



Texas Association for
Home Care & Hospice
Leading ★ Advancing ★ Advocating

Winter Conference

Thursday, February 19, 2026

2:00pm-3:00pm

7b. Trailblazing Financial Management Strategies for Sustainable Hospice Success

Presented by:

Brian Lebanion, CEO/Consultant, BC Healthcare Consulting, LLC

Thank you to our Partners:



Trailblazing Financial Management Strategies for Sustainable Hospice Success

Balancing Compliance, Cash Flow & Long-Term Sustainability



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Session Overview

- Navigating an increasingly complex reimbursement environment
 - Key financial risk areas in hospice operations
 - Practical strategies for improving financial visibility
 - Moving from reactive to proactive financial leadership

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The Current Hospice Financial Landscape

- Increased regulatory scrutiny and audit activity
 - Pressure from wage index and reimbursement updates
 - Workforce shortages impacting cost structures
 - Growing demand for financial transparency and accountability

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Revenue Cycle Performance: Key Drivers

- Timely Notice of Election (NOE) submissions
 - Clean claim rates and billing accuracy
 - Accounts receivable aging trends
 - Denial management and ADR response strategy

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Revenue Cycle Metrics That Matter

- Days in AR
 - Percentage of AR over 90 days
 - Net collection rate
 - Write-offs and credit balance trends



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Strengthening Cost Reporting & Margin Analysis

- Understanding direct vs. indirect costs
 - Aligning cost reports with operational data
 - Service line margin analysis
 - Using cost data for strategic planning

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Regulatory & Payment Impacts

- Hospice Final Rule updates
 - CMS issued the FY 2026 Hospice Wage Index, Payment Rate Update, and HQRP Final Rule (CMS-1835-F) — effective Oct 1, 2025.
 - Updates impact **payment rates, wage index, cap amount, admissions policy, quality reporting, and face-to-face documentation.**
 - **2.6% overall payment increase** for FY 2026 — ~\$750M more to hospices nationally.
 - This is based on a **3.3% market basket increase minus a 0.7% productivity adjustment.**
 - **Hospice aggregate cap increases to \$35,361.44** for FY 2026.
 - Non-compliant hospices (no quality data) face a **net rate reduction (~-1.4%)**

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Hospice Wage Index

Hospice wage index updates reflect geographic cost differences.

Maintains policy that wage index decreases are capped at **no more than -5%** year-to-year.

Important for hospices in areas with revised statistical area delineations.

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Admissions & Attestation Changes



Physician IDG member may now recommend hospice admission — aligns payment regs with certification rules.



Revised face-to-face encounter attestation: a signed and dated clinical note may satisfy the requirement.



Reduces administrative burden while maintaining compliance standards.

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HQRP & Quality Reporting

- Continued transition from **HIS** to the **HOPE (Hospice Outcomes and Patient Evaluation) tool** beginning Oct 1, 2025.
- Providers must report HOPE data via **iQIES platform** and prepare for future HQRP measure expansions.
- Strengthens quality measurement and accountability.



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Operational Implications



Revenue Impact: Higher base payments and cap may improve cash flow but require careful forecasting.



Compliance Risk: Ensure face-to-face and quality data processes align with updated rules.



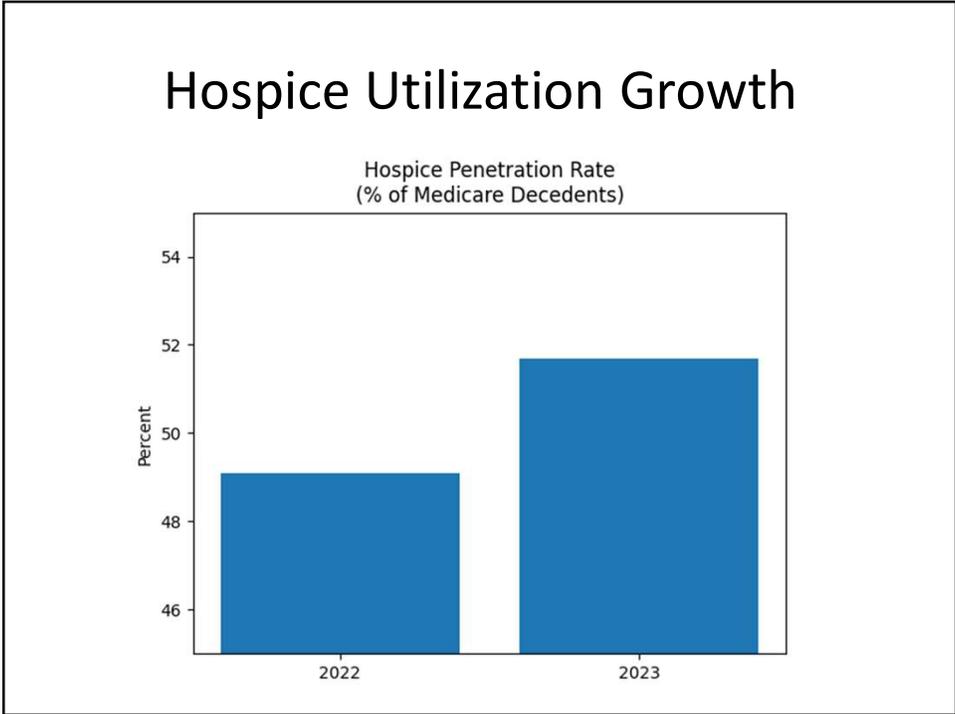
Training & Tech: Update policies, EHR templates, and staff training for HOPE submission via iQIES.

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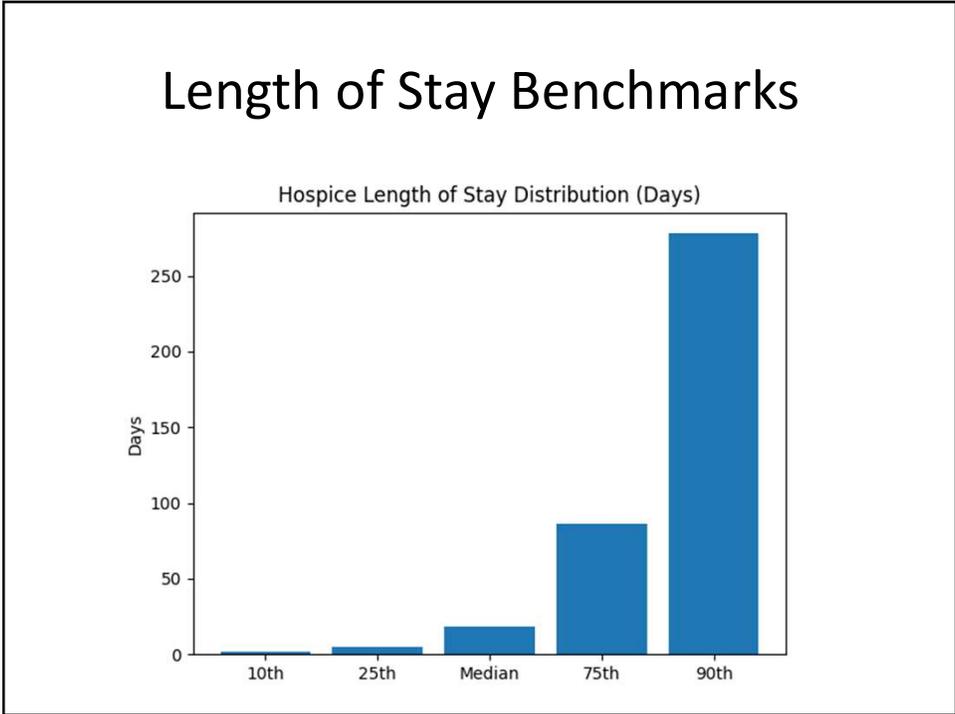
MedPAC Hospice Benchmarks Financial & Operational Dashboard

March 2025 Report Highlights for Strategic
Leaders

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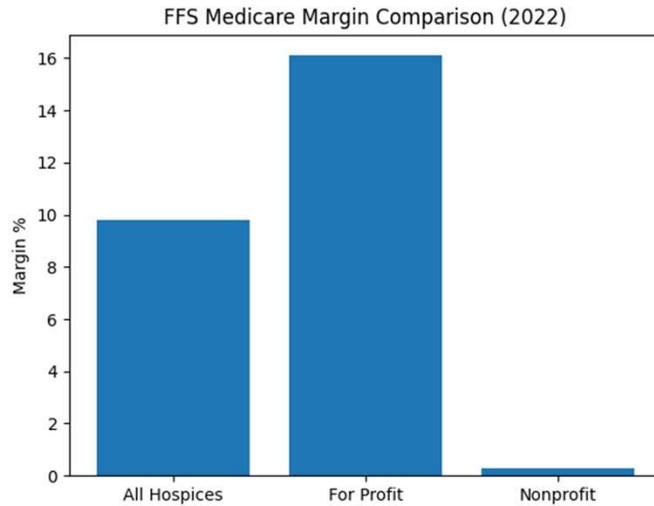


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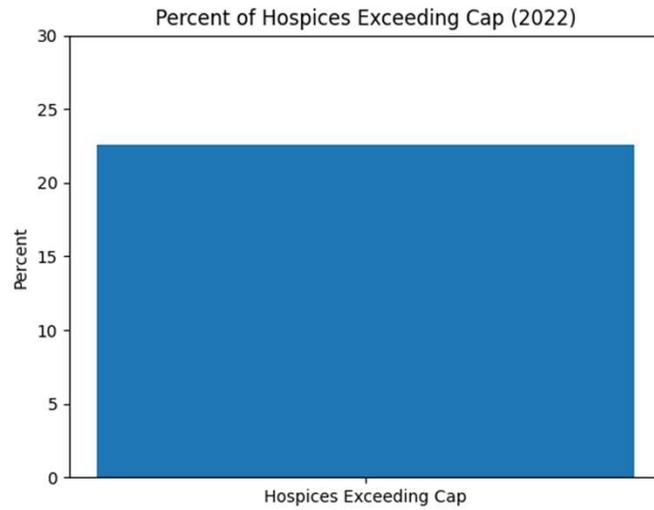
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Medicare Margin Comparison



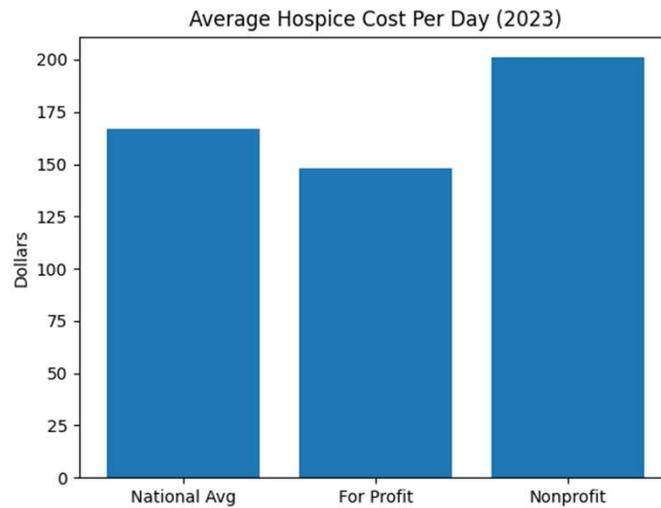
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Aggregate Cap Risk Exposure



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Cost Per Day Benchmark

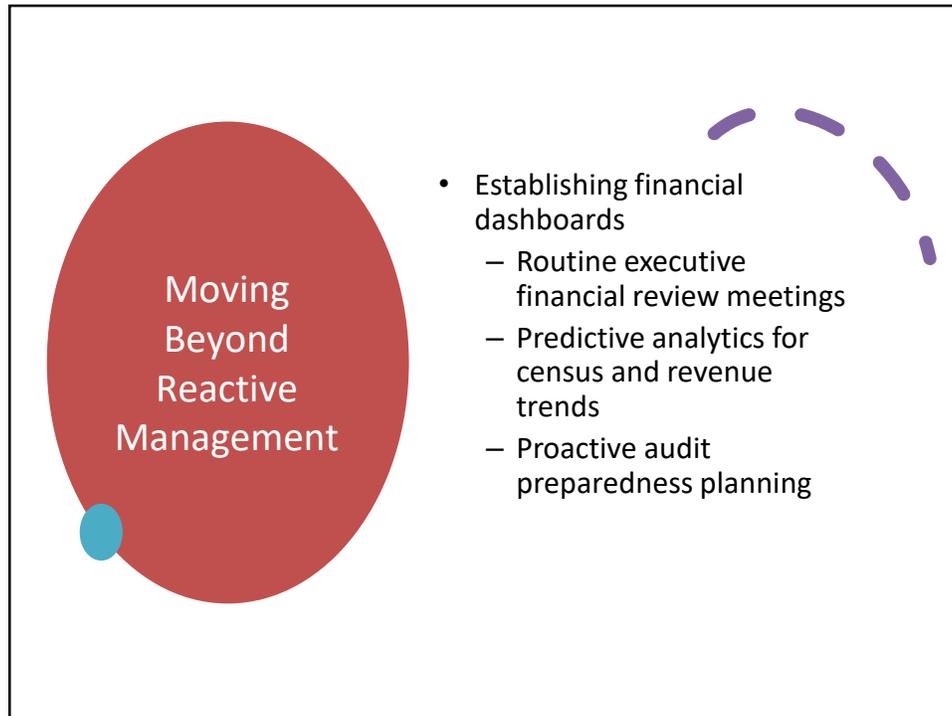


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Executive Financial Takeaways

- National hospice margin remains strong (~8–10%)
 - Profitability closely tied to long stays (>180 days)
 - 22.6% of hospices exceed aggregate cap
 - Live discharge national rate: 18.5%
 - MedPAC recommends eliminating FY2026 update

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Moving Beyond Reactive Management

- Establishing financial dashboards
 - Routine executive financial review meetings
 - Predictive analytics for census and revenue trends
 - Proactive audit preparedness planning

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Data-Driven Decision Making

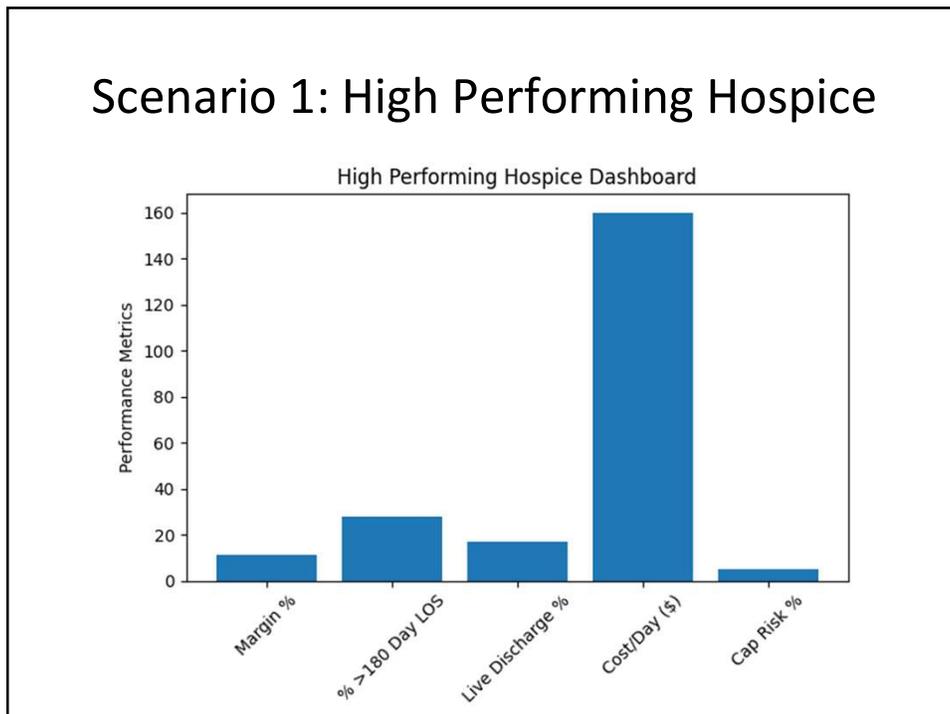
- Integrating clinical and financial data
 - Using KPIs to guide operational improvements
 - Forecasting for staffing and growth
 - Aligning financial goals with mission and patient care

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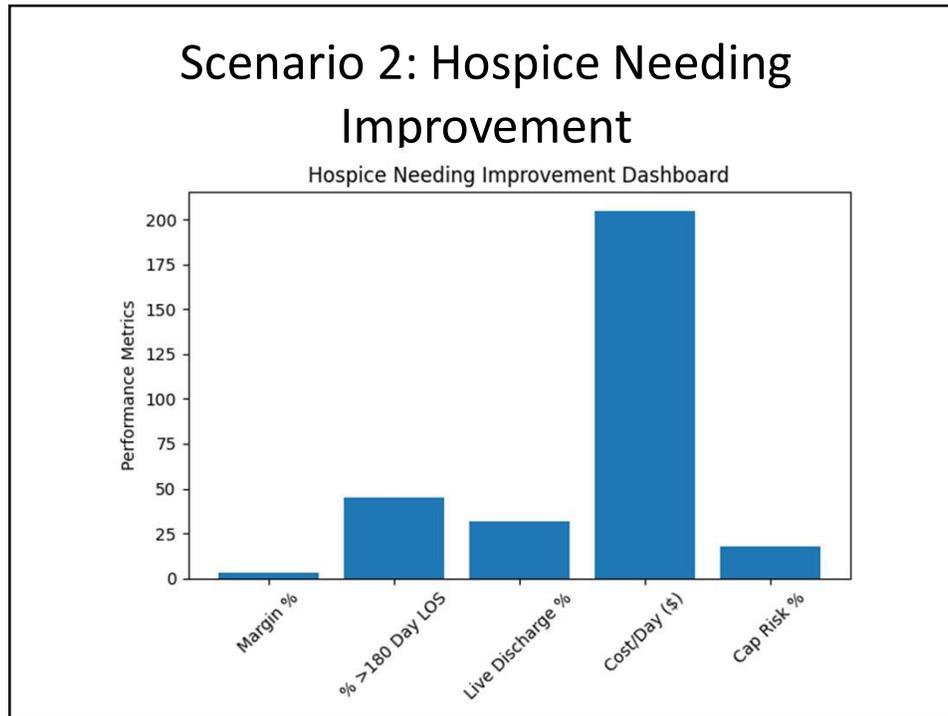


- Diversifying referral sources
 - Evaluating expansion opportunities carefully
 - Technology investments for efficiency
 - Strategic partnerships and community engagement

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Using the Dashboard to Drive Improvement

High Performing Hospice Strategy:

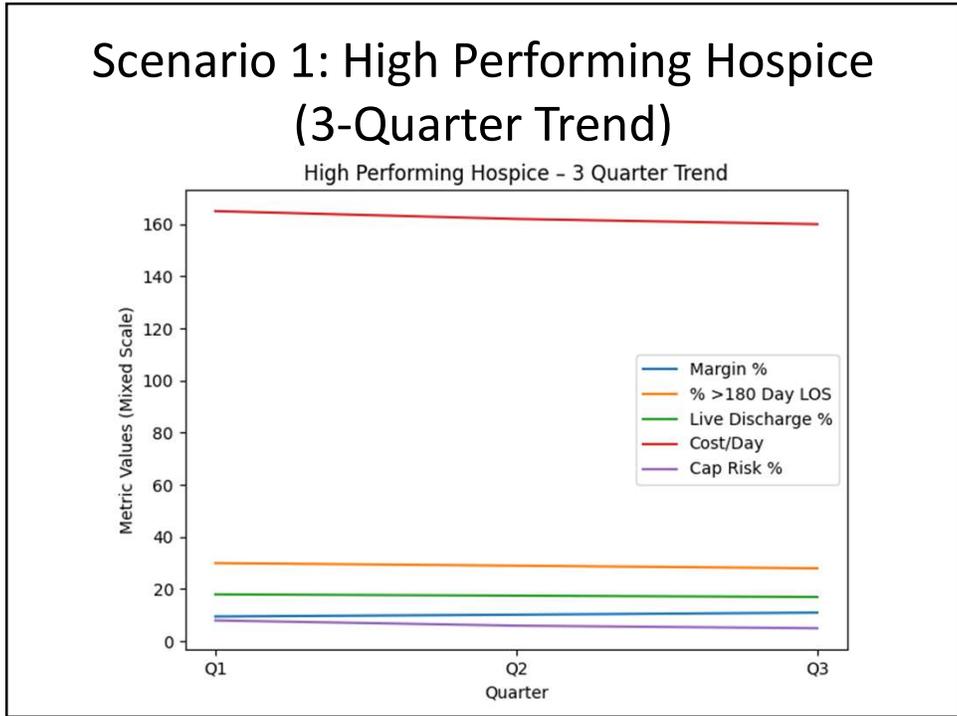
- Continue monthly cap projections and LOS monitoring
- Maintain cost discipline and staffing productivity
- Audit long-stay documentation quarterly

Hospice Needing Improvement Strategy:

- Implement rolling 12-month cap forecast immediately
- Review eligibility for patients >150 days
- Reduce cost per day via staffing & routing analysis
- Investigate high live discharge causes

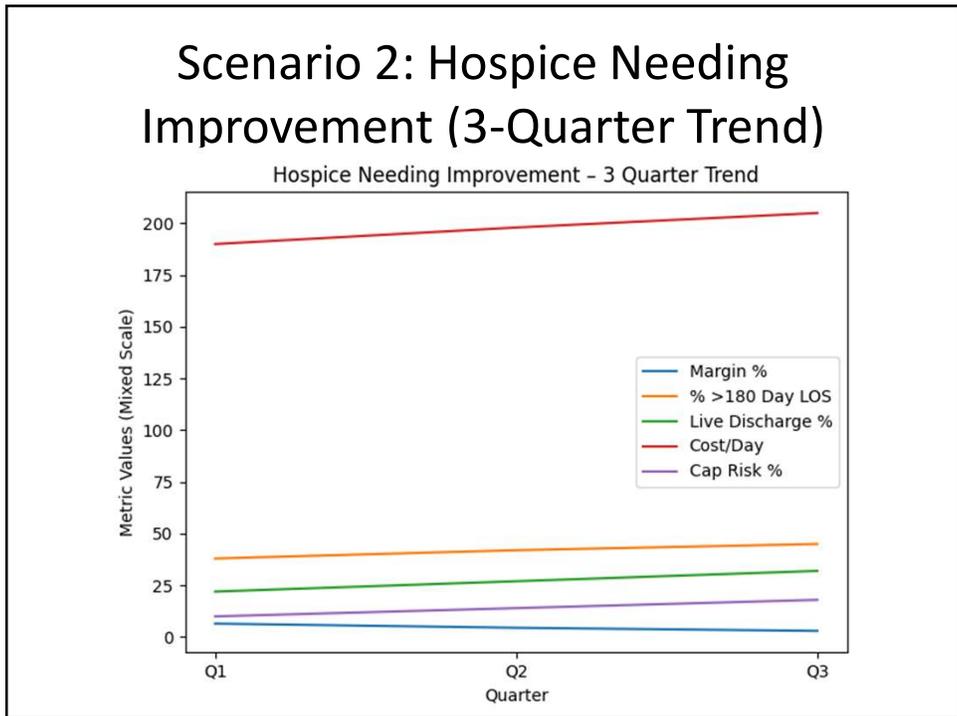
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Scenario 1: High Performing Hospice (3-Quarter Trend)



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Scenario 2: Hospice Needing Improvement (3-Quarter Trend)

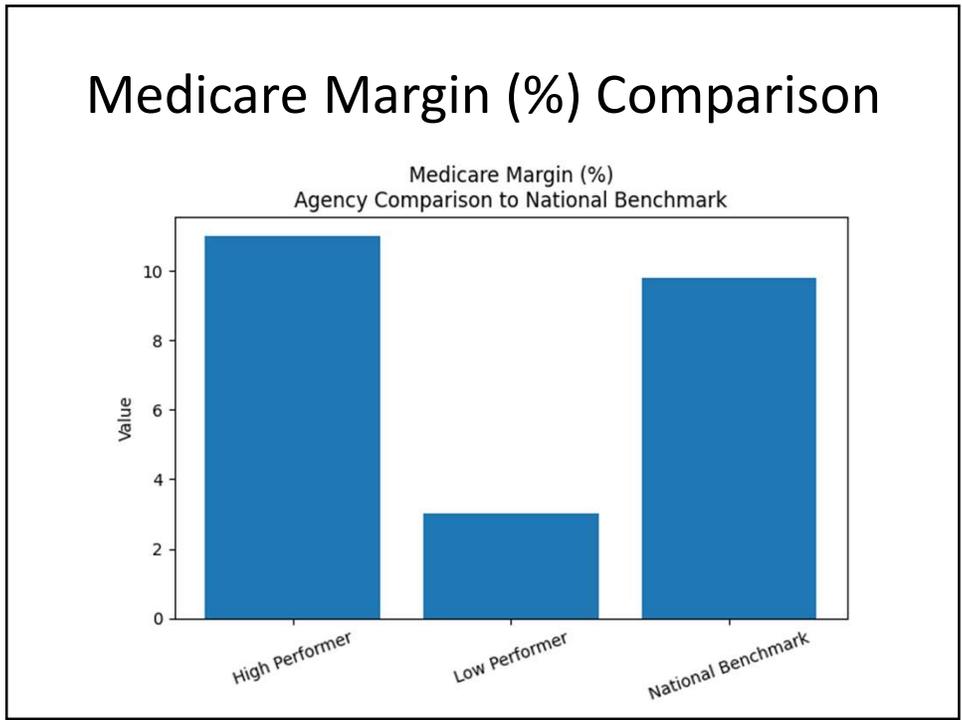


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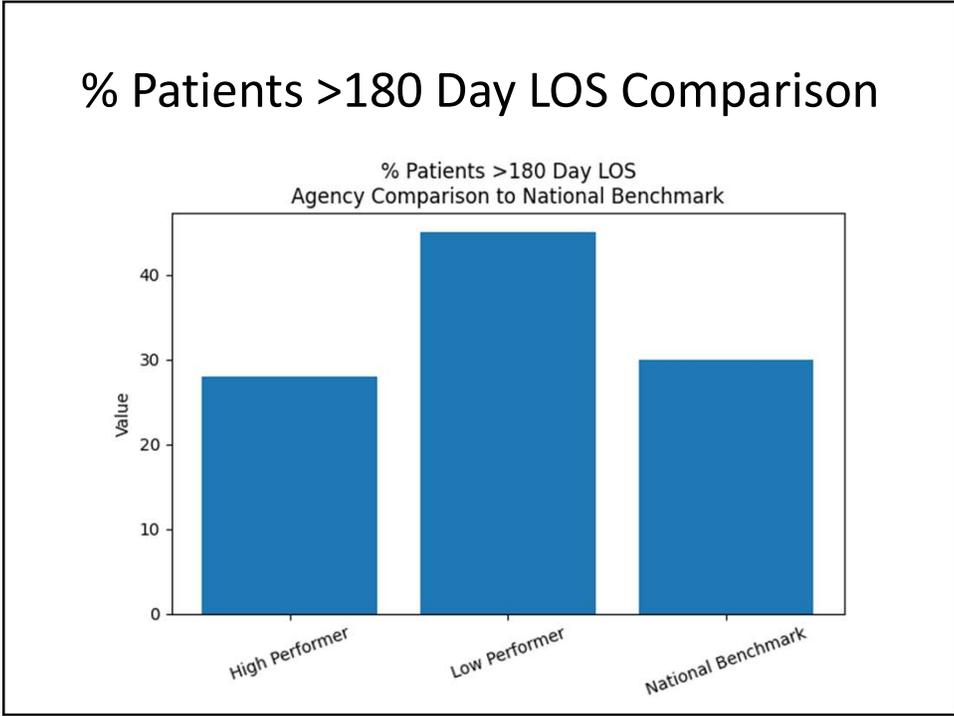
How Leadership Uses 3-Quarter Trends to Improve

High Performing Hospice Actions:	Hospice Needing Improvement Actions:
<ul style="list-style-type: none"> • Sustain LOS discipline with quarterly long-stay review • Maintain cost efficiency and staffing productivity tracking • Continue monthly cap projection monitoring 	<ul style="list-style-type: none"> • Immediate rolling 12-month cap forecast • Interdisciplinary review for patients >150 days • Reduce cost per day via staffing & operational review • Investigate drivers of rising live discharges

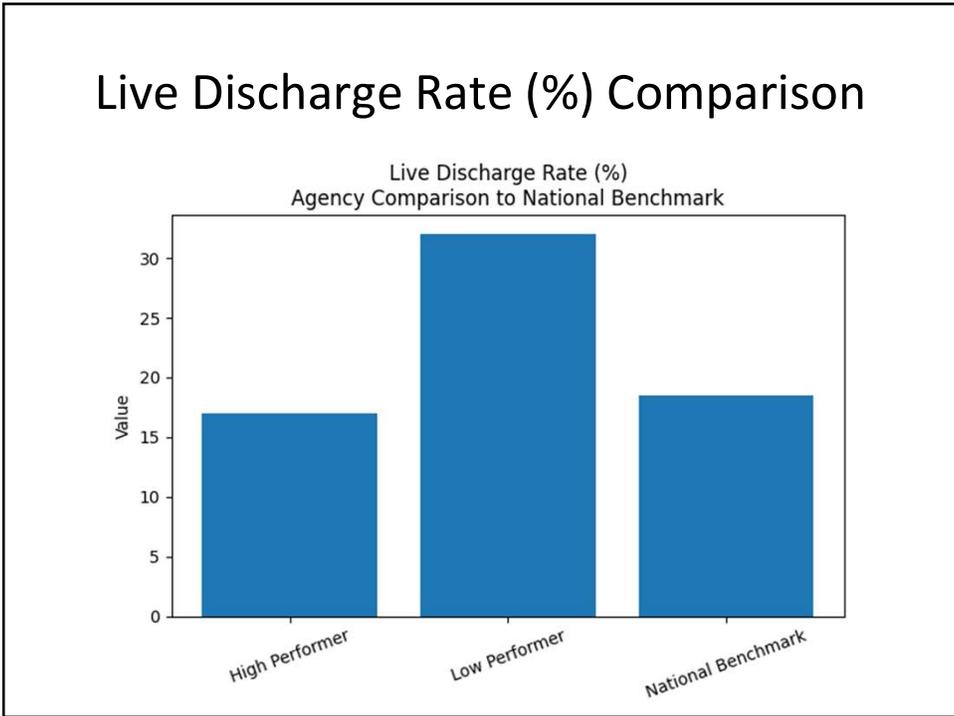
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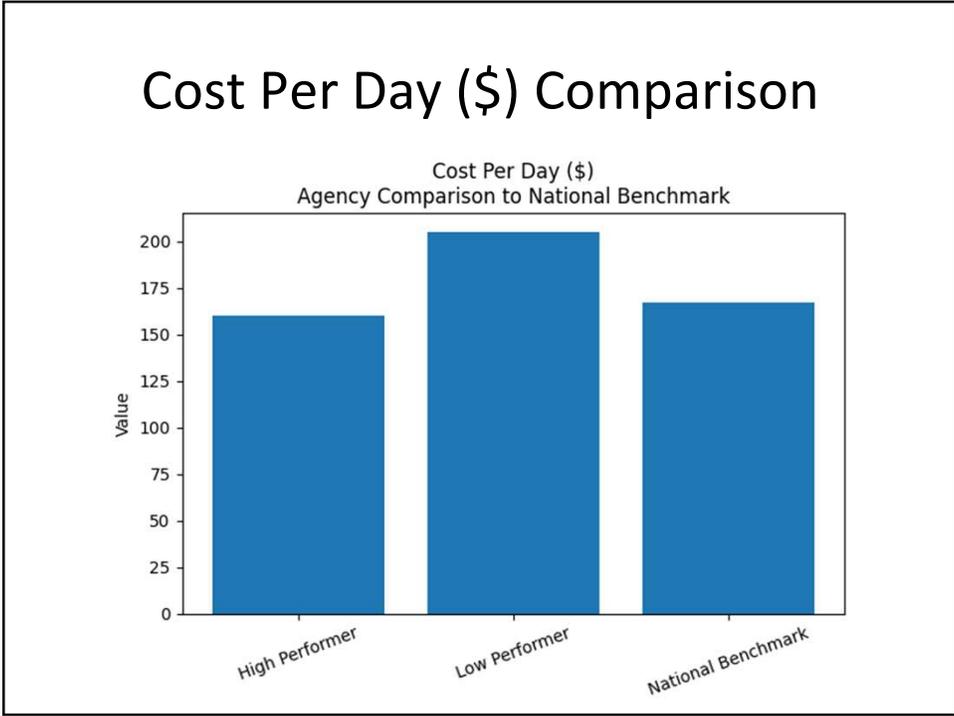
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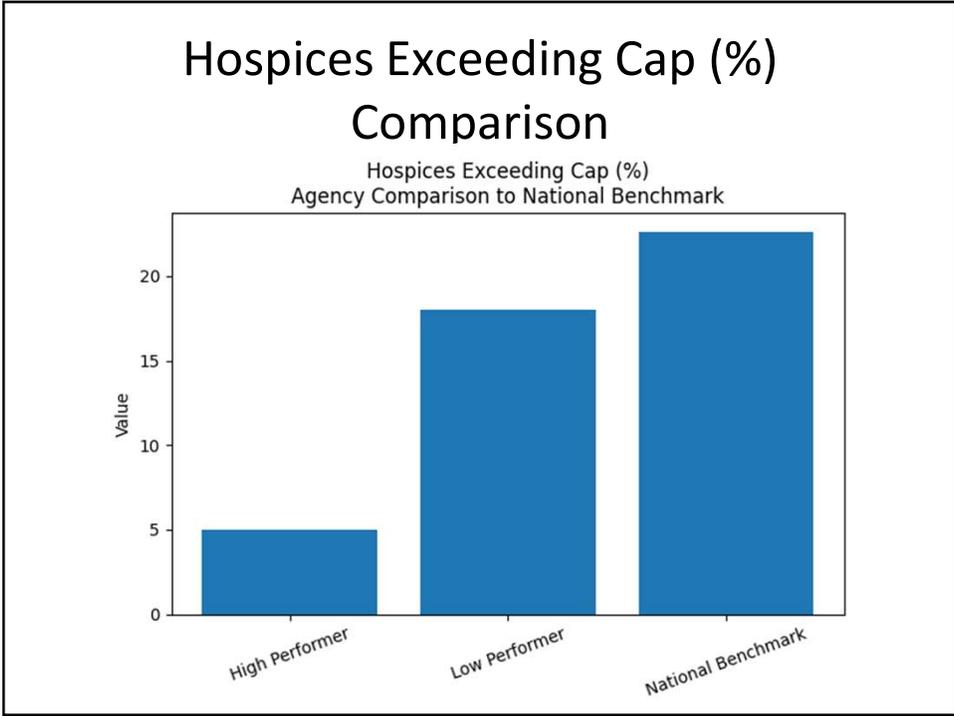
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Executive Interpretation of Benchmark Positioning

High Performer:

- Margin above national benchmark indicates operational strength
- Controlled LOS and discharge rates reduce compliance exposure
- Low cap risk supports sustainable growth

Low Performer:

- Margin below national norm signals financial stress
- Elevated LOS & live discharge increase audit risk
- Cost and cap exposure require immediate dashboard oversight

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Understanding Hospice Cap Management

- Inpatient Cap vs. Aggregate Cap
 - Real-time cap monitoring vs. retrospective review
 - Risk indicators: length of stay trends, payer mix, ADR exposure
 - Strategies to avoid year-end cap surprises

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Building a Cap Monitoring Framework

- Monthly cap projections using updated census data
 - Rolling 12-month trend analysis
 - Scenario planning for high-risk patients
 - Interdisciplinary collaboration for LOS management

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How the Hospice Self-Aggregate Cap Works

- **1** What is the Aggregate Cap?
 - Annual limit on total Medicare payments a hospice can receive
 - Calculated: (# Medicare beneficiaries served) × (Annual Cap Amount)
 - If total payments exceed cap → hospice must repay excess
- **2** Cap Year Timeframe
 - October 1 – September 30 (Federal Fiscal Year)
 - Reconciliation occurs after year-end
 - Self-monitor monthly to avoid year-end surprises
- **3** Key Risk Drivers
 - High percentage of patients >180 days
 - Long neurological or dementia stays
 - High live discharge rates

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Hospice Aggregate Cap – Critical Compliance Details Providers Must Know

Cap Year

- Federal Fiscal Year: October 1 – September 30
- Reconciliation performed after year-end by MAC

Filing & Reporting Requirements

- Cap calculation completed by MAC using claims data
- Provider must monitor and validate calculation (self-cap tracking recommended monthly)
- Repayment demand letters typically issued following MAC reconciliation

If You Exceed the Cap

- Hospice must repay excess Medicare payments
- Failure to repay may result in recoupment or offset from future payments

Reopening & 3-Year Look Back

- MACs may reopen cap determinations for up to 3 years
- Adjustments can occur due to claims corrections or audits
- Maintain documentation supporting beneficiary counts & payment calculations

Additional Operational Considerations

- Long stays (>180 days) significantly increase cap exposure
- High live discharge rates often correlate with cap exceedance risk
- Board-level reporting of projected cap liability is best practice

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Aggregate Cap – Agency UNDER Cap Example

- Annual Cap Amount (example): \$34,465
 - Medicare Beneficiaries Served: 120
 - Allowed Cap = $120 \times \$34,465 = \$4,135,800$
 - Actual Medicare Payments Received: \$3,900,000
 - Result: \$235,800 BELOW cap → No repayment owed

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Aggregate
Cap –
Agency
EXCEEDS
Cap
Example

- Annual Cap Amount (example): \$34,465
 - Medicare Beneficiaries Served: 80
 - Allowed Cap = $80 \times \$34,465 = \$2,757,200$
 - Actual Medicare Payments Received: \$3,200,000
 - Repayment Owed = $\$3,200,000 - \$2,757,200 = \$442,800$

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Inpatient
Cap (20%
Rule) –
Agency
UNDER
Limit

- Rule: Inpatient Days (GIP + Respite) \leq 20% of Total Hospice Days
 - Total Hospice Days: 20,000
 - Inpatient Days: 3,500
 - Percent Inpatient = $3,500 \div 20,000 = 17.5\%$
 - Result: Under 20% → No payment adjustment required

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Inpatient
Cap (20%
Rule) –
Agency
EXCEEDS
Limit

- Rule: Inpatient Days (GIP + Respite) \leq 20% of Total Hospice Days
 - Total Hospice Days: 15,000
 - Inpatient Days: 4,000
 - Percent Inpatient = $4,000 \div 15,000 = 26.7\%$
 - Result: Over 20% \rightarrow Excess inpatient days paid at Routine Home Care rate



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Key
Takeaways

- Monitor cap exposure continuously
 - Optimize revenue cycle performance
 - Leverage cost reporting strategically
 - Lead with data for sustainable hospice success



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Questions
&
Discussion

- What financial risks are most pressing in your organization?
 - Where can better data improve decision-making?

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Contact
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