COMMUNITY HEALTHCARE

Provider Newsletter | Winter 2024

HEALTH EQUITY FOR ALL

CHILD & PERINATAL PSYCHIATRY ACCESS NETWORK

NEW MEDICAID PROVIDER INCENTIVE PROGRAMS

TRANSLATION/INTERPRETER SERVICES

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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AT COMMUNITY FIRST, WE DON'T JUST PROVIDE HEALTH PLANS. WE'RE DRIVEN TO MAKE A DIFFERENCE.

Every year, we donate millions of dollars and advocate for people across our communities so that they can live better, healthier lives. One of the areas we're most invested in is health equity.

HEALTH EQUITY FOR ALL

In short, health equity means "the state in which everyone has a fair and just opportunity to attain their highest level of health."

Community First staff and our network of Providers can work together to help identify areas to improve health equity for our Members, especially the ones who are affected by economic, historical, and/or societal factors that can lead to worse health outcomes.

IT'S UP TO ALL OF US TO REMOVE BARRIERS TO CARE

As we work toward Health Equity and Health Equity Plus Accreditation through the National Committee for Quality Assurance (NCQA), we want to ensure that our Provider network is serving all of our Members with high-quality, inclusive, welcoming, and compassionate care.

To better support our contracted Community First Providers as they serve Members with health equity in mind, we've created several health equity Provider resources, including self-guided trainings, tip sheets authored by medical professionals, and more. You can find all our health equity documents on the Community First Provider Portal or on our website.

> Community First Inclusion Policy Q&A
> Cultural & Linguistic Competency Provider Training
> Health Equity in Diverse Populations: LGBTQ+
> How Providers Can Better Serve Black Patients
> Most Common Languages Spoken by Community First Members
> Non-Medical Drivers of Health Protocol
> Provider Guide to Address Non-Medical Drivers of Health
> Translation/Interpreter Services for Members

HEALTH INEQUITY HARMS PEOPLE ON A PERSONAL, LOCAL, AND GLOBAL LEVEL

With your help, we can remove barriers, stigma, and other obstacles to quality health care and help heal our communities. Thank you for your support, dedication, and partnership.

Sources

https://www.cdc.gov/health-equity/what-is/index.html

NEW CLINICAL PRACTICE GUIDELINES RELEASED

Community First has adopted new medical, behavioral health, and preventive health Clinical Guidelines.

Community First's Clinical Guidelines are based on up-to-date scientific knowledge and are able to be followed in daily medical practice.

Read Community First's Clinical Practice Guidelines to review all adopted guidelines, including the scientific source upon which each guideline is based.

To request a paper copy of the Clinical Guidelines, fill out the Education Request Form and mail to:

Community First Health Plans
Attn: Provider Relations Department
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

You may also fax the Education Request Form to 210-358-6199 or call 210-358-6055 to speak with a Community First Health Educator.

NEWLY ADOPTED CLINICAL PRACTICE GUIDELINES

- > Asthma
- > Bronchiolitis
- > COVID-19
- > Hepatitis C Virus Infection
- > HIV
- > Outpatient Parenteral Antibiotics

Case Management Services

Case Management is a key component of Community First's Population Health Management strategy. The Case Management (CM) Program provides comprehensive, personalized Case Management services and goal setting for Members who 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. Using this approach, our interdisciplinary Case Management team relies on experienced professionals from diverse backgrounds including social work, nursing, mental health, home care, and home health. The team provides the Member with resources that can help them get the best care possible by utilizing the right Providers, in the right setting, and in the right time frame.

Community First Case Managers serve as the Member's primary point of contact. The relationship between the Member and Case Manager must be built on trust to foster mutual respect, and to establish a rapport that facilitates communication among the family, caregivers, and other health care team members.

Our Case Management teams are committed to working with Members, their family, doctors, and other Providers on their health care team, to improve the Member's overall health and wellness and to obtain all needed services.

Case Management is free, voluntary, and available to any Community First Member.

If you would like to refer a patient who may benefit from Case Management, please email the Community First Case Management referral form to chelp@cfhp.com. A Case Manager will contact the Member to discuss their individual health care needs.

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

Holistic Approach

A PRESCRIPTION FOR WELLNESS

Our Health & Wellness programs were designed to provide guidance to our Members so that they can achieve better health outcomes. A referral to our programs helps us complement your efforts as a caring, engaged Provider. Please review our family of programs.

Asthma Matters

Asthma Management Program

> Education about the causes or 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 be eligible for a $10 gift card for completing asthma education, a $10 gift card for receiving a flu shot, and up to $80 in gift cards for completing home visits with San Antonio Kids BREATHE ($35 for the first visit, $10 for the second visit, and $35 for the third visit).**

Diabetes in Control

Diabetes Management Program

> Diabetes education classes
> Information on how to control blood sugar
> Tips for talking to Providers
> Blood sugar testing and supplies
> One-on-one access to a Health Educator
> Referral to YMCA Diabetes Prevention Program including a complimentary four-month YMCA membership

*Qualifying Members may be eligible for up to $60 in gift cards for Members with diabetes participating in the Diabetes in Control: Diabetes Management Program (includes a $20 gift card for completing the Community First diabetes assessment, a $10 gift card for completing diabetes educations, a $10 gift card for receiving a dilated eye exam, and a $10 gift card once every six months for submitting A1C results).**

Healthy Expectations Maternity Program

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

*Qualifying Members may be eligible for a total of $150 in gift cards ($30 each for the following: Community First Health Assessment, agreeing to receive health education text messages, attending all required pre- and postnatal checkups, receiving a flu shot during pregnancy, and attending a Mommy & Me Baby Shower). There is also a $30 reimbursement for birthing classes.**

Healthy Mind

Behavioral Health Program

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

Healthy Living

Lifestyle Management Program

> One-on-one contact with a Health Educator
> Referral to YMCA Weight Loss Program, including a complimentary 4-month YMCA membership
> Case Management for high-risk Members
> Access to Zumba and other fitness classes at no cost

Healthy Heart

Blood Pressure Management Program

> One-on-one contact with a Health Educator
> Case Management for high-risk Members

Refer a Patient

If you have a patient who could benefit from participating in one or more of our Health & Wellness Programs, we encourage you to contact Population Health Management at 210-358-6055 or email healthyhelp@cfhp.com.

You can also advise the patient to:

> Take our online Health Assessment available on our website at CommunityFirstHealthPlans.com/Health-and-Wellness-Programs, or
> Email healthyhelp@cfhp.com, or
> Call 210-358-6055 to speak with a Health Educator.

All Health & Wellness Programs are provided at no cost, and Members can opt out of a program at any time.

Community First strives to provide the best quality services to our Members. A referral to our family of Health & Wellness programs helps us complement your efforts as a caring, engaged Provider.

** Limitations and restrictions apply. For eligibility requirements, please call 210-358-6055 or email healthyhelp@cfhp.com.*

PAPER CLAIMS MAILING ADDRESS

Providers have the right to appeal the denial of a claim by Community First. Providers are encouraged to fill out and submit a Claim Appeal Form electronically. To do so, log into the Community First Provider Portal, click on the "Office Management" tab, and complete the "Community First Claim Appeal Form."

If you prefer to submit your appeal by mail, send the completed form and a copy of the EOP, along with any information related to the appeal, to our paper claims mailing address at:

Community First Health Plans
P.O. Box 240969
Apple Valley, MN 55124

Please note: Appeals submitted without the Claim Appeal Form or with inaccurate or incomplete information will be rejected. The Provider will receive a rejection notification from our Provider Relations Department. If you have any questions, please contact Provider Relations at **210-358-6294** or ProviderRelations@cfhp.com.

DENIALS OF COVERAGE

Community First does not provide financial incentives (rewards) to physicians or employees who conduct Utilization Management (UM) activities for issuing decisions that deny, limit, or discontinue medical necessary covered services. Denials are based on the lack of medical necessity or the lack of a covered benefit.

Information on UM criteria utilized to make a decision can be provided by Member or authorized representative on an individual basis. Requests may be made by contacting Population Health Management (PHM) at 210-358-6050, Monday through Friday, from 8 a.m. to 5 p.m. and pressing "3," when prompted, for authorization to request this information.

Community First's UM staff is also available Monday through Friday, from 8 a.m. to 5 p.m. at 1-800-434-2347 to assist you with any questions you may have regarding the processing of a request for services. Calls received after hours are handled by an on-call nurse through our 24/7 Nurse Advice Line.

Should a Community First staff member attempt to contact you regarding any issues for services, they will provide you with their full name and title.

Members who need language assistance or TTY services to discuss concerns regarding UM or any concern involving medical and or behavioral health services should call 1-800-434-2347 (TTY 711) and we will be happy to provide assistance.

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

7 TIPS TO HELP BUILD MEANINGFUL PATIENT CONNECTIONS

For additional resources and Provider education, log in to the Community First Provider Portal at CommunityFirstHealthPlans.com/ProviderPortal.

01

SHOW RESPECT

Appreciate the patient as a whole person, including their beliefs, values, personal experience, and perspective.

02

PREPARE WITH INTENTION

Familiarize yourself with the patient you are about to meet. Create a ritual to center yourself and focus before each visit.

03

LISTEN FULLY AND WITH INTENTION

Sit down, lean forward, and position yourself to actively listen. Try not to interrupt; your patient is your most valuable source of information.

04

AGREE ON WHAT MATTERS MOST

Find out what your patient cares about and incorporate their priorities into the visit agenda.

05

CONNECT WITH THE PATIENT'S STORY

Tune in to your patient's emotions. Acknowledge and validate them to become a trusted partner.

06

EXPLORE EMOTIONAL CUES

Recognize, name, and validate your patient's emotions to become a trusted partner.

07

SELF-AWARENESS

Recognize and appreciate your own values, boundaries, and emotions as they arise in the patient-physician relationship.

References:
Zulman D.M., Haverfield M.C., Shaw J.G. et al. Practices to Foster Physician Presence and Connection With Patients in the Clinical Encounter. *JAMA*. 2020;323(1):70-81. doi:10.1001/jama.2019.19003

Fueher S., Weil A., Osterberg L.G. et al. Building Authentic Connection in the Patient Physician Relationship. *J Prim Care Community Health*. 2024 Jan-Dec; 15: 21501319231225996. doi: 10.1177/21501319231225996.

CHILD PSYCHIATRY ACCESS NETWORK & PERINATAL PSYCHIATRY ACCESS NETWORK COVERAGE

Texas Child Psychiatry Access Network (CPAN) and Perinatal Psychiatry Access Network (PeriPAN) are free, simple, trusted resources that Texas health care clinicians can call on and count on. Mental health is complex. Call for a rapid peer consultation and get the support you need.

CPAN and PeriPAN child and reproductive psychiatrists and mental health experts help you expand your capacity to meet the standard of mental health care for your patients. They provide real-time, no-cost, evidence-based support, including one-time patient-psychiatrist direct consults when indicated.

Why CPAN?

» One in five children has a diagnosable mental, behavioral, or developmental disorder, and many more children and youth have persistent mental health

Why PeriPAN?

» One in five perinatal women has a mental health condition. Mental health needs are the leading underlying cause of pregnancy-related death in the U.S.

Why CPAN and PeriPAN?

> Texas children, youth, and perinatal patients are experiencing unprecedented mental health challenges and are facing a shortage of psychiatrists and other mental health clinicians.

> Health clinicians report feeling more confident treating their patients' mental health needs after consulting with CPAN/PerioPAN.

> Access programs, like CPAN and PeriPAN, improve mental health outcomes.

How it Works.

> **Call 888-901-2726 Monday-Friday, 8 a.m. to 5 p.m.** and speak directly to a mental health expert within 5 minutes and a psychiatrist within 30 minutes.

> Leave a message anytime to schedule a convenient call-back time.

> Enrolled Providers can text using your CPAN/PeriPAN team's unique texting number.

"It was just a joy to be able to call my local PeriPAN hub and get a call back from a psychiatrist within 15 minutes. I collaborated with that psychiatrist for the betterment of my patient. It was just easy to use and so accessible."

Martin Hechanova, MD, OB/GYN

NO CALL IS TOO SMALL. PSYCHIATRY EXPERTS ARE HERE TO SUPPORT YOU.

How do CPAN and PeriPAN help?

> Provide the real-time support and mental health expertise you need to treat your patient.

> Vet and compile lists of local referrals and resources individualized to your patient in one business day.

> When needed, psychiatrists provide one-time direct patient consults at no cost to you or the patient or family.

> Offer free CMEs, ethics credits, and collaborative learning opportunities.

> Your time consulting with CPAN or PeriPAN may be billable via time or complexity-based coding and if outside the global window.

"CPAN is an incredible partner. As a pediatrician, knowing that I have a strong referral base and quick access to peer consultation is invaluable.

Angela Moemeka, MD, MBA, Pediatrician

The Child Psychiatry Access Network, CPAN, can enhance child and youth mental health care at your practice and save you time.

The Perinatal Psychiatry Access Network, PeriPAN, can enhance your capacity to provide the perinatal mental health standard of care your patients need.

There is no cost to you or your patients for these evidence-based, clinician-to-clinician programs.

For more information, call 888-901-2726 , email COSH@bcm.edu, or go to TXCPAN.org and TXPeriPAN.org.

2025 MEDICAID & CHIP PROVIDER INCENTIVE PROGRAMS

Community First is committed to improving the health of our Members by supporting access to high-quality, cost-effective health care. As such, Community First will continue to provide value-based performance incentives for Medicaid and CHIP Providers to improve quality and close care gaps for our Members.

Medicaid/CHIP PCP Incentive Program

Below is a description of Community First's Incentive/Level 2 Alternative Payment Program beginning January 1, 2025 for Primary Care Providers (PCPs).

The CHIP, STAR, and STAR Kids Programs afford Providers/groups the potential to earn an additional $4.00, $5.00, and $15.00 per Member per month (pmpm), respectively.**

- **Participation Eligibility**
  Participation eligibility is evaluated on a quarterly basis:
  - CHIP Program: PCPs (or PCP Group) in good standing who have a CHIP panel size of 100 or more and Member satisfaction*
  - STAR Program: PCPs (or PCP Group) in good standing who have a STAR panel size of 100 or more and Member satisfaction*
  - STAR Kids Program: PCPs (or PCP Group) in good standing who have a STAR Kids panel size of 100 or more and Member satisfaction*

- **Program Description**
  In addition to the above-stated "Participation Eligibility," incentive rewards for each line of business are based on an accumulation of points on individual line of business metrics. There are four (4) metrics for CHIP, five (5) metrics for STAR, and four (4) metrics for STAR Kids. Financial rewards will be paid on a quarterly basis through this program. **Please note:** When calculating points earned for the Community First quality incentive, metrics with low volume will be marked as non-applicable for that quarter. In addition, if the performance in any given quarter led to an accumulation of negative points this will be adjusted against the overall quarterly points accumulation. This may result in a reduction or no incentive payouts. Please refer to the following chart:

Line of Business	Patient-Centered Medical Home (PCMH)	Potentially Preventable Admissions (PPA)	Potentially Preventable Visits (PPV)	Follow-up on ADHD Medication - Initiation (ADD)	Childhood Immunization - Combo 10 (CIS)	BMI Percentile Documentation (WCC)	Use of First-Line Psychosocial Care (APP)
CHIP	✓	N/A	✓	N/A	✓	✓	N/A
STAR	✓	✓	✓	✓	✓	N/A	N/A
STAR Kids	✓	N/A	✓	✓	N/A	N/A	✓

Medicaid Prenatal and Postpartum Provider Incentive Program

Below is a description of Community First's Incentive/Level 2 Alternative Payment Program beginning January 1, 2025 for prenatal and postpartum care Providers based on HEDIS® technical specifications and the provision of services.

Prenatal/postpartum care Providers can be awarded up to $80.00 per STAR Member in addition to regular fees for service reimbursement.**

- **Notification of Pregnancy (NOP) - $25 per Notification**
  The NOP online form must be completed through the secure Community First Provider Portal following the initial prenatal visit when a Member is first enrolled with Community First. You can access the NOP form by logging into the Provider Portal and clicking "Notice of Pregnancy Form" in the "Quick Access" section on the Portal home page. NOP forms must be accurately completed and submitted electronically (faxed submissions do not qualify for this program) through the Community First Provider Portal within 60 days from the date of the **first prenatal visit** for each Community First STAR Member. Only NOP forms submitted with complete accuracy through the Community First Provider Portal for STAR Members with corresponding claims will be considered eligible for this incentive program. Providers will receive $25.00 for each timely and accurate notification of pregnant Members on a quarterly basis.

- **Timeliness of Prenatal Care - $25 per Initial Visit Only**
  Providers that provide timely initial prenatal care visits as defined by HEDIS® (Initial prenatal care visit as a Member of this health plan in the first trimester, on the enrollment start date or within 42 days of enrollment in the Health Plan) to STAR Members will receive $25.00 in addition to the contracted fee for service payment for rendered services. A valid claim must include appropriate CPT/ICD-10 Codes and any necessary modifiers. In addition, the qualifying 10-digit Provider NPI and taxonomy of the rendering Provider must be on the claim.

- **Postpartum Care - $30 per Community First Member**
  Providers that provide postpartum care as defined by HEDIS® (postpartum visit on or between 7 and 84 days after delivery) will receive $30.00 for Community First STAR postpartum Members with verified eligibility on the service date in addition to the contracted payment for services rendered. A valid claim must include appropriate CPT/ICD-10 Codes and any necessary modifiers. The rendering Provider's qualifying taxonomy and 10-digit NPI must be on the claim.

2025 MEDICAID & CHIP PRO

Medicaid Mental Health Care Providers Incentive Program

Below is a description of Community First's Incentive/Level 2 Alternative Payment Program beginning January 1, 2025 for Mental Health Care Providers based on HEDIS® technical specifications and the provision of services.

Mental health care Providers can be awarded up to $100.00 for each 7-day Follow-Up After Hospitalization for Mental Illness (FUH) for STAR and STAR Kids Members, in addition to regular fees for service reimbursement.

- **Follow-Up After Hospitalization for Mental Illness (FUH)**
  Providers that provide 7-day Follow-Up After Hospitalization for Mental Illness (FUH) care as defined by HEDIS® (Follow-Up After Hospitalization for Mental Illness within 7 days after discharge but excluding on the date of discharge) will receive $100.00 for Community First Members with verified eligibility on the date of service in addition to the contracted payment for rendered services to Community First STAR and STAR Kids Members.** A valid claim must include appropriate CPT/ICD-10 Codes and any necessary modifiers. The rendering Provider's qualifying taxonomy and 10-digit NPI must be on the claim.

Thank you to our dedicated Behavioral Health Providers for prioritizing patient care during this vulnerable time.

Your efforts toward this measure reduce readmission rates and enhance mental health outcomes. Additionally, you will earn incentives that recognize your commitment to improving patient lives.

We encourage you to participate in all Community First Incentive Programs. If you have any questions about these programs, please contact **Narkunan Kesavaram** at nkesavaram@cfhp.com or 210-358-6268.

Please note: The Community First Provider Incentive program is designed to align with the state's P4Q Metrics and quality metrics. If there is an extraordinary circumstance (i.e., pandemic, changes to the P4Q metrics by HHSC, etc.), Community First reserves the right to update the Provider Incentive Program.

**Member satisfaction will be evaluated quarterly and assessed through the number of times a PCP switch occurs due to a Member's "dissatisfaction with the PCP and/or office staff." This rate will be no more than five (5) Members per 1,000 Member months during the previous rolling twelve (12) month period.*

*** Financial rewards will be paid on a quarterly basis through this program.*

VIDER INCENTIVE PROGRAMS

The Results Are In! Community First Puts Our Members First

Each January, Community First Health Plans, Inc. and Community First Insurance Plans (Community First) develop an annual Quality Improvement Plan (QIP) to improve our services. Then, at the end of each year, we evaluate the results to help identify our successes, opportunities for improvement, and develop quality activities and programs for the following year.

This year's annual evaluation revealed improvement in key areas. These results help Community First move toward our goal of continuous improvement, problem resolution, and delivery of the highest quality health care and services in a safe manner.

Highlights of this year's QIP evaluation include:

- Community First transitioned from JIVA, our previous medical management system, to Clinical Care Advance (CCA). CCA integrates with the core administrative system (QNXT), to gain greater operational efficiencies. Some of these efficiencies include: improved system performance and reduction of manual processes; opportunity to gain a better understanding of our Members and Providers and provide a higher level of service through data analysis; and improved productivity tracking and management.
- In October 2023, Community First earned NCQA Interim Health Plan Accreditation for the Marketplace/Exchange line of business.
- In July 2024, Community First received First Full Health Plan Accreditation. This survey includes the review of policy and program plans and also the reports and materials to ensure Community First is following the program plans and policies.
- Enhanced Member and Provider portal features were deployed.
- A content strategy leading Members and Providers to the most relevant digital communication platforms was improved.
- The distribution of monthly e-news for Members and Providers, website traffic, and portal accounts significantly increased.

- The annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member satisfaction surveys revealed Members are satisfied with Community First.
  - Medicaid Child respondents rated overall satisfaction with the health plan, health care, and rating of the personal doctor at the 95th percentile nationally.
  - Commercial Adult respondents rated overall satisfaction with the health plan, health care, rating of the personal doctor, and rating with the specialist above the 75th percentile nationally.
  - In 2024, Community First initiated the Qualified Health Plan (QHP) Enrollee Experience Survey for the Marketplace/ Exchange line of business. The survey includes all of the core CAHPS® Medicaid Adults survey questions and additional questions added to collect needed data specific to this population.
    - In the baseline year of the QHP, nine of the ten measures rated above the 71st percentile when compared to Press Ganey Book of Business (BoB).
- Providers surveyed indicated satisfaction with Community First above the 70th percentile in:
  - Overall satisfaction with Community First
  - How Community First compares to three other health plans in the service delivery area
  - Finance Issues
  - Utilization and Quality Management
  - Provider Relations

Opportunities identified and key goals for the future include:

- Pursue NCQA Health Equity, Health Equity Plus Accreditation, and the Medicaid Module
- Successful re-procurement of the STAR, STAR Kids, and CHIP contracts and a successful operational launch of the STAR+PLUS contract

You can learn more details about Community First's performance on measures of clinical care and Member satisfaction by viewing the Measurement Year 2023 HEDIS® and 2024 CAHPS and QHP summary in this newsletter.

Healthcare Effectiveness Data and Information Set®

Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of Americans' health plans to assess performance on a comprehensive set of standardized performance measures of important health care interventions and outcomes. The measures are designed to assist purchasers and consumers in comparing the performance of different health plans.

The current HEDIS set addresses preventive services, chronic disease management, behavioral health care, appropriateness/overuse of services, and value (i.e., diabetes, asthma, heart disease, behavioral health, and patient satisfaction). HEDIS measures include, but are not limited to:

- Childhood and adolescent immunizations
- Prenatal and postpartum care
- Follow-up care for children prescribed ADHD medication – initiation phase
- Follow-up after hospitalization for mental illness within 7 days
- Appropriate treatment for children with upper respiratory infection
- Controlling high blood pressure for patients with diabetes
- Eye exam for patients with diabetes
- Controlling high blood pressure
- Breast and cervical cancer screening

Physicians are increasingly participating in performance measurement activities, especially in the context of pay-for-performance initiatives that are taking shape across the country. As such, Community First focused on quality-of-care metrics for the STAR, CHIP, and STAR Kids programs, which were closely aligned to the State quality metrics such as immunizations for children, prenatal and postpartum care, follow-up after hospitalization for mental illness within 7 days, and follow-up care for children prescribed ADHD medication – initiation phase.

There are two types of measures in HEDIS:

1. Effectiveness of Care
2. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Effectiveness of Care measures focus on the quality of care Members received in the previous year. Measures are compiled using claims and medical record information.

The chart below lists key areas where Community First scored in the 50th to 90th percentile of the National Committee of Quality Assurance (NCQA) when compared to all the health plans in the United States that submitted HEDIS data in Measurement Year 2023. Quality measures for the Medicaid and CHIP membership focused on well-child and adolescent visits and prenatal care. Some of these HEDIS measures were also used in the administration of the physician incentive program.

Community First Measurement Year 2023
HEDIS® Effectiveness of Care Strengths
STAR, STAR Kids

Quality of Care Measure	STAR	STAR Kids
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase (ADD)	**50th percentile**	**50th percentile**
Cervical Cancer Screening (CCS)	**90th percentile**	**N/A**
Timely Prenatal Care (PPC)	**50th percentile**	**50th percentile**

Community First Measurement Year 2023
HEDIS® Effectiveness of Care Strengths
Commercial

Quality of Care Measure	Commercial
Postpartum Care	**50th percentile**
Timely Prenatal Care	**50th percentile**
Blood Pressure Control for Patients with Diabetes (BPD)	**75th percentile**

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** is a survey of Member experience. It measures Member satisfaction with their care through a rating of four main categories:

1. Overall health plan
2. Overall health care provided
3. Overall experience with the Member's doctor
4. Overall satisfaction with care given by the Member's specialist

These measures are intended to capture information that cannot be gathered through claims and medical record reviews.

In 2024, Community First initiated the Qualified Health Plan (QHP) Enrollee Experience Survey for the Marketplace/Exchange line of business. The survey includes all of the core CAHPS® Medicaid Adults survey questions and additional questions added to collect needed data specific to this population.

Community First's goal for the CAHPS survey was to score in the 90th percentile in each survey category or incrementally increase a survey category's rating to the next percentile level each year until the goal is reached (e.g., move from the 25th percentile to the 33rd percentile).*

The table below provides a summary of the areas of strength in Member satisfaction:

CAHPS Survey Categories	Medicaid Child	Commercial Adult	Marketplace Adult
Rating of Health Plan	95th percentile	75th percentile	89th percentile
Rating of Health Care	95th percentile	90th percentile	89th percentile
Rating of Personal Doctor	95th percentile	75th percentile	99th percentile

Areas of opportunity for improvement: *Getting Care Quickly and Getting Needed Care*

As we prepare to begin a new year, Community First is motivated to continue to improve our delivery of high-quality care and in service in a safe manner. We always welcome recommendations from our Members, Providers, and other Physicians. Contact us with questions, concerns, or comments by contacting the Provider Relations team at 210-358-6294 or emailing ProviderRelations@cfhp.com.

USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS (APP)

Community First is committed to working with our Providers to improve the quality of care for our Members. This Provider Tip Sheet provides information about a 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.

PSYCHOSOCIAL CARE MEASURE CODES

HCPCS

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

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

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

PEMS Address Attestation/ Non-Compliance

The Texas Medicaid & Healthcare Partnership (TMHP) is requesting Providers review and update practice addresses 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 Provider address differences between the MCOs ecosystem and the Master Provider File (MPF) extracted from PEMS.

For additional guidance on updating your address in PEMS, please visit the PEMS Instructional Site.

Effective November 22, 2024, and mandated by the Consolidated Appropriations Act (CAA), Section 5123, Texas Medicaid providers must now also disclose whether their practice location is physically accessible to people with disabilities and whether their practice has a website. This applies to all provider types and practice locations. New fields will be added to the Provider Enrollment and Management System (PEMS) to capture this information.

RESOURCES

- "How to update the Provider address in PEMS" YouTube video
- TMHP Contact Center: 800-925-9126 (Select option 3 for questions about updating Provider address)
- Community First Provider Relations: 210-358-6294 | ProviderRelations@cfhp.com
- TMHP Providers Must Disclose in PEMS Whether Practice Location Is Accessible/Has Website

Appropriate Testing for Pharyngitis (CWP) & Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

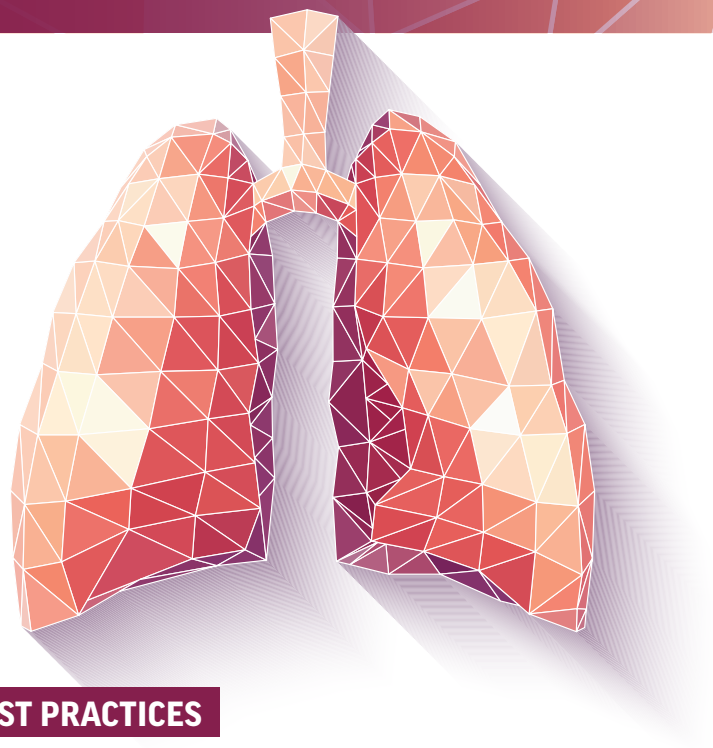
Community First is dedicated to improving the quality of care for our Members by providing essential information about two important Healthcare Effectiveness Data and Information Set (HEDIS®) measures: **the avoidance of antibiotic treatment for acute bronchitis and acute bronchiolitis**, and **appropriate testing for pharyngitis.**

AVOIDANCE OF ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS/BRONCHIOLITIS (AAB).

Our goal is to ensure safer antibiotic use to reduce the incidence of antibiotic resistance. Current guidelines recommend against antibiotic treatment for acute bronchitis in adults who are otherwise healthy, while also recognizing antibiotics may be necessary in certain Members with an appropriate diagnosis to support antibiotic use.

HEDIS® MEASURE DESCRIPTION

The percentage of episodes for Members ages three months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.



BEST PRACTICES

At least 90% of acute bronchitis episodes are viral, hence antibiotics may be unnecessary and result in adverse effects and contribute to antimicrobial resistance. A prospective observational study showed no difference in outcomes when antibiotics were prescribed to patients with green or yellow sputum, indicating that this is not a useful indicator of bacterial infection.[1] Multiple Cochrane reviews showed no benefit to using antibiotics

Applicable codes	
Description	**Codes**
Acute Bronchitis	J20.3-J20.9, J21.0, J21.1, J21.8, J21.9
Pharyngitis	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

for acute bronchitis in otherwise healthy individuals and those with delayed or no antibiotic treatment.[2,3]

Strategies to assist can include[4,5]:

- Address patient concerns in a compassionate manner.
- Discuss expected course of illness and cough duration (2 to 3 weeks).
- Describe the infection as a viral illness rather than bacterial or a "chest cold".
- Explain that antibiotics do not improve symptoms and can lead to adverse effects and antibiotic resistance.
- Discuss the treatment plan and supportive therapy like over-the-counter medications.

1. Butler, C.C. et al. (2011) 'Antibiotic prescribing for discoloured sputum in acute cough/lower respiratory tract infection', *European Respiratory Journal, 38(1)*, pp. 119–125. doi:10.1183/09031936.00133910.

2. Smith, S.M. et al. (2014) 'Antibiotics for acute bronchitis', *Cochrane Database of Systematic Reviews* [Preprint]. doi:10.1002/14651858.cd000245.pub3.

3. Spurling, G.K. et al. (2013) 'Delayed antibiotics for respiratory infections', *Cochrane Database of Systematic Reviews* [Preprint]. doi:10.1002/14651858.cd004417.pub4.

4. Kinkade S. et al. (2016) 'Acute bronchitis.' *Am Fam Physician.* 94(7), pp. 560–565. PMID: 27929206.

5. Albert R.H. (2010) 'Diagnosis and treatment of acute bronchitis." *Am Fam Physician.* 82(11), pp. 1345–50. PMID: 21121518.

APPROPRIATE TESTING FOR PHARYNGITIS (CWP)

Our goal is to ensure proper testing and treatment of pharyngitis to prevent the spread of sickness, while reducing the unnecessary use of antibiotics that can lead to adverse clinical outcomes such as Clostridium difficile infections and antibiotic resistance.

HEDIS® MEASURE DESCRIPTION

The percentage of episodes for Members three years and older where the Member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

BEST PRACTICES

The most common bacterial cause of acute pharyngitis is Group A streptococcal (GAS), which is responsible for 5-15% of sore throat visits in adults and 20-30% in children. Therefore, accurate diagnostic testing via rapid antigen detection test (RADT) and/or culture should be performed since most clinical features do not discriminate between GAS and viral pharyngitis. Common respiratory virus causes include adenovirus, rhinovirus, and respiratory syncytial virus. Appropriate antimicrobial therapy is imperative as well to prevent the progression to more severe complications and transmission to close contacts of the patient.

1. Shulman, S.T. et al. (2012) 'Clinical practice guideline for the diagnosis and management of Group A streptococcal pharyngitis: 2012 update by the Infectious Diseases Society of America', *Clinical Infectious Diseases,* 55(10). doi:10.1093/cid/cis629.

2. *Clinical guidance for Group A streptococcal pharyngitis* (2022) *Centers for Disease Control and Prevention.* Available at: https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html (Accessed: 30 August 2024).

Applicable codes	
Description	**Codes**
CPT: Group A Strep Test	87070, 87071, 87081, 87430, 87650-87652, 87880

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

QUICK **REFERENCE GUIDE** FOR NURSING FACILITY **PROVIDERS**

This guide provides contracted Community First Nursing Facility Providers assistance with billing and claims, instructions, answers to frequently asked questions, and guidance to prevent claim denials and/or rejections.

NURSING FACILITY RESPONSIBILITIES

The Nursing Facility is responsible for providing the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the Member as defined by and in accordance with the comprehensive assessment and plan of care.

In addition, Nursing Facilities are responsible for, but not limited to:

- Contacting Community First to verify Member eligibility
- Obtaining prior authorization for services requiring prior authorization
- Coordinating Medicaid or Medicare benefits
- Notifying Community First of changes in Members' physical condition or eligibility within one business day of identification
- Collaborating with the Community First Service Coordinator in managing Members' health care
- Managing continuity of care for Members
- Documenting coordination of referrals and services provided between Primary Care Providers (PCPs) and specialists
- Allowing Service Coordinators and other key personnel access to Members' complete medical records information as follows:
  - » Medical record documentation must comply with the timelines, definitions, formats, and instructions specified by Texas Health and Human Services Commission (HHSC)
  - » Nursing Facility Providers must make medical records available within three business days of a request by Community First

  - » If at the time of request for access to medical records, HHSC, Office of Inspector General (OIG), or another state or federal agency believes records are about to be altered or destroyed, the Nursing Facility must provide records at the time of the request or in fewer than 24 hours
- Allowing Service Coordinators to participate in the plan of care (POC) development and interdisciplinary team (IDT) meetings involving Members
- Ensuring 24-hour availability of clinical staff to identify and respond to Member needs
- Coordinating with the Member's PCP
- Providing notice to the designated Service Coordinator via phone, fax, email, or other electronic means no later than one business day after the following events:
  - » A significant, adverse change in the Member's physical or mental condition or environment that could potentially lead to hospitalization
  - » An admission to or discharge from the Nursing Facility, including admission or discharge to a hospital or other acute facility, skilled bed, Long-term Services and Supports (LTSS) Provider, non-contracted bed, or another Nursing or Long-term Care facility
  - » An emergency room visit
  - » Nursing Facility-initiated, involuntary discharge of a Member from a facility
- Submitting Form 3618 or Form 3619, as applicable, to HHSC's administrative services contractor
- Submitting Minimum Data Set (MDS) assessments, as required to federal Centers for Medicare & Medicaid Services (CMS), and associated MDS Long-Term Care Medicaid Information Section to HHSC's administrative services contractor
- Completing and submitting Preadmission Screening and Resident Review (PASRR) Level I Screening information to HHSC's administrative services contractor
- Coordinating with local authorities (LAs) and local mental health authorities (LMHAs) to complete a PASRR Level 2 Evaluation when an individual has been identified through the PASRR Level 1 Screen as potentially eligible for PASRR specialized services
- Informing Members of covered services and the costs for non-covered services prior to rendering these services by obtaining a signed private pay form from the Member
- Informing Members on how to report abuse, neglect, or exploitation
- Training staff on how to recognize and report abuse, neglect, or exploitation
- Informing both Community First and HHSC of any changes to the Provider's address, telephone number, group affiliation, or other key demographic or licensing information

THE NURSING FACILITY RESIDENT MUST BE:

- Medicaid-eligible for the dates of service billed,
- In the Nursing Facility for the dates of service billed; and
- Have a current medical necessity determination for the dates of service billed.

NURSING FACILITY TRANSFERS

Residential Nursing Facility stays are not preauthorized by Community First for STAR+PLUS Members. As such, Nursing Facilities are not required to obtain prior authorization or approval from Community First for the transfer between facilities, whether the sending or receiving Nursing Facility is a participating Community First Provider or not. Nursing Facilities are required to notify Community First within one business day of a Member's admission into, or discharge or transfer out of, their facilities. Continuity of care, the authorization waiver period, and standard prior authorization rules apply to acute, LTSS, and add-on services for Members transferring between Nursing Facilities.

BILLING AND CLAIMS ADMINISTRATION

All Nursing Facilities must be in good standing with HHSC for the dates of service billed (i.e., not on vendor payment hold for any reason).

Community First will withhold or reject all or part of a payment for a claim submitted by the Provider if:

- The Provider has been excluded or suspended from the Medicare, Medicaid, or CHIP programs for fraud, waste, or abuse.
- The Provider is on a full or partial payment hold under the authority of HHSC or its authorized agent(s).
- The Provider has debts, settlements, or pending payments due to HHSC or the state or federal government.
- A claim for Nursing Facility unit rates does not comply with the HHSC criteria for clean claims.
- A claim for Medicare-covered services for dual-eligible Members is not first submitted to the Medicare payer.

All Nursing Facility services must be billed using an electronic billing format that is 5010, level seven edit-compliant, via the HIPAA 837I format for a CMS 1450 claim form. **No paper claims will be accepted.**

Nursing Facility Providers have the following options for submitting claims:

ELECTRONIC DATA INTERCHANGE (EDI)			
PAYER NAME	**ELECTRONIC CLEARINGHOUSE**	**PAYER ID**	**SUPPORTED TRANSACTIONS**
COMMFIRST	Availity LLC	COMMF	837P/837I
CFHP	ClaimMD	CFHP	837P/837I
Community First	Claim Logic	COMMF	837P/837I

TEXAS MEDICAID & HEALTHCARE PARTNERSHIP (TMPH) WEBSITE CLAIM PORTAL

Nursing Facilities may bill Community First at any frequency they choose. Community First provides several electronic vehicles to facilitate submissions.

PLEASE NOTE:

- Clean claims for Nursing Facility unit rate and Nursing Facility Medicare Coinsurance submitted for Medicaid Members are adjudicated within 10 days from the date the Provider submits a clean claim. Clean claims not adjudicated within 10 days of submission by Community First are subject to interest payments. Claims must be filed within 365 days of the date of service.
  - » Community First will request any additional information necessary to adjudicate a deficient claim from the Provider within 10 days from the received date.
  - » Community First will adjudicate deficient-pended or deficient-denied claims for which additional information is requested within 10 days from the date of receipt of the requested information.
  - » Community First will process to adjudicated-denied status any deficient-pended or deficient-denied claims for which the requested additional information is not received within 10 days from the date Community First requested the information from the Provider.
  - » Community First will make every effort to avoid making more than one request for additional information in connection with a specific claim. The Explanation of Payments will provide explanations of how a claim or service was paid, why it was denied, and what, if any, is needed from the Provider.
- Clean claims for Nursing Facility add-on services or other services negotiated into the Provider's contract and submitted for Medicaid Members are adjudicated within 30 days from the date of received clean claim. Clean claims not adjudicated within 30 days of receipt by Community First are subject to interest payments. Claims must be filed within 95 days of the date of service.
- Adjudication edits are based on the Member's eligibility, benefit plan, authorization status, HIPAA coding compliance, and our claim processing guidelines. Claim coding is subject to review using code-editing software.
- Claim reimbursement is based on the Provider's contract. Community First is responsible for paying qualified Providers their liability insurance and an enhanced fee to Nursing Facility Providers who are part of the HHSC Direct Care Staff Rate Enhancement Payment program. The fees will be built into the Provider's unit rate payment fee schedule.
- Claims submitted by a Nursing Facility must meet the HHSC criteria for clean claims submission as described in UMCM Chapter 2.3, Nursing Facility Claims Manual.

- Community First will identify each applicable reason code and specific information requirements to inform the Provider of the precise data fields and issues related to each claim. The claims system employs a preset hierarchy of deficient-pended or deficient-denied reasons that will provide sufficient information to the Provider regarding the primary issue related to the claim.

The bill code crosswalk is a cross-referenced code set used to match the Texas Long-term Care (LTC) local codes to the National Standard Procedure codes. Providers must use information on the bill code crosswalk, associated with the bill code that reflects the service billed to claim payment for the services. Refer to the Long-term Care Billing Crosswalk posted to HHSC for the most current billing codes and modifiers.

The types of services included in the HHSC unit rate for Nursing Facility Providers are room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable Nursing Facility rate enhancements and professional and general liability insurance.

When the Member has Medicare Advantage as their primary insurance, Nursing Facilities should submit a coinsurance claim with revenue code 0101 with a copy of the primary EOP.

When the Member has traditional Medicare as primary insurance, Nursing Facilities should bill a coinsurance claim with revenue code 0101 in the first line of the body of the claim.

When billing for STAR+PLUS MMP coinsurance for skilled claims, Nursing Facilities should bill revenue code 0101 in the body of the skilled Nursing Facility claim.

When billing for Medicare Part B deductible services, Nursing Facilities will continue to send Part B deductible claims to TMHP.

Community First is not responsible for payment of some Medicaid benefits, known as "carve-out" or "non-capitated" services, such as:

- HHSC hospice services
- PASRR screenings or evaluations
- Specialized services

These services must be submitted to the TMHP website. *The Texas Medicaid Provider Procedures Manual*, also on the TMHP website, provides a complete list of these services.

ADD-ON SERVICES

Nursing Facility add-on services refer to services provided in a Nursing Facility setting by the Nursing Facility or another network health care professional but are not included in the Nursing Facility daily rate, such as emergency dental care, physician-ordered rehabilitative services, augmentative communication devices, and custom-powered wheelchairs. Add-on services require prior authorization through the Community First Service Coordinator. Once an add-on service is authorized, the Nursing Facility will secure the service. Community First will pay authorized add-on services directly to the health care professional who provides these services.

ADD-ON SERVICES	
CODE	**SERVICE DESCRIPTION**
N0400s	Medicare Skilled Clearinghouse
N0500s	Ventilator-full
N0501s	Ventilator-partial
N0600s	Emergency Dental
G0452, G0453, G0467, G0468, G0480	Occupational Therapy
G0454, G0455, G0469, G0470, G0957	Physical Therapy
G0456, G0457, G0471, G0472	Speech Therapy
G0500	DME
G0955, G0958, G0959, G0970	Wheelchairs, etc.

NON-COVERED SERVICES

Before rendering services, Providers must inform Members they will be charged for the cost of services that are not covered by Community First or HHSC. A Provider who chooses to deliver non-covered services must:

- Understand only services that are medically necessary, including hospital admissions and other services, will be reimbursed.
- Obtain the Member's signature on an acknowledgment form prior to the provision of services, specifying that the Member will be held responsible for payment of services.
- Understand the Member may not be billed and that the Provider may not take recourse against the Member for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the Medicaid program.

ADJUSTMENTS

Community First will automatically adjust previously adjudicated claims within 30 days from the date of receipt of a change in data from the State to reflect adjustments to items such as, but not limited to, Nursing Facility daily rates, Provider contracts, service authorizations, applied income, level of service, and Resource Utilization Group (RUG).

Any adjustments besides the ones listed above and some denials may require a corrected claim from the Nursing Facility Provider. Corrected claims must be submitted within 120 days from the date of the Explanation of Payment (EOP). They may be submitted electronically with a type of bill (TOB) 217 referencing the original claim number. Corrected claims will be adjudicated within 10 days from the date they are received.

Below are some examples of why a Nursing Facility would need to submit a corrected claim:

- Incorrect tax ID
- Incorrect units billed
- Two different RUG levels billed on the same line
- Updates to date span
- Invalid or missing attending Provider ID

Contact Community First Provider Relations at ProviderRelations@cfhp.com or 210-358-6294 if you have any questions.

SECOND OPINIONS

Community First Members have the right to seek a second opinion from a qualified health care professional. We encourage our network of Providers to make Members aware of this option and comfortable with their decision to get a second opinion, especially with complex conditions or specialized procedures. If an appropriate Provider or specialist is not available in the Community First network, Community First will arrange for the Member to obtain a second opinion out-of-network at no additional cost than if the service was obtained in-network.

TRANSLATION/INTERPRETER SERVICES FOR MEMBERS

ACCESS TO INTERPRETER SERVICES

Community First provides free, **24-hour** access to interpreter services for Community First Members with limited English proficiency (LEP) or who use sign language. Interpreters are available in over 200 languages by request.

Community First delivers interpretation in the following ways:

1. Over the phone (Telephonic)
2. By video (Video Remote Interpretation VRI)
3. In-person (Onsite)

Please call **Community First Member Services** to arrange for interpretation.

Plan	Phone Number	Toll-Free
STAR Medicaid	210-358-6060	1-800-434-2347
STAR Kids/STAR+PLUS	210-358-6403	1-855-607-7827
CHIP	210-358-6300	1-800-434-2347
Medicare Advantage Alamo Plan & DSNP (HMO)	210-358-6386	1-833-434-2347
University Community Care Plan (HIE)	210-358-6400	1-888-512-2347
University Family Care Plan	210-358-6090	1-800-434-2347
Commercial HMO	210-358-6070	1-800-434-2347

To communicate with Members who are deaf, hard of hearing, or have speech difficulties, Providers may use Relay Texas. Dial **711** and give the relay operator (RO) the Member's telephone number. The RO will then connect and communicate via the Member's preferred communication type (Talk to Text or TTY, Voice Carry Over or VCO, Internet, American Standard Code for Information Interchange or ASCII, etc.)

INTERPRETATION DELIVERY METHODS

The method of delivery for interpretation depends on the type of medical appointment. Community First strives to provide meaningful access to language services and tailors the method of delivery to the needs of the Member and the specific appointment.

1. **Over the phone**
    - Telephonic interpretation is the best method for most routine appointments.
    - Use a wireless phone with speaker capabilities for best results.
    - Call Member Services to be immediately connected to an interpreter. No advanced notice required.
2. **Video Remote Interpretation (VRI)**
    - VRI is the best method for more complex appointments or if the Member needs access to a sign language interpreter.
    - VRI is HIPAA compliant. It can be accessed from any standard smartphone, tablet, or laptop equipped with a webcam and requires no special software.
    - Call Member Services at least two business days before the appointment to schedule VRI and be prepared to provide the following information:
        - » Member name, Community First Member ID number, and language spoken.
        - » Provider name and appointment information.
        - » Email address or phone number that can receive text messages where a link can be sent for the scheduled VRI session.
    - Please note that on-demand VRI is available as a backup.
3. **In-person**
    - Onsite interpretation should be used for the most complex appointments or when VRI is not possible.
    - Call Member Services at least two business days before the appointment to schedule in-person interpretation and be prepared to provide the following information:
        - » Member name, Community First Member ID number, and language spoken.
        - » Provider name and appointment information.
        - » Detailed address, including suite and floor number, where to park, and other helpful information.

LANGUAGE RIGHTS AND THE LAW

- Section 1557 of the Affordable Care Act (ACA) requires that all limited English proficient (LEP) beneficiaries' language access needs be met for all medical appointments.
- To refuse an LEP beneficiary access to language services is a violation of that individual's civil rights.
- The ACA also prohibits Providers from requesting a beneficiary to provide their own interpreter or rely on a staff member who is not qualified to communicate directly with the LEP individual.
- Please remember it is never permissible to ask a minor, family Member, or friend to interpret.
- Community First complies with all guidance set forth in the ACA and Title VI of the Civil Rights Act, which includes Member instructions for accessing language services printed in Member materials, like the Member Handbook.

UPDATING YOUR PROVIDER INFORMATION—MADE EASY

Keeping your Provider information up to date and on record with Community First is essential for ensuring seamless communication with your patients and facilitating timely claims processing. Whether you need to update your practice structure, address, phone number, Tax ID number, or other details, we offer two easy ways to submit your changes online.

VIA OUR WEBSITE:

You can update your information by completing our Provider Information Change Form online at CommunityFirstHealthPlans.com under the Providers dropdown menu.

Follow these steps:

- **Complete the Form**: Fill in the required fields with your current and new information.
- **Submit the Form**: Submit the form for processing.

VIA THE PROVIDER PORTAL:

You can also update your details through our secure Provider Portal.

Follow these steps:

- **Log into the Community First Portal**: Go to the Provider Portal and log in with your credentials.
- **Navigate to Form**: Once logged in, locate the resources tab and select *Information Change Form.*
- **Submit Changes**: Enter your updated details and submit.

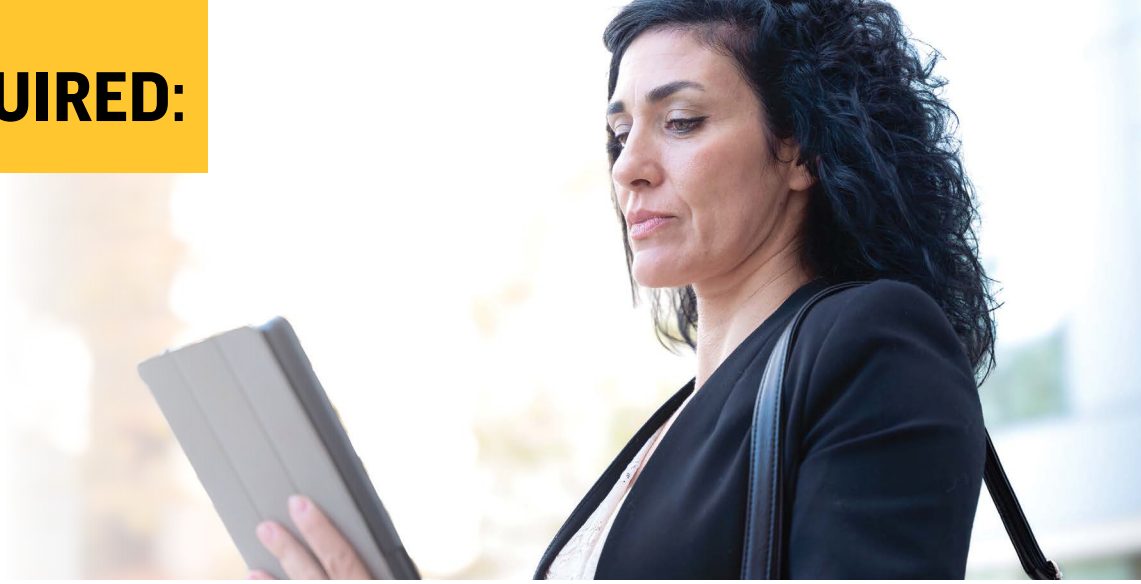
Processing Time: Changes will be processed within 10 business days, and if additional information is needed, our team will reach out.

Need Assistance or Have Questions?
Please reach out to our Provider Relations team.

Call: 210-358-6294 (Monday through Friday, 8:30 a.m. to 5 p.m.)

Email: ProviderRelations@cfhp.com.

ACTION REQUIRED:



ZELIS ePAYMENT REGISTRATION

With Zelis' recent acquisition of Payspan, Community First transitioned to the **Zelis Payments Network** effective August 1.

As a result, Providers need to take the following steps to enroll with Zelis to continue receiving electronic payments.

1. Visit CommunityFirst.epayment.center/register.
2. You will be questioned about a registration code. Select "No" and click "Next."
3. Complete the indicated fields in the "About Your Practice" section and click "Submit Request."
4. You should receive **two** emails.
   - The first email will be sent immediately, informing you that you will receive a registration code within 48 hours.
   - The second email will contain your registration code. It is usually a combination of numbers and letters. You will need this code to proceed with the ePayment registration.
5. Return to CommunityFirst.epayment.center/register.
6. When questioned about a registration code, select "Yes." Enter your Practice TIN, Corporate NPI, and the registration code you received via email.

If you encounter any issues and/or do not receive a confirmation email with your registration code, please check your spam filter.

If you need further assistance, please email help@epayment.center or call Zelis at:

- 855-774-4392 (questions about the Community First ePayment Center)
- 877-828-8770 (general inquiries about Zelis Payment Network)

YOU WILL NEED THE FOLLOWING TO ENROLL:

- Federal tax identification number (TIN) or employer identification number (EIN)
- Your practice's corporate name and principal information
- Bank account routing transit number (RTN) or ABA routing number
- Bank account number

If you are already enrolled with Zelis, you do not need to take any action to receive electronic payments in the Zelis Payments Network.

Please email help@epayment.center with questions.

Joining Forces for Healthier Pregnancies

option care health®

COMMUNITY FIRST HEALTH PLANS

Community First has partnered with Option Care® Women's Health to assist our high-risk obstetrical Members. Option Care delivers a rapid response to referrals and quick turnaround for coverage verification with 24/7/365 support for Providers and patients.

Option Care provides quality, high-risk obstetrical care for management of the following:

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

PATIENT SERVICES

Nausea and Vomiting Hyperemesis Program™

- Treatment of conditions such as hyperemesis, dehydration, malabsorption, and malnutrition
- Ondansetron Pump (Subcutaneous or PICC) with or without hydration
- Metoclopramide Pump (Subcutaneous or PICC) with or without hydration
- Parenteral Nutrition (PN)

Diabetes in Pregnancy Program™

- Comprehensive diabetes education for the insulin and non-insulin requiring patients
- Personalized meal planning and dietary coaching
- Monitoring of blood glucose levels to achieve therapeutic range

Hypertension in Pregnancy Program™

- Comprehensive education regarding hypertension in pregnancy, blood pressure monitoring, and telephonic assessment

Other services include a 24/7 Call Center staffed by highly trained OB Registered Nurses to answer questions or concerns, coaching, education, and home visits.

REFERRALS MADE EASY

From the moment of referral, Option Care clinicians and specialists assist with everything from intake through completion or maintenance. Patients are provided with continuous support every step of the way, helping manage every hurdle and leaving no lapses in care.

To begin the referral process:

1. Fill out the appropriate Prescriber Order Form or begin the referral process online.
2. Attach prenatal records, insurance information, and recent labs.
3. Fax to 877-865-9133. For assistance, call 888-304-1800.
4. If needed, a prior authorization form will be faxed to the prescriber for review and signature.

MORE INFORMATION

Contact Option Care for your next high-risk pregnancy management referral. Call 888-304-1800 or visit OptionCareHealth.com for more information.

If you have questions about the referral process and Community First's partnership with Option Care, please call Community First Population Health Management at 210-358-6050 or email chelp@cfhp.com.

Provider Relations Directory

Use our Community First Provider Relations Directory to find a Representative who can assist with inquiries like administrative policies, changes and updates, and new Provider onboarding. Access the directory any time on the Community First Provider Portal or website.

PROVIDER ENGAGEMENT MANAGER

John Rodriguez

Phone: 210-358-6407 | Email: jrodriguez@cfhp.com

- Large Physician Groups
- Hospitals
- Rural Health Clinics (RHC)
- Federally Qualified Health Centers (FQHC)
- Urgent Care Centers

SR. PROVIDER RELATIONS REPRESENTATIVE – BEHAVIORAL HEALTH

Marisa Vargas

Phone: 210-358-6425 | Email: mvargas@cfhp.com

- Behavioral Health
- Intensive Outpatient Providers (IOP) and Inpatient Services
- Substance Use Disorder (SUD) Treatment Facilities
- Licensed Professional Counselors (LPC)
- Psychiatry
- Mid-Level Practitioners Specializing in Psychiatry
- ABA Therapy
- Social Work and Licensed Clinical Social Work (LCSW)
- Targeted Mental Health Case Management (TMCM)

PROVIDER RELATIONS REPRESENTATIVE – PCP

Amanda Garcia

Phone: 210-358-6336 | Email: agarcia2@cfhp.com

- Primary Care Physicians
- Pediatrics
- Texas Health Steps
- OB/GYN
- Doulas and Community Health Workers

PROVIDER RELATIONS REPRESENTATIVE – SPECIALTY

Veronica Fuentes

Phone: 210-358-6419 | Email: vfuentes@cfhp.com

- Specialty Providers
- Pain Management
- Pharmacy/Infusion Services
- Labs
- Durable Medical Equipment (DME)

PROVIDER RELATIONS REPRESENTATIVE – LTSS

Selina Casares

Phone: 210-358-6041 | Email: scasares@cfhp.com

- Nursing Facilities
- Assisted Living Facilities
- Adult Day Care
- Adult Foster Care
- Long-Term Support Services (LTSS)
- Consumer Directed Services (CDS)
- Adaptive Aids/Custom Home Modification Providers
- Private Duty Nursing
- Respite Care
- Home Health

PROVIDER RELATIONS REPRESENTATIVE – THERAPY

Marvelin Torres

Phone: 210-358-6106 | Email: mtorres@cfhp.com

- Physical Therapy
- Occupational Therapy
- Speech Therapy

PROVIDER RELATIONS REPRESENTATIVE – OPERATIONS

Faith Rippy

Phone: 210-358-6447 | Email: frippy@cfhp.com

- Letters of Interest (LOI) Questions
- Network Adequacy Review Committee (NARC)
- Provider Office Staff Advisory Committee (POSAC)
- General Inquiries

COMMUNITY FIRST HEALTH PLANS

COMMUNITY FIRST INSURANCE PLANS

Non-Discrimination Notice

Community First Health Plans, Inc. and Community First Insurance Plans (Community First) comply with applicable federal civil rights laws and do 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) y Community First Insurance Plans cumplen con las leyes federales de derechos civiles aplicables y no discriminan 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 COMMUNITY FIRST INSURANCE 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 م ب ر ات ص ل باﻟ 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 إذا م لحوظة : 711 :او ل ال مص هات

URDU: ک ال ۔ ہ ی ں د س ت ای ب م ی ں م فت خدمات ک ی ددم ک ی ز ب ان ک و آپ ت و ہ ی ں،ل ت ے ب و دو ا آپ ا گ ر داد : 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. با

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 मे 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, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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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