WEEKLY PULSE | ISSUE 12

HomeCare

Weekly Pulse

Tuesday, September 8, 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

A few small changes this week can still turn into unpaid visits.

Nothing in this issue is especially complicated. But several states changed a form, a login process, an authorization route, a payer or an EVV requirement. Those are the changes that get missed in day-to-day work and show up later as denials. Texas, Virginia, Michigan, Indiana and Ohio deserve the most attention this week.

SEP 1	SEP 3	SEP 30	OCT 1	OCT 1
TX CUTOVER	OH + IN	FL + IN	VA + IL	FL CMS

THE ONE THING I WOULD DO

Keep one shared list of every client affected by a change.

Texas is a good example. Baylor Scott & White and FirstCare stopped participating in Texas Medicaid after August 31. Older dates of service stay with the old plan. September 1 and later dates move to the new MCO, and EVV may need to be updated too. The easiest way to keep this straight is one list with the client, the key dates, what needs to change, who owns it and whether the first claim worked.

Research current through September 8, 2026.

USEFUL THIS WEEK

When something changes, put the affected clients on one list.

Most transition problems are simple. Billing has one date. Authorization has another. EVV was never updated. Or everyone thought someone else owned the change. A shared transition list prevents a lot of that. It does not need to be fancy.

1

Client + program

Name the client, service, program and current payer. Keep one row for each client/service combination that is actually affected.

2

Key dates

Write down the last date under the old setup and the first date under the new one. Keep filing and appeal deadlines in their own fields.

3

Authorization

Note whether the current authorization stays valid, whether a new one is needed and who is responsible for getting it.

4

System changes

List any payer code, EVV authorization, portal, clearinghouse or login change that has to be made.

5

Owner + result

Put one person on it. Keep the item open until the first new transaction clears and the claim pays.

KEEP IT SIMPLE

One list. One owner. One status. The point is to keep the change from getting lost between intake, authorization, EVV and billing.

USEFUL THIS WEEK | CONTINUED

Six simple steps when a payer or rule changes.

You do not need a new committee or a complicated project plan. You need to know who is affected, what date the change starts and whether the new setup actually works.

1 FIND
Identify the clients and services the change actually affects.

2 SPLIT
Separate dates of service before and after the effective date.

3 CHECK
Verify eligibility, payer and authorization using the current state or payer source.

4 UPDATE
Make the payer, EVV, portal, clearinghouse or login changes that are required.

5 TEST
Check the first new EVV record, eligibility response or claim acknowledgement. Save the proof.

6 WATCH
Do not close the item just because setup is done. Watch the first claim through payment.

TEXAS EXAMPLE

Baylor Scott & White and FirstCare left Texas Medicaid managed care effective September 1. Dates of service through August 31 stay with the old plans, and TMHP says providers have 95 days to submit those claims. September 1 and later dates move to the member's new MCO. For EVV-required services, the new MCO and authorization also need to be reflected in EVV. That is exactly the kind of change that belongs on one shared list.

Why I am spending time on this

This is not just a Texas issue. Florida has an October 1 plan change. Illinois has an October 1 eligibility change for some members. Michigan is changing how HHAeXchange users log in. Virginia has new authorization forms. Different states, same management problem: someone has to own the client list and the effective date.

TEN-STATE HOMECARE PULSE

MICHIGAN

HHAeXchange users are moving to MiLogin. NEW THIS MONTH

WHO THIS AFFECTS HHAeXchange Payer and Provider Agency Portal users, plus certain Services Portal users.

Michigan says HHAeXchange Portal users will have to access the portal through MiLogin during September. Most payer and provider agency users should use MiLogin for Business. Certain employer-of-record users use MiLogin for Citizens. The notice does not give one exact cutover date, so this is worth testing now.

WHAT TO DO

- Have each user sign in through the correct MiLogin account and make sure the existing HHAeXchange credentials work.
- Make one person responsible for portal access and user problems.
- Keep this separate from last week's HHAeXchange+ mobile-app MFA change. They are two different login changes.

ILLINOIS

Some Medicaid members may lose full coverage October 1. WATCH OCT 1

WHO THIS AFFECTS Members affected by the new federal noncitizen Medicaid eligibility rules.

HFS says federal eligibility changes take effect October 1 for many noncitizens. Some members have been told that their current Medicaid health plan will end September 30, and HFS is sending more notices in September. Agency staff do not need to interpret immigration rules. They do need to check the official eligibility and payer record for clients who may be affected.

WHAT TO DO

- For clients flagged by an official notice or eligibility check, verify eligibility and payer before October 1 and again after October 1.
- Use the state's eligibility record, plan data and the member notice. Do not ask billing or scheduling staff to decide immigration status.
- Escalate any coverage or payer change before the next affected visit.

FLORIDA

Florida is taking comments on FD Waiver rates through September 30. FD WAIVER

WHO THIS AFFECTS Familial Dysautonomia Waiver providers. The CMS Plan change is separate.

AHCA has proposed changes to Familial Dysautonomia Waiver rates, the rate-setting method and transportation language. Comments are open through September 30. This is not a statewide home-care rate change. Separately, current CMS Plan members are still scheduled to move to Molina on October 1.

WHAT TO DO

- If you serve the FD Waiver, review the proposed rate and transportation changes against what you are doing today.
- If the proposal creates a real cost or access problem, submit a specific comment by September 30.
- If you serve CMS Plan members, keep the October 1 Molina transition on a separate client list.

TEN-STATE HOMECARE PULSE | CONTINUED

VIRGINIA

Use the new CCC Plus forms by October 1. DUE OCT 1

WHO THIS AFFECTS CCC Plus Waiver providers, including personal care, private duty nursing, respite and services facilitation.

DMAS updated the CCC Plus Waiver Provider Manual on September 2 and revised the DMAS-97A/B Plan of Care and DMAS-99 assessment forms. Providers must use the new versions no later than October 1. DMAS says older versions submitted after that date can result in a service authorization denial.

WHAT TO DO

- Replace the old DMAS-97A/B and DMAS-99 forms in shared drives, EHRs, intake packets and authorization folders now.
- Tell the staff or vendor that prepares authorization packets about the October 1 deadline.
- Review anything already in progress that may be submitted on or after October 1.

TEXAS

Texas has two live changes to watch. LIVE NOW

WHO THIS AFFECTS EVV-required services statewide, plus members moving from Baylor Scott & White or FirstCare Medicaid plans.

First, the allowed share of EVV transactions using alternative devices dropped from 75% to 50% on September 1. Second, Baylor Scott & White and FirstCare ended Texas Medicaid participation after August 31. TMHP says dates of service through August 31 stay with the old plan and have a 95-day submission window. September 1 and later claims under those old plans will be rejected.

WHAT TO DO

- Run the EVV Usage Report and make sure alternative-device use is below 50%.
- Separate August 31-and-earlier dates from September 1-and-later dates for members who changed plans.
- For EVV-required services, confirm the new MCO and authorization are in EVV before billing the new plan.

OHIO

PDN authorization routing changed September 3. LIVE NOW

WHO THIS AFFECTS Private duty nursing across FFS, PASSPORT, DODD waivers, Ohio Home Care Waiver and managed care.

Ohio's new rule 5160-12-02.3 took effect September 3. Where the PDN authorization goes now depends on the member. FFS non-waiver and PASSPORT requests go to ODM. DODD waiver requests start with the county board SSA. Ohio Home Care Waiver requests start with the waiver case manager. Managed-care providers follow the MCO process. The rule also covers emergency PDN.

WHAT TO DO

- Make sure each PDN client is tied to the correct authorization route.
- Do not use one generic PA process for every PDN case.
- Update the emergency-PDN procedure so staff know what has to be documented and who must be notified.

TEN-STATE HOMECARE PULSE | CONTINUED

PENNSYLVANIA

Check this week's PROMISe RA for date-of-death recoveries. NEW RA ALERT

WHO THIS AFFECTS PROMISe providers, except provider type 07.

Pennsylvania posted a September 7 remittance-advice alert after an audit found date-of-death discrepancies. DHS recovered claims where the eligibility record showed the member died before the billed date of service. The alert explains which ICNs are affected and what to do if the death date is wrong or the service actually occurred before the recorded death date.

WHAT TO DO

- Check the current RA for these recovery adjustments.
- Compare the billed date of service with the official date-of-death record before writing anything off or rebilling.
- If the death date is wrong, contact the county assistance office. If the service was before the death date, correct and resubmit the claim.

INDIANA

Storm-related billing relief is available, but you have to request it. TEMPORARY RELIEF

WHO THIS AFFECTS IHCP fee-for-service and managed care cases affected by the August severe storms and flooding.

IHCP Bulletin BT2026147 gives temporary billing and authorization flexibility through November 30 for disaster-related disruptions. Retrospective authorization may be accepted when submitted within 60 calendar days of the date of service. Timely-filing relief is separate. It has to be requested and supported; it is not automatic.

WHAT TO DO

- Put affected cases on a separate disaster list with the member, date of service, problem and supporting documentation.
- Submit retrospective authorization as soon as possible. Do not wait for the November 30 end date.
- If you need timely-filing relief, use the required claim note and attach documentation. Do not assume the deadline was waived.

TEN-STATE HOMECARE PULSE | CONTINUED

MASSACHUSETTS

MassHealth has a new Provider Handbook. NEW RESOURCE

WHO THIS AFFECTS All MassHealth providers. Service-specific manuals, regulations and bulletins still control.

MassHealth announced a new Provider Handbook on September 1. It looks useful as a starting point for finding processes and resources. It is not a replacement for the service-specific manual, regulation, transmittal or payer instruction that actually controls the claim.

WHAT TO DO

- Add the handbook to the team's approved resource list.
- Use it to find the right rule or process, then verify the source that actually governs the service.
- Do not rewrite an HHA or LTSS procedure based only on a handbook summary.

OREGON

No major statewide home-care billing change this week. QUIET WEEK

WHO THIS AFFECTS Oregon Health Plan Medicaid LTSS and in-home services.

I did not find a new broad statewide home-care billing, EVV or authorization change in the official Oregon provider updates reviewed for September 1-8. There is nothing here that should cause an agency to rewrite its workflow this week.

WHAT TO DO

- Keep current eligibility, authorization, EVV and claim exceptions moving.
- Ignore notices that do not apply to your provider type or program.
- Keep watching OHA Provider Matters and the OHP provider portal for a material change.

DATES THAT MATTER

These are worth putting on the calendar.

SEP 1	Texas: 50% EVV alternative-device limit begins; BSW/FirstCare Medicaid participation ends.	**SEPTEMBER**	Michigan: HHAeXchange portal access moves to MiLogin. The notice reviewed does not give one exact cutover day.
SEP 3	Ohio: new PDN authorization and provider rules take effect.	**SEP 30**	Florida: comments close on the Familial Dysautonomia Waiver amendment.
SEP 30	Indiana: Rendering Provider Agreement/Attestation is no longer required for certain already-enrolled linkage transactions.	**OCT 1**	Virginia: new CCC Plus DMAS-97A/B and DMAS-99 forms become mandatory.
OCT 1	Illinois: federal noncitizen Medicaid eligibility changes take effect for affected members.	**OCT 1**	Florida: current CMS Plan members transition to Molina.
NOV 30	Indiana: current storm-related billing and authorization flexibilities end unless extended.	**95 DAYS**	Texas: old-plan claims for BSW/FirstCare dates of service through Aug. 31 must be submitted within the stated filing window.

THIS WEEK'S SHORT LIST

If I were running the billing operation, these are the things I would make sure happened this week.

1 **MICHIGAN** Test MiLogin access now instead of waiting for the HHAeXchange cutover.
2 **TEXAS** Separate old-plan and new-plan dates of service and make sure EVV is updated.
3 **VIRGINIA** Remove the old CCC Plus forms before October authorization work is submitted.
4 **ILLINOIS** Build an October 1 eligibility recheck list for clients who may be affected.
5 **INDIANA** Track storm-related authorization and timely-filing requests separately.
6 **PENNSYLVANIA** Check the current RA for date-of-death recoveries.
7 **OHIO** Make sure every PDN case is going through the right authorization path.
8 **FLORIDA** If applicable, review the FD Waiver proposal and keep CMS Plan transition work separate.

BY FRIDAY, I WOULD WANT THREE YES ANSWERS

- [ ] Did we identify every client affected by a September or October change?
- [ ] Does each change have an owner and an effective date?
- [ ] Where the change is already live, did we test the first new transaction?

CLOSING BRIEF

The practical point

THE SIMPLE VERSION

Know which clients are affected. Know the date. Know who owns the change. Then check the first claim. If those four things are clear, most transition problems are manageable.

THE BOTTOM LINE THIS WEEK

Most of this week is ordinary operational stuff. That is why it gets missed.

A form changes. A payer changes. A login changes. An authorization goes to a different place. None of that is hard by itself. The problem is when the change sits between departments and nobody notices until the claim comes back. Keep the affected client list tight, give each item an owner and watch the first claim after the change. That is enough.

QUESTION FOR OPERATORS

Which of these changes actually affects your agency this week?

- JB
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SOURCE NOTES

1. Michigan MDHHS, HHAeXchange Electronic Visit Verification Portal Access is Moving to MiLogin; Michigan EVV program pages, reviewed Sept. 8, 2026.

2. Illinois HFS, NEW Changes Coming to Medicaid; Health Benefits for Immigrants; Medicaid HR 1 FAQs, reviewed Sept. 8, 2026.

3. Florida AHCA, Familial Dysautonomia Waiver amendment public notice/comment period, Sept. 1-30, 2026; CMS Plan Transition resources.

4. Virginia DMAS, CCC Plus Waiver Provider Manual Update, Chapters II and IV; new Appendix E; DMAS-97A/B and DMAS-99 update, effective Sept. 2, 2026; Virginia EVV page.

5. Texas TMHP/HHSC, EVV Alternative Device Reduction Schedule; Sept. 2, 2026 update on Baylor Scott & White and FirstCare claim filing; EVV transition guidance.

6. Ohio Administrative Code Chapter 5160-12, including Rule 5160-12-02.3, Private duty nursing: procedures for service authorization, effective Sept. 3, 2026.

7. Pennsylvania DHS, PROMISe Remittance Advice Alert, Date of Death Recovery, banner dated Sept. 7, 2026.

8. Indiana Health Coverage Programs, BT2026147, Temporary billing and authorization flexibilities related to August 2026 severe storms, Sept. 3, 2026; BT2026149, Sept. 8, 2026.

9. MassHealth, Provider Remittance Advice Message Text - September 2026, Sept. 1, 2026, announcing the MassHealth Provider Handbook.

10. Oregon Health Authority, OHP provider portal and official provider resources reviewed through Sept. 8, 2026.