home state health™

Behavioral Health Provider Manual

1-855-694-HOME (4663)
TTY: 1-877-250-6113, Relay 711

HomeStateHealth.com

Welcome to Home State Behavioral Health

Welcome to the Home State Health provider network. We look forward to a long and mutually rewarding partnership as we work together in the delivery of mental health and substance abuse services to Home State Health (Home State) members in Missouri.

The Home State Behavioral Health Provider Manual is designed to answer your questions about our behavioral health program and to explain how we manage the delivery of mental health and substance abuse services to the members we serve.

This manual provides a description of Home State Health's treatment philosophy and the policies and procedures administered in support of this philosophy. It also describes the requirements established by Home State Health and its clients and the performance standards for Network Providers in the delivery of services to members. Home State Health will provide bulletins as needed to incorporate any needed changes to this manual online at www.Home State Health.com. Additionally, we offer a wealth of resources for our Missouri providers on our website including this Manual and provider forms.

We look forward to working with you and providing you with support and assistance. We hope you find your relationship with Home State Health a satisfying and rewarding one.

About Home State Health

MISSION

Creating innovative solutions that drive quality health care for vulnerable populations.

VISION

To establish a national presence as an industry leading, health solutions organization for children, Medicaid, and specialty therapies.

GOAL

To improve outcomes and deliver savings through innovation.

Home State Behavioral Health

As an integral part of our core philosophy we believe quality behavioral healthcare is best delivered locally. Home State Health is a clinically driven organization that is committed to building collaborative partnerships with providers.

Home State Health defines "behavioral health" as inclusive of acute and chronic psychiatric and substance abuse disorders as referenced in the most recent International Statistical Classification of Diseases and Related Health Problems (ICD-10). Home State Health provides quality, cost effective behavioral healthcare services for members of Home State Health through a comprehensive provider network of qualified behavioral health providers.

An experienced provider network is essential to provide consistent, superior services to our members. To achieve our goals, Home State l Health builds strong, long-term relationships

with our provider network. This Provider Manual was designed to assist you with the administrative and clinical activities required for participation in our system. Home State Health prefers and encourages a partner relationship with our provider network. Member care is a collaborative effort that draws on the expertise and professionalism of all involved.

Managed Care Philosophy

Home State Health is strongly committed to the philosophy of providing appropriate treatment at the least restrictive level of care that meets the member's needs.

We believe careful case-by-case consideration and evaluation of each member's treatment needs are required for optimal medical necessity determinations. We believe members need to be fully involved in their care and participate in decisions regarding treatment needs.

Unless inpatient treatment is strongly indicated and meets Medical Necessity Criteria, outpatient treatment is generally considered the first-choice treatment approach. Many factors support this position:

- Outpatient treatment allows the member to maximize existing social strengths and supports, while receiving treatment in the setting least disruptive to normal everyday life.
- Outpatient treatment maximizes the potential of influences that may contribute to treatment motivation, including family, social, and occupational networks.
- Allowing a member to continue in occupational, scholastic, and/or social activities increases the potential for confidentiality of treatment and its privacy. Friends and associates need not know of the member's treatment unless the member chooses to tell them.
- Outpatient treatment encourages the member to work on current individual, family, and job- related issues while treatment is ongoing. Problems can be examined as they occur, and immediate feedback can be provided. Successes can strengthen the member's confidence so that incremental changes can occur in treatment.
- The use of appropriate outpatient treatment helps the member preserve available benefits for potential future use. Benefits are maximized for the member's healthcare needs.

At Home State Health, we take privacy and confidentiality seriously. We have processes, policies and procedures in place to comply with applicable federal and state regulatory requirements.

We appreciate your partnership with Home State Health in maintaining the highest quality and most appropriate level of care for our members.

Quick Reference Guide

Home State Health Contact Information:
Home State Behavioral Health
(855) 694-HOME (4663)
www.HomeStateHealth.com

Eligibility Verification:
Phone: (855) 694-HOME (4663)
Secure Provider Portal:
www.Home State Health.com

ERA/EFT Enrollment:
Please call PaySpan Health at (877) 331-7154 or visit www.payspanhealth.com

EDI Vendors:
Gateway EDI: (800) 969-3666
Emdeon: (800) 845-6592
Availity: (800) 282-4548
SSI: (800) 880-3032)
For a full listing of EDI vendors visit us at WWW.HomeStateHealth.com

Home State Health's Behavioral Health Payor ID Number is 68068

Benefits/Covered Services:
Please refer to your fee schedule and the Missouri Covered Services & Authorization Guidelines document within the Provider Manual.

Prior Authorization and Medical Management
(855) 694-HOME (4663)
www.Home State Health.com

Home State Health Member and Provider Services:
(855) 694-HOME (4663)
TDD/TYY: 1-877-250-6113

Claims Guidelines:
Claims must be submitted within 180 days of the date of service.

Claims Address:
Home State Behavioral Health
PO Box 7400
Farmington, MO 63640-3827

Claims Support:
(855) 694-HOME (4663)

Claims Appeals Address:
Home State Behavioral Health Appeals
PO Box 6000
Farmington, MO 63640-3827

After-Hours Admissions:
Please call NurseWise at (866) 864-1459 for emergency admissions after-hours and on weekends

Medical Necessity Appeals:
Home State Behavioral Health
Attn: Appeals Coordinator
12515-8 Research Blvd., Suite 400
Austin, TX 78759
Fax: (866) 694-3649

The Home State Health Provider Network and Service Area

Home State Health reimburses claims for the covered behavioral health and substance abuse benefits for the entire state of Missouri.

Network Provider Selection Process

Home State Health contracts with the following behavioral health provider types:

- Community Mental Health Centers (CMHCs)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Licensed Psychiatrists
- Licensed Psychologists
- Psychology Interns (Supervised)
- Licensed Psychiatric Advance Practice Nurses
- Licensed Professional Counselors
- Licensed Master Social Workers
- Licensed Clinical Social Workers
- Licensed Psychiatric Clinical Nurse Specialists
- Licensed Psychiatric Mental Health Nurse Practitioners
- Licensed Home Health Psychiatric Nurse
- Licensed Psychiatric Nurse
- Licensed Marriage and Family Therapist
- Missouri Certified Substance Abuse Counselors
- State Certified Behavioral Health or Substance Abuse Programs
- QBHP – Qualified Behavioral Health Providers
- QSAP – Qualified Substance Abuse Providers
- Federally Qualified Health Centers
- Rural Health Clinics
- Psychiatric Hospitals
- General Hospitals offering psychiatric and/or substance abuse services

We work with providers that consistently meet or exceed Home State Health clinical quality standards and are comfortable practicing within the managed care arena, including those providers that demonstrate and support Home State Health's integrated care approach to member care. Network Providers should support a brief, solution-focused approach to

treatment and should be engaged in a collaborative approach to the treatment of Home State Health's members.

Home State Health consistently monitors network adequacy. Network Providers are selected based on the following standards:

- Clinical expertise;
- Geographic location considering distance, travel time, means of transportation, and access for members with physical disabilities;
- Potential for high volume referrals;
- Specialties and accessibility standards, including meeting the Americans with Disabilities Act (ADA) requirements, to best meet our members' needs;
- Ability to accept new patients;
- Ability to act as the member's medical home; and
- Experience in utilizing evidence-based practices in working with seriously mentally ill (SMI) and developmentally delayed/disabled (DD) populations.

Home State Health contracts its provider network to support and meet the linguistic, cultural and other unique needs of every individual member, including the capacity to communicate with members in languages other than English and communicate with those members who are deaf or hearing impaired.

The Network Provider's Office

Home State Health reserves the right to conduct Network Provider site visit audits. Site visits may be conducted as a result of member dissatisfaction or as part of a chart audit. The site visit auditor reviews the quality of the location where care is provided. The review assesses the accessibility and adequacy of the treatment and waiting areas.

General Network Practitioner Office Standards

Home State Health requires the following:

- Office must be professional and secular;
- Offices and facilities must be easily accessible with accommodations for members with disabilities as required and covered by titles II and III of the Americans with Disabilities Act (ADA) of 1990;
- Provide designated accessible parking spaces;
- Appropriate door sizes for clear openings with easy opening mechanism;
- Provide adequate space in clinic rooms to turn a wheelchair;
- Provide sign language interpreters, large-print materials, audio recordings, videotapes with captioning, notepads, pencils, and readers to meet alternative communication needs;
- Signs identifying office must be visible;

- Display all marketing and health education materials provided by contracted health plans in an equal fashion;
- Office must be clean, and free of clutter with unobstructed passageways;
- Office must have a separate waiting area with adequate seating;
- Clean restrooms must be available;
- Office environment must be physically safe;
- Network Practitioners must have a professional and fully confidential telephone line and twenty- four (24) hour availability;
- Member records and other confidential information must be locked up and out of sight during the workday; and
- Medication prescription pads and sample medications must be locked up and inaccessible to members.

Network Provider Concerns

Network Providers who have concerns about Home State Health should contact the Provider Relations department or Quality Improvement department at (866) 864-1459 to register these complaints. All concerns are investigated, and resolution is provided to the Network Provider on a timely basis.

Verifying Member Enrollment

Network Providers are responsible for verifying eligibility every time a member schedules an appointment, and when they arrive for services.

Network Providers should use either of the following options to verify member enrollment:

- Contact Home State Behavioral Health Customer Service at (855) 694-HOME (4663)
- Verify online at www.HomeStateHealth.com

Until the actual date of enrollment with Home State Health, Home State Health is not financially responsible for services the prospective member receives. In addition, Home State Health is not financially responsible for services members receive after their coverage has been terminated.

Network Provider Standards of Practice

Network Providers are required to:

- Refer members with known or suspected physical health problems or disorders to the member's
- PCP for examination and treatment;

- Send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent;
- Only provide physical health services if such services are within the scope of the Network Provider's clinical licensure;
- Network Providers must ensure members that are discharging from inpatient care are scheduled for outpatient follow-up and/or continuing treatment prior to the member's discharge. Home State Behavioral Health strives to meet the National Committee for Quality Assurance (NCQA) Health Care Effectiveness Data and Information Set (HEDIS) guidelines for follow up and/or continuing treatment after an inpatient visit. To that end, Home State Behavioral Health requires
- Network Providers to ensure that outpatient treatment occurs within seven (7) days following the date of discharge;
- Contact members who have missed appointments within twenty-four (24) hours to reschedule;
- Comply with Home State Health appointment access standards;
- Ensure all members receive effective, understandable and respectful treatment provided in a manner compatible with their cultural health beliefs and practices and preferred language (which can be accomplished by engaging professional interpreter services at the onset of treatment);
- Comply with all State and federal requirements governing emergency, screening and post- stabilization services;
- Provide member's clinical information to other providers treating the member, as necessary, to ensure proper coordination and treatment of members who express suicidal or homicidal ideation or intent, consistent with State law;
- Exchange information with member's PCP and/ or other behavioral health providers upon member consent;
- Comply with all Home State Health non-discrimination and cultural competency requirements; and
- Accommodate the needs of members with disabilities.

Network Providers are requested to:

- Submit all documentation in a timely fashion;
- Comply with Home State Health's Case Management and UM processes;
- Cooperate with and participate in all Home State Behavioral Health's Quality Improvement (QI) activities as requested;
- Use appropriate Medical Necessity and Evidence-based Best Practices when formulating treatment plans and requesting ongoing care;
- Assist members in identifying and utilizing community support groups and resources;
- Maintain confidentiality of records and treatment and obtain appropriate written consents from members when communicating with others regarding member treatment;

- Notify Home State Health of any critical incidents;
- Notify Home State Health of any changes in licensure, any malpractice allegations and any actions by your licensing board (including, but not limited to, probation, reprimand, suspension or revocation of license);
- Notify Home State Health of any changes in malpractice insurance coverage;
- Notify Home State Health of any change of address/location within thirty (30) days of the change;
- Complete credentialing and re-credentialing materials as requested by Home State Health;
- Maintain an office that meets all standards of professional practice, and
- Report to Home State Health when Provider has reached 85% of capacity and/or has limitations on the number of referrals that will be accepted.

Reporting Provider or Member Waste, Abuse or Fraud Waste, Abuse and Fraud (WAF) System

Home State Health is committed to the ongoing detection, investigation, and prosecution of waste, abuse and fraud (WAF).

- **Waste –** Use of healthcare benefits or dollars without real need. For example, prescribing a medication for thirty (30) days with a refill when it is not known if the medication will be needed.
- **Abuse –** Practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Home State Health program, including, but not limited to practices that result in unnecessary cost to the Home State Health program for services that are not Medically Necessary, or that fail to meet professionally recognized standards for healthcare. It also includes Enrollee practices that result in unnecessary cost to the Home State Health program.
- **Fraud –** An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the Home State Health program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable Federal or State healthcare fraud laws. Examples of provider fraud include lack of referrals by PCPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Enrollee fraud include improperly obtaining prescriptions for controlled substances and card sharing.

Home State Health, in conjunction with its management company, Centene Corporation, operates a WAF unit. If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at (866) 685-8664. Home State Health and Centene take reports of potential WAF seriously and investigate all reported issues.

Authority and Responsibility

The President/CEO and Vice President of Compliance at Home State Health share overall responsibility and authority for carrying out the provisions of the compliance program.

Home State Health is committed to identifying, investigating, sanctioning and prosecuting suspected WAF.

The Home State Health provider network shall cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, at the provider and/or subcontractor's own expense.

Home State Health staff, its provider network and their personnel and/or subcontractor personnel, shall immediately refer any suspected WAF to the Medicaid Fraud Control Unit of Missouri within the Office of the Attorney General at the following address:

Mail: Medicaid Fraud Control Unit Missouri Attorney General's Office

Medicaid Fraud Control Unit
P.O. Box 899
Jefferson City, MO 65102
Email: attorney.general@ago.mo.gov
Phone: 800-286-3932

Hotline Number - A toll-free hotline number has been established to report potential WAF issues. The hotline number is (866) 685-8664. The number is available for use by any person, including Home State Health employees and subcontractors. It is against corporate policy to retaliate against anyone who makes a referral. All callers have the option to remain anonymous.

Providers may also contact the Home State Health Compliance Department with WAF questions or concerns by phone at (855) 694-HOME (4663).

Credentialing

Credentialing Requirements

The Home State Health behavioral health provider network consists of Community Mental Health Centers (CMHCs), Certified Community Behavioral Health Clinics (CCBHCs), Licensed Psychiatrists, Licensed Psychologists, Psychology Interns (supervised), Licensed Psychiatric Advance Practice Nurses, Licensed Professional Counselors, Licensed Master Social Workers, Licensed Clinical Social Workers, Licensed Psychiatric Clinical Nurse Specialists, Licensed Psychiatric Mental Health Nurse Practitioners, Licensed Home Health Psychiatric Nurse, Licensed Psychiatric Nurse, Missouri Certified Substance Abuse Counselors, State Certified Behavioral Health or Substance Abuse Programs, QBHP – Qualified Behavioral Health Providers, QSAP – Qualified Substance Abuse Providers, Federally Qualified Health Centers, Rural Health Clinics, and Psychiatric Hospitals.

Home State Health Network Providers must adhere to the following requirements:

- In order to continue participation with our organization, all Network Providers must adhere to Home State Health's Clinical Practice Guidelines and Medical Necessity Criteria.
- Network Providers must consistently meet our credentialing standards and Home State Health guidelines on Primary Care Physician (PCP) notification.
- Failure to adhere to guidelines and standards at any time can lead to termination from our network.
- Notification is required immediately upon receipt of revocation or suspension of the Network Provider's State License by the State of Missouri.
- In order to be credentialed in the Home State Health network, all individual Network Practitioners must be licensed to practice independently.
- For MDs and DOs, Home State Health will require proof of the Network Practitioner's medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training, as applicable.
- License/Certification must be current, active, and in good standing.
- MDs and DOs must have hospital privileges and/or a coverage plan. Hospital privileges must be current and active.
- All Network Practitioners' graduate degrees must be from an accredited institution.
- All Network Providers are subject to the completion of primary source verification of the Network Provider through our Credentialing Department.
- The Network Provider agrees to complete and provide appropriate documentation for this primary source verification in a timely manner.
- The Network Provider further agrees to provide all documentation in a timely manner required for credentialing and/or re-credentialing.
- The Network Provider agrees to maintain adequate professional liability insurance as set forth in the Provider Agreement with Home State Health.

- All credentialing applications are subject to consideration and review by the Home State Health Credentialing Committee which meets monthly.

The credentialing and re-credentialing process will include verification of the following for MDs and DOs:

- Good standing of privileges at the hospital designated as the primary admitting facility;
- Valid Drug Enforcement Administration (DEA) certificates (where applicable).

Network Providers selected for participation must successfully complete the Home State Health credentialing process. As part of that process, Network Providers must submit the following documentation:

- Current and active CAQH (Council for Affordable Quality HealthCare) registration;
- Statement regarding history of loss or limitation or privileges or disciplinary activity;
- A statement from each Network Practitioner applicant regarding the following: any physical or mental health problems that may affect the Practitioner's ability to provide healthcare; any history or chemical dependency/substance abuse; any history of loss of license and/or felony conviction;
- A copy of current Missouri license(s) to practice;
- Malpractice fact sheet: Network Providers must carry $1/$3M in coverage, or such other amounts as required by State law;
- Copy of applicable diploma(s) and or certificates;
- MDs and DOs are also asked to supply Drug Enforcement Administration (DEA) registration, and Board Certification(s);
- Current curriculum vitae, which includes at least five (5) years of work history with explanation in writing for a six (6) month, or more, gap; and
- Any sanction imposed on the Network Provider by Medicare or Medicaid.

It is the Network Providers' responsibility to notify Home State Health of any of the following within ten (10) days of the occurrence:

- Any lawsuits related to professional role;
- Licensing board actions;
- Malpractice claims or arbitration;
- Disciplinary actions before a State agency and Medicaid/Medicare sanctions;
- Cancellation or material modification of professional liability insurance;
- Member complaints against practitioner;
- Any situation that would impact a Network Provider's ability to carry out the provisions of their Provider Agreement with Home State Health, including the inability to meet member accessibility standards Changes or revocation with DEA certifications, hospital staff changes or NPDB or Medicaid/Medicare sanctions.

Please notify Home State Health immediately of any updates to your Tax Identification Number, service site address, phone/fax number, and ability to accept new referrals in a timely manner so that our systems are current and accurately reflect your practice. In addition, we ask that you please respond to any questionnaires or surveys submitted regarding your referral demographics, as may be requested from time to time.

Credentialing of Health Delivery Organizations

(CMHCs and other Behavioral Health Providers/Facilities)

Prior to contracting with Health Delivery Organizations (HDO), Home State Health verifies that the following organizations have been approved by a recognized accrediting body or meet Home State Behavioral Health standards for participation, and are in good standing with state and federal agencies:

- Hospital or Facility
- Community Mental Health Center (CMHC)
- Certified Community Behavioral Health Clinic (CCBHC)

Home State Health recognizes the following accrediting bodies*:

- CARF - Commission on Accreditation of Rehabilitation Facilities
- COA - Council on Accreditation
- JCAHO - Joint Commission on Accreditation of Healthcare Organizations.
- NCQA - National Committee for Quality Assurance
- URAC - Utilization Review Accreditation Commission
- Council on Accreditation of Services for Family & Children

**This list may not be inclusive of all accrediting organizations*

For those organizations that are not accredited, an on-site evaluation will be scheduled to review the scope of services available at the facility, physical plant safety, the Quality Improvement program, and Credentialing and Re-credentialing Policies and Procedures. Home State Behavioral Health may substitute a Center for Medicare and Medicaid Services (CMS) or state review in lieu of the site visit. Home State Health would require the report from the organization to verify that the review has been performed and the report meets its standards. Also acceptable is a letter from CMS or the applicable state agency which shows that the facility was reviewed and indicates that it passed inspection.

Re-Credentialing Requirements and Schedule

Missouri Network Providers will be re-credentialed every three (3) years. Home State Health Network Providers will receive notice that they are due to be re-credentialed well in advance of their credentialing expiration date and, as such, must have a current CAQH registration on file. Failure to attest and/or update your information on CAQH in a timely manner, can result in termination from the network.

Quality indicators including but not limited to, complaints, appointment availability, critical incidents, and compliance with discharge appointment reporting will be taken into consideration during the re- credentialing process.

Council for Affordable Quality HealthCare (CAQH)

Home State Health utilizes the Council for Affordable Quality HealthCare (CAQH) to streamline the credentialing/ re-credentialing process. If you are not registered, please complete the registration process online at www.caqh.org or call the help desk at 888-599-1771.

Right to Review and Correct Information

All providers participating with Home State Health have the right to review information obtained by Home State Health to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as malpractice insurance carriers and the licensing/certification agencies. This does not allow a provider to review references, personal recommendations or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process is erroneous, or should any information gathered as part of the primary source verification process differ from that submitted, providers have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the provider will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to Home State Health. The Home State Health Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Home State Health Credentialing Policies and Procedures

Home State Health maintains written credentialing and re-credentialing policies and procedures that include the following:

- Formal delegation and approvals of the credentialing process;
- A designated credentialing committee;
- Identification of Network Providers who fall under its scope of authority;
- A process which provides for the verification of the credentialing and re-credentialing criteria;
- Approval of new Network Providers and imposition of sanctions, termination, suspension and restrictions on existing Network Providers;
- Identification of quality deficiencies which result in Home State Health's suspension, termination or sanctioning of a Network Provider; and
- A process to implement an appeal procedure for Network Providers whom Home State Health has terminated.

Home State Health Credentialing Committee

The Home State Health Credentialing Committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination and direction of the credentialing procedures, including provider participation, denial and termination. The Home State Health Credentialing Committee meets monthly, at a minimum ten (10) times per year.

Status Change Notification

Network Providers must notify Home State Health immediately of any change in licensure and/or certifications that are required under federal, State, or local laws for the provision of covered behavioral health services to members, or if there is a change in Network Practitioner's hospital privileges. All changes in a Network Provider's status will be considered in the re-credentialing process.

Network Provider Demographic/Information Updates

Network Providers should advise Home State Health with as much advance notice as possible for demographic/ information updates. Network Provider information such as address, phone and office hours are used in our Provider Directory and having the most current information accurately reflects our Missouri provider network. Please use the Home State Health Provider Information Update Form located on our website at www.homestatehealth.com.

Completed Provider Information Update Forms should be sent to Home State Health at CHHS_Provider_Roster@Centene.com.

Network Provider Request to Terminate

Network Providers requesting to terminate from the network must adhere to the Termination provisions set forth in their Provider Agreement with Home State Health. This notice can be mailed or faxed to the Provider Relations Department. The notification will be acknowledged by Home State Behavioral Health in writing and the Network Provider will be advised on procedures for transitioning members if indicated.

Home State Behavioral Health fully recognizes that a change in a Network Provider's participation status in Home State Health's provider network is difficult for members. Home State Behavioral Health will work closely with the terminating Network Provider to address the member's needs and ensure a smooth transition as necessary. A Network Provider who terminates the contract with Home State Health must notify all Home State Health members who are currently in care at the time and who have been in care with that Network Provider during the previous six (6) months. Treatment with these members must be completed or transferred to another Home State Health Network Provider within three (3) months of the notice of termination, unless otherwise mandated by State law. The Network Provider needs to work with the Home State Health Care Management Department to determine which members might be transferred, and, which members meet Continuity of Care Guidelines to remain in treatment.

Home State Health's Right to Terminate

Please refer to your Provider Agreement with Home State Health for a full disclosure of causes for termination. **As stated in your Provider Agreement, Home State Health shall have the right to terminate the Provider Agreement by giving written notice to the Network Provider upon the occurrence of any of the following events:**

- Termination of Home State Health's obligation to provide or arrange mental health/ substance abuse treatment services for members of Home State Health;
- Restriction, qualification, suspension or revocation of Network Providers' license or certification;
- Network Provider's loss of liability insurance required under the Provider Agreement with Home State Behavioral Health;
- Network Provider's exclusion from participation in the Medicare or Medicaid program;
- Network Provider's insolvency or bankruptcy or Network Provider's assignment for the benefit of creditors;
- Network Provider's conviction, guilty plea, or plea of nolo contendere to any felony or crime involving moral turpitude;
- Network Provider's ability to provide services has become impaired, as determined by Home State Health, at its sole discretion;
- Network Provider's submission of false or misleading billing information;
- Network Provider's failure or inability to meet and maintain full credentialing status with Home State Health;
- Network Provider's breach of any term or obligations of the Provider Agreement;
- Any occurrence of serious misconduct which brings Home State Health to the reasonable interpretation that a Network Provider may be delivering clinically inappropriate care; or
- Network Provider's breach of Home State Health Policies and Procedures.

Network Provider Appeal of Suspension or Termination of Contract Privileges

If a Network Provider has been suspended or terminated by Home State Health, contact the Home State Health Provider Partnership Management department at (855) 694-HOME (4663) to request further information or discuss how to appeal the decision.

For a formal appeal of the suspension or termination of contract privileges, the Network Provider should send a written reconsideration request to Home State Health to the attention of the Quality Improvement Department:

Home State Health
Attn: Quality Improvement Department
11720 Borman Drive
St. Louis, MO 63146

Please note that the written request should describe the reason(s) for requesting reconsideration and include any supporting documents. This reconsideration request must be postmarked within thirty (30) days from the receipt of the suspension or termination letter to comply with the appeal process.

Home State Health will use the Provider Dispute Policy to govern its actions. Details of the Provider Dispute Policy will be provided to the Network Provider with the notification of suspension/ termination. To request a copy of Home State Health's Provider Dispute Policy, please contact the Quality Improvement Department at (855) 694-HOME (4663).

Each Network Provider will be provided with a copy of their fully executed Provider Agreement with Home State Health. The Provider Agreement will indicate the Network Provider's Effective Date in the network and the Initial Term and Renewal Term provisions in Home State Behavioral Health's provider network. The Provider Agreement will also indicate the cancellation/ termination policies. There is no "right to appeal" when either party chooses not to renew the Provider Agreement.

Cultural Competency

Cultural Competency within the Home State Health Network is defined as "a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members."

Home State Health is committed to the development, strengthening, and sustaining of healthy provider/ member relationships. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Network Providers must ensure the following:

- Members understand that they have access to medical interpreters, signers, and TTY services to facilitate communication without cost to them.
- Care is provided with consideration of the members' race/ ethnicity and language and its impact/ influence of the members' health or illness.
- Office staff that routinely comes in contact with members have access to and participate in cultural competency training and development.
- The office staff responsible for data collection make reasonable attempts to collect race and language specific member information.
- Treatment plans are developed, and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.

- Office sites have posted and printed materials in English, Spanish, or other prevailing languages within the region.

Understanding the Need for Culturally Competent Services

The Institute of Medicine's report entitled "Unequal Treatment," along with numerous research projects; reveal that when accessing the healthcare system people of color are treated differently. Research also indicates that a person has better health outcomes when they experience culturally appropriate interactions with medical providers. The path to developing cultural competency begins with self- awareness and ends with the realization and acceptance that the goal of cultural competency is an ongoing process. Network Providers should note that the experience of a member begins at the front door.

Failure to use culturally competent and linguistically competent practices could result in the following:

- Member's feelings of being insulted or treated rudely;
- Member's reluctance and fear of making future contact with the Network Practitioner's office;
- Member's confusion and misunderstanding;
- Non-compliance by the member;
- Member's feelings of being uncared for, looked down upon and devalued;
- Parents' resistance to seek help for their children;
- Unfilled prescriptions;
- Missed appointments;
- Network Provider's misdiagnosis due to lack of information sharing;
- Wasted time for the member and Network Provider; and/or
- Increased grievances or complaints.

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Home State Health is committed to helping you reach this goal.

Take the following into consideration when you provide services to Home State Health members:

- What are your own cultural values and identity?
- How do/can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?

Facts about Health Disparities

- Government-funded insurance consumers face many barriers to receiving timely care.
- Households headed by Hispanics are more likely to report difficulty in obtaining care.
- Consumers are more likely to experience long wait times to see healthcare providers.
- African American Medicaid consumers experience longer waits in emergency departments and are more likely to leave without being seen.
- Consumers are less likely to receive timely prenatal care, more likely to have low birth weight babies and have higher infant and maternal mortality.
- Consumers that are children are less likely to receive childhood immunizations.
- Patient race, ethnicity, and socioeconomic status are important indicators of the effectiveness of healthcare.
- Health disparities come at a personal and societal price.

Access and Coordination of Care Provider Access Standards

Home State Health members may access behavioral health and substance abuse services through several mechanisms. Members do not need a referral from their Primary Care Physician (PCP) to access covered behavioral health and covered substance abuse services. Caregivers or medical consenters may self-refer members for behavioral health services.

Home State Behavioral Health adheres to National Committee for Quality Assurance (NCQA) and State accessibility standards for member appointments. **Network Providers must make every effort to assist Home State l Health in providing appointments within the following timeframes:**

Type of Appointment	Scheduling Time Frame for Appointment
Urgent Care –appointments for illness, injuries which require care immediately but do not constitute emergencies (e.g. symptoms which are of sudden or severe onset, but which do not require emergency room services)	Within twenty-four (24) hours
Routine care with symptoms	Within one (1) week or five (5) business days; whichever is earlier
Routine care without symptoms	Within thirty (30) calendar days
Behavioral Health and Substance Abuse Hospital follow up Services	Aftercare appointments within seven (7) calendar days of hospital discharge.

Type of Appointment	Scheduling Time Frame for Appointment
Behavioral Health and Substance Abuse Emergent Services	Immediately (Non-life threatening- within 6 hours)

If you cannot offer an appointment within these timeframes, please refer the member to Home State Health at (855) 694-HOME (4663) so that the member may be rescheduled with an alternative provider who can meet access standards and the member's needs.

Network Providers shall ensure that services provided are available on a basis of twenty-four (24) hours a day, seven (7) days a week, as the nature of the member's behavioral health condition dictates. Network Providers will offer hours of operation that are no less than the hours of operation offered to commercial insurance enrollees and shall ensure members with disabilities are afforded access to care by ensuring physical and communication barriers do not inhibit members from accessing services.

Network Providers should call the Home State Health Provider Partnership Management department at (855) 694-HOME (4663) if they are unable to meet these access standards on a regular basis. Please note that the repeated inability to accept new members or meet the access standards can result in suspension and/or termination from the network. All changes in a Network Provider's status will be considered in the re-credentialing process.

Home State Health Access Standards

Home State Health ensures network adequacy and promotes quality of care and service to members in part, by establishing, implementing, and evaluating standards for member geographic access to practitioners and facility services. **Home State I Health will strive to meet the following accessibility requirements:**

Transport time shall not exceed sixty (60) minutes from member to provider. After Hours Access Standards

Network Practitioners must provide coverage for their practice twenty-four (24) hours per day, seven (7) days per week. This type of coverage may include a published after-hours telephone number, pager, or answering service. Members must be given instructions for what to do and whom they can call after hours; voicemail alone after hours is not acceptable.

Open Panels

Home State Health shall ensure network providers are open to new patients and that ninety percent (90%) of network psychiatrists have open panels and are accepting new patients.

Demographics

Home State Health shall ensure accuracy of provider demographics and a ninety percent (90%) accuracy rate for psychiatrists on Home State Health's online directory.

Provider Assessment

Home State Health will assess its appointment and after-hours standards and will ensure that these service standards are being met by conducting one or more of the following:

- Calls from staff to verify: Contracted Providers' appointment availability as stated above; hours of operation; demographics; and confirm whether the provider's panel is open or closed.
- Phantom after-hours calls from the staff to monitor that the provider has adequate 24/7 service availability.

No Show Appointments

A "no show" is defined as a failure to appear for a scheduled appointment without notification to the provider with at least twenty-four (24) hours advance notice. No show appointments must be recorded in the member record.

A "no show" appointment may never be applied against a member's benefit maximum. Home State Health members may not be charged a fee for a "no show" appointment.

Network Practitioners may contact Home State Health via the Provider Portal, email or phone to inform Home State Health about members who do not keep appointments.

Home State Health Care Coordinators will contact the member to:

- reinforce the importance of attending appointments;
- assess and help address barriers such as transportation; and
- assist in rescheduling if needed.

No New Referral Periods

Network Practitioners are required to notify Home State Health when they are not available for appointments. **Network Practitioners may place themselves in a "no referral" hold status for a set period of time without jeopardizing their overall network status. "No referral" is set up for Network for the following reasons:**

- Vacation
- Full practice
- Personal leave
- Other personal reasons

Network Providers must contact their Home State Health Provider Partnership Associate to set up a "no referral" period. Please refer to our Provider Partnership Assignment at www.HomeStateHealth.com to determine your assigned Provider Partnership Associate.

Network Practitioners must have a start date and an end date indicating when they will be available again for referrals. A "no referral" period will end automatically on the set end date.

Coordination between Home State Health and Behavioral Health

Home State Health works to educate and assist physical health and behavioral health practitioners in the appropriate exchange of medical information. Behavioral health utilization reporting is prepared and provided to Home State Health on a monthly basis and is shared with Home State Health's management and executive leadership quarterly. Provider performance is compared to state and national performance thresholds and benchmarks to assess for over and underutilization of services, quality of service provision, and areas for improvement. Performance on any standard that does not meet performance thresholds and/or exhibits continued poor performance will result in a corrective action plan (CAP). Home State Behavioral Health works with its providers on CAP development and interim reporting to resolve performance issues and improve member quality of care.

Quality Improvement

Home State Health's Quality Improvement (QI) Program is based on the principles of Continuous Performance Improvement (CPI) and utilizes the Plan, Do, Study Act (PDSA) model of CPI in the development and evaluation of quality activities. All quality activities are designed to improve the quality of care to Home State Health members. The QI Program is data driven and incorporates data feeds from all Home State Health functional units, creating a culture of quality throughout the organization. The Home State Health QI Program includes clinical, network, customer service, and service utilization and provider complaints as core business metrics. Further, the Home State Health QI program coordinates with the Home State Health QI program to support continuity, coordination and improved integration of member care.

Home State Health is committed to providing quality care and clinically appropriate services for our members. In order to meet our objectives, Network Providers must participate and adhere to our programs and guidelines.

Monitoring Clinical Quality

What does Home State Health monitor?

- Access to care standards;
- Adherence to Clinical Practice Guidelines;
- Communication with PCPs and other behavioral health practitioners;
- Critical Incidents;
- Quality of Care (QOC) concerns;
- Member confidentiality;
- High-risk member identification, management and tracking;
- Inpatient discharge follow-up care;
- Inpatient admissions, readmissions and lengths of stay;
- Provider grievances;
- Service utilization patterns;

- Provider satisfaction; and,
- Member satisfaction

How does Home State Health monitor quality?

Home State Health evaluates available administrative data (claims and service authorizations) along with member and provider surveys as methods to monitor quality. Hybrid methods (those that include administrative as well as medical record review) occur as a result of trends in critical incidents, provider complaints and QOCs.

Results of ongoing quality monitoring are communicated to Network Practitioner groups for technical assistance and in the development of performance improvement and corrective action plans (CAPs). Trends in performance and results of CAPs are evaluated and reviewed by Home State Health during the re- credentialing process.

Network Provider Participation in the QI Process

Home State Health Providers are expected to monitor and evaluate their own compliance with performance requirements to assure the quality of care and service provided. Providers are expected to meet Home State Health's performance requirements and ensure member treatment is efficient and effective by:

- Cooperating with medical record reviews and reviews of telephone and appointment accessibility;
- Cooperating with Home State Health's complaint review process;
- Participating in Provider satisfaction surveys; and
- Cooperating with reviews of quality of care issues and critical incident reporting.

In addition, Providers are invited to participate in Home State Health's QI Committees and in local focus groups.

Confidentiality and Release of Member Information

Home State Health abides by applicable federal and State laws which govern the use and disclosure of mental health information and alcohol/ substance abuse treatment records.

Similarly, Home State Health network providers are independently obligated to comply with applicable laws and shall hold confidential all member records and agree to release them only when permitted by law, including but not limited to 42 CFR et seq., when applicable.

Federal and States Laws Governing the Release of Information

The release of certain information is governed by a myriad of Federal and/or State laws. These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol /substance abuse treatment and communicable disease records.

For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the State level place further restrictions on the release of certain information, such as mental health, communicable disease, etc.

For more information about any of these laws, refer to following:

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.hhs.gov and then select "Regulations and Guidance" and "HIPAA – General Information";
- Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: www.samhsa.gov.
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within the Home State Behavioral Health network are independently obligated to know, understand and comply with these laws.

Home State Behavioral Health takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

Please contact the Home State Health Privacy Officer by phone at or in writing (refer to address below) with any questions about our privacy practices.

Home State Health
Compliance Department
11720 Borman Drive
St. Louis, MO 63146

Please instruct any member to contact Member Services with questions about our privacy practices using the contact information provided below:

Home State Health
11720 Borman Drive
St. Louis, MO 63146

Communication with the Primary Care Physician

Home State Health encourages primary care physicians (PCPs) to consult with their patients' mental health Network Practitioners. In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required.

Network Practitioners should communicate not only with the member's PCP whenever there is a behavioral health problem or treatment plan that can affect the member's medical condition or the treatment being rendered by the PCP, but also with other behavioral health clinicians who may also be providing service to the member.

Network behavioral health and substance abuse providers must complete a health status screen, at the initial point of contact and as part of the re-assessment process for members in treatment. Network behavioral health and substance abuse providers must refer members with physical health conditions (as indicated by the screen) to their primary care provider for evaluation and treatment of the physical health condition.

A form to be used in communicating with the PCP and other behavioral health providers is located on our website at www.homestatehealth.com. Network Providers can identify the name and number for a member's PCP on the front-side of the Member ID Card.

Network practitioners should screen for the existence of co-occurring mental health and substance abuse conditions and make appropriate referrals. Practitioners should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment.

Home State Health requires that Network Practitioners report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the Network Practitioner's responsibility to keep the member's PCP informed of the member's treatment status and progress in a consistent and reliable manner. Such consent shall meet the requirements set forth in 42 CFR et seq., when applicable. If the member requests this information not be given to their PCP, the Network Practitioner must document this refusal in the member's treatment record, and if possible, the reason why.

The following information should be included in the report to the PCP:

- A copy of the mental health intake assessment;
- Identified barriers to member's success with current treatment plan, if applicable;
- The results of an initial psychiatric evaluation;
- Current psychotropic medications, including initiation of and major changes in medication regime, within fourteen (14) days of the visit or medication order;
- The results of functional assessments; and
- Member's functional and clinical status upon completion of treatment.

Consent for Disclosure

Home State Health recognizes communication as the link that unites all the service components and a key element in any program's success. To further this objective, Network Practitioners shall obtain consent for disclosure of information from the member when required by federal and/or state law to release clinical information to a member's physical health practitioner and, if applicable, other behavioral health practitioners as needed.

If the member refuses to consent to a release, when required by law, such as in relation to alcohol and substance abuse treatment records, the Network Practitioner should document the refusal along with the reasons for declination in the medical record.

Critical Incident Reporting

A Critical Incident is defined as any occurrence which is not consistent with the routine operation of a Mental Health/ Substance Abuse Network Provider. It includes, but is not limited to: injuries to members, a suicide/ homicide attempt by a member while in treatment, death due to suicide/ homicide, sexual battery, medication errors, member escape or elopement, altercations involving medical interventions, or any other unusual incident that has high risk management implications. A Critical Incident Report must be completed for any Home State Behavioral Health member by the Network Provider within twenty-four (24) hours of, or notification of, such an occurrence.

The Critical Incident Report Form is located on Home State Health's website at www.homestatehealth.com. Submit completed Critical Incident Reports to the following address:

Mail: Home State Health
Attn: Quality Improvement Department
11720 Borman Drive
St. Louis, MO 63146

Abuse and Neglect Reporting

Providers are required to report all incidents that may include abuse and neglect consistent with the Department of Human Services Act, the Adults with Disabilities Domestic Abuse Intervention Act and the Abused and Neglect Child Reporting Act. Reports regarding elderly Enrollees who are over the age of 60 will be reported to Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570, Phone: (573) 751-4842, Elder Abuse and Neglect Hotline (800) 392-0210. Reports concerning children should be directed to the Missouri Department of Social Services, Children's Division hotline at (800) 392-3738, The Children's Division staff this hotline 24 hours a day, 7 days a week, 365 days a year.

Home State Health will offer training to providers about the signs of abuse or neglect.

Member Concerns about Network Providers

Members who have concerns about Home State Health Network Providers should contact Home State Health to register their concern. All concerns are investigated, and feedback is

provided on a timely basis. It is the Network Provider's responsibility to provide supporting documentation to Home State Health if requested. Any validated concern will be taken into consideration when re- credentialing occurs and can be cause for termination from Home State Health's provider network. This process is referenced in your Provider Agreement with Home State Health.

Records and Documentation

Network Providers need to retain all books, records and documentation related to services rendered to members as required by law and in a manner that facilitates audits for regulatory and contractual reviews.

The Network Provider will provide Home State Health and other regulatory agencies access to these documents to assure financial solvency and healthcare delivery capability, to investigate complaints and grievances, and to meet the reporting requirements specified in the contract between Home State Health and the MO HealthNet Managed Care, subject to regulations concerning confidentiality of such information.

Access to documentation must be provided upon reasonable notice for all inpatient care. This provision shall survive the termination and or non-renewal of a Provider Agreement with Home State Health.

Reporting and Metric Requirements

Network Providers may be required to submit timely to Home State Health reports or performance metrics as required by Home State Health's contract with the MO HealthNet Managed Care, and/or Home State Health's requirements for NCQA accreditation. Such metrics shall include but not be limited to provider rosters by service location, average number of days to receive an emergent appointment, average number of days to receive a routine appointment, network adequacy and similar measures. Home State Health and Network Provider shall work together to find solutions when performance standards are not met.

Record Keeping and Retention

The clinical record is an important element in the delivery of quality treatment because it documents the information to provide assessment and treatment services. Sample forms are located on our website at www.homestatehealth.com and Network Practitioners are encouraged to use for members.

As part of our ongoing Quality Improvement program, clinical records may be audited to assure the quality and consistency of Network Provider documentation, as well as the appropriateness of treatment. Before charts can be reviewed or shared with others, the member must sign an authorization for release. Chart Audits of member records will be evaluated in accordance with these criteria.

Clinical records require documentation of all contacts concerning the member, relevant financial and legal information, consents for release/ disclosure of information, release of information to the member's PCP, documentation of member receipt of the Statement of member's Rights and Responsibilities, the prescribed medications with refill dates and quantities, including clear evidence of the informed consent, and any other information from

other professionals and agencies. If the Network Practitioner is able to dispense medication, the Network Practitioner must conform to drug dispensing guidelines set forth in the Home State Health drug formulary.

Network providers shall retain clinical records for members for as long as is required by applicable law. These records shall be maintained in a secure manner but must be retrievable upon request.

Treatment Record Guidelines

Home State Health requires treatment records to be maintained in a manner that is current, detailed and organized and which permits effective and confidential patient care and quality review.

Treatment record standards are adopted that are consistent with the National Committee for Quality Assurance. The adopted standards facilitate communication, coordination and continuity of care and promote efficient, confidential and effective treatment. Medical records must be prepared in accordance with all applicable State and Federal rules and regulations and signed by the medical professional rendering the services.

Home State Health's minimum standards for provider medical record keeping practices include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of patient information. **The following thirteen (13) elements reflect a set of commonly accepted standards for behavioral health treatment record documentation:**

1. Each page in the treatment record contains the patient's name or ID number.
2. Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
3. All entries in the treatment record are dated and include the responsible clinician's name, professional degree and relevant identification number, if applicable.
4. The record is legible to someone other than the writer.
5. Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the patient has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
6. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status and the results of a mental status exam, are documented.
7. Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with written protocols.
8. Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
9. A medical and psychiatric history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and

psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic). For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.

10. A current DSM diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.
11. Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable. Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers and health care institutions are included, as appropriate.
12. Informed consent for medication and the patient's understanding of the treatment plan are documented.
13. Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives. Documented interventions include continuity and coordination of care activities, as appropriate. Dates of follow-up appointments or, as applicable, discharge plans are noted.

Preventative Behavioral Health Programs

Home State Health offers the Perinatal Depression Screening Program as a preventative behavioral health program for our members. The Perinatal Depression Screening Program offers depression screening to members who are pregnant via a brief, easy to answer survey, in order to identify members who would benefit from behavioral health services. Members can complete the surveys in their PCP offices, CMHC, or submit the survey directly to Home State Health. Each member who participates receives communication from Home State Health regarding the outcome of their survey answers and resources available to them. If a member screens positive for depression while pregnant or after delivery, a Home State Health clinical staff person will call to attempt to outreach and engage the member in services and/or finding community resources. Home State Health communicates the survey findings and outreach attempts to the member's medical provider as well to support coordination of care.

Home State Health appreciates your assistance in promoting this preventative behavioral health program. You can refer your members to the program directly when you assess a member is at risk for, or screened positive for, depression while pregnant or post-delivery. If you would like more information about the program or if you have suggestions as to how we can improve our preventative behavioral health program, please contact the Quality Improvement department at (855) 694-HOME (4663).

Complaints, Grievances and Appeals

Member Grievances and Provider Complaints

Grievances

A member grievance is defined as any member expression of dissatisfaction about any matter other than an "adverse action". A provider complaint is any provider expression of dissatisfaction about any matter other than a claims dispute.

***Note**: Throughout this Manual, we will consider the term "grievance" to refer to both member grievances and provider complaints as the resolution processes are the same. Provider complaints include disputes regarding policies, procedures or any aspect of Home State Health's administrative functions including proposed actions.*

The grievance process allows the member, or the member's authorized representative (provider, family member, etc.) acting on behalf of the member, to file a grievance either orally or in writing within 30 calendar days of the event covering the dissatisfaction. Home State Health shall acknowledge receipt of each grievance in writing within 5 working days of receipt of the grievance. A provider MAY NOT file a grievance or appeal on behalf of a member without written designation by the member or the member's representative. Any individual who makes a decision on grievances will not be involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, Home State Health shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the member's condition or disease. Home State Health values its providers and will not take punitive action against providers who file a grievance on a member's behalf. To file a complaint, please call (855) 694-HOME (4663). A Home State Health customer service representative will assist you in filing a grievance.

Acknowledgement

Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the member, representative or provider, the staff will document the resolution details. Member notification of the grievance resolution shall be made in writing within two business days of the resolution. The Grievance and Appeals Coordinator (GAC) will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five business days of receipt of the written grievance.

Grievance Resolution Time Frame

Grievance resolution will occur as expeditiously as the member's health condition requires, not exceeding 30 calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the GAC, in coordination with other Home State Health staff as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the member, representative or provider filing the grievance. Expedited grievance reviews will be

available for members in situations deemed urgent, such as a denial of an expedited appeal request, and will be resolved within 24 hours.

Home State Health may extend the resolution of a grievance by up to 14 calendar days if the member or a member representative requests the extension or if Home State Health determines that there is a need for additional information and the extension is in the member's interest. For any extension not requested by the member, Home State Health will give the member written notice of the reason for the extension within two working days of the decision to extend the timeframe.

Notice of Resolution

The GAC will provide written resolution to the member, representative or provider within 30 calendar days of receipt. The letter will include but need not be limited to all information considered in investigating the grievance, findings and conclusions, the deposition of the grievance, and the right to a second level review by the Grievance Appeal Committee (GAC) if the member is not satisfied.

The grievance response shall include, but not be limited to, the decision reached by Home State Health, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the enrollee. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for five years.

Grievances may be submitted by written notification to:

Mail: Home State Health
Attn: Quality Improvement Department
11720 Borman Drive
St. Louis, MO 63146

Appeals

An appeal is the request for review of a "Notice of Adverse Action". A "Notice of Adverse Action" is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or the denial of a member's request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the Home State Health network. The review may be requested in writing or orally within ninety (90) calendar days of receiving the Notice of Adverse Action; an oral request, must be followed up with a written, signed appeal.

Requests for appeals within the standard timeframe must be resolved within 45 days of receipt of the appeal, with a 14-day extension possible if additional information is required. The legal guardian of the Member (for minors or incapacitated adults), a representative of the minor designated in writing, or a provider acting on behalf of the Member with the Member's written consent, has the right to file an appeal of an action on behalf of the Member. Home State Health shall provide written notice that the appeal has been received within ten business days of its receipt, including the expected date of resolution. Members may request

that Home State Health review the Notice of Adverse Action to verify if the right decision has been made.

If a member is receiving authorized services that are now denied and wishes to keep getting these services, an appeal must be submitted in writing within 10 calendar days of the denial letter. The request must clearly state that the member wishes to keep getting the denied services. Member can keep getting these services until the appeal decision is rendered. If the appeal decision upholds Home State Health's denial, the member may have to pay for the services.

Expedited Appeals

Expedited appeals may be filed when either Home State Health or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum functioning. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding three working days from the initial receipt of the appeal. Home State Health may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Home State Health provides evidence satisfactory to the State that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, Home State Health shall provide written notice to the member of the reason for the delay. Home State Health shall make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow-up within two calendar days with a written notice of action.

Written notice shall include the following information:

(a) The decision reached **by Home State Health;**

(b) The date of decision;

(c) For appeals not resolved wholly in favor of the member, the right to request a State fair hearing and information as to how to do so; and

(d) The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the Home State Health decision.

Grievances may be submitted verbally or in writing to:

Mail: Home State Health Grievance and Appeals Coordinator
11720 Borman Drive
St. Louis, MO 63146

State Fair Hearing Process

Home State Health will include information in the Member Handbook, online and via the appeals process to members of their right to appeal directly to the State. The member has the

right to appeal to the State at the same time they appeal to Home State Health, after exhausting appeal rights with Home State Health, or instead of appealing to Home State Health.

Any adverse action or appeal that is not resolved wholly in favor of the member by Home State Health may be appealed by the member or the member's authorized representative to the State for a fair hearing. Home State Health's denial of payment for Missouri Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed. Appeals must be requested in writing by the member or the member's representative within 90 days of the member's receipt of notice of adverse action.

Home State Health shall comply with the State's fair hearing decision. The State's decision in these matters shall be final and shall not be subject to appeal by Home State Health.

Reversed Appeal Resolution

If Home State Health or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, Home State Health will authorize the disputed services promptly and as expeditiously as the member's health condition requires. Additionally, in the event that services were continued while the appeal was pending, Home State Health will provide reimbursement for those services in accordance with the terms of the final decision rendered by the States and applicable regulations.

To request a State Fair Hearing, call (800) 392-2161 toll free or (573) 751-6527 at your expense. TDD users, call (800) 735-2966. If you speak another language you can ask for an interpreter at no cost to you.

To File a Medicaid State Hearing in writing:

MO HealthNet Division Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102

Member Rights and Responsibilities

Home State Health Member Rights and Responsibilities

Home State Health Members have the right to:

- Be treated with respect and dignity;
- Receive needed medical services;
- Privacy and confidentiality (including minors) subject to state and federal laws;
- Select your own PCP;
- Refuse treatment;
- Receive information about your health care and treatment options;
- Participate in decision-making about your health care;
- Have access to your medical records and to request changes, if necessary;
- Have someone act on your behalf if you are unable to do so;
- Get information on our Physician Incentive Plan, if any, by calling 1-855-694-HOME (4663);
- Be free of restraint or seclusion from a provider who wants to: Make you do something you should not do; Punish you; Get back at you; or Make things easier for him or her;
- Be free to exercise these rights without retaliation;
- Receive one copy of your medical records once a year at no cost to you Additional Rights;
- Receive information about Home State, its services, its practitioners and providers and member rights and responsibilities;
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
- To voice grievances or appeals about Home State or the care it provides;
- To make recommendations regarding the Home State's member rights and; responsibilities policy;
- Protection of oral, written and electronic information across the organization.

It is the responsibility of Home State Health Members to:

- Call Home State to order a member ID card if yours is lost;
- Carry your Home State member ID card AND your MO HealthNet card at all times;
- Contact your PCP first when needing medical care;
- Only use the emergency room in an emergency;
- Follow all instructions given by your health care provider;

- Follow appointment scheduling rules;
- Make and keep PCP appointments or call ahead to cancel;
- Make sure your child sees his/her PCP for regular check-ups and shots;
- Supply information (to the extent possible) that the organization and its providers need in order to provide care;
- Follow plans and instructions for care that you have agreed to with your providers;
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Civil Rights

Home State Health provides covered services to all eligible members regardless of: Age, Race, Religion, Color, Disability, Sex, Sexual Orientation, National Origin, Marital Status, Arrest or Conviction Record, or Military Participation.

All Medically Necessary covered services are available to all members. All services are provided in the same manner to all members. All persons or organizations connected with Home State Health who refer or recommend members for services shall do so in the same manner for all members.

Customer Service

The Home State Health Customer Service Department

Home State Health operates a toll-free emergency and routine Behavioral Health Services Hotline, answered by a live voice and staffed by trained personnel, Monday through Friday 8:00 a.m. to 6:00 p.m. Central Time. After hours services are available during evenings, weekends and holidays. The after-hours service is staffed by customer service representatives with registered nurses and behavioral health clinicians available 24/7 for urgent and emergent calls.

The Home State Health Customer Service department supports the Mission Statement in providing quality, cost- effective behavioral health services to our customers. We strive for customer satisfaction on every call by doing the right thing the first time and we show our integrity by being honest, reliable and fair.

The Customer Service department's primary focus is to facilitate the authorization of covered services for members for treatment with a specific clinician or clinicians.

The Home State Health Customer Service department assists Network Providers with the following:

- Verifying member eligibility;
- Verifying member benefits;
- Providing authorization information;
- Referrals; and,

- Troubleshooting any issues related to eligibility, authorizations, referrals, or researching prior services.

Verifying Member Enrollment

Network Providers are responsible for verifying eligibility every time a member schedules an appointment, and when they arrive for services.

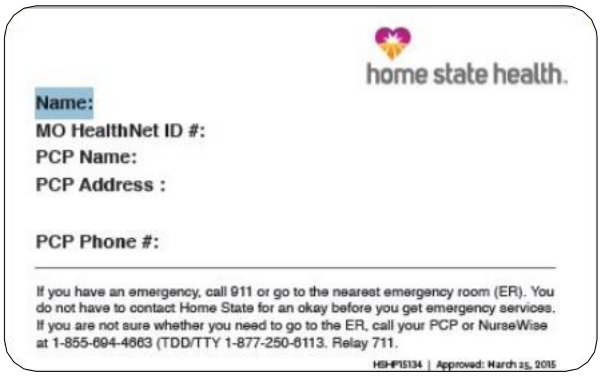
Network Providers should use either of the following options to verify member enrollment:

- Contact Home State Health Customer Service at (855) 694-HOME (4663);
- Access the Home State Behavioral Health Provider Website at www.homestatehealth.com

Until the actual date of enrollment with Home State Health, Home State Health is not financially responsible for services the prospective member receives. In addition, Home State Health is not financially responsible for services members receive after their coverage has been terminated. The Provider must implement a policy prior to providing non-emergency services to an adult MO HealthNet Managed Care member that requests and inspects the adult member's MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility) and health plan membership card. If the adult member does not produce their health plan membership card, and the provider verifies eligibility and health plan enrollment, the provider may provide service if they have notified the health plan that the member has no health plan identification card. The provider must document this verification in the member's medical record.

Home State Health Member ID Cards

Front



Back

- Name
- MO HealthNet ID #
- PCP Name/Number
- Important Member & Provider Phone Numbers
- Medical/Behavioral claims address
- Website address

Interpretation/Translation Services

Home State Health is committed to ensuring staff are educated, aware and sensitive to the linguistic needs and cultural differences of its Members. In order to meet this need, Home State Behavioral Health's Customer Service team is staffed with Spanish and English bilingual personnel. Trained professional language interpreters, including those proficient in American Sign Language, can be made available face-to-face at your office. Interpreters are also available telephonically to assist Providers with discussing technical, medical, or treatment information with Members as needed. Home State Health requests a five-day prior notification for face- to-face services.

To access TDD services for members who are hearing impaired, contact:
TDD/TYY: 1-877-250-6113

Key Information: To access interpreter services for Home State Health members, contact Customer Service at (855) 694-HOME (4663).

NurseWise

NurseWise is Home State Health's after-hours nurse referral line which is a bilingual care line consisting of both customer service representatives and registered nurses who respond to inquiries from eligible individuals and their eligible dependents. Verification of eligibility for service, demographic information verification and administrative questions may be answered by NurseWise representatives. NurseWise provides after- hours phone coverage seven (7) days per week including holidays.

NurseWise provides after hours assistance with the following:

- emergency and urgent care matters;
- health questions and identification and treatment of health issues;
- eligibility verification;
- inpatient admission notification;
- notification of primary care and other providers when warranted
- coordination of appropriate transportation for health services; and
- questions regarding participating status of providers.

Benefit Overview

Home State Health covers all behavioral health services defined in the Missouri HealthNet comprehensive benefit package. **Services for Home State Health members include, but are not limited to the following:**

- Inpatient Mental Health Hospitalization & Medical Detoxification;
- Observation;
- Intensive Outpatient Program (IOP);
- Partial Hospitalization Program (PHP);
- Electroconvulsive Therapy (ECT);
- Crisis Intervention;
- Outpatient Mental Health services including medication management;
- Community Mental Health Center services;
- Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) behavioral health services.

The following services are not covered by Home State Behavioral Health and must be billed to the State:

- Child/adolescent residential services;
- Autism waiver services;
- Comprehensive Substance Treatment Abuse and Rehabilitation (C-STAR) services;
- Community Psychiatric Rehabilitation services;
- Targeted case management services;
- Smoking cessation pharmacologic and behavioral intervention services;
- Developmental disabilities waiver services;
- Services provided as part of an IEP;
- Services provided to children within Category of Aid 4.

For a listing of service codes and authorization requirements, please refer to the Covered Professional Services & Authorization Guidelines located on the Home State Health website at www.homestatehealth.com. Network Providers should refer to their Provider Agreement with Home State Health to identify which services they are contracted and eligible to provide.

Please note that all services performed must be medically necessary.

Specialty Therapy and Rehabilitative Services

Home State Health offers Home State Health members access to all covered, medically necessary outpatient home health, physical, occupational and speech therapy services. Home State Health remains committed to ensuring that physical medicine services provided to our members are consistent with nationally recognized clinical guidelines. Therefore, prior authorization is required for outpatient home health, physical, occupational, or speech therapy services. This prior authorization program will be managed by National Imaging Associates (NIA). As the nation's leading specialty health care management company, NIA delivers comprehensive and innovative solutions to improve quality outcomes and optimize cost of care. Under terms of the agreement between Home State Health and NIA, Home State Health will oversee the NIA Physical Medicine Prior Authorization program and continue to be responsible for claims adjudication.

Prior authorizations can be obtained via NIA's website, www.RadMD.com or by calling Home State Health at 1-855-694-HOME (4663) and following the prompts.

Please keep in mind you will need to ensure that the member's benefit has not been exhausted prior to providing services, even if an "Approved Authorization" has been obtained. The purpose of NIA is to verify medical necessity of physical medicine services, and not to manage the member's benefits.

Utilization Management

The Utilization Management Program

The Home State Health Utilization Management department's hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 5:00 p.m., local time. Additionally, clinical staff is available after hours if needed to discuss urgent UM issues. UM staff can be reached via our toll- free number at (855) 694-HOME (4663). The Home State Health Utilization Management team is comprised of qualified behavioral health professionals whose education, training and experience are commensurate with the Utilization Management reviews they conduct.

Home State Health is committed to compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Interim Final Rule and subsequent Final Ruling.

Home State Health will ensure compliance with MHPAEA requiring parity of both quantitative limits (QTLS) applied to MH/SUD benefits and non-quantitative limits (NQTLS). Home State Health administers benefits for Substance Use Disorder (SUD) and/or services for mental health conditions as designated and approved by the contract and Plan benefits. MHPAE does not preempt State law, unless law limits application of the act. We support access to care for individuals seeking treatment for Mental Health conditions as well as Substance Use Disorders and believe in a "no wrong door" approach. Our strategies, evidentiary standards and processes for reviewing treatment services are no more stringent than those in use for medical/surgical benefits in the same classification when determining to what extent a benefit is subject to NQTLs.

The Home State Health Utilization Management Program strives to ensure:

- Member care meets Medical Necessity Criteria;
- Treatment is specific to the member's condition, is effective and is provided at the least restrictive, most clinically appropriate level of care;
- Services provided are of high clinical quality;
- Utilization Management policies and procedures are systematically and consistently applied; and
- Focus on member and family recovery, resiliency and hope.

Home State Health's utilization review decisions are made in accordance with currently accepted behavioral healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Medical Necessity Criteria are used for the review and approval of treatment. Plans of care that do not meet Medical Necessity guidelines are referred to a licensed physician advisor or psychologist for review and peer to peer discussion.

Home State Health conducts utilization management in a timely manner to minimize any disruption in the provision of behavioral healthcare services. The timeliness of decisions adheres to specific and standardized time frames yet remains sufficiently flexible to accommodate urgent situations. Utilization Management files includes the date of receipt of information and the date and time of notification and resolution.

Home State Health's Utilization Management Department is under the direction of our licensed Medical Director. The Utilization Management Staff regularly confer with the Medical Director or physician designee on any cases where there are questions or concerns.

Member Eligibility

Establishing member eligibility for benefits and obtaining an authorization before treatment is essential for the claim's payment process. It is the responsibility of the Network Provider to monitor the member's ongoing eligibility during the course of treatment.

Network Providers should use either of the following methodologies to verify member eligibility:

Contact Home State Health Customer Service at 855-694-HOME (4663) or access the provider web portal at www.homestatehealth.com.

Outpatient Notification Process

Network Providers need to adhere to the Covered Professional Services & Authorization Guidelines set forth in this Manual when rendering services. Please refer to the Covered Professional Services & Authorization Guidelines to identify which services require prior authorization. Home State Health does not retroactively authorize treatment.

Outpatient Treatment Request (OTR)/ Requesting Additional Sessions

Provider should verify eligibility and benefits prior to rendering services each month. Some outpatient services may require an authorization after a certain number of visits have been completed. When requesting additional sessions for outpatient services that require authorization, the network provider must complete a request for authorization. The fastest way to submit your Outpatient Treatment Report (OTR), is using our secure provider portal at https://provider.Home State Behavioral Health.com and selecting the link to the secure provider portal. If the provider is unable to submit a request via the Home State Behavioral Health secure portal, then an OTR form can be completed and faxed to Home State Behavioral Health at 866-694-3649 for clinical review. The OTR can be found at www.Home State Behavioral Health.com under Providers/Resources/Forms. Please refer to the notification section of the Home State Health website regarding prior authorization requirements. This information can be found at www.homestatehealth.com/providers/Missouri/provider-tools/notifications. Network providers may call the Customer Service department at (855) 694-HOME (4663) to check the status of an OTR. Network providers should allow up to 2 business days to process non-urgent requests.

IMPORTANT:

The OTR must be completed in its entirety. The diagnoses as well as all other clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delay and/or denials.

Home State Health will not retroactively certify routine sessions. The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.

Failure to submit a completed OTR can result in delayed authorization and may negatively impact your ability to meet the timely filing deadlines which will result in payment denial.

Home State Health's utilization management decisions are based on Medical Necessity Criteria and established Clinical Practice Guidelines. Home State Health does not reimburse for unauthorized services and each Provider Agreement with Home State Health precludes Network Providers from balance billing (billing a member directly) for covered services with the exception of copayment and/or deductible collection, if applicable.

Home State Health's authorization of covered services is an indication of Medical Necessity, not a confirmation of member eligibility, and not a guarantee of payment.

Guidelines for Psychological Testing

Psychological testing must be prior authorized for either inpatient or outpatient services. Testing, with prior- authorization, may be used to clarify questions about a diagnosis as it directly relates to treatment.

It is important to note that:

- Testing will not be authorized by Home State Health for ruling out a medical condition.
- Testing is not used to confirm previous results that are not expected to change.

A comprehensive initial assessment (90791 and 90792) should be conducted by the requesting Psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the practitioner is contracted and credentialed with Home State Health.

Practitioners should submit a request for Psychological Testing that includes the specific tests to be performed. Home State Health's Psychological Testing Authorization Request form is located on our website at www.homestatehealth.com.

Medical Necessity

Member coverage is not an entitlement to utilization of all covered benefits but indicates services that are available when medical necessity criteria are satisfied. Network Providers are expected to work closely with Home State Health's Utilization Management department in exercising judicious use of a member's benefit and to carefully explain the treatment plan to the member in accordance with the member's benefits offered by Home State Health.

Home State Health uses *Locus/CaLocus* Criteria for both adult and pediatric behavioral health guidelines. *Locus/CaLocus i*s a nationally recognized instrument that provides a consistent, evidence-based platform for care decisions and promotes appropriate use of services and improved health outcomes. Additionally, Home State Health has adopted the Missouri State Medicaid Manual service descriptions and medical necessity guidelines for all community-based services.

The *Locus/CaLocus* criteria set is proprietary and cannot be distributed in full; however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. Community- Based Services criteria can be found on the Home State Behavioral Health website at: www.homestatehealth.com.

Locus/CaLocus and our Community Based Services criteria are reviewed on an annual basis by the Home State Health Provider Advisory Committee that is comprised of Network Providers as well as Home State Health clinical staff.

Home State Health is committed to the delivery of appropriate service and coverage, and offers no organizational incentives, including compensation, to any employed or contracted UM staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and UM staff is encouraged to bring inappropriate care or service decisions to the attention of the Medical Director.

Concurrent Review

Home State Health's Utilization Management Department will concurrently review the treatment and status of all members in inpatient (including crisis stabilization units) and partial hospitalization through contact with the member's attending physician or the facility's Utilization and Discharge Planning departments. The frequency of review for all higher levels of care will be determined by the member's clinical condition and response to treatment. The review will include evaluation of the member's current status, proposed plan of care and discharge plans.

Peer Clinical Review Process

If the Utilization Manager is unable to certify the requested level of care based on the information provided, they will initiate the peer review process.

For continued stay requests, the physician or treating practitioner is notified about the opportunity for a telephonic peer-to-peer review with the Peer Reviewer to discuss the plan of treatment. The Peer Reviewer initiates at least three (3) telephone contact attempts within twenty-four (24) hours prior to issuing a clinical determination. All attempts to reach the requestor are documented in the Utilization Management Record. If the time period allowed to provide the information expires without receipt of additional information, a decision is made based on the information available. When a determination is made where no peer-to- peer conversation has occurred, a provider can request to speak with the Peer Reviewer who made the determination within one (1) business day. Providers should contact Home State Health at (855) 694-HOME (4663) to discuss UM denial decisions.

The Peer Reviewer consults with qualified board-certified sub-specialty psychiatrists when the Peer Reviewer determines the need, when a request is beyond his/ her scope, or when a healthcare practitioner provides good cause in writing.

As a result of the Peer Clinical Review process, Home State Health makes a decision to approve or deny authorization for services.

Notice of Action (Adverse Determination)

When Home State Health determines that a specific service does not meet criteria and will therefore not be authorized, Home State Health will submit a written notice of action (or denial) notification to the treating Network Practitioner, providers rendering the service(s) and the member. **The notification will include the following information/ instructions:**

1. The reason(s) for the proposed action in clearly understandable language;
2. A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy to understand summary;
3. A statement that the criteria, guideline, benefit provision, or protocol will be provided upon request;
4. Information on how the provider may contact the Peer Reviewer to discuss decisions and proposed actions. When a determination is made where no peer-to-peer conversation has occurred, the Peer Reviewer who made the determination (or another Peer Reviewer if the original Peer Reviewer is unavailable) will be available within one (1) business day of a request by the treating provider to discuss the determination;
5. Instructions for requesting an appeal including the right to submit written comments or documents with the appeal request; the member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision;
6. For all urgent precertification and concurrent review clinical adverse decisions, instructions for requesting an expedited appeal; and,
7. The right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

Discharge Planning

Follow up after hospitalization is one of the most important markers monitored by Home State Health to help members remain stable and to reduce preventable readmissions into acute levels of care. Follow up after discharge is monitored closely by the National Committee for Quality Assurance (NCQA), which has developed and maintains the Health Care Effectiveness Data Information Set (HEDIS). Even more importantly, increased compliance with this measure has been proven to minimize no-shows in outpatient treatment, thereby improving member engagement in behavioral health services.

While a member is in an inpatient facility receiving acute care services, Home State Health's Utilization and Case Managers work with the facility's treatment team to make arrangements for continued care with outpatient Network Practitioners. Every effort is made to collaborate with the outpatient practitioners to assist with transition back to the community and a less restrictive environment as soon as the member is stable. Discharge planning should be initiated on admission.

Prior to discharge from an inpatient setting, an ambulatory follow-up appointment must be scheduled within seven (7) days after discharge. Home State Health Coordination/Case Management staff will follow-up with the member prior to this appointment to remind him/her of the appointment. If a member does not keep his/her outpatient appointment after discharge, Network Practitioners should inform Home State Health as soon as possible. Upon notification

of a no- show, Care Coordination staff will follow up with the member and assist with rescheduling the appointment and provide resources as needed to ensure appointment compliance.

Continuity of Care

When members are newly enrolled and have previously received behavioral health services, Home State Health will authorize care as needed to minimize disruption and promote continuity of care. Home State Health will work with non-participating providers (those that are not contracted and credentialed in Home State Health's provider network) to continue treatment or create a transition plan to facilitate the transfer of a member's care to a participating Network Provider.

In addition, if Home State Health determines that a member is in need of services that are not covered benefits, the member will be referred to an appropriate provider and Home State Health will continue to coordinate care including discharge planning.

Home State Health will ensure appropriate post-discharge care when a member transitions from a State institution, and will ensure appropriate screening, assessment and crisis intervention services are available in support of members who are in the care and custody of the State.

Clinical Practice Guidelines

Home State Health has adopted many of the clinical practice guidelines published by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry as well as evidence-based practices for a variety of services. **Clinical practice guidelines adopted include but are not limited to**:

Treatment of Bipolar Disorder, Treatment of Major Depressive Disorder, Treatment of Schizophrenia, and Post Traumatic Stress Disorder. Clinical Practice Guidelines may be accessed through our web site, www.homestatehealth.com, or you may request a paper copy of the guidelines by contacting your network representative or by calling (855) 694-HOME (4663). Copies of our evidence-based practices can be obtained in the same manner. Compliance with Clinical Practice Guidelines is assessed annually via analysis of associated HEDIS measures as part of the quality improvement evaluation process.

Network Provider Trainings

The Training and Education Course Catalog contains information about our comprehensive clinical training program, designed to enhance the knowledge, skills and performance of healthcare professionals who empower our members to make positive health behavior changes. We offer many courses to support continuing education for providers, enhance integrated care, and expand use of best practices. Participants can receive continuing education, for some classes, and receive certificates of attendance related to certain licensing requirements.

Who can attend our courses?

Course participants come from all aspects of healthcare. They include behavioral healthcare providers, primary care physicians, long-term services and supports providers, specialty therapy and rehabilitative service providers, and providers/stakeholders involved in the child welfare system. Their reasons for attending our workshops are as varied as the topics and range from the practical — such as “authorizations” — to the profound — such as “culture of poverty” or “childhood traumatic grief.”

What are the course topics?

Multiple training topics explore ways for physical and behavioral health providers to coordinate services, such as integrated care, cultural competency, common psychotropic medications, positive psychology, strengths-based treatment model and motivational interviewing. In addition, we offer a workshop to explain the use of psychotropic medications in treating mental health and substance use disorders.

Our trainers have extensive knowledge in a variety of health topics, including behavioral health; speech, respiratory, occupational and physical therapy; nursing; exercise physiology; nutrition; diabetes; smoking cessation; case and utilization management; care coordination; data systems; organizational development; long-term services and supports; and child welfare. We are here to help you with information regarding our education and training workshops, all designed to support the treatment you provide our members and improve member outcomes.

How to access our programs

While we believe the best training is conducted face to face using experiential-oriented approaches, we know this isn't always possible. That's why the training team is equipped to deliver training sessions in a variety of modalities, including in-person, online, interactive sessions; recorded webinars; and self-paced e-learning modules. We offer several convenient ways to register for existing programs and to request additional training sessions. Please visit our website where you can view program information and register for available sessions. If you have further questions, please contact us at https://www.envolveu.com/contact-us.html, or you may reach out to us directly.

Relias Learning

We know that it can be a challenge for you and your staff to find time to attend trainings and educational opportunities. We offer online clinical education through Relias Learning. All Relias Learning courses are free of charge and available 24 hours a day, seven days a week. Many of the Relias Learning courses offer continuing education units (CE), and there is no limit to the number of online courses providers are permitted to take. For information and a complete course catalog, please log in or sign up for Relias Learning. Our valued providers and caregivers may also utilize the Relias continuing education e-learning system as well.

How to access Relias

1. Visit http://centenetraining.training.reliaslearning.com.
2. Click “Need a user account? Register now.”
3. Complete the required information.

You will have instant access to Relias' library of online learning, including courses that may qualify for continuing education credit. https://www.envolveu.com/secure-provider-portal/clinical-training.html

Advance Directives

Home State Health is committed to ensuring that Home State Health members know of and are able to avail themselves of their rights to execute Advance Directives. Home State Health is equally committed to ensuring that its Network Providers and office staff are aware of and comply with their responsibilities under federal and State law regarding Advance Directives.

Network Providers must ensure adult members or member representatives over the age of eighteen (18) years receive information on Advance Directives and are informed of their right to execute Advance Directives. Network Providers must document such information in the permanent member medical record.

Home State Health recommends:

- The first point of contact in the Network Provider office should ask if the member has executed an Advance Directive. The member's response should be documented in the medical record.
- If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Directive to the Network Provider's office and document this request.
- An Advance Directive should be included as a part of the member's medical record, including mental health Directives.
- If a Behavioral Health Advance Directive exists, the Network Provider should discuss potential emergencies with the member and/ or family members (if named in the Advance Directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.
- If an Advance Directive has not been executed, the first point of contact within the office should ask the member if they desire more information about Advance Directives.
- If the member requests further information, member Advance Directive education/ information should be provided.

Case Management Program

Home State Health's case management model uses an integrated team of registered nurses, licensed mental health professionals, social workers and non-clinical staff. The model is designed to help members obtain needed services and assist them in coordination of their healthcare needs whether they are covered within the Home State Health array of covered services, from the community, or from other non- covered venues. We recognize that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the enrollee and all treating providers to assist our members to achieve the highest possible levels of wellness, functioning, and quality of life.

The program includes a systematic approach for early identification of members' needs through screening and assessment. In partnership with our members, we will develop and implement an individualized care plan that is comprehensive and will incorporate the full range of needed services we identify with our enrollees. Our teams will engage members to be fully participatory in their health decisions and offer education as well as support for achieving enrollee goals. Care plans will be shared with all treating providers and our Care Coordinators will serve to facilitate exchange of information between providers and with members.

We look forward to hearing from you about any Home State Health members you think can benefit from outreach by a case management team member.

To contact a case manager please call Home State Health at (855) 694-HOME (4663).

Disease Management

Home State Health offers disease management programs to Home State Health members with Depression to provide a coordinated approach in managing the disease and improve the health status of the member. This is accomplished by identifying and providing the most effective and efficient resources, enhancing collaboration between medical and behavioral health providers and ongoing monitoring of outcomes of treatment. Each of Home State Health's disease management programs are based on clinical practice guidelines and include research evidence-based practices. Multiple communication strategies are used in disease management programs to include written materials, telephonic outreach, and web-based information, in person outreach through the Member Connections program and case managers, and participation in community events.

Claims

Home State Health Claims Department Responsibilities

Home State Health's claims processing responsibilities are as follows:

- •Reimburse Clean Claims (see Clean Claim section below) within the timeframes outlined by the Prompt Payment Statute and MoRS 376.383.
- Reimburse interest on claims in accordance with the guidelines outlined in the Prompt Pay Statute.

Claims eligible for payment must meet the following requirements:

- The member is effective (eligible for coverage through Home State Health) on the date of service;
- The service provided is a covered service (benefit of Home State Health) on the date of service; and
- Home State Health's prior-authorization processes were followed.

Home State Health's reimbursement is based on clinical licensure, covered service billing codes and modifiers, and the compensation schedule set forth in the Network Provider's Agreement with Home State Health. Reimbursement from Home State Health will be accepted by the Network Provider as payment in full, not including any applicable copayments or deductibles.

It is the responsibility of the Network Provider to collect any applicable copayments or deductibles from the member.

Clean Claim

A clean claim is a claim submitted on an approved or identified claim format (CMS-1500 or CMS-1450 ["UB-04"] or their successors or electronic equivalents) that contains all data fields required by Home State Health and the State, for final adjudication of the claim. A clean claim has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment. The required data fields must be complete and accurate. A Clean Claim must also include Home State Health's published requirements for adjudication, such as: NPI Number, Tax Identification Number, or medical records, as appropriate. Clean Claims do not include claims submitted by or on behalf of a Provider who is under investigation for fraud or abuse, or a claim that is under review for medical necessity.

Claims lacking complete information are returned to the Network Provider for completion before processing or information may be requested from the provider on an Explanation of Benefit (EOB) form. This will cause a delay in payment.

Explanation of Payment (EOP)

An Explanation of Payment (EOP) is provided with each claim payment or denial. The EOP will detail each service being considered, the amount eligible for payment, copayments/ deductibles deducted from eligible amounts, and the amount reimbursed.

If you have questions regarding your EOP, please contact Home State Health's Claims Customer Service department at (866) 864-1459.

Network Provider Billing Responsibilities

Please submit claims immediately after providing services. Claims must be received within one hundred eighty days (180) days of the date the service(s) are rendered. Claims submitted after this period will be denied payment for untimely filing.

Claim Submission Options

Home State Health's providers are strongly encouraged to utilize our available electronic means for claim submission. Electronic claim submission results in improved processing accuracy as well as quicker claim adjudication and payment.

Web Portal Claim Submission

Home State Health's Secure Provider Portal provides an array of tools to help you manage your business needs and to access information of importance to you. You may register by visiting www.homestatehealth.com and creating a username and password. **Once registered you may begin utilizing these additional available services:**

- Submit Professional and Institutional claims individually or as batches
- Submit corrected claims
- View and check claim status
- View and download payment history
- View and print member eligibility
- Contact us securely and confidentially

EDI Clearinghouses

Home State Behavioral Health's Network Providers may choose to submit their claims through a clearinghouse. **Home State Health accepts EDI transactions through the following vendors:**

Trading Partner	Payer ID	Contact Number
Emdeon	68068	(800) 845-6592
Gateway EDI	68068	(800) 969-3666
SSI	68068	(800) 880-3032
Availity	68068	(800) 282-4548

Paper Claim Submission

Please submit Clean Claims on a CMS-1500 Form or a CMS-1450 Form (“UB-04”) or their successors. Network

Providers must submit paper claims to the following address for processing and reimbursement:

Home State Behavioral Health
Attn: Claims PO Box 7400
Farmington, MO 63640-3827

Imaging Requirements for Paper Claims

Home State Health uses an imaging process for claims retrieval. **To ensure accurate and timely claims capture, please observe the following claims submission rules:**

Do:

- Use original red claim forms.
- Submit all claims in a 9” x 12” or larger envelope.
- Ensure typed print aligns properly within the designated boxes on the claim form.
- Submit on a proper form; CMS-1500 or CMS-1450 (“UB04”).

Do Not:

- Submit handwritten claims.
- Circle any data on claim forms.
- Add extraneous information to any claim form field.
- Use highlighter on any claim form field.
- Submit carbon copied claim forms.
- Submit claim forms via fax.

Common Claim Processing Issues

It is the Network Provider’s responsibility to obtain complete information from Home State Health and the member and then to carefully review the CMS-1500, or its successor claim form and/or CMS-1450 (“UB-04”), or its successor claim form, prior to submitting claims to Home State Health for payment. This prevents delays in processing and reimbursement.

Some common problem areas are as follows:

- Failure to obtain prior authorization.
- Federal Tax ID number not included.
- Provider’s NPI number not included in field 24J (CMS-1500) or field 56 (CMS-1450).

- Insufficient Member ID Number. Network providers are encouraged to call Home State Behavioral Health to request the member's Medicaid ID prior to submitting a claim.
- Visits or days provided exceed the number of visits or days authorized.
- Date of service is prior to or after the authorized treatment period.
- Network Provider is billing for unauthorized services, such as the using the wrong CPT Code.
- Insufficient or unidentifiable description of service performed.
- Member exceeded benefits.
- Claim form not signed by Network Provider.
- Multiple dates of services billed on one CMS-1500 claim form are not listed on separate claim detail lines.
- Diagnosis code is incomplete or not specified to the highest level available – be sure to use 4th and 5th digit when applicable.

Services that are not pre-certified and require prior authorization may be denied. Home State Health reserves the right to deny payment for services provided that is not medically necessary.

Electronic Funds Transfer and Electronic Remittance

Home State Health and PaySpan are in a partnership to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment.

Using this free service, providers can take advantage of EFTs and ERAs to settle claims electronically, without making an investment in additional software. Following a fast-online enrollment, you will be able to receive ERAs and import the information directly into your Practice Management or Patient Accounting System, eliminating the need to key remittance data off of paper advices.

Visit www.payspanhealth.com to enroll or call PaySpan Health at (877) 331-7154.

Home State Behavioral Health Billing Policies

Member Hold Harmless

Under no circumstances is a member to be balance billed for covered services or supplies. If the Network Provider uses an automatic billing system, bills must clearly state that they have been filed with the insurer and that the participant is not liable for anything other than specified un-met deductible or copayments (if any).

Please Note:

- A Network Provider's failure to authorize the service(s) does not qualify/ allow the Network Provider to bill the member for service(s).
- Home State Health members may not be billed for missed sessions ("No-Show").

Non-Covered Services

If a Network Provider renders a non-covered service to a member, the Provider may bill the member only if he/ she has obtained written acknowledgement from the member, prior to rendering such non-covered service, that the specific service is not a covered benefit under Home State Health, and that the member understands they are responsible for reimbursing the Provider for such services.

Claims Payment and Member Eligibility

Home State Health's Network Providers are responsible for verifying member eligibility for each referral and service provided on an ongoing basis.

When Home State Health refers a member to a Network Provider, every effort has been made to obtain the correct eligibility information. If it is subsequently determined that the member was not eligible at the time of service (member was not covered under Home State Health or benefits were exhausted), a denial of payment will occur and the reason for denial will be indicated on the Explanation of Payment (EOP) accompanying the denial.

In this case, the Network Provider should bill the member directly for services rendered while the member was not eligible for benefits.

It is the member's responsibility to notify the Network Provider of any changes in his/her insurance coverage and/or benefits.

Coordination of Benefits

Coordination of benefits will be done for all members with two or more types of insurance coverage. The plan that is primary pays its full benefits first. The primary insurance carrier's explanation of payment (EOP) or explanation of benefits (EOB) is then sent to the secondary carrier (Home State Health) for coordination of benefits. The EOP or EOB will explain the primary's payment or denial process. Home State Health will coordinate benefits for members as the secondary payer.

Claims requiring coordination of benefits must be submitted to Home State Health within the lesser of 365 days from date of service or 90 days from date of the primary payer's EOP or EOB.

For Medicare cross-over claims, Home State Health shall coordinate benefits for dual eligible members by paying the lesser amount of: Home State Health's allowed amount minus the Medicare payment, or the Medicare co- insurance and deductible up to Home State Health's allowed amount.

Retro Authorization

If your claim was denied because you did not have an authorization number, please send a request in writing for a Retroactive Authorization, explaining in detail the reason for providing services without an authorization.

Network Providers must submit their Retroactive Authorization request to:

Mail: Home State Health
Attn: Appeals Department
12515-8 Research Blvd., Suite 400
Austin, TX 78759
Fax (866)-714-7991

Retro Authorizations will only be granted in rare cases. Repeated requests for Retro Authorizations will result in termination from the Home State Health provider network due to inability to follow policies and procedures.

If the authorization contains unused visits, but the end date has expired, please call the Home State Health Customer Service department at (855) 694-HOME (4663) and ask the representative to extend the end date on your authorization.

Resolving Claims Issues

Claim Requests for Reconsideration, Claim Disputes and Corrected Claims

Corrected claims must be submitted within 180 days from the date of service. All claim requests for reconsiderations and claim disputes must be received within 180 days from the date of original notification of payment or denial was issued.

If a provider has a question or is not satisfied with the information s/he has received related to a claim, there are five effective ways in which the provider can contact Home State.

1. **Review the claim in question on the secure Provider Portal:**
    - Participating providers, who have registered for access to the secure provider portal, can access claims to obtain claim status, submit claims or submit a corrected claim.
2. **Contact a Home State Provider Services at 1-855-694-HOME (4663):**
    - Providers may inquire about claim status; payment amounts or denial reasons. A provider may also make a simple request for reconsideration by clearly explaining the reason why the claim is not adjudicated correctly.
3. **Submit an Adjusted or Corrected Claim to Home State:**
    - **Corrected claims must clearly indicate they are corrected in one of the following ways:**

      Submit corrected claim via the secure Provider Portal.

        - Follow the instructions on the portal for submitting a correction.

      Submit corrected claim electronically via Clearinghouse.

        - Institutional Claims (UB): Field CLM05-3 = 7 and REF*F8 = Original Claim Number.
        - Professional Claims (HCFA): Field CLM05-3 = 6 and REF*F8 = Original Claim Number.

4. **Submit a "Request for Reconsideration" to Home State:**

- A request for reconsideration is a written communication (i.e. a letter) from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical records.
- The request must include sufficient identifying information which includes, at a minimum, the patient name, patient ID number, date of service, total charges and provider name.
- The documentation must also include a detailed description of the reason for the request.
- **Mail Requests for Reconsideration to:**

Home State Behavioral Health
Attn: Reconsideration
PO Box 7400
Farmington, MO 63640-3827

5. **Submit a "Claim Dispute Form" to Home State:**

- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- The Claim Dispute Form can be located on the provider website at www.HomeStateHealth.com.
- To expedite processing of your dispute, please include the original Request for Reconsideration letter and the response.
- **Mail your "Claim Dispute Form" and all other attachments to:**

Home State Behavioral Health
Attn: Claims Dispute
PO Box 7400
Farmington, MO 63640-3827

If the Provider Service contact, the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Home State shall process, and finalize all corrected claims, requests for reconsideration and disputed claims to a paid or denied in accordance with State law and regulations.

Refunds and Overpayments

Home State Health routinely audits all claims for payment errors. Claims identified to have been underpaid or overpaid will be reprocessed appropriately. Providers have the responsibility to report overpayments or improper payments to Home State Health.

If your claim was processed with an overpayment or has resulted in a request for recoupment, you may submit all payments to the following address:

Home State Behavioral Health
PO Box 952790
St. Louis, MO 63195

Claims Integrity Team

Home State's Claims Integrity team consists of Provider Support Liaisons and Provider Reimbursement Specialists who are dedicated to quick and accurate resolution of claim discrepancies.

Provider Support Liaisons are your first source of contact. The liaisons receive extensive claims training in order to provide claims support for providers and provide first call resolution.

Provider Reimbursement Specialists investigate to identify root cause for systemic issues as well as identify and report any trends.

You can reach the Claims Integrity Team by calling 1-855-694-HOME (4663). Follow the prompts for Provider Services/Claims.

National Provider Identifier (NPI)

Home State Health requires all claims be submitted with a Network Provider's National Provider Identifier (NPI). This will be required on all electronic and paper claims. Network Providers must ensure Home State Health has their correct NPI Number loaded in their system profile. Typically, each Network Provider's NPI Number is captured through the credentialing process.

Applying for an NPI

Providers can apply for an NPI via the web or by mail.

- **To Register Online:**
  To register for an NPI using the web-based process, please visit the following website www.nppes.cms.hhs.gov/NPPES.

Click on the link that says, "If you are a healthcare provider, the NPI is your unique identifier." Then click on the link that says, "Apply online for an NPI." This should be the first link. Follow the instructions on the web page to complete the process.

- **To Register by Mail:**
  To obtain an NPI paper application, please call (800) 465-3203 (NPI Toll-Free).

Submitting Your NPI to Home State Health

Please visit www.homestatehealth.com to submit your NPI number. Network Providers may elect to contact the Home State Health Provider Relations department by phone to share their NPI.