



Partners in Health

Quarterly Provider Newsletter



From the Desk of:
Shawn Furey

Plan President & CEO

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I'm pleased to welcome you to our *Q2 Provider Newsletter* and to share a few words as I recently stepped into my role as Plan President & CEO for Home State Health.

While I am new to this role, I am not new to Home State. I've had the privilege of serving our organization for more than 12 years, most recently in Government Relations, where I worked closely with providers, community partners, and state stakeholders. That experience has reinforced just how critical our provider relationships are to delivering high-quality, accessible care for our members.

At Home State Health, we are deeply committed to supporting you and your patients. Our teams work every day to ensure our members have access to high-quality health care and that you have a coordinated, efficient, and responsive experience working with us. We recognize the complexity of today's healthcare environment and the many challenges you navigate in caring for our members.

As we move forward together, our focus remains on partnership by listening, collaborating, and continuously improving the provider and member experience. Your dedication and expertise are essential to our shared success, and we are grateful for the care you provide to our members across Missouri.

Thank you for all that you do. Please don't hesitate to reach out if you have questions or need support. We value our partnership and look forward to continuing our work together.



Provider Announcements

Model of Care (MOC) Training ● ●

Model of Care Training Required

The Centers for Medicare & Medicaid Services (CMS) require health plans to provide annual education and training regarding our Special Needs Plan (SNP) Model of Care to providers who treat our SNP members. This applies to our Dual Eligible Special Needs Plan (D-SNP) members, who are eligible for both Medicare and Medicaid.

As stated in our provider manual, all providers who treat our D-SNP members, regardless of network participation status, must complete Model of Care training annually by December 31.

How to Access Training

The Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC) training is available for download and self-study at:

- [Wellcare by Allwell MOC Training](#) or
- [Wellcare MOC Training](#)

We appreciate the quality care you provide to our members, as well as your compliance with CMS D-SNP MOC reminder training requirements. Home State Health's MOC is focused on the unique needs of your dually eligible Medicare-Medicaid patients. Our MOC includes information on the clinical support programs we offer you and your Medicare-Medicaid covered patients.

For additional information on how to work with our health plan to manage SNP members, please visit our [Provider Resources page\(s\)](#) at:

- [Wellcare by Allwell Provider Resources](#) or
- [Wellcare Provider Resources](#)

The [Provider Resources](#) page includes links to provider manuals, Quick Reference Guides, Clinical Practice Guidelines, and more.



Medicare Telehealth Flexibilities Extended Through 2027 ● ●

Medicare has extended their current telehealth flexibilities through December 31, 2027 for all eligible Medicare providers. Telehealth policies allow:

Members may receive telehealth services from **any location**—no rural or originating-site limitations.

- **No restrictions** on which types of providers may deliver telehealth. Starting January 1, 2028, physical therapists, occupational therapists, speech-language pathologists, and audiologists can no longer furnish Medicare Telehealth services.
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can serve as Medicare distant site providers for non-behavioral/mental telehealth services.
- An in-person visit within six months of an initial Medicare behavioral/mental telehealth service, and annually thereafter, is not required.
- **No technology requirement**—audio-only telehealth is permitted for certain non-behavioral, non-mental health services.
- **Teladoc** services remain available **24/7 at \$0 cost share**.
- Telehealth from in-network providers applies the **same cost share** as an in-office visit (e.g., PCP or specialist rates). Members should refer to their EOC for full cost-share details.

If you have any questions, please contact your Provider Engagement Representative.

Provider Announcements, continued

Providing Quality Care ● ● ●

Helping You Care for Your Patients Is Our Top Priority

Home State Health offers helpful resources on homestatehealth.com to support you in providing great care for your patients. Clear communication and trust make a real difference in patient satisfaction and health outcomes. Home State Health appreciates the care you take in building strong, lasting relationships with your patients.

Annual Member Experience Surveys

The Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS), the Qualified Health Plan Enrollee Experience Survey (QHPEES), and the Outpatient Mental Health Survey (OPMH) offer your patients opportunities to report their satisfaction with their healthcare, including their experience with their clinicians, providers, and the health plan. Survey results are used to determine patient and member satisfaction, their likelihood of staying with their practitioner, provider, or health plan, and opportunities to improve satisfaction with their healthcare.

Annual Provider Satisfaction Survey

You play a vital role in providing high-quality care to our members, and your experience with Home State Health matters. Each year, we invite providers to share feedback through our Provider Satisfaction Survey. Your input helps us improve and shape future quality initiatives—so if you receive the survey, please take a few moments to complete it.

Home State Health's Support Doesn't Stop There

Our website contains essential information, including:

- Member and provider rights and responsibilities
- Health equity resources
- Language services and resources
- Provider credentialing rights
- The Utilization Management process
- Pharmaceutical procedures and Preferred Drug List (PDL)
- Clinical criteria
- How to access care management services

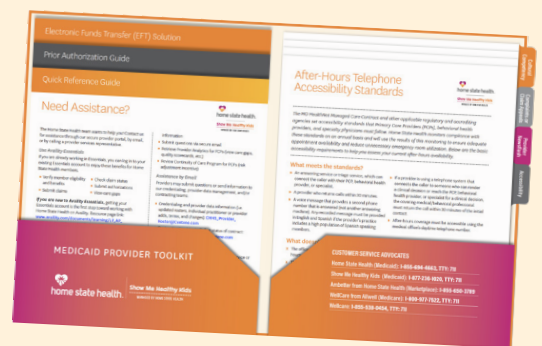
Read more now at: homestatehealth.com/providers/tools-resources/quality-care.html

If you have additional questions or need specific support, call Provider Services at: **1-855-694-4663**.

New Provider Toolkit ● ●

To support our network providers, Home State Health has developed a comprehensive Provider Toolkit. This toolkit offers essential resources to help providers work effectively with the health plan, including guidance on prior authorization, claims and payments, key contact information, after-hours and accessibility requirements, and cultural competency expectations. Together these resources support the delivery of high-quality, patient-centered care. The Provider Toolkit is available on our website under

Provider Resources and can be accessed here: homestatehealth.com/providers/tools-resources.html





Provider Announcements, continued



Submitting Prior Authorizations – Fast, Secure, and Online ●●●●●

To help streamline prior authorization requests and reduce processing delays, **Home State Health encourages providers to submit prior authorizations electronically** using our secure provider tools.

Providers can submit, view, and track authorization requests through **Availity Essentials** or the **Home State Health Secure Provider Portal**, both available 24/7 and designed to support efficient, secure workflows.

Why submit electronically?

Electronic submission helps support:

- Faster intake and processing of authorization requests
- Realtime tracking and status visibility
- Secure exchange of clinical documentation
- Fewer followups and reduced administrative burden

Where to submit authorizations:

- **Availity Essentials** – A single, secure location to submit authorizations, check status, and manage multiple payer interactions
- **Home State Health Secure Provider Portal** – Direct access to submit, view, and track authorization requests for Home State Health members

If you are already using Availity Essentials, you can continue to submit authorizations there for Home State Health plans. Providers new to Availity can create a free account to get started.

Submitting **one prior authorization request per service** helps us process requests more efficiently and avoid delays.

Need help? Provider support is available:

- **Via phone using the contact information available at the end of this newsletter**
- In portal-based training and resources, which are available at:
 - » **Availity Essentials:** Availity Essentials
 - » Home State Health: **Provider Training**

Submitting prior authorizations electronically helps keep requests moving smoothly and supports timely care for our members. Thank you for partnering with Home State Health to make administrative processes easier for your team and your patients.


Provider Announcements, continued

2026 Pharmacy Formulary Changes ● ●

On **January 1, 2026**, some drugs were no longer covered on our Medicare Part D formulary(ies). To assist our providers, we have included the list below of the most commonly prescribed drugs removed along with the drug’s 2026 formulary alternative(s). Please refer to the list to identify the appropriate options for your patients.

Product Name	Formulary Alternative
OneTouch	Accu-Chek Guide, True Metrix
Insulin Degludec	Insulin Glargine-yfgn, Insulin Glargine U-300
diclofenac 2% solution	diclofenac 1.5% topical solution
Humira (adalimumab)	Cyltezo (adalimumab-adbm)*, Yuflyma (adalimumab-aaty)*, Tyenne (tocilizumab-aazg)*, Steqeyma (ustekinumab-stba)*, Cosentyx*, Otezla*, Rinvoq*, Skyrizi*, Tremfya*
Actemra (tocilizumab)	Cyltezo (adalimumab-adbm)*, Yuflyma (adalimumab-aaty)*, Tyenne (tocilizumab-aazg)*, Steqeyma (ustekinumab-stba)*, Cosentyx*, Otezla*, Rinvoq*, Skyrizi*, Tremfya*
Austedo, Austedo XR	tetrabenazine*, Ingrezza*
Trulance	lubiprostone, Linzess
Bydureon BCise	Mounjaro*, Ozempic*, Rybelsus*, Trulicity*
Gammagard Liquid	Gamunex-C*
Xultophy	Soliqua
abiraterone 500mg	abiraterone 250mg tab*, abirtega 250mg tab*
Fasenra	Dupixent*, Xolair*
Vivitrol	acamprosate, disulfiram
Opsumit	ambrisentan*, bosentan*, sildenafil 20mg*, tadalafil 20mg*
	* Prior Authorization Required

If you determine that it is necessary for your patient to continue to receive the non-formulary drug in 2026, you will need to submit a Coverage Determination request **after January 1, 2026**.

Request forms are located on our website on the Coverage Determinations and Redeterminations for Drugs page or you can call to request authorization.

Wellcare by Allwell	Wellcare
wellcare.com/allwellMO Medicare Pharmacy Services: 800-867-6564	wellcare.com/Medicare Medicare Pharmacy Services 855-538-0454



Quality



Updates Regarding the Center for Disease Control (CDC) Childhood and Adolescent Immunization Schedule ● ● ● ● ●

We want to provide clarification following the recent updates to the CDC Childhood and Adolescent Immunization Schedule (January 5, 2026).

Coverage for childhood vaccines has not changed. *Home State Health* will continue to cover recommended childhood immunizations in accordance with federal requirements, state policy, and plan contracts. Our commitment remains ensuring uninterrupted access to vaccines and supporting providers in delivering preventive care.

What You Need to Know

- Childhood vaccines recommended by the CDC as of December 31, 2025, remain covered under federal insurance programs and Affordable Care Act plans
- No loss of coverage or reimbursement is expected because of the recent CDC schedule updates

- Coverage continues under Medicaid Early and Periodic Screening Diagnostic and Treatment (EPSDT) requirements, ensuring access to preventive services for children
- Vaccines available through the Vaccines for Children (VFC) program remain unchanged

We recognize there has been national discussion regarding recent CDC schedule language updates, and providers may have questions about how this affects quality measures and reporting.

Key clarification: There is currently a difference between evolving clinical guidance language and formal quality measurement specifications.

- Healthcare Effectiveness Data Information Set (HEDIS) measures are established by NCQA and typically do not change in real time with policy or guidance updates

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Quality, continued

- At this time, NCQA/HEDIS immunization measure specifications have NOT changed
- Although CDC language has shifted, the quality measures providers are scored on remain the same
- Performance measurement, gap reports, and incentive program metrics are unchanged for the current measurement year

We will monitor for NCQA or regulatory updates and share any changes quickly.

Effective Vaccine Communication Strategies

- **Use a presumptive approach.** Start with statements like «It's time for your vaccines today» rather than «What do you think about vaccines?» This normalizes vaccination as routine medical care rather than an optional choice.
- **Reinforce social norms.** Stating “most of my patients get these vaccines” framing vaccination as the standard choice and refusal as outlier behavior.
- **Build trust by building bridges:** Acknowledge and understand concerns. Remember that parents and patients believe they are doing the right thing for themselves and their children. Too much information and trying to “show the data” often backfires. Parents and patients respond better to narratives and your shared experiences.
 - » Inquire about their concerns on the vaccine and validate their feelings. Then ask for permission to share your thoughts that may address a specific concern.
 - » Vaccine conversations should be ongoing. Parents and patients who initially refuse may change their minds over time with consistent messaging from their trusted provider.

Give your patients trusted resources to help “prebunk” misconceptions before they take hold.

- [HealthyChildren.org](https://www.healthychildren.org)
- [Follow Pediatricians for Trustworthy Content on Children's Health \(pdf\)](#)

Counter specific misconceptions. Use evidence-based responses to common myths:

- **“Vaccines cause the flu”:** Explain that side effects like fever or fatigue represent the body's natural immune response, not infection. It is actually a good thing. It means your immune system is preparing itself for the real infection.
- **“Too many vaccines overload the immune system”:** Explain our immune system sees thousands of antigens every day. The vaccine is training your immune system, so it is ready for the real infection.
- **Vaccines are unsafe:** Address safety transparently. Instead of simply stating vaccines are “safe,” explain the rigorous testing process, robust surveillance systems before, during and after vaccines are licensed for use.
- **Why are there different vaccine schedules?** Acknowledge to your patients that this may be confusing and you are there to answer any questions they might have. Although HHS has a new vaccine schedule, the science behind vaccines and their safety had not changed. The American Academy of Pediatrics released its 2026 Recommended Child and Adolescent Immunization Schedule, which has been endorsed by 12 major medical organizations including the American Academy of Family Physicians, American Medical Association, Infectious Diseases Society of America, and Pediatric Infectious Diseases Society. This schedule continues to recommend protection from 17 diseases as routine.

 **Quality, continued**



When EPSDT requirements are met and documented, Medicaid reimburses at the EPSDT rate, reflecting the full scope of preventive work. Most providers already perform these visits and the components — they just need to code them correctly.

What Counts as a FULL EPSDT Visit?

A full EPSDT screen includes all the following components:

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam (age appropriate, respectfully draped) appropriate, respectfully draped)
- Immunization review and administration if due
- Laboratory testing as age or risk appropriate or risk appropriate
- Blood lead testing at 12 and 24 months (risk questionnaires do not replace testing)
- Health education and anticipatory guidance
- Vision screening or surveillance
- Hearing screening or surveillance
- Dental screening, counseling, and referral if needed
- Any necessary referrals, diagnostics, or follow-up

**Based on guidance from the American Academy of Pediatrics and Bright Futures Guidelines: aap.org/periodicityschedule*

Early Planning for Well Visits ● ● ● ● ●

Preventive care visits for children and adolescents is an important part of pediatrics, family medicine, and general practitioners. Yet in the rush of busy clinic schedules, it's easy for families and providers to fall behind these visits. Early planning helps ensure infants, children, and teenagers receive timely preventive care, developmental surveillance, and the anticipatory guidance that supports healthy growth. Most clinicians caring for children use the AAP Bright Futures guidelines, the national standard for preventive care in children and adolescents. Did you know that these preventive visits fall under EPSDT?

EPSDT in Missouri:

What Providers Need to Know

Missouri's EPSDT program is called Healthy Children and Youth (HCY). HCY provides comprehensive preventive and primary care services for all MO HealthNet eligible children and youth under age 21.

EPSDT includes three types of screenings: eligible children and youth under age 21.

- Full office visits
- Partial office visits
- Interperiodic screenings (as medically necessary)

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Quality, continued

Coding a FULL EPSDT Visit Correctly

1. Start with the correct primary diagnosis code:

- Z00.110 – Newborn under 8 days
- Z00.111 – Newborn 8–28 days
- Z00.121 – Routine child exam with abnormal findings
- Z00.129 – Routine child exam without abnormal findings
- Z00.00 – Routine adult exam without abnormal findings (for 18 years and up)
- Z00.01 – Routine adult exam with abnormal findings (for 18 years and up)

2. Choose the correct preventative CPT code by age (New patient/Established patient):

- Infants <1 year: 99381 / 99391
- Children 1–4 years: 99382 / 99392
- Children 5–11 years: 99383 / 99393
- Adolescents 12–17 years: 99384 / 99394
- Young adults (18 years and up, through age 20): 99385 / 99395

3. Diagnosis codes that should NOT be billed with EPSDT visits:

- Z00.6 – Encounter for examination for normal comparison and control in a clinical research program
- Z00.8 – Encounter for other general examination
- Z02.1 – Encounter for preemployment examination
- Z02.3 – Encounter for examination for recruitment to armed forces
- Z02.4 – Encounter for examination for driving license
- Z02.81 – Encounter for paternity testing
- Z02.83 – Encounter for blood alcohol and blood drug testing alcohol and blood drug testing

4. ADD the EP modifier to the CPT code

- **The most common EPSDT error is missing the EP modifier.** Most clinicians already provide full EPSDT services during routine well visits. The EP modifier simply tells Medicaid, “This was an EPSDT visit.”
- **Adding the EP modifier to the CPT code is required.** It’s what ensures the visit is recognized as EPSDT and reimbursed correctly.

Common EPSDT Billing & Coding Errors

- **Wrong preventative CPT code for the child’s age**
 - » Ex: Billing 99392 (1-4 years) for a 5-year-old instead of 99393
- **Wrong visit type**
 - » Ex: Billing a new patient for established patient
 - » Ex: Billing a sick visit (99213) when the child came for a well visit
- **Missing or incorrect modifiers**
 - » Ex: Completing all EPSDT components but forgetting EP modifier
 - » Ex: Using EP with a non-preventative diagnosis
 - » Ex: Forgetting 52 on a partial EPSDT screen (EP + 52)
- **Incorrect diagnosis code**
 - » Ex: Using a sick diagnosis as the primary diagnosis for a well visit
 - » Ex: Using one of the DO NOT BILL WITH THESE diagnosis codes and not one of the newborn, ROUTINE child or adult examination visit diagnosis codes listed above
- **Not coding immunizations, lead tests, or labs correctly**
 - » Ex: Giving vaccines but not billing vaccine or admin codes
 - » Ex: Completing the 12-month lead test but forgetting to bill the CPT code
- **Lead Testing: Clarifying the Timing**
 - » The 12-month lead test must be completed at the 12-month well visit once the child is ≥12 months old.
 - » The 24-month lead test must be completed at the 24-month well visit once the child is ≥24 months old.

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Quality, continued



- **Incorrect use of Full vs. Partial EPSDT screens**
 - » FULL = EP modifier when all 10 components are completed
 - » Partial = EP + 52 modifiers when 5 or more components are completed but include at least the following 5 components:
 - **Growth assessment:** Growth parameters reviewed and documented on growth chart
 - **Focused physical examination**
 - **Immunizations:** Reviewed and administered as age-appropriate / not administered due to [reason]
 - **Laboratory testing:** Age- and risk-appropriate labs reviewed/ordered/performed as indicated
 - **Lead toxicity screening:** Lead risk assessment completed and blood testing addressed per MO guidelines

By scheduling early, planning carefully, coding accurately, and consistently applying the EP modifier, your practice can efficiently manage well-visits and school physicals for all ages. EPSDT isn't extra work. It's the work you already do. EPSDT is part of your patients' routine care, and your efforts significantly improve pediatric health outcomes.

Risk ---

Coding Corner – Documentation Best Practices

This Quarter's Focus: Strengthening Documentation Accuracy

- **Clearly document chronic conditions**
 - » Chronic conditions that affect patient management should be addressed and documented at least once a year. Make sure the documentation reflects the current status so the record shows an accurate clinical picture.
- **Use “history of” only when appropriate**
 - » “History of” should be used for conditions that have fully resolved. If the condition is ongoing, being monitored, or influences patient care, document it as active—even if the condition is stable.
- **Ensure diagnoses are properly linked**
 - » For conditions that require linkage—such as diabetes with a complication—be sure the relationship is clearly stated in the documentation. This supports accurate coding and more precisely captures the patient's health status.
- **Avoid unspecified diagnoses when more detail exists**
 - » If the chart supports a more specific diagnosis, document it accordingly. Specificity helps maintain high-quality data and reduces coding ambiguity.

As always, please stay connected with your coding team and refer to your ongoing education resources to ensure you have a complete and current understanding of these topics.



Claims Information

6 Degrees Health Inpatient Hospital Clean Claim Reviews and All Patient Refined Diagnostic Related Groups (APR-DRG) Validation ● ●

In 2025, Home State Health implemented the following programs to ensure accurate APR-DRG payments for impacted inpatient hospital claims.

When Home State Health requests additional information, providers are directed to send it to the address or other destination mentioned in the request letter or risk receiving a technical denial.

6 Degrees Health Reviews

Claims subject to 6 Degrees Health review will pay at the APR-DRG rate; however, additional information may be needed before any outlier payments can be made. 6 Degrees Health sends letters requesting this information. Providers can submit requested information via mail, fax, or email as outlined in the request letter.

More on this clean claim process:

- Certain high-dollar claims will be identified for review.
- For identified claims, 6 Degrees Health sends letters requesting comprehensive itemized bills and related documentation.
- Upon receipt of the documentation,

if the 6 Degrees Health review results in findings, they will issue a letter explaining the results and next steps. If there are no findings, the claim will be processed as billed.

- If you do not respond to the documentation request, no additional reimbursement will be issued.

For more information on Clean Claim reviews, please refer to the following Payment Policies on Home State Health’s website: [Clinical & Payment Policies | Home State Health](#)

- CC.PI.04 Clean Claim Reviews
- CC.PI.06 Cost to Charge Adjustments on Clean Claim Reviews
- CC.PI.10 Unbundling Adjustments on Clean Claim Reviews

Denial Reason Codes			
EX Code	Description	RARC	CARC
EXn0	Percentage of contracted rate paid. Submit itemized bill for review.	N26	252
EXn9	Itemized bill not received as requested.	M127	226
EXm4	Claim outlier payment adjusted based on claim review.		70
EXm5	Itemized bill required for claim review	N26	252

APR-DRG Validation

HSB will review certain APR-DRG eligible claims before or after payment to ensure the diagnosis and procedure codes match the medical records. This helps confirm that the billing is supported by the documentation.

- **Pre-payment Review:** Claims selected for pre-payment review will be denied until the required medical records are submitted.

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Claims, continued

- Post-payment Review:** Cotiviti will send up to three requests for medical records after payment. If records are not submitted within the specified timeframes, the claim will be recouped. For provider groups using an electronic medical record (EMR) system, medical records will be requested through an agreed upon method and would then be made available for retrieval by way of the EMR system provided/used by the provider.

For more information, please visit Home State Health’s website: [APR-DRG Payment System](#).



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

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