



Partners in Health

Quarterly Provider Newsletter



From the Desk of
Chris Hoover
Senior Director, Care Management

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Welcome to our Provider Newsletter!

As someone who has spent more than a decade with Centene and Home State Health, I continue to be inspired by the incredible work happening across our provider network every day. I joined Centene in 2015 and have been fortunate to serve in a variety of leadership roles supporting care management, population health, and programs for some of our most vulnerable members. I feel so fortunate to have the privilege of working alongside an amazing team dedicated to improving the health and well-being of Missouri families.

Every day, our care managers, care coordinators, community health workers, nurses, behavioral health specialists, providers, and community partners come together to help members overcome barriers that can impact their health. Care Management is about much more than coordinating services. It is about relationships. It is about understanding each member's unique story and working collaboratively to support their goals. Most importantly, it is about ensuring that no member feels like they are facing their challenges alone.

I have had the opportunity to witness countless examples of providers and care managers working together to improve outcomes for our members. These partnerships are critical to our success. When providers, health plans, caregivers, and community organizations collaborate, we are better

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able to identify needs early, close gaps in care, and connect members to the right resources at the right time. Together, we can continue to improve health outcomes while creating a more connected, member-centered healthcare experience.

On behalf of our entire Care Management team, thank you for the compassionate, high-quality care you provide every day. Together, we are making a difference—one member, one family, and one success story at a time.



Provider Announcements

Home State Health Achieves NCQA Health Outcomes Accreditation and Renews NCQA Health Plan Accreditation ● ●

Effective June 15, 2026, Home State Health achieved **NCQA Health Outcomes Accreditation** and successfully renewed its **NCQA Health Plan Accreditation** for its Missouri Medicaid health plan.

NCQA Health Outcomes Accreditation recognizes organizations that use standardized data collection and measurement to better understand the unique health needs of the populations they serve and to address differences in health outcomes, member experience, and access to care.

These achievements reflect Home State Health's ongoing commitment to quality improvement, equitable care, and better health outcomes for the members and communities we serve. We appreciate the partnership of our providers and community organizations, whose collaboration helps deliver high-quality, member-centered care across Missouri.

What This Means for Providers

Home State Health's NCQA Health Outcomes Accreditation and renewed Health Plan Accreditation demonstrate our commitment to continuous quality improvement, population health management, and advancing equitable health-care outcomes for Missouri Medicaid members.

About NCQA

The National Committee for Quality Assurance (NCQA) is an independent, nonprofit organization dedicated to improving healthcare quality through accreditation, measurement, data, training, and credentialing. NCQA's HEDIS® measures are among the most widely used tools for evaluating healthcare performance and driving quality improvement. Learn more at [ncqa.org](https://www.ncqa.org).



Provider Announcements, continued

Open Enrollment for 2027 is here and your patients may have questions ● ● ●



Open Enrollment is November 1 - January 15

- Enroll by December 15 for coverage that starts January 1
- Enroll by January 15 for coverage that starts February 1



Outside the yearly Open Enrollment, you can get coverage or change plans only if you:

- Have a life change or income that qualifies for a Special Enrollment Period.
- Qualify for Medicaid or the Children's Health Insurance Program (CHIP). You can enroll any time of year and coverage can start immediately. [Learn more about these programs.](#)



Where can I find more information?

[Tips about the Health Insurance Marketplace® | HealthCare.gov](#)

[Affordable Health Insurance in Missouri | Ambetter from Home State Health \(ambetterhealth.com\)](#)



Annual Enrollment is October 15 - December 7

- Enroll by December 7 for coverage that starts January 1
- Anyone with Medicare may make changes to their coverage



Open Enrollment is January 1 - March 31st

- Members can make a one-time change to their plan
- Coverage starts the 1st of the month following enrollment

Ambetter from Home State Health is Becoming Ambetter Health ●

ambetter
HEALTH®

Beginning November 1, 2026, Ambetter from Home State Health will rebrand as Ambetter Health. This update reflects a fresh new name and logo while keeping the same commitment to serving our members and provider partners. Please note this is a name and logo change only – member coverage will remain the same through December 31, 2026. Keep an eye out for the new Ambetter Health branding coming soon.



Provider Announcements, continued

Out-of-State Ambetter Member Guidance ●

REFERRAL NOT REQUIRED

PREMIER	MEMBER: [Jane Doe]	
	Subscriber: [John Doe]	
	Subscriber ID: [XXXXXXXXXX]	Member ID: [XXXXXXXXXXXXXX]
	Plan: [Plan Name]	
	[Plan Name Cont'd]	
	RXBIN: 003858 RXPCN: A4 RXGROUP: 2CVA Effective Date: [00/00/00]	
	[Network] Network Coverage Only	
	COPAYS PCP: [\$25 Copay per visit] Specialist: [\$50 Copay per visit] Urgent Care: [\$50 Copay per visit] ER: [50% after ded.]	COST SHARES INN DED Ind/Fam: [\$4,000/\$8,000] OON DED Ind/Fam: [\$8,000/\$16,000] INN MOOP Ind/Fam: [\$8,000/\$16,000] OON MOOP Ind/Fam: [\$16,000/\$32,000]
For detailed benefit information, please visit AmbetterHealth.com/copays		

HEALTH MAINTENANCE ORGANIZATION QHP | TDI
REFERRAL REQUIRED

VALUE	MEMBER: [Jane Doe]	
	Subscriber: [John Doe]	
	Subscriber ID: [XXXXXXXXXX]	Member ID: [XXXXXXXXXXXXXX]
	Plan: [Plan Name]	
	[Plan Name Cont'd]	
	RXBIN: 003858 RXPCN: A4 RXGROUP: 2DSA Effective Date: [00/00/00]	
	[Network] Network Coverage Only	
	PCP: [\$25 Copay per visit] Specialist: [\$50 Copay per visit] Urgent Care: [\$50 Copay per visit] ER: [50% after ded.] Rx (Tier 1/2/3/4): [\$3 Copay per prescription/\$20 Copay per prescription/\$50 Copay per prescription/45% after ded.]	INN DED Ind/Fam: [\$4,000/\$8,000] OON DED Ind/Fam: [\$8,000/\$16,000] INN MOOP Ind/Fam: [\$8,000/\$16,000] OON MOOP Ind/Fam: [\$16,000/\$32,000]
For detailed benefit information, please visit AmbetterHealth.com/copays		

REFERRAL NOT REQUIRED

SELECT	MEMBER: [Jane Doe]	
	Subscriber: [John Doe]	
	Subscriber ID: [XXXXXXXXXX]	Member ID: [XXXXXXXXXXXXXX]
	Plan: [Plan Name]	
	[Plan Name Cont'd]	
	RXBIN: 003858 RXPCN: A4 RXGROUP: 2CVA Effective Date: [00/00/00]	
	[Network] Network Coverage Only	
	COPAYS PCP: [\$25 Copay per visit] Specialist: [\$50 Copay per visit] Urgent Care: [\$50 Copay per visit] ER: [50% after ded.]	COST SHARES INN DED Ind/Fam: [\$4,000/\$8,000] OON DED Ind/Fam: [\$8,000/\$16,000] INN MOOP Ind/Fam: [\$8,000/\$16,000] OON MOOP Ind/Fam: [\$16,000/\$32,000]
For detailed benefit information, please visit AmbetterHealth.com/copays		

Reminder: Verify Eligibility and Authorization Requirements for Out-of-State Ambetter Members

Before rendering services, providers should confirm the following:

- Ambetter from Home State Health participating providers should verify eligibility, network participation, plan type, and authorization requirements before providing services to out-of-state Ambetter members.
- Ambetter members may be enrolled in different plan products and provider networks, and coverage rules may vary based on the member's home plan and state. Providers should review the member's ID card and confirm eligibility through the secure provider portal to identify the member's plan product, network, and any applicable referral or prior authorization requirements.

Completing these verification steps before care is rendered can help reduce avoidable claim denials and administrative delays.

The plan types are found on the member ID card.

Premier plans may allow out-of-state reciprocity with participating providers; however, some services may still require prior authorization.

Select and **Value** plans generally do not include broad out-of-state provider reciprocity and are typically limited to true medical emergencies when care is received outside the member's home coverage state. Claims for non-emergency services provided to out-of-state Ambetter Value Plan members may be denied if pre-approval is not obtained.

For prior authorization information, visit AmbetterHealth.com to locate the appropriate state-specific Ambetter website and access the applicable Pre-Auth tool. If authorization is required, follow the guidance provided in the tool.



Quality

Why the Notification of Pregnancy (NOP) Matters: Creating Opportunities for Better Outcomes ● ●

Early identification of pregnancy is one of the most important steps in improving maternal and infant health outcomes. Submitting a Notification of Pregnancy (NOP) as soon as pregnancy is confirmed allows Home State Health to identify pregnant members earlier, assess risk, and connect members to maternity support services throughout pregnancy.

Members identified during the first trimester are substantially more likely to engage with Care Management than those identified later in pregnancy. Earlier identification provides additional opportunities to address clinical and social risk factors, reinforce prenatal care, and connect members to community resources and supports.

Home State Health data show that delayed pregnancy identification is associated with lower Care Management engagement rates. Among infants requiring NICU care, babies born to members whose pregnancies were identified during the second trimester experienced a longer average NICU length of stay compared to those identified during the first trimester. While many factors influence outcomes, these findings suggest that earlier identification creates more opportunities for coordinated support and intervention.

Additionally, Home State Health has historically observed approximately a 3% improvement in NICU utilization rates among pregnancies with an NOP on file compared to those without an NOP, further highlighting the value of early identification and proactive outreach.

Providers play a critical role in this process. Timely NOP submission strengthens collaboration between providers and Home State Health, helping ensure members receive the support and services needed for healthy pregnancies and improved birth outcomes.



How to Submit an NOP and Connect a Member to Care Management

Providers may submit a Notification of Pregnancy through the **MO HealthNet Division (MHD) MHD NOP and Risk Screening Portal**.

To refer a member to Care Management or learn more about maternity support services:

- Email HSHPCareManagement@Centene.com
- Call **1-855-694-4663**
- Submit a referral through the Home State Health **Notice of Pregnancy** webpage

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Quality, continued

Learn More About Maternal Health Resources and Care Management

Join the **Optimizing Benefits for Maternal and Infant Health Meetings**, a collaborative effort between the MO HealthNet Division, MCOs, and community partners. Sessions highlight available maternity benefits, Care Management services, doulas, transportation, oral health resources, and other supports available to MO HealthNet members.

Did You Know?

Providers may receive an additional **\$50 claim payment for entering prenatal screenings in the MO HealthNet Division (MHD) NOP and Risk Screening Portal**. To receive reimbursement, providers must follow MO HealthNet billing requirements and submit a claim using the appropriate billing codes.

Members may receive **up to two prenatal screenings per calendar year**, allowing both the diagnosing provider and the obstetric provider to be reimbursed when they collect and enter NOP and risk screening information. For additional guidance on the NOP workflow and billing process, view the **Notification of Pregnancy and Risk Screening Workflow and Billing** presentation and resources available through MHD.

New: HR1 Work Requirement Exemption

Timely NOP submission helps ensure pregnant members are identified early, connected to available maternity resources, and appropriately assigned a pregnancy ME code.

This designation supports exemption from HR1 work requirements and can avoid the need for members to separately submit evidence of pregnancy.

Getting Ready for the 2026-2027 Influenza Season ●●●●●

The American Academy of Pediatrics (AAP) continues to recommend annual influenza vaccination for everyone 6 months and older. Recent seasons have shown how quickly influenza can become severe across all age groups, especially for young children, older adults, pregnant individuals, and people with chronic medical conditions.

AAP recommends annual influenza vaccination of all children without medical contraindications starting at 6 months of age

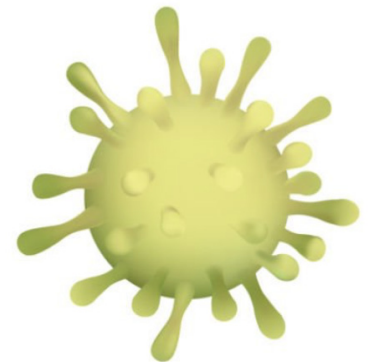
All children and their families should be vaccinated for influenza, emphasis should be placed on ensuring that high-risk children and their families, household contacts and caregivers.

High risk people

- Children <5 years, especially those <2 years
- Pregnant women
- Those 65 or older
- Children born preterm or early term
- Residents of a chronic care facility or nursing home

Underlying medical problems

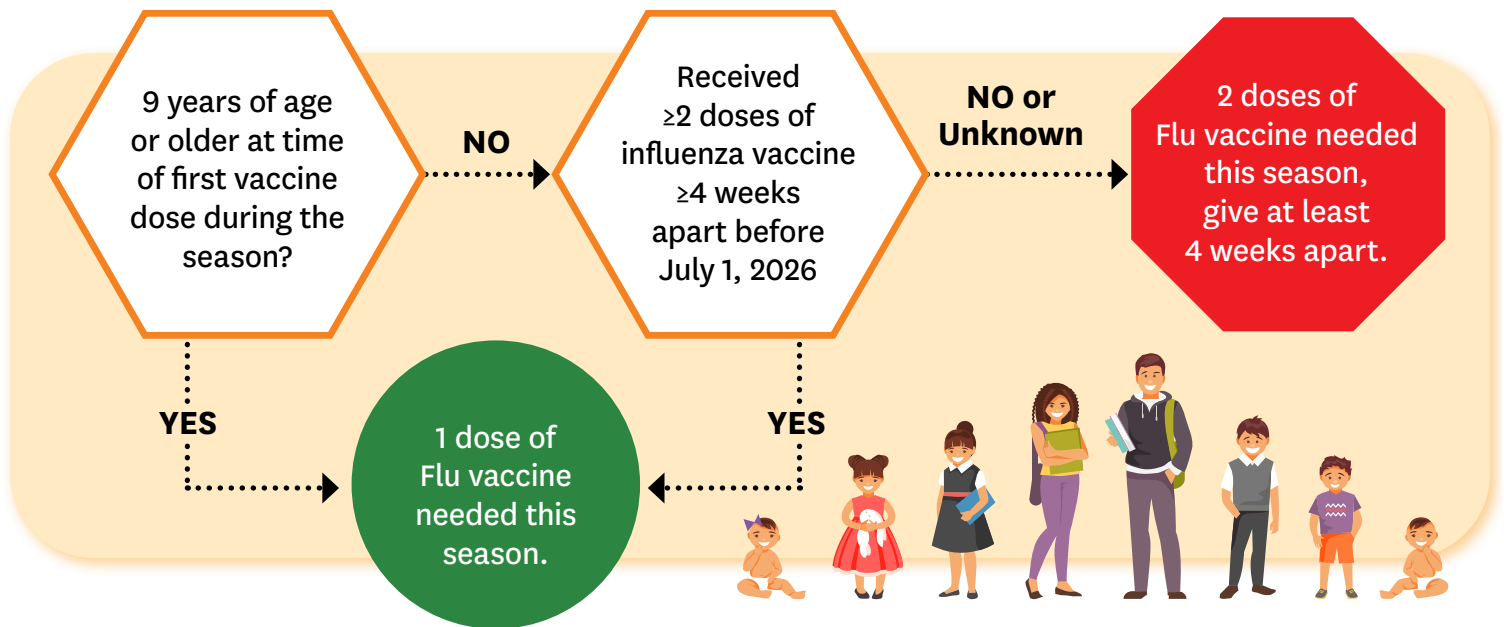
- Heart disease
- Lung disease
- Kidney disease
- Liver disease
- Blood disease
- Metabolic disease
- Neurologic disease
- Obesity
- Immunosuppression



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Quality, continued



Dosing

Flu vaccine should be given as soon as it is available and throughout the flu season. Ideally everyone should be vaccinated by the end of October to get the best protection.

Injectable Influenza vaccine is recommended for pregnant and breastfeeding women as it protects them and their baby.

For adults 65 years and older, one of the following higher dose or adjuvanted influenza vaccines is preferred: Fluzone High Dose (HDIV3), Flublok (RIV3), or Flud (aIV3, adjuvanted). If none of these three vaccines is then any other available age-appropriate influenza vaccine should be given.

FluMist (LAIV) remains an option for healthy individuals 2–49 years for families who prefer a needle free option.

Remember, giving that first dose early is especially important for those who need 2 doses.

Key strategies

- Review the need for influenza vaccine at all visits. Start the conversation early to prepare your patients and their families to get vaccinated when it is time.
- Vaccinate at all visit types (well visits, sports physicals, acute care visits, follow-up visits, etc.)
- Try to Increase influenza vaccine availability giving it at all visit types, setting up walk-in flu vaccine appointments and expanded hours for flu vaccine.
- Send influenza vaccine reminder messages as the flu season approaches.
- Reach out to high-risk patients first.
- Use evidence-based messaging about the need for flu vaccine setting appropriate expectations for the influenza vaccine.

Helpful tips for vaccine communication:

www.aap.org/vaccinecommunication

Together we can help protect our members against influenza and influenza-associated complications, hospitalizations and deaths.



Quality, continued

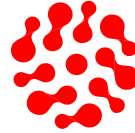
Upcoming AMA-Approved CPT Maternity Care Coding Changes ● ● ● ● ●

In collaboration with the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA) CPT Editorial Panel has approved a shift away from the long-standing global obstetric billing model to a phase-based, visit-level structure. Maternity care will be reported across four distinct phases of care: antepartum, labor management, delivery, and postpartum. This change is intended to better reflect modern, team-based obstetric practice and to support more accurate attribution, quality measurement, and claims reporting.

For additional guidance, please refer to: [CPT Maternity Care Services Codes and Guidelines | AMA](#) and [Payment for Obstetric Services | ACOG](#). As we receive additional guidance from MHD, more information will be shared related to state specific changes.

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](#)



Risk

Risk Adjustment Coding Corner ● ● ● ● ●

As respiratory illness season approaches, encourage patients to schedule any remaining Annual Wellness Visits and routine follow-up appointments before the end of the year. These visits provide valuable opportunities to review overall health. You can address preventive care needs such as missed or needed immunizations, check for missed or needed preventative screenings such as mammograms, HgbA1c and colonoscopies as well as ongoing assessment of chronic conditions.

Provider documentation plays an important role in risk adjustment. Accurate and complete documentation helps reflect the full health status of your patients, supports care coordination, and ensures chronic conditions are appropriately captured each year. Remember to document all conditions that are monitored, evaluated, assessed, addressed, or treated during the encounter.

“Risk adjustment is a way to help make sure doctors and other health providers are paid fairly for the people they treat—providers get paid more for patients who have more health problems than for healthy patients who may not need as many services. It evens the playing field, recognizing that not all patients are the same, so that providers are able to treat patients with different health care needs and not just healthier, less costly patients.”

—cms.gov/priorities/innovation/key-concepts/risk-adjustment

With end of year approaching, now is a great time to help patients get the care they need.



Claims Information



Electronic Visit Verification (EVV): What It Is and How It Works ● ● ● ● ●

Electronic Visit Verification (EVV) is a federally mandated system used to verify that home and community-based services were delivered as authorized. EVV electronically records and validates visit information for personal care and home health care services to help ensure members receive approved services and that providers are accurately reimbursed. EVV requirements were established under the 21st Century Cures Act and are used by Medicaid programs nationwide.

Key Information Captured by EVV

- Member/Participant Medicaid ID
- Date of service
- Time the service began and ended
- Provider Medicaid ID
- Caregiver information
- Procedure code and modifier
- Number of service units provided

These data elements are used to verify service delivery and support claims payment.

How EVV Works

Step 1: Service Is Delivered

A caregiver visits the member and provides the authorized service. The caregiver records the visit electronically using an EVV-approved system.

Step 2: Visit Data Is Submitted

The providers EVV vendor transmits visit information to the **EVV Aggregator Solution (EAS)**. Providers are responsible for ensuring visit data is submitted accurately and timely.

Step 3: Visit Verification

The EAS reviews the visit and places it in a verified status when all required information is present and valid. Providers should regularly review the EAS to ensure visit records are complete and accurate.

Step 4: Claim Submission

The provider submits a claim through the normal claims submission process. No special claim submission method is required.

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Claims, continued

Step 5: Claims Validation

The claim is compared against the verified EVV visit in the EAS. The following elements must match:

- Member Medicaid ID
- Date(s) of Service
- Provider Medicaid ID
- Procedure Code/Modifier
- Number of Units

If all required data matches, the claim can continue through payment processing.

Common Reasons Claims Do Not Match EVV Records

Claims may be denied or flagged when:

- The provider is not using EVV.
- The EVV vendor is not sending visit data to the EAS.
- The visit is not in a verified status.
- The provider Medicaid ID does not match.
- The member Medicaid ID (DCN) does not match.
- Units on the claim do not match units recorded in EVV.
- No visit exists for the submitted date or procedure code.
- The claim is submitted before EVV data is transmitted to the EAS.

Why EVV Is Important

- **Improves Program Integrity:** EVV helps verify that authorized services were delivered to eligible members and reduces the risk of improper billing.
- **Supports Claims Accuracy:** Matching claims to verified visits improves payment accuracy and reduces the need for rework and corrections.
- **Enhances Compliance:** Providers are required to comply with EVV requirements and maintain accurate visit records. Non-compliance may result in administrative action or claim denials.



Frequently Asked Questions

Does EVV change how claims are submitted?

No. Claims are submitted through existing claims processes. EVV adds a validation step that compares claim information to verified visit data.

What happens if no matching EVV visit is found? Claims may be denied if a corresponding verified EVV visit cannot be matched to the claim.

How often should providers review EVV data? Providers are expected to routinely review their EAS records to ensure visits are accurate, complete, and verified.

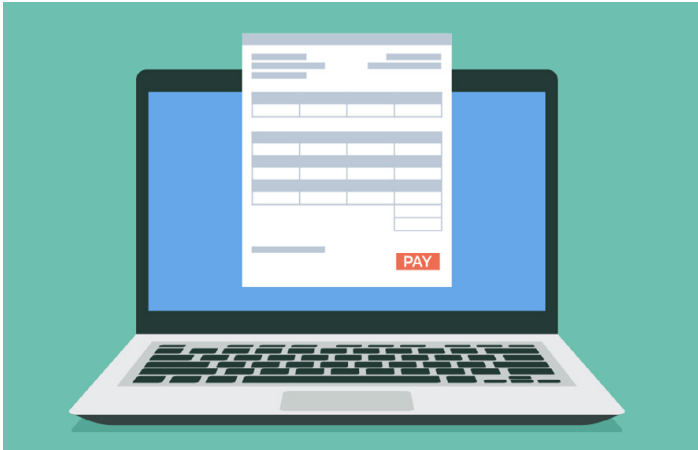
Summary

Electronic Visit Verification (EVV) is a required process that electronically documents and verifies home-based healthcare services. EVV data must accurately match the information submitted on claims, including the member ID, service dates, provider ID, procedure codes/modifiers, and units. By ensuring visit information is complete, verified, and transmitted to the EVV Aggregator Solution, providers can reduce claim denials and maintain compliance with Medicaid requirements.

Resources:

MO-DSS Dedicated Page, See “Education & Training” <https://mydss.mo.gov/mhd/evv>

Claims, continued



Balance Billing ● ● ●

Balance billing occurs when a healthcare provider bills a patient for the difference between the provider's charge and the amount paid by insurance. This typically happens with out-of-network providers or facilities.

In contrast, in-network providers agree to accept the insurance payment in full and cannot balance bill patients. For Medicaid, balance billing is explicitly prohibited, ensuring patients are not financially responsible for amounts beyond Medicaid coverage.



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

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

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