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INTRODUCTION

Welcome

Welcome to Home State Health Plan (Home State). We thank you for being part of Home State's network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Home State works to accomplish this goal by partnering with the providers who oversee the healthcare of Home State's members.

About Us

Home State is a Managed Care Organization (MCO) contracted with the Missouri Department of Social Services to serve Missouri members through the Medicaid managed care program, MO HealthNet. Home State has the expertise to work with Missouri members to improve their health status and quality of life. Home State's management company, Centene Corporation ("Centene"), has been providing comprehensive managed care services to individuals receiving benefits under Medicaid and other government- sponsored healthcare programs for more than 27 years. Centene operates local health plans and offers a wide range of health insurance solutions to individuals and to the rising number of uninsured Americans. It also contracts with other healthcare and commercial organizations to provide specialty services. Home State is a physician-driven organization that is committed to building collaborative partnerships with providers. Home State will serve our Missouri members consistent with our core philosophy that quality healthcare is best delivered locally.

Mission

Home State strives to provide improved health status, successful outcomes, and member and provider satisfaction in a coordinated care environment. Home State has been designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind. We hope that you will assist Home State in reaching these goals and look forward to your active participation.

How to Use This Reference Manual

Home State is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality healthcare benefits. We are committed to provide comprehensive information through this Provider Reference Manual as it relates to Home State's operations, benefits, and policies and procedures to providers. This Provider Reference Manual will be posted on Home State's website where providers can review and

print it free of charge. Providers will be notified via Bulletins and notices posted in its provider secure website and in its weekly Explanation of Payment notices, of material changes to this Manual. For hard copies or CD copies of this Provider Reference Manual **please contact** the Provider Services department ("Provider Services") at 1-855-694-HOME (4663) or if you need further explanation on any topics discussed in the manual.

KEY CONTACTS

The following chart includes several important telephone and fax numbers available to your office. When calling Home State, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number ("TIN") number
- Member's ID number or MO HealthNet ID number

Health Plan Information		
	Home State 16090 Swingley Ridge Road, Suite 500 Chesterfield, MO 63017 www.HomeStateHealth.com	
Department	**Telephone Number**	**Fax Number**
Provider Services	1-855-694-HOME(4663) TDD/TYY: 1-877-250-6113	1-866-390-4429
Member Services	1-855-694-HOME(4663) TDD/TYY: 1-877-250-6113	1-866-390-4429
Authorization Request Concurrent Review Case Management Authorization Requests for PT, OT, and ST	1-855-694-HOME (4663)	1-855-286-1811 1-866-390-3139 1-877-276-8960 1-855-254-1798
NurseWise (24/7 Availability)	1-855-694-HOME (4663)	
Missouri Department of Social Services	1-573-751-3425 (MO HealthNet) Text Telephone 1-800-735-2966	1-573-751-6564
Medical Claims	**Reimbursement Rate Dispute**	**Medical Necessity Appeal**
Home State Attn: Claims PO Box 4050 Farmington, MO 63640-3829	Home State Attn: Claim Disputes PO Box 4050 Farmington, MO 63640-3829	Home State Attn: Medical Necessity 16090 Swingley Ridge Road Suite 500 Chesterfield, MO 63017
Electronic Claims Submission		
Home State c/o Centene EDI Department 1-800-225-2573, ext. 25525 or by e-mail to: EDIBA@centene.com		

PRODUCT SUMMARY

MO HealthNet Managed Care population is comprised of beneficiaries whom are in a category of eligibility listed below:

ELIGIBLE POPULATIONS

- Eligibility of Parents/Caretakers, Children, Pregnant Women, and Refugees:
  - Parents/Caretakers and Children eligible under MO HealthNet for Families, and Transitional MO HealthNet Assistance
  - Children eligible under MO HealthNet for Poverty Level Children
  - Women eligible under MO HealthNet for Pregnant Women and 60 days post-partum
  - Individuals eligible under Participants of Refugee MO HealthNet
  - Individuals who are eligible under the above groups and are Autism or Developmental Disabilities (DD) waiver participants
- Eligibility of Other MO HealthNet Children in the Care and Custody of the State and Receiving Adoption Subsidy Assistance:
  - All children in the care and custody of the Department of Social Services
  - All children placed in a not-for-profit residential group home by a juvenile court
  - All children receiving adoption subsidy assistance
  - All children receiving non-medical assistance (i.e., living expenses) that are in the legal custody of the Department of Social Services shall remain the responsibility of the Department of Social Services.
- State Child Health Plan: Missouri has an approved combination State Child Health Plan under Title XXI of the Social Security Act (the Act) for the Children's Health Insurance Program (CHIP).

VOLUNTARY POPULATIONS

MO HealthNet Managed Care eligibles in the above specified eligibility groups may voluntarily disenroll from the Managed Care Program or choose not to enroll in the Managed Care Program if they:

- Are eligible for Supplemental Security Income (SSI) under Title XVI of the Act
- Are described in Section 501(a)(1)(D) of the Act
- Are described in Section 1902 (e)(3) of the Act
- Are receiving foster care or adoption assistance under part E of Title IV of the Act
- Are in foster care or otherwise in out-of-home placement
- Meet the SSI disability definition as determined by the Department of Social Services

Enrollment

The Missouri Department of Social Services, the Family Support Division (FSD) is responsible for eligibility determinations. The state agency will conduct enrollment activities for MO HealthNet Managed Care eligibles. Please visit www.dss.mo.gov/MHD/ for more information on the MO HealthNet enrollment process.

Provider Restrictions

Providers shall not conduct or participate in health plan enrollment, disenrollment, and transfer or opt out activities or attempt to influence a member's enrollment. Prohibited activities include:

- Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet Managed Care
- Requiring or encouraging the member and/or guardian to use the opt out as an option in lieu of delivering health plan benefits
- Mailing or faxing MO HealthNet Managed Care enrollment forms
- Aiding the member in filling out health plan enrollment forms
- Aiding the member in completing on-line health plan enrollment
- Photocopying blank health plan enrollment forms for potential members
- Distributing blank health plan enrollment forms
- Participating in three-way calls to the MO HealthNet Managed Care enrollment helpline
- Suggesting a member transfer to another health plan
- Other activities in which a provider attempts to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan

Provider Marketing Guidelines

Home State and its participating providers may conduct marketing activities to MO HealthNet Managed Care members subject to MO HealthNet guidelines.

Providers must submit all member marketing materials to Home State prior to distributing. Home State will submit marketing and educational materials on behalf of the provider to MO HealthNet for written approval.

Providers may advise MO HealthNet Managed Care members of the plans in which they participate through the following communications:

- Equally display a list of all plans in which they participate
- Equally display all participating health plan logos

- Provide all participating health plan phone numbers
- Equally display all contracted health plan provided marketing and health education materials
- A letter to previous fee-for-service recipients who may be eligible for MO HealthNet Managed Care, informing them of all health plans with which they participate

VERIFYING ELIGIBILITY

Member Eligibility Verification

To verify member eligibility, please use one of the following methods:

1.Log on to the secure provider portal at www.HomeStateHealth.com. Using our secure provider website, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member MO HealthNet ID and date of birth.

2.Call our automated member eligibility IVR system. Call 1-855-694-HOME (4663) from any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24-hours a day. The automated system will prompt you to enter the member MO HealthNet ID and the month of service to check eligibility.

3.Call Home State's Provider Services. If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-855-694-HOME (4663). Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the member name or member MO HealthNet ID to verify eligibility.

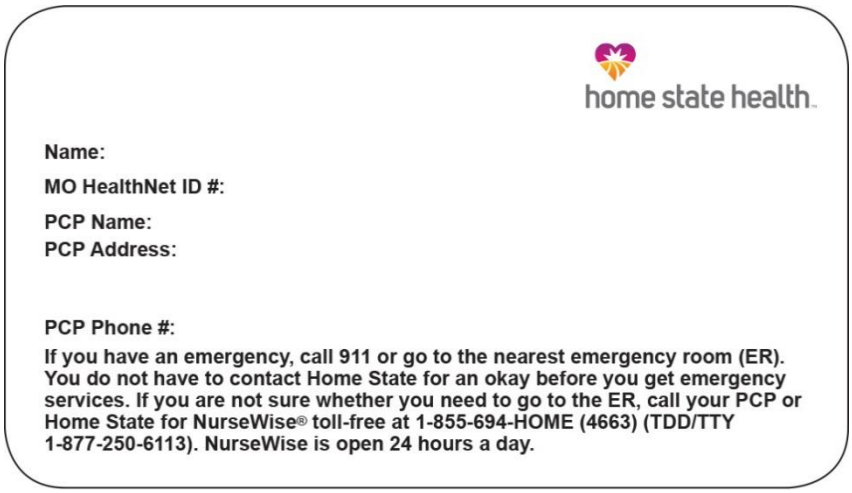
Through Home State's secure provider web portal, PCPs are able to access a list of eligible members who have selected their services or were assigned to them. The Patient list is reflective of all changes made within the last 24 hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, such as a missed Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. In order to view this list, log on to www.HomeStateHealth.com. **Since eligibility changes can occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage, please use one of the above methods to verify member eligibility on date of service.**

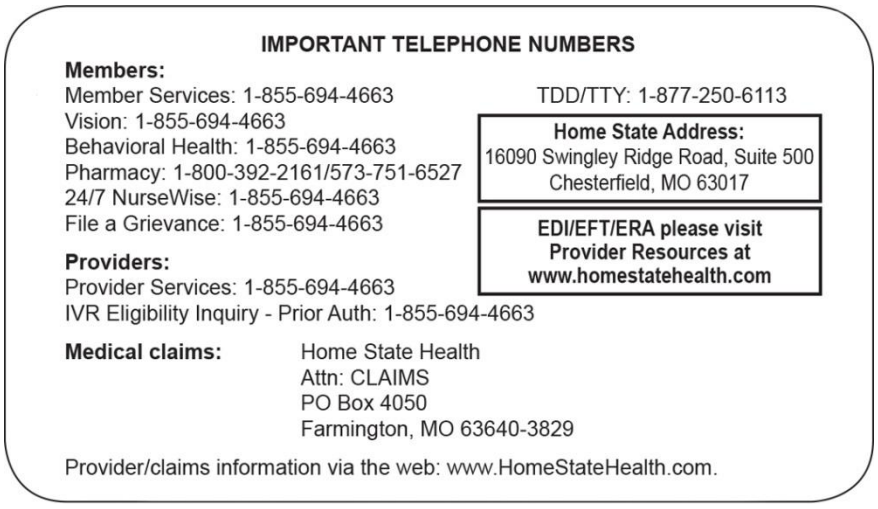
All new Home State members receive a Home State member ID card. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card. **Since member ID cards are not a guarantee of eligibility, providers must verify members' eligibility on each date of service**.

Member Identification Card

Providers are required to implement a policy of requesting and inspecting an adult member's MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility) and health plan membership card, prior to

providing non-emergency services. If you suspect fraud, please contact Provider Services at 1-855-694-HOME (4663) immediately. Members must keep the state-issued MO HealthNet ID card in order to receive benefits not covered by Home State, such as Pharmacy services. Members are directed to present both identification cards when seeking non-emergency services.



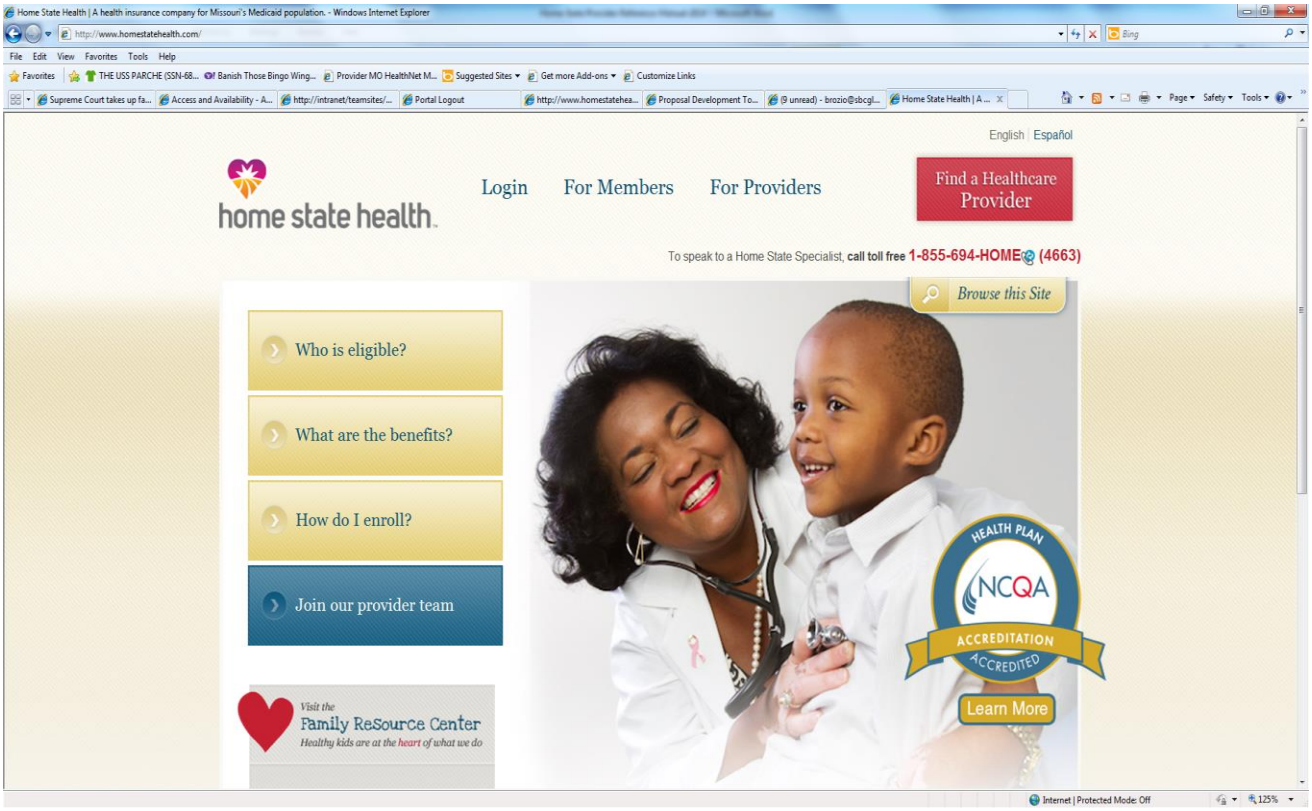


Home State Website

The Home State website can significantly reduce the number of telephone calls providers need to make to the health plan. Utilizing the website allows immediate access to current provider and member information 24 hours, seven days a week. Please contact your Provider Relations Representative or our Provider Services department at 1-855-694-HOME (4663) with any questions or concerns regarding the website.

Home State's website is located at www.HomeStateHealth.com. Physicians can find the following information on the website:

- Provider Reference Manual
- Provider Billing Manual
- Prior Authorization List
- Forms
- Home State News
- Clinical Guidelines
- Provider Bulletins
- Check to See if an Authorization is Required



Secure Website

Home State website allows providers to obtain information at your convenience (24/7) without having to make a phone call. Home State's contracted providers and their office staff has the opportunity to register for our **secure provider website.** Here, we offer tools which make obtaining and sharing information easy! It's simple and secure! Go to www.HomeStateHealth.com to register. On the home page, select the Login link on the top right to start the registration process.

Through the **secure** site you can:

- Check member eligibility
- View Members' health record
- View the PCP panel (patient list)
- View and submit claims and adjustments
- View payment history
- Submit demographic changes
- View and submit authorizations
- View member health record
- View member gaps in care
- View quality scorecard
- Contact us securely and confidentially

We are continually updating our website with the latest news and information, so save to your Internet "Favorites" list and check our site often. Please contact a Provider Relations Representative for a tutorial on the secure site.

PRIMARY CARE PROVIDERS (PCP)

The primary care provider (PCP) is the cornerstone of Home State's service delivery model. The PCP serves as the "medical home" for the member. The "medical home" concept assists in establishing a member-provider relationship, supports continuity of care, patient safety, leads to elimination of redundant services and ultimately more cost effective care and better health outcomes. Home State offers a robust network of PCPs to ensure every member has access to a medical home within the required travel distance standards (30 miles in the rural regions, 20 miles in basic county and 10 miles in the urban regions). Home State requests that PCP's inform our member services department when a Home State member misses an appointment so we may monitor that in our system and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of Emergency Room services.

Provider Types That May Serve As PCPs

Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners and Nurse Practitioners. The PCP may practice in a solo or group setting or at a FQHC, RHC or outpatient clinic. Home State may allow some specialists to serve as a member's PCP for members with multiple disabilities or with chronic conditions as long as the specialists agrees, in writing, and is

willing to perform the responsibilities of a PCP as stipulated in this handbook.

Member Panel Capacity

All PCPs shall state the number of members they are willing to accept into their panel. When the PCP has reached 85 percent capacity, the PCP must notify Home State. Home State **DOES NOT** guarantee that any provider will receive a certain number of members.

Suggested panel sizes are as follows:

- Physicians – 1: up to 2,500
- Nurse Practitioner 1: up to 1,000
- Physician with physician extenders (Nurse Practitioner/Physician Assistant; and Certified Nurse Midwife for OB/GYNs only) may increase basic physician ratio of 1: up to 2,500 by 1,000 per extender.

A PCP shall not refuse to treat members as long as the physician has not reached their stated panel size.

Providers shall notify Home State in writing at least forty-five (45) days in advance of his or her inability to accept additional MO HealthNet covered persons under Home State agreements. In no event shall any established patient who becomes a Covered Person be considered a new patient. Home State prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-MO HealthNet members.

Assignment of Medical Home

Home State offers a robust network of primary care providers to ensure every member has access to a "medical home" within the required travel distance standards (10 miles in the urban areas, 20 miles in basic county, and 30 miles in the rural areas).

For those members who have not selected a PCP during enrollment, Home State will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the following criteria and in the sequence presented below:

1. Member history with a PCP. The algorithm will first look to see if the member is a returning member and attempt to match them to previous PCP. If the member is new to Home State, claim history provided by the state will be used to match a member to a PCP that the member had previous relationship where possible.

2. Family history with a PCP. If the member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member's family, such as a sibling, is or has been assigned to.

3. Geographic proximity of PCP to member residence. The auto-assignment logic will ensure members travel no more than 30) miles in the rural regions, 20 miles in basic county, and 10 miles in the urban regions.

4. Appropriate PCP type. The algorithm will use age, gender, and language (to the extent they are known) and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.

Pregnant women should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, Home State will assign one for her newborn.

Medical Home Model

Home State is committed to promoting a medical home model of care that will provide better healthcare quality, improve self-management by members of their own care and reduce avoidable costs over time. Home State will actively partner with our providers, with community organizations, and groups representing our members to achieve this goal through the meaningful use of health information technology (HIT).

From an information technology perspective, we will be offering several HIT applications for our network providers. Our secure **Provider Portal** offers tools that will help support providers in the medical home model of care. These tools include:

- Online Care Gap Notification
- Member Panel Roster including member detail information
- Trucare Service Plan
- Health Record
- Provider Overview Report

Primary Care Provider (PCP) Responsibilities

Primary Care Providers (PCP) shall serve as the member's initial and most important contact. PCP's responsibilities include, but are not limited, to the following:

- Establish and maintain hospital admitting privileges sufficient to meet the needs of all linked members, or entering into an arrangement for management of inpatient hospital admissions of members;
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs and chronic conditions;
- Educate members on how to maintain healthy lifestyles and prevent serious illness
- Provide screening, well care and referrals to community health departments and other agencies in accordance with MO HealthNet provider requirements and public health initiatives;
- Conduct a behavioral health screen to determine whether the member needs behavioral health services;
- Maintain continuity of each member's healthcare by serving as the member's medical home;

- Offer hours of operation that are no less than the hours of operating hours offered to commercial members or comparable to commercial health plans if the PCP does not provide health services to commercial members;
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide;
- Ensure follow-up and documentation of all referrals including services available under the State's fee for service program;
- Collaborate with Home State's case management program as appropriate to include, but not limited to, performing member screening and assessment, development of plan of care to address risks and medical needs, linking the member to other providers, medical services, residential, social, community and to other support services as needed;
- Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services.
- Adhere to the EPSDT periodicity schedule for members under age 21;
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization; as well as coordinating services the member is receiving from another health plan during transition of care;
- Share the results of identification and assessment for any member with special health care needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated; and
- Actively participate in and cooperate with all Home State's quality initiatives and programs.

PCPs may have a formalized relationship with other primary care providers to see their members when needed. However, PCPs shall be ultimately responsible for the above listed activities for the members assigned to them.

Referrals

As promoted by the Medical Home concept, PCPs should coordinate the healthcare services for Home State members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, **paper referrals *are not* required**. To better coordinate a members' healthcare, Home State encourages specialists to communicate to the PCP the results of the consultant and subsequent treatment plans.

In accordance with State Law, providers are prohibited from making referrals to healthcare entities with which the provider or a member of the providers' family has a financial relationship.

Vaccines for Children (VFC) Program

Federally-provided vaccines are available at no charge to public and private providers for eligible children ages newborn through 18 years through the VFC program. MO HealthNet requires providers who administer immunizations to qualified MO HealthNet eligible children to enroll in the VFC program. The Missouri Department of Health and Senior

Services (DHSS) administers the VFC program. Providers should contact the DHSS at:

Missouri Department of Health and Senior Services-Section of Vaccine Preventable and Tuberculosis Disease Elimination
P.O. Box 570
Jefferson City, Missouri 65102
(800) 219-3224 or fax (573) 526-5220

Home State participating providers who administer vaccines must enroll in the VFC program through the DHSS. Participating providers must utilize the VFC program for Home State members.

Home State will reimburse an administration fee per dose to providers who administer the free vaccine to eligible members **except** to those providers enrolled as rural health clinics (RHCs) or Federally Qualified Health Centers (FQHCs). Please refer to the Home State Provider Billing Manual for
instructions on how to submit claims.

Home State encourages specialists to communicate to the PCP the need for a referral to another specialist. This allows the PCP to better coordinate their members' care and become aware of the additional service request.

Specialist Responsibilities

Specialists are required to report to Home State limitations on the number of referrals accepted. The Specialist must notify Home State when the Specialist reaches 85 percent capacity.

Home State encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the members' care and ensure the referred specialty physician is a participating provider within the Home State network and that the PCP is aware of the additional service request. The specialty physician may order diagnostic tests without PCP involvement by following Home State's referral guidelines.

Emergency admissions will require notification to Home State's Medical Management Department within one (1) business day, following the date of admission to conduct medical necessity review. This includes observation stays. All non-emergency inpatient admissions require prior authorization from Home State.

The specialist provider must:

- Maintain contact with the PCP
- Obtain authorization from Home State's Medical Management Department ("Medical Management") if needed before providing services
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for or provide on-call coverage through another source 24-hours a day

for management of member care
- Maintain the confidentiality of medical information
- Actively participate in and cooperate with all Home State's quality initiatives and programs.

Home State providers should refer to their contract for complete information regarding providers' obligations and mode of reimbursement or contact their Provider Relations Representative with any questions or concerns.

Mainstreaming

Home State considers mainstreaming of its members an important component of the delivery of care and expects its participating providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered services or availability of a facility
- Providing a Home State member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: different waiting rooms or appointment times or days)
- Subjecting a member to segregation or separate treatment in any manner related to covered services

Appointment Accessibility Standards

Home State follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Home State monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency room utilization.

Type of Appointment	Scheduling Time Frame
Primary Care Providers	
Routine care without symptoms (e.g. well child exams, routine physicals)	Within 30 calendar days
Routine care with symptoms (e.g. persistent rash, recurring high grade temperature)	Within one week or five business days, whichever is earlier.
Urgent Care (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services)	Within 24-hours
Emergent or emergency visits	Immediately upon presentation
Pregnant Women	
First trimester appointments	Within seven calendar days of first request

Second trimester appointments	Within seven calendar days of first request
Third trimester appointments	Within three days of first request
High risk pregnancies	Within three calendar days of identification of high risk, or immediately if an emergency exists
Behavioral Health and substance abuse services	Aftercare appointments within seven calendar days after hospital discharge
Behavioral Health and substance abuse emergent services	Immediately
In Office waiting time for scheduled appointments (defined as time spent both in the lobby and in the exam room)	Not to exceed one hour from the scheduled appointment time.

Covering Providers

PCPs and specialty physicians must arrange for coverage with another Home State network provider during scheduled or unscheduled time off. In the event of unscheduled time off, please notify Provider Relations of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement.

Telephone Arrangements

PCPs and Specialists must:

- Answer the member's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
    - o After hours telephone care for non-emergent, symptomatic issues within 30 minutes
    - o Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record

Note*: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to member receiving urgent or emergent care.*

Home State will monitor appointment and after-hours availability on an on-going basis

through its Quality Improvement program ("QIP").

24-Hour Access

Home State's PCPs and specialty physicians are required to maintain sufficient access to covered physician services and shall ensure that such services are accessible to members as needed 24-hours a day, seven days a week.

- A provider's office phone must be answered during normal business hours
- During after- hours, a provider must have arrangements for:
    - Access to a covering physician,
    - An answering service,
    - Triage service, or
    - A voice message that provides a second phone number that is answered. Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish speaking members.

Examples of Unacceptable After-Hours Coverage include, but are not limited to:

- The provider's office telephone number is only answered during office hours;
- The provider's office telephone is answered after-hours by a recording that tells patients to leave a message;
- The provider's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
- Returning after-hours calls outside thirty minutes.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, PCP, specialty physician, or covering medical professional must return the call within thirty (30) minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Home State will monitor providers' offices through scheduled and un-scheduled visits conducted by Home State's Provider Relations staff.

Provider Directory Demographic Changes

To ensure accurate information is provided to our members, MO HealthNet Division and Home State require advanced notice of any demographic changes, such as location, office hours, hospital privileges, and phone and fax number. Please provide this information to Home State at least thirty (30) days prior to the effective date of the change. Demographic changes can be submitted via Home State's secure provider portal at www.HomeStateHealth.com.

Hospital Responsibilities

Home State utilizes a network of hospitals to provide services to Home State members. Hospital services providers must be qualified to provide services under the MO HealthNet program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the RFP.
Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services
- Notify Home State's Medical Management department by sending an electronic file of the ER admission by the next business day. The electronic file should include the member's name, MO HealthNet ID, presenting symptoms/diagnosis, DOS, and member's phone number.
- Notify Home State's Medical Management department of all admission within one (1) business day.

- Notify Home State's Medical Management department of all newborn deliveries within one (1) business day of the delivery

Home State hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

Advance Directives

Home State is committed to ensure that its members are aware of and are able to avail themselves of their rights to execute advance directives. Home State is equally committed to ensuring that it's providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and providers delivering care to Home State members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

Home State recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an advance directive and 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 advance directive to the PCP's office and document this request in the member's medical record

- An advance directive should be included as a part of the member's medical record and include mental health directives

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

Voluntarily Leaving the Network

Providers must give Home State notice of voluntary termination following the terms of their

participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to Home State or the member.

Home State will notify affected members in writing of a provider's termination, within 30 calendar days prior to the effective date of termination and no more than 15 calendar days of the receipt of the termination notice from the provider, provided that such notice from the provider was timely. If the terminating provider is a PCP, Home State will assign the member to a new PCP and notify the member their rights to change their PCP.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 days, the anniversary date of the member's coverage, or until Home State can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, Home State will reimburse the provider for the provision of covered services for up to 90 days from the termination date. In addition, Home State will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from Home State

Home State will also provide written notice to a member within 30 days, prior to the effective date of termination and no more than 15 calendar days of receipt of the termination notice from the provider, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.

CULTURAL COMPETENCY

Cultural competency within Home State is defined as "the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand, racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner."

Home State 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.

Home State as part of its credentialing will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist provider's in developing culturally competent and culturally proficient practices.

Network providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the members' race/ethnicity and language and its impact/influence on the members' health or illness
- Office staff that routinely interact with members have access to and participate in cultural competency training and development
- Office staff that is responsible for data collection makes reasonable attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children
- Treatment plans are developed with consideration of the members race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on healthcare
- Office sites have posted and printed materials in English and Spanish, and if required by Missouri Department of Social Services, any other required non-English language

BENEFIT EXPLAN ATION AND LIM ITATIONS

Home State Benefits

Home State network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this Provider Reference Manual, please contact Provider Services at1-855-694-HOME (4663) from 8:00 a.m. to 5:00 p.m. (CST) Monday through Friday. A Provider Services Representative will assist you in understanding the benefits.

Home State covers, at a minimum, those core benefits and services specified in our Agreement with MO HealthNet and are defined in the Missouri Medical State Plan, administrative rules, and Department policies and procedure handbook. **Home State members may not be charged or balance billed for covered services.**

The following list is not intended to be an all-inclusive list of covered services. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines.

Service	Coverage	Benefit Limitation	Comments
Allergy Services	Covered	No limits or age restrictions	
Ambulatory Surgery Center	Covered		
Anesthesia Services	Covered		
Behavioral Health Services	Covered	Includes Community Based, Inpatient and Outpatient Services.	Services administered by Cenpatico Behavioral Health.
Circumcisions (Routine/Elective)	Covered (added benefit)	For infants up 30 days after birth	
Dental Services	Covered	Limited to children under 21 and certain pregnant women. • 1 Cleaning every 6 months • Extractions and fillings • 1 set of x-rays per 24 month period • Other dental services are available • Orthodontic braces are only covered if medically necessary Adult coverage is limited to treatment of trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury, and dental services when the absence of dental treatment would adversely affect a pre-existing medical condition.	
Dialysis	Covered		
Durable Medical Equipment (DME)	Covered		
Early Periodic Screening Diagnosis and Treatment	Covered	For members less than 21 years old	
Emergency Room Services	Covered		
Enteral & Parenteral Nutrition for Home Use	Covered		
Environmental Lead Assessment	Covered	Limited to children under 21 Limited to 1 initial assessment per year	
Family Planning	Covered		
FQHC & RHC Services	Covered		
Hearing Aids and Related Services	Covered	Limited to children under 21.	

Home Health Care Services	Covered	Children under age 21 Limited to 2 skilled nurse visit, occupational therapy, speech therapy and physical therapy evaluation Adults 21 and over: Limited to 100 visits per year	For OT, PT, and ST, please see the STRS Authorization guidelines in this manual
Hospice Care	Covered	Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made.	
Hospital Services: Inpatient	Covered		
Hospital Services: Outpatient	Covered		

Hysterectomy	Covered	Not covered if preformed for the following reasons: • The hysterectomy was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or • if there was more than one purpose to the procedure, it would *not* have been performed except for the purpose of rendering the individual permanently incapable of reproducing	*Consent Form Required*
Laboratory Services	Covered		
Maternity Care Services	Covered	Includes: • Nurse mid-wife services • Pregnancy related services • Services for conditions that might complicate pregnancy	
Orthotics & Prosthetics (O&P)	Covered		
Physician, and Nurse Practitioner Services	Covered		

Podiatrist Services	Covered	21 and Older Excludes: trimming of nondystrophic nails, any number; debridement of nail(s) by any method(s), one (1) to five (5); debridement of nail(s) by any method(s), six (6) or more; excision of nail and nail matrix, partial or complete; and strapping of ankle and/or foot	
Radiology and x-rays	Covered		
Sterilization Procedures	Covered		Consent Form Required

Therapy (OT, PT, ST) Services (Outpatient) and comprehensive day rehabilitation	Covered	Limited to children under 21 and adult pregnant women with ME codes 18, 43, 44, 45, and 61. Services for pregnant women are limited to the following: ST/PT/OT services are covered through the **home health** benefit when the adult pregnant member is medically homebound. PT/OT services provided by a **rehabilitation center** or **independent provider** are limited to adaptive training for a prosthetic, orthotic device, or if ST for adaptive training for an artificial larynx. **Outpatient hospital** providers can provide medically necessary PT services without limitation, OT if it is for adaptive training for a prosthetic, orthotic device, or if ST for adaptive training for an artificial larynx.	For OT, PT, and ST, please see the STRS Authorization guidelines in this manual
Transplant Service	Covered	Pre and Post-Transplant Services Only	
Transportation	Covered per MoHealthNet eligibility guidelines		

Routine Vision Services and Eyewear	Covered	Under 21: 1 eye exam per year 1 pair of glasses per year 21 and Older: 1 eye exam every 2 (two) years 1 pair of glasses every 24 months Some benefit and eligibility restrictions may apply For specific questions regarding medical conditions or diseases of the eye, please contact Home State Health Plan at 1-855-694-HOME (4663)	

Additional Benefits	
Start Smart for Your Baby 17-P program	
Start Smart Birthdays Program	
Circumcision	Non-medically necessary for infants up to 30 days after birth
Transportation	Enhanced transportation services to all WIC appointments and on a case to case exception basis, related pharmacy and other treatment facilities.

Non Contracted and Non Covered Services

Service	Comment
Abortion	MO HealthNet Fee for Service
Chiropractic Services	Not Covered
Home Births	MO HealthNet Fee for Service
Prescription Drugs	MO HealthNet Fee for Service

Non-Emergent Medical Transportation

Home State will provide non-emergent transportation for covered services requested by the member or someone on behalf of the member. At the time of transport, the member must be eligible with Home State through a medical eligibility code that includes this benefit. ME codes 08, 52, 57, 64, 73, 74, 75 are excluded from this benefit. Home State requests its participating providers including its transportation vendor to inform our Member Services department when a member misses a transportation appointment so that it can monitor and educate the member on the importance of keeping medical appointments.

Network Development and Maintenance

Home State will ensure the provision of covered services as specified by the State of Missouri. Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the MO HealthNet network adequacy requirements for the Managed Care Organization networks. Home State will develop and maintain a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with MO HealthNet's access and availability requirements.

Home State offers a network of primary care providers to ensure every member has access to a medical home within the required travel distance standards (30 miles in the rural regions, 20 miles in basic county, and 10 miles in the urban regions). Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners and Nurse Practitioners. (More information on Primary Care Physicians and their responsibilities can be found in this manual). In addition, Home State will have available, at a minimum, the following specialists for members on at least a referral basis:

Allergy
Dermatology
Family Medicine
General Practice
Internal Medicine
Cardiology
Endocrinology
Obstetrics
Ophthalmology
Optometry
Orthopedics
Otolaryngology
Pediatric (General)
Pediatric (Subspecialties)
Physical Medicine and rehab
Gastroenterology
Hematology/Oncology
Infectious Disease
Nephrology
Pulmonary Disease
Rheumatology
Neurology
Podiatry
Psychiatrist-Adult/General
Psychiatrist-Child/Adolescent
Psychologist/Other Therapies
Surgery/General
Urology
Vision Care/Primary Eye care

In the event Home State's network is unable to provide medically necessary services required under the contract, Home State shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances. For assistance in making a referral to a specialist or subspecialties for a Home State member, please contact our Medical Management team at 1-855-694-HOME (4663) and we will identify a provider to make the necessary referral.

Tertiary Care

Home State offers a network of tertiary care inclusive of level one and level two trauma

centers, burn centers, Neonatal intensive care units, perinatology services, rehabilitation facilities, comprehensive cancer services, comprehensive cardiac services and medical sub specialists available 24-hours per day in the geographical service area. In the event Home State network is unable to provide the necessary tertiary care services required, Home State shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

MEDICAL MANAGEMENT

Overview

Home State's Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays). After normal business hours, NurseWise staff is available to answer questions about prior authorization. Medical Management services include the areas of utilization management, case management, disease management, and quality review. The department clinical services are overseen by the Home State medical director ("Medical Director"). The VP of Medical Management has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Medical Management contact:

Medical Management
1-855-694-HOME (4663)
Fax 1-855-286-1811
www.HomeStateHealth.com

Utilization Management

The Home State Utilization Management Program (UMP) is designed to ensure members of Home State receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, and ancillary care services.

Home State's UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under- utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of case and/or disease management for members at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all Home State members establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic

condition self-management
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals

See the section on Specialty Therapy and Rehabilitation Services for information about authorization of outpatient and home health occupational, physical and speech therapy services.

Referrals – Paper referrals are not required; however PCP's should coordinate the healthcare services for Home State members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters. To better coordinate a members' healthcare, Home State encourages specialists to communicate to the PCP the results of the consultant and subsequent treatment plans.

Notifications - A provider is required to promptly notify Home State when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

Prior Authorizations - Some services require prior authorization from Home State in order for reimbursement to be issued to the provider. All out-of-network services require prior authorization. To verify whether a prior authorization is necessary or to obtain a prior authorization, call:

Home State
Medical Management/Prior Authorization Department
Telephone 1-855-694-HOME (4663)
Fax 1-855-286-1811
www.HomeStateHealth.com

Prior Authorization requests may be done electronically following the ANSI X 12N 278 transaction code specifications. For more information on conducting these transactions electronically contact:

Home State
C/o Centene EDI
Department
1-800-225-2573, extension 25525
Or by e-mail at:
EDIBA@centene.com

Self-Referrals

The following services do not require prior authorization or referral:

- Emergency services including emergency ambulance transportation
- OB/GYN services with a participating provider
- Women's health services provided by a Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner (CNP)
- Family planning services and supplies from a qualified MO HealthNet

family planning provider

- Testing and treatment of communicable disease
- General optometric services (preventative eye care) with a participating provider
- Note: Except for emergency services, family planning services, and treatment of communicable disease, the above services must be obtained through Home State network providers.

Prior Authorization and Notifications

Prior authorization is a request to the Home State Utilization Management (UM) department for approval of services on the prior authorization list before the service is delivered.

Authorization must be obtained prior to the delivery of certain elective and scheduled services. **Prior authorization should be requested at least five (5) calendar days before the scheduled service delivery date or as soon as need for service is identified**. Services that require authorization by Home State are noted in the table below. The PCP should contact the UM department via telephone, fax or through our website with appropriate supporting clinical information to request an authorization. All out-of-network services require prior authorization. Below is a Table reflecting those services that require prior authorization. (This may not be an all-inclusive list. Please visit www.HomeStateHealth.com.)

Procedures/Services	Inpatient Authorization	Ancillary Services
✓ All procedures and services performed by out of network providers (except ER, urgent care, family planning, and treatment of communicable disease)	✓ All elective/scheduled admissions at least **5** business days prior to the scheduled date of admit	✓ Air Ambulance Transport (non-emergent fixed wing airplane)
✓ Potentially Cosmetic including but not limited to: bariatric surgery, blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures	✓ All services performed in out-of network facility	✓ DME purchases costing $500 or more or rental of $250 or more

✓ Experimental or investigational	✓ Hospice care	✓ Home healthcare services including home hospice, home infusion, skilled nursing, personal care services, and therapy
✓ High Tech Imaging (i.e. CT, MRI, PET)	✓ Rehabilitation facilities	✓ Orthotics/Prosthetics billed with an "L" code costing $500 or more or rental of $250 or more
✓ Hysterectomy	✓ Skilled nursing facility	✓ Therapy (ongoing services) Occupational Physical Speech
.	✓ Transplant related support services including pre-surgery assessment and post-transplant follow up care	✓ Hearing Aid devices including cochlear implants
✓ Oral Surgery	✓ Notification for all Urgent/Emergent Admissions: ✓ Within one (**1)** business day following date of admission ✓ Newborn Deliveries must include birth outcomes	✓ Genetic Testing
✓ Pain Management		

Emergency room and post stabilization services never require prior authorization. Providers should notify Home State of post stabilization services such as but not limited to the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within one business day of the service initiation. Providers should **notify Home State of emergent inpatient admissions (including observation) within one business day** of the admission for ongoing concurrent review and discharge planning. Maternity admissions require notification and information on the delivery outcome. Clinical information is required for ongoing care authorization of the service.

Failure to obtain authorization may result in administrative claim denials. Home State providers are contractually prohibited from holding any Home State member financially liable for any service administratively denied by Home State for the failure of the provider to obtain timely authorization.

Authorization Determination Timelines

Home State decisions are made as expeditiously as the member's health condition requires. For standard service authorizations, the decision will be made within two (2) business days from receipt of necessary medical information and notification within one (1) business day after the decision is made (not to exceed a total 14 calendar days from receipt of the request unless an extension is requested). "Necessary information" includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in an administrative denial of the requested service. For urgent/expedited requests, a decision and notification is made within 24-hours of the receipt of the request. Approval or denial of non-emergency services, when determined as such by emergency room staff, shall be provided within thirty (30) minutes of request. Involuntary detentions (ninety-six (96) hour detentions or court ordered detentions) or commitments shall not be prior authorized for any inpatient days while the order of detention or commitment is in effect. For concurrent review of ongoing inpatient admission and other services such as outpatient rehabilitation, home care or ongoing specialty care, decisions are made within 24-hours of receipt of necessary information, and notification within one (1) business day after the decision is made. Written or electronic notification includes the number of days of service approved, and the next review date.

Second and Third Opinions

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Home State network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Members have a right to a third surgical opinion when the recommendation of the second surgical opinion fails to confirm the primary recommendation and there is a medical need for a specific treatment, and if the member desires the third opinion. Out-of-network and in-network providers require prior authorization by Home State when performing second and third opinions.

Clinical Information

Authorization requests may be submitted by fax, phone or secure web portal. Authorization

determinations may be communicated to the provider fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. When calling our prior authorization department, a referral specialist will enter demographic information and then transfer the call to a Home State nurse for the completion of medical necessity screening. During heavy call volumes, a nurse may answer the telephone and complete the medical necessity screening during the call. For all services on the prior authorization list, documentation supporting medical necessity will be required.

Home State clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Home State is entitled to request and receive protected health information (PHI) for purposes of treatment, payment
and healthcare operations, with the authorization of the member.

Information necessary for authorization of covered services may include but is not limited to:

- Member's name, Member ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate.

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

Clinical Decisions

Home State affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Home State does not reward practitioners or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Home State Medical Director, is responsible for making utilization management (UM)

decisions in accordance with the member's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Peer to Peer Discussions

In the event of an adverse determination, including a denial, reduction, or termination of coverage, the provider may request a peer-to-peer discussion with the medical director. At the time of notification of denial, the provider will be notified of this right, and has two (2) business days to initiate a peer-to-peer discussion.

Medical Necessity

Medical necessity is defined for Home State members as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines
- Not primarily for the personal comfort or convenience of the member, family, or provider
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member
- Furnished in a setting appropriate to the patient's medical need and condition and, when supplied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service
- Not experimental or investigational or for research or education

Review Criteria

Home State has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at1-855-694-HOME (4663). Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling the Home State main toll-free phone number and asking for the Medical Director. A case manager may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals with the member's consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Home State Health Plan
Complaint and Grievance Coordinator
16090 Swingley Ridge Road
Suite 500
Chesterfield, MO 63017
1- 855-694-HOME (4663)
Fax Numbers:
Medical Necessity Appeals-1-877-309-6762
Member Grievances-1-866-390-4429
Concurrent Review-1-866-390-3139
Prior Authorization 1-855-286-1811
Inpatient Notification 1-866-390-2739

New Technology

Home State evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the Home State population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-855-694-HOME (4663).

Notification of Pregnancy

Members that become pregnant while covered by Home State may remain a Home State member during their pregnancy. The managing or identifying physician should notify the Home State prenatal team by completing the Notification of Pregnancy (NOP) form within five days of the first prenatal visit or confirmation of pregnancy. Providers are expected to identify the estimated date of confinement and delivery facility. See the Case Management section for information related to our Start Smart for Your Baby® program and our 17-P program for women with a history of early delivery.

Concurrent Review and Discharge Planning

Nurse Case Managers perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending physician. The Case Manager will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within 24 hours of receipt of necessary information, and notification within one (1) business day after the decision is made. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or c-section delivery does not require concurrent review, however; the hospital must notify Home State within one business day of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to Home State was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have their Home State Health Plan card or otherwise indicated MO HealthNet coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of the request, not to exceed 180 calendar days from the date of service.

SPECIALTY THERAPY AND REHABILITATION SERVICES

Home State offers our members access to all covered, medically necessary outpatient physical, occupational and speech therapy services through Cenpatico, Specialty Therapy and Rehabilitative Services (STRS).

Providers need to adhere to the Covered Professional Services & Authorization Guidelines set forth in this Manual when rendering services. Network Providers may provide a covered initial evaluation/assessment to a member without seeking authorization from Cenpatico.

Non-Network Providers must complete an Outpatient Treatment Request (OTR) form for all services. Once the evaluation/assessment is completed, all Providers must submit a fax or web authorization to Cenpatico to obtain authorization for services. Cenpatico does not retroactively authorize treatment.

Prior authorization for outpatient and home health occupational, physical or speech therapy services, as well as comprehensive day rehabilitation, should be submitted to Cenpatico STRS using the Outpatient Treatment Request (OTR) form located at www.Cenpatico.com.

Cenpatico STRS Outpatient Therapies Prior Authorization
Fax number: 1-855-254-1798

In the event that the practitioner is unable to provide timely access for a member, Cenpatico will assist in securing authorization to a practitioner to meet the member's needs in a timely manner.

STRS Medical Necessity Criteria

Cenpatico STRS created and applies medical necessity criteria developed using Clinical Practice Guidelines of the physical, occupational and speech professional associations, as well as InterQual Criteria for both Adults and Pediatrics guidelines. The criteria can be found on the Cenpatico website at: www.Cenpatico.com. Cenpatico STRS utilizes Occupational, Physical and Speech Therapists to process Outpatient Treatment Request. Our specialized approach allows for real time interaction with the provider to best meet the overall therapeutic needs of the members.

STRS Outpatient Treatment Request (OTR)

When requesting sessions for outpatient and home health therapy services that require authorization, the Provider must complete an Outpatient Treatment Request (OTR) form and submit the completed form to Cenpatico for clinical review prior to provision of services. The OTR is located on our website at www.cenpatico.com. Providers may call the Customer Service department at 1-855-694-HOME (4663) to check status of an OTR. Providers should allow up to two (2) business days after date of receipt to process non-urgent requests.

IMPORTANT:

- The OTR must be completed in its entirety. Failure to submit a completed request will result in an upfront rejection will not be processed, and providers will be required to resubmit to be considered for authorization. The following are considered an incomplete submission:
    - Name of Provider is missing/illegible
    - Contact name was not provided and/or is illegible
    - Eligibility cannot be verified for the member with the information provided
    - MD Signature on Prescription or Plan of Care is missing, outdated or stamped (must be actual or electronic signature)

    - Documentation of Verbal Order is missing or out of date (not required if there is a prescription)
    - Plan of Care or Evaluation missing or out of date
- A Plan of Care (POC). Specific requirements are as follows:
    - Home Health: Must be updated and signed every 60 days
    - EPSDT: Must be updated and signed every 6 months
- Physician prescription or physician signed POC must be included in submission
- Cenpatico will not retroactively certify routine sessions. Exceptions:
    - Member did not have their Medicaid card or otherwise indicate Medicaid coverage (providers should check eligibility prior to services being rendered)
    - Services authorized by another payer who subsequently determined member was not eligible at the time of services
    - Member received retro-eligibility from Department of Medicaid Services.
- The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.
- Cenpatico's utilization management decisions are based on Cenpatico's established Medical Necessity Guidelines. Cenpatico does not reimburse for unauthorized services and each Provider Agreement precludes Network Providers from balance billing (billing a member directly) for covered services with the exception of copayment and/or deductible collection, if applicable. Cenpatico's authorization of covered services is an indication of Medical Necessity, not a confirmation of member eligibility, and not a guarantee of payment.

STRS Appeals

For outpatient and home health, physical, occupational, and speech therapy claims appeals, please submit via fax to (866) 716-7991 or via mail to:

Cenpatico
Attn: Appeals
504 Lavaca, Suite 850
Austin, TX 78701

For more detailed information related to Grievances and Appeals, see the applicable section in of this manual.

For more detailed information about Cenpatico STRS, please visit our website at www.Cenpatico.com.

HI TECH RADIOLOGY SERVICES

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, Home State is using National Imaging Associates (NIA) to provide prior authorization services and utilization. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA
- PET Scan
- Myocardial Perfusion Imaging – Nuclear Cardiology
- MUGA Scan
- Transthoracic Echocardiology
- Transesophageal Echocardiology
- Stress Echocardiography

KEY PROVISIONS:

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the **ordering** physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

NIA provides an interactive website to obtain on-line authorizations. Please visit www.RadMD.com for more information or call our Provider Services department at 1-855-694-HOME (4663). To reach NIA for urgent requests or other questions, please call 1-855-694-HOME (4663) and follow the prompt for high tech imaging authorizations.

EARLY AND PERIODIC SCREENING , DIAGOSTIC AND TREATMENT

The Healthy Children and Youth (HCY)/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is MO HealthNet's comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. HCY/EPSDT services include periodic screening, vision dental and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State's Medicaid plan to the rest of the MO HealthNet population.

Home State and its providers will provide the full range of HCY/EPSDT services as defined in, and in accordance with, Missouri state regulations and Missouri Department of Social

Services' policies and procedures for HCY/EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care. This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are to be included in the periodic health screening assessment:

a) Comprehensive health and development history (including assessment of both physical and mental development)
b) Comprehensive unclothed physical examination
c) Immunizations appropriate to age and health history
d) Assessment of nutritional status
e) Laboratory tests
f) Annual verbal lead assessment beginning at age six months and continuing through age 72 months
g) Blood testing is mandatory at 12 and 24 months or annually if residing in a high risk area as defined by the Department of Health and Senior Services regulation
h) Developmental assessment
i) Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
j) Dental screening (oral exam by primary care provider as part of comprehensive exam). Recommend that preventive dental services begin at age six through 12 months and be repeated every six months
k) Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids; and
l) Health education and anticipatory guidance

Provision of all components of the HCY/EPSDT service must be clearly documented in the PCP's medical record for each member.

Home State requires that providers cooperate to the maximum extent possible with efforts to improve the health status of Missouri citizens, and to actively participate in the increase of percentage of eligible members obtaining HCY/EPSDT services in accordance with the adopted periodicity schedules. Home State will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations.

For HCY/EPSDT and immunization billing guidelines please visit our Website at www.HomeStateHealth.com for Home State's Provider Billing Manual.

EMERGENCY CARE SERVICES

Home State defines an emergency medical condition as a medical, behavioral health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairments of bodily functions; (3) serious dysfunction of any bodily organ or part; (4) Serious harm to self or others due to an alcohol or drug abuse emergency; (5) injury to self or bodily harm to others; or (6) with respect to a pregnant woman having contractions: (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or the unborn.

Members may access emergency services at any time without prior authorization or prior contact with Home State. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or Home State 24-hour Nurse Triage Line (NurseWise) for assistance; however, this is not a requirement to access emergency services. Home State contracts with emergency services providers as well as non-emergency providers who can address the member's non-emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by Home State when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Home State. Emergency services are covered and reimbursed regardless of whether the provider is in Home State's provider network as long as the provider is located within the United States. Emergency services obtained outside the United States are not covered by the State or Home State Health Plan. Payment will not be denied for treatment obtained within the United States under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or
2. A representative from the Plan instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, Home State requires Notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this handbook.

24/ 7 Nurse Line

Our members have many questions about their health, their primary care provider, and/or access to emergency care. Our health plan offers a nurse line service to help members proactively manage their health needs, decide on the most appropriate care, and encourage members to talk with their physician about preventive care.

NurseWise is our 24-hour, 7 day per week nurse line for members. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the NurseWise service. Our staff often answers basic health questions, but is also available to triage more complex health issues using nationally-recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use NurseWise to request information about providers and services available in the community after hours, when the Home State Member Services department ("Member Services") is closed. The NurseWise staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse at any time – day or night. If you have any additional questions, please call Provider Services or NurseWise at 1-855-694-HOME (4663).

Women's Healthcare

Home State will provide direct access to a health specialist in network for core benefits and services necessary to provide women routine and preventive health care services in addition to the member's PCP if the provider is not a women's health specialist. Members are allowed to utilize their own PCP or any family planning service provider for family planning services without the need for a referral or a prior authorization. In addition, members will have the freedom to receive family planning services and related supplies from an out of network provider without any restrictions. Family planning services include examinations, assessments, traditional contraceptive services, preconception and interconception care services. Home State will make every effort to contract with all local family planning clinic and providers and will ensure reimbursement whether the provider is in or out of network.

PUBLIC HEALTH PROGRAMS

Women, Infants and Children (WIC) Program

Women, Infants and Children (WIC) is a special supplemental nutrition program which provides services to pregnant women, new mothers, infants and children up to their 5th birthday based on nutritional risk and income eligibility. The primary services provided are health screening, risk assessment, nutrition education and counseling, breastfeeding promotion and referrals to health care. Supplemental food is provided at no cost to participants.

Eligibility

Eligibility is based on three things, category, income and nutritional risk.

Categories include:

- Women - pregnant women, postpartum breastfeeding women up to one year after delivery while nursing, and postpartum non-breastfeeding women up to six months after delivery or termination of the pregnancy.
- Infants – from birth up to one year of age.
- Children – from one year of age up to their 5th birthday.

Income:
Calculated on the family income at 185% or less of federal poverty level.

Home State requires providers to provide and document the referral of pregnant, breast-feeding, or postpartum women, or a parent/guardian of a child under the age of five, as indicated, to the WIC Program as part of the initial assessment of members, and as a part of the initial evaluation of newly pregnant women.

PARENTS AS TEACHERS (PAT)

PAT is a home-school-community partnership which supports parents in their role as their child's first and most influential teachers. Every family who is expecting a child or has a child under the age of kindergarten entry is eligible for PAT. PAT services include personal visits from certified parent educators, group meetings, developmental screenings, and connections with other community resources.

PAT programs collaborate with other agencies and programs to meet families' needs, including Head Start, First Steps, the Women Infants and Children Program (nutrition services), local health departments, the Family Support Division, etc. Independent evaluations of PAT show that children served by this program are significantly more advanced in language development, problem solving, and social development at age three than comparison children, ninety-nine point five percent (99.5%) of participating

families are free of abuse or neglect, and early gains are maintained in elementary school, based on standardized tests.

The PAT program is administered at the local level by the public school districts in the State of Missouri. Families interested in PAT may contact their local district directly. PAT also accepts referrals from other sources including medical providers. Home State encourages providers to refer members to their local PAT program.

CLINICAL PRACTICE GUIDELINES

Home State clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, Home State adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. Home State providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a sample of the clinical practice guidelines adopted by Home State.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

For links to the most current version of the guidelines adopted by Home State, visit our website at www.HomeStateHealth.com

CASE MANAGEMENT PROGRAM

Home State case management model is designed to help your Home State members obtain needed services, whether they are covered within the Home State array of covered services, from community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary case management team in recognition that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. Our case management team will integrate covered and non-covered services and provide a holistic approach to a member's medical, as well as function, social and other needs. We will coordinate access to services such as behavioral health, dental and pharmacy services.Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A case management team is available to help all providers manage their Home State members. Listed below are programs and components of services that are available and can be accessed through the case management team. We look forward to hearing from you about any Home State members that you think can benefit from the addition of a Home State case management team member.

To contact a case manager call:

Home State
Case Management Department
1-855-694-HOME (4663)

High Risk Pregnancy Program

The OB CM Team will implement our **Start Smart for Your Baby® Program** (Start Smart), which incorporates case management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age. The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing case management to high and moderate risk members through the postpartum period and infants through the first year of life. A case manager with obstetrical nursing experience will serve as lead case manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life when they remain members. The OB/Neonate team has physician oversight advising the team on overcoming obstacles, helping identify high risk members, and recommending interventions. These physicians will provide input to Home State Medical Director on obstetrical care standards and use of newer preventive treatments such as **17 alpha-hydroxyprogesterone caproate (17-P**).

Home State offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the Home State case manager who will check for eligibility. The case manager can coordinate the ordering and delivery of the 17-P directly to the physician's office or coordinate home care for administration, if needed. A prenatal case manager will contact the member and do an assessment regarding compliance. The nurse

will remain in contact with the member and the prescribing physician during the entire treatment period. Contact the Home State high risk pregnancy department for enrollment in the 17-P program.

Complex Teams

These teams will be led by clinical licensed nurses with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The Home State complex teams will manage care for members whose needs are primarily functional as well as those with such complex conditions as hemophilia, breast/cervical cancer, trauma, organ transplants, and renal dialysis. Foster care members and children with special health care needs are at special risk and are also eligible for enrollment in case management. Home State will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better health care choices.

A **Transplant Coordinator** will provide support and coordination of pre-surgery and post follow up care for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the Home State case management department for assessment and case management services. Each candidate is evaluated for coverage requirements. Home State will coordinate coverage for transplant services with the state agency..

MemberConnections® Program

MemberConnections is Home State outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our case management program in order to link Home State and the community served. The program recruits staff from the local community being served to establish a grassroots support and awareness of Home State within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections through numerous sources. Members who phone Home State to talk with Home State Member Services department may be referred for more personalized discussion on the topic they are inquiring about. Case managers may identify members who would benefit from one of the many MemberConnections components and complete a referral request. Providers may request MemberConnections referrals directly to the Connections Representative or their assigned case manager. Community groups may request that a Connections Representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Community Connections: Connection Representatives are available to present to group setting during events initiated by state entities, community groups, clinics, or any other

approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Mo HealthNet coordinated care is all about, overview of services offered by Home State, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and Home State.

Home Connections: Connection Representatives are available on a full-time basis whenever a need or request from a member or provider arises. All home visits are pre-scheduled with the member unless the visit is a result of being unable to locate a member. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive health care, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.

Phone Connections: Connection Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered.

To contact the MemberConnections Team call:
Home State
Case Management
1-855-694-HOME(4663)

Chronic Care/Disease Management Programs

As a part of Home State services, Disease Management Programs (DM) are offered to members. Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrated care. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Nurtur, Centene's disease management subsidiary, will administer Home State disease management program. Nurtur's programs promote a coordinated, proactive, disease-specific approach to management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. Home State programs include but are not limited to: asthma, diabetes and depression.

All members identified as having a targeted diagnoses such as, but not limited to the following: major depression, asthma, and diabetes will be offered the opportunity to enroll in a Disease Management program. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk members with co-morbid or complex conditions will be referred for case management program evaluation.

To refer a member for disease or care management call:
Home State
Case Management
1-855-694-HOME (4663)

PROVIDER RELATI ONS DEPARTMENT

Provider Orientation

Home State's Provider Relations department is designed around the concept of making your experience a positive one by being your advocate within Home State. Upon credentialing approval by Home State, each provider/practitioner is assigned a dedicated provider relations representative. Within 30 days of the provider's effective date, the provider relations representative will contact the provider to schedule an orientation.

Responsibilities

The Provider Relations Department is responsible for providing the services listed below which include but are not limited to:

- Maintenance of existing Home State Provider Reference Manual
- Conducting quarterly joint operating committee meetings
- Conduct in person provider visits
- Researching of trends in claims inquiries to Home State
- Network performance profiling
- Individual physician performance profiling
- Physician and office staff orientation
- Hospital and ancillary staff orientation
- Ongoing provider education, updates, and training

The goal of the department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Home State enrolled membership.

To contact the provider relations specialist for your area contact our Provider Services toll-free help line at 1-855-694-HOME (4663). Provider Services Representatives work with Provider Relations Specialists to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with Home State.

Top 10 Reasons to Contact a Provider Relations Representative

1. To report any change to your practice (i.e. practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance.)
2. Initiate credentialing of new providers.
3. To schedule an in-service training for new staff.
4. To conduct ongoing education for existing staff.
5. To obtain clarification of policies and procedures.
6. To obtain clarification of a provider contract.
7. To request fee schedule information.

8. To obtain responses to membership list questions.
9. To obtain responses to claims questions.
10. To learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility.

BILLING AND CLAIMS SUBMISSION

General Guidelines

This Provider Reference Manual describes general billing and claim submission guidelines. Please visit our Website at www.HomeStateHealth.com for Home State's complete Provider Billing Manual.

Home State processes its claims in accordance with applicable State prompt pay requirements.

Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with Home State for payment of covered services. It is important that providers ensure Home State has accurate billing information on file. Please confirm with your Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

We recommend that providers notify Home State as soon as possible, but no later than 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service,
- The service provided is a covered benefit under the member's contract on the date of service, and
- Referral and prior authorization processes were followed, if applicable.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the guidelines outlined in this handbook and the provider billing manual located at www.HomeStateHealth.com.

Clean Claim Definition

A clean claim is defined as a claim received by Home State for adjudication which has been completed and submitted in the nationally accepted format without apparent defect in its

form, completion, or content. In addition, a clean claim is in compliance with all standard coding guidelines and contains no defect, impropriety, and contains all required substantiating documentation. A clean claim contains no particular circumstance requiring uncommon treatment which would otherwise delay or prevent timely payment of the claim. The following exceptions apply to this definition: (a) a claim for which fraud is detected or suspected; and (b) a claim for which a Third Party Resource should be responsible.

Non-Clean Claim Definition

A non-clean claim is defined as a submitted claim that requires further investigation or development beyond the information contained in the claim. The errors or omissions in the claim may result in; a) a request for additional information from the provider or other external sources to resolve or correct data omitted from the claim; b) the need for review of additional medical records; or c) the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Timely Filing

Providers must submit all original claims (first time claims) and encounters to Home State within 180 calendar days of the date of service.

All corrected claims, requests for reconsideration or claim disputes must be received within 180 calendar days from the date of notification of payment or denial is issued.

Electronic Claims Submission

Network providers are encouraged to participate in Home State electronic claims/encounter filing program. The plan has the capability to receive an ANSI X12N 837 professional, institutional or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

For more information on electronic filing and what clearinghouses Home State has partnered with, contact:

Home State
C/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at:
EDIBA@centene.com

Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Home State Payer ID is 68069 and we work with the following clearinghouses:

- Emdeon
- SSI
- Trizetto Provider Solutions
- Availity

Paper Claims Submission

All claims and encounters should be submitted to:

INITIAL CLAIMS, CORRECTED CLAIMS and REQUESTS FOR RECONSIDERATION:

Home State
ATTN: CLAIMS DEPARTMENT
P.O. BOX 4050
Farmington, MO 63640-3829

CLAIM DISPUTES:
NOTE: Please use the Claim Dispute Form located at www.HomeStateHealth.com

Home State
ATTN: CLAIMS DEPARTMENT
P.O. BOX 4050
Farmington, MO 63640-3829

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Home State provides an innovative web-based solution for Electronic Funds Transfers (EFT's) and Electronic Remittance Advices (ERA's). Through this service, providers can take advantage of EFTs and ERAs to settle claims electronically. As a Provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information, please visit our provider home page on our website at www.HomeStateHealth.com. If further assistance is needed, please contact Provider Services 1-855-694-HOME (4663).

Claim Payment

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 90 percent within 15 business days of the receipt
- 99 percent within 30 calendar days of the receipt

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

Home State is always the payer of last resort. Home State providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Home State members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform Home State that efforts have been unsuccessful. Home State will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Home State will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

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 Service Representative 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
- Mail corrected claims to:

  Home State
  Attn: Corrected Claim
  PO Box 4050
  Farmington, MO 63640-3829
  - All paper claim forms *must* be typed or printed, and in the original red and white version to ensure clean acceptance and processing. No handwritten information will be accepted on the claim form.
  - Paper claims must clearly be typewritten or stamped as **"RE-SUBMISSION" or "CORRECTED CLAIM" and must include the original claim number; or the original EOP must be included with the resubmission.**
  - Failure to type or stamp the claim as a resubmission and include the original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.
  - The Claim Adjustment Form can be located on the provider website at www.HomeStateHealth.com

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
     Attn: Reconsideration
     PO Box 4050
     Farmington, MO 63640-3829

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
  Attn: Claim Dispute
  PO Box 4050
  Farmington, MO 63640-3829

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.

ENCOUNTERS

What is an Encounter Versus a Claim?

An ***encounter*** is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. For example; if you are the PCP for a Home State member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a **"**proxy claim") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero dollar amounts. **It is mandatory that your office submits encounter data.** Home State utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by MO HealthNet and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an Explanation of Payment (EOP) .

A ***claim*** is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to a Home State member.

Procedures for Filing a Claim/Encounter Data

Home State encourages all providers to file claims/encounters electronically. See the Electronic Claims Submission section and the Provider Billing Manual for more information on how to initiate electronic claims/encounters.

Billing the Member

Home State reimburses only services that are medically necessary and covered through MO HealthNet's MCO. Members cannot be charged or balance billed for covered services.

Member Acknowledgement Statement

A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the member has exceeded the program limitations for a particular service only if the following condition is met:

Prior to the service being rendered, the provider has obtained and kept a written member acknowledgement statement signed by the client stating,

> **I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Missouri's Coordinated Care Network program as being reasonable and medically necessary for my care. I understand that Home State through its contract with the Missouri Department of Social Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.**

For more detailed information on Home State billing requirements, please refer to the Billing Manual available on the website www.HomeStateHealth.com

CREDENTIALING and RECREDENTIALING

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by the Home State, as well as government regulations and standards of accrediting bodies.

Note: In order to maintain a current provider profile, providers are required to notify Home State *if any relevant changes to their credentialing information in a timely manner.*

Providers must submit at a minimum the following information when applying for participation with Home State:

- Complete signed and dated Missouri Standardized Credentialing application or authorize Home State access to the CAQH (Council for Affordable Quality Health Care).
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Missouri regulations regarding malpractice coverage or alternate coverage.
- Copy of current Missouri Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the state in which they practice.
- Current copy of specialty/board certification certificate, if applicable

- Curriculum vitae listing, at minimum, a five year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 120 days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA),if applicable

Home State will verify the following information submitted for Credentialing and/or Re-credentialing:

- Missouri license through appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Review five year work history
- Review federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General)

Once the application is completed, the Home State Credentialing Committee ("Credentialing Committee") will render a final decision on acceptance following its next regularly scheduled meeting.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

Credentialing Committee

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination.

Committee meetings are held at least quarterly and more often as deemed necessary.

Note*: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.*

Site visits are performed at practitioner offices within 60 days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner's site visit score is less than 80 percent, the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

Re-Credentialing

To comply with accreditation standards, Home State conducts the re-credentialing process for providers at least every thirty six months from the date of the initial credentialing

decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the Home State network. As part of the re-credentialing process, Home State will review records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine if the provider is adhering to Home State's advance directive policy as stated in this manual.

In between credentialing cycles, Home State conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate Missouri State Licensing Agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry insures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Home State reviews monthly reports released by the Office of Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid.

A provider's agreement may be terminated if at any time it is determined by the Home State Credentialing Committee that credentialing requirements are no longer being met.

Home State Health Plan will promptly notify the State agency of any denial of provider credentialing or re-credentialing. This is in addition to reporting provider terminations on a quarterly fraud and abuse report. The state agency shall, pursuant to 42 CFR 100.3 (b), promptly notify HHS-OIG of the denial of credentialing or re-credentialing where that denial is based on a determination that the provider has been excluded from participation in Medicare, Medicaid, CHIP, or any other Federal health care program; has failed to renew its license or certification registration, or has a revoked professional license or certification; has been terminated by the state agency; or has been excluded by OIG under 42 CFR 1001.1001 or 1001.1051.

Right to Review and Correct Information

All providers participating within the Home State network have the right to review information obtained by Home State to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing 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 to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they 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 Home State credentialing department. Upon receipt of this information, the provider will have 30 days to provide a written explanation detailing the error or the difference in information to the. The Home

State Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All providers who have submitted an application to join Home State have the right to be informed of the status of their application upon request. To obtain status, contact the Home State Provider Relations department at 1-855-694-HOME(4663).

Right to Appeal Adverse Credentialing Determinations

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within 30 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the Home State network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 30 days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.

RIGHTS AND RESPONSIBILITIES

Member Rights

Home State members have the following **rights**:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her healthcare, including the right to refuse treatment.
- To receive complete information about their specific condition and treatment options, regardless of cost or benefit coverage,
- To seek second opinions
- To obtain information about available experimental treatments and clinical trials and how such research can be accessed
- To obtain assistance with care coordination from the PCP's office.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To express a concern or appeal about Home State or the care it provides and receives a response in a reasonable period of time
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected.
- To implement an advance directive as required in 42 CFR§438.10(g)(2)
- To choose his/her health professional to the extent possible and appropriate, in accordance with 42 CFR §438.6(m)

- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under MO HealthNet FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- Freedom to exercise the rights described herein, without any adverse effect on the member's treatment by MO HealthNet, Home State, its providers or contractors.
- To receive all information— e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives.—in a manner and format that may be easily understood as defined in the Provider Agreement and this Member Handbook.
- To receive assistance from both MO HealthNet and the Enrollment Broker in understanding the requirements and benefits of Home State.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.

Member Responsibilities

Home State members have the following **responsibilities**:

- To provide , to the extent possible, information needed by providers for their care:
- Make their primary care provider their first point of contact when needing medical care:
- Follow appointment scheduling processes; and
- Follow instructions and guidelines given by providers

Provider Rights

Home State providers have the **right** to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members' care
- Have their patients act in a way that supports the care given to other patients and that helps keep the provider's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in members' treatment plans
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Make a complaint or file an appeal against Home State and/or a member
- File a grievance with Home State on behalf of a member, with the member's consent
- Have access to information about Home State quality improvement programs, including program goals, processes, and outcomes that relate to member care and services

- Contact Home State Provider Services with any questions, comments, or problems,
- Collaborate with other healthcare professionals who are involved in the care of members

Provider Responsibilities

Home State providers have the **responsibility** to:

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments
    - Provide information regarding the nature of treatment options
    - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may self-administered
    - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
- Treat members with fairness, dignity, and respect
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow members to request restriction on the use and disclosure of their personal health information
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
- Tell a member, prior to the medical care or treatment, that the service(s) being rendered are not a covered benefit. Inform the member of the non-covered service and have the member acknowledge the information. If the member still request the service, obtain the acknowledgement in writing (private pay agreement) prior to rendering the service. Regardless of any understanding worked out between the provider and the member about private payment, that agreement becomes null and void if a claim is submitted to the health plan.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal

- Respect members' advance directives and include these documents in the members' medical record
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions

- Allow members to obtain a second and third opinion, and answer members' questions about how to access healthcare services appropriately
- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in Home State data collection initiatives, such as HEDIS and other contractual or regulatory programs
- Review clinical practice guidelines distributed by Home State
- Comply with Home State Medical Management program as outlined in this Reference Manual.
- Disclose overpayments or improper payments to Home State
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
- Obtain and report to Home State information regarding other insurance coverage
- Notify Home State in writing if the provider is leaving or closing a practice
- Contact Home State to verify member eligibility or coverage for services, if appropriate
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
- Not be excluded, penalized, or terminated from participating with Home State for having developed or accumulated a substantial number of patients in the Home State with high cost medical conditions
- Coordinate and cooperate with other service providers who serve MO HealthNet members such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships and school based programs as appropriate
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
- Disclose to Home State, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between Home State and the physician or physician group

GRIEVANCES AND APPEALS PROCESS

Member Grievances

A member grievance is defined as any member expression of dissatisfaction about any matter other than an "adverse action".

The grievance process allows the member, (or the member's authorized representative (family member, etc.) acting on behalf of the member or provider acting on the member's

behalf with the member's written consent), to file a grievance either orally or in writing. Home State will acknowledge receipt of each grievance in the manner in which it is received. Any individuals who make 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 shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the member's condition or disease. [42 CFR § 438.406] Home State values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf. Home State will provide assistance to both members and providers with filing a grievance by contacting our Member/Provider Services Department at 1-855-694-HOME (4663).

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. The Complaint and Grievance Coordinator (CGC) 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 ten (10) business days of receipt.

Grievance Resolution Time Frame

Grievance Resolution will occur as expeditiously as the member's health condition requires, not to exceed 30 calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the CGC, in coordination with other Home State 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 and will be resolved within 72 hours. Home State may extend the timeframe for disposition of a grievance for up to 14 calendar days if the member requests the extension or the health plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. If Home State extends the timeframe, it shall, for any extension not requested by the member, give the member written notice of the reason for the delay.

Notice of Resolution

The CGC will provide written resolution to the member, representative or provider within the timeframes noted above. The letter will include the resolution and MO HealthNet requirements.

The grievance response shall include, but not be limited to, the decision reached by Home State, 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 member in accordance with MO HealthNet policies. A copy of verbal complaint logs and records of disposition or written grievances shall be retained for seven years.

Grievances may be submitted by written notification to:

Home State Health Plan
Complaint and Grievances Coordinator (CGC)
Home State
16090 Swingley Ridge Rd., Suite 500
Chesterfield, MO 63017
1-855-694-4663

Appeals

An appeal is the request for review of an adverse action. An 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 network. The review may be requested in writing or orally, however oral requests must be followed up in writing unless an expedited resolution is requested. Members may request that Home State review the adverse action to verify if the right decision has been made. Appeals must be made within 90 calendar days from the date on Home State's notice of action. Home State shall acknowledge receipt of each appeal in writing within 10 business days after receiving an appeal. Home State shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Home State receives the appeal. Home State may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Home State demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Home State shall provide written notice to the member of the reason for the delay.

Expedited Appeals

Expedited appeals may be filed when either Home State 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 function. 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 72 from the initial receipt of the appeal. Home State may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Home State provides evidence satisfactory to the MHD that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, Home State shall provide written notice to the member of the reason for the delay. Home State 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 followed by a written notice of action within the timeframes as noted above.

Notice of Resolution

Written notice shall include the following information:

a) The decision reached by Home State;
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 decision.

Call or mail all appeals to:
Home State
Complaint and Grievances Coordinator (CGC)
16090 Swingley Ridge Rd., Suite 500
Chesterfield, MO 63017
1-855-694-HOME (4663)

State Fair Hearing Process

Home State will include information in the Member Handbook, online and via the appeals process to members of their right to appeal directly to the MHD. The member has the right to request a State Fair Hearing at any time during the appeal process not to exceed 90 calendar days from the date of the notice of action.

Any adverse action or appeal that is not resolved wholly in favor of the member by Home State may be appealed by the member or the member's authorized representative to the MHD for a fair hearing conducted in accordance with 42 CFR 431 Subpart E Adverse actions include reductions in service, suspensions, terminations, and denials. Home State's denial of payment for MO HealthNet covered services and failure to act on a request for services within required timeframes may also be appealed. Appeals must be requested orally or in writing by the member or the member's representative within 90 days of the member's receipt of notice of adverse action unless an acceptable reason for delay exists

For member appeals, Home State is responsible for providing to the MHD and to the member an appeal summary describing the basis for the denial. For standard appeals, the appeal summary must be submitted to the MHD and the member at least 10 calendar days prior to the date of the hearing. For Standard resolution, the state will reach it's decision within ninety (90) calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing. For expedited appeals, (that meet the criteria set forth in 42 CFR 438.410), if the appeal was heard first through the health plan appeal process the state shall reach it's decision within three working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process but was not

resolved using the health plan's expedited appeal timeframes, or was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes If the appeal was made directly to the State fair hearing process without accessing the health plan appeal process the state shall reach it's decision within three working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

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

Continuation of Benefits

Members have the right to request continuation of benefits during an appeal or State fair hearing filing. If Home State Health Plan's actions are upheld in a hearing, the member may be liable for the cost of any continued benefits.

Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if the Home State 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 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 will provide reimbursement for those services in accordance with the terms of the final decision rendered by the MHD and applicable regulations.

To File A MO HealthNet State Hearing:
MO HealthNet Division
PO Box 6500
Jefferson City, MO 65102-6500

Provider Complaints and Appeals

A **Complaint** is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Home State's policy, procedure, claims, or any aspect of Home State's functions. Home State logs and tracks all complaints whether received verbally or in writing. A provider has 30 days from the date of the incident, such as the original remit date, to file a complaint. After the complete review of the complaint, Home State shall provide a written notice to the provider within 30 calendar days from the received date of the Plan's decision.
An **Appeal** is the mechanism which allows providers the right to appeal actions of Home State such as a claim denial, prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Home State. A provider has 30 calendar days from Home State's notice of action. Home State shall acknowledge receipt of each appeal within 10 business days after receiving an appeal. Home State shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Home State receives the appeal. Home State may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Home State demonstrates (to the

satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Home State shall provide written notice to the member of the reason for the delay.

Expedited Appeals may be filed when either Home State 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 function. 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 72 hours from the initial receipt of the appeal. Home State may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Home State provides evidence satisfactory to the MHD that a delay in rendering the decision is in the member's interest.

WASTE, FRAUD AND ABUSE

Waste Abuse and Fraud (WAF) System

Home State takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with Missouri and federal laws. Home State, in conjunction with its management company, Centene, successfully operates a waste, abuse and fraud unit. Home State performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system; please review the Billing and Claims section of this handbook. The Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against those providers, individually or as a practice, commit waste, abuse, and/or fraud. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Some of the most common WAF practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes

- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call OIG's Hotline at 1-800-HHS-TIPS (1-800-447-8477), directly to a MO HealthNet Fraud Control Unit (MFCU), or our anonymous and confidential WAF hotline at 1-866-685-8664. Home State and Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

Please Note: *Due to the evolving nature of wasteful, abusive and fraudulent billing, Home State and Centene may enhance the WAF program at any time. These enhancements may include but is not limited to creating, customizing or modifying claim edits, upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of adherent billing patterns.*

Authority and Responsibility

The Home State Director of Regulatory Affairs & Compliance has overall responsibility and authority for carrying out the provisions of the compliance program. Home State is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Home State provider network will 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, including investigations.

QUALITY IMPROVEMENT

Home State culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Home State recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Home State will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, Home State will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the

Home State QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

Program Structure

The Home State Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Assessment and Performance Improvement Committee (QAPIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the QI, UM, and Credentialing programs. Home State maintains policies and procedures for quality assessment, utilization management, and continuous quality improvement. These policies and procedures are evaluated periodically to determine impact and effectiveness.

The following sub-committees report directly to the Quality Assessment and Performance Improvement Committee:

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- CLAS Task Force
- HEDIS Steering Committee
- Performance Improvement Team
- Member, Provider, Hospital and Community Advisory Committees
- Joint Operations Committees
- Peer review Committee (Ad Hoc Committee)

Practitioner Involvement

Home State recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Home State encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as but not limited to, the QIC, Credentialing Committee and select ad-hoc committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the Home State members. Home State QAPI

Program incorporates all demographic groups, lines of business, benefit packages, care settings, providers and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care (depending upon the product), and ancillary services, and operations.

Home State primary QAPI Program goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

To that end, the Home State QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulations
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Data collection, analysis, and reporting
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection and prevention
- Information management
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member satisfaction
- Member Services
- Network Performance
- Organizational structure
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan accessibility
- Provider availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider satisfaction
- Provider Services
- Quality management
- Records management
- Selection and retention of providers (credentialing and recredentialing)
- Utilization Management, including under and over utilization

Patient Safety and Quality of Care

Patient Safety is a key focus of Home State QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. Home State employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

Home State QIC reviews and adopts an annual QAPI Program and Work Plan based on managed care Medicaid appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Home State to monitor improvement over time.

Annually, Home State develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QAPIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Results, conclusions, recommendations, and implemented system changes are reported to the QIC quarterly..., Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Home State communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter and the Home State web portal at www.HomeStateHealth.com.

At any time, Home State providers may request additional information on the health plan programs including a description of the QAPI Program and a report on Home State progress in meeting the QAPI Program goals by contacting the Quality Improvement department.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Missouri State Medicaid contract.

As both the Missouri and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. Missouri purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of quality indicators such as HEDIS.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using only administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see Home State website and HEDIS brochure for more information on reducing HEDIS medical record reviews). Measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who will be conducting the Medical Record Reviews (MRR) for HEDIS?

Home State will contract with a national MRR vendor, to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May

each year. At that time, you may receive a call from a medical record review representative if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Home State which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-855-694-HOME (4663).

Provider Satisfaction Survey

Home State conducts an annual provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Home State, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well we are meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

Provider Profiling and Incentive Programs

Over the past several years, it has been nationally recognized that pay-for-performance (P4P) programs, which include provider profiling, have emerged as a promising strategy to improve the quality and cost-effectiveness of care. Home State currently uses a pay-for-performance program that includes physician profiling to improve care and services provided to Home State members.

The P4P program promotes efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, beneficial, timely, patient-centered, efficient and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, NCQA and NQF. Additionally, Home State will provide an opportunity for financial reward to PCPs and specialists using an incentive payment that encourages accurate and timely submission of preventive health and disease monitoring services in accordance with evidence-based clinical practice guidelines.

The goals of Home State P4P program are:

- Increase provider awareness of his/her performance in key areas
- Motivate providers to establish measurable performance improvement processes relevant to Home State member populations in their practices
- Use peer performance data and/or other established benchmarks to identify outlier provider practices that reflect best practices or less than optimal performance
- Increase opportunities for Home State to partner with providers to achieve measurable improvement in health outcomes by developing, implementing, and monitoring practice-based performance improvement initiatives

Home State will accomplish these goals by:

- Producing and distributing provider-specific reports containing meaningful, reliable, and valid data for evaluation by Home State and the provider.
- Creating incentives for provider implementation of practice-based performance improvement initiatives that are pertinent to Home State member populations linked with adopted evidence-based clinical practice guidelines and that yield measurable outcomes.
- Establishing and maintaining an open dialogue with profiled providers related to performance improvement.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Home State in publications such as newsletters, bulletins, press releases, and recognition in our provider directories as well as being eligible for applicable financial incentive programs. More information on our incentive programs can be found on the provider web portal or by contacting Home State Contracting and/or Provider Relations departments.

MEDICAL RECORDS REVIEW

Medical Records

Home State providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Home State to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Home State requires providers to maintain all records for members for at least seven (7) years. See the Member Rights section of this handbook for policies on member access to medical records.

Required Information

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Home State's practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and
- ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.

- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.
- Any corrections, additions, or change in any medical record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change.

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

Medical Records Transfer for New Members

When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Home State members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

Medical Records Audits

Home State will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. Home State will provide written notice prior to conducting a medical record review.