Partners in Health

Quarterly Provider Newsletter

IN THIS ISSUE

From the desk of
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Plan Chief Operating Officer

I have been honored to be part of Home State Health's operations team for more than five years. During that time, our teams have been on a continuous learning (and listening) journey, focusing on improving service for participating providers and health outcomes for our members. While we pay more than 99% of first-time claims in 30 days and answer more than 90% of calls within 30 seconds, we know there is more to do. For 2025, our goals include but are not limited to:

- Enhancing our providers' digital self-service experience by launching the Availity Secure Provider Portal;
- Offering providers the opportunity to select their preferred payment and remittance advice methodology: EFT/ACH, virtual credit card or paper;
- Improving provider directory data accuracy through additional validation and auditing;
- Streamlining and enriching provider performance reporting with a focus on providing each provider with actionable patient and/or claim information;
- Expanding availability of provider-focused educational materials; and
- Using Availity editing tools at the point of claim submission and receipt to align more fully with national claim standards and requirements and streamline provider claims submission.

Billing & Claims

Correct coding reminders for 2025

The new year is a good time for provider billing offices to brush up on how best to select accurate and up-to-date medical codes for billing purposes including use of codes based on patient diagnosis and procedures, appropriate modifier usage, and adherence to national coding guidelines like the Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes. Attention to correct coding requirements ensures accurate claim processing and minimizes potential payment denials.

New or updated codes:

January is when CMS code changes including adds, changes and terms occur. Please ensure your billing office is using the most current version of each code set.

Coding guidelines:

Home State Health uses coding guidelines published by nationally recognized organizations including the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS).

Common coding errors:

Frequent coding mistakes include upcoding (billing for a higher level of service than performed), invalid and/or improper use of modifiers, invalid or incomplete diagnosis code, add-on codes used when no primary codes are billed, incorrect place of service for procedure, invalid procedure code for member age.

Documentation requirements:

It is important that your medical documentation is clear and detailed and supports the chosen codes, ensuring the link between services provided and the billed codes. Two standard methods of ensuring code supportive clinical documentation are:

- **SOAP:** an acronym for Subjective, Objective, Assessment, and Plan, which is a standardized method for documenting patient encounters in healthcare.
- **MEAT:** an acronym in medical documentation that stands for Monitor, Evaluate, Assess, and Treat, and is used to help providers ensure proper documentation for risk adjustment and Hierarchical Condition Category (HCC) processes.

Compliance with NCCI edits:

Home State Health applies National Correct Coding Initiative (NCCI) edits, which identify procedures that are typically not billed together.

Coding education and resources:

Your billing office can familiarize themselves with our Coding, Clinical and Payment policies by visiting **https://www.homestatehealth.com/providers/tools-resources/clinical-payment-policies.html**.

They can also visit our Coding resources site for more information on accurate, clear and complete diagnosis coding: **https://www.homestatehealth.com/providers/tools-resources/coding-page.html**

Home State Health Coding, Clinical and Payment policies apply to both behavioral and medical claims processing.

Provider Announcements

Open Enrollment for 2025 is here and your patients may have questions

Below is a quick reference guide to help make it easier for you to give them accurate information.

Open Enrollment is January 1 - March 31st

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

How do people know if they need to change plans?

People in a Medicare health or prescription drug plan should always review the materials their plans send them, like the "Evidence of Coverage" (EOC) and "Annual Notice of Change" (ANOC). If their plans are changing, they should make sure their plans will still meet their needs for the following year. If they're satisfied that their current plans will meet their needs for next year and it's still being offered, they don't need to do anything.

Special Enrollment Periods

- You can make changes to your Medicare Advantage and Medicare drug coverage when certain events happen in your life, like if you move or you lose other coverage

Where can I find more information?

1-800-MEDICARE or Medicare.gov · English (homestatehealth.com)

Ambetter Health Solutions to begin January 1, 2025

Ambetter Health Solutions is a new offering from Ambetter Health that will be available to individuals who receive a defined contribution from their employer to purchase individual health insurance, such as through Individual Coverage Health Reimbursement Arrangements (ICHRAs). Ambetter Health Solutions will be available to these individuals to purchase insurance for themselves and their families on an off-exchange basis.

Ambetter Health Solutions' member benefits are consistent with other Ambetter Health offerings.

Ambetter Health Solutions will go live in Georgia, Indiana, Ohio, Missouri, Mississippi, and South Carolina on January 1, 2025. Additionally, you may see members from out-of-state seeking care.

There is no action required of you to begin serving Ambetter Health Solutions members. Your current Ambetter agreement provides for your participation.

Provider Announcements, con't

Medicare (Part D) Prescription Payment Plan

The Medicare Prescription Payment Plan (M3P) is a payment option that helps members manage out-out-pocket Part D costs. The program allows prescription costs to be spread across monthly payments that are billed directly to the member. When a member fills a prescription for a drug covered by Part D, they won't pay anything at the pharmacy. Instead, the member will receive a bill each month from the plan.

Members can sign up for the program over the phone, online, or with a paper form.

Here are some important things to know:

When does the program go live?	**The program will be effective Jan. 1, 2025.**
Are there any specific criteria the member must meet to qualify for the M3P program?	▪ If the member is enrolled in a PDP or MAPD plan with Part D cost-sharing and has active or future effective coverage, they can elect to participate in the program. ▪ There is no minimum threshold for the cost of their medications to sign up. However, the member cannot pick and choose which medications are applied. ▪ If a member is terminated from M3P for non-payment during the plan year, they are not permitted to re-enroll in the program unless coverage was reinstated by paying any past-due balances. ▪ Members also will be ineligible for participation in the M3P program in future years if they owe an overdue M3P balance on that plan.
What is the turnaround time once a member applies for the program?	For members who enroll telephonically or online the election is processed essentially in "real time" and this information will be transmitted to their pharmacy immediately upon M3P election approval.
Will all covered Part D prescriptions be subject to the M3P program once a member opts in?	Yes. All covered Part D prescriptions will be processed under the program once a member opts in. Pharmacies will be instructed to submit all claims under the M3P Bin/PCN.
If a member switches plans, will they need to opt into the M3P program again?	Yes. If a plan change occurs, the member's participation in M3P under their previous plan will end. They will continue to be invoiced for any balances owed until they are paid in full. If the member wants to enroll in M3P under their new plan, they will need to re-elect and will receive separate invoices under their new plan.
How is the member's monthly M3P bill calculated?	The monthly bill is based on what the member owes for any new prescriptions they fill, plus the previous month's balance, divided by the number of months left in the year. This means their monthly bill will change throughout the year.

NOTE: Members must enroll in the M3P program through their plan; they will not be able to enroll in the program through their local pharmacy.

Provider Announcements, con't

Appointment Accessibility Standards

Home State Health, Ambetter from Home State Health, Wellcare, and Wellcare by Allwell follow accessibility requirements set forth by applicable regulatory and accrediting agencies. Home State monitors compliance with these standards to ensure adequate appointment availability and to reduce unnecessary emergency room utilization.

24-Hour Access

Home State Health's Primary Care providers, Behavioral Health providers, and Specialty providers 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.

Appointment Accessibility Standards

All provider types shall adhere to appointment standards. The time elapsed between the request for an appointment and the scheduled appointment should not exceed the standards set forth by regulatory and accrediting agencies.

All access standards can be found in the applicable provider manual:

- Home State Health Provider Manual
- Ambetter from Home State Health Provider Manual
- Wellcare by Allwell Provider Manual
- Wellcare Provider Manual

Home State Health transitions to Availity Essentials

Home State Health has chosen Availity Essentials as its new, secure provider portal. Starting January 20, 2025, you can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access Home State Health, Ambetter from Home State Health, Wellcare, and Wellcare by Allwell payer resources via Availity Essentials.

If you are already working in Essentials, you can log in to your existing Essentials account to enjoy these benefits for Home State Health members beginning January 20. 2025:

- Use Availity Essentials to verify member eligibility and benefits, submit claims, check claim status, submit authorizations, and more.
- Look for additional functionality in Home State Health's payer space on Essentials and use the heart icon to add apps to **My Favorites** in the top navigation bar. Our current secure portal will still be available for other functions you may use today.
- Access Manage My Organization – Providers to save provider information. You can then auto-populate that information repeatedly to eliminate repetitive data entry and reduce errors.

If you are new to Availity Essentials, getting your Essentials account is the first step toward working with Home State Health on Availity.

Getting started: Designate an Availity administrator for your provider organization.

Your provider organization's designated Availity administrator is the person responsible for registering your organization in Essentials and managing user accounts. This person should have legal authority to sign agreements for your organization.

Please Note: Our current secure portal will still be available for other functions you may use today.

Provider Announcements, con't

2025 Formulary Changes

On January 1, 2025, some drugs will no longer be covered on our Medicare Part D Plan formulary(ies). To assist our providers, we have included the list below of the most commonly prescribed drugs being removed along with the drug's 2025 formulary alternative(s). Please refer to the list to identify the appropriate options for your patients.

Product Name	Formulary Alternative
Basaglar KwikPen	Insulin Glargine-yfgn
Gemtesa	Tolterodine, Solifenacin, Oxybutynin, Myrbetriq
Fiasp	Insulin Aspart
Pulmicort Flexhaler	Arnuity Ellipta
Levalbuterol HFA	Albuterol Sulfate HFA, Ventolin HFA
Emgality	Aimovig*
Silodosin	Tamsulosin, Alfuzosin ER, Finasteride, Dutasteride
Veltassa	Sodium Polystyrene Sulfonate, Lokelma
Fesoterodine ER	Tolterodine, Solifenacin, Oxybutynin, Myrbetriq
Simbrinza	Brimonidine 0.15% & 0.2%, Brinzolamide, Dorzolamide, Dorzolamide-Timolol, Combigan Alphagan P 0.1%
Vyzulta	Latanoprost, Travoprost, Lumigan
Xeljanz, Xeljanz XR	Yuflyma*, Cyltezo 40 mg/0.8mL*, Humira*, Enbrel*, Rinvoq*, Skyrizi*, Stelara*
Forteo	Teriparatide 620 mcg/2.48mL*
Procrit	Retacrit*
	* Prior authorization required

If you determine that it is necessary for your patient to continue to receive the non-formulary drug in 2025, you will need to submit a Coverage Determination request **on or after December 2, 2024.**

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

Wellcare by Allwell	Wellcare
www.wellcare.com/allwellMO **Medicare Pharmacy Services:** **1-800-867-6564**	www.wellcare.com/Medicare **Medicare Pharmacy Services:** **1-855-538-0454**

Provider Announcements, con't

Doula services is now a covered benefit

Effective for dates of service on or after October 1, 2024, doula services are available to all MO HealthNet (Medicaid) enrolled pregnant women as preventive services when recommended by a physician or other licensed practitioner of the healing arts.

This includes prenatal, during delivery, and throughout the 12-month postpartum period. Doula services provide a stable source of psycho-social support and education throughout the perinatal period and during the birth. This benefit allows pregnant women to access specially trained community-based doulas with the aim of improving a range of maternal and infant health outcomes by enhancing the participants relevant knowledge and encouraging healthy behaviors.

Doulas are now enrolling with the State and contracting with the health plan. To find the closest participating doula for your patients, visit the **Find a Provider** tool on the Home State Health website. If your practice employs or works with a Doula, encourage them to **contract** with Home State today.

View the **MO HealthNet Provider Bulletin** for more information on covered services, eligible providers, enrollment information, and procedure codes.

Quality

Notification of Pregnancy process

MO Healthnet has partnered with all 3 Managed Care plans to develop and implement a standardized process for submitting Notifications of Pregnancy (NOP) forms. Effective January 1, 2025, all providers will be required to submit NOPs via the **NOP and Risk Screening Portal**. The new NOP and Risk Screening Form will replace Home State's NOP form and providers will no longer be able to submit NOPs through our provider portal or via fax. Upon submission in the MHD NOP and Risk Screening Portal, the provider will receive confirmation of the submission. This information will then be sent to Home State. Our care management team will then make outreach to all members identified through the NOP process and will offer care management services, review benefits, and explore opportunities to support the member.

MHD Provider Education team hosted several trainings on the new portal in October and November to support a smooth transition. The information from those trainings can be found here: **Notification of Pregnancy and Risk Assessment | mydss.mo.gov**

Quality

Planning your well visits for 2025

The beginning of the year is a perfect time to begin planning out your patients' annual well visits. A recommendation by you makes your patients more likely to schedule. Planning early gives you time to get your patients scheduled, gives you adequate time to follow-up on appointment cancelations and gives your patients time to complete recommended screenings by the end of the year.

Well visits are an opportunity to go over recommended screenings, discuss preventative measures, review medications, and catch up on immunizations. What preventative health items do you focus on to keep your members healthy? Well visits are a time to monitor growth, development, exercise, and nutrition. It is a time to make sure members are filling their medications and getting appropriate medications for their underlying diseases such as asthma, atherosclerotic cardiovascular disease (ASCVD), and high blood pressure. As your patient's provider, you are a key driver of coordination of their healthcare and their overall wellbeing.

- **What do you include in your yearly well visits?**
- **Do you record height, weight, and BMI?**
  In members under 18 years of age, don't forget that BMI should be documented as a BMI percentile.
- **Do you check and document blood pressure at these visits?**
- **Does your assessment include identification of each patient's Social Determinants of Health (SDoH) barriers?**
- **Do you remind patients about the need for a yearly dental visit? All MO HealthNet Medicaid members have preventive dental visit benefits.**
  For infants and children, the American Academy of Pediatrics recommends following Bright Futures Guidelines.

DIFFERENT TYPES OF WELL VISITS:

Infants

- Your infant patients need 6 well visits BEFORE they turn 15 months.
- If a patient is behind in well visits, you can do their 15-month well visit a little early to meet this quality HEDIS measure.

Toddlers

- Toddlers need an 18-month, 24-month, and 30-month well visits.
- Remember, to meet the vaccine quality measure, ALL primary series vaccines need to be completed before 24 months of age.
- Yes, you CAN do an 18-month well visit as late as 23 months. Get all those missed vaccines BEFORE they turn 24 months.

Children, Teenagers, and Adults

- Everyone 3 years and up needs a yearly well visit.
- School physicals and sports physicals also count toward the yearly well visit.

Adults 65 and Older, and Patients with Certain Disabilities:

- **Do you and your patient know the difference between the Welcome to Medicare visit, Annual Wellness visit (AWV) and a routine physical exam?**

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- **Welcome to Medicare Preventative Visit:** Medicare Part B (Medical Insurance) covers one "Welcome to Medicare" preventive visit within the first 12 months that members have Part B. This "Welcome to Medicare" visit isn't a physical exam.
- **Annual Wellness Visit:** If a member has had Medicare Part B (Medical Insurance) for longer than 12 months, they can get a yearly "Wellness" visit to develop or update their personalized plan to help prevent disease or disability, based on their current health and risk factors. The yearly "Wellness" visit isn't a physical exam. The first yearly "Wellness" visit can't take place within 12 months of the member's Part B enrollment or their "Welcome to Medicare" preventive visit. However, they don't need to have had a "Welcome to Medicare" preventive visit to qualify for a yearly "Wellness" visit.
- **Annual Routine Physical Exam:** An annual physical exam includes an examination of the heart, lung, abdominal and neurological systems, as well as a hands-on examination of the body (such as head, neck, and extremities) and detailed medical/family history, in addition to services included in the Annual Wellness Visit.

Focus on Immunizations

Vaccines are essential for both adults and children. Although many people get health information from social media, a strong recommendation from you increases the likelihood that they will obtain these necessary vaccines for themselves and their children.

Careful planning and processes to coordinate well visits with vaccine administration is key to success in getting your patients immunized and you getting credit for what you do. Make sure support staff knows the time sensitive nature of certain vaccines when scheduling or rescheduling patients for their well visits. Make sure vaccines obtained at the health department, health fairs and pharmacies are entered into your patients' charts. Have adequate stock of vaccines when possible so you never miss an opportunity to immunize. Catching up on missed vaccines at non-well visits and having walk in vaccine clinic days are only some of best practices in immunizing patients.

For those pediatric patients, remember they need TWO flu vaccines before they turn TWO. So, yes you CAN give your pediatric patients their second flu vaccine as late as June. Why, the following flu season, they will only need 1 flu vaccine. Bonus, if your patients get 2 flu vaccines before they turn 24 months, this will help you meet the childhood vaccine quality HEDIS measure.

Needed for your Adult Quality HEDIS measure are the Tdap or Td, Hep B, Influenza Vaccine, Zoster and pneumococcal vaccines.

Here is a full list of adult vaccines: https://www.immunize.org/wp-content/uploads/catg.d/p4030.pdf

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Focus on Screening

Both children and adults have recommended routine screenings.

What screenings do you incorporate in the care of your patients?

Lead Screening for Children	6 months to 6 years For HEDIS they need at least one lead test (capillary or venous blood test) before they turn 24 months.
Developmental Screening and Social-Emotional Screening	Starting at 2 months of age
Autism Screening	18 and 24 months of age
Dental Visit	Yearly starting at 1 year of age
Chlamydia Screening	16-24 years
Depression Screening	12 years and up
Post-Partum Screening for your Post-Partum Patients	For pediatric providers: The American Academy of Pediatrics (AAP) recommends postpartum depression screening at the 1-, 2-, 5-, and 6-month well-child visits. For OB providers: American College of Obstetricians and Gynecologists (ACOG) recommends that screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits using a standardized, validated instrument.
Cervical Cancer Screening	Starting at 21 years of age
Breast Cancer screening	50-75 years
Colorectal Cancer Screening	45-75 years
Osteoporosis Screening	Women 67-75 years

Contact Provider Partnership:

HomeStateHealth.com	Home State: 1-855-694-4663 / TTY: 711
HomeStateHealth.com	Show Me Healthy Kids: 1-877-236-1020 / TTY: 711
Ambetter.HomeStateHealth.com	Ambetter: 1-855-650-3789 / TTY: 711
Wellcare.com/AllwellMO	Wellcare By Allwell: MAPD 1-855-766-1452 / D-SNP: 1-833-298-3361 / TTY:711
Wellcare.com	Wellcare: MAPD1-833-444-9088 / D-SNP:1-833-444-9089 / TTY: 711

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