WEEKLY PULSE · ISSUE 10 Monday, August 24, 2026

HomeCare Weekly Pulse

MICHIGAN · ILLINOIS · FLORIDA · VIRGINIA · TEXAS · OHIO · PENNSYLVANIA

The most important Medicaid, payer, EVV, enrollment, authorization and operating updates since the last issue. Published every Monday for home care professionals.

THE LEAD

The denial code is the last event — not the first.

A claim reaches the remittance after eligibility, payer assignment, provider enrollment, authorization, scheduling, documentation, EVV, coding and submission have already had their chance to fail. The denial is the visible end of that chain.[1][2]

That is why a denial code should start the investigation, not finish it. A CARC can explain the financial adjustment. A RARC can add detail. The portal may add still more. None of them, by themselves, proves the earliest operational failure.

This week's lead turns denial work into a controlled diagnosis: read the complete response, verify the governing facts, find the first failed handoff, choose one supported remedy, preserve the evidence and close only when the corrected adjudication or payment appears.

01	02	03	04	05	06
Eligibility & payer	Authorization	Service, units & EVV	Rate & payer configuration	Claim construction	Adjudication & denial

The operating question is not "What code did we get?" It is "Where did the transaction first stop matching the authoritative record?"

NATIONAL WATCH · PROJECTED RULEMAKING

The home care overtime rule is back on the calendar.

The Department of Labor's 2026 regulatory agenda projects a November 2026 final rule on the companionship and live-in worker exemptions. It is not final. Agencies should model exposure, not change pay practice based on a projected date.

DENIAL DIAGNOSIS FIELD GUIDE

The fastest route to cash is the earliest failure.

Use the same six-step sequence for every denial. The point is not to make every claim follow the same remedy. It is to make every remedy follow a documented diagnosis.

1 READ

Capture the group code, CARC, RARC, portal message, claim status and payer correspondence — not only the one-line denial label.

2 VERIFY

Check eligibility, payer assignment, enrollment, authorization, units, EVV status, documentation, claim data and timely-filing rules in authoritative systems.

3 DIAGNOSE

Find the earliest mismatch. A later denial may be only the symptom produced by an earlier eligibility, authorization, routing or visit problem.

4 CHOOSE

Select one supported path: correction, replacement, void and rebill, resubmission, documentation response, payer correction, appeal or escalation.

5 DOCUMENT

Keep the original response, screenshots, confirmation numbers, dates, contacts, attachments, filing proof and the next follow-up date together.

6 PREVENT

Repair the upstream control that allowed the failure: intake, payer mapping, authorization loading, schedule-to-EVV match, claim edit or close-out review.

CHOOSE THE REMEDY AFTER THE FACTS

CORRECT

The payer and underlying facts are right, but the claim data or transaction can be fixed.

APPEAL / DISPUTE

The payer appears wrong after the controlling facts and filing rules have been verified.

HOLD & VERIFY

A key fact is unresolved. More submission activity would add noise, duplicates or deadline risk.

THE CONTROL

One denial. One diagnosis. One documented next move.

Repeated submission is not a resolution path.

FROM THE HCRI DENIAL DIAGNOSIS & RESOLUTION GUIDE

Three denials. Three different remedies.

CARCs and RARCs are essential parts of the remittance record, but the code combination still has to be reconciled to the payer portal, eligibility, authorization, EVV and claim data.[1][2][3]

AUTHORIZATION SIGNAL	**WHAT APPEARED** The claim says authorization is missing.	**EARLIEST FAILURE** The authorization is valid, but the claim's modifier does not match the authorized service.	**SUPPORTED MOVE** Correct the claim data. An appeal would defend a claim that was built incorrectly.
TIMELY-FILING SIGNAL	**WHAT APPEARED** The payer says the filing window expired.	**EARLIEST FAILURE** The clearinghouse accepted the original transaction, but the payer portal does not show receipt.	**SUPPORTED MOVE** Preserve acceptance evidence, verify the payer's rule and dispute or appeal if the record supports it.
EVV SIGNAL	**WHAT APPEARED** The claim denies for visit verification.	**EARLIEST FAILURE** The visit exists, but an unresolved exception prevented it from reaching matched or verified status.	**SUPPORTED MOVE** Resolve the exception, confirm the final EVV state and use the payer's supported correction or resubmission path.

PREVENT THE SECOND DENIAL

INTAKE CONTROL Verify eligibility, payer and program lane before service and again when coverage changes.	**SERVICE CONTROL** Reconcile authorization, schedule, units, caregiver credentials and EVV before claim creation.	**CLOSE-OUT CONTROL** Trend root causes, not only denial codes. Close the item on corrected adjudication or cash.

FREE OPERATOR RESOURCE

Medicaid Denial Diagnosis & Resolution Guide

Use the full reference at the billing desk and in denial-review meetings.

READ THE GUIDE →

homecarerevenueinstitute.org/resources

INDUSTRY WATCH

Two developments to model — not operationalize yet.

Neither item below changes today's Medicaid claim workflow. Both could materially change home care economics or benefit design if they advance.

DOL RULEMAKING	FEDERAL LEGISLATION
Projected final rule: November 2026 · Not final	Introduced proposal · Not a current Medicare benefit

LABOR RULE

The companionship exemption debate has moved back onto the federal calendar.[16]

The Department of Labor's 2026 unified agenda projects a November final rule on the application of Fair Labor Standards Act exemptions to domestic-service workers employed by third parties. The underlying proposal would revisit the 2013 restrictions on the companionship-services and live-in domestic-worker exemptions.

The agenda itself describes competing effects: labor cost, consumer cost and Medicaid spending on one side; worker earnings, turnover, recruitment and access to care on the other. The timing is projected, and the substance is not final.

WHAT TO DO NOW

- Model scenarios by service line, state, payer and overtime concentration. Do not use a regulatory agenda date as a payroll instruction.
- Identify contracts or rate structures that would not absorb a labor-cost change, and document the assumptions behind the exposure.
- Keep compliance decisions with qualified labor counsel and the final governing rule — not a newsletter summary.

BENEFIT DESIGN

A Medicare personal-care proposal would be separate from today's home health benefit.[17]

The Medicare at Home Act proposes a new Part B personal-care benefit of up to 20 hours per week for qualifying beneficiaries. The bill text treats the service as distinct from the existing Medicare home health benefit.

It is proposed legislation — not an enrollment path, coverage rule or billing opportunity. The useful signal is strategic: federal policymakers are again debating whether ongoing personal care belongs inside Medicare's benefit structure.

OPERATING LINE

Watch the direction. Keep today's work inside today's rules.

MICHIGAN — Transition protection does not remove the need to reconcile the receiving payer.[45]

PROGRAM LANE MI Choice ↔ MICH transitions. The letters do not change unrelated Home Help or managed-care claims.

Michigan is allowing service continuity during 2026 transitions between MI Choice and the Medicare Integrated Care for Home Health program. The state says providers may continue services and receive reimbursement even when delivery occurs before the receiving entity finishes authorization.

That protection is important, but it does not tell an agency whether the receiving entity has loaded the provider, service, hours, effective date and claim route correctly. Transition files still need a member-level reconciliation.

OPERATOR ACTION

- Build a MI Choice/MICH transition roster with prior payer, receiving payer, enrollment date, authorization status, service dates and claim status.
- Preserve the outgoing and incoming records. Escalate missing transition data rather than waiting for a denial to reveal the gap.

ILLINOIS — A $1.35 million sanction turns service-hour reductions into an evidence problem.[6]

PROGRAM LANE HealthChoice Illinois managed care; Persons with Disabilities and Persons who are Elderly waiver services. Not a statewide stop-service order.

Illinois HFS sanctioned Meridian $1.35 million and required corrective action after finding problems in waiver service reductions, notices, person-centered records, informal-support documentation, supervisory review and appeal handling. HFS also imposed an enrollment hold effective August 22.

The enrollment hold does not direct existing providers to stop authorized services or stop billing. For agencies, the immediate risk is a service schedule, authorization, notice or appeal record that no longer agrees with the others.

OPERATOR ACTION

- Identify Meridian members with recent or pending hour reductions. Retain the current written authorization, notice, plan of care, appeal status and schedule together.
- Escalate conflicting or unclear instructions. Do not interpret member rights, promise an appeal outcome or substitute an agency decision for the controlling record.

FLORIDA — Today's training should produce a transition exception list.[789]

PROGRAM LANE Children's Medical Services Plan transition to Molina. Unrelated SMMC, waiver and fee-for-service lanes remain separate.

Molina's Home Health Provider Training is scheduled for August 24. Current CMS Plan members transition to Molina on October 1, and Molina materials also identify an HHAeXchange implementation for authorization, scheduling, EVV and billing workflows.

OPERATOR ACTION

- Leave training with named owners and due dates for contracting, roster and credentialing, member mapping, authorizations, HHAeXchange linkage, claim routing and first-payment validation.
- Treat training attendance as a readiness test. The agency's internal completion date should be earlier than October 1.

VIRGINIA — Keep agency claims and consumer-directed payments in separate reconciliation lanes.[1011]

PROGRAM LANE CCC Plus waiver; agency-directed and consumer-directed services. Fiscal-agent payment is not an agency claim lane.

Virginia's July 1 rate updates remain an open reconciliation item. DMAS said managed-care loading may take 30 to 60 days after the August 13 posting, followed by automatic reprocessing approximately 30 days after plan systems are updated.

Consumer-directed services use a fiscal/employer agent arrangement that varies by CCC Plus plan, while agency-directed services remain in the provider claim workflow. Combining those populations can make a claim variance look like an attendant-payroll problem — or the reverse.

OPERATOR ACTION

- Maintain an agency-claim variance file by MCO, code and date of service. Keep consumer-directed attendant payment exceptions in a separate fiscal-agent queue.
- Do not close the July rate item because a plan says it will reprocess. Close when the remittance and additional cash match the expected amount.
- If a member uses both delivery models, reconcile each lane independently and retain the service plan that identifies the arrangement.

TEXAS — The activation email was the beginning. September 1 is the revenue deadline.[1213]

PROGRAM LANE STAR+PLUS · Community First Choice · fee-for-service. Map the portal and transaction path by program and payer.

TMHP sent the IAMOnline activation email on August 18. Separately, the EDI cutover from VPN connectivity to SFTP is scheduled for September 1, with mandatory batch testing through August 31. Providers that have not migrated risk interruptions to batch claims, eligibility, claim status and remittance transactions.

A successful portal login does not prove that a clearinghouse, billing vendor or internal batch process can send and receive the revenue transactions the agency depends on.

OPERATOR ACTION

- Activate primary and backup users; confirm multifactor access to the specific applications each role needs.
- Require evidence of an end-to-end batch test: outbound claim or test file, acknowledgment, status response and inbound ERA path.
- Keep STAR+PLUS plan routing, CFC service rules and fee-for-service submission paths distinct in the cutover tracker.

THE TEST

Access is a user control. Transaction flow is a revenue control.

OHIO — Statewide rollout is complete. The remaining work is exception resolution.[14]

PROGRAM LANE Ohio HCBS · managed care · Next Generation MyCare. Resolve at the member, authorization and transaction level.

Next Generation MyCare completed its statewide rollout on August 1. The useful question is no longer whether the new program is coming. It is which members, authorizations, EVV records and claims still do not agree after transition.

Ohio's provider materials continue to route organizations to MyCare transition resources. No new broad statewide home care billing directive was identified in the August 17–22 review window, so the Pulse is not manufacturing a second announcement.

OPERATOR ACTION

- Reconcile member assignment, waiver authorization, EVV, payer ID, 277CA status, ERA/EFT and first clean payment in one exception file.
- Take unresolved examples — not general transition questions — to the plan or state. Record the answer, owner and escalation date.
- Close an exception only after the transaction and payment path works for the affected member and service.

PENNSYLVANIA — August eligibility outreach is starting before the January 2027 rules.[15][18]

PROGRAM LANE Community HealthChoices · OLTL · PROMISe. Eligibility notices apply by eligibility category, not by agency assumption.

Pennsylvania says current Medicaid expansion recipients will begin receiving mailings in August about work-requirement changes scheduled for January 2027. Monthly outreach is expected through the end of 2026.

Many people receiving HCBS may be outside the affected expansion category or may qualify for an exemption. An agency should not determine either. The operating task is to recognize the notice, direct the member to official help and keep verifying eligibility and plan assignment in the authoritative record.

OPERATOR ACTION

- Train intake, scheduling and billing staff to recognize the notice without interpreting eligibility or exemption status.
- Route member questions to Pennsylvania DHS or the member's official assistance channel; document the referral and recheck coverage.
- Keep CHC plan assignment, OLTL waiver records and fee-for-service/PROMISe claim routing in separate fields. One does not substitute for another.

CARRY-FORWARD RULE

If the facts are unchanged and the exception is closed, remove it from the work queue.

DATES THAT MATTER

Put these on the operating calendar now.

RESEARCH CURRENT THROUGH AUGUST 22, 2026

AUG 24
Florida: Molina CMS Plan Home Health Provider Training.

AUG 31
Texas: mandatory SFTP batch-testing window closes.

SEPT 1
Texas: SFTP connectivity requirement begins for affected batch EDI submitters.

SEPT 3
Florida: Molina CMS Plan PDN/FHHA training.

OCT 1
Florida: current Children's Medical Services Plan members transition to Molina.

NOV 2026
Federal: DOL projects final home care exemption rule; timing and substance are not final.

DEC 31
Michigan: MI Choice/MICH continuity guidance applies through at least year-end.

JAN 2027
Pennsylvania: scheduled Medicaid work-requirement changes begin for affected recipients.

THIS WEEK'S CONTROL PLAN

Diagnose before you submit again.

1. **READ THE WHOLE RESPONSE**
   Capture every code, message, status and attachment associated with the claim.
2. **VERIFY THE CONTROLLING FACTS**
   Reconcile payer, eligibility, authorization, units, EVV, documentation and filing rules.
3. **FIND THE EARLIEST FAILURE**
   Fix the first mismatch in the workflow — not only the last message in the remittance.
4. **CHOOSE ONE SUPPORTED PATH**
   Correct, replace, void, resubmit, document, dispute, appeal or escalate based on evidence.
5. **CLOSE ON RESULT**
   Require corrected adjudication or payment. A promise to reprocess is not closure.

BY FRIDAY, THE ANSWERS SHOULD BE YES

- ☐ Every recurring denial has a root-cause category and documented next action.
- ☐ Every affected Illinois service-hour reduction has a current written record and escalation status.
- ☐ Texas primary and backup users are active, and batch SFTP evidence is retained.
- ☐ Ohio MyCare exceptions have transaction-level evidence and an escalation date.
- ☐ Every Michigan MI Choice/MICH transition has a payer and authorization map.
- ☐ Every Florida CMS Plan transition gap has a named owner and internal due date.
- ☐ Virginia agency rate variances and consumer-directed payment issues are separate.
- ☐ Pennsylvania notices are routed to official help and coverage is reverified.

CLOSING BRIEF

THE OPERATING TRUTH

Repeated submission is not a control.

A denial resent without diagnosis can create duplicates, obscure the history and consume the filing window. Protect cash by proving what failed, what authority controls the fix, what evidence supports it and what corrected result closed it.

THE BOTTOM LINE THIS WEEK

The code names the adjustment. The evidence names the work.

The agencies that protect cash will know which claims share a root cause, which remedy each claim requires, what deadline governs it and what corrected outcome actually arrived.

QUESTION FOR OPERATORS

Which denial category creates the most rework in your agency: eligibility, authorization, EVV, payer routing or timely filing?

— JB

Julio Barea · Publisher & Editor · My Care Operator

HOW THIS ISSUE WAS BUILT

Official sources first. Operator implications second.

Research was current through August 22, 2026 using CMS, DOL, federal legislation, state Medicaid agencies, official managed-care materials and the HCRI denial guide.

Factual updates are tied to source notes. Operator Action sections are My Care Operator's editorial translation of what those developments mean for workflow, access, claims, cash and escalation.

Share the signal forward to the person who owns enrollment, authorizations, EVV, payer setup or cash reconciliation in your agency.

FREE DENIAL GUIDE

homecarerevenueinstitute.org/resources

SOURCE NOTES

1. CMS, Health Care Payment and Remittance Advice.
2. X12, Claim Adjustment Reason Codes and Remittance Advice Remark Codes.
3. Medicaid.gov, Electronic Visit Verification.
4. Michigan MDHHS, L 26-47, MICH and MI Choice continuity of care, Aug. 10, 2026.
5. Michigan MDHHS, L 26-48, MICH and MI Choice transition coordination, Aug. 10, 2026.
6. Illinois HFS, Meridian HealthChoice Illinois HCBS sanction, Aug. 14, 2026.
7. Molina Healthcare of Florida, CMS Plan Provider Training Schedule, Aug. 2026.
8. Florida AHCA, Children's Medical Services Plan transition to Molina.
9. Molina Healthcare of Florida, HHAeXchange implementation training, Aug. 2026.
10. Virginia DMAS, Waiver Rate Updates Effective July 1, 2026, Aug. 13, 2026.
11. Virginia DMAS, Consumer-Directed Services.
12. TMHP, IAMOnline Activation Email Sent August 18, 2026.
13. TMHP, EDI Connectivity Change Rescheduled for September 1, updated Aug. 18, 2026.
14. Ohio Medicaid, Next Generation MyCare program and provider resources.
15. Pennsylvania DHS, Medicaid Changes Coming in January 2027.
16. U.S. DOL, 2026 Unified Agenda; Application of the FLSA to Domestic Service.
17. Medicare at Home Act, introduced bill text, Aug. 2026.
18. Pennsylvania DHS, Community HealthChoices Operations Memos.