments are subject to a statutory aggregate cap, which limits the overall payments made to a hospice annually. The hospice cap amount for FY 2026 is $35,361.44 (FY 2025 cap amount of $34,465.34 increased by the FY 2026 hospice payment update percentage of 2.6%).



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Cap Calculation Requirement

- Following are the Hospice Cap values as calculated by CMS:
  - ➢2022 Cap: $31,297.61 (2022 Cap year runs from 10/01/21 – 09/30/22)
  - ➢2023 Cap: $32,486.92 (2023 Cap year runs from 10/01/22 – 09/30/23)
  - ➢2024 Cap: $33,494.01 (2024 Cap year runs from 10/01/23 – 09/30/24)
  - ➢2025 Cap: $34,465.34 (2025 Cap year runs from 10/01/24 – 09/30/25)
  - ➢**2026 Hospice FINAL Aggregate Cap Amount** for 2026 is **$35,361.44**

Finalize cap update regulatory change – CAA 2023 extends utilization of APU % update (instead of CPI-U) through CY2032

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TABLE 5: Quality Measures in Effect for the FY 2026 Hospice Quality Reporting Program

Hospice Quality Reporting Program
Hospice Items Set (HIS) and Hospice Outcomes and Patient Evaluation (HOPE)
Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment Measure at Admission includes: 1. Patients Treated with an Opioid who are Given a Bowel Regimen 2. Pain Screening 3. Pain Assessment 4. Dyspnea Treatment 5. Dyspnea Screening 6. Treatment Preferences 7. Beliefs/Values Addressed (if desired by the patient)
Administrative Data, including Claims-based Measures
Hospice Visits in the Last Days of Life (HVLDL)
Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1)–Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2)–Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey
CAHPS Hospice Survey 1. Communication with Family 2. Getting Timely Help 3. Treating Patient with Respect 4. Emotional and Spiritual Support 5. Help for Pain and Symptoms 6. Training Family to Care for Patient 7. Care Preferences 8. Rating of this Hospice 9. Willing to Recommend this Hospice

Current Quality Measures for FY2026 HQRP

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(1) Continuous Home Care (CHC) or General Inpatient (GIP) Provided

(2) Gaps in Skilled Nursing Visits

(3) Early Live Discharges

(4) Late Live Discharges

(5) Burdensome Transitions (Type 1) – Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission

(6) Burdensome Transitions (Type 2) – Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital

(7) Per-beneficiary Medicare Spending

(8) Skilled Nursing Care Minutes per Routine Home Care (RHC) Day

(9) Skilled Nursing Minutes on Weekends

(10) Visits Near Death

Hospice Care Index (HCI)

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Hospice Care Index (HCI) Detail

1. **Continuous Home Care (CHC) or General Inpatient (GIP)** - % of CHC and GIP level of care days reflected on the Medicare claims during the reporting period. (Need to be greater than 0%)
2. **Gaps in Nursing Visits** - Number of Medicare Elections that had Gaps in Nursing Visits greater than 7 days within a 30-day period. (Need to be < 90%)
3. **Early Live Discharges** - % of Early Live Discharges within 7 days of admission compared to other hospice providers (Need to be < 90%)
4. **Late Live Discharges** - % of Late Live Discharges on or after 180 days from the hospice admission compared to other hospice providers (Need to be < 90%)
5. **Burdensome Transitions (Type 1)** - % of Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission (Need to be < 90%)

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Hospice Care Index (HCI) Detail

6. **Burdensome Transitions (Type 2)** - % of Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital (Need to be < 90%)
7. **Per-beneficiary Medicare Spending** compared to other hospice providers - Calculate by the total # of payments, Medicare paid to hospice providers divided by the total # of hospice beneficiaries served. (Need to be < 90%)
8. **Nurse Care Minutes per Routine Home Care (RHC) Day** - Average SN Care Minutes per RHC Day compared to other hospice providers (Need to be Greater than 10%)
9. **Skilled Nursing Minutes on Weekends** –SN Minutes on the Weekends (Saturday & Sunday) out of all SNV during RHC services days (Need to be Greater than 10%)
10. **Visits Near Death** - The number of Visits Near Death reflected on the Medicare claims compared to other hospice providers. The % of beneficiaries receiving at least one visit by a SN or social worker during the last three days of the patient's life (Need to be Greater than 10%) - A visit on the date of death, the date prior to the date of death, or two days prior to the date of death).

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Provisional Period of Enhanced Oversight (PPEO)

- CMS has placed newly enrolled hospices located in Arizona, California, Nevada and Texas in a period of enhanced oversight. Just expanded to Georgia & Ohio.
- Goal is to reduce fraud, waste and abuse.
- Includes medical review such as prepayment review.
- For the period of enhanced oversight, new hospices include those:
  - Newly enrolled in the Medicare Program as of July 13, 2023.
  - Submitting a change of ownership (CHOW) that meets all the regulatory requirements under 42 CFR 489.18
  - Hospices undergoing a 100% ownership change that doesn't fall under 42 DVF 489.18
  - Reactivating after being in a deactivated status

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Provisional Period of Enhanced Oversight (PPEO)

- CMS will notify hospice agencies of impending PPEO with a letter that includes the effective date of the enhanced oversight period, duration of enhanced oversight period and notice they may do a medical review of all claim.
- Failure to respond to ADR requests may result in claim denial or revocation of Medicare Enrollment.
- Oversight can be 30 days to 1 year.
- CMS can continue to conduct medical review after the PPEO has ended.
- The effective date of the PPEO's commencement is when the new provider or supplier **submits its first claim** rather than the date the first service was performed or the effective date of the ownership change

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Revalidation

- Every five years, the Centers for Medicare and Medicaid Services requires providers to revalidate their Medicare enrollment record. Failure to respond to our notice to revalidate will result in a hold on Medicare payments and possible deactivation of Medicare enrollment. Palmetto GBA returns informational claims messaging for providers that are due to revalidate. The following informational message will be provided on claims that have been adjudicated if a revalidation is due.
- **Your Medicare enrollment record is due for revalidation. Failure to respond may result in a hold on payments and possible deactivation of your enrollment.**
- Please visit the CMS website to confirm your revalidation due date.

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Provisional Period of Enhanced Oversight (PPEO)

- It is important to note that PPEO is not the same process as a TPE review. Under PPEO a lower number of claims is pulled and there do not have to be "rounds" of review. For example, a new hospice may have ten records reviewed with CMS taking final action after the review. The Alliance has heard from some new hospices in California, Texas, Arizona and Nevada that they have had more claims pulled for review after the initial record request and they have had the opportunity for education. However, the opportunity to receive education and/or to have additional records reviewed is not required under PPEO.
- Actions that CMS can take after review under PPEO include but are not limited to termination from the Medicare program, termination with a re-enrollment bar, and extended prepayment review.

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Hospice Medical Review is SERIOUS!

Your Medicare enrollment and Medicare billing privileges are being revoked effective January 18, 2026 for the following reasons:

42 CFR §424.535(a)(8)(ii) - Abuse of Billing Privileges
The Centers for Medicare & Medicaid Services (CMS) has determined that [redacted] has engaged in a pattern or practice of submitting claims that fail to meet Medicare requirements, in violation of 42 CFR 424.535(a)(8)(ii). [redacted] has failed to meet Medicare requirements by submitting noncompliant claims without documentation to support that the services were reasonable or necessary.

A review of [redacted] submitted claims was conducted. This review consisted of 3 claims with dates of service from [redacted] Of the 3 claims reviewed, 2 were denied. The reasons for denial were identified as: the physician narrative statement was either missing or invalid and the information provided did not support a terminal prognosis of six months or less. The noncompliant billing is reflected on the attachment titled *Enclosure A*. [redacted] was educated regarding the submission of these noncompliant claims.

An additional review of [redacted] submitted claims was conducted. This review consisted of 5 claims with dates of service from [redacted] Of the 5 claims reviewed, 4 were denied. The reasons for denial were identified as: documentation submitted did not include the beneficiary requested election statement addendum and the information provided did not support a terminal prognosis of six months or less. The noncompliant billing is reflected on the attachment titled *Enclosure B*. By letter dated October 29, [redacted] was educated regarding the submission of these noncompliant claims.

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OIG Investigating Payments

- For 30 of 100 sample items, payments to acute-care hospitals for outpatient services provided to hospice enrollees complied with Medicare requirements. For the remaining 70 sample items, however, payments did not comply with the requirements. Specifically, our medical reviewer found that Medicare paid acute-care hospitals for outpatient services that palliated or managed hospice enrollees' terminal illnesses and related conditions. These services were already covered as part of the hospices' per diem payments and should have been provided directly by the hospices or under arrangements between the hospices and acute-care hospitals. Medicare improperly paid the acute-care hospitals because, among other causes: (1) the prepayment edit process was not properly designed; (2) most acute-care hospitals reviewed only whether outpatient services palliated or managed terminal illnesses, not related conditions; (3) Medicare guidance lacks details; and (4) Medicare contractors did not conduct prepayment or postpayment reviews.

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OIG Investigating Payments

- OIG made six recommendations to CMS, including that CMS:
- CMS concurred with five of six recommendations but did not concur with our first recommendation. CMS stated that it has concerns about the feasibility and effectiveness of the type of modifications to the system edits described in our report. After reviewing CMS's comments, we refined our first recommendation. Improving CMS's system edit processes could help reduce improper payments going forward.

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OIG Investigating Payments

1. Improve system edit processes to help reduce improper payments for outpatient services provided by acute-care hospitals to hospice enrollees.
2. Educate acute-care hospitals to understand that each hospice enrollee's hospice election statement addendum is available on request, and educate hospices to provide the addendum if requested to help an acute-care hospital assess whether an outpatient service palliated or managed an enrollee's terminal illness and related conditions.
3. Continue to educate hospices that they should be providing to enrollees virtually all necessary services that palliate or manage terminal illnesses and related conditions either directly or through arrangements.
4. Educate acute-care hospitals to analyze not only whether outpatient services palliated or managed enrollees' terminal illnesses but also whether outpatient services palliated or managed a condition related to a terminal illness.

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OIG Investigating Payments

5. Clarify the language in the Manual (chapter 11, section 50), and in other CMS or MAC guidance documents or educational initiatives, if necessary, to specifically mention "related conditions" so that the language is consistent with Federal regulations and the Federal Register in stating that services not related to enrollees' terminal illnesses and related conditions may be billed to Medicare with condition code 07.
6. Direct MACs or other appropriate contractors, such as Recovery Audit Contractors, to:

   (1) analyze Medicare claims data to identify acute-care hospitals that have aberrant billing patterns for condition code 07, and conduct Targeted Probe and Educate reviews of these acute-care hospitals; and

   (2) conduct prepayment or postpayment reviews of acute-care hospital claims for outpatient services provided to hospice enrollees and billed with condition code 07.

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Notice of Election

The Notice of Election (NOE), Type of Bill (TOB) 8XA, is submitted when the hospice receives a signed election statement from the beneficiary acknowledging that he/she wishes to enroll in the Medicare Hospice Benefit. The NOE must be submitted to Medicare within 5 days of the date of election in order to be timely. Hospices can submit the NOE via the Direct Data Entry (DDE) system, Electronic Data Interchange (EDI) or hard copy (if applicable).

For EDI submissions, Medicare encourages hospices to submit batch transmissions with groups of NOEs separate from batch transmissions with groups of claims. This practice may reduce the risk that translator-level rejections related to NOEs, if they occur, that could impact payments to the hospice.

Hospices should also ensure that they monitor their acceptance reports at regular intervals. In addition, hospices should be aware that the NOE is subject to the batching process, which means it may be one to two days before the hospice will see the NOE in DDE if it was accepted.

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NOE Timeliness

- **If an NOE is not filed timely, the hospice will be ineligible for payment** from the effective date of election until the day the NOE is received by the MAC - timely-filed NOE is **submitted to, and accepted by**, the MAC within 5 calendar days after the effective date of election.
- CMS allows batch file transmissions of NOEs
- Example of timely/untimely NOE calculation:
  - Admission date = 02/02/2025 - Day 1 = 02/03/2025
  - Day 2 = 02/04/2025 - Day 3 = 02/05/2025
  - Day 4 = 02/06/2025 - Day 5 = 02/07/2025 This is the NOE “due date”.

  If NOE received and accepted before 02/07/2025, it is timely.
  If NOE received and accepted on 02/07/2025, it is timely.
  If NOE received and accepted on/after 02/08/2025, it is untimely.

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NOE Timeliness Exceptions

CMS finalizes an exceptions policy for failure to meet timely filing of the NOE; a hospice may be eligible for an exception to the consequences of late filing of the NOE:

1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate;
2. An event that produces a data filing problem due to a CMS or MAC systems issue beyond the control of the hospice;
3. A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC; or
4. Other circumstances determined by CMS to be beyond the control of the hospice.

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Have any questions?
Scan the QR Code to schedule a call!
Thank You for Participating!
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