



EVERYTHING YOU NEED TO KNOW

State of the Industry Newsletter



As we look toward the close of 2026, one thing is clear: healthcare leaders are being asked to do more with greater precision. Regulatory changes, reimbursement pressures, workforce challenges, and evolving models of care are reshaping how organizations operate and plan for the future. In this issue, we share insights and data to help you navigate these challenges, protect financial performance, and identify opportunities to build stronger, more sustainable organizations. That is the work that matters.

Your success is our mission. Let's achieve it together.

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ICD-10-CM Changes That Could Impact Home Health Claims for FY2027

By: J'non Griffin, RN MHA HCS-D, HCS-O, COS-C, HCS-H, HCS-C

CMS released the FY2027 ICD-10-CM code files in June, and the update brings 190 new billable diagnosis codes, 30 deletions, and 4 revisions, all effective for patient encounters on or after October 1, 2026. Several of the changes land squarely in diagnoses we see every day in [home health](#). The one to watch most closely is dilated cardiomyopathy: the longstanding code I42.0 is being subdivided into more specific codes, and claims submitted with the old I42.0 after October 1 will be denied. Since cardiomyopathy frequently drives the MMTA Cardiac clinical group under PDGM, agencies should audit active patients now for this code. Other additions worth flagging for your teams include 2 new BMI codes, Z68.18 and Z68.19, for underweight adults, which will strengthen malnutrition and nutritional risk documentation, and a new code, Z86.17, for personal history of *Clostridioides difficile* infection, useful for infection control history on our medically complex admissions. Coders should also note that this year's update includes a notable number of changes to instructional notes, including Excludes1 and Excludes2 notes and Code First and Use Additional Code notes, so reviewing the [Tabular List instructions for your common codes](#) before October 1 is strongly recommended.

Now for the billing piece that catches agencies every year. Under [PDGM](#), a 60-day certification period contains 2 30-day payment periods, which means a patient whose episode begins before October 1 may have been coded with a diagnosis from the current code set that is revised, replaced, or deleted when the new codes take effect. In plain terms: if your patient started care in September with a code that changes, the second 30-day period claim with dates of service in October must carry the valid FY2027 code, even though nothing about the patient's condition changed. Claims submitted with outdated codes for visits on or after October 1 will be rejected. Some agencies simply wait for the rejection and then correct and resubmit, but proactively updating the codes before submission reduces [reimbursement delays](#).

The good news is that preparation is straightforward. Pull a report of your active census, identify patients carrying any of the 30 deleted codes, and map them to their replacements using the FY2027 Conversion Table, which identifies the codes that become inactive on October 1, 2026 and their replacement codes. Confirm your EHR and coding software vendors have loaded the FY2027 code set, brief your billers on the second-period correction issue, and schedule a denial review for October and November to catch anything that slips through. A little work in September saves a lot of rework in the fourth quarter.

**Cut costs
up to 40%.**

**SimiTree delivers
98–99% coding
accuracy with
a 24–48 hour
turnaround.**

**Faster coding.
Fewer errors.
Better outcomes.**

START SAVING



Next: [The Strategic Budget](#) →

Beyond Cost-Cutting: How to Build a Smarter Budget for Better Performance

By: Anne-Marie Fontenot and TaKeshia Dozier

For post-acute and behavioral health providers, budget season shouldn't automatically become an exercise in cutting expenses. Most organizations are already thoughtful about managing costs. The greater opportunity is often understanding whether the organization is getting the full financial and operational return from the resources it already has. That means looking beyond individual expense lines and asking bigger questions: Are [payor contracts](#) producing the expected reimbursement? Are coding and billing processes [capturing the revenue you've earned](#)? Is [staffing](#) aligned with actual capacity and demand? Are [software investments](#) eliminating work – or creating more spreadsheets and manual processes? When were vendor contracts last reviewed, and do they still make sense for the organization today?

The budget should also expose where [operations and financial performance](#) aren't aligned. Intake and admissions challenges can limit growth before a patient ever reaches the clinical team. Poor workflows or organizational structures can leave staff underutilized even when headcount itself isn't the problem. RCM and claims issues can create a significant gap between revenue earned and cash collected. Technology that doesn't integrate can add administrative work instead of eliminating it. Looking at these areas together – revenue optimization, staffing utilization, technology, organizational structure, vendor relationships, and revenue cycle – creates a much clearer picture of where there is opportunity to improve performance without defaulting to staffing cuts.

One of the most valuable budget conversations may be asking leadership 2 simple questions: If you had 10% more to invest next year, where would you put it and what return would you expect? If you had 10% less, what would you change – and why? Then ask one more: What did last year's results teach us that should change this year's plan? A budget built around those conversations becomes more than a financial target. It becomes an operational roadmap for protecting margin, investing intentionally, and growing responsibly.

Next: Revenue Cycle Accountability →

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From Reactive to Proactive: Strengthening Revenue Cycle Management in Home Health and Hospice

By: Nicholas Corbi and Brian Harris

As we head into the fourth quarter of 2026, post-acute healthcare revenue cycle teams are facing continued payor, regulatory, reimbursement, and operational pressures that are directly impacting agency cash flow and financial performance. [Denials](#) and underpayments, reimbursement pressure, and [staffing constraints](#) remain significant areas of concern, while increasingly complex payer requirements are creating additional opportunities for revenue leakage. For home health and hospice agencies, these challenges are often compounded by front-end breakdowns, including incomplete insurance verification, authorization delays, eligibility issues, missing documentation, and delayed orders, that ultimately surface as billing delays, denials, and [increased accounts receivable \(AR\)](#). At the same time, increased regulatory scrutiny of home health and hospice billing and enrollment activity makes documentation, compliance, and claim integrity increasingly important. Agencies should respond by treating revenue cycle as an end-to-end financial control process, rather than simply a back office billing function. Establishing clear accountability across Intake, Insurance Verification, Authorization, Clinical Management, Billing, and Collections is critical to [maintaining a healthy revenue cycle](#). Agencies should also routinely monitor pre bill audit results, denial trends, unbilled revenue, AR aging, and cash collections to identify and address revenue risk before it impacts the bottom line.

SimiTree works claims, denials, and follow-up daily, so cash doesn't just sit and wait.

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The agencies best positioned to navigate these pressures will be those that shift from reactive revenue recovery to proactive revenue protection. This requires leadership to establish a consistent operating cadence around the metrics that directly influence cash, including clean claim rate, unbilled days, denial rate and root cause, AR aging, days sales outstanding, authorization turnaround, and cash collections versus expectation. These measures should be reviewed routinely by branch, payer, and process owner, with corrective actions tied to measurable financial impact rather than simply activity or volume. Agencies should also conduct regular reimbursement and underpayment reviews, maintain payer specific requirements and authorization matrices, and leverage available [EMR and RCM reporting to identify where revenue is becoming trapped](#) before it reaches AR. Ultimately, a high performing revenue cycle should serve as an early warning system for the organization, connecting operational performance to financial outcomes and enabling leadership to intervene before process inefficiencies become material cash flow and margin challenges.

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Agencies must also have contingency plans in place to address backlogs that arise, while leveraging standard benchmarking and accountability metrics to address issues before they move beyond manageable for standard operations. If a backlog does arise, revenue cycle leaders must quickly assess the scope of the issue and more important the resource need to effectively address outstanding items. This analysis may vary based on function (i.e. [missing authorization](#) vs. outstanding accounts receivable) but should highlight whether the backlog can be surmounted internally or if external temporary resources are needed. If the [external route is elected](#), it is important to understand the onboarding time required for these resources to be effective, and how the training of these resources could potentially delay resolution of the backlog. Revenue cycle teams should also be conservative in projections for backlog clearance, especially since it is difficult to control or accelerate the timelines on which payors with reprocess items. For example, SimiTree typically approaches AR clean-ups as requiring 3 sweeps through the AR over a 4 to 6 month period, with the volume of claims included decreasing with each sweep. This can be more of an art than a science, but resources must find the balance between fighting for every dollar and the diminishing returns of additional actions on an account. Most importantly, dedicated KPI tracking should be maintained throughout the project to evaluate progress since clean-up work initiated and projected project end dates. As these complexities show, the goal is to avoid finding yourself in this position, but it is even worse to not be prepared with a plan of attack if a backlog does arise.

Next: CCBHC Sustainability →

99.6%
collection rate

\$2B+
processed yearly

450+
providers already
utilizing

CLARITY
unifies EMR,
clearinghouse,
& billing data.

See risks *before*
they impact
cash flow.

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CCBHC Funding, Medicaid Changes, and the Road to Behavioral Health Sustainability

By: TaKeshia Dozier

Behavioral Health continues to evolve as organizations constantly try to find additional ways to provide access to more patients, ensure that this access creates positive outcomes for those receiving the services, integrate physical and behavioral health to ensure that the “whole” person is being treated while navigating through constant reimbursement pressure and increasingly complex Medicaid requirements. Certified Community Behavioral Health Clinics (CCBHCs) are one of the examples of this. The opportunity to provide the long term impact that the community requires is significant. The bigger issue lies not in obtaining the funding but whether the organization can use those initial grant funds to create operations that are financially and operationally sustainable once the grant period ends.

The CCBHC grants and the expansion of these grants represents one of the most significant opportunities in behavioral health. 10 additional states joined the demonstration in 2026 and there will be a continued investment to extend access to comprehensive community based care in more communities. This brings the total number of participating states to 30. At the same time, SAMHSA announced \$223.1 million in 2026 CCBHC funding opportunities, including \$117.1 million for improvement and advancement grants, \$94 million for planning, development, and implementation grants, and \$12 million for state planning grants. The \$94 million for planning, development, and implementation is structured as such: 94 awards of up to \$1 million per year for up to 4 years. Both the SAMHSA grants and the Medicaid demonstration expansion support the broader CCBHC strategy; however, they are separate funding sources. Needless to say, both of these help to provide greater access to mental health and substance use disorder services, crisis response, care coordination, peer support, and whole person care. Now, it is obvious that these grants help to provide greater access. The bigger question is how to use these funds (which are temporary) to build models that are sustainable thus allowing organizations to permanently provide much needed care.

We applied for the grant. We are awarded the funds. Now the real work begins. These funds have to be viewed as a springboard for sustainable programming and operations. Leadership must see this as an opportunity to develop a sustainable model and not the opportunity to subsidize one that is not sustainable. We have to remember that the grant budget is temporary and we have to build a model that helps the organization when the grant period ends. Clinics must serve individuals regardless of their ability to pay or place of residence and has to be prepared to address mental health and substance use disorder needs across the entire life cycle. Organizations must also require timely access, crisis services, care coordination, evidence based practices, and quality reporting.

Audit-Ready. Every Time.
Real-time CCBHC quality measure tracking,
no more scrambling before a review.

SEE HOW
IT WORKS



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One of the most important features of the CCBHC Demonstration is the prospective payment system (PPS). Participating states select an approved PPS methodology that is designed to reimburse CCBHCs for the expected cost of delivering the required services. The organizations in the demonstration portion of the grant period must submit annual cost reports with supporting data. This creates a stronger path to funding comprehensive care than traditional fee-for-service reimbursement alone and fundamentally changes the financial conversation. Organizations cannot manage CCBHC reimbursement as a simple traditional fee for service billing model with additional services providing another layer of reimbursement. Leadership must understand the state's PPS methodology and how it works. With PPS-1 through PPS-4 now available, it is prudent that the organization understands which methodology their state has selected as well as how that methodology affects encounter reporting, crisis reimbursement, quality incentives, cost reporting, and overall financial performance. Reimbursement is no longer simply financial but is also operational. PPS requires you to ask, Is the encounter eligible? Was the service included

in the PPS payment? Was the correct provider, location, and service information reported? Are all eligible services being captured? Are the services being duplicated or carved out correctly? Does the cost report accurately reflect the staff, technology, overhead, and non-billable work required to operate the model? These items affect the rate, the integrity of the claim, the reliability of reported data, and the ability to demonstrate what it actually costs to provide care.

Along with the change in payment structure, CCBHC organizations must also file a cost report. CMS updated the cost report in March 2026 which further makes this not just a financial exercise but also an operational one. Cost reporting must begin long before the report is due. Accounting and reporting should be designed so that information required to support the cost report is captured throughout the year. All aspects of the organization including the general ledger, payroll, encounter data, and overhead allocation methodologies should [tell the same financial story](#). If all of the systems are not aligned, the organization may struggle to support the cost report model, evaluate performance, or provide reliable information for rate development.

Drowning in CCBHC Reporting?

**Automate quality
measures, state
reports, and cost
reporting, all in
one platform.**

REQUEST DEMO



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The first six months should be used to build the infrastructure that will be in place after the grant. Although you may have to hire quickly, ensure that you establish an approved staffing model that can create a cost structure that can be sustained. Purchase technology that is appropriate and supports the workflows, encounter data, quality measures, cost reporting, and billing requirements the organization will actually use. Establish the following:

- Governance structure that combines clinical, operational, financial, compliance, technology, and quality.
- Service and workforce matrix that identifies required services, staffing credentials, supervision, capacity, and productivity.
- Sustainable operating budget that separates temporary grant supported costs from recurring costs that will remain after the grant period.
- Revenue cycle plan that addresses eligibility, capturing encounters, payer requirements, claims, denials, payment reconciliation, and PPS reporting.
- [Cost reporting process](#) that aligns the general ledger, payroll, encounter data, allocation methodology, and supporting documentation.
- Performance dashboard that brings together access, census/volume, workforce, quality, utilization, revenue cycle, reimbursement, and cost.
- Sustainable grant plan that identifies how each major expense or service will be supported when grant funding ends.

Just as CCBHC programs are designed to integrate the physical and mental needs of the client, sustainability involves integrating the financial and operational aspects of the organization. Quality performance is not only a clinical issue. Under some PPS methodologies, quality is directly connected to bonus payments. Patient access affects staffing and scheduling. Care coordination affects labor costs. Encounter capture affects reporting and reimbursement. Technology affects quality reporting, billing, and cost. Hence an [executive dashboard](#) must be designed to view both [financial and clinical KPIs](#) so that leadership can see all aspects of the model in one place.

The one thing that is always looming in behavioral health is Medicaid. Medicaid is always changing and although it is a federal program, each state places its own caveats which makes it a more complex environment. And why would 2027 be any different? CMS has issued an interim final rule implementing an 80 hour per month community engagement requirement for certain Medicaid adults. States are required to implement this requirement no later than January 1, 2027. The rule does include certain exemptions such as individuals who are medically frail or people who are participating in a drug or alcohol rehab or treatment program. Please note that each state is responsible for determining who is subject to the requirement and who meets the requirements for the exemption.

For behavioral health organizations, front end eligibility becomes more difficult but ultimately even more important. Organizations should not attempt to make Medicaid eligibility determinations themselves but must understand their state's approach and really strengthen eligibility verification, re-verification, intake questions, documentation workflows, patient communication, and referral processes. Those organizations who serve substance use disorder populations should pay close attention to how their state operationalizes treatment program exemption and what documentation will be needed to support it. After all, lack of coverage is not just an access issue but will quickly become a revenue cycle and continuity of care issue.

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In the meantime, this is what senior leadership should be focused on and the questions that you should ask yourselves:

1. What does the organization look like after the grant? Build a forecast that shows positions, services, technology, and infrastructure that should remain once the grant funding ends.
2. What is your state's PPS methodology? Ensure that leaders from all departments (finance, RCM, clinical, compliance, and quality) understand what creates a payable encounter, what is included in the rate, and what data is needed to support the payment.
3. Is your cost reporting structure operational? Reconcile financial, payroll, encounter, and service data throughout the year, not just at year end.
4. What additional costs will be incurred at this capacity? Review staffing and tie any staffing growth and service expansion to access needs, productivity, utilization, reimbursement, and the ability to sustain those costs after the grant ends.
5. Have we connected quality to financial performance? Build dashboards that show how access, outcomes, staffing, and reimbursement are working together or where they are not aligned.
6. Are we prepared for Medicaid eligibility changes? Review your front end processes and monitor state specific implementation requirements.
7. Do we have an exit strategy for every grant funded expense? Know how costs that are associated with the grant will be reduced, replaced, or sustained once the grant period ends.

The organizations that succeed will not necessarily be the ones who add the most services or spend the grant monies the quickest. They will be the organizations that use this time and money to build a sustainable model for the future. This is the biggest lesson. New funding can create access but funding alone does not create sustainability. Sustainability is determined by understanding the cost of care, building the right workforce, capturing the correct data, protecting reimbursement, measuring performance and ultimately making decisions regarding the future of the services and not just the current funding.

Next: Cost Reporting →

2025 Home Health Trends: What the Data Reveals

By: Patrick Daly & James Fiderio

SimiTree annually prepares the largest number of [Medicare cost reports](#) in the home health industry. Using the combined data compiled from ~1500 selected agencies, SimiTree has derived [key statistical analyses and benchmarks](#) pertaining to the vital financial and operational KPI’s used in the home health industry to deliver a sneak peek at 2025 trends. These analyses provide insight into the financial and operational performance of the industry, as well as providing the data analytics needed to identify key trends within the industry. From these derived calculations we have noted many of our key findings in the analysis provided below.

The home health industry in 2025 saw increases in median cost per visit (CPV) across most major disciplines compared to the prior year. SimiTree typically benchmarks against median costs per visit rather than average costs per visit as this mirrors the approach taken by CMS and MedPAC. The most notable increase in total CPV was in PT (\$241 CPV) and PTA (\$133 CPV) services, both of which increased ~12% year over year. Another interesting finding was an 11% decrease year over year in MSW (\$201 CPV) cost per visit. Overall, though total CPV across all disciplines increased ~4% in 2025. Drilling down to direct cost per visit tells a different story though, with an average 3% decrease across all disciplines. The largest variances year over year were in MSW and HHA, down 14% and 11% compared to prior year. In summary, cost per visit is on the rise in the home health industry from an overall standpoint, however non-direct expenses seem to be driving most of the rise in total costs.

	2025 Total CPV	2024 Total CPV	Percentage Change
RN	\$234	\$218	7.2%
LPN	\$122	\$122	-0.1%
PT	\$241	\$216	11.6%
PTA	\$133	\$118	12.4%
OT	\$206	\$189	9.2%
COTA	\$126	\$121	3.9%
ST	\$194	\$192	0.8%
MSW	\$201	\$226	-11.3%
HHA	\$80	\$82	-2.0%

	2025 Direct CPV	2024 Direct CPV	Percentage Change
RN	\$118	\$116	1.7%
LPN	\$61	\$63	-3.8%
PT	\$129	\$120	7.5%
PTA	\$71	\$68	3.9%
OT	\$109	\$108	1.0%
COTA	\$67	\$70	-4.9%
ST	\$103	\$110	-6.3%
MSW	\$102	\$118	-13.6%
HHA	\$37	\$42	-10.8%

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From a regional perspective, the southwest region accounted for the highest overall average cost per visit at \$353, meanwhile the Southeast region was the lowest at an average of \$170 per visit.

Provider revenue mix was relatively in line with prior year. In 2025, Medicaid as a % of revenue dropped from 2.5% to 1.1% and Medicare dropped from 59.2% to 58.2%. These year-over-year variances attributed to an increase in other payer revenue from 38.3% to 40.7%, very likely due to increasing usage of managed care plans across the industry. From a regional perspective the revenue distribution can change drastically. Medicaid occupies a much larger slice of the revenue pie (15%-17%) in the Northeast and Midwest regions, while Medicare accounts for up to 69% of revenue for Great Plains region providers.

LUPA rates were constant year over year at ~8% nationally. Although the median rate at 8% remains relatively unchanged year-over-year, one thing to note is the discrepancy between agencies in the 25th percentile (7.04%) compared to the 75th percentile (8.31%).

**Reduce Cost
Reporting Risk.**

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We've walked in your shoes – we are clinicians, leaders, and trusted partners dedicated to advancing home health, hospice, and behavioral health. Together with our clients, we build a healthier future for the communities we serve.

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