

Edition - Oct 2026

Care in Motion

The Value-Based Care Playbook



— Open Enrollment Starts the Clock



54 Days to Review, Decide, and Prepare

Medicare Open Enrollment : October 15 through December 7

New Coverage Begins : January 1

For members, Open Enrollment is a time to compare coverage and make decisions. For health plans, ACOs, IPAs, MSOs, provider groups, and care management teams, it is also a critical preparation period.

A coverage change may affect provider relationships, medication access, active authorizations, scheduled services, and ongoing care management. The question is not only whether an enrollment decision was completed. It is whether the care already in motion will continue without interruption.

— When Coverage Changes, Care Must Keep Moving

Medicare Open Enrollment runs from **October 15 through December 7**, with coverage changes taking effect **January 1**. The timeline is straightforward. Managing the transition is not.

Organizations may not immediately know when a member changes coverage. That delay can affect provider access, medications, authorizations, scheduled services, care management assignments, and the availability of clinical information.



Before January 1, healthcare organizations should be prepared to identify:

- ✓ Medications, authorizations, & scheduled services that may be affected
- ✓ Members whose coverage or provider network may change
- ✓ The team responsible for outreach and reconciliation
- ✓ Whether the next step in care remains on track

A strong playbook turns a coverage change into a coordinated response.

Official Medicare information:

<https://www.medicare.gov/health-drug-plans/open-enrollment>



— Read the Full Field

Some members actively choose new coverage. Others must make a change because their current plan is no longer available.

A 2026 JAMA study found that approximately **1 in 10 beneficiaries enrolled in HMO or PPO Medicare Advantage plans faced forced disenrollment** because their plan exited the market or reduced its service area. The analysis represented approximately **2.9 million beneficiaries**, with rural communities more likely to be affected.



For healthcare organizations, the finding raises an important operational question:

? Can your teams identify a coverage change before it becomes a disruption in care?

<https://pmc.ncbi.nlm.nih.gov/articles/PMC12917741/>



— Coverage Changes Can Reach the Point of Care



Coverage can change in a day. Established care cannot always follow as quickly. Provider relationships, monitoring services, and follow up responsibilities may need to be confirmed or reestablished.

July 2026 JAMA Network Open study examined **281,620 Medicare beneficiaries with hypertension**. Compared with matched beneficiaries who remained in traditional Medicare, those who switched to Medicare Advantage experienced lower adoption of remote patient monitoring, greater clinician loss without replacement, and higher hypertension related emergency department visits and hospitalizations.

The researchers described these findings as associations, not proof that switching coverage directly caused the outcomes. Still, the results point to the importance of protecting clinician relationships, monitoring services, and follow up during coverage transitions.

? If a member's coverage changes on January 1, how quickly can your organization confirm that their clinician, monitoring, and follow up remain in place?

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2852336>



— Turn Attribution Data Into An Open Enrollment Play

Medicare Open Enrollment creates an opportunity for provider organizations to connect with attributed members before coverage decisions are finalized.

Using information available within AaNeelCare®, organizations can review their attributed Medicare population, identify members whose ongoing care may be affected by a coverage change, and prioritize outreach before January 1.

Run the Member Play

- 1 See the full population.**
Review attributed Medicare members across participating providers, locations, and health plans.
- 2 Prioritize outreach.**
Identify members with chronic conditions, upcoming appointments, active care management, scheduled services, open care gaps, or established specialist relationships.
- 3 Prepare care teams.**
Make sure providers and staff understand the organization's plan participation for the upcoming year and know where to direct members for official Medicare and plan information.
- 4 Start the conversation**
Remind members to consider whether their providers, specialists, medications, hospitals, and scheduled services will remain available under the coverage they are reviewing.
- 5 Extend the reach.**
Use targeted text or email outreach to connect with members who may not have an appointment before Open Enrollment closes.
- 6 Prepare for January 1.**
Review eligibility and attribution changes, welcome newly attributed members, and identify existing members whose care may require follow up.

Put The Play Into Motion

Your AaNeel Account Executive can work with your organization to:

- ✓ Segment the appropriate attributed member population
- ✓ Develop targeted outreach lists
- ✓ Coordinate text or email campaigns
- ✓ Tailor messaging to organizational needs and participating plans
- ✓ Establish a follow up process for January coverage changes

The information is already available. The next play is turning it into timely outreach.

Contact your AaNeel Account Executive to begin planning your attributed member outreach campaign before Medicare Open Enrollment begins.

— Some Proven Plays Still Win

Healthcare continues to introduce new technology, new data sources, and new models of care. Yet the fundamentals of effective coordination have not changed.

Keep information current.

Validate eligibility, provider relationships, medications, contact information, and active care plans. Outdated information can prevent teams from recognizing who may be affected by a coverage change.

Reach out before transition.

Prioritize members with chronic conditions, active monitoring, scheduled services, or ongoing care management. Early communication creates time to identify access concerns before January 1.

Close the loop

A referral, notification, or transferred record does not confirm that care continued. Verify that the appropriate clinician remains involved, the next service is scheduled, and responsibility for follow up is clearly assigned.

These practices are not new, but they remain effective because **keeping care connected depends on consistent execution.**

— What We Are Watching



CMS Expands Connected Chronic Care

On September 15, CMS announced that the ACCESS Model will add heart failure, COPD, substance use disorders, and tobacco cessation beginning in spring 2027. The model serves people with Original Medicare and connects payment to measurable outcomes through options that may include virtual care, health coaching, remote monitoring, and connected devices.

[Learn more](#) →



Medicare Advantage Switching Continues to Increase

A September 2026 study found that voluntary switching between Medicare Advantage plans increased from 2016 through 2022, particularly among beneficiaries who were also eligible for Medicaid. Each change may introduce a different provider network, plan structure, or care management relationship. For healthcare organizations, switching is not only an enrollment trend. It is a signal to verify that members remain connected to the people and services supporting their care.

[Learn more](#) →

The Final Read

Open Enrollment may change coverage, but every organization in the care ecosystem has a role in protecting the care already in motion.

The strongest play is not simply recognizing that a change occurred. It is understanding what may be affected, reaching the right member, assigning responsibility, and confirming that care continues.

When January 1 arrives, will your organization be ready to make the next play?