Provider Newsletter | Summer 2024

COMMUNITY HEALTHCARE

COMMUNITY FIRST PROVIDER PORTAL: TOOLS & FEATURES

HOW OUR PORTAL STREAMLINES CLAIMS MANAGEMENT & MORE

NEW HEALTH EQUITY RESOURCES FOR PROVIDERS

JOIN OUR STAR+PLUS NETWORK, EFFECTIVE SEPTEMBER 1, 2024

GUIDANCE FOR FUM, EED, & HBD HEDIS® MEASURES

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:
CommunityFirstHealthPlans.com
210-227-2347 or toll-free 1-800-434-2347

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COMMUNITY FIRST HEALTH PLANS COMMUNITY FIRST INSURANCE PLANS

Utilization Management: The Process Behind the Decision

Community First 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.

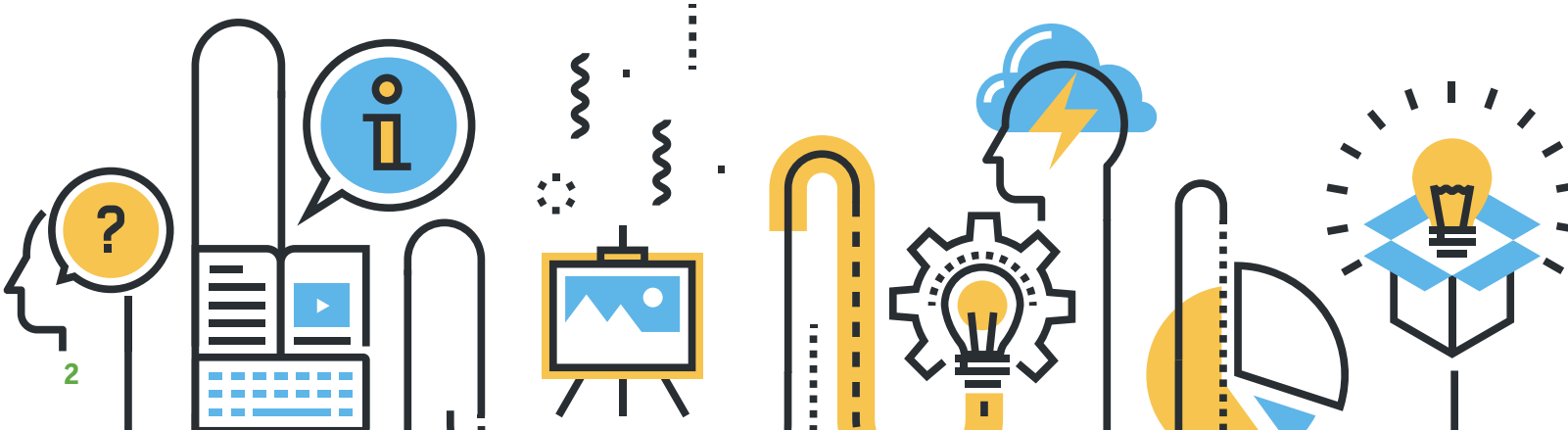
Appeals

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.



PROVIDING MEMBER-CENTRIC CARE

Community First 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 prefer 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

CASE MANAGEMENT:
HOW WE CAN HELP YOUR PATIENTS

What is Case Management?
Case Management is a key component of Community First's Population Health Management (PHM) strategy. The Case Management Program provides comprehensive, personalized Case Management services and goal setting for Members who have complex medical needs and require a wide variety of resources to manage their health and improve their quality of life.

Community First embraces a holistic approach to managing quality of life by treating every Member as a whole. Within this holistic approach, our interdisciplinary team relies on experienced professionals from diverse backgrounds including social work, nursing, mental health, home care, and home health.

What is a Case Manager?
Case Managers serve as the primary point of contact and collaborate with the Member, their family members, and all relevant service providers to help the Member understand their condition and how to best take care of themselves. Our Case Managers are trained Registered Nurses or social workers.

Our Case Management teams also provide the Member with resources that can help them get the best care possible utilizing the right Providers, in the right setting, and in the right time frame.

What services does Case Management include?
Case Management services include the following:

- Complex Case Management.
- Systematic assessment of the patient's medical, functional, and psychosocial needs.
- System-based approaches to ensure timely receipt of all recommended preventive care services.
- Medication reconciliation with review of adherence and potential interactions.
- Oversight of patient self-management of medications.
- Coordination of care with home and community-based clinical service providers.

Case Coordination and Service Management:
Case Coordination and Service Management are essential, ongoing sub-components of Community First's Case Management Program. In these sub-components, Providers working with a particular Member share important clinical information and have clear, shared expectations about their roles. Equally important, they work together to keep Members and their families informed and to ensure that effective referrals and transitions take place.

What services does Case Coordination and Service Management include?

- Oversight of transitions between and among health care providers and settings.
- Referrals to other clinicians.
- Follow-up after an emergency department visit or facility discharge.
- Community First's Case Management team is committed to working with our Members, their family, doctors, and other members of their health care team to improve the Member's overall health and to obtain the services they need.

Case Management Referral
If you would like to refer a Member who could benefit from Case Management, please complete the Case Management referral form.

Visit CommunityFirstHealthPlans.com/Providers.

1. Click on the health plan you service.
2. Select "Provider Resources" under the Provider dropdown menu.
3. Select Provider Forms.
4. Complete and email the form to chelp@cfhp.com.

A Case Manager will then contact the Member to discuss their individual health care needs.

If you would like to learn more about our Case Management Services, please call Community First Population Health Management at **210-358-6050**.

Mobile, Specialized Care for Young Women's Wellness

Betty's co.

A NEW, COVERED SERVICE FOR COMMUNITY FIRST MEMBERS

Community First has partnered with Betty's Co. to bridge the gap in young, female patient care.

Betty's Co. provides gynecology + mental health + wellness care from advanced women's health practitioners in boutique mobile clinics stationed across the Greater San Antonio area. Together, we can improve the health care journey for adolescents, ensuring they receive the attention and support they deserve at every stage of their development.

learn more

bettysco.com

Patient Referrals

- Betty's Co. specializes in bringing inclusive women's health care services to women+ ages 13 to 45 in underserved areas.
- Call **210-572-4931** or scan the QR code to refer a patient.

UPDATED ASTHMA ACTION PLAN NOW AVAILABLE:

GUIDANCE FOR HEALTH CARE PROVIDERS

Managing asthma in children requires collaboration between health care providers, parents, and caregivers.
ALL children with asthma should have an Asthma Action Plan filled out by their healthcare provider.

The South Texas Asthma Coalition has released a new, updated Asthma Action Plan for 2024.

The South Texas Asthma Coalition (STAC) has released a new Asthma Action Plan as a fillable form (PDF) designed to be completed electronically. The electronic template allows Providers to complete the plan using pull-down selections and clicking the appropriate boxes. If Providers need to select a medication/dose/instruction that is not listed on the pull-down menu, they can type in their selection.

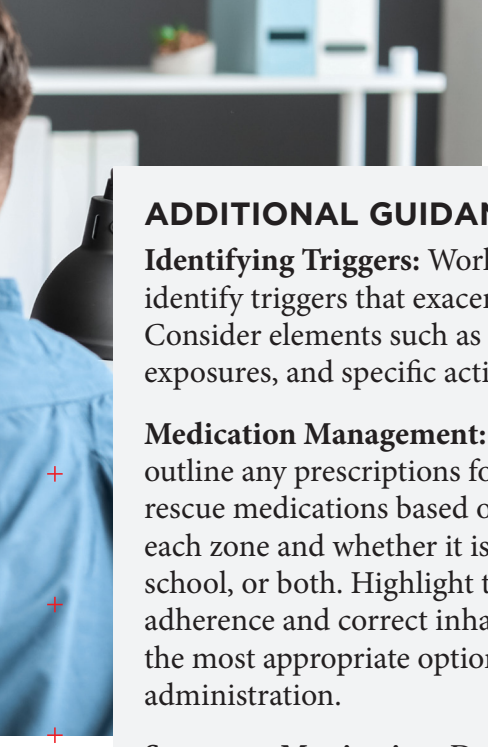
INSTRUCTIONS

Download the updated STAC Asthma Action Plan and follow these general recommendations:

- If typing instructions instead of selecting a dropdown option, use plain language (e.g. "Four times a day".)
- Assure the copy is signed by the primary care provider (PCP).
- Give at least TWO copies to the patient's family (for home and school) and keep one copy for the patient's medical record.
- Select whether the patient is allowed to self-administer their inhaler. If a selection is not made, the Provider will be unable to sign the form electronically.

Providers should complete medications prescribed for each zone (GREEN, YELLOW, RED)

- Provider must specify the name of the medication, dosage, when to take it, and check the box for where it can be taken (home/school).
- GREEN Zone: Preventative medication(s)
- YELLOW Zone: Quick-relief medication(s)
- RED Zone: Emergency medication(s)



ADDITIONAL GUIDANCE

Identifying Triggers: Work with the family to identify triggers that exacerbate the child's asthma. Consider elements such as allergens, environmental exposures, and specific activities.

Medication Management: Choose and clearly outline any prescriptions for daily controller and rescue medications based on severity/control for each zone and whether it is to be given at home, school, or both. Highlight the importance of adherence and correct inhaler technique. Select the most appropriate option for medication self-administration.

Symptom Monitoring: Determine guidelines for monitoring asthma symptoms. Review Asthma Action Plan zones (GREEN, YELLOW, and RED) with parents and child to educate them on symptoms and when to administer medication appropriately. Promote open communication with parents to address any developing issues quickly.

Emergency Response: Develop a detailed emergency response plan (RED zone) detailing steps for escalating care during severe asthma exacerbations. Ensure parents are well equipped to handle emergencies and know when immediate medical attention is required.

Communication and Education: Provide parents with education on asthma management, covering symptom recognition, proper medication administration and the importance of adherence. Advise parents to share the Asthma Action Plan with everyone involved in the child's care; the child's primary caretaker, daycare provider, school nurse, coach, after-school coordinator, and anyone else in charge of their child's care, emphasizing the importance of a coordinated approach.

Community First offers Members Health & Wellness Programs, including Asthma Matters: Asthma Management Program. If you feel a patient could use more support with asthma education and case management, please refer them, and a Health Educator will contact them. You can refer a Member by calling Population Health Management at 210-358-6055 or emailing healthyhelp@cfhp.com. Asthma Matters participants may be eligible to receive*:

- $80 in gift cards for completing San Antonio Kids BREATHE home visits
- $10 gift card for getting a flu shot
- Mask with aerosol chamber
- Allergy-free pillow protector
- $10 gift card for completing required asthma education

ROUTINE REVIEWS & UPDATES

Schedule regular follow-up appointments to evaluate the child's Asthma Action Plan. Adjust the plan as necessary based on the child's response to treatment and any changes in triggers or symptoms.

A cooperative approach involving Providers, parents, and the child is indispensable for effective asthma management. By implementing an individualized Asthma Action Plan, Providers significantly contribute to the well-being of children with asthma, fostering a healthier future.

PROVIDER RESOURCES

Questions about the STAC Asthma Action Plan should be directed to Mandie Tibball Svatek, MD at 210-450-5364 or svatekm@uthscsa.edu.

Providers can also refer to these specific instructions for completing the Asthma Action Plan.

If you'd like printed copies in English or Spanish for your office setting, please contact Community First Population Health Management at 210-358-6055 or email healthyhelp@cfhp.com.

HOW PROVIDERS CAN BETTER SERVE THE BLACK COMMUNITY

A CHALLENGING LANDSCAPE:

African Americans face unique health challenges due to a variety of factors, such as limited access to quality health care, socio-economic disparities, and unequal distribution of resources such as affordable housing, nutrition options, and education. The health disparities African Americans face contribute to an increased risk of several health conditions such as obesity, heart disease, high blood pressure, Type 2 diabetes, and colorectal cancer. It is important to acknowledge and respect the experiences of this community and work towards creating a more equitable and inclusive health care system for all.

Resources:
Community First aims to provide fair and equal access to care for our Members in, to be leaders in recognizing and eliminating social barriers, and to champion diversity within the Community First workplace that reflects the populations we serve. Please log in to the Community First Provider Portal to view Health Equity resources, including a Non-Medical Drivers of Health (NMDOH) Guide to assist providers with community-based referrals.

THE ROLE OF HEALTH CARE PROVIDERS:

To improve outcomes in the community, health care providers need to be culturally competent. A comprehensive understanding of the factors that contribute to poor health outcomes is essential to ensure equitable access, address disparities, and provide effective treatment to this demographic. It is important to:

- Foster a safe and respectful environment
- Treat patients with dignity
- Promote trust-building
- Ensure that patients feel valued, heard, and included in their care

Information should be communicated in plain language that is easy to understand. Providers should commit to addressing questions and identifying any concerns that patients may be hesitant to express. It is crucial to promote preventive care within the context of Black history and culture.

Important Update:

Transition to zelis Payments Network

Effective August 1, 2024, Community First will transition to Zelis, a company modernizing the business of health care. This comes as a result of Zelis' recent acquisition of Payspan. Payspan is Community First's current provider of health care electronic payment and reimbursement automation services. The combination of the two companies will bring together their capabilities in the new Zelis Advanced Payment Platform, Zelis said in a 2022 press release.

Action Required

As a result, you will need to take the following steps to enroll with Zelis to continue receiving electronic payments. You'll need your TIN/EIN, corporate name and principal info, RTN/ABA routing number, and bank account number to enroll.

Next Steps

1. **Visit CommunityFirst.epayment.center/register**
2. **Follow the instructions to obtain a registration code (a link will be sent to you)**
3. **Follow the link to complete your registration and set up your account**
4. **Log in to the portal and enter your bank account information to enroll**
5. **Review and accept the ACH Agreement and click "Submit"**
6. **Your bank account will be validated before electronic fund transfer (can take up to 6 business days)**

Assistance

For assistance, call 855-774-4392 or email help@epayment.center.

If you're already enrolled with Zelis, no further action is needed.

PROVIDER TIP SHEET

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (FUM) WITHIN 7 DAYS

Why is the FUM HEDIS® Measure important?

Evidence suggests that individuals who receive follow-up care within 7 days after a behavioral health-related Emergency Department (ED) visit have fewer repeat ED visits, improved physical and mental function, and increased compliance with their care plan. **Providers should encourage follow-up care after ED visits.**

What does the FUM Measure assess?

The FUM Measure assesses the percentage of emergency department (ED) visits for Members six years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within 7 days of the ED visit.

When does a Member "pass" the measure?

A Member "passes" the measure by attending a follow-up visit with any practitioner (to include PCPs, pediatricians, and mental health providers) after a principal diagnosis of a mental health disorder or of intentional self-harm and any diagnosis of a mental health disorder within 7 days after an ED visit, including visits that occur on the same date as the ED visit.

Which services qualify to meet this measure?

- Telehealth
- Observation
- Telephone call
- Intensive outpatient
- Partial hospitalization
- Electroconvulsive therapy
- Outpatient office-based care
- Community mental health center
- Mental health outpatient office-based care
- Online assessment (e-visit or virtual check-in)

Best Practice Recommendations

- Offer telehealth and phone visits.
- Submit claims in a timely manner.
- Use appropriate documentation and correct coding.
- Educate staff on local resources to assist with barriers such as transportation needs.

- Coordinate care between behavioral health and primary care providers by sharing progress notes and updates. Make reminder calls to Members before scheduled appointments and after any missed appointments to reschedule.
- Review medications with patients to ensure they understand the purpose, appropriate frequency, and method of administration for each prescribed medication.
- Ensure flexibility when scheduling appointments for patients who were recently seen in the ED to allow for appointments to be scheduled within 7 days of discharge.

CPT Codes for Behavioral Health Billing				
Visit Type	**CPT**	**HCPCS**	**POS**	**UBREV**
Unspecified Visits	90791 90792 90832 90833 90834 90836 90837 90838 90839 90840 90845 90847 90849 90853 90875 90876 99221 99222 99223 99231 99232 99233 99238 99239 99251 99252 99253 99254 99255	N/A	N/A	N/A
BH Outpatient	98960 98961 98962 99078 99201 99202 99203 99204 99205 99211 99212 99213 99214 99215 99241 99242 99243 99244 99245 99341 99342 99343 99344 99345 99347 99348 99349 99350 99381 99382 99383 99384 99385 99386 99387 99391 99392 99393 99394 99395 99396 99397 99401 99402 99403 99404 99411 99412 99483 99492 99493 99494 99510	G0155 G0176 G0177 G0409 G0463 G0512 H0002 H0004 H0031 H0034 H0036 H0037 H0039 H0040 H2000 H2010 H2011 H2013 H2014 H2015 H2016 H2017 H2018 H2019 H2020 T1015	03 05 07 09 11 12 13 14 15 16 17 18 19 20 22 33 49 50 71 72	0510 0513 0515 0516 0517 0519 0520 0521 0522 0523 0526 0527 0528 0529 0900 0902 0903 0904 0911 0914 0915 0916 0917 0919 0982 0983
Partial Hospitalization or Intensive Outpatient	N/A	G0410 G0411 H0035 H2001 H2012 S0201 S9480 S9484 S9485	52	0905 0907 0912 0913
Observation with a Mental Health or Community Mental Health Center	99217 99218 99219 99220	N/A	53	N/A
Electroconvulsive Therapy	90870	N/A	N/A	N/A
Online Assessments	98969 98970 98971 98972 99421 99422 99423 99444 99457	G0071 G2010 G2012 G2061 G2062 G2063	N/A	N/A
Telephone Visits	98966 98967 98968 99441 99442 99443	N/A	02 10	N/A

Overview of the Medical Home

The American Academy of Pediatrics (AAP) describes the medical home simply as a "place where everybody knows your name and your medical records are complete." It is not a building or a single place because it is bigger than the four walls of a primary care medical practice.

What is a medical home/health home?

A **medical home or health home** is a consistent source of health care, combined in one place, that a patient receives through their Primary Care Provider. The medical home support team also includes families, service coordinators, specialists and subspecialists, nurses, therapists, dentists, pharmacists, community resources, and more.

A patient-centered medical home encircles the patient and engages the health care team to create a personalized plan for reaching health goals. Patient-centered care is care that is relationship-based and makes the patient feel known, respected, involved, engaged, and knowledgeable.

A **patient-centered medical home** is:

- Accessible
- Family-centered
- Compassionate
- Comprehensive
- Continuous
- Coordinated
- Culturally effective

It features comprehensive primary care delivery, care coordination across multiple services and settings, and teamwork amongst staff, all of whom work to their highest abilities.

Sources:
https://www.aap.org/en/practice-management/medical-home/
https://www.txhealthsteps.com/static/courses/medhm/sections/section-1-2.html
https://thepcc.org/
https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/office-disability-services-coordination/person-centered-practices-training-providers

How can a health home help a patient?

Studies show that medical homes providing patient-centered care are linked to "positive outcomes, including improved physician-patient communication and relationships, higher patient satisfaction, better recall of information and treatment adherence, better recovery, and improved health outcomes." Medical homes also offer increased practice efficiency and productivity and help reduce costs.

Research shows that certain populations experience gaps in effective care coordination:

> Black children

> Hispanic/Latino children

> Children in immigrant families

> Children with special health care needs

Improving primary care through the medical home is imperative for these children. Educating parents about their child's needs and assisting them with access to needed resources are important first steps that providers can currently take in addressing the disparities in receiving family-centered care and care coordination.

What if my patient doesn't have a medical home?

Community First provides access to a medical home to all STAR Kids Member and any Community First Medicaid Member who requests a health home. If your patient does not have a medical home, contact their Service Coordinator or the Community First Service Coordination Department at **1-855-607-7827.** Service Coordinators can help a patient coordinate care, even if their provider does not offer medical home services.

Here are general steps providers can follow to set up a medical home for a child:

1. Work with the SC and parents/guardians to develop an Individual Service Plan (ISP) coordinating the full range of services the child needs. With the parents' permission, the ISP is posted in the Community First Provider Portal, where the child's PCP or specialist can view and access it.

2. Encourage parents to keep a folder to organize all important information about their child's physicians and specialists, appointments, hospitalizations, therapies, medications, allergies, emergency plans, and more. Ask them to bring this information to all medical appointments and share it with their whole care team.

3. Ask questions and communicate. Check to make sure the parents understand what is going on with their child's care. The Community First SC, can help them find resources if they need extra help.

4. Work with teens patients and their parents to help them understand their care plan as they transition to adult care. Teenagers should become more informed about and responsible for their care. Help teens understand their care folder and let them know they need to begin to participate in speaking up for themselves to address their medical and health care needs.

Community First is committed to supporting its network providers in achieving recognition as Patient Centered Medical Homes (PCMH) and will promote and facilitate the capacity of primary care practices to function as medical homes by using systematic, patient-centered and coordinated care management processes.

For more information and best practice models visit the following web sites:

> Joint Commission PCMH Accreditation Program

> National Center for Medical Home Implementation

> NCQA Patient Centered Medical Home Recognition Program

> Patient-Centered Primary Care Collaborative

> Primary Care Development Corporation

> Understanding and Running a Patient-Centered Medical Home

> Texas Health Steps - Overview of the Medical Home

HEDIS® Eye Exam for Patients with Diabetes (EED)

Regular checks for diabetic retinopathy is vital for your patients' eye health. **The Eye Exam for Patients with Diabetes (EED)** is a quality measure used by the Centers for Medicare & Medicaid Services (CMS) to assess the percentage of members 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam. Currently, only about 60% of people with diabetes have a yearly screening for diabetic retinopathy. Left unmanaged, diabetes can lead to serious health conditions, including vision loss and blindness. Regular eye exams are the best way to reduce the risk of blindness and maintain a healthy and productive life.

Best Practices

A retinal or dilated eye exam must be performed by an eye care professional annually for patients with positive retinopathy and every two years for patients without evidence of retinopathy.

> Review diabetic services needed at each office visit.

> Refer patients to an optometrist or ophthalmologist for a dilated or retinal eye exam annually and explain why this is different than a routine eye exam.
  - Routine eye exams for glasses, glaucoma, or cataracts do not count. It must be a dilated/retinal exam.
  - Educate patients about the importance of routine screening and medication compliance.

> Diabetic eye exams are covered under the patient's medical insurance and may be subject to copays and deductibles.

> Required documentation: date of service, eye exam results, and eye care professional's name with credentials are required.

> Patient reported eye exams are acceptable with the above documentation.

> If the name of the eye care professional is unknown, document that an optometrist or ophthalmologist conducted the exam.
  - Review the report and document abnormalities in the active problem list.
  - Eye exam result documented as unknown does not meet criteria.
  - Evidence of prosthetic eye(s) is acceptable for enucleation.
    > Unilateral enucleation would still require an exam on the other eye.

> Optical coherence tomography is considered imaging and is eligible for use. The fundus/retinal photography must have the date, result, and eye care professional credentials documented.

Coding Tips

When results are received from an eye care professional or the patient reports an eye exam, submit the results on a $0.01 claim with the appropriate codes.

Value Set Name	Code	Definition	Code System
Eye Exam With Evidence of Retinopathy	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)	CPT-CAT-II
Eye Exam With Evidence of Retinopathy	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)	CPT-CAT-II
Eye Exam With Evidence of Retinopathy	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)	CPT-CAT-II
Eye Exam Without Evidence of Retinopathy	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)	CPT-CAT-II
Eye Exam Without Evidence of Retinopathy	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)	CPT-CAT-II
Eye Exam Without Evidence of Retinopathy	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy (DM)	CPT-CAT-II

HEDIS® Hemoglobin A1c Control for Patients with Diabetes (HBD)

When diabetes isn't properly managed, it can result in serious comorbidities, such as heart disease, stroke, high blood pressure, vision loss, kidney problems, nerve damage, amputations, and even premature death. Effective management of diabetes is crucial to regulate blood sugar levels, minimize the chances of complications, and extend life expectancy. Collaborating with health care professionals, individuals can effectively manage diabetes by adhering to medication schedules, maintaining a nutritious diet, engaging in regular physical activity, and quitting the use of tobacco products.

Learn about essential strategies to achieve HbA1c control and meet Healthcare Effectiveness Data and Information Set (HEDIS) standards.

What is the HBD measure?

The Hemoglobin A1c Control for Patients with Diabetes (HBD) measure assesses the percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

> HbA1c Control (<8.0%).

> HbA1c Poor Control (>9.0%).

HbA1c testing should be completed 2-4 times per year. The last HbA1c result of the year counts toward the HEDIS score.

Best Practices

> Schedule the patient's lab testing before office visits to review results and adjust treatment plans if needed.

> Documentation in the medical record must include a note indicating the date when the most recent HbA1c test was performed in the measurement year along with result or findings. Always list the date of service, result, and test together.

> Use reported value and not threshold for result.

> Re-evaluate the patient's care plan and repeat HbA1c testing as needed.

Coding Tips

Use CPT Category II codes when billing for HbA1c test.

Value Set Name	Code	Definition	Code System
HbA1c Level Greater Than 9.0	3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)	CPT-CAT-II
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)	CPT-CAT-II
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)	CPT-CAT-II
HbA1c Level Less Than 7.0	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)	CPT-CAT-II
HbA1c Test Result or Finding	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)	CPT-CAT-II
HbA1c Test Result or Finding	3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)	CPT-CAT-II
HbA1c Test Result or Finding	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)	CPT-CAT-II
HbA1c Test Result or Finding	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)	CPT-CAT-II

COMMUNITY FIRST PROVIDER PORTAL

HOW OUR PORTAL STREAMLINES CLAIMS MANAGEMENT & MORE

Create an account or log in now to begin using the benefits and features of the Community First Provider Portal, a secure resource designed to simplify prior authorization processes and claims management.

Provider Portal Features:

- Submit claims and claim appeal requests
- Search claims, check status, and view the EOP
- Confirm membership and verify coverage
- Submit authorization requests
- View authorization approvals, denials, and other documents
- Receive Community First and HHSC news alerts

Questions? Portal users can find step-by-step guides and register for additional portal training under the Quick Access menu.

Scan the QR code to log in or register for a free account.

CommunityFirstHealthPlans.com/ProviderPortal | Provider Relations: 210-358-6294 | ProviderRelations@cfhp.com

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 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 visits 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:

- Medicaid personal care services.
- 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?

Community First Providers can view EVV updates from Texas Health and Human Services (HHSC) and Community First online at Medicaid.CommunityFirstHealthPlans.com/EVV, in addition to:

- EVV Contact Information for general inquiries and unlock requests
- Community First and HHSC EVV Training and Education Requirements
- EVV unlock request forms and job aids

Recent EVV Provider Updates

- EVV Compliance Grace Period Extended for Personal Care Services to December 31, 2024
- Proprietary System Operator (PSO) Onboarding Process Information for FMSAs and Program Providers
- Program and Service Requirements Schedules Available in EVV System

PROVIDER TIP SHEET

MANAGEMENT OF PREECLAMPSIA

Preeclampsia is characterized by new onset of hypertension and proteinuria or hypertension and significant end-organ dysfunction, with or without proteinuria after 20 weeks of gestation or postpartum. **In the U.S., hypertensive disorders, including preeclampsia, contribute to 7.4% of pregnancy-related deaths.** Mental health issues, such as postpartum depression and post-traumatic stress disorder, can also be associated with preeclampsia.

Best Practices for Preeclampsia Management

Prenatal

> **Early Identification and Risk Assessment:** Conduct a thorough risk assessment during the initial prenatal visit, considering medical history, predisposing factors, and non-medical drivers of health (NMDOH). Identify high- and moderate-risk patients promptly.

Risk Factors

High Risk

> Kidney disease
> Diabetes mellitus
> Multifetal gestation
> Chronic high blood pressure
> Previous occurrence of preeclampsia
> Autoimmune conditions, such as lupus

Moderate Risk

> First-time pregnancy
> Body mass index (BMI) over 30
> Pregnancy more than 10 years after a previous pregnancy
> Family history of preeclampsia (mother or sister)
> Black race
> Low income
> Age 35 or older
> In vitro fertilization (IVF)
> Complications in previous pregnancies, such as having a baby with low birth weight

Treating Preeclampsia

> **Regular Monitoring:** Educate patients on preeclampsia signs and symptoms. Initiate early and frequent monitoring for high-risk patients, including regular blood pressure checks. Encourage pregnant women to monitor their own blood pressure at home, reporting any readings above 140/90. Emphasize fetal movement self-monitoring. Stress the importance of regular prenatal care throughout the pregnancy.

> **Lifestyle Modification:** Empower patients to make lifestyle changes, including dietary modifications, exercise, and adequate sleep.

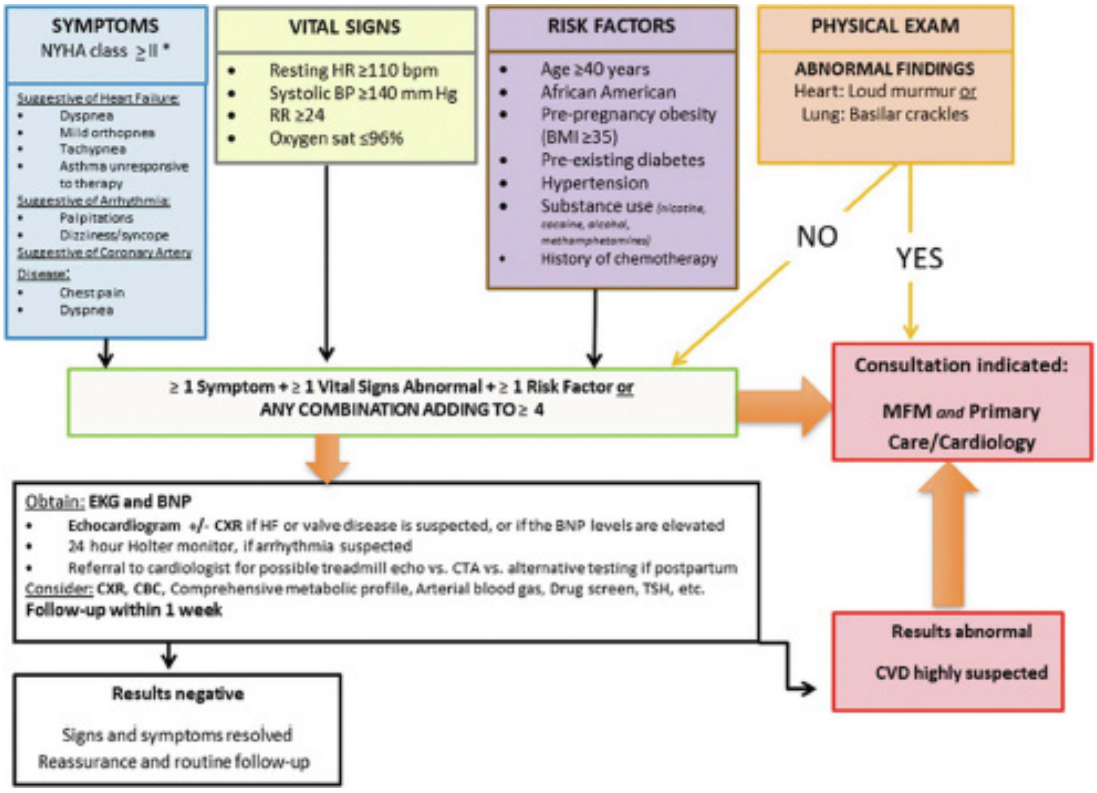
- **Antihypertensive Medication and Low-dose Aspirin Use:** Consider antihypertensive therapy for women whose blood pressure is persistently elevated over 150/100 mmHg. Initiate low-dose aspirin use before 16 weeks' gestation for high-risk patients and patients with two or more moderate risk factors.
- **Laboratory Tests:** Repeat laboratory tests of biochemical and hematological parameters 2–3 times a week, based on the severity and progression of the disease.
- **Customized Prenatal Care Models:** Explore models such as group care, telehealth, and Connected Care visits for customized prenatal care.

Postpartum

- Preferentially use NSAIDs over opioid analgesics.
- Continue blood pressure measurement postpartum for all women.
- Prescribe antihypertensive medication if hypertension persists after delivery.
- Schedule a blood pressure check visit 3-10 days post-delivery. For mothers on medications, recommend a return visit in 3 days; for those without medications, suggest a return visit in 7-10 days.

Cardiovascular Disease Screening Advisory:

Preeclampsia increases the risk of cardiovascular disease, a leading cause of maternal mortality in the U.S. during and after pregnancy. ACOG recommends screening individuals with clinical indications using the provided algorithm.



Sources:

- National Partnership for Maternal Safety Consensus Bundle on Severe Hypertension During Pregnancy and the Postpartum Period - The American College of Obstetricians and Gynecologists
- Care Plan for Individuals at Risk for Preeclampsia: Shared Approach to Education, Strategies for Prevention, Surveillance, and Follow-up - American Journal of Obstetrics & Gynecology
- Preeclampsia & Pregnancy - American College of Obstetricians and Gynecologists

A Prescription for Wellness

Community First 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
> 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.*

PEMS Address Attestation/ Non-Compliance

The Texas Medicaid & Healthcare Partnership (TMHP) is requesting Providers review and update their practice addresses and taxonomy codes within the Provider Enrollment and Management System (PEMS).

KEY DETAILS

Collaborative testing between Texas Health and Human Services Commission (HHSC) and Managed Care Organizations (MCOs) has identified differences in practices addresses between MCO ecosystems and the Master Provider File (MPF) extracted from PEMS. The Texas Medicaid & Healthcare Partnership (TMHP) is also reviewing enrollment information for National Provider Identifier (NPI) in PEMS. During this review, discrepancies were also found between the provider taxonomy codes in PEMS and those in the National Provider Plan and Enumeration System (NPPES).

Providers should validate their information in PEMS prior to September 30, 2024 to avoid claim denials.

RESOURCES

> PEMS Instructional Site
> Correcting Taxonomy Codes in PEMS
> Updating Provider Addresses in PEMS - YouTube
> TMHP Contact Center: 800-925-9126 (Select option 3)

Health Equity For All Patients:
Provider Resources

When patients feel seen, heard, and safe, they are more likely to go to the doctor and be honest about their health. At Community First, we endeavor to make our Members feel comfortable and respected during every experience with our staff and Providers, helping to improve health equity within our community.

Toward this end, we have been researching ways to provide culturally and linguistically appropriate care for our Members. We are compiling a series of Provider tips, guide, and training modules that include an abundance of helpful resources for our Provider network. As you are at the front line of patient care, we understand how important it is to include you in our efforts to provide the best, most inclusive, high-quality care where patients of every income level, race, nationality, ethnic background, sexual orientation, and gender identity feel heard, respected, and well-cared for.

Visit our Health Equity Resources page or log into the Community First Provider Portal to find these materials and additional resources on health equity:

- Community First Inclusion Policy and Q&A
- Cultural & Linguistic Competency Provider Training
- Non-Medical Drivers of Health (NMDOH) Protocol
- Provider Guide to Address Non-Medical Drivers of Health
- Tips on Caring for Diverse Populations

Thank you for all you do to make your patients feel welcome and heard.

INCLUSION AT COMMUNITY FIRST

Community First provides fair and equal access to care for Members in our service delivery area, to be leaders in recognizing and eliminating social barriers, and to champion diversity within the Community First workplace that reflects the populations we serve.

Data from the Centers for Disease Control and Prevention (CDC) shows that racial and ethnic minority groups in the U.S., including Black, Hispanic, American Indian/Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander (NHOPI) communities, experience a significantly higher burden of disease, injury, premature death, and disability. This disproportionate burden can lead to lower socioeconomic status and quality of life and shorter life expectancy.

Q: How does Community First define inclusion for our Members?

A: Inclusion refers to how others show that individuals are valued as respected members of the group, team, organization, or community. At Community First, inclusion is intentionally designed and actively incorporated into our processes and practices. Ongoing engagement with our individual Members ensures opportunities and pathways for access to, and participation in, all aspects of a Member's care, especially decision-making.

Q: What are the benefits of inclusion for staff and Members?

A: Inclusion benefits the entire Community First organization, from governing leadership, to staff, to enrolled community members. For staff, inclusion creates a sense of comfort and belonging, reflecting the larger community, thus increasing engagement, fostering creativity, and enhancing satisfaction. By fostering an atmosphere of inclusion for our Members, we are building a safe environment where they feel valued, respected, and empowered. We always strive to tailor inclusive care to each Member's health care needs, no matter their socioeconomic, racial, or cultural background, gender identity, or abilities.

Q: How can Community First employees promote inclusion in their respective departments?

A: Community First promotes the health and well-being of all Members, regardless of their identity, background, ability, and social barriers. This starts with our staff understanding the importance of inclusion in our company culture, and as outlined in our policies, NCQA accreditation documents, and care coordination practices. We convey these principles to our Members and each other by using respectful and appropriate language, listening actively, asking for consent, and avoiding assumptions and stereotypes. Using the right words can help establish trusting relationships. Making sure Members feel safe and included also means keeping an open mind about different behaviors, identities, and expressions.

Using inclusive language in health care can help reduce stigma, address non-medical drivers of health (NMDOH), and improve health outcomes. Please use the following resource for more information on inclusive language:

> *Northwest Family Guide – Inclusive Language Guide*
> *Advisory Board – Incorporating Inclusive Language*

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

Assess 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:

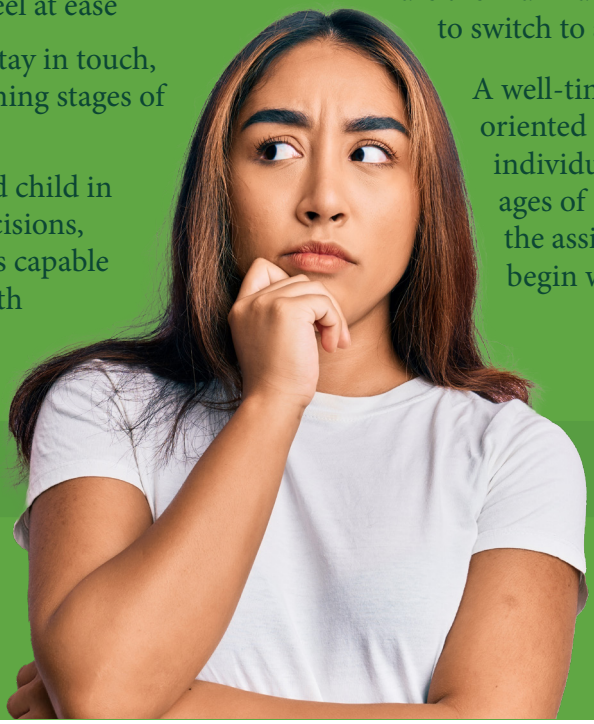
> Encouraging them to choose a new doctor with whom they trust and feel at ease

> 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.

2024 CDC IMMUNIZATION SCHEDULES

The **2024 CDC Child and Adolescent Recommended Immunization Schedule** and the **Adult Recommended Immunization Schedule** are now available and effective immediately. The schedules reflect ongoing advancements in vaccination recommendations and clearer guidance for health care professionals. Below, we've outlined key updates adopted and made official by the CDC director.

CHILD AND ADOLESCENT IMMUNIZATION SCHEDULE

New or updated recommendations have been incorporated for the following vaccines:

- Influenza vaccine
- Pneumococcal vaccines
- Respiratory syncytial virus monoclonal antibody (RSV-mAb)
- COVID-19 vaccines
- Respiratory syncytial virus vaccines (RSV)
- Inactivated poliovirus vaccine (IPV)
- Mpox vaccine
- Meningococcal serogroups A, B, C, W, Y vaccine (MenACWY-TT/MenB-FHbp)

Vaccine Removals: Diphtheria and tetanus toxoid adsorbed vaccine (DT), 13-valent pneumococcal conjugate vaccine (PCV13), bivalent COVID-19 mRNA vaccines, and meningococcal serogroups A, C, W, Y polysaccharide diphtheria toxoid conjugate vaccine (MenACWY-D, Menactra) have been removed from all sections of the schedule due to discontinued distribution or recommendation for use in children and adolescents in the United States.

Clarifications: Clarifications have been provided for the following vaccines:

- Diphtheria, tetanus, and acellular pertussis vaccine (DTaP)
- Haemophilus influenzae type b vaccine (Hib)
- Human papillomavirus vaccine (HPV)
- Measles, mumps, and rubella vaccine (MMR)
- Serogroup B meningococcal vaccine (MenB)
- Tetanus, diphtheria, and acellular pertussis vaccine (Tdap)

Other Substantial Changes: Substantial revisions have been made to Table 3, which outlines the immunization schedule by medical indication. The definitions for the legend colors have been updated to better highlight additional vaccination recommendations for each medical condition and to align with the adult immunization schedule.

SCHEDULE CHANGES FOR 2024

COVID-19: Updates have been made to align with the latest COVID-19 vaccination guidelines for children and adolescents. Dosing and intervals may vary depending on vaccination history and immune status. General population guidance is provided in the "Routine vaccination" section, with specific advice for moderately or severely immunocompromised individuals detailed in the "Special situations" section.

DTaP: Language in the "Routine vaccination" section has been revised to provide clarity on primary and booster doses.

HPV: In the "Routine vaccination" section, the recommendation for interrupted schedules has been removed, as this information is now presented on the Cover Page and applies to all vaccines. Additionally, to enhance clarity, the phrase "of any valency" has been added to the bullet point, "No additional dose recommended when any HPV vaccine series of any valency has been completed using the recommended dosing intervals."

Influenza: Hyperlinks to the 2023–24 influenza recommendations and a bullet point for the 2024–25 influenza recommendations have been added. In the "Special situations" section, all bullets describing recommendations for persons with a history of egg allergy have been removed. Individuals with any severity of egg allergy can now receive any influenza vaccine indicated for their age and health status.

MMR: The bullet point, "If MMRV is used, the minimum interval between MMRV doses is 3 months," has been relocated to the end of the notes section. Additionally, revisions have been made to the "Routine vaccination", "Catch-up vaccination", and "Special situations" sections to clarify that this minimum interval applies universally.

MenACWY: All references to Menactra have been removed, as this vaccine is no longer distributed in the United States. Information regarding the use of the newly licensed pentavalent meningococcal vaccine (Penbraya) has been included at the end of the MenACWY notes.

MenB: A summary of recommendations for Penbraya has been added, along with a link to a resource assisting health care providers with shared clinical decision-making recommendations for MenB vaccination.

Mpox: A new section has been added to outline recommendations for the use of Jynneos in adolescents aged 18 years, including considerations for sexual risk factors and vaccination during pregnancy.

Pneumococcal: Updated recommendations for the 15-valent pneumococcal conjugate vaccine (PCV15), PCV20, and PPSV23 are now reflected in the "Routine vaccination", "Catch-up vaccination", and "Special situations" sections. Additionally, chronic kidney disease, chronic liver disease, and moderate to severe persistent asthma have been included in the list of medical conditions that increase the risk for invasive pneumococcal disease.

MEMBER RIGHTS AND RESPONSIBILITIES

Community First recognizes the importance of a three-way relationship among its Members, Providers and their health plan. Member education about health care responsibilities is important because it helps Members get greater benefits from their plan.

Community First Providers can find Member Rights and Responsibilities listed in each plan's Community First Provider Manual. Members can find the same list in their plan's Member Handbook.

For more information about Member Rights and Responsibilities, please contact Community First Member Services at 1-800-434-2347.

Poliovirus: The "Catch up vaccination" section now includes updated recommendations for 18-year-old adolescents. Most adolescents in this age group, born and raised in the United States, can assume prior poliovirus vaccination. In the "Special situations" section, guidance is revised to administer a one-time IPV booster to 18-year-olds who completed the primary series and face increased poliovirus exposure risk.

RSV-mAb: A new section now details the use of nirsevimab in infants and young children. The "Routine immunization" section covers recommendations for infants aged < 8 months, while the "Special situations" section addresses age-eligible children undergoing cardiac surgery with cardiopulmonary bypass, and those aged 8–19 months at higher risk for severe RSV disease. Guidance on immunization timing, including variations for jurisdictions with differing RSV seasonality, is provided.

RSV: A new section now outlines recommendations for maternal RSV vaccination with Abrysvo (Pfizer Inc.), administered seasonally. Guidance emphasizes two prevention approaches for severe respiratory syncytial virus disease in infants: administering Abrysvo to pregnant individuals at 32–36 weeks' gestation or nirsevimab to the infant. Timing guidance is provided, with considerations for jurisdictions experiencing RSV seasonality variations from the continental United States.

Tdap: The "Routine vaccination" and "Catch-up vaccination" sections have been revised to clarify that the Tdap dose recommended at age 11–12 years is the adolescent Tdap booster dose.

ADULT IMMUNIZATION SCHEDULE

New or updated recommendations have been incorporated for the following vaccines:

- Influenza vaccine
- Respiratory syncytial virus vaccines (RSV)
- COVID-19 vaccines
- Inactivated poliovirus vaccine (IPV)
- Mpox vaccine (Mpox)
- Meningococcal serogroups A, B, C, W, Y vaccine (MenACWY-TT/MenB-FHbp)

Vaccine Removals: Any reference to meningococcal serogroups A, C, W, Y polysaccharide diptheria toxoid conjugate vaccine (MenACWY-D [Menactra]) has been removed from the schedule because this product is no longer distributed in the United States.

Clarifications: Clarifications have been provided for the following vaccines:

- Human papillomavirus vaccine (HPV)
- Hepatitis A (HepA), and hepatitis B (HepB)
- Measles, mumps, and rubella vaccine (MMR)
- Tetanus, diphtheria, and acellular pertussis vaccine (Tdap)

SCHEDULE CHANGES FOR 2024

COVID-19: All adults are now advised to receive a minimum of one dose of the updated (2023–2024 Formula) COVID-19 vaccine. Dosing requirements and intervals may differ depending on vaccination history, immune status, and vaccine type. The COVID-19 notes section is divided into two parts: "Routine vaccination" for the general population and "Special situations" for those with moderate or severe immunocompromised status.

HepA: The bullet in the "Routine vaccination" section was revised to align with ACIP policy, stating, "Any person not fully vaccinated who requests vaccination." Further details on the HepA vaccine regimen are provided within the bullet.

HepB: The "Routine vaccination" section now includes more context and details in the bullets concerning risk-based vaccination for individuals aged ≥60 years. Furthermore, a note has been added at the section's end, outlining the shared clinical decision-making recommendation for individuals in this age group with diabetes.

HPV: The "Routine vaccination" section has been streamlined by removing guidance on interrupted schedules, as it's now provided on the Cover Page. Age ranges have been reordered chronologically for clarity. Additionally, the words "of any valency" were added to the bullet stating "No additional dose recommended when any HPV vaccine series of any valency has been completed using the recommended dosing intervals."

Influenza: Hyperlinks to the 2023–24 influenza recommendations and a bullet point for the 2024–25 influenza recommendations have been added. In the "Special situations" section, all bullets describing recommendations for persons with a history of egg allergy have been removed. Individuals with any severity of egg allergy can now receive any influenza vaccine indicated for their age and health status. Lastly, the bullet concerning Guillain-Barré syndrome has been removed, as this information is now available in the Appendix section under contraindications and precautions.

MMR: Minor changes were made to the "Routine vaccination" section to improve language clarity.

Mpox: Mpox vaccination is a new addition to the "Notes" section of the adult immunization schedule. Risk factors warranting routine Jynneos vaccination are listed. Bullets on Jynneos use among health care providers and pregnant persons are provided at the section's end.

Pneumococcal: Minor clarifications were made in both the "Routine vaccination" and "Special situations" sections regarding guidance and minimum dose intervals for pneumococcal vaccines.

Poliovirus: The "Routine vaccination" section now emphasizes completing the 3-dose IPV primary vaccination series for adults known or suspected to be unvaccinated or incompletely vaccinated. A statement was added suggesting that most U.S.-born adults were likely vaccinated against polio as children. In the "Special situations" section, guidance is provided for administering a one-time, lifetime IPV booster dose to adults who have completed the primary series and are at higher risk of poliovirus exposure.

RSV: A new RSV notes section has been introduced. It starts with a "Routine vaccination" segment outlining the use of Abrysvo (Pfizer Inc.) in pregnant individuals during 32–36 weeks' gestation from September through January in most of the continental United States. Additionally, a sub-bullet now recommends either maternal RSV vaccination or infant immunization with nirsevimab (RSV monoclonal antibody) to prevent respiratory syncytial virus lower respiratory tract infection in infants. A note at the section's end acknowledges varying RSV seasonality across jurisdictions and advises providers to follow local guidance on maternal RSV vaccine timing.

In the "Special situations" section, shared clinical decision-making for vaccination of individuals aged ≥ 60 years is described; Abrysvo (Pfizer Inc.) or Arexvy (GSK) may be used. Furthermore, a resource link has been included to aid health care providers with shared clinical decision-making for RSV vaccination. Lastly, a note lists risk factors and medical conditions for providers to consider when assessing a patient's risk for severe RSV disease and potential vaccination benefits.

Tdap: A note was added at the end of the Tdap section to clarify that a dose of Tdap received at age 10 years may be counted as the adolescent dose routinely recommended at age 11–12 years.

Please refer to the 2024 CDC Immunization Schedules and ACIP Vaccine Recommendations and Guidelines for detailed guidance on vaccine administration.

Sources

https://www.cdc.gov/vaccines/schedules/hcp/imz/child-schedule-notes.html
https://www.cdc.gov/vaccines/schedules/hcp/imz/child-index.html
https://www.cdc.gov/mmwr/volumes/73/wr/mm7301a2.htm
https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-index.html
https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-schedule-vaccines.html
https://www.cdc.gov/vaccines/schedules/hcp/schedule-changes.html

COMMUNITY FIRST
MEDICAID
STAR+PLUS

Community First is proud to announce that effective September 1, 2024, we will officially offer the STAR+PLUS program.

We encourage Community First Providers to add the STAR+PLUS product to their existing contract TODAY! We also welcome non-contracted Providers to participate in our network. Community First is currently accepting inquiries for STAR+PLUS network participation for PCPs, behavioral health, specialty care, long-term services and supports, and more.

ABOUT STAR+PLUS

STAR+PLUS is a Texas Medicaid-managed care program for adults who have disabilities or are age 65 or older. Adults in STAR+PLUS get Medicaid health care and long-term services and support through a health plan that they choose.

Long-term services and supports includes things like:

> Help in the home with basic daily activities.

> Help making changes to the home so the patient can safely move around.

> Short-term care to provide a break for caregivers.

A main feature of STAR+PLUS is Service Coordination. A Community First STAR+PLUS staff member works with the Member, the Member's family, and the Member's doctors and other providers to help the Member get the medical and long-term services and support they need.

COMMUNITY FIRST WILL OFFER STAR+PLUS IN BEXAR COUNTY AND THE SURROUNDING COUNTIES:

HOW TO ADD STAR+PLUS TO YOUR CONTRACT

Contracted Providers can email ProviderRelations@cfhp.com or call 210-358-6294 to request participation.

Providers interested in joining our network as a STAR+PLUS Provider can complete our Letter of Interest (LOI) available on our website at CommunityFirstHealthPlans.com/Providers and allow up to 30 days for evaluation and response to your inquiry.

We encourage all interested Providers to begin the STAR+PLUS credentialing process as soon as possible in anticipation of unavoidable delays throughout the credentialing process.

You will need the following information to complete the LOI:

> Federal Tax ID #

> NPI #

> TPI #

> TH Steps TPI # (PCPs only)

> API # (LTSS only)

The addition of STAR+PLUS product to Community First's existing lines of business represents a significant expansion of our services and demonstrates our commitment to delivering high-quality care to a vulnerable, special needs pouplation. By integrating medical, behavioral, and long-term care services under one umbrella, we aim to streamline and improve our Members' overall health care experience.

Community First is proud of our diverse network of exceptional health care professionals who help to ensure our Members have access to the health care they need. **Thank you for your interest in joining the STAR+PLUS network.**

COMMUNITY FIRST OFFERS THE FOLLOWING PRODUCTS

- STAR Medicaid
- STAR Kids
- STAR+PLUS (Effective September 1, 2024)
- CHIP/CHIP Perinate
- Medicare Advantage (HMO)
- Medicare Advantage D-SNP (HMO)
- Health Insurance Exchange (Marketplace)
- Commercial HMO

PROVIDER INCENTIVES

Community First also offers incentives to our Medicaid network providers.

To see what incentives are currently available, log in to the secure Community First Provider Portal or turn to page 18.

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.

Pharmacy Benefit Program

Community First 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 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**.

COMMUNITY FIRST
HEALTH PLANS

Non-Discrimination Notice

Community First Health Plans, Inc. (Community First) 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 does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Community First provides free 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 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 services, please contact Community First Member Services at the number on the back of your Member ID card or 1-800-434-2347. If you're deaf or hard of hearing, please call 711.

If you feel that Community First failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a complaint with Community First Executive Director of Compliance & Risk Management by phone, fax, or email at:

Kethra Barnes
Executive Director of Compliance & Risk Management
Phone: 210-510-2607 | TTY: 711
Fax: 210-358-6014
Email: DL_CFHP_Regulatory@cfhp.com

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

You can 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 | TTY: 1-800-537-7697

Complaint forms are available at:
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Aviso sobre no discriminación

Community First Health Plans, Inc. (Community First) 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 no excluye o trata de manera diferente a las personas debido a su raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual.

Community First 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, y otros)

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

- Intérpretes calificados
- Información escrita en otros idiomas

Si usted necesita recibir estos servicios, comuníquese al Departamento de Servicios para Miembros de Community First al 1-800-434-2347. TTY (para personas con problemas auditivos) al 711.

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

Kethra Barnes
Director ejecutivo de cumplimiento y gestión de riesgos
Teléfono: 210-510-2607 | Línea de TTY gratuita: 711
Fax: 210-358-6014
Correo electrónico: DL_CFHP_Regulatory@cfhp.com

Si usted necesita ayuda para presentar una queja, Community First está disponible para ayudarlo. Si usted desea presentar una queja sobre reclamos, elegibilidad o autorización, comuníquese con Servicios para Miembros de Community First llamando al 1-800-434-2347.

Usted también puede presentar una 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 TTY gratuita: 1-800-537-7697

Los formularios de queja están disponibles en:
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

COMMUNITY FIRST
HEALTH PLANS

Language Assistance

ENGLISH: ATTENTION: Free language assistance services are available to you. Call 1-800-434-2347 (TTY: 711).

SPANISH: ATENCIÓN: Si habla español, usted tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-434-2347 (TTY: 711).

VIATNAMESE: 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: 711).

CHINESE: : 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: 711).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-434-2347 (TTY: 711)번으로 전화해 주십시오.

ARABIC: رق م 1-800-434-2347 ق ب م ر ات ص ل اب ل مجان . ل ك ف ت وت ى ة ال ل غ وع دة ال م اس خدمات ف إن ال ل غ ة،اذا ك ر ت تحدث ك نت م لحوظة : 711: تاو ال ال مص هات

URDU: ک ال ۔ ہ ی ں د س ت ای ب م ی ں م فت خدمات ک ی دم ک ی ز ب ان ک و آپ ت و ہ ی ں،ل ت ے ب و دو را آپ ا گ ر راد : خ رب 1-800-434-2347 (TTY: 711).

TAGALOG: 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: 711).

FRENCH: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-434-2347 (ATS: 711).

HINDI: ध्यान द: यद आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-434-2347 (TTY: 711) पर कॉल कर।

PERSIAN: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تامین گردیده. 1-800-434-2347 (TTY: 711) فراهم می باشد. اب

GERMAN: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-434-2347 (TTY: 711).

GUJARATI: ध्यान दे: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-800-434-2347 (TTY: 711) पर कॉल करे।

RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-434-2347 (телетайп: 711).

JAPANESE: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:711)まで、お電話にてご連絡ください.

LAOTIAN: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທຣ 1-800-434-2347 (TTY: 711).

FOR EVERY GENERATION

COMMUNITY FIRST HEALTH PLANS

We believe health care coverage should be easy and available for every child, parent, and member of your family...**for every generation.**

We offer health plans designed for:

- Expectant Mothers & Newborns
- Children, Teens, & Adults
- Children and Adults with Intellectual and/or Developmental Disabilities
- Senior Citizens

1-800-434-2347 • CommunityFirstHealthPlans.com

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