WEEKLY PULSE | ISSUE 11

HomeCare

Weekly Pulse

Monday, August 31, 2026

MICHIGAN | ILLINOIS | FLORIDA | VIRGINIA | TEXAS | OHIO
PENNSYLVANIA | OREGON | MASSACHUSETTS | INDIANA

The Medicaid, payer, EVV, enrollment, authorization and operating changes that matter to home care agencies.

THE LEAD

September starts with five clocks already running.

This week is less about announcements and more about deadlines. Michigan changes the login path used by HHAeXchange+ mobile users today. Texas closes its batch EDI testing window today and cuts over tomorrow. Indiana adds an optional prior-authorization workflow tomorrow. Ohio adds a broad fee-for-service home health PA requirement October 1. Florida reaches the final month before the CMS Plan moves to Molina.

AUG 31	AUG 31	SEP 1	OCT 1	OCT 1
MI MFA	TX TEST	TX + IN	OH PA	FL CMS

THE BIGGEST NEW REVENUE CONTROL

Retroactive eligibility can create coverage - and still leave the claim unbillable.

Virginia made that problem explicit this week: for applicable services, providers must obtain retrospective service authorization before billing and request it within 90 calendar days of the Medicaid eligibility determination date. The lesson is bigger than Virginia: a retroactive coverage date does not erase authorization or filing clocks.

Research current through August 30, 2026.

OPERATOR ARTICLE

Five dates control a retroactive Medicaid claim.

Retroactive eligibility is one of the easiest places for an otherwise good billing team to lose cash. The member becomes eligible for an earlier period, so the claim suddenly looks billable. But coverage is only one control. The authorization, payer and timely-filing rules still have their own dates.

1

Date of service

What was actually delivered? Confirm service, units, caregiver or clinician, documentation and EVV status where required.

2

Coverage effective date

Was the member eligible for that date of service, and under which Medicaid program or delivery system? Retroactive coverage can move this date backward.

3

Eligibility determination date

When did Medicaid actually determine the member eligible? A state may use this date to start a retrospective-authorization clock. Virginia now uses a 90-calendar-day clock for applicable services.

4

Authorization submission and effective dates

Does the service require authorization, and does the authorization cover the service, units, provider and dates? Retroactive eligibility does not automatically create authorization.

5

Claim filing deadline

What date controls initial filing, corrected filing, reconsideration or appeal? Do not assume a retroactive eligibility decision automatically extends every payer deadline.

THE CONTROL

Put all five dates in one retro-coverage case record. If billing owns only the claim deadline and authorization owns only the approval, the agency can still miss the gap between them.

OPERATOR ARTICLE | CONTINUED

Turn retroactive coverage into a controlled work queue.

The safe workflow is not "eligibility changed, send the claim." It is a short case-management process that proves every upstream requirement before submission.

1 TRIGGER

When retroactive or delayed eligibility appears, open a retro-coverage case immediately. Record the determination date and the source evidence.

2 ISOLATE

List the affected dates of service, service codes, units, program, payer and provider location. Do not mix unrelated service lanes into the same case.

3 VERIFY

Confirm the authoritative eligibility span and payer assignment for each affected date. If managed care is involved, verify the plan rule rather than applying fee-for-service assumptions.

4 AUTHORIZE

Determine whether retrospective service authorization is required, the submission method and the deadline. Submit the complete request and preserve confirmation evidence.

5 BILL

Release the claim only when the required authorization and claim-routing facts are supported. Track timely filing independently; do not let authorization work consume the filing window unnoticed.

6 CLOSE

Close on adjudication and cash - not merely on an authorization approval or a payer promise to reprocess.

VIRGINIA - LIVE EXAMPLE

Effective August 24, DMAS says applicable services for a member approved for retroactive Medicaid eligibility require service authorization before billing. Providers must request retrospective authorization within 90 calendar days of the eligibility determination date. DMAS also says managed-care plans may use different guidelines under their contracts.

Why this matters beyond one state

The operating principle is portable even when the exact rule is not: eligibility, authorization and timely filing are separate controls. Never import Virginia's 90-day rule into another state. Do import the discipline of finding the correct clock before the claim moves.

TEN-STATE HOMECARE PULSE

MICHIGAN

MFA hits the HHAeXchange+ mobile app today. NEW TODAY

PROGRAM LANE EVV - HHAeXchange+ mobile users across affected Michigan Medicaid EVV programs.

Beginning August 31, all HHAeXchange+ mobile app users must complete multi-factor authentication. Users can receive a code by text or email and will repeat MFA every 30 days. MDHHS tells users to keep the email address in CHAMPS current. For agencies, this is a field-access issue that can become a visit-capture and cash issue within a shift.

OPERATOR ACTION

- Test caregiver login and code delivery before the first affected visit, not at clock-in time.
- Fix stale email/contact information and identify a support path for users who cannot receive the code.
- Track login failures separately from visit exceptions so an access problem is not misdiagnosed as EVV noncompliance.

ILLINOIS

No new broad statewide home-care directive identified this week. QUIET WEEK

PROGRAM LANE HealthChoice Illinois / HCBS / EVV. Keep prior exceptions only where they remain unresolved.

HFS provider notices show no new statewide home-care billing or EVV directive during the August 24-30 review window. Last week's Meridian service-hour issue remains operational only for members whose authorization, notice, plan of care, schedule or appeal record still conflicts. HFS also maintains an MCO EVV-responsibility policy that can help diagnose stuck agency-based authorization/EVV handoffs, but it is not a new rule this week.

OPERATOR ACTION

- Remove closed Meridian cases from the work queue.
- For open authorization/EVV mismatches, escalate the specific member and transaction with the supporting IMPACT, authorization and visit evidence.
- Keep the team focused on live exceptions.

FLORIDA

One month to Molina: move from training attendance to member-level readiness. CARRY FORWARD - DEADLINE MATTERS

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

Current CMS Plan members transition to Molina on October 1. AHCA says existing appointments, prescriptions and prior authorizations will be honored. Molina has a Provider Insights & Updates session August 31, General Onboarding September 2 and PDN/FHHA training September 3. The useful test now is whether each affected member has a complete operational path - not whether someone attended a webinar.

OPERATOR ACTION

- Reconcile the CMS member roster to Molina contracting/credentialing, existing authorization and service schedule.
- Confirm the HHAeXchange and claim-routing setup used by the agency for the affected service line.
- Set an internal completion date before October 1 and leave training with named unresolved exceptions.

TEN-STATE HOMECARE PULSE | CONTINUED

VIRGINIA

Retroactive eligibility now starts a separate authorization clock. NEW

PROGRAM LANE Virginia Medicaid - applicable services requiring service authorization; fee-for-service and managed care must be checked separately.

DMAS issued a new bulletin August 24 requiring retrospective service authorization before billing applicable services for members approved for retroactive Medicaid eligibility. The request must be made within 90 calendar days of the eligibility determination date; late requests are denied for timeliness. DMAS also reminds providers to verify eligibility at least monthly and says MCOs may use different guidelines under contract.

OPERATOR ACTION

- Create a retro-eligibility queue keyed to the determination date, not just the retroactive coverage date.
- Before billing, verify whether the service requires retrospective authorization and which entity controls the request.
- Retain the eligibility determination, authorization submission proof and final authorization with the claim evidence.

TEXAS

Carry-forward because it matters: batch EDI testing ends today. DEADLINE TODAY

PROGRAM LANE TMHP batch EDI submitters using the legacy VPN path; real-time submitters are not the target of this cutover.

TMHP's home page still directs batch submitters to complete trading-partner testing by August 31, with the SFTP connectivity change scheduled for September 1. Separately, TMHP says the September 7 EFT distribution will be delayed one business day to September 8 because of fiscal-year close. The EDI risk is revenue-path continuity; the EFT notice is a cash-timing issue, not a denial.

OPERATOR ACTION

- Require proof that the production SFTP path is ready - not only a successful portal login.
- Confirm outbound and inbound transactions with the clearinghouse, billing vendor or internal EDI owner and retain testing evidence.
- Adjust September 7-8 cash expectations for the announced one-business-day EFT delay where applicable.

OHIO

Every fee-for-service state-plan home health claim needs PA starting October 1. NEW

PROGRAM LANE Ohio Medicaid state-plan home health fee-for-service. Applies to members including waiver participants.

A provider update published August 27 states that beginning October 1, all Ohio Medicaid state-plan home health fee-for-service claims require prior authorization. A 90-day grace period allows waiver-recipient claims that require PA to continue paying while case-manager coordination occurs; it is a transition window, not a permanent exemption.

OPERATOR ACTION

- Inventory every FFS state-plan home health member and date of service that can cross October 1.
- Confirm the authorization owner, documentation and PNM submission path before the first affected service date.
- Treat the waiver grace period as time to complete the PA process - not permission to ignore it.

TEN-STATE HOMECARE PULSE | CONTINUED

PENNSYLVANIA

Off-cycle revalidation is a provider-location risk, not routine paperwork. NEW PROVIDER-ENROLLMENT WATCH

PROGRAM LANE PROMISe enrollment / providers identified by DHS as high risk.

Pennsylvania added Medical Assistance Bulletin 99-26-06 on August 21 for off-cycle revalidation of high-risk providers. The operational point is narrow: this is not a new revalidation deadline for every agency. It matters if DHS identifies a provider or service location for the off-cycle process. High-risk screening can include home health categories and certain risk events under Pennsylvania's enrollment rules.

OPERATOR ACTION

- Make sure the enrollment/revalidation contact email and PROMISe service-location records are current.
- Route any off-cycle revalidation notice to a named owner the day it arrives; preserve submission and screening evidence.
- Review old overpayments, enrollment changes and other known screening issues before assuming the normal revalidation date controls.

INDIANA

Atrezzo adds an optional InterQual workflow September 1. NEW

PROGRAM LANE Indiana Medicaid fee-for-service prior authorization requests submitted through Atrezzo.

IHCP Bulletin BT2026142 says providers submitting FFS PA requests through Atrezzo may optionally use integrated InterQual criteria beginning September 1. The workflow is intended to guide completeness and clinical information before submission. It is voluntary, and completing it does not guarantee approval or replace Indiana Medicaid coverage rules and the clinical review hierarchy.

OPERATOR ACTION

- Decide whether the PA team will use the integrated workflow and update the internal SOP accordingly.
- Use the workflow as a completeness check, not as an approval prediction or substitute for the governing Indiana rule.
- Do not confuse this with Indiana's separate EDI+ modernization notice, which currently requires no trading-partner action.

TEN-STATE HOMECARE PULSE | CONTINUED

MASSACHUSETTS

MassHealth changed the dual-eligible TPL instructions for home health. NEW TO PULSE COVERAGE

PROGRAM LANE MassHealth home health agency billing - Appendix D, third-party-liability exceptions.

MassHealth Transmittal Letter HHA-60 revised the Home Health Agency Manual Appendix D, effective August 14. The change clarifies billing for dual-eligible Medicare and Medicaid members and updates the Third Party Appeals Unit contact information. This is a billing-desk change: the current manual needs to be the version the team actually uses.

OPERATOR ACTION

- Replace saved or printed copies of Appendix D with the revised version.
- Review dual-eligible claim workflows and make sure billers are using the updated TPL exception instructions before correcting or appealing a claim.
- Update escalation/contact references so an old Third Party Appeals Unit path does not add avoidable delay.

OREGON

No material statewide home-care billing or EVV change identified this week. QUIET WEEK

PROGRAM LANE Oregon Medicaid LTSS / in-home services. Continue current program and payer controls.

The August 24-30 official-source review did not identify a new broad statewide Medicaid home-care billing, EVV or authorization directive that warrants changing an agency workflow this Monday. Oregon's Agency with Choice option remains a newer 2026 program development, but it does not trigger a new billing control this week.

OPERATOR ACTION

- Keep prior open enrollment, authorization, service and payment exceptions moving to closure.
- Do not change billing or EVV workflow based on the absence of a new notice; continue to use the governing program and payer sources.
- Escalate live member or transaction problems and close watch items that no longer have an active exception.

DATES THAT MATTER

Put these on the operating calendar now.

AUG 31	Michigan: HHAeXchange+ mobile-app MFA begins.	AUG 31	Texas: batch SFTP trading-partner testing deadline.
AUG 31	Florida: Molina CMS Plan Provider Insights & Updates session.	SEP 1	Texas: TMHP batch SFTP connectivity cutover; Indiana: optional Atrezzo InterQual workflow begins.
SEP 2	Florida: General CMS Plan onboarding.	SEP 3	Florida: PDN/FHHA CMS Plan training.
SEP 8	Texas: announced EFT payment date for funds normally distributed Sept. 7.	OCT 1	Florida: CMS Plan moves to Molina; Ohio: FFS state-plan home health PA requirement begins.
DEC 31	Pennsylvania: year-end is a key boundary in the state's 2026 high-risk revalidation initiative for affected providers.	ONGOING	Virginia: retrospective authorization requests must be tracked from each eligibility determination date.

THIS WEEK'S CONTROL PLAN

Protect access, authorization and transaction flow before they become denials.

1 **MICHIGAN** Prove field users can complete MFA before an EVV visit depends on it.
2 **TEXAS** Get written evidence that the batch SFTP path is production-ready.
3 **VIRGINIA** Open every retroactive-eligibility case with the determination date and authorization deadline.
4 **OHIO** Build the October 1 FFS home health PA inventory now.
5 **FLORIDA** Turn the CMS transition into a member-level exception roster.
6 **MASSACHUSETTS** Update the home health TPL desk guide for dual-eligible billing.
7 **INDIANA** Decide whether the PA team will use the optional InterQual workflow.
8 **PENNSYLVANIA** Make off-cycle revalidation notices impossible to lose in a generic inbox.

BY FRIDAY, THE ANSWERS SHOULD BE YES

- [ ] EVV users can authenticate without disrupting visits.
- [ ] Retroactive-eligibility cases have explicit authorization and filing clocks.
- [ ] October 1 transitions have named owners and member-level evidence.

CLOSING BRIEF

The operating truth

Deadlines do not fail all at once.

They fail at handoffs: the user who cannot authenticate, the authorization that was never opened, the payer route that was never tested, the provider notice that sat in an inbox. This week's work is to make those handoffs visible before they become unpaid claims.

THE BOTTOM LINE THIS WEEK

Five clocks. One owner for each.

The strongest agencies will not wait for September to expose August readiness gaps. They will know which access, authorization, enrollment and transaction deadlines are live, who owns each one, what evidence proves completion and what result closes the item.

QUESTION FOR OPERATORS

Which deadline could stop cash first in your agency this week: EVV access, authorization, enrollment, payer transition or EDI connectivity?

- JB
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SOURCE NOTES

1. Michigan MDHHS, User Verification Updates are coming to the HHAeXchange Mobile App - MFA effective Aug. 31, 2026.
2. Illinois HFS, Provider Notices; Managed Care Program Policies including MCO-073, Electronic Visit Verification - MCO Responsibilities.
3. Florida AHCA, CMS Plan Transition; Molina Healthcare of Florida, CMS Plan Provider Training Schedule Update.
4. Virginia DMAS, Submitting Retrospective Service Authorization Requests for Retroactive Eligibility, effective Aug. 24, 2026.
5. Texas TMHP, New Batch Submission Method / EDI connectivity resources; EFT Payments Delayed Due to Fiscal Year End, Aug. 25, 2026.
6. Buckeye Health Plan provider update, Aug. 27, 2026, communicating Ohio Medicaid FFS home health PA requirement effective Oct. 1, 2026.
7. Pennsylvania DHS, Medical Assistance Bulletin 99-26-06, Off-Cycle Revalidation of High-Risk Providers, Aug. 21, 2026.
8. Indiana Health Coverage Programs, BT2026142, Atrezzo Provider Portal PA submission enhancement, Aug. 25, 2026; BT2026141 EDI+ migration.
9. MassHealth, Transmittal Letter HHA-60, Revised Appendix D, effective Aug. 14, 2026.
10. Oregon Health Authority / Oregon Department of Human Services official Medicaid LTSS and in-home services pages reviewed through Aug. 30, 2026.