Partners in Health

Quarterly Provider Newsletter

From the Desk of:
Kim Bales
Senior Director, Operations

IN THIS ISSUE

Our goal, first and foremost, is claims payment accuracy, and we continue to use every tool and piece of feedback available to enhance this. Accuracy matters because it supports providers, members, and the integrity of our process.

At Home State Health, we understand that claims disputes can be challenging, and we are committed to making the process as clear and helpful as possible.

Your feedback matters to us. In our recent survey, you asked us to continue improving the quality of our responses—and we're listening.

When a denial is upheld, our team strives to provide detailed feedback so you understand the reason behind the decision. Our goal is to support you in resolving issues quickly and help prevent similar situations in the future.

Your feedback and partnership are essential as we work toward improvements that benefit everyone.

Just a quick reminder—the best way to submit a claim dispute is by using the Claims Dispute Form, preferably through the Provider Portal for faster processing. If the portal isn't an option, you can also mail the form.

You'll find the form and instructions on our website or in the Provider Manual for each line of business:

Home State Health	Ambetter	Wellcare	Wellcare by Allwell

Thank you for everything you do for your patients—our members—and for partnering with us to keep claims processing smooth and accurate. We're here to help, and your feedback is invaluable. Please continue to participate in our surveys and share your thoughts—they truly make a difference.

Provider Announcements

Empowering Medicare Members to Live Healthier Lives

At Wellcare, we are committed to offering our members the coverage they need—and more. Our Medicare Advantage plans are designed to help members live better, healthier lives, and we know that starts with benefits that meet their diverse needs.

You play a critical role in helping our members understand everything their plan has to offer—and how to make the most of it.

One of the ways we support healthier lifestyles is through the **Wellcare Spendables® Card**—a flexible, supplemental benefit included in many of our plans. This card helps members extend their coverage by allowing them to use their benefit dollars where they need it most.

How It Works

For **Non-SNP Members**, plans offering this benefit include a **monthly allowance of $57 to $100**, depending on the specific plan. Unused dollars **roll over month-to-month**, giving members added flexibility.

These funds can be used for:

- Eligible Over-the-Counter (OTC) items
- **Dental, vision, and hearing services**, including out-of-pocket costs and additional services beyond plan limits

Enhanced Support for D-SNP Members

All **D-SNP members** receive the same core benefits as Non-SNP members, with a **monthly allowances ranging from $90 to $203** depending on their plan.

In addition to the OTC and dental, vision, and hearing services, **D-SNP members with qualifying chronic conditions** may be eligible* for **Special Supplemental Benefits for the Chronically Ill (SSBCI)**, which expand their Spendables® options to include:

- **Healthy Food:** Fresh or prepared foods from covered categories, with in-store, online, and meal delivery options
- **Gas (Pay-at-the-Pump):** Convenient fuel purchases directly at the pump
- **Rent and Utilities Assistance:** Payments made directly to service providers
- **Pest and Insect Control:** In-store or online purchases of control items and access to in-home treatment services
- **NEW for 2026: Home Assistance & Safety Items:** Products and modifications that support independent living and home safety

Eligibility Process

- **Current Members:** Wellcare utilizes internal claims data and predictive analytic tools to assess members' risk and health status. These tools help identify members who meet the required eligibility criteria.
  - » Once a current member is identified as eligible, they will **automatically be enrolled** in the SSBCI benefit and will receive a **detailed benefit letter** in the mail explaining their new benefits.
- **New Members:** Because claims data may not yet be available for newly enrolled members, a **manual attestation process** is available.
  - » Providers can submit attestations by visiting: **ssbci.rrd.com**
  - » Once the attestation is verified and approved, the member will be granted access to SSBCI benefits.

Provider Announcements, continued

Important Update: New Submission Addresses for Pre-Service (Prior Authorization) Appeals

Effective January 1, 2026, health care providers will need to use the addresses listed below when submitting appeals related to authorizations and other pre-service determinations. This change is part of our ongoing efforts to streamline operations and improve processing times for provider inquiries.

What's Changing?

We are consolidating and updating our pre-service appeal submission addresses. Providers must now send all pre-service appeal documentation to one of the addresses listed below. Please review the updated information below and begin using these addresses starting January 1, 2026.

Pre-Service Appeal Submission Addresses

Product	Medical Authorization Appeal	Behavioral Health Appeal
Home State Health and Show Me Healthy Kids	Home State Health/Show Me Healthy Kids PO Box 10287 Van Nuys, CA 91410	Centene Behavioral Health Dept. PO Box 10378 Van Nuys, CA 91410-0378
Ambetter from Home State Health	Ambetter from Home State Health PO Box 10341 Van Nuys, CA 91410	Centene Behavioral Health Dept. PO Box 10378 Van Nuys, CA 91410-0378
Wellcare	Wellcare PO Box 31368 Tampa, FL 33631-3368	Wellcare PO Box 31368 Tampa, FL 33631-3368
Wellcare by Allwell	Wellcare by Allwell PO Box 3060 Farmington, MO 63640-3822	Wellcare by Allwell PO Box 3060 Farmington, MO 63640-3822

Submission Guidelines

To ensure timely processing, please include the following with your appeal submission:

- A completed appeal form
- Supporting clinical documentation
- A copy of the original denial notice
- Any additional relevant information

Appeals submitted to outdated addresses after January 1st may be delayed or returned.

Post-service (claim) reconsideration reminders!

Providers are encouraged to use our secure electronic submission portals for faster processing:

- Availity Essentials
- Home State Health Provider Portal
- Wellcare Provider Portal

Post service (claim) reconsideration requests may also be submitted in writing:

CONTINUED

Home State Health and Show Me Healthy Kids Attn: Claim Reconsideration

PO Box 4050
Farmington, MO 63640-3829

Ambetter from Home State Health Attn: Claim Appeal

PO Box 5010
Farmington, MO 63640-5010

Wellcare Attn: Claim Payment Disputes

PO Box 31370-3370
Tampa, FL 3331-3370

Wellcare by Allwell Attn: Reconsiderations

PO Box 3060
Farmington, MO 63640-3822

Submission Guidelines

To ensure timely processing, please include the following with your claim reconsideration submission:

- A completed Claim Dispute form
- Supporting documentation
- Any additional relevant information

Questions?

If you have questions about this process or need assistance, please contact Provider Services at the numbers listed at the bottom of this newsletter or visit our Provider Portal.

Provider Satisfaction Survey Results

Your Feedback Drives Our Improvements

Each year, Home State Health conducts a **Provider Satisfaction Survey** to better understand your needs and experiences. This survey serves as the foundation for key improvement initiatives that help us deliver the best possible support. **Your feedback is essential—it ensures we focus on the issues that matter most to you.**

Based on your input, we've implemented some enhancements to improve your overall experience. Here are some highlights:

Provider Engagement Enhancements

- We **restructured our Provider Engagement Team** to include **Senior Provider Engagement Network Specialists**.
- These specialists have completed **extensive training** to support core business functions such as **claims, eligibility, and prior authorization**.
- This change enables our **Provider Engagement Account Managers** to collaborate more closely with **Quality Practice Advisors**, focusing on performance improvement in areas like **quality metrics, closing care gaps, and value-based payment models**.

IMPACT: Provider satisfaction in these areas increased by **40% from 2024 to 2025**.

Claims Submissions, Status, and Payments

We are committed to ensuring **accurate and timely claims processing**. To support this, we conduct **regular internal audits** to verify provider data and configuration. These efforts help guarantee precision and efficiency in claims payment.

IMPACT: Provider satisfaction with the **timeliness and accuracy of claims payments** increased by **35% from 2024 to 2025**.

Thank you for sharing your feedback—it truly makes a difference. We look forward to continuing to partner with you to improve processes and deliver exceptional service.

Claims Information

Billing Reminder: Avoid Duplicate Procedure Code Denials

We've seen an increase in claim denials for "Procedure Code Previously Billed on Historical Claim (EOP)/Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services (835)."

This often occurs when one provider bills the global component of a procedure while another bills the technical or professional component for the same service.

Example of Proper Billing:

An X-ray is performed at a freestanding radiology clinic and interpreted by a physician not employed by the facility:

- **Technical Component (TC):** The clinic bills the X-ray code with modifier TC to cover equipment, supplies, and staff.
- **Professional Component (26):** The interpreting physician bills the same code with modifier 26 for the interpretation.

When to Bill for a Global Service

A global service includes both components. If the interpreting physician also owns the equipment, the claim should be submitted **without modifiers TC or 26**, and the full fee is billed for both technical and professional services.

Identifying Codes with Separate Components

Not all codes permit the use of technical or professional modifiers. Please refer to the **correct coding documentation for each line of business** on its official website for verification.

To Help Prevent These Denials

- **Confirm billing responsibility** before submitting claims. If your practice is only performing the technical or professional portion, do not bill the global code.
- **Review coding guidelines** for procedures that have separate global, technical, and professional codes.
- **Coordinate with other providers** involved in the patient's care to ensure components are billed accurately and only once and with the correct modifiers if applicable:
  - » -26 (Professional Component)
  - » -TC (Technical Component)

Accurate coding and provider collaboration help reduce payment delays, improve compliance and avoid a denial.

Risk

Risk Adjustment Roundup

This quarter brings several important updates and changes from The Centers for Medicare and Medicaid Servies (CMS) that directly impact risk adjustment accuracy. Our goal is to provide clear, practical guidance that helps streamline your workflow.

Below are the biggest and most important changes that providers should be aware of this quarter.

Continued Phase-In of the CMS Hierarchical Condition Categories (HCC) Model (Version 28)

CMS is entering the next stage of its transition to the updated risk adjustment model. This is the largest shift to the HCC structure in over a decade, and it impacts how many chronic conditions map for risk scoring.

What providers need to know:

- Some commonly used diagnoses no longer map under V28, even though they did previously.
- Specificity matters more than ever. Conditions must be detailed, current, and clinically supported.
- Chronic conditions must be recaptured at least once per calendar year with full MEAT (**Monitor, Evaluate, Assess/Address, Treat**) documentation.
- The model increases reliance on linkage (e.g., diabetes + Chronic Kidney Disease (CKD) stage, heart failure type).

ICD-10 Annual Code Updates: Effective October 1

Each year, CMS updates ICD-10 codes, and this cycle includes meaningful changes across several high-impact clinical categories.

Updates most relevant this quarter:

- New and revised behavioral health codes
- Expanded social determinants of health (SDoH) options
- Updated codes for obesity and metabolic disorders
- Clarifications for heart failure and CKD staging
- Revised pediatric and adolescent behavioral diagnoses

Providers are encouraged to review EHR templates and confirm that the updated codes are available and mapped appropriately. Watch for an upcoming invitation to our next Practice Manager Advisory Committee meeting, where we'll share important updates on coding changes.

Telehealth Continues to Qualify for Risk Adjustment (With Required Documentation)

Telehealth remains an approved avenue for capturing HCCs, which is especially important for members with barriers to in-person care.

Documentation must include:

- A valid, billable encounter
- Modality (video vs. audio-only) clearly stated
- Clinical evidence of MEAT for each diagnosis
- Assessment and plan addressing the condition being billed

Reinforcement on Problem List Use

CMS has reaffirmed that diagnoses on a problem list alone cannot be used for risk adjustment. To qualify, the condition must be evaluated and addressed during the visit. Look for:

- Current symptoms or disease status
- Medication or treatment discussion
- Exam findings or labs reviewed
- Follow-up instructions

This continues to be one of the most common audit findings across all provider types.

Quality

Spotlight on Home Visiting Services: Supporting Healthier Moms and Babies

Home Visiting Services are a powerful way to support pregnant members and new parents in the comfort of their own homes. These personalized visits offer education on pregnancy, infant care, safe sleep, and parenting, while also connecting families to important resources like healthcare, behavioral health, food access, and more. By building a trusting relationship with a trained professional, members receive consistent guidance and support throughout their journey.

Home Visiting Services have been shown to improve birth outcomes, increase prenatal care engagement, and strengthen long-term health for both moms and babies. It's a proven approach that helps families thrive—one visit at a time. Participation in services is voluntary, and members may enroll either during the prenatal period or after delivery.

Home Visiting Services are covered through Home State Health's In-Lieu of Service (ILOS) program starting 12/1/2025. Services are available to pregnant members who meet the following criteria:

- Have a Notification of Pregnancy (NOP) on file and meet one of the following:
  - Members who are high or very high risk
  - Members who are at moderate risk and have indicated a lack of a support system.
  - Members with a history of domestic abuse.

If a member doesn't meet the criteria listed above, they may still qualify for Home Visiting Services—just not through the ILOS program.

Home Visiting Services provided through the ILOS may be delivered until the child is 1 year of age or through the end of mom's eligibility with the health plan, whichever comes first.

If you have a member who you feel would benefit from Home Visiting Services please reach out to our Care Management Program by calling 1-855-694-4663 ext. 6075125 or emailing **HSHPCareManagement@Centene.com**. Our team will then connect with the member and submit referrals through the CRIS system to start Home Visiting Services.

Quality, continued

Finding Hope Program

The Finding Hope program is a new program available to our members as of 10/1/2025. This program provides telephonic outreach, education, and support services to assist members in improving self-management skills to effectively manage perinatal depression and/or substance misuse to optimize quality of life. Members will have a dedicated Home State Health point of contact who specializes in supporting behavioral health needs during pregnancy. The care management (CM) team will connect members with behavioral health providers, help identify and manage triggers, promote healthy coping strategies, set realistic goals, and support the overall well-being of both the member and their baby. Members can be enrolled into the program both prenatally and postpartum.

Eligibility Criteria

Members aged 12 and older are eligible for the program if they are currently pregnant or within one year postpartum and meet one or more of the following criteria:

- Have a medical or pharmacy claim indicating a diagnosis of depression and/or substance use or misuse.
- Have self-reported depression, history of substance use/misuse, or ongoing substance use

If you have a member who you feel would benefit from participation in the Finding Hope program, please reach out to our Care Management Program by calling 855-694-4663 ext. 6075125 or send an email to the HSHPCareManagement@Centene.com mailbox.

Understanding the Member Lock-In Program

The Member Lock-In program helps ensure members use medical services appropriately and safely. It is designed to identify members who may be utilizing multiple providers or seeking excessive or unnecessary care, including medications, office visits, or other services and supplies.

Members may be identified through the Missouri Medicaid Audit and Compliance (MMAC) team or through the health plan's claims review process as high utilizers of services and a potential candidate for either the pharmacy lock-in or provider lock-in program.

- **Pharmacy Lock-In:** The member is required to use a specific pharmacy for all prescription medications. MMAC will send the member a letter notifying them of the lock-in and what pharmacy they are locked into and for what length of time.
- **Provider Lock-In:** The member is required to see one designated provider for prescribing purposes. This lock-in process is supported at the health plan. The member will receive outbound calls and letters from the care management team in an attempt to engage in services and discuss the lock-in program.

If the health plan determines that a member would benefit from a provider lock-in, the provider will be contacted by a member of our team. As a provider, you will receive a letter requesting your collaboration and support with the lock-in process.

Throughout the lock-in period, the care management team will continue to work with both the member and the provider or pharmacy to ensure appropriate care and support are maintained.

If you have any questions regarding Member Lock-ins please reach out to our Care Management team via the HSHPCareManagement@Centene.com mailbox.

Quality, continued

Note: Measure specifications and reporting requirements are subject to change based on NCQA updates. Providers should refer to the official NCQA website for the most current information: https://www.ncqa.org/blog/hedis-my-2026-whats-new-whats-changed-whats-retired/

Healthcare Effectiveness Data and Information Set (HEDIS) MY 2026 Measure Changes/ Updates *(SUBJECT TO CHANGE)*

Category	Measure & Identifier	Description / Notes
New Measures	Acute Hospitalizations Following Outpatient Orthopedic Surgery (HFO)	Risk-adjusted measure for age 65+ post-outpatient orthopedic surgery
	Acute Hospitalizations Following Outpatient General Surgery (HFG)	Risk-adjusted measure for age 65+ after outpatient general surgery
	Acute Hospitalizations Following Outpatient Colonoscopy (HFC)	Risk-adjusted measure for age 65+ after outpatient colonoscopy procedure
	Acute Hospitalizations Following Outpatient Urologic Surgery (HFU)	Risk-adjusted measure for age 65+ after outpatient urologic surgery
	Disability Description of Membership (DDM)	Descriptive measure: % of members enrolled with disability status, by source
	Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)	ECDS measure for persons 5–64 with follow-up within 30 days
	Tobacco Use Screening and Cessation Intervention (TSC-E)	ECDS measure for persons 12+ screened for tobacco use and received intervention
Updated Measures	Statin Therapy for Patients With Cardiovascular Disease (SPC-E)	Age/sex bands updated, exclusions removed, ASCVD identification updated
	Statin Therapy for Patients With Diabetes (SPD-E)	Age/sex bands updated, exclusions removed, ASCVD identification updated
	Social Need Screening and Intervention (SNS-E)	Added HCPCS/ICD-10 Z codes, updated exclusions for all ages
	Adult Immunization Status (AIS-E)	Added COVID-19 vaccine indicator for persons age 65+
	Follow-Up After High-Intensity Care for SUD (FUI)	Updated to allow SUD diagnoses in any claim position, includes peer support services
ECDS-Only Measures	Lead Screening in Children (LSC-E)	ECDS-only reporting; administrative/hybrid retired
	Statin Therapy for Patients With Cardiovascular Disease (SPC)	ECDS-only reporting; administrative/hybrid retired
	Statin Therapy for Patients With Diabetes (SPD)	ECDS-only reporting; administrative/hybrid retired
Retired Measures	Asthma Medication Ratio (AMR)	Retired; no longer aligns with current guidelines
	Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	Retired; replaced by TSC-E

Improving the Follow-Up After Hospitalization for Mental Illness (FUH) Measure Rate

Follow-Up After Hospitalization for Mental Illness (FUH) measure is a National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set® (HEDIS) measure which requires coordination between hospitals, outpatient behavioral health providers, care managers, and health plans.

This measure is a critical HEDIS metric that tracks whether patients discharged from inpatient psychiatric care receive timely follow-up with a mental health provider within 7 days and 30 days of discharge.

Provider Strategies for FUH

Proactively scheduling visits, coordinating care, and addressing barriers can improve outcomes and meet quality benchmarks that reflect high standards of mental health care.

1. **Schedule Follow-Up Before Discharge**
   - Proactively book follow-up appointments to occur within 7 days of discharge.
   - Use discharge planning tools to ensure continuity of care.
2. **Leverage Expanded Visit Types**
   - Encourage use of peer support, residential treatment, and collaborative care options.
   - Document visits accurately to ensure they count toward FUH compliance.
3. **Improve Documentation**
   - Ensure mental health diagnoses are clearly documented in the chart and coded on the claim.
   - Use standardized templates to capture all necessary visit details.

4. **Coordinate Across Teams**
   - Work with case managers, social workers, and behavioral health specialists to support transitions.
   - Use shared care plans and EHR alerts to track follow-up needs.
5. **Address Barriers to Care**
   - Offer telehealth options when appropriate (Note: different types of coverage, Medicaid, Ambetter, and Medicare, may have different coverage and billing requirements for telehealth services)
6. **Educate Patients and Families**
   - Reinforce the importance of follow-up care in preventing relapses and promoting recovery.

Language Needs

Our Commitment

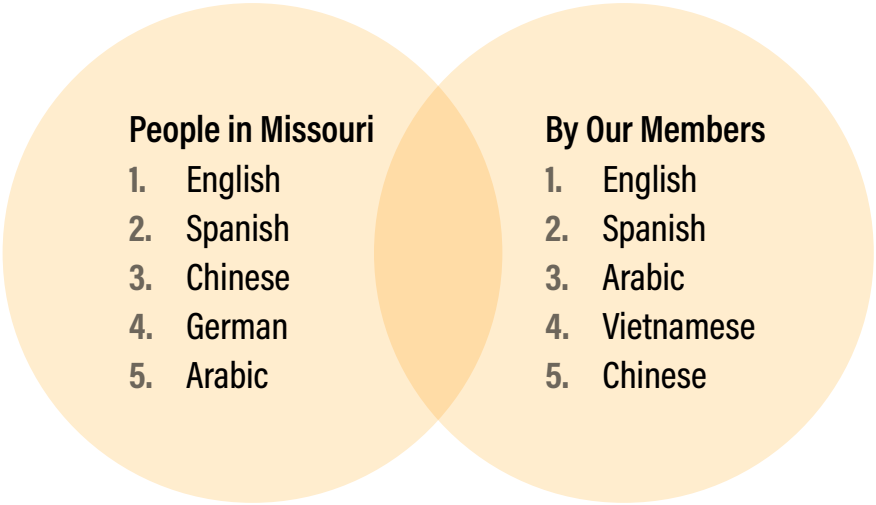
Marginalized communities in Missouri, including racial and ethnic minorities, low-income individuals, and rural residents, experience significant barriers to healthcare, contributing to higher rates of chronic disease like diabetes, heart disease, and cancer. Language, health literacy, and cultural differences can further complicate access to effective and culturally sensitive care.

Home State Health's goal is to ensure every member has a fair and just opportunity to attain their highest level of health. That's why we ensure services are easy to access for all members including those with different languages, backgrounds, beliefs, and abilities.

We are committed to embracing equity and inclusion in all the work we do as we transform the health of the communities we serve, one person at a time.

Languages Spoken by Potential and Current Members

Annually we review the cultural, ethnic, racial, and linguistic needs of our members and work to improve identified gaps. To ensure services are available for potential members, we also review the languages spoken across the state of Missouri. As you can see in the image, the top languages spoken in Missouri are English, Spanish, Chinese, German, and Arabic. The top languages spoken by our members are English, Spanish, Arabic, Vietnamese, and Chinese. Four of the five top languages are the same between our current and potential members.



Languages Spoken by Your Members

As a provider it is important to know the languages spoken by your members and their interpretation needs to ensure these are not barriers to receiving the best possible care.

Members' Preferred Language can be viewed or exported from Home State Health's Secure Provider Portal. After logging in, navigate to the Patient List to review active patients and their preferred languages or download the information to review offline.

Language, Interpretation, and Translation Services

Home State Health provides language assistance and interpreter resources in all threshold languages including American Sign Language at no cost to members. We provide support services for hearing impaired members through Telecommunications Device for the Deaf (TDD).

Home State responds to requests for telephonic interpreters immediately, and within 2-3 business days for requests at provider offices. For in-person interpreter services please complete the Interpreter Services Request and fax it to 1-866-390-4429.

Review Home State Health's Provider Webpage for more information about our language services and additional provider resources.

CONTINUED

Quality, continued

We're Here to Help

Providing culturally responsive care requires a willingness to understand and respect differences and a commitment to continuous learning and development. Home State Health is here to support you on this journey!

We provide access to training and tool kits designed to enhance knowledge, skills, and performance of healthcare professionals as they develop proficiency in cultural responsiveness. Visit Home State Health's **Provider Website** for these resources and more including the links below:

- **Home State Health Equity Toolkit**
- **Culturally Appropriate Care & Health Equity Training**

Availity®

Need assistance?

The Availity portal **Availity Essentials** and Home State Health's legacy portal **Home State Health** are available 24/7 for your convenience. These user-friendly platforms allow you to:

- Verify member eligibility
- Submit and track claims
- Submit and check prior authorization requests

Access the tools you need—anytime, anywhere.

Clinical & Payment Policies

As part of our commitment to transparency and supporting member access to high-quality care, Home State Health routinely reviews and updates our clinical and administrative policies. We encourage providers to stay informed by reviewing the latest updates regularly.

You can access our current policies here: **Clinical & Payment Policies**.

Contact Provider Partnership:

HomeStateHealth.com	Home State: 1-855-694-4663 / TTY: 711
HomeStateHealth.com	Show Me Healthy Kids: 1-877-236-1020 / TTY: 711
Ambetter.HomeStateHealth.com	Ambetter: 1-855-650-3789 / TTY: 711
Wellcare.com/AllwellMO	Wellcare By Allwell: 1-800-977-7522 / TTY:711
Wellcare.com	Wellcare: 1-855-538-0454 / TTY: 711

Provider Services Department
1-855-694-HOME (4663) TTY 711
7711 Carondelet Ave.
St. Louis, MO 63105