home state health™

Welcome to Home State Health

Quality Healthcare is at the Heart of What We Do

1/1/2022

Home State Health Overview

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WHO WE ARE

AT A GLANCE

Medicaid

340 EMPLOYEES

250,000 Members

OPERATIONS IN **114** counties

125 Hospitals

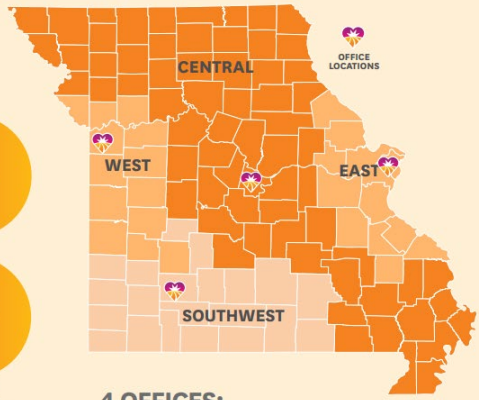
Serving **ALL** of Missouri

17,000 Providers

CHIP

TANF

FOSTER CARE



4 OFFICES:
St. Louis, Jefferson City, Independence and Springfield
+ state-wide staff based in the field

OUR PURPOSE

Transforming the Health of the community, one individual at a time.

OUR MISSION

Better health outcomes at lower costs

OUR BRAND PILLARS

Focus on Individuals | Active Local Involvement | Whole Health

Our local approach provides **accessible, high quality and culturally sensitive healthcare services** to our members. Our integrated care coordination model can only be delivered effectively by a local staff, resulting in **meaningful job creation in Missouri.**

Managed Care Regions

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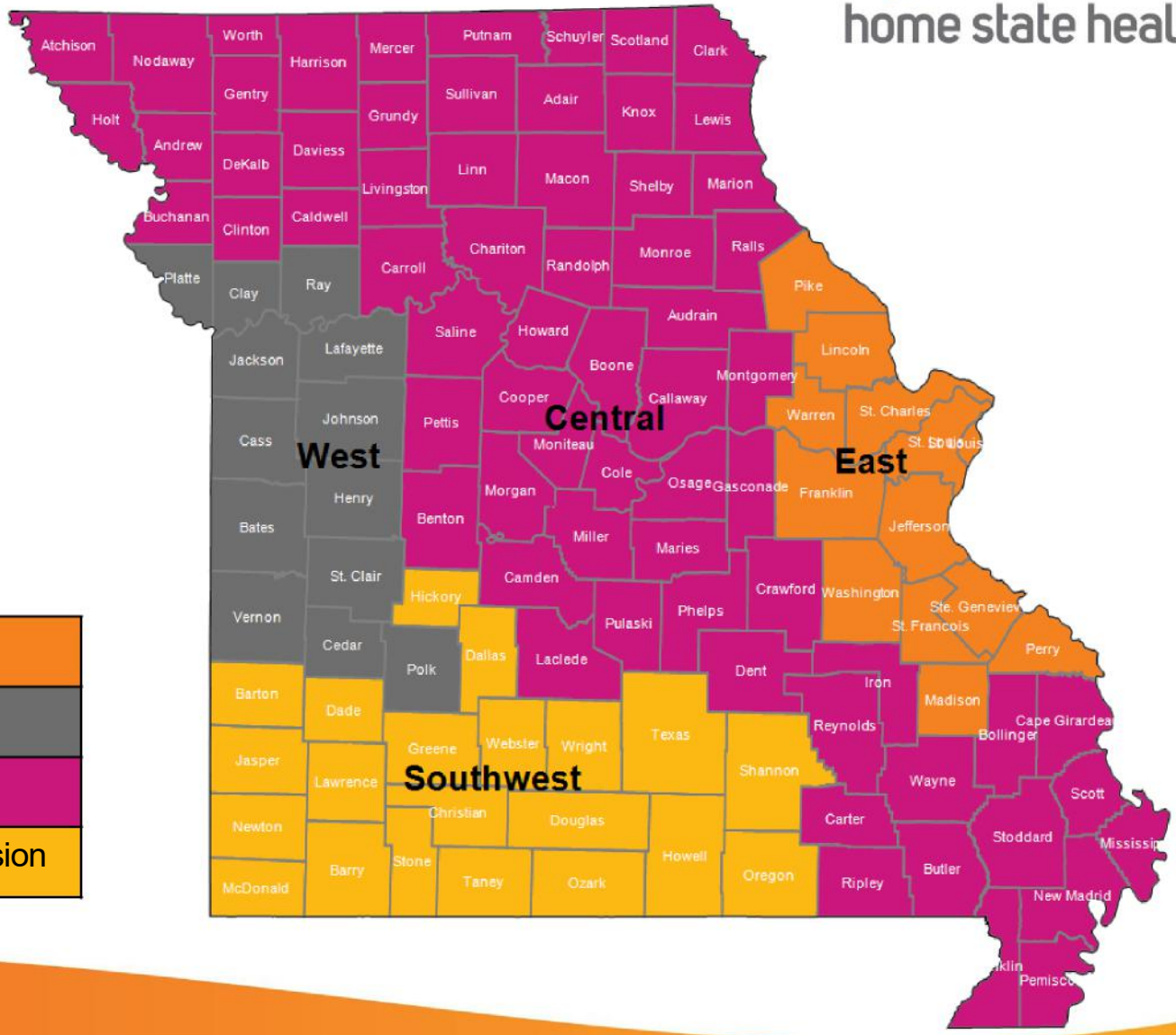

- Current East
- Current West
- New Central
- Southwest Expansion

Who is Eligible for MO HealthNet Managed Care?

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Women age 18-55 with no health insurance

Children under age 19

Parents or Caretakers of children

Adult age 19-64

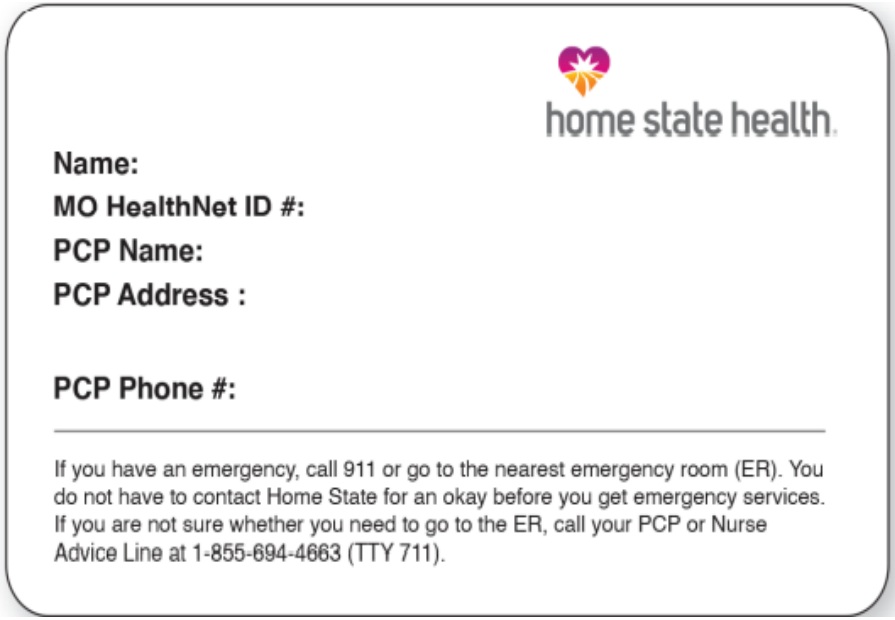
Pregnant Women and unborn child

Senior 65 and older

Persons with Disabilities

Home State Member ID Card

Medicaid ID Cards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Name:

MO HealthNet ID #:

PCP Name:

PCP Address :

PCP Phone #:

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact Home State for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Nurse Advice Line at 1-855-694-4663 (TTY 711).


IMPORTANT TELEPHONE NUMBERS

Members:

Member Services: 1-855-694-4663 TTY 711

Dental: 1-855-694-4663

Vision: 1-855-694-4663

Behavioral Health: 1-855-694-4663

Pharmacy: 1-800-392-2161/573-751-6527

24/7 Nurse Advice Line: 1-855-694-4663

File a Grievance: 1-855-694-4663

Home State Address:
11720 Borman Drive
St. Louis, MO 63146

EDI/EFT/ERA please visit Provider Resources at www.homestatehealth.com

Providers:

Provider Services: 1-855-694-4663

IVR Eligibility Inquiry - Prior Auth: 1-855-694-4663

Medical claims: Home State Health Plan
Attn: CLAIMS
PO Box 4050
Farmington, MO 63640-3829

Provider/claims information via the web: www.HomeStateHealth.com.

Verifying Member Eligibility

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

- Member eligibility can be verified through Home State's secure portal at www.HomeStateHealth.com

Customer Service

We strive for customer satisfaction on every call by doing the right thing the first time.

Toll free emergency and routine Behavioral Health Services Hotline, answered by a live voice and staffed by trained personnel Monday through Friday 8:00 a.m. to 6:00 p.m. Central Time at 866-864-1459.

The Home State Customer Service department assists Network Providers with trouble-shooting any issues related to eligibility, authorizations, referrals, researching prior services or technical questions.

Behavioral Health Services

Home State Behavioral Health UM and Customer Service staff can be reached directly at 1-866-864-1459 or at 1-855-694-HOME (4663) and follow the prompts.

For TDD access for members who are hearing impaired, contact Missouri Relay Customer Service:

- **TTY:** 711
- **Voice:** 866-735-2460

Behavioral Health Providers access the secure provider portal at www.HomeStateHealth.com

Authorization guidelines and forms can be found at https://www.homestatehealth.com/providers/behavioral-health.html

Claims should be submitted electronically through Gateway, Emdeon, and SSI and Availity. Payor ID is **68068**. You can also submit claims through the secure Web portal.

Home State's Philosophy

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Local Approach

- Quality healthcare is best delivered locally.
- Local approach enables us to ensure accessible, high quality and culturally sensitive healthcare services to our members.
- Our care coordination model utilizes integrated programs administered by a local staff.

Care Coordination / Service Delivery

- Promote a medical home for each member.
- Partner with trusted providers.
- Ensure consumers receive the right care, in the right place, at the right time.

Continuous Quality Improvement

- Achieve demonstrated improvement in consumer safety, health, and satisfaction.

Coordinating Care

Studies show that providing integrated care results in better outcomes

Information exchange with the PCP is essential when:

- Prescribing medication
- Ordering diagnostic testing
- A substance abuse problem exists
- Member's behavioral health condition resembles a medical condition
- Member's progress toward meeting their goals is established

How does Home State help?

- Educate members on the importance of treatment compliance
- Help members obtain needed services
- Assist in coordination of covered services and community services
- Face to Face Care Management

The name of the member's PCP is listed on the front-side of their member ID card. Behavioral Health Providers can access the Referral and Consultation Communication between Primary care and Specialist Physicians (PDF) at https://www.homestatehealth.com/providers/behavioral-health.html

Home State Transportation Services

Medical Transportation Management (MTM)

- Home State contracts with MTM to provide non-emergency medical transportation for Home State members

- Benefits include routine visits, **same day PCP and OB visits**, mileage reimbursement, urgent visits, hospital discharges, and multi-leg trips (i.e. trip to the pharmacy immediately following a covered appointment)*

- MTM may be reached at 1-855-694-HOME (4663) or www.MTM-Inc.net

*Visitwww.HomeStateHealth.com to view Covered Services and Guidelines

Home State Medical Management

24 Hour Nurse Line

- The 24 hour nurse line is a toll-free phone line through which callers can reach both Customer Care Professionals and Registered Nurses.
- The nurse triage service provides access to a broad range of health-related services including: general benefit questions/member service inquiries, medical triage for health issues, health education, urgent pharmacy re-fills and transportation for treatment and crisis interventions (as applicable).
- Members can reach the 24 hour nurse line by calling Home State Health's main phone line: 855-694-4663 (HOME)

- **Services Include**:

> Nurse Triage and Crisis Management
> Member Support and Health Education

Case Management

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We recognize that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the member and all treating providers to achieve the highest possible levels of wellness, functioning and quality of life.

Home State's case management model uses an integrated team of:

- Licensed mental health professionals
- Registered nurses
- Social workers
- Non-clinical staff

Home State's case management model is designed to:

- Educate members on the importance of treatment compliance
- Help members obtain needed services
- Assist in coordination of covered services, community services, or other non-covered venues

To contact our Case Management Department, call 866-864-1459

Behavioral Health Network

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Home State contracts with a comprehensive behavioral health network

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

Provider Participation Responsibilities

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Home State emphasizes it's commitment to quality of care by ensuring providers adhere to the following

- Provide Home State Health Plan members with a professional level of care and efficiency consistent with community standards.
- Prepare and maintain complete medical records and other required documents for all member care.
- Participate in quality improvement activities, utilization review activities, orientations, continuing education and other medical management components.
- Abide by ethical principles of their profession.
- Display all marketing and health education materials provided by contracted health plans in an equal fashion

Home State communicates with providers to inform them of their participation responsibilities, credentialing and application status and network requirements.

Behavioral Health Services

Services for Home State Health members include, but are not limited to the following:

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

Note: Please refer to the Covered Services & Authorization Guidelines section of the Home State Behavioral Health Provider Manual for a listing of billing codes. Network Providers should refer to their Provider Agreement with Home State to identify which services they are contracted and eligible to provide.

Behavioral Health Authorizations

For **standard treatment requests**, Home State Health makes a determination within two (1) business days of receiving the necessary information for routine services, not to exceed fourteen (14) business days of the request.

- For requests **MEETING** criteria, the Provider will be notified of approval and authorization.

- For requests **NOT** meeting criteria, Peer Reviewers will conduct reviews within the level of care turn around time standards.

Note: Please refer to the Covered Services & Authorization Guidelines section of the Home State Behavioral Health Provider Manual for a listing of billing codes

Inpatient Authorizations

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- Inpatient authorizations are conducted via live telephonic review.
- Provider must call within 24 hours of an emergent inpatient admission; after-hours calls will be taken by NurseWise and authorized until the next business day when a live review is done.
- Locus/CaLocus medical necessity criteria are applied to all mental health cases and all chemical dependency cases.
- Home State focuses on collaborating with providers to ensure the best care and outcomes possible, and coordination with our ICM/CC staff is imperative.

Outpatient Treatment Requests (OTR)

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Outpatient Treatment Request (OTR) forms will need to be completed to request additional outpatient services per the Cenpatico Covered Services & Authorization Guidelines.

- Please refer to the Cenpatico Covered Services & Authorization Guidelines section of the Provider Manual for a listing of billing codes.

- The OTR form and Covered Services & Authorization Guidelines will be posted online at https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/MOMO_OutpatientTreatmentRequestForm_2222018.pdf

- Missouri providers can also create and view prior authorization requests via the Secure Provider Portal. To access:

1. Go towww.homestatehealth.com
2. Login.
3. Click Authorizations. The Authorization Summary will display.
4. Click Create Authorizations.

Elements of an OTR

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Member and provider identification in full

- This is a critical part of the OTR in order to process the OTR timely

Axes I – V

- Using DSM-5 format
- Date first and last seen as well as PCP communication to be included

Functional Outcomes

- 10 questions to be asked of the member or guardian prior to submitting treatment request for continued authorization of services.
- Responses should be from member/guardian's perspective and not clinician's observation

Therapeutic approach to be used with this member

- Specifically, evidence based treatment modality to be used

Level of Improvement to date

Current symptoms and functional impairments

- Clinical presentation from the clinician's perspective should be documented here
  - Substances used and dates last used to be included in this section

Elements of an OTR

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Risk Assessment (Current suicidality, homicidally, and safety planning)

- Indicate if psychiatric evaluation has been completed and if not, please give reason.

Current Measurable Goals

- Goals should be measurable and updated/modified over time.
- Use the SMART technique

Requested Authorization information is on the last page

- Only fill in the items needing pre-authorization at this time
- Frequency (how often is the member seen) and Intensity (how long is each session).
- Requested start date for THIS authorization (can be up to two weeks in the future).
- Anticipated completion date of the service.
- Can only backdate 1 business day so please send in before you use your last session!

Elements of an OTR

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Measurable Goals/Objectives/Interventions (be SMART)

- *Objective* Goals are SMART, **not** Vague
- SPECIFIC–Who, What, When, Where, and How
- MEASURABLE– Intensity, Frequency, Duration of Symptoms
- ATTAINABLE–Within the member's scope for the current treatment episode?
- REALISTIC – Is the bar set too high or too low for this member?
- TIMELY– Is it an opportune time for the member to pursue the identified goals?

Transmitting OTR

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RightFax System

- Completed OTRs should be faxed to (866) 694-3649
- System accepts attachments to OTR (e.g., Progress Notes, Treatment Plan Updates)
- Ensure that all OTR's include all requested demographic information for client (Name, DOB, SSN, ID Number) and provider (Group or Individual Name, Tax ID Number, NPI Number, Medicaid Number, Phone and Fax numbers)
- Make sure OTR is signed by the clinician
- Provider will be receive response within 2-14 days following OTR submission date
- Earliest allowable start date is one business day prior to submission date

Behavioral Follow-Up Visits After Discharge

- As an NCQA accredited organization, Home State adheres to HEDIS 7 day follow-up measures when a member has been discharged from an inpatient setting.

- Our expectation is that a member will have a follow up appointment scheduled with a licensed behavioral health professional within 7 days at the time of discharge. Home State case management staff are able to assist as needed with scheduling this appointment.

- Additionally, Home State case management staff will follow up with members after discharge to assist with alleviating any barriers to treatment compliance with this appointment.

Home State Health Plan's Quality Improvement Program Overview

Home State's culture, systems and processes are structured around its mission to improve the health of our members.

- **Home State's Board of Directors** has the ultimate authority and oversight of the quality of care and service provided to members.

- **The Quality Improvement Committee** is composed of HSHP's senior management with physician representation directly accountable to the Board of Directors.

- **The Purpose of the QIC** is to provide oversight and direction in assessing the appropriateness of services provided and to continuously enhance and improve the quality of care and services provided to members

HSHP Quality Improvement Committee (QIC) Overview

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The Quality Improvement Committee (QIC) oversees:

- Credentialing Committee
- Utilization Management Committee
- Pharmacy and Therapy Committee
- Performance Improvement Team
- Member and Provider Advisory Committee
- Peer Review Committee (Ad Hoc Committee)
- Community Advisory Committee

Medical Record Release

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- It has been brought to our attention that providers often feel uncertain if they should release medical records without written consent.

- If a Managed Care health plan member has a MO HealthNet identification card, they have signed an application and a release to all MO HealthNet providers. The MO HealthNet Managed Care health plans are a representative of the State through their signed contract.

Claim Operations

- **Initial Claims** must be received within 180 calendar days from the date of service

- **Corrected claims** must be received within 180 calendar days from explanation of payment

- Home State's BH Medical Payer ID is **68068** with the following clearinghouses:
  > Emdeon
  > SSI
  > Trizetto Provider Solutions
  > Availity
- Initial claims and corrected claims may be submitted through our secure web portal **A complete list of Clearinghouses can be found on our Website at www.HomeStateHealth.com**

Billing Tips

- Home State Health implements benefit and contract (including fee schedule updates) within 60 days of release from the applicable state agency. The health plan does not reprocess claims.

- Submission of claims (electronically, web-based, or paper) is considered provider verification that all data is true, accurate and complete.

- By accepting payment (via check or ACH/EFT), providers indicate they understand that the payment is from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

- In order for Home State Health to issue payment, all NPI's on a claim - rendering, site, servicing and group - must be enrolled in the MO Healthnet program.

- Providers may only participate under one contract.

Request for Reconsideration and Claims Dispute

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Request for Reconsideration

- Verbal or written request to reconsider or adjust a claim
- Must be submitted within 180 days of original remittance advice

Claim Disputes

- Request for Reconsideration must be submitted first
- Must be submitted within 180 days of original remittance date
- Claim Dispute Form can be found atwww.HomeStateHealth.com
- Written claim disputes can be sent to:

Home State Health Plan
Attn: Claims Dispute
P.O. Box 7400
Farmington, MO 63640

Provider Complaints and Appeals

Complaint-Verbal or written expression of dissatisfaction with any of HSHP functions such as policies, procedures. Complaints must be submitted within 30 days of the incident such as the original remit date.

Appeal-The right to appeal actions of HSHP such as policies, procedures, or prior authorization denial. Appeals must be submitted 30 days from HSHP's notice of action.

Written complaints and appeals:

Home State Health Plan

Complaint and Grievance Coordinator

11720 Borman Drive

Chesterfield, MO 63017

Verbal Complaints: 1-855-694-HOME (4663)

Visitwww.HomeStateHealth.com to view Provider Manual and details of Provider Complaints and Appeals

PaySpan® Payment and Remittance Advice

- Home State and **PaySpan** Health have partnered to provide **EFT** and **ERA** services
- This service is FREE
- **ERA's** can be imported directly into Practice Management systems
- Once contracted, **PaySpan** will issue a registration code and the online enrollment process takes 5 to 10 minutes to complete.
- Contact Provider Services for more information or visit www.PaySpan.com

Marketing Guidelines for Providers

- Home State Health and Providers may conduct marketing activities to MO HealthNet members, subject to MO HealthNet guidelines and prior approval.
- Providers submit all member marketing materials to Home State prior to distributing. Home State submits marketing materials to MO HealthNet for written approval.
- Providers may advise MO HealthNet members of the plans in which they participate through the following communications:
  - Equally displaying a list of all plans in which they participate
  - Equally displaying all participating health plan logos
  - Providing all participating health plan phone numbers
  - Equally displaying all contracted health plans 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 plan with which they participate

Cultural Competency

- *Cultural Competency* 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.

- Home State believes its Members are entitled to dignified, appropriate, and quality care and expects this of its providers and of the HSHP staff serving our Members

- Providers are encouraged to complete the U.S. Department of Health & Human Services Physician Practical Guide to Culturally Competent Care

Mainstreaming

- **Home State and Providers** are expected 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, physical or behavioral disabilities.

- **Prohibited Practices include**:
  - ➢denying a member a covered service or availability of a facility
  - ➢ providing services to a Home State member differently that other “public” or private pay members

Waste Abuse and Fraud

- The **Waste, Abuse and Fraud Program** is overseen by Home State's Vice-President of Compliance.
- Overall responsibility and authority for carrying out the provisions of the compliance program
- Commitment to identify, investigate, sanction and prosecute suspected fraud and abuse
- Provider Network expected to cooperate fully with Waste, Abuse and Fraud investigations and proceedings
- Anonymous and confidential Hotline at 1-866-685-8664
- All reports of potential waste, abuse or fraud are taken very seriously and are thoroughly investigated

PHI can be shared under TPO (Treatment, Payment or Operations)

- **Treatment** – the provision, coordination, or management of health care and related services by a healthcare provider(s), to include 3rd party healthcare providers and health plans for treatment alternatives and health-related benefits. *Example: A PCP discloses identifying information to Home State Health when obtaining authorization for services.*

- **Payment** - activities to determine eligibility benefits and to ensure payment for the provision of healthcare services. *Example: Provider submitting a claim with PHI to Home State Health for the purpose of payment for services.*

- **Health Care Operations** – activities that manage, monitor, and evaluate the performance of a health care provider or health plan. *Example: CMS conducting an internal audit.*

Access and Availability Physical and Behavioral Health

- **Routine care without physical or behavioral health symptoms** -within thirty (30) calendar days

- **Routine care with physical or behavioral health symptoms** -within one (1) week or five (5) business days; whichever is earlier

- **Urgent care for physical or behavioral appointments** for illness, injuries which require care immediately but do not constitute emergencies -within 24 hours

- **Behavioral Health and Substance Abuse Emergent** – Immediately (non-life threatening within 6 hours) or direct member to a crisis center. If a crisis center is not available in the member's area, direct the member to the ER.

- **Wait times for physical and behavioral health appointments**(defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments should not exceed one hour from the scheduled appointment

- **Aftercare physical and behavioral health appointments** -within (7) seven calendar days of hospital discharge (Home State can assist with scheduling)

After Hours 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. Home State Health monitors provider compliance through after-hours calls. Primary Care Providers and Specialists must adhere to the following response time for telephone call-back waiting times:

- After hours telephone care for non-emergent, symptomatic issues within 30 minutes
- Same day for non-symptomatic concerns

After-hour calls should be documented in a written format in either an after-hour call log or some other method, then transferred to the member's medical record. 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 provider, an answering service, triage service or a voice message that providers a second phone number that is answered.

New Credentialing – Adding a Provider/Practitioner

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Adding to an existing Agreement-Non-Delegated

Provider – Facility/Group: Including RHC, FQHC, Ancillary, ASC, etc.

- Completed Applicable Credentialing Application (Facility/Group)
- Non-Delegate Roster (located on website) – List Provider as an "add"
- Completed Disclosure of Ownership Form
- W-9

Practitioner – Physician, Nurse Practitioner, Physician Assistant, etc.

- Non-Delegate Roster (located on website) – List Practitioner as an "add"
- Completed Disclosure of Ownership Form
- Advance Directive attestation
- W-9

Email credentialing materials to CHHS_PROVIDER_ROSTER@CENTENE.COM

*NOTE: When credentialing is complete, a letter notifying you of such will be mailed.

Non-Delegated Provider Roster

Home State's non delegated roster template can be used when adding a practitioner to a group with an existing contract or making changes to a practitioner. This should only be used for providers who do not have a delegated credentialing contract with Home State. The non-delegated roster can be found on our website at **https://www.homestatehealth.com/content/homestate-migrate/en_us/providers/tools-resources.html.**

Information must be completed for each practitioner. If a practitioner serves more than one location, complete a row for each.

Please send the completed roster to our Provider Data Management Department at CHHS_PROVIDER_ROSTER@CENTENE.COM

Delegated Provider Roster

Providers who have a delegated credentialing contract with Home State should submit a roster on a monthly basis identifying all new Practitioners, any changes to existing Practitioners (i.e., demographic changes; name changes), and Practitioner terminations.

Delegated entities must submit a full roster on a quarterly basis. This should present a comprehensive list of all credentialed practitioners in the health system. This approach minimizes the risk of processing incorrect data and enables a more efficient process.

Home State's roster template can be found on our website at https://www.homestatehealth.com/content/homestate-migrate/en_us/providers/tools-resources.html

Please send the completed roster to our Provider Data Management Department at CHHS PROVIDER ROSTER@CENTENE.COM

Web-Based Tools

Through Home State website, providers can access:

- Provider Reference Manual
- Provider Billing Manual
- Prior Authorization List
- Authorization Search by Code
- Operational Forms
- Home State Health News
- Clinical Guidelines
- Provider newsletter

Logon towww.HomeStateHealth.com and become a registered provider

Provider Secure Portal

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Through our secure portal, providers can:

- Verify eligibility and benefits
- View eligibility list
- View Care Plans
- View and submit authorizations (Effective 1/1/2021 all authorizations must be submitted via the Provider Secure Web Portal.)
- Submit and check status of claims
- Review payment history
- Submit Provider Demographic Updates
- Secure Contact Us

Value Home State Health Brings to Providers

- **Timely and accurate** claims payment
- **Local**, dedicated resources
- **Case managers** who serve an extension of physician offices
- **Education and support** of providers and staff through designated Provider Relations Representative
- **Provider participation** on health plan committees and boards
- **Member Education**, Outreach and Support
- **Limited** prior authorizations
- **Electronic transaction** capabilities
- **Web based tools** for administrative functions

We strive to reduce administrative hassles so providers can focus on what they do best — providing quality healthcare to consumers

Provider Services

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Provider Services Representatives assist with:

- Member benefits and eligibility
- Our Find a Provider online directory
- Authorization requirements
- Claim submission requirements
- Evidence of payment (EOP)/remittance advice support
- Payspan (EFT/ERA) assistance
- Provider data review
- Payment and clinical policy questions
- Website/portal questions, including password reset
- Appeal and claim reconsideration guidance

Claims Inquiries

If you have questions after checking claim or authorization status online, please contact Provider Services at:

- **Home State Health** (Medicaid): 855-694-4663

HSH Provider Network Specialist

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Top Reasons to Contact your Provider Network Specialist:

- Changes to your practice (Locations, NPI, TIN numbers)
- Credentialing of a new practitioner
- In-service training for new providers/staff
- On-going education for existing staff
- Clarification of policies and procedures
- Clarification of a provider contract
- Assistance with the secure portal
- Electronic solutions training on web authorizations, claims submissions and eligibility checks

Provider Network Specialists

East Region
Edna Fields
Phone: 636-735-4673
Email: Edna.Fields@homestatehealth.com

Southeast Region
Kelli R Wilbourn
Phone: 636-534-4666
Email:Kelli.R.Wilbourn@homestatehealth.com

Central Region
Carrie Goodrich
Phone: 636-534-4621
Email: Carrie.Goodrich@homestatehealth.com

Southwest Region
Name: Melissa Cave
Phone: 417-210-3128
Email: Melissa.Cave@homestatehealth.com

Western Region
Jennifer Bennett
Phone: 913-472-2384
Email: Jennifer.Bennett@homestatehealth.com

Northwest Region
Stephanie Hoobing
Phone: 913-220-0771
Email: Stephanie.D.Hoobing@homestatehealth.com

Questions?

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