Partners in Health

Quarterly Provider Newsletter

IN THIS ISSUE

From the Desk of

Ryan Litteken

Plan Chief Operating Officer

Welcome to the Home State Q3 Provider Newsletter. I'm excited to reconnect with you, having previously served as the Home State CFO from Q1 2016–Q1 2022, and now re-joining Home State as the COO in Q2 2026. It's truly humbling and deeply gratifying to be back, serving our customers across Missouri, and collaborating with such a dedicated provider community.

First and foremost, thank you for the care you deliver every day for your patients—our Home State members—often under significant constraints related to staffing shortages, complex patient social needs, administrative burden, and uncertainty from recent regulatory changes. Your commitment does not go unnoticed, and I'm grateful for everything you do.

Looking ahead to the 2nd half of 2026, I believe it's more important than ever for Home State and our provider partners to be closely aligned to overcome these challenges and drive better outcomes for our Missouri members. Our commitment to strengthening this partnership is reflected in several key investments we're making to support you. Here's a brief overview:

- We're simplifying the prior authorization process by modernizing our systems, enhancing communication, and narrowing the scope, all aimed at reducing complexity for you and your teams

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- Our call center technology was upgraded to Amazon Web Service (AWS), which we believe will deliver a more responsive and effective experience
- Provider directory data is receiving extra attention, with greater validation and auditing to ensure members have the most accurate information at their fingertips so they know where to get appropriate care.
- Amplifying our provider reporting capabilities so you'll have more actionable insights to support your patients' care.

Investing in improvements is only the first step. Listening and working closely with you to strategize on ways to use this information is key to both our success and at the heart of our mission: Transforming the health of the communities we serve, one person at a time.

Provider Announcements

Credentialing and Recredentialing Reminder for Providers

To support a smooth credentialing and recredentialing process, we are sharing a few important reminders and best practices. Taking proactive steps now can help prevent delays and ensure continued participation in the network.

Understanding the Recredentialing Cycle

Recredentialing is completed every three years and is initiated several months before the current cycle expires. Early preparation is key to avoiding interruptions in network participation.

Keep Your CAQH Profile Current

Credentialing outreach is sent to the contact listed in the practitioner's CAQH profile. Please ensure:

- Your **credentialing contact information is accurate and up to date**
- Your **CAQH attestation is current**
- **Centene has active permission to access your CAQH profiles**

Outdated or incomplete CAQH information is one of the most common causes of delays in the credentialing and recredentialing process.

Steps to Take if a Practitioner Fails Credentialing/Recredentialing

If you are notified that a practitioner has not successfully completed credentialing or recredentialing:

1. **Submit the practitioner on a roster to CHHS_PROVIDER_ROSTER@CENTENE.COM**
2. **A new credentialing case will then be initiated**

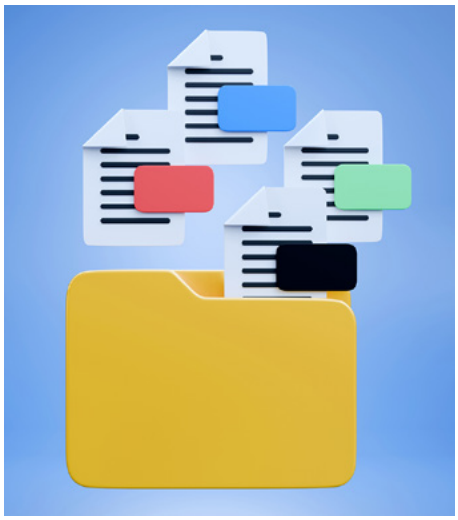
Before submitting, please ensure that the practitioner's **CAQH profile is fully updated and compliant with all requirements listed above,** as incomplete information may delay reprocessing.

Key Takeaway

Maintaining accurate and up-to-date CAQH information and responding promptly to outreach are critical to ensuring a seamless credentialing experience and avoiding unnecessary disruptions.

Provider Announcements, continued

Maintaining an Accurate Provider Directory



Importance of an Accurate Provider Directory

Maintaining an accurate provider directory is essential for improving network adequacy. Provider directories are comprehensive lists of in-network healthcare providers produced by all health care plans, including Home State Health. These directories serve as invaluable resources for both members seeking healthcare providers and for regulators who monitor the adequacy of our provider networks.

Consequences of Inaccurate Information

When provider directory data is inaccurate or incomplete, it becomes difficult for members, especially those seeking behavioral health or primary care services, to locate and access the healthcare they need. This issue can also result in Home State Health receiving penalties from monitoring agencies.

Home State Health Policy

With these considerations in mind, Home State Health has implemented a policy designed to better serve members and ensure compliance with regulatory requirements. According to this policy, contracted providers cannot opt out of inclusion in our provider directories at their primary location. Furthermore, if a secondary location affects Home State Health's network adequacy, suppression of that directory listing will not be permitted.

Panel Status Updates

Providers may continue to update their panel status, which allows them to close their panels or accept only current patients. This status is accurately reflected in our directories.

Roster Updates

Home State Health relies on providers to keep their roster information current and accurate. Regular updates help ensure the provider directory reflects the most up-to-date information for members and regulators.

Providers are expected to submit any changes in their roster composition to Home State Health on a monthly basis. These updates may include additions of new providers, terminations, address changes, and other relevant modifications. In addition to these monthly updates, Home State Health requests that providers submit a comprehensive, full roster on a quarterly basis. This quarterly submission allows for reconciliation and ensures that any information missed in prior monthly updates is captured and accurately reflected in the directory. Rosters should be submitted to the following address: **CHHS_PROVIDER_ROSTER@CENTENE.COM**

Contact Information

If you have any questions or concerns regarding our Provider Directory Policy, please contact a Home State Health representative:

- Phone: **1-855-694-HOME (4663)**
- Email: **HomeStateProvider@centene.com**

Provider Announcements, continued

New Stranded Patient Line for Facilities Assisting Participants with Non-Emergency Medical Transportation

Dealing with a scheduled ride that doesn't show up can be stressful for both your staff and your patients. To streamline support, the MO HealthNet Division (MHD) has launched a dedicated Stranded Patient Line to ensure no MO HealthNet participant who has a confirmed ride under the Non-Emergency Medical Transportation (NEMT) Program is left waiting at your facility without a solution.

This new line was created to remove administrative hurdles and prioritize safety by eliminating the need to hunt for different phone numbers based on various health plans, have faster rides for stranded participants, and improved real-time communication between your facility, MTM (MO HealthNet's transportation broker), and the MO HealthNet Managed Care health plans.

If a MO HealthNet participant's scheduled transportation fails to arrive and they are considered stranded at your facility, call the new consolidated line immediately:

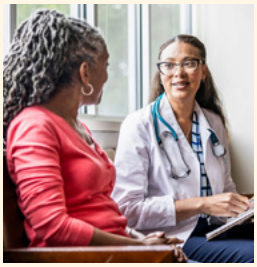
1-866-TELL-MTM (1-866-835-5686)

Keep this number posted at your discharge desk for quick access!

The system is designed to get you to the right person quickly:

- Verify with the participant, or in **eMOMED**, if the participant has MO HealthNet coverage (traditional Medicaid) or is enrolled with a MO HealthNet Managed Care health plan.
- Call **1-866-835-5686** and select the Health Plan: You will be prompted to choose the participant's specific plan.
  - » Option 1: Healthy Blue
  - » Option 2: Home State Health
  - » Option 3: MO HealthNet Division (traditional Medicaid)
  - » Option 4: Show Me Healthy Kids
  - » Option 5: United Healthcare
  - » Option 6: Unsure
- Confirm "Stranded" Status:
  - » If YES: You are routed directly to an MTM representative for urgent assistance.
  - » If NO: Your call is routed to the appropriate health plan's Member Services line.

This line can also be used to initiate a formal complaint on behalf of a participant. If the participant is not currently stranded, the system will route you to the correct grievance process.



Behavioral Health Webpage Update

We've recently updated our **Behavioral Health webpage** to make it easier to navigate and find resources to help support high-quality health care. This centralized resource includes prior authorization details, resource documents, provider manuals, training opportunities, secure portal support, and other helpful materials. Be sure to check the page often for updates and resources designed to support your practice.

Availity

Availity Editing Services

In June, Home State Health began using **Availity Editing Services (AES)** to help streamline your claims process—just like you've already experienced with **Ambetter**.

What's Changing?

You'll start seeing **real-time rejection messages** from Home State Health through Availity, directly in your current workflow. These messages help identify claim errors early, giving you the **option** (not a requirement) to correct and resubmit before the claim goes to the health plan for processing.

Why This Helps You:

- **Fewer errors** and **faster payments**
- **Improved claim accuracy**
- **Reduced turnaround time**
- **No surprises**—you're already familiar with this process from Ambetter (and other payers who use the Availity secure portal)

How It Works:

- Review the AES message in your Practice Management System (PMS or the Availity portal)
- Decide whether to update the claim
- If the message doesn't apply, you can **resubmit as-is**—this bypasses the edit.
- Whether you edit or bypass, **be sure to submit** the claim so it can be processed.

Important Notes:

- AES is **not a denial tool** and doesn't replace downstream edits.
- If you use a PMS, check your **claims workbasket or queue reports** for edits.
- If you submit via the Availity portal, edits will appear in your **standard reports**.

Not on the Availity Portal?

Sign up today! Benefits include the ability to check eligibility and benefits, manage claims, submit prior authorizations and complete other secure administrative tasks, all in a secure, multi-payer platform.

Providers can enroll in Availity Essentials by having their organization's administrator register on the Availity portal, entering key details and assigning user roles.

Need Help?

- For AES or Portal support, contact **Availity Client Services** at 1-800-AVAILITY (282-4548) Monday–Friday, 8 a.m. to 8 p.m. ET
- For general questions, contact our **Provider Service Center** Monday–Friday, 8 a.m. to 8 p.m. ET
  - » Home State Health **1-855-694-4663**
  - » Show Me Healthy Kids **1-877-236-1020**

***Want to learn more?** Join Availity's free webinars and learn how to access and manage AES reports:*

- **Send and Receive EDI Files – Training Demo**
  - » Learn where to find your edit reports in Availity Essentials.
- **EDI Reporting Preferences – Training Demo**
  - » Learn how your Availity Administrator can set up reporting preferences.

Pharmacy Prior Authorization Prescriber Guide

Providers and pharmacies must verify prior authorization (PA) requirements before dispensing medications. Emergency services do not require PA. PA is typically required for medications that are non-preferred (not on the Preferred Drug List), require step therapy, exceed quantity limits, or are obtained from out-of-network pharmacies/providers. **Failure to obtain required PA may result in claim denial.**

How to Submit a Pharmacy Prior Authorization

Home State Health / Show Me Healthy Kids The Medicaid pharmacy benefit is a carve-out of managed care organizations and is covered by MO HealthNet under Medicaid fee-for-service.	**Pharmacy Help Desk Phone: 1-800-392-8030**	
	Pharmacy Help Desk Fax: 1-573-636-6470	
	PA Form: https://mydss.mo.gov/mhd/pharmacy	
	CyberAccess Prescription Pad https://www.cyberaccessonline.net/cyberaccess/Login.aspx	
Ambetter	**Web Portal (Preferred)** Ambetter Provider Portal *Fastest & most efficient method. Direct status updates available.*	
	Fax: Non-Specialty: 1-800-977-4170 · Specialty (Buy & Bill): 1-855-690-5433	
	PA Forms — Cover My Meds **Non-Specialty PA Form (PDF) · Specialty PA Form (PDF)**	
Wellcare	**Electronic PA (ePA) — CoverMyMeds** *Fastest electronic submission*	
	Online Form — Complete the Drug Determination Form at wellcare.com	
	Fax: 1-866-388-1767 *Complete a Coverage Determination Request (PDF) and fax*	
	Standard Mail: Wellcare Pharmacy-Coverage Determinations P.O. Box 31397 Tampa, FL 33631-3397	**Overnight Mail:** 8735 Henderson Rd, Ren. 4 Tampa, FL 33634
Wellcare by Allwell	**Electronic PA (ePA) — CoverMyMeds** *Fastest electronic submission*	
	Online Form: Complete the Drug Determination Form at https://wellcare.homestatehealth.com	
	Fax: 1-866-226-1093 **Complete a Coverage Determination Request (PDF) and fax**	
	Standard Mail: Wellcare by Allwell Pharmacy-Coverage Determinations P.O. Box 31397 Tampa, FL 33631-3397	

***Determination Communication:** *PA decisions are communicated via web portal, fax, or phone, depending on how the request was submitted.*

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Provider Announcements, continued

What to Include in Your PA Request

Medicaid	Marketplace and Medicare
▪ Participant's MO HealthNet ID Number (DCN) ▪ Participant's Name ▪ Drug, strength, dosage form, and dosing schedule requested ▪ Diagnosis may be required ▪ Requested duration of approval **MO HealthNet reimburses all diabetic testing supplies through the MO HealthNet Pharmacy Program. Durable Medical Equipment (DME) providers may bill for diabetic supplies on a pharmacy claim and be reimbursed through the MO HealthNet Pharmacy Program.*	▪ Diagnosis and clinical indication ▪ Treatment history (previous therapies tried/failed) ▪ Clinical rationale for requested medication ▪ Supporting medical records (if applicable)
Incomplete submissions may delay processing	

Prior Authorization Turnaround Times (Marketplace and Medicare only)

- Retail Non-Urgent Prior Authorization turnaround time is **72 hours**
- Retail Urgent Prior Authorization turnaround time is **24 hours**
- Medical Pharmacy Non-Urgent Prior Authorization turnaround time is **72 hours**
- Medical Pharmacy Urgent Prior Authorization turnaround time is **24 hours**

When is PA Commonly Required?

- Specialty medications
- High-cost therapies
- Medications administered in outpatient or home settings
- Drugs requiring special handling or vendor routing

Verify Before You Prescribe

Use the plan's tools to verify PA requirements before prescribing or dispensing:

HomeStateHealth.com

Ambetter.HomeStateHealth.com

Wellcare.com

Best Practices

- Always verify PA requirements first
- Submit via the appropriate channel
- Include complete documentation upfront (see "**How to Submit a Pharmacy Prior Authorization**" page 6)
- Check for special vendor routing

Quality

Continuity of Care Changes Implemented for Medicaid

Home State Health is aligning its Continuity of Care (COC) process with America's Health Insurance Plans (AHIP) best practices to support smoother member transitions between health plans.

For new members who are actively receiving medically necessary services, the health plan will honor previously approved authorizations during a transition period, when applicable. For in-network providers and covered benefits, authorizations may be honored for up to 90 days. For out-of-network providers or non-covered services, continuity of care will follow contractual requirements, with a transition period of up to 60 days, as applicable.

Providers may submit documentation of an existing authorization to facilitate continuity of care. If documentation is not available, standard authorization review processes will apply.

These updates are designed to reduce disruption in care, improve continuity for members, and streamline administrative processes for providers. No immediate action is required; however, providers should ensure appropriate staff are familiar with the updated process.

For questions, please contact your Provider Relations representative.

Strengthening Outcomes Through Annual Preventative Visits (APV) and Adults' Access to Preventative/Ambulatory Health Services (AAP) Performance

Annual preventive visits are a cornerstone of high-quality, proactive care. They provide a valuable opportunity to engage patients in their overall health, assess risk factors, and address key preventive needs before issues escalate. From recommended screenings and immunizations to chronic condition management, these visits help ensure patients stay on track and are supported throughout the year.

Beyond individual patient benefits, completing at least one preventive or ambulatory visit during the measurement year plays a vital role in meeting performance benchmarks for the Adults' Access to Preventive/Ambulatory Health Services (AAP) measure. This measure reflects how effectively we are connecting adults ages 20 and older, across Medicaid, Medicare, and Marketplace populations, to essential care.

Prioritizing annual preventive visits early in the year creates a strong foundation for success. It allows care teams the time needed for meaningful follow-up, care coordination, and timely referrals. Early engagement also helps close care gaps, reduce avoidable emergency department utilization, and prevent complications before they arise.

Most importantly, these visits reinforce the patient-provider relationship. By keeping patients actively connected to their primary care team, we improve continuity of care, enhance the patient experience, and drive stronger quality outcomes across the board.

Let's continue to make preventive care a priority; starting early, staying consistent, and delivering the comprehensive care our patients deserve.

Important Update: Specialized Formula Coverage Changes Effective July 1, 2026

Effective **July 1, 2026**, the Women, Infants, and Children (WIC) program will no longer provide coverage for specialized formulas.

As a result, coverage for specialized formulas will transition to the **Durable Medical Equipment (DME)** benefit.

What This Means for Providers

- Specialized formulas will now follow the **standard DME process**.
- Some formulas will require **prior authorization (PA)**.
- It is important for providers to **verify PA requirements** before submitting requests.

Provider Responsibilities

To ensure timely access to formula for members, providers should:

- Verify whether the formula is a specialized formula not covered by WIC prior to submitting a DME request
- **Review prior authorization requirements** to determine if a PA is needed
- **Submit all required clinical documentation** to support medical necessity
- **Send orders to an in-network DME provider** to facilitate processing and delivery
- Providers and/or members should contact in-network DME providers to confirm which vendors carry the specific formula needed, as availability may vary by supplier.

Key Reminders

- Inclusion of complete and accurate clinical information will help prevent delays
- Submitting to an **in-network DME vendor** ensures smoother coordination and member access
- Following established DME and PA processes will support timely approvals

If you have questions regarding prior authorization requirements or in-network DME providers, please refer to the provider portal or contact Provider Services at 1-855-694-4663 for Home State Health or 1-877-236-1020 for Show Me Healthy Kids.

Risk

Risk Adjustment Coding Corner

As we enter the third quarter, there is still time to complete annual visits and capture key chronic conditions. Summer is an ideal time to schedule Annual Wellness Visits (AWVs) before end-of-year demand increases. While many school physicals are complete, sports physicals and other visits remain an opportunity to address preventive care and document ongoing conditions.

Keep in mind:

- Use every visit: Include chronic condition assessment and documentation, even during sports or acute visits.
- Ensure annual recapture: Chronic conditions must be documented each year to be counted.
- Annual well visits, sports physicals, and school physicals are ideal opportunities to review vaccines that are due or overdue and provide catch-up vaccinations when needed. Using every visit as an opportunity to vaccinate also allows time to address questions and concerns. Early planning for the seasonal flu vaccine can help make this year's vaccination efforts more successful.

Claims Information

Billing Tips for Diagnosis Pointers

A diagnosis pointer tells the payor which diagnosis explains (supports) a specific service on the claim.

Why it Matters

Using the correct pointer shows the payor:

- Why the service was done
- That the service is medically necessary

Using them correctly helps avoid claim denials, processing delays, and ensures proper payment.

Tip: Always make sure the first (primary) diagnosis pointer links the specific diagnosis listed in Box 21 that demonstrates medical necessity for each procedure. The primary diagnosis pointers can be different for each service billed.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z433 B. Z933 C. Q423 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
														ZZ	000000000X
01	27	26				12		A4414	NU	BC	194	44	10	NPI	XXXXXXXXXX
01	27	26				12		A4452	NU	BC	33	21	44	NPI	

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