What Home Health and Hospice Agencies Actually Need From Software

A buyer's-eye view from the administration side of the office

By Charlo Mouton

Software vendors love to demo the dashboard. Agency administrators rarely care about the dashboard. What they care about is whether the claim goes out on time, whether the surveyor finds the signed order, and whether anyone can tell them, at 4:45 on a Friday, which visits are still missing documentation.

I spent more than a decade in home health and hospice administration: operations, billing, and compliance. This is a practical list of what agencies need from software, written for the people who build it and the people who buy it.

1. Deadlines the system tracks for you

Home health and hospice run on clocks. Many of them have real money attached.

- **Notice of Admission (home health).** Since 2022, Medicare home health agencies must submit a Notice of Admission within five calendar days of the start of care. File late, and payment is reduced for each day you missed.
- **Notice of Election (hospice).** Hospices face a similar five-day window after the election date, with consequences for late filing.
- **30-day billing periods.** Under the Patient-Driven Groupings Model (PDGM), home health billing runs in 30-day periods. Each period needs complete documentation before the final claim.
- **Signed orders and plans of care.** Physician signatures on plans of care and orders are a constant chase, and unsigned orders can hold up billing.
- **Assessment timing.** OASIS assessments, recertifications, and hospice recertifications all have defined windows.

Good software does not just store these dates. It surfaces them before they are missed, names the person responsible, and escalates when something slips. A spreadsheet of due dates is a record. A system that tells the intake coordinator on day three that the NOA has not gone out is a safeguard.

What to ask a vendor: "Show me what happens on day four when an NOA hasn't been filed. Who gets notified, and how?"

2. Billing that catches problems before the payer does

Most cash-flow problems in home health start upstream of billing. A visit wasn't documented. An order wasn't signed. Authorization for a non-Medicare payer expired. By the time a denial comes back, the work to fix it is three times harder.

Agencies need:

- **Pre-billing checks** that flag missing visit notes, unsigned orders, or documentation gaps before a claim is built.
- **Clear claim status** without logging into three different portals.
- **Denial tracking by reason**, so a pattern ("we keep getting denied for X with this payer") becomes visible in weeks, not quarters.
- **Payer-specific rules** for Medicaid managed care and commercial plans, which rarely match Medicare's.

What to ask a vendor: "What percentage of your customers' claims go out clean on the first pass, and how do you measure it?"

3. HIPAA safeguards that are built in, not bolted on

Every vendor will say "HIPAA" in the first five minutes. Buyers should push past the word.

HIPAA does not have a government certification. There is no such thing as being "HIPAA certified." What matters is whether the vendor will sign a **Business Associate Agreement (BAA)**, whether their own hosting and subcontractors will sign BAAs with them, and whether the product actually supports the Security Rule's safeguards.

In practice, look for:

- **Role-based access**, so an aide sees their own patients' visit details and not the entire census.
- **Audit logs** that record who viewed or changed a record and when, kept long enough to answer questions during an investigation.
- **Multi-factor authentication** and automatic session timeouts, especially on shared or field devices.
- **Encryption** of data in transit and at rest.
- **Secure messaging**, so staff stop texting patient details from personal phones.

What to ask a vendor: "Will you sign a BAA, and which of your subcontractors have signed BAAs with you?" Then ask to see the audit log for a test record.

4. Field tools for the people doing the visits

Clinicians and aides do their work in kitchens, cars, and driveways, often with poor signal. Software that assumes a desk and a good connection will be worked around, and workarounds are where documentation gaps begin.

Field staff need:

- Mobile documentation that works **offline** and syncs when service returns.
- **Electronic Visit Verification (EVV)** that meets state Medicaid requirements. The 21st Century Cures Act required EVV for Medicaid personal care and home health services, and states have implemented it in different ways.
- Visit notes that are quick to complete accurately, so charting does not spill into evenings.

What to ask a vendor: "Let me try your mobile app in airplane mode."

5. Survey readiness on demand

State surveys and accreditation visits can arrive with little notice. Administrators need to pull records, policies, training files, and evidence of corrective actions quickly.

Agencies need:

- **Personnel file tracking**: licenses, TB tests, competencies, in-service hours, with expiration alerts.
- **Quality and incident tracking**, tied to follow-up actions with owners and due dates.
- **A clean audit trail** showing who did what and when, so the agency can prove its process ran, not just that it exists.

What to ask a vendor: "If a surveyor asked for every record touched by a specific nurse in the last 60 days, how long would it take to produce?"

6. Back-office work that doesn't live in email

A surprising amount of agency operations still runs through inboxes, sticky notes, and shared spreadsheets: referral follow-ups, staffing changes, payroll questions, vendor invoices, and policy updates. These are not clinical tasks, but they decide whether the clinical work gets done.

The best systems give every task an owner, a deadline, and a home tied to the right record. That idea shaped Nebula, the back-office workspace I am building at Galaxia, now in early access. It is designed for office and staff operations and is built so patient information stays out of it.

7. Honest implementation and support

Switching systems is one of the riskiest things an agency does. Data migration, staff training, and parallel billing can strain a small office for months.

Buyers should ask for:

- A **written implementation plan** with named contacts.
- **References from agencies of similar size and service mix**, not just the vendor's largest customer.
- A clear answer on **data export**: if you leave, how do you get your records out, and in what format?

The bottom line

Agencies don't need more features. They need fewer missed deadlines, fewer denied claims, fewer surprises at survey time, and staff who are not charting at midnight. Vendors who build around those outcomes, and buyers who test for them during the demo, will both come out ahead.

Charlo Mouton is a writer and the founder of Galaxia. He writes about healthcare operations, compliance, and fintech for business readers. This article is general information, not legal, billing, or compliance advice. Check current CMS and state rules before acting.