NO. 3

SimiTree

2026 Q2

EVERYTHING YOU NEED TO KNOW

State of the Industry Newsletter

Welcome to the third issue of our newsletter! As the healthcare landscape continues to evolve, we're bringing you timely insights to help you stay informed and prepared. This quarter, we explore AI trends shaping the future of healthcare, the latest updates to the Home Health and Hospice Proposed Rules, the new Hospice Service and Spending Variation Index (SSVI), and practical strategies for reducing coding holds through stronger intake processes.

Your success is our mission, and we're just getting started.

IN THIS ISSUE:

AI: The Heart of the Modern EHR

By: Ayesha Shakoor, MSW, CHPM, LSSHP, CLHP, LSSGB and Aldin Fauni, MSHI, BSN, RN, RHIA, CHISP

Providing care is entering a new phase of digital maturity. Across home health, hospice, and behavioral health, the conversation is shifting from "Can our EHR store the information?" to "Can our EHR help us act on it faster, better, and with less administrative strain?"

That is where artificial intelligence comes in. When thoughtfully embedded into the EHR, AI can help post-acute organizations reduce documentation burden, improve care coordination, identify risk earlier, and support clinicians with smarter, more timely workflows. In behavioral health, where meaningful clinical information is frequently contained in narrative notes, assessments, treatment plans, and longitudinal histories, AI also creates an opportunity to make complex information more accessible without diminishing the importance of clinical interpretation.

Why AI in the EHR Matters

The EHR is more than a record-keeping system. It is the operational center of clinical documentation, scheduling, compliance, billing, communication, and quality reporting. If AI is going to create real value, it cannot live as a separate tool that staff have to remember to open. It has to work inside the EHR where clinicians, schedulers, billers, and leaders already spend their time.

That distinction matters. Point solutions can create novelty, but embedded AI creates adoption. When intelligence is delivered in the context of the existing workflow, users are more likely to trust it, use it, and benefit from it.

This is particularly relevant in behavioral health, where a clinician may need to review a combination of intake assessments, progress notes, medication history, risk evaluations, treatment-plan updates, and information from other providers before making a care decision. AI embedded within the EHR can help surface that information at the point of care rather than requiring clinicians to search across multiple records and screens.

continued →

Where AI Creates the Most Value

The strongest use cases are usually the ones that remove friction from repetitive work. In post-acute care, that includes documentation support, referral intake, chart summarization, visit prioritization, and compliance monitoring. A systematic review of AI-supported clinical documentation found applications involving the structuring and classification of clinical information, documentation-quality evaluation, trend identification, and error detection (Perkins et al., 2024).

A few examples stand out:

- Drafting visit narratives from dictated or structured input.
- Summarizing long clinical histories so staff can quickly find what matters.
- Extracting key details from referrals, faxed documents, or external records.
- Supporting schedule optimization based on geography, skill, and availability.
- Flagging missing documentation or potential quality risks before they become downstream problems.
- Identifying patterns in behavioral health documentation, treatment plans, or follow-up needs.
- Highlighting when required behavioral health assessments, safety plans, treatment-plan reviews, or discharge follow-ups may be incomplete or overdue.
- Organizing longitudinal information such as symptoms, interventions, response to treatment, and changes in level of risk so clinicians can more readily evaluate progress over time.

These are not futuristic ideas. They are practical applications that can reduce manual effort while improving consistency and responsiveness.

In behavioral health settings, emerging research also suggests that AI-assisted documentation can be feasible and acceptable to mental health providers when it is integrated appropriately and does not compromise documentation quality (McCrudden et al., 2026). The most immediate opportunity is not autonomous decision-making, but thoughtful assistance with the administrative and information-management tasks surrounding care.

continued →

Why Post-Acute is Uniquely Ready

Post-acute care is especially well suited for AI-enabled EHR workflows because the environment is inherently complex. In home health and hospice, care often spans multiple settings, data arrives in fragmented form, and clinical teams must make decisions quickly without always having the full picture. In behavioral health, clinicians face equally demanding documentation, coordination, and engagement challenges, often with high variability in patient needs and communication patterns.

Behavioral health information can also be highly contextual. Changes in language, engagement, functioning, living circumstances, support systems, medication adherence, or attendance may be clinically significant even when they do not appear in a single structured field. AI can help bring those patterns forward for clinician review, provided organizations recognize that a pattern identified by technology is a prompt for assessment — not a clinical conclusion.

AI can help bridge that gap by organizing information, highlighting patterns, and reducing the time it takes to move from data to action. For organizations managing growth, staffing challenges, rising acuity, or increasing administrative load, that kind of support can be transformative.

Why Behavioral Health Requires a Distinct Approach

Behavioral health is an important part of this conversation because it shares many of the same adoption drivers as home health and hospice, while also adding unique complexity. Documentation can be time-intensive, follow-up can be inconsistent, and care plans often depend on continuous reassessment and coordination across providers.

AI can support behavioral health teams by summarizing notes, identifying missed follow-up opportunities, organizing treatment history, and helping clinicians stay focused on the most clinically relevant information. It can also support intake and triage workflows, where speed and clarity are critical to timely access to care.

For example, an AI-enabled EHR could help intake teams organize referral information, identify missing records, distinguish immediate safety concerns from routine clinical needs, and route the referral to the appropriate service or level of review. During ongoing treatment, it could help clinicians see whether symptoms, functional goals, interventions, and progress documented across multiple encounters remain aligned with the treatment plan.

AI may also help organizations monitor care continuity by identifying missed appointments, interrupted services, incomplete follow-up after a crisis encounter, or patterns suggesting that a person is becoming disengaged from treatment. These indicators should not be treated as definitive judgments about a patient. Instead, they can give care teams an earlier opportunity to review the situation and determine whether outreach or reassessment is appropriate.

continued →

Behavioral health organizations must also account for the sensitivity of the information being analyzed. Clinical narratives may contain information about trauma, substance use, family relationships, housing instability, safety concerns, and other deeply personal experiences. Because language and behavior can be interpreted differently across cultures, communities, and clinical contexts, behavioral health AI must be evaluated for bias, accuracy, and unintended consequences before it is used broadly.

Just as in other post-acute settings, the goal is not to replace clinical judgment. The goal is to reduce friction so clinicians can spend more time on patient care and less time searching, sorting, and rewriting.

Adoption Requires More Than Technology

The biggest mistake organizations make is treating AI adoption as a software feature rollout. It is not. It is a workflow redesign effort.

Successful adoption requires clear governance, clinical oversight, and change management. Agencies need to define what the AI is allowed to do, where human review is required, how exceptions are handled, and how performance will be measured. Without those guardrails, even strong technology can create confusion or mistrust.

The World Health Organization emphasizes that, in the context of AI for health, "humans should remain in full control of health-care systems and medical decisions" (World Health Organization, 2021, p. 27). This principle is especially important in behavioral health, where recommendations or summaries may affect risk assessments, treatment decisions, level-of-care determinations, and how a patient's history is understood by future providers.

Governance should therefore address more than data privacy. Organizations should determine who is responsible for reviewing AI-generated content, how inaccuracies are corrected, whether patients should be informed when AI supports documentation, how potentially biased outputs are evaluated, and when the technology should not be used. Behavioral health providers should also confirm that AI-generated language accurately reflects the patient's presentation and does not introduce stigmatizing, overly definitive, or unsupported conclusions.

Trust is essential in clinical settings. Staff will adopt AI when they see that it saves time, improves clarity, and supports their professional judgment rather than replacing it.

continued →

Start With Focused Use Cases

The best implementation strategy is to start small. Choose one high-friction workflow, define success criteria, and pilot the solution with a limited group of users. Documentation support and referral intake are often good starting points because they are common, measurable, and easy to evaluate.

For behavioral health organizations, an initial pilot might focus on drafting progress-note content, summarizing treatment history, identifying incomplete intake information, or monitoring whether required follow-up activities have occurred. Measures of success should include more than time saved. Organizations should also evaluate documentation accuracy, clinician satisfaction, patient privacy, workflow impact, correction rates, and whether the tool introduces biased or clinically inappropriate language.

From there, organizations can expand into more advanced areas such as predictive risk scoring, proactive care coordination, and dynamic workflow recommendations. Predictive use cases require a higher level of scrutiny because behavioral health risk is complex and cannot always be reliably understood from historical EHR data alone. Any risk score or recommendation should remain transparent, clinically reviewed, and connected to a defined response process.

The key is to prove value early and build confidence over time.

The Real Promise of AI

The real value of AI in the EHR is not just automation. It is better care.

When administrative burden goes down, clinicians have more time for patients. When information is easier to find, teams make faster decisions. When risk is identified earlier, intervention can happen sooner. And when the EHR becomes a smarter partner in the workflow, the entire organization becomes more responsive.

For behavioral health professionals, that promise also includes more time for listening, therapeutic engagement, collaborative planning, and the human interaction at the center of effective care. AI is most valuable when it strengthens that relationship rather than competing with it.

For health IT leaders, the strategic question is no longer whether AI will enter the EHR. It already has. The better question is whether your organization will adopt it intentionally, govern it wisely, and use it to create measurable value for staff and patients alike.

Up next quarter, we'll be talking about EHR implementation timelines.

Next: Home Health Regulatory →

Contact SimiTree to discuss how we can help position your organization for success.

CONNECT →

2027 Home Health Proposed Rule: The Raise & The Risk

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

The ome health industry received a welcome surprise with the release of the CY 2027 Proposed Rule in the form of an estimated 2.4% increase in global spending. This represents the first increase in a Home Health Proposed Rule since the CY 2022 rule. In analyzing the rate setting further, CMS has refrained from including a permanent behavioral adjustment as had become common in recent years, stating that perceived behavioral changes beginning in CY 2023 are not related solely to the transition from the PPS model to the PDGM model. CMS did infuse a -3.0% temporary behavioral adjustment in an effort to claw back dollars that they feel were overpaid to the industry throughout PDGM's lifespan. These temporary adjustments are expected to continue in the coming years as well, but it is positive to see that CMS is applying the temporary adjustment in a manner that still results in an overall spending increase. While this does represent unexpected rate relief, providers must still be vigilant in budgeting for the next year as rate impacts will vary region to region and even a 2.4% increase may not match the rising costs of care the industry has incurred.

On top of rate setting, the Proposed Rule also includes several other items worth monitoring by industry providers. On the Home Health Quality Reporting Program (HHQRP) front, the Proposed Rule includes revisions to the submission deadlines for quarterly data, shifting the OASIS and HHCAHPS APU data reporting to a calendar year timeframe beginning in 2028, and commentary on aligning HHQRP more closely with the Home Health Value-Based Purchasing (HHVBP) model. Providers must also pay close attention to the fraud and abuse measures detailed in the rule, which builds upon other recent regulatory updates such as the moratorium on new providers. Key takeaways from this area include expansion to retroactive revocations rather than 30 days after notice, further scrutiny on changes of ownership and ownership relationships to bad actors, and despite this being the home health rule, commentary on assessing the proximity of hospice Medical Directors and Administrators to the agency's service area.

continued →

Finally, CMS included a few requests for information (RFIs) in the Proposed Rule, most notably seeking feedback on a home health-specific wage index, adding a quality measure to home health for advanced care planning, and the role and relationship of palliative care to the home health benefit. The last RFI here is certainly very interesting and one to pay attention to throughout the rulemaking period and over the next couple of years, as there are several directions in which this conversation could proceed based on the feedback provided.

For further detail on the CY 2027 Home Health Proposed Rule and what agencies need to do to prepare, we encourage you to watch SimiTree's comprehensive webinar and analysis!

Did you miss this live webinar? Don't worry! You can catch the recording here.

WATCH THE WEBINAR NOW →

Next: Hospice Regulatory →

Hospice Proposed Rule Includes a Service and Spending Variation Index (SSVI)

By: Maureen Kelleher

In 2024, Medicare paid a total of $2,065,335,136 for non-hospice Medicare Part A and Part B services provided during hospice election periods. During the same period, non-hospice Medicare Part D payments totaled $813,107,802. In addition, hospice beneficiaries paid approximately $335.1 million in out-of-pocket cost sharing for prescription medications.

Using the most recent data from 2024 and 2025, CMS developed a scoring system, labeled the Service and Spending Variation Index (SSVI), for all hospice programs that submitted claims in these years. Eight of the metrics are quality based, such as "No continuous care or no General Inpatient Care" or "Percentage of live discharges where beneficiaries return to the same hospice in seven (7) days." Eight metrics are related to the non-hospice spending for Medicare Part A, B, and D. (Table 9 in the Federal Register Vol. 91, No. 65 describes the threshold values and points).

Impact On Hospices

CMS will use these scores to profile providers as a source of credible information for identifying potentially fraudulent behavior, which may result in increased audit activity for higher-risk providers. The scores may also have quality and payment implications, with discussions including potential penalties of 10% or more for non-compliance.

What To Do Now

Know your program's score (which can be found at www.cms.gov). Scores range from 0 to 16, with higher scores indicating greater potential risk. If your program's score is 10 or higher, review your policies, procedures, and documentation related to covered and non-covered items and services to ensure they align with Medicare requirements.

Educate hospice patients and their families about the hospice benefit, with particular emphasis on financial responsibilities, covered versus non-covered services, and related versus unrelated conditions. In addition, the FY 2027 Proposed Rule includes a requirement to provide the Notice of Non-Covered Items, Services, and Drugs addendum to all hospice patients. Organizations should begin planning now for implementation should this requirement be finalized.

Next: Coding & OASIS →

The Importance of a Strong Intake Process

By: Tiffany Fuller

Intake is the first checkpoint for ensuring a home health episode is reimbursable and audit-defensible. A weak intake process pushes problems downstream into holds and denials that cost far more to resolve than catching them at the door. Across SimiTree's client base, Face-to-Face documentation issues account for 14% of charts on hold, with an average hold time of 7 days and wound documentation issues account for 20% of charts on hold, averaging 14 days. Together, these two categories represent a significant share of avoidable revenue delays, and both are addressable at intake.

Face-to-Face (F2F) Validation

The F2F encounter is a condition of payment, not a formality. Intake should confirm that the encounter falls within the required window (90 days prior to SOC or 30 days after), reflects the physician's own clinical documentation, and clearly supports both homebound status and skilled need. Given that F2F issues alone account for 14% of holds and add roughly a week to resolution, flagging an incomplete or untimely F2F at intake, before the first visit, gives the agency time to resolve it proactively rather than reactively.

Primary Reason for Home Health

The primary diagnosis must be clearly supported by the referral and F2F documentation and must align logically with the ordered disciplines and frequencies. A mismatch between the stated reason for care and the services ordered is a common trigger for holds. Resolving this at intake, before the SOC visit, prevents the clinician from having to reconcile conflicting information mid-episode.

Wound Documentation

Wound care episodes carry the largest hold burden of any category — 20% of charts and a 14-day average hold, nearly double the F2F average. Intake should confirm wound location, etiology, staging, size, and treatment history are documented at referral, and that orders specify dressing type, frequency, and skilled rationale. Because wound staging directly affects OASIS scoring and PDGM grouping, inconsistencies caught at intake prevent the longest and costliest holds in the entire process.

The Net Effect

F2F and wound documentation issues combined represent a substantial share of total hold volume and hold duration. Strengthening intake validation in these two areas alone; confirming F2F timing and content and ensuring wound documentation is complete before the episode begins, is one of the highest-leverage opportunities to reduce hold rates and accelerate cash flow.

THANK YOU. WE'LL SEE YOU NEXT QUARTER.

SimiTree

Your success is our mission.

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.

800.949.0388 **SimiTreeHC.com** **ContactUs@SimiTreeHC.com**