Medicare Post-Open Enrollment Essentials Best Practices for Home Health Agencies



PRESENTED BY:

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2026 Home Health Webinar Series

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Regina Wild is an experienced healthcare professional with more than 15 years in the industry, bringing a well-rounded background in nursing, business development, and contracting/credentialing. She also holds a certification in revenue cycle management. Regina's expertise spans a variety of healthcare settings, giving her a broad perspective on the challenges and opportunities providers face. Her primary focus is Managed Care contracting, where she helps providers improve reimbursements, strengthen referral relationships, and grow their market presence. Regina is passionate about supporting healthcare organizations and guiding them through the complexities of an ever-changing healthcare landscape.

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Topics



ENROLLMENT PERIODS
IMPORTANT TIMELINES



OPERATIONAL BEST
PRACTICES

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Enrollment Periods

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Medicare Enrollment Periods

Initial Enrollment (3 months before they turn 65 to 3 months after 65)

21 months after they start receiving disability

Immediately if they receive ALS disability

ESRD- 4 months after start of dialysis

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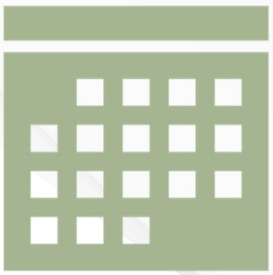
Medicare Advantage Enrollment Periods

- Annual Open enrollment October 15- December 7th- changes take effect January 1st
- Medicare Advantage Open enrollment- January 1- March 31- takes effect 1st of following month
- Special enrollment-
  - Move service areas
  - Moved out of an institution SNF/ IRF
  - Released from jail
- Understanding Medicare Advantage and Medicare drug plan enrollment.



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More Special Enrollment Periods

- Lose Medicaid coverage
- Switch to a Plan with 5-star quality rating
- If current plan has a 3-star rating for last 3 years
- Dual Eligible
  - January-March
  - April-June
  - July-September
  - In 2025 they can change monthly
- Chronic Special needs- Can join anytime
- Group Coverage or Employment coverage ends

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- IEP- 7 months to enroll in Medicare for the first time when you turn 65
- AEP- October 15th-Dec 7th- Make changes to your Part C and/ or Part D coverage
- OEP- Jan1st- March 31- enrollees can switch one time to another plan or back to Medicare
- SEP= Special enrollment Period- Qualifying events

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Important Timeline

If member enrolls during open enrollment – it **should** show by January 1st

Health plans are required to notify Medicare by the last day of each month of any enrollments

Medicare has until the 10th of the month to update the eligibility



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Operational Focus

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The January 1 patient transition: where breakdowns occur

An operational chain with compounding downstream risk

01 Member changes plan → **02** Agency network status differs → **03** Authorization / billing process changes → **04** Visits or claims disrupted

Control point: confirm member ID, effective date, exact product / PBP, network status, servicing provider, and authorization route.

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Continuity of care: an important CMS protection

Minimum 90-day transition for an active course of treatment in qualifying MA plan switches

A new MA coordinated care plan may not require prior authorization for an active course of treatment during the first 90 days of enrollment.

WHAT IT DOES

Creates a regulatory protection intended to reduce treatment interruption when an enrollee switches to a new MA coordinated care plan.

WHAT IT DOES NOT DO

Automatically establish in-network status, resolve payment terms, eliminate medical-necessity rules, or guarantee claim payment.

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Prior authorization: operational standards now matter

Decision timelines became effective in 2026; payer APIs scheduled for 2027

72 HOURS

Maximum for expedited medical-service prior authorization decisions, subject to applicable rules and clinical urgency.

7 CALENDAR DAYS

Maximum for standard medical-service requests under CMS-0057-F, with applicable exceptions.

JAN 1, 2027

Payer prior-authorization APIs scheduled to go live; integration is a change-management opportunity.

Executive action: standardize submissions, capture denial reasons, escalate late decisions, and test payer workflows before January.

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Referral relationships will feel the change

Hospitals and physicians need confidence that your agency can accept the patient

- Publish a product-specific referral acceptance matrix by county and payer network.
- Give discharge planners a single escalation contact for coverage / authorization bottlenecks.
- Maintain a rapid eligibility + product verification process before acceptance and at start of care.
- Track referrals declined or delayed because of network, authorization, or benefit concerns.
- Educate partners about continuity protections without promising authorization or payment.

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90-day readiness roadmap

Assign executive ownership and checkpoints

OCT 8–31

Map exposure

Top 10 payer products; plan exits; county networks; contract rates; high-risk current patients.

NOV 1–DEC 15

Lock processes

Authorization transition playbooks; patient outreach; hospital partner matrix; escalation owners.

Jan 1–JAN 15

Verify & triage

Reverify Jan 1 eligibility, reconcile open auths, active care, payer effective dates and claims.

JAN–MAR

Monitor switches

Monthly OEP rechecks, payer scorecard, referral fallout, denials, collections and clinical delays.

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Five metrics for the CEO dashboard

Lead indicators reveal problems before collections are affected

01	% active MA census reverified for next effective date
02	Open PA exceptions > target turnaround
03	Payer-related start-of-care delays / missed visits
04	Claims denied or underpaid after plan switch
05	Net revenue per visit and days in A/R by MA product

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Executive decisions to make now

ACCOUNTABILITY

Name one executive sponsor and operational leads across managed care, intake, clinical operations and RCM.

VISIBILITY

Fund product-level eligibility intelligence, payer reporting, and a weekly risk scorecard.

PROTECTION

Approve a continuity-of-care exception and payer escalation workflow.

STRATEGY

Prioritize contracting based on unit economics, access, quality and referral demand.

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A Proactive Payer Change Detection Strategy

Best practice	Recommended agency action
Monitor payer announcements	Review plan exits, service-area changes, contract terminations, and network participation updates
Review Annual Notices of Change (ANOCs)	Encourage patients to review their notices, normally distributed in September, for changes effective January 1
Track plan-level changes	Identify changes in the actual plan, not just the insurance company's name

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A Proactive Payer Change Detection Strategy

- A familiar payer name does not guarantee the same benefits, network, administrative rules, or reimbursement arrangement.
- Agencies need to distinguish between the insurance carrier, Medicare Advantage plan, contracted product, and claims administrator.
- A current eligibility verification does not prove that the same coverage will remain active January 1.
- A pre-January verification should be followed by confirmation once the new coverage is effective.
- **Best practice: Create a centralized 2027 Payer Change Matrix managed by your contracting or managed care department.**

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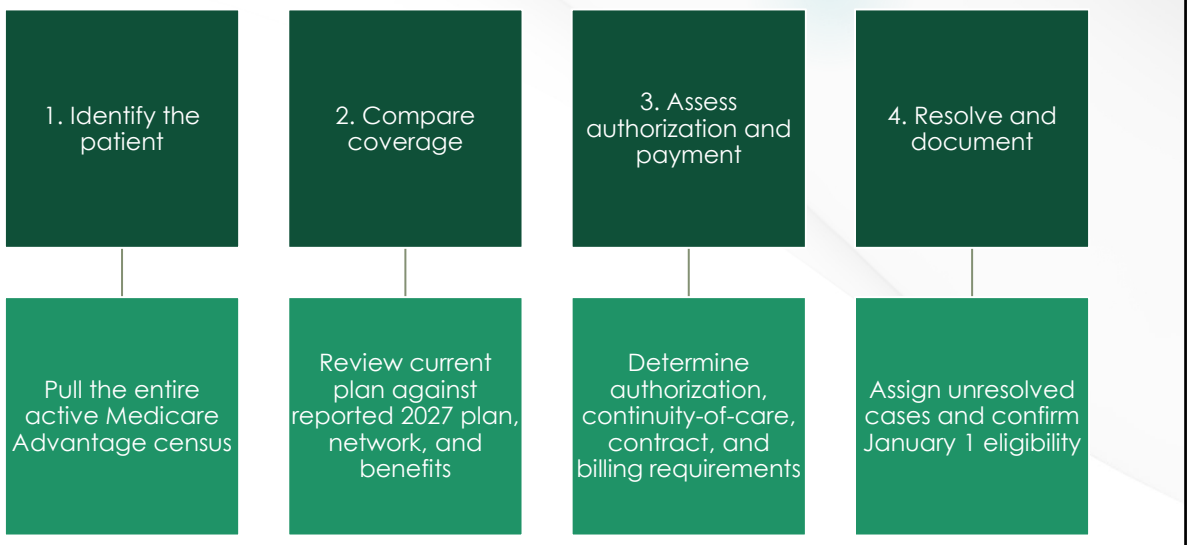

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Priority classification

- High
- Plan termination, confirmed out-of-network status, disputed authorization, or immediate continuity-of-care risk.
- Medium
- Reported plan change awaiting confirmation, uncertain authorization transfer, or benefit changes requiring follow-up.
- Low
- Coverage and network confirmed, with required authorization and billing documentation complete

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Important CMS protection:

- For patients actively undergoing treatment who switch to a new Medicare Advantage coordinated care plan, CMS requires a minimum 90-day transition period during which the new plan cannot require prior authorization for the active course of treatment. This protection does not automatically establish network participation or payment terms. CMS.gov

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Staff Training: Every Department Has a Role

- I recommend role-specific training rather than one general open enrollment presentation. Each department needs to understand what to identify, how to respond, and when to escalate.

Department	Required training	Recommended frequency
Intake / Admissions	Insurance verification, plan identification, product/network differences, and effective dates	Initial training + weekly during transition
Authorization Team	New-plan requirements, authorization tracking, transition protections, denials, and expedited requests	Initial training + weekly case reviews
Clinical Managers / Field Staff	Recognizing plan changes, documenting continuity needs, and reporting coverage concerns	Initial training + refresher

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Staff Training: Every Department Has a Role

Billing / Revenue Cycle	Payer IDs, claims routing, effective-date splits, contractual rates, and denial prevention	Initial training + weekly reconciliation
Managed Care / Contracting	Plan exits, new products, contract participation, payer bulletins, and escalation contacts	Weekly monitoring
Leadership	Financial exposure, at-risk census, operational delays, and payer-level performance	Weekly dashboard

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- Medicare Verification
- Medicaid Verification
- Health Plan Verification
- Every patient
- Every admission/ Re-cert
- Every month
- Pre-claim

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Five essential training modules

- **Module 1: Accurate eligibility and benefits verification**
- Teach staff to :
  - Confirm payer
  - Identify Exact plan/product
  - Obtain correct Member ID
  - Establish effective date
  - Verify agency network participation
  - Clarify authorization rules
  - Document patient cost-sharing where applicable
  - Require verification at admission, at the coverage transition, and whenever a new plan is reported.

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Module 2: Prior authorization and continuity of care

- Train staff
  - On the 90-day active-treatment transition protection
  - What clinical documentation to retain
  - How to request expedited reviews
  - How to escalate inappropriate authorization barriers

CMS.gov

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Module 3: Patient and referral-source communication

- Teach staff to:
  - Ask about plan changes without steering beneficiaries toward a particular insurer
  - Explain the need for updated coverage information
  - Notify clinical leadership when continuity of care could be affected

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Module 4: Revenue cycle and reimbursement protection

- Train billing staff to:
  - Identify services spanning December and January
  - Assign the correct coverage to each date of service
  - Verify claims submission requirements
  - Distinguish payer denials from eligibility or authorization errors

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Module 5: 2027 electronic prior authorization readiness

- **CMS requires impacted payers to implement new prior authorization API capabilities beginning January 1, 2027.**
- Train designated staff on:
  - Supported payer/EHR workflows
  - Electronic status tracking
  - Denial reason documentation and fallback procedures
- *Not every agency system will necessarily have an integrated workflow available on day one.*

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Training recommendation

- Use actual patient scenarios, followed by a short competency exercise.
- For example, present a patient currently receiving home health services under one MA plan who elects a different plan effective January 1. Ask intake, authorization, clinical, and billing teams to demonstrate their respective next steps.

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Suggested Performance Targets

AGENCY-DEFINED TARGETS

2027 Coverage Verified	Network Status Confirmed	Authorization Review Complete	Staff Competency Completion	High-Risk Case Resolution
95%	100%	100%	100%	100%
Active MA census with coverage confirmed for the relevant effective date.	Plans/products represented in the census reviewed for agency participation.	Affected patient cases assessed for new-plan authorization and transition requirements.	Relevant employees who completed assigned training and demonstrated competency.	Escalated cases resolved or assigned documented continuity-of-care plans.

Targets are proposed management goals, not CMS-mandated performance standards.
Verify effective-date coverage again when January 2027 begins.

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Practical tool: Payer Change Tracking Checklist

- ☐ Current insurance carrier and exact plan/product recorded
- ☐ New 2027 insurance carrier, plan/product, and effective date obtained
- ☐ January coverage verification completed when effective
- ☐ Agency participation confirmed for the new plan/product
- ☐ Patient's active treatment and continuity requirements reviewed
- ☐ Prior authorization status documented
- ☐ Applicable reimbursement and claims-routing requirements confirmed
- ☐ Responsible team member and escalation status documented
- ☐ Patient and clinical team appropriately notified

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One additional recommendation:

- Designate a single Medicare Advantage transition coordinator to maintain the payer change matrix, lead weekly cross-functional meetings, and report unresolved patient and financial exposure to executive leadership. This person does not need to perform every task, but should own the process and escalation pathway.

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Take Aways



- Open enrollment readiness is not simply an eligibility verification process. It is a coordinated patient retention, continuity-of-care, revenue protection, and payer management strategy. Every department must know how to identify a payer change, what action is required, and who is accountable for resolving it.

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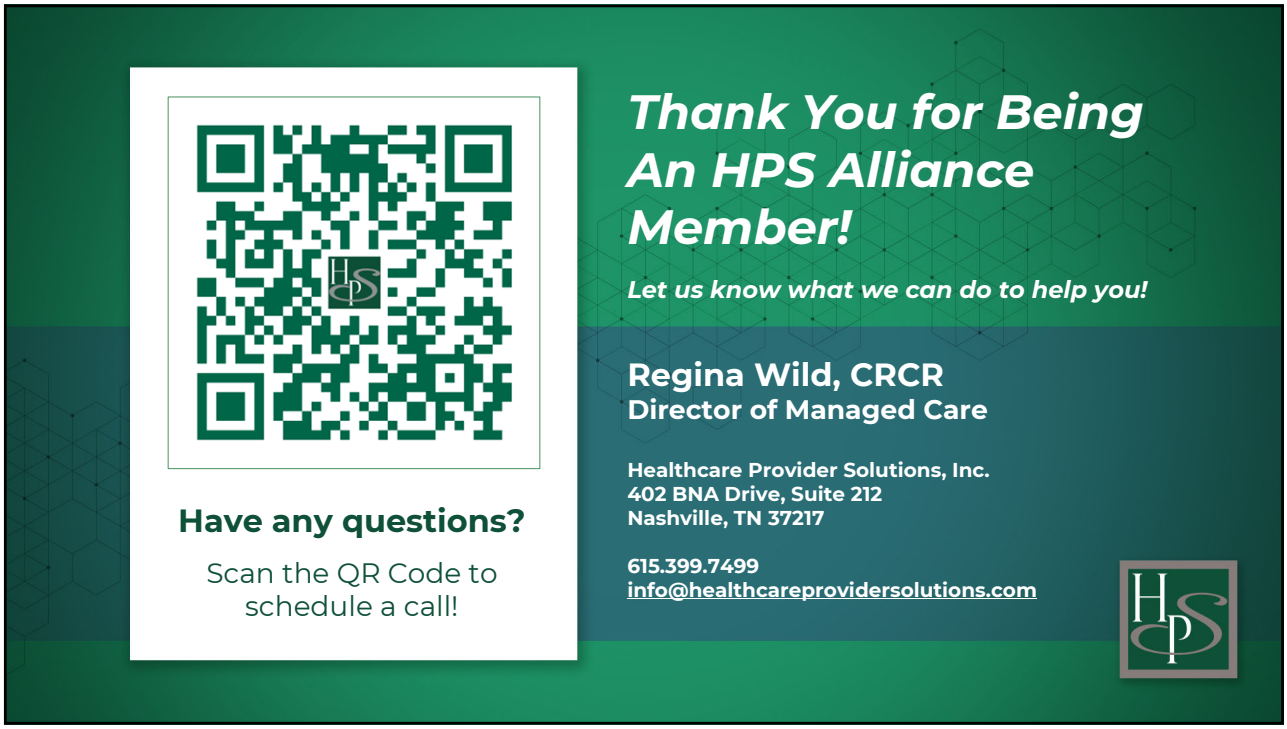
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