COMMUNITY HEALTHCARE

Provider Newsletter | Summer 2023

MEDICAID RENEWALS ARE BACK:
Help Your Patients Stay Covered!

COMING SOON! PRIOR AUTHORIZATION DECISIONS MOVING TO PROVIDER PORTAL

EDUCATE YOUR PATIENTS: ORDER FREE HHSC-APPROVED COLLATERAL

URGENT: REQUIRED PEMS ADDRESS UPDATES

THE END OF CONTINUOUS MEDICAID COVERAGE

MAIN OFFICE
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

COMMUNITY OFFICE AT AVENIDA GUADALUPE
1410 Guadalupe Street, Suite 222
San Antonio, Texas 78207

VISIT OUR WEBSITE OR CALL AT:
CommunityFirstHealthPlans.com
210-227-2347 or toll-free 1-800-434-2347

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ALL PRIOR AUTHORIZATION COMMUNICATIONS MOVING TO THE PROVIDER PORTAL

Community First will soon add new functionality to the Community First Provider Portal, allowing Providers to use the Portal's authorization module to view decisions/outcomes of prior authorization requests for services.

If you are not currently using the Portal to submit authorizations, we encourage you to familiarize yourself with the process now. We are confident that this change will result in more efficient communications surrounding the authorizatoin process.

PROVIDER ASSISTANCE
We're Here To Help

Community First Health Plans values the relationship with our contracted Providers.

We are happy to provide assistance, address concerns, and answer questions about the following:

- Provider Portal (i.e., registration and functionality)
- Provider education, resources, and tip sheets
- Staff safety, education, and resources
- Point of contact for Member-related issues
- Staff training
- Contracting
- Credentialing
- Provider terminations
- Updates/changes to your information (i.e., address, phone/fax number, tax ID number, etc.)
- Provider forms (i.e., Member Education, Provider Education, Provider Concerns, Grievances/ Complaints, etc.)

For assistance with any of the matters listed above or to get access to resources, please contact your assigned Provider Relations Representative at 210-358-6294 or ProviderRelations@cfhp.com.

We are here to help.

Background:

Providers can currently use the Provider Portal to:

- Verify Member eligibility
- Review prior authorization requirements
- Submit authorization requests
- Upload supporting documents as part of a request
- Save an authorization request and return to complete and submit it at a later time
- View the status of a request
- Perform an advanced search for submitted requests

Providers should continue to use the Portal for the actions listed above with the addition of reviewing authorization decision/outcomes beginning in August 2023.

Community First is developing training and resources to help Providers navigate these changes. Please check the Provider Portal for updates and/or refer to the list below.

Resources:

- Provider Training Sessions
- Provider Portal Login
- About the Provider Portal

Questions?

Contact Provider Relations at 210-358-6294 or email ProviderRelations@cfhp.com.

PROVIDER TIP SHEET

HEALTH CARE TRANSITION FROM ADOLESCENCE TO ADULTHOOD

The transition from childhood to adulthood is filled with many changes, including a transition from a pediatric to an adult model of care. According to **"Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home"**, a clinical report from the American Academy of Pediatrics, optimal health care is achieved when each person, at every age, receives medically and developmentally appropriate care. The goal of a planned health care transition is to maximize lifelong functioning and well-being for all youth, including those who have special health care needs and those who do not.

The following information was compiled to help Community First Providers guide teen and young adult patients and their parents/guardians/caregivers through a successful Health Care Transition (HCT), preparing them for an adult model of care.

HCT Team

A young adult's HCT team includes:

- Young adult
- Parents/guardians
- Primary care provider
- Specialty care providers
- Other providers or support staff, if appropriate

AGE 12 TO 14

1

TRANSITION POLICY

Discuss transition policy

AGE 14 TO 18

2

TRANSITION TRACKING AND MONITORING

Track progress

AGE 14 TO 18

3

TRANSITION READINESS

Asses skills

A Provider's Role

A HCT focuses on building a teen/young adult's independent health care skills, including self-advocacy, which will prepare them for the adult model of care. Providers should also help patients find new adult providers with experience caring for special health care needs, if applicable.

Pediatricians can offer support to patients and their parents by:

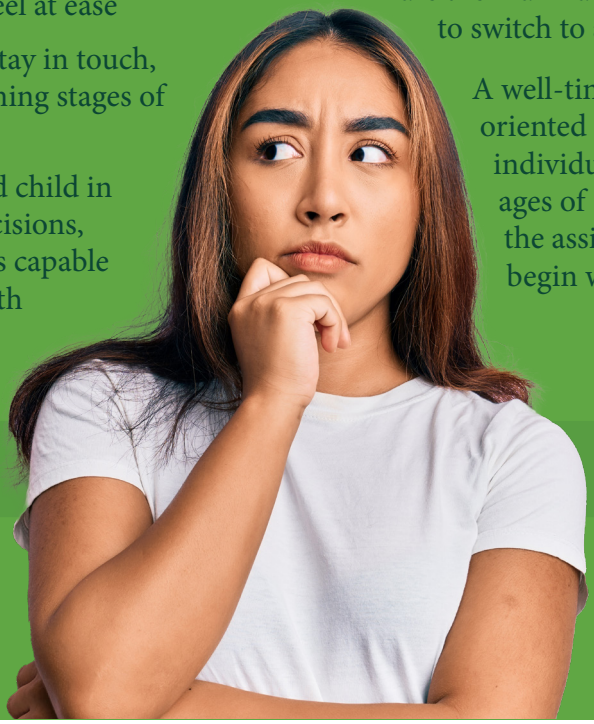
> Encouraging them to choose a new doctor with whom they trust and feel at ease

> Encouraging them to stay in touch, especially in the beginning stages of the transition

> Aiding both parent and child in making health care decisions, and until the child feels capable of managing their health themselves, the parent may discuss the possibility of the child granting the parent temporary access to medical records

> Explaining that the adolescent's decision to take responsibility for their actions is a normal stage of growing up and that doing so is a sign of maturity

> Helping parents begin the process of finding a new doctor and transferring the child's records before the child leaves pediatric care



Timeline

The age and developmental stage of the adolescent are the main factors determining whether it is time to switch to an adult health care provider.

A well-timed transition from child-to adult-oriented health care is unique to each individual and ideally occurs between the ages of 18 and 21 years, is determined with the assistance of a pediatrician, and should begin when the child is 14 or 15 years old.

AGE 14 TO 18

4

TRANSITION PLANNING

Develop HCT plan, including medical summary

AGE 18 TO 21

5

TRANSFER AND/OR INTEGRATION INTO ADULT CENTERED CARE

- Transfer to adult-centered care
- Integration into adult practice

AGE 18 TO 26

6

TRANSITION COMPLETION AND ONGOING CARE WITH ADULT CLINICIAN

- Confirm transfer completion
- Elicit consumer feedback

Reference: White PH, et al. Pediatrics. 2018. PMID: 30348754. Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home.

Applied Behavior Analysis: A New Benefit for Children with AUTISM

Effective February 1, 2022, the *Texas Medicaid Provider Procedures Manual (TMPPM), Children's Services Handbook*, has been updated to include autism services benefits, including Applied Behavior Analysis (ABA) evaluation and treatment.

ABA is a benefit of the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) for Texas Medicaid recipients who are 20 years of age or younger and who have met the criteria outlined in the Autism Services benefit description in the TMPPM.

How does ABA therapy work?

If a patient is eligible for ABA services, they can receive services in the home, community, or in a clinic by a Licensed Behavioral Analyst (LBA).

ABA therapy can help:

- Encourage positive and adaptive behaviors.
- Apply skills across everyday settings, so the Member can improve their health, safety, and independence.

How to help your patients

Patients will need to be evaluated to determine if they qualify for Medicaid ABA services. You can help patients by:

- Checking the criteria needed for the diagnosis of ASD, found in the Texas Medicaid Provider Procedures Manual.
- Advising them to call Community First Health Plans Member Services on the back of their Member ID card or The Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at **800-925-9126**.
- Encouraging patients to use the LBA Online Provider Lookup (OPL) with TMHP

What other covered autism services are available for patients?

Community First covers many services for children with autism, including:

- Case Management/Care Coordination
- Early Childhood Intervention
- Medical nutrition counseling provided by a licensed dietitian
- Occupational, physical, and speech therapy
- Outpatient behavioral health services
- Physician services, including medication management

HHSC encourages Providers to share the following resources with Members to learn more about the ABA benefit available for clients with autism spectrum disorder ASD.

Medicaid Applied Behavior Analysis (ABA) Services for Children and Youth With Autism flyer (English)

Medicaid Applied Behavior Analysis (ABA) Services for Children and Youth With Autism flyer (Spanish)

ABA works best when parents and caregivers use the training and strategies in their daily lives. Your involvement is needed!

OUR COMMITMENT:

FOCUSED CARE FOR OUR MOST VULNERABLE MEMBERS

STAR Kids Members are enabled to maximize their health and well-being when both Providers and managed care organizations work together. Based on this foundation, the Texas Health and Human Services Commission (HHSC) has selected two Member perception questions administered through the Consumer Assessment of Healthcare Providers & Systems (CAHPS) and the National Survey on Children's Health as part of the 2023 Pay-for-Quality measures.

The questions are as follows:

1. Percentage of caregivers of Members under the age of 18 who said someone helps arrange or coordinate their child's care; and
2. Percentage of caregivers of Members under the age of 18 who said in the last six months it was always easy to get special medical equipment or devices, special therapy, and/or treatment and counseling for the child (Member).

As a primary care provider or specialist, we ask that you help our Members navigate the health care system and troubleshoot their questions or concerns. Our Service Coordinators are committed to doing the same. Together, we can ensure a focused, Member-centric approach to delivering high-value health care.

In addition, we request your support in encouraging STAR Kids Members to participate in the **STAR Kids Screening and Assessment Instrument (SK-SAI)**, which provides eligibility for Long-Term Services and Supports (LTSS). The SK-SAI also helps Community First ensure that necessary services are in place, preventing gaps in care and unplanned hospitalizations while reinforcing provider care plans.

Please be aware that the SK-SAI assessment is now required to be completed in-person. Telehealth appointments are no longer permitted. The SK-SAI will be completed in the patient's home or at another location of their choice at a time that is convenient for them.

Community First would like to thank all of our valued Providers for working collectively to ensure the health and safety of our Members in the STAR Kids program.

COMMUNITY FIRST
HEALTH PLANS

PROVIDER TIPS

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Community First Health Plans is committed to working with our Providers to improve the quality of care for our Members. The following information has been compiled to inform Providers of the Healthcare Effectiveness Data and Information Set (HEDIS®) measure concerning the importance of utilizing psychosocial interventions for children and adolescents (1-17 years of age) before considering antipsychotic medications.

Our goal is to ensure that safer first-line psychosocial interventions are utilized, and that children and adolescents do not unnecessarily incur the risks associated with antipsychotic medications.

HEDIS® Measure Description

The percentage of children and adolescents ages 1-17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as their first-line treatment.

HEDIS® Best Practices

Psychosocial care, which includes behavioral interventions, psychological therapies, and skills training – among others – is the recommended first-line treatment option for children and adolescents diagnosed with non-psychotic conditions such as attention-deficit disorder and disruptive behaviors.

When prescribed, antipsychotic medications should be part of a comprehensive, multi-modal plan for coordinated treatment that includes psychosocial care.

Best practices for this population include the following actions:

- Schedule telehealth appointments for patients who have a new prescription for an antipsychotic medication and document psychosocial care as first-line treatment.
- Regularly review the ongoing need for continued therapy with antipsychotic medication.
- Monitor the patient closely for side effects.
- Establish a baseline and continuously monitor metabolic indices to ensure appropriate management of side effects.
- Educate and inform parents/guardians of the increased side effect burden of multiple concurrent antipsychotics on children's health and the implications for future physical health concerns, including obesity and diabetes.

Exclusions

Exclude patients for whom first-line antipsychotic medications may be clinically appropriate, including those with at least one acute inpatient encounter or two outpatient encounters during the measurement year with a diagnosis of:

- > Schizophrenia
- > Schizoaffective disorder
- > Bipolar disorder
- > Psychotic disorder
- > Autism
- > Other developmental disorders
- > Patients in hospice or using hospice services anytime during the measurement year

Psychosocial Care Measure Codes

CPT			
90832	90837	90845	90853
90833	90838	90846	90875
90834	90839	90847	90876
90836	90840	90849	90880

HCPCS			
G0176	H0037	H2013	S9484
G0177	H0038	H2014	S9485
G0409	H0039	H2017	
G0410	H0040	H2018	
G0411	H2000	H2019	
H0004	H2001	H2020	
H0035	H2011	S0201	
H0036	H2012	S9480	

Fraud, Waste, & Abuse

As a Community First Health Plans network provider, you have a responsibility to be aware of and report Fraud, Waste, and Abuse (FWA). If you have a concern or if you suspect that a Community First, Member, pharmacist, or another Provider is doing something wrong, please report it.

What is Fraud, Waste, & Abuse?

- > Fraud is when you do something wrong on purpose to gain a benefit. It is intentional.
- > Waste is being careless or misusing a service or item in a way that it was not intended to be used.
- > Abuse is behaving in a manner that goes against known acceptable practices and results in unnecessary costs.

How do I report Fraud, Waste, & Abuse?

1. Report directly to Community First by completing the online form available on our Fraud, Waste, & Abuse webpage
2. Report directly to Community First by phone, email, fax, or regular mail using the Suspicious Activity Report form
3. Report to the Office of Inspector General by phone at **1-800-436-6184** or complete the OIG form online.

Visit our Fraud, Waste, & Abuse webpage for more information.

Refunding Overpayments

New Mailing Address

THIS INFORMATION APPLIES TO PROVIDER REFUNDS ONLY.

If you believe you have received an overpayment from Community First Health Plans or we have identified an overpayment and requested a refund, please submit the following :

- **A check issued to Community First Health Plans in the amount of the overpayment**
- **The name and ID number of the Member for whom we have overpaid**
- **The dates of service**
- **Supporting documentation**

Please mail this information to:

Community First Health Plans
P.O. Box 2409
San Antonio, TX 78298

Please note, the overpayment mailing address listed above is different from our corporate mailing address.

New! Order Educational Materials For Patients Through Community First Collateral Library

Community First Health Plans has launched a new online Provider Collateral Library to help supply our network of Providers with free, professionally printed, educational materials designed to inform Medicaid/ CHIP patients about the End of Continuous Medicaid Coverage.

Visit our Provider Collateral Library to order materials in English and Spanish, including:*

- Posters
- Rack cards
- Brochures

All materials have been approved by Texas Health and Human Services Commission and have been developed to help ALL eligible individuals, families, and children in Texas currently covered under Medicaid/CHIP understand exactly what steps they need to take to keep their coverage.

Please use our online order form to order materials of your choice.

There is no charge to order materials. We will arrange for free delivery to your office setting. Providers are also welcome to download/print the materials on their own.

We are proud to be your partner in health and provide you with resources to help educate and inform your patients.

OPTION CARE
Women's Health

Community First Health Plans partners with Option Care Women's Health to assist our high-risk obstetrical Members. Option Care provides quality high-risk obstetrical care delivered by specialized nurses for the management of the following conditions:

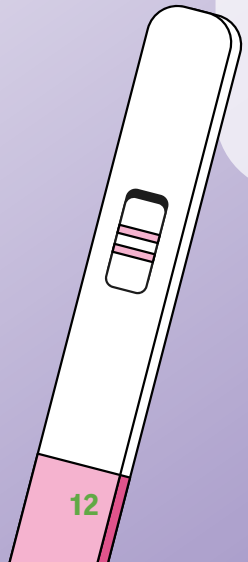
- Hyperemesis gravidarum
- Preterm labor
- Pregnancy-induced hypertension
- Gestational diabetes

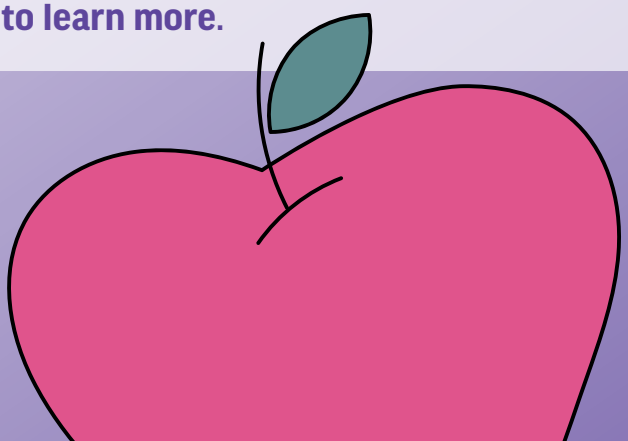
Option Care also provides home visits, a 24/7 Call Center, compliance coaching, and education.

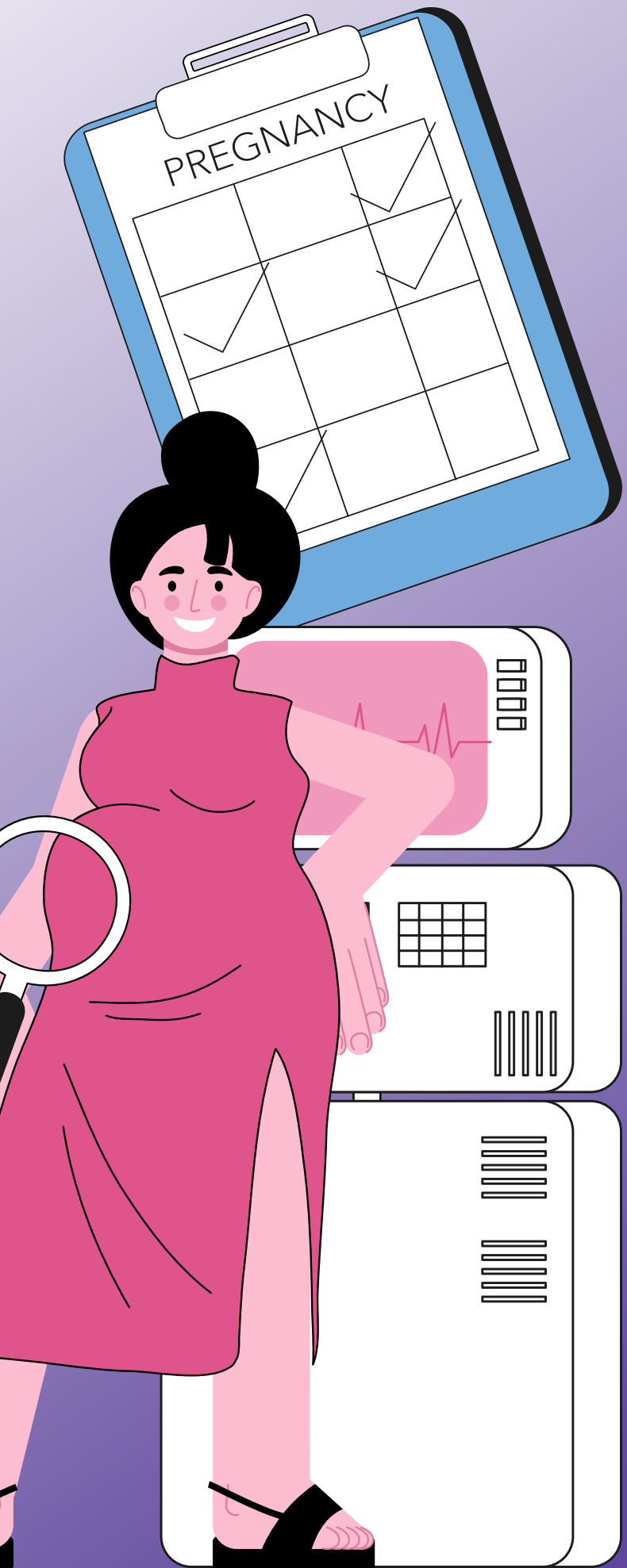
If you would like to refer a high-risk obstetrical Community First Member to Option Care, make a referral:

- Online at OptionCareHealth.com/Healthcare-Providers/Refer-a-Patient
- By fax at 877-865-9133
- By email at OC-WH@optioncare.com using the online referral form
- By phone at 888-304-1800

Call Community First Population Health Management at 210-358-6050 to learn more.







Pharmacy BENEFITS:
NAVITUS HEALTH SOLUTIONS

Below, you will find important information about Community First Member pharmacy benefits managed by Navitus Health Solutions, including how to find the most recent Preferred Drug List. Please review carefully.

Community First Health Plans offers Members prescription drug benefits through our pharmacy benefits partner, Navitus Health Solutions. Take the following steps to log in to the Navitus Provider Portal.

1. Visit **Prescribers.Navitus.com**
2. Click "Sign In" located on the upper right hand corner of your screen.
3. Enter your NPI number and state.

Once logged in, Providers can access the following information:

> List of covered drugs, also called a formulary, and other information including drug tiers and quantity limits.

> Updates to the formulary.

> Prior authorization forms and clinical criteria used for certain medications.

> Information on how to request a formulary exception.

> List of network pharmacies and specialty pharmacies.

The Texas Vendor Drug Program publishes a Preferred Drug List (PDL) for Medicaid Members every January and July. This list contains preferred covered medications and requirements for using non-preferred medications.

For the most up-to-date version of the Medicaid PDL, please visit **Medicaid Pharmacy Prior Authorization and PDL**.

To obtain a paper copy, please contact Member Services at **210-227-2347**.

Utilization Management: The Process Behind the Decision

Community First Health Plans utilizes evidence-based criteria and clinical guidelines to make Utilization Management (UM) decisions. The criteria are applied in a fair, impartial, and consistent manner that serves the best interest of our Members.

Community First approves or denies services based on whether the service is medically needed and a covered benefit. Criteria used to make a determination are available upon request.

Service Review

A service review for authorization will occur before a Member receives care. All requests are reviewed by our experienced clinical staff. Service requests that fall outside of standard criteria and guidelines are reviewed by our physician staff for plan coverage and medical necessity.

If care is received that was not authorized in advance (for emergency services), a service review will occur before the claim is processed. Please note that a service review that happens after (emergency) services are received does not guarantee payment of claims.

Generally, your office staff will request prior authorization from Community First before providing care. You have a responsibility to make sure you are following Community First rules for providing care.

Out-of-Network Care

Requests for out-of-network services involve an evaluation of whether the necessary and covered services can be provided on time by a network Provider. Community First does not cover out-of-network care without prior approval.

Hospital Care

Community First also reviews care our Members receive while in the hospital. We assist hospital staff in making sure our Members have a smooth transition home or to their next care setting.

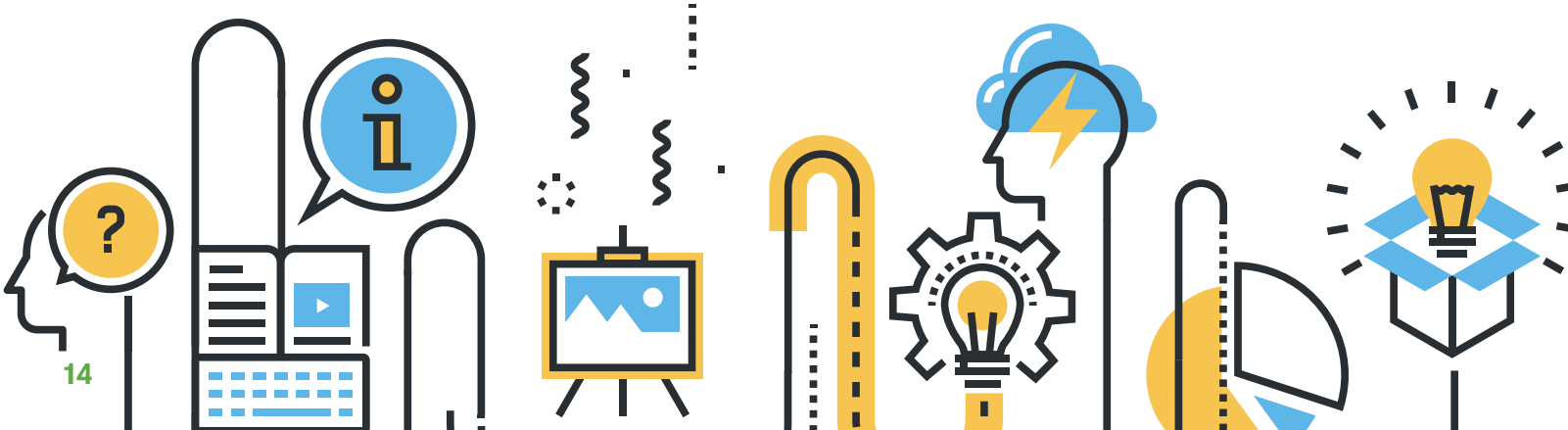
Appeals

The Member, the Member's representative, or a physician acting on behalf of the Member may appeal a decision denying a request for services. Members can file an appeal through the Community First appeals process.

More Information

To obtain more information about UM criteria used to make decisions about your patient's health care, contact Population Health Management. Call **210-358-6050** and press "3" for authorizations, Monday through Friday from 8 a.m. to 5 p.m.

Our UM staff is also available to assist you with any questions you may have regarding processing a request for services. Calls or communications received after hours will be addressed by the next business day. Should our staff attempt to reach you, they will provide you with their full name and title at Community First Health Plans.



A Prescription for Wellness

Community First Health Plans has a family of dedicated programs designed to help our Members improve their health, control a chronic condition, and experience a healthy pregnancy. Members can also earn rewards and incentives for participating. Please call 210-358-6055 or email healthyhelp@cfhp.com for patient referrals.

Asthma Matters

Asthma Management Program

> Education about the causes/triggers of asthma
> Tips to achieve normal or near-normal lung function
> Advice on how to participate in physical activity without symptoms
> Ways to decrease the frequency and severity of flare-ups

Qualifying Members may also receive a hypoallergenic pillowcase and gift cards for health-related items.*

Diabetes in Control

Diabetes Management Program

> Diabetes education classes
> Information on how to control blood sugar
> Blood sugar testing and supplies
> Referral to YMCA Diabetes Prevention Program, including a complimentary four-month YMCA membership*

Qualifying Members may also receive up to $50 in gift cards for health-related items.*

Healthy Expectations Maternity Program

> One-on-one contact with a Health Educator
> Prenatal and postpartum education
> Home visits for high-risk pregnancies
> Mommy & Me baby shower

Qualifying Members may also receive gift cards for completing prenatal services, reimbursement for birthing classes or toward a pregnancy item, and more.*

Healthy Mind

Behavioral Health Program

> Help determining the type of behavioral health assistance needed
> Information to help choose the right professional counselor or doctor
> Care Management for high-risk Members

Healthy Heart

Blood Pressure Management

> Information about how to manage your blood pressure
> Referral to YMCA Blood Pressure Program, including a complimentary four-month YMCA membership*
> Healthy lifestyle tips
> Medication management

Healthy Living

Healthy Lifestyle Management

> Information about weight management, healthy eating, and exercise
> Assistance for Members with severe health concerns
> Community resource referrals
> Referral to YMCA Weight Loss Program: 16 Weeks to Wellness, including a complimentary four-month YMCA membership*

Referring Providers and/or patients can learn more at CommunityFirstHealthPlans.com/Health-and-Wellness-Programs.

**Eligibility requirements may apply.*

End of Continuous Medicaid Coverage What Providers Need To Know

After three years, the End of Continuous Medicaid Coverage is here. Millions of Texans – mostly children and new moms – are at risk of losing their Medicaid/ CHIP coverage beginning this summer.

Working to keep patients covered.

Continuous Medicaid covered ended March 31, 2023. Your patients' Medicaid coverage may be impacted.

Medicaid clients should ensure their information with the Health and Human Services Commission (HHSC) is accurate, so they get important updates about their coverage. HHSC will tell all Medicaid clients when it is time for them to renew their Medicaid coverage. They must respond to any renewals or information requests from HHSC.

How You Can Help Your Patients

Tell your patients to:

> Look for a notice in the mail labeled "Action Required" in a yellow envelope from HHSC and respond quickly when they get it.

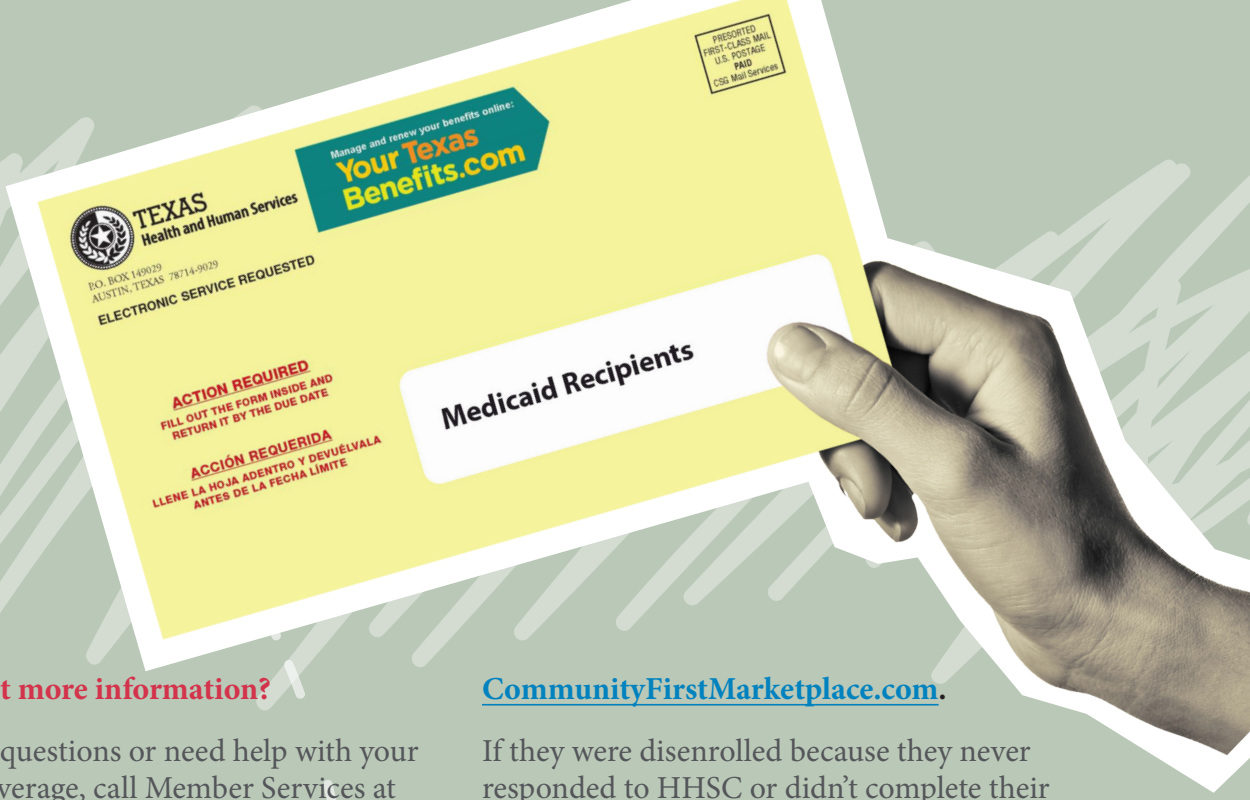
> Update their information as soon as possible, especially if their contact information has changed. They can do this by logging into their account at YourTexasBenefits.com or through the Your Texas Benefits mobile app.

> If they don't have an account, they can create one on the website or mobile app. Or they can call 2-1-1 and choose option 2 to update their information.

Questions You Might Get Asked

Q: Why is this important? What happens if I don't take any action?

A: You might lose your Medicaid coverage. That's why it's important for you to update your information with HHSC and respond quickly to any notices you get from them.



Q: Where can I get more information?

A: If you have any questions or need help with your Texas Medicaid coverage, call Member Services at the number on the back of your health plan member ID card. You can also call HHSC at 2-1-1 and choose option 2 (or call 1-877-541-7905).

Q: What happens if I don't get a notice from HHSC?

A: If you've recently moved, HHSC may not have your most up-to-date contact information. They may have sent it to an old address. If you're worried you might not have gotten any notices from HHSC because they don't have your current address or that there's been a mistake, call 2-1-1 and choose option 2.

Questions You Might Have

Q: How do I verify my patient's Medicaid coverage?

A: You can verify client eligibility for Medicaid through the Texas Medicaid & Healthcare Partnership's (TMHP) TexMedConnect portal. You can also call 2-1-1. Press option 2 after the language prompt, and then option 2 again. Be prepared to provide your National Provider Identifier (NPI).

Q: If my patient is uninsured, where can they go for coverage?

A: If your patient was found ineligible for Medicaid, their case has been automatically sent to the **Health Insurance Exchange®** to be considered for coverage options. Community First Health Plans offers plans on the Exchange. Patients can learn more at **CommunityFirstMarketplace.com**.

If they were disenrolled because they never responded to HHSC or didn't complete their renewal application, they should call 2-1-1, go to **YourTexasBenefits.com**, and submit their renewal for benefits right away.

Resources & Assistance

Community First can help patients renew their Medicaid/CHIP coverage, or if they no longer qualify, our staff can help them apply for University Community Care Plan through the Health Insurance Exchange®

Patient Resources:

> **RenewMyTexasBenefits.com**
Step-by-step renewal guides, brochures, videos, sample HHSC documents, and an online form to request help.

> **Avenida Guadalupe Community Office**
Computer lab and bilingual, in-person assistance with Medicaid/CHIP applications and renewals.

Provider Resources:

> **Provider Collateral**
Professionally printed HHSC-approved materials designed to be displayed/distributed in Provider office settings to help education patients about Medicaid renewals.

Source: https://www.hhs.texas.gov/sites/default/files/documents/provider-info-sheet.pdf

COMMUNITY FIRST
HEALTH PLANS

NON-EMERGENCY MEDICAL TRANSPORTATION

Community First Providers can help STAR, STAR Kids & Medicare Advantage/D-SNP Members schedule NO COST non-emergency medical transportation (NEMT) through our transportation partner, Medical Transportation Management (MTM).

Do you have a patient in need of transportation?

Providers can help schedule both routine and life-sustaining appointments for patients through MTM. Here's how:

1. CALL MTM DIRECTLY

1-888-444-0307 (TTY 7-1-1)

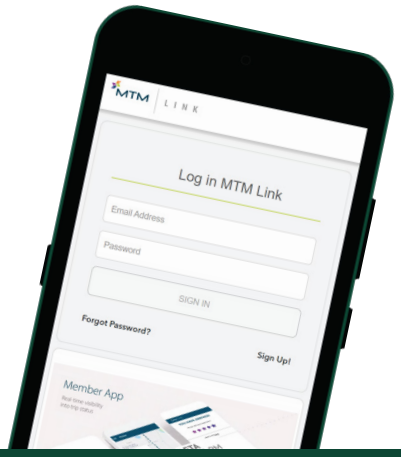
Monday through Friday, from 8:00 a.m. to 5:00 p.m.
Call at least 48 hours before the scheduled appointment.

2. BOOK ONLINE

Providers can also book and manage a ride online at **mtm-inc.net/healthcare-providers/**

MTM

To assist a Member after hours, please call **1-888-444-0824.**



NEMT services include:

- Passes or tickets for travel by train, bus, or air
- Curb-to-curb transportation
- Mileage reimbursement
- Travel expenses (for Members under age 20)
- Travel expenses for attendants

When you call MTM, please be ready to provide:

- Member's Medicaid or Medicare ID number
- Name, address, and phone number of the health care setting they will be traveling to
- The medical reason for the Member's visit

Health care providers can email CO@mtm-inc.net for more information and assistance.

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LTSS: Who Qualifies & What's New

What is LTSS?

LTSS stands for Long Term Services and Supports. LTSS encompasses services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

Who Qualifies for LTSS?

Community First STAR Kids Members ages 0-20 who either:

- receive SSI,
- receive disability-related Medicaid services, and/or
- are enrolled in the Medically Dependent Children Program (MDCP).

Waiver Programs

Children or youth currently enrolled in an Individual Developmental Disabilities/Individuals with Intellectual Disabilities (IDD/IID) waiver such as CLASS, DBMD, HCS, or TXHmL will be required to enroll in a STAR Kids health plan in their area in order to receive acute care services through their STAR Kids health plan. All LTSS services are provided through their waiver program.

What is EVV?

EVV stands for Electronic Visit Verification. EVV is a computer-based system that verifies the occurrence, type, and location of certain authorized Medicaid service vists by electronically documenting the precise time a visit begins and ends.

It is a state and federal requirement that an EVV system must be used when providing the following Medicaid services:

- Effective January 1, 2021, EVV is required for Medicaid personal care services.
- Effective January 1, 2024, EVV is required for Medicaid home health care services.

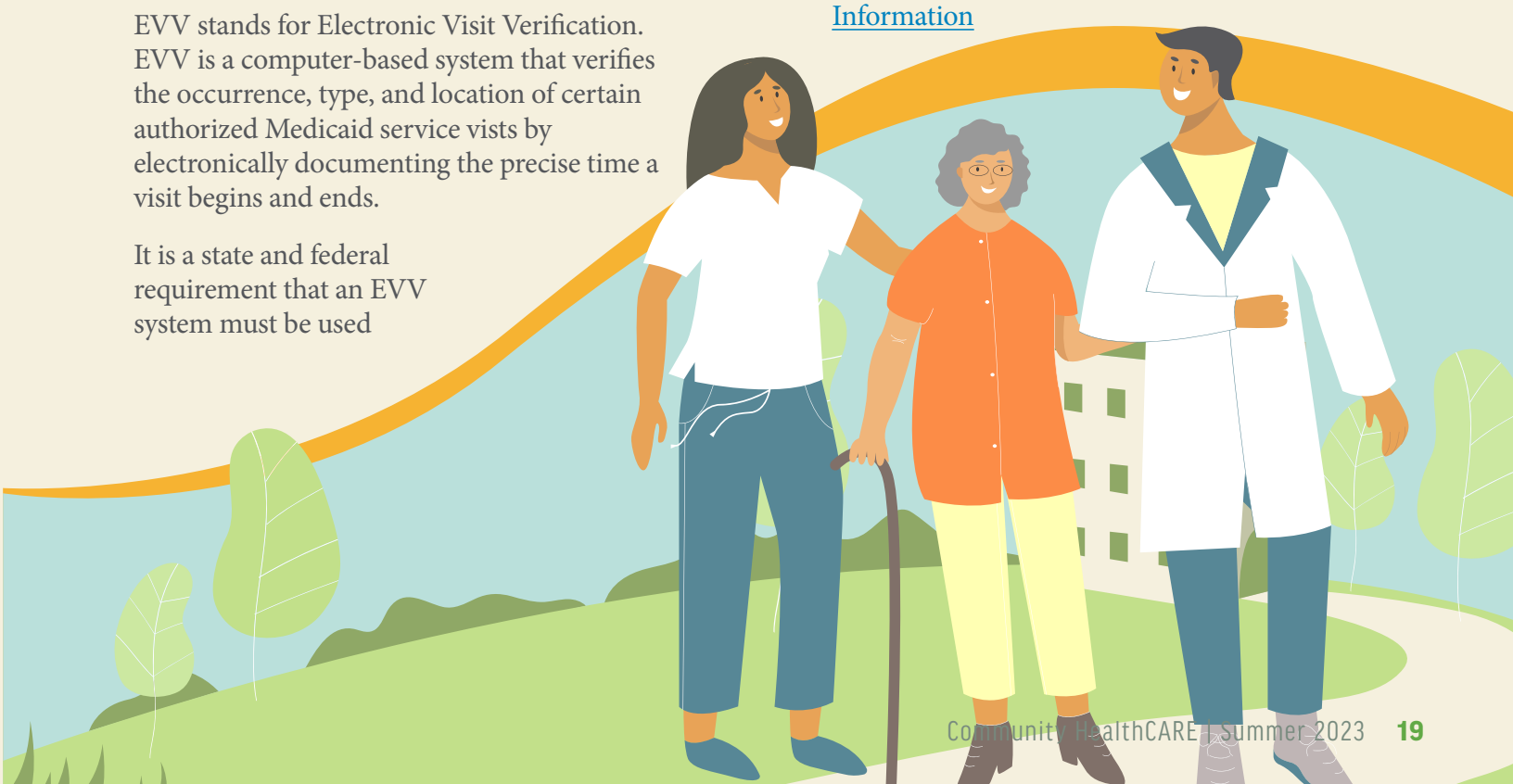
Review a full list of affected services at Programs, Services and Service Delivery Options Required to Use EVV

What's New?

- When a program provider or FMSA fails to meet and maintain the minimum EVV Usage Score of 80% in a state fiscal year quarter, the payer may send a notice of non-compliance to enforce progressive enforcement actions based on the number of occurrences within a 24-month period
- Effective October 1, 2023, users of the current EVV vendor systems (DataLogic/Vesta or First Data/AuthentiCare) must transition to HHAeXchange or receive approval as an EVV Proprietary System Operator (PSO)

More Information

- EVV Contract Awarded to Accenture and HHAeXchange
- EVV Vendor Transition Overview
- Programs, Services and Service Delivery Options Required to Use EVV
- Community First EVV Resources & Contact Information



Providers Required to Update Their Practice Addresses in PEMS

Effective June 13, 2023, Texas Medicaid & Healthcare Partnership (TMHP) requires Providers to review and update their practice addresses in PEMS.

Collaborative testing between Texas Health and Human Services Commission (HHSC) and Managed Care Organizations (MCOs) has identified Provider address differences between the MCOs and the Master Provider File (MPF) extracted from Provider Enrollment and Management System (PEMS).

If the Provider performs services at locations other than those listed in PEMS, the Provider must take action to add those addresses to their enrollment record.

> For nonperforming Providers with practice locations that require an address correction, submit a **Maintenance - Practice Location – Address Change** request. For practice locations that are currently not enrolled, submit an **Existing Enrollment request**.

> For performing Providers with practice locations that are currently not enrolled, submit either a **Maintenance - Add/Modify Performing Provider request** or an **Existing Enrollment request.**

Providers are strongly encouraged to follow the PEMS guidance provided in forthcoming communications. Meeting the address synchronization between MCOs and PEMS will proportionately reduce claim denials for Providers and improve the accuracy of encounter reporting and network adequacy to MCOs.

NON-COMPLIANCE

Important: Providers that neglect to update their address information within the specified period as required by TMHP will experience the following:

> Payment denial code will be applied by PEMS if the Provider is not actively enrolled in PEMS

> Community First will reject the claim for those Providers not actively enrolled in PEMS

RESOURCES

> Providers Required to Update Their Practice Addresses in PEMS

> How to update the Provider address in PEMS (YouTube)

> PEMS Instructional Site

> TMHP Contact Center: 800-925-9126 (Select option 3 for questions about address updates)

PRIVATE DUTY NURSING PRIOR AUTHORIZATION

UPDATED DOCUMENTATION REQUIREMENTS

Please review the prior authorization process for Private Duty Nursing (PDN) services, along with the specific documentation requirements for requested services. Please note that Community First is responsible for authorizing all PDN services.

The following requirements must be met to obtain PDN services:

- The documentation submitted with the request must be consistent and complete.
- The requested services must be for nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.
- Medical Necessity for requested services must be clearly documented, including specifics of client's condition and caregiving needs.
- The amount and duration of PDN must always be commensurate with the client's medical needs.
- Requests for services must reflect changes in the client's condition that affect the amount and duration of PDN.
- The explanation of the Member's current medical needs must be sufficient to support a determination by Community First's Medical Director/Physician Reviewer that the requested services correct or ameliorate the Member's disability, physical or mental illness, or chronic condition.
- The Member's nursing needs cannot be met on an intermittent or part-time basis through Texas Medicaid (Title XIX) home health services skilled nursing services.
- The **CCP Prior Authorization Request Form (F00012)** must identify the delineated scope and duration of PDN services being requested to include:
  - HCPC code (T1000),
  - UA (specialized services), and
  - U6 (MDCP) modifier, as appropriate.

Please review the **PDN Prior Authorization Documentation Requirements** Provider Notice for more information, including a list of required clinical documentation, prior authorization instructions, authorization extensions, documentation needed to request an increase in units, instructions in the event of a Provider change, and more.

For additional guidance, refer to the **TMHP PDN Authorization Request Packet**. Please note that this packet is for reference only. All required forms and documentation must be returned to Community First.

Thank you for your attention to this matter.

THSteps
Vision Screenings

As stated in the Texas Medicaid Provider Procedures Manual: Children's Services Handbook, Section 4.3.12.2.4, a vision screening is required at each THSteps medical checkup.

> Visual acuity tests are required at specific ages defined in the THSteps Periodicity Schedule

> Subjective screenings through Provider observation or informant report are required at other checkups.

Additionally, all patients must undergo screening for any eye abnormalities using a combination of history, observation, and physical exams. If identified as high risk, the patient must be referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population. Patients with abnormal visual acuity screening results should also be referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population.

The following vision screening CPT codes are part of THSteps checkups and cannot be reimbursed individually.

> 99177 OCULAR INSTRUMNT SCREEN BIL

> 99174 OCULAR INSTRUMNT SCREEN BIL

> 99173 VISUAL ACUITY SCREEN

> 92553 AUDIOMETRY AIR & BONE

Vision screening for patients who are birth through 20 years of age can be conducted at any primary care provider's office visit, as stated in Section 4.3.3.1, outside of a THSteps Preventive Care Medical Checkup, provided that the following criteria are met:

> Request from a parent

> Referral from a school vision screening program

> Referral from a school nurse

THSteps Hearing Screenings

As stated in the Texas Medicaid Provider Procedures Manual: Children's Services Handbook, Section 4.3.12.2.4, a hearing screening is a mandatory requirement at every Texas Health Steps (THSteps) checkup for patients between birth and 20 years old.

> After passing their newborn hearing screening, infants' hearing should be monitored in accordance with the THSteps Periodicity Schedule

> Audiometric screenings should be conducted at the ages specified on the THSteps Periodicity Schedule

> Subjective screenings through Provider observation or informant report are required at other checkups.

THSteps checkups incorporate the following CPT codes for Audiometric screenings, which are not reimbursed separately:

> 92551 – Screening test, pure tone, air only

> 92552 – Pure tone audiometry (threshold) air only

> 92553 – Pure tone audiometry (threshold) air and bone

If deemed medically necessary, hearing screens conducted outside of newborn and THSteps medical checkups may be eligible for reimbursement without prior authorization using CPT code 92551.

THSteps Acute Visits

As stated in the Texas Medicaid Provider Procedures Manual: Children's Services Handbook, Section 4.4.1, an acute visit is defined as the discovery of an acute or chronic condition that requires evaluation and management (E/M) beyond the required components for a THSteps medical checkup.

An acute visit is NOT an insignificant or trivial problem or abnormality that is discovered in the process of performing a checkup and does not require the additional work and performance of the key components of a problem-oriented E/M service.

If an acute or chronic condition that requires E/M beyond the required components for THSteps medical checkup is discovered, a separate E/M procedure code may be considered for reimbursement for the same date of service as a checkup, or the client can be referred for further diagnosis and treatment.

Modifier 25

Modifier 25 is used to indicate that a patient's condition required a significant, separately identifiable E/M service by the same physician or other qualified health care professional (QHP) on the same day of the procedure or other service.

> Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a THSteps checkup.

> The medical record documentation for the separate EM services must stand on its own for the EM code (acute visit) billed.

> Referencing the chart or portions of the THSteps checkup for any of the key elements (i.e., history, exam, medical decision-making) will not support a separate acute visit billed.

Billing Criteria

1. Appropriate level E/M code (99202-99205) (99212-99215) billed with Modifier 25
2. Documentation that supports medical necessity and the key elements of a separate E/M visit including:
   - Distinct medical history and/or separate examination
   - Medical decision-making
3. Diagnosis related to the acute visit and treatment
4. Separate claim without benefit code EP1

Documentation

> Avoid referencing the THSteps checkup or history for the acute visit.

> Identify and document "new" or "acute" problems separately.

> Document separately treatment or management of "chronic" condition(s) that are "beyond" the THSteps service.

> Document separately the "additional work" performed to support the "acute" visit, apart from the THSteps visit.

CPT Codes for Acute Visits

As of 2021, Evaluation and Management Services (EM) codes are determined by:

> Total time for visit performed on date of encounter, or

> Medical Decision Making (MDM)

The level of history or physical examination does not determine the level of CPT code.

For more information, visit CMS National Correct Coding Initiative Edit (NCCI edits)

PROVIDER COMPLIANCE
TEXAS HEALTH STEPS

PROVIDING MEMBER-CENTRIC CARE

Community First Health Plans uses a Member-Centric Population Health Management (PHM) strategy that allows us to focus on care that addresses each Members' preferences, needs, and values. The framework of this strategy identifies the needs of our community, stratifies these needs for intervention, and focuses on the transition to value-based care in our contracted network.

The tools in our PHM strategy include the following:

Health Assessments. Health Assessments collect important information about Members, including their health literacy, risks and health behaviors, demographics, values, and special needs. Health Assessments also help us connect with our Members at all stages of life (i.e., early childhood, adolescence, adulthood, and old age), and better understand how they approach conditions and want to receive information.

Risk Stratification. Risk Stratification arranges Members into meaningful categories for personalized intervention targeting. This includes everyone in our Member population, from low-risk to high-risk. Most health care costs are incurred by a minority of the population so it is important to strategize as to where to target investments that can yield the highest return, both in improved health outcomes and cost reductions.

Enrollment and Engagement. Enrollment and engagement include coordination of care across all settings for every Member. Engaging Members in their health care helps them to appropriately access care and services. Enrollment and engagement include self-determined participation in intervention-directed activities that are in alignment with the Members' goals.

Person-Centered Interventions. Person-centered clinical and wellness interventions include a broad range of approaches and activities tailored to improve the health and well-being of an individual. These interventions can direct resources toward the areas of greatest population risk and opportunities for health improvement. This includes disease management, medication adherence, lifestyle management, and ongoing behavioral health coaching and education.

Providers play a key role in our overall strategy, including promoting healthy habits and increasing Member engagement in our Health & Wellness Programs. Our current Health & Wellness Programs include:

- **ASTHMA MATTERS**
  Asthma Management Program
- **DIABETES IN CONTROL**
  Diabetes Management Program
- **HEALTHY MIND**
  Behavioral Health Program
- **HEALTHY LIVING**
  Healthy Lifestyle Program
- **HEALTHY EXPECTATIONS MATERNITY PROGRAM**
- **HEALTHY HEART**
  Blood Pressure Management Program

To read more about these program, please turn to page 15.

COMMUNITY FIRST
HEALTH PLANS

Non-Discrimination Notice

Community First Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Community First Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Community First Health Plans provides free auxiliary aids and services to people with disabilities to communicate effectively with our organization, such as:

Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, and other written formats)

Community First Health Plans also provides free language services to people whose primary language is not English, such as:

Qualified interpreters
Information written in other languages

If you need these auxiliary services, please contact Community First Member Services at 1-800-434-2347. TTY (for hearing impaired) at 210-358-6080 or toll free 1-800-390-1175.

If you wish to file a complaint regarding claims, eligibility, or authorization, please contact Community First Member Services at 1-800-434-2347.

If you feel that Community First Health Plans failed to provide free language services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can contact the Chief Compliance & Quality Officer by phone, fax, or email at:

Susan Lomba
Chief Compliance & Quality Officer
Phone: 210-510-2463, TTY number: 1-800-390-1175
Fax: 210-358-6014
Email: slomba@cfhp.com

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

You may also file a complaint by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, TDD number: 1-800-537-7697

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html

Aviso de no discriminación

Community First Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual. Community First Health Plans no excluye o trata de manera diferente a las personas debido a raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual.

Community First Health Plans proporciona asistencia y servicios gratuitos a personas con discapacidades para comunicarse efectivamente con nuestra organización, como:

Intérpretes calificados de lenguaje de señas
Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)

Community First Health Plans también ofrece servicios gratuitos lingüísticos a personas cuyo idioma principal no es el inglés, como:

Intérpretes calificados
Información escrita en otros idiomas

Si necesita recibir estos servicios auxiliares, comuníquese al Departamento de Servicios para Miembros de Community First al 1-800-434-2347. TTY (para personas con problemas auditivos) al 210-358-6080 o al número gratuito 1-800-390-1175.

Si desea presentar una queja sobre reclamos, elegibilidad, o autorización, comuníquese al Departamento de Servicios para Miembros de Community First al 1-800-434-2347.

Si cree que Community First Health Plans no proporcionó servicios lingüísticos gratuitos o fue discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual, puede comunicarse con la directora del calidad y cumplimiento por teléfono, fax, o correo electrónico al:

Susan Lomba
Directora de calidad y cumplimiento
Teléfono: 210-510-2463, línea de TTY gratuita: 1-800-390-1175
Fax: 210-358-6014
Correo electrónico: slomba@cfhp.com

También puede presentar un queja de derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos de manera electrónica a través del portal de quejas de derechos civiles, disponible en:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

También puede presentar una queja por correo o por teléfono al:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
Teléfono: 1-800-368-1019, línea de TDD gratuita: 1-800-537-7697

Los formularios de queja están disponibles en:
http://www.hhs.gov/ocr/office/file/index.html.

COMMUNITY FIRST
HEALTH PLANS

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-434-2347 (TTY: 1-800-390-1175).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-434-2347 (TTY: 1-800-390-1175).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務. 請致電 1-800-434-2347 (TTY:1-800-434-2347)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-434-2347 (TTY: 1-800-390-1175)번으로 전화해 주십시오.

ق م ب ر ات ص ل باﻟ مجان . ل ك ف ت وت ى ة الﻟ وغ عدة الﻟ م اس خدمات ف إن الﻟ رق م 1-800-434-2347
ل غة،اذا ك ر ت تحدث ك نت إذا م لحوظة : 1-800-390-1175 :واﻟ الﻟ مص هاتﻟ

ک الﻟ ـ ہ ی ں د س ت ای ب م ی ں م فت خدمات ک ی ددم ک ی زب ان ک و آپ ت و ہ ی ں،ل تے ب و دو ارا آپ
اگ ر دار : خ بر 1-800-434-2347 (TTY: 1-800-390-1175).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-434-2347 (TTY: 1-800-390-1175).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-434-2347 (ATS: 1-800-390-1175).

ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-434-2347 (TTY: 1-800-390-1175) पर कॉल कर।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما تماس بگیرید. 1-800-434-2347 (TTY: 1-800-390-1175) فراهم می باشد. با

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-434-2347 (TTY: 1-800-390-1175).

ध्यान दें: यदि आप हदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-434-2347 (TTY: 1-800-390-1175) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-434-2347 (телетайп: 1-800-390-1175).

注意事項：日本語を話される場合，無料の言語支援をご利用いただけます. 1-800-434-2347 (TTY:1-800-390-1175)まで、お電話にてご連絡ください.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສຽ ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-434-2347 (TTY: 1-800-390-1175).

27 YEARS

3 MILLION

lives impacted

COMMUNITY FIRST
HEALTH PLANS

PROUD TO BE LOCAL
PROUD TO BE YOUR PLAN.

FACEBOOK **@COMMUNITYFIRSTHEALTHPLANS** • TWITTER **@CFHEALTHPLANS** • INSTAGRAM **@CFHEALTHPLANS**