COMMUNITY HEALTHCARE

Provider Newsletter | Summer 2026

NEW! Pre-Authorization Check Tool Now Available

Upcoming Policy Changes Related to Claims Processing

Provider Incentive Program for Mental Health Providers

NEW COMMUNITY ASSISTANCE OFFICE

Local Support For Your Patients

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

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

COMMUNITY ASSISTANCE OFFICE AT VIDA
3611 Jaguar Parkway, 2nd floor
San Antonio, TX 78224

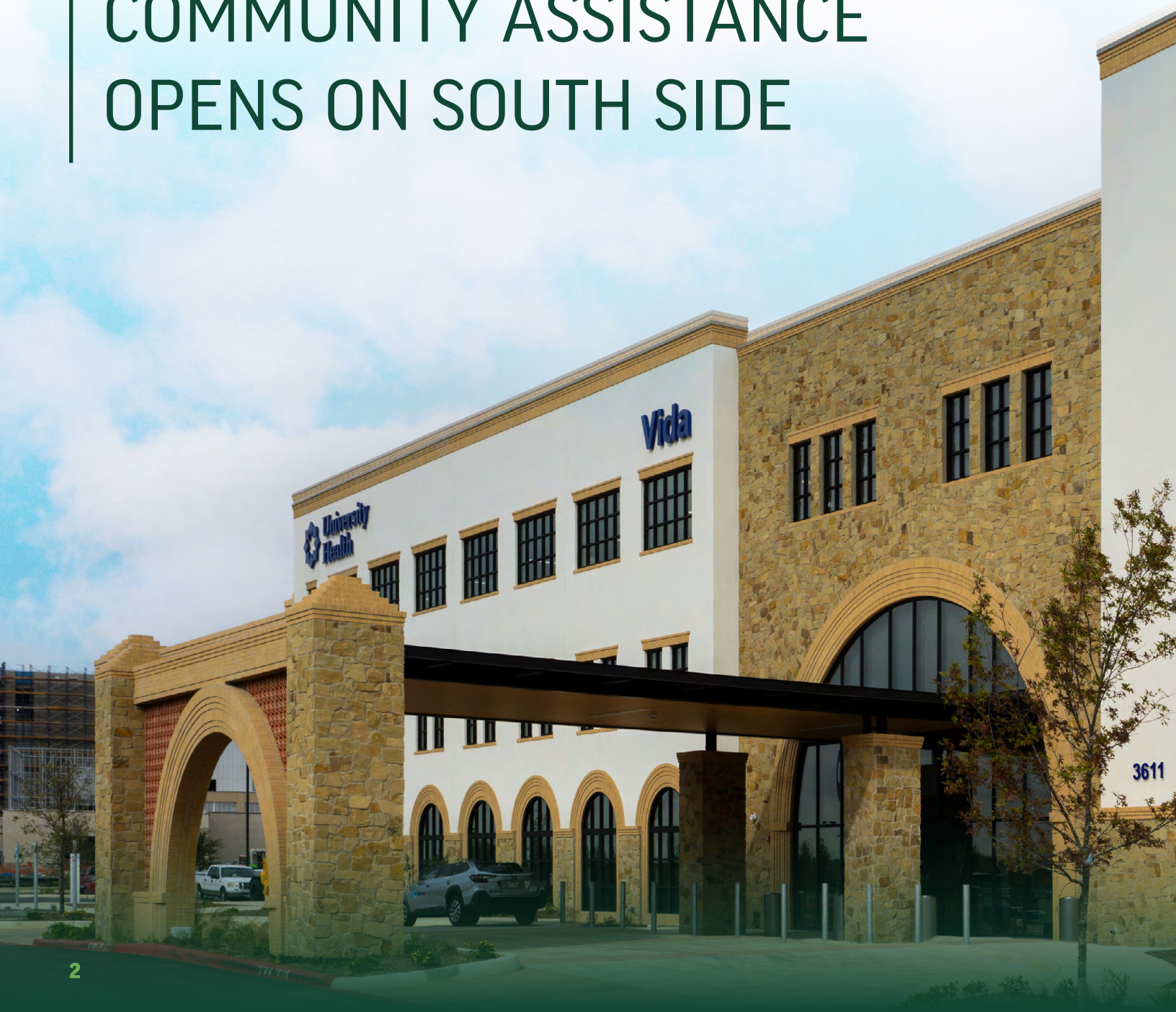
VISIT OUR WEBSITE OR CALL AT:
CommunityFirstHealthPlans.com
210-227-2347 or
toll-free 1-800-434-2347

COMMUNITY FIRST HEALTH PLANS

COMMUNITY FIRST INSURANCE PLANS

CONNECT YOUR PATIENTS TO COMMUNITY SUPPORT

NEW COMMUNITY FIRST COMMUNITY ASSISTANCE OPENS ON SOUTH SIDE



Providers, we are committed to supporting you and the patients you serve.
As health care providers practicing in Bexar County and surrounding areas, you are well aware of the challenges our community faces: health disparities, high poverty rates, and chronic illness. Nearly 1 in 5 residents under 65 are uninsured.

To better meet the needs of our Members — your patients — and our community, we are expanding. **We are excited to announce the opening of our new Community Assistance Office at Vida, located on San Antonio's south side, bringing care and services closer to the families who need them most.**

HOW DO COMMUNITY ASSISTANCE OFFICES HELP PROVIDERS AND PATIENTS?

At our community assistance offices, we guide your patients through coverage eligibility, the application process, and provide referrals to community resources for food, jobs, education, and special health care needs.

We also help Community First insured patients understand their coverage and benefits and renew their plan. Assistance is available in English and Spanish.

Our community assistance offices are designed to operate as a one-stop destination dedicated to helping our neighbors stay healthy and well by ensuring coverage meets their health needs while also connecting them directly with trusted local non-profit organizations who are deeply invested in our community and ready to support a wide range of needs beyond health care.

REFER YOUR PATIENTS TO US!

When patients have reliable coverage, they are more likely to seek preventive care, follow through with treatment, and attend regular appointments. This leads to earlier diagnoses and better management of chronic conditions. And when wider needs are being addressed, patients are more engaged in their care and more likely to build stronger, collaborative relationships with their providers.

WHERE IS THE NEW COMMUNITY ASSISTANCE OFFICE LOCATED?

Our new **Community Assistance Office at Vida** is located on San Antonio's far south side, at the University Health Vida complex, across from Texas A&M University – San Antonio. Members and anyone in need of services are welcome to visit Vida or our **Community Assistance Office at Avenida Guadalupe** located on the city's west side serving our community for 30+ years.

1 **Community Assistance Office at Vida**
3611 Jaguar Parkway, 2nd floor
San Antonio TX 78224

2 **Community Assistance Office at Avenida Guadalupe**
1410 Guadalupe St., Ste. 222
San Antonio, TX 78207

FAQS

Do patients need to be insured with Community First to visit a Community Assistance Office?
No, we are here to serve ALL community members who need our guidance and support.

Do patients need an appointment?
Walk-ins are welcome! However, patients do have the option to make an appointment by calling 210-227-2347, Monday through Friday, 8:30 a.m. to 5:00 p.m. or online at CommunityFirstHealthPlans.com/Community-Office

Are the offices family-friendly?
Yes! Children and families are always welcome. Our offices are equipped with toys, books, and kid-friendly activities.

Can patients receive personalized, confidential support?
Yes, we have private meeting rooms available where we can answer questions and provide information.

LOOKING AHEAD

We are planning to open additional community assistance offices across San Antonio and surrounding counties in the near future to broaden our reach and improve the lives of those we serve.

We pride ourselves on being the only local coverage option that is visibly active in the community, and we are thankful for your partnership in care.

We are here to help!

Sources:
University Health's Institute for Public Health (2023). Community Health Needs Assessment Report UH. universityhealth.com/public-health/-/media/Files/Public-Health/Reports/South-Bexar-County-Community-Health-Needs-Assessment-CHNA.ashx

LTSS: Who Qualifies for Services

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:

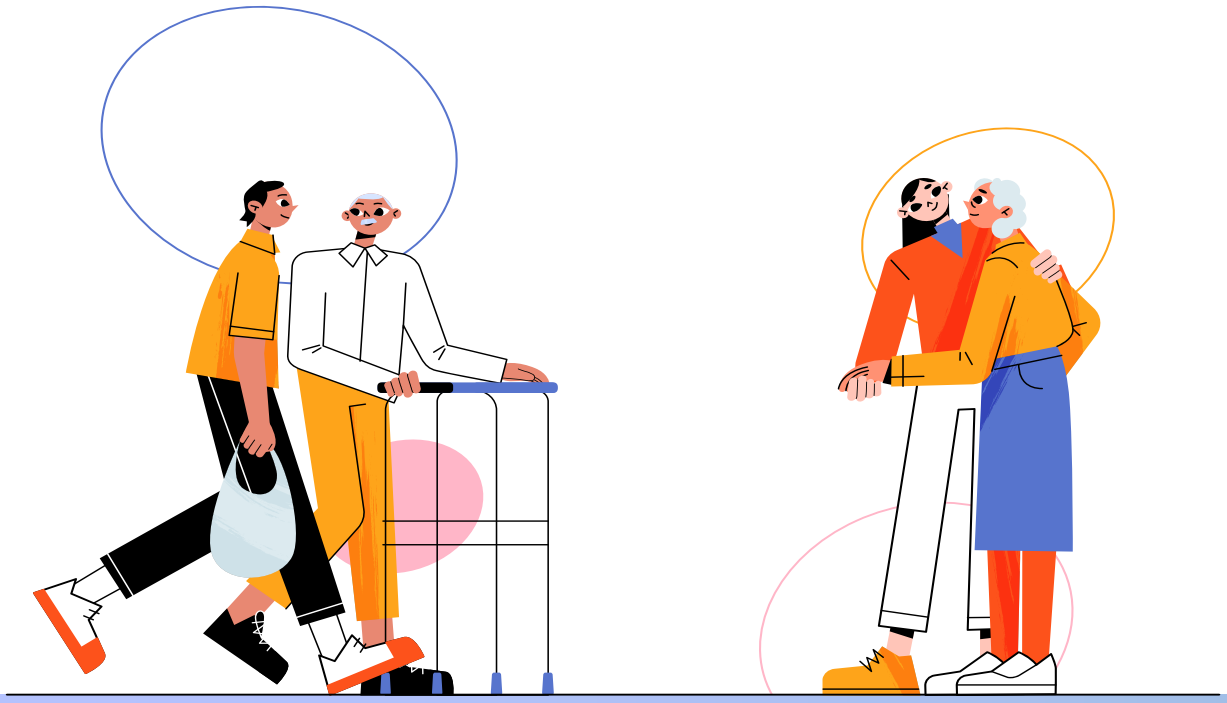
- Receive Supplemental Security Income (SSI)
- Receive disability-related Medicaid services
- Are enrolled in the Medically Dependent Children Program (MDCP)

Community First STAR+PLUS members who meet at least one of the following:

- Age 21 or older, getting Supplemental Security Income (SSI) benefits and able to get Medicaid due to low income.
- Not getting SSI and need the type of services in STAR+PLUS HOME and Community-Based Services.
- Age 21 or older, getting Medicaid through what are called "Social Security Exclusion programs" and meet program rules for income and asset levels.
- Age 21 or over residing in a nursing home and receiving Medicaid while in the nursing home.
- In the Medicaid for Breast and Cervical Cancer program

Waiver Programs

Individuals 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 or STAR+PLUS health plan. All LTSS services are provided through their waiver program.



EVV COMPLIANCE & OPERATIONS FOR AGENCIES AND FMSAS

This resource provides program Providers, Financial Management Services Agencies (FMSAs), and Proprietary System Operators (PSOs) with key updates, responsibilities, and operational expectations under the Electronic Visit Verification (EVV) Policy Handbook and EVV guidelines published by Texas Health and Human Services Commission (HHSC).

EVV Overview for Providers, FMSAs & PSOs

Electronic Visit Verification (EVV) is a computer-based system used to electronically document and verify the delivery of certain Medicaid services—including date, time, service type, and location of service delivery.

The EVV Policy Handbook outlines mandatory EVV standards and requirements for:

- Program Providers
- Financial Management Services Agencies (FMSAs)
- Consumer Directed Services (CDS) Employers
- Proprietary System Operators (PSOs)

EVV is required for Medicaid personal care services (as of January 1, 2021) and home health care services (as of January 1, 2024) under the 21st Century Cures Act.

Compliance Expectations for Agencies and FMSAs

1. Adherence to EVV Policy Requirements

Agencies and FMSAs must fully comply with:

- EVV Policy Handbook rules
- Stand-alone EVV policies posted on the HHSC EVV webpage
- Additional program and licensure rules applicable to their service area

If operating as or applying to be a Proprietary System Operator (PSO), you must also adhere to PSO-specific requirements noted in the handbook and maintain compliance even when content has not yet been fully updated for PSOs.

2. EVV System Responsibilities

Agencies, FMSAs, and approved PSOs are responsible for:

- Ensuring attendants and CDS employees clock in and out using an approved EVV system (vendor or proprietary).
- Maintaining accurate service records for visits, including reason codes when visit maintenance is needed.
- Providing training and education to staff and CDS employers on visit verification requirements.

3. Complete Visit Maintenance Requirements Accurately

When visit data is incomplete or incorrect, agencies/FMSAs must perform visit maintenance, including:

- Selecting appropriate EVV reason codes
- Adding required free-text documentation

Improper or insufficient visit maintenance may trigger compliance actions.

4. EVV Compliance Reviews

HHSC and Community First conduct EVV compliance reviews to ensure adherence to:

- Visit verification rules
- Proper use of reason codes
- Alignment between EVV data and claims

Agencies and FMSAs should remain review-ready by maintaining:

- Up-to-date staff training
- Clear documentation trails
- Internal audit and monitoring processes

EVV Clock In/Clock Out Methods (What Your Staff Must Support)

Attendants must use one of the following:

- EVV mobile method (through an approved mobile app)
- Alternative device placed in the Member's home
- Member's home landline telephone

Agencies/FMSAs must train staff on proper use of these methods and ensure no use of the Member's personal cellphone for EVV.

If an alternative device is used, agencies are responsible for:

- Installation
- Ensuring it remains in the Member's home
- Replacing devices that are removed, damaged, or tampered with

Documentation & Reporting Expectations

Claims Submission
Claims must match verified EVV visit data. Mismatches will result in claim denials. Providers should ensure that all visit details, including service codes, units, and dates of service, are accurately documented in EVV prior to claims submission.

Reason Codes
Accurate reason codes must be used when correcting or validating visits. Each reason code selected must clearly align with the documented issue and include sufficient supporting detail to justify the change and ensure compliance during EVV audits or reviews.

Record Retention
All EVV related documentation must be maintained per HHSC retention rules (typically 5 years unless superseded by contract requirements).

System Updates, Revisions & Training Requirements

Handbook Revisions

Recent EVV Policy Handbook revisions include updated compliance standards, clarified language, new definitions, and changes to accessibility requirements (removal of graphics, diagrams, etc.).

Training

- HHSC regularly updates EVV training on the HHS Learning Portal.
- Agencies, FMSAs, and CDS Employers must complete required EVV trainings after revisions.
- Community First offers live, virtual training sessions designed specifically for Community First Providers. Visit CommunityFirstHealthPlans.com/Provider-Educational-Sessions to register.

Proprietary System Operator (PSO) Notes (If Applicable)

Texas Medicaid & Healthcare Partnership (TMHP) oversees:

- PSO approval and processing
- Operational readiness reviews
- Vendor compliance monitoring

Agencies seeking PSO status must follow TMHP's guidelines and maintain compliance across all EVV rules.

Support & Resources

- **HHSC EVV Webpage:** The HHSC EVV webpage provides access to official emergency services contacts, policies, handbook updates, grievance forms, and statewide guidance related to EVV requirements.
- **TMHP EVV Portal:** The TMHP EVV Portal offers user guides, billing code tables, system resources, and information related to EVV operations and compliance monitoring.
- **Community First Provider EVV Webpage:** The Community First Provider EVV webpage provides EVV guidance, training materials, and the latest policy updates specific to Community First.
- **Community First Provider Porta:** The Community First Provider Portal supports day-to-day administrative workflows, allowing Providers to submit claims and appeals, check claim status, verify Member eligibility, and manage authorization requests. The portal also provides access to key STAR Kids tools, including the STAR Kids Screening and Assessment Instrument (SK-SAI) and the STAR Kids Individual Service Plan (SK-ISP), helping Providers stay informed of patient needs and support effective care coordination.

Final Notes for Agencies & FMSAs

Maintaining EVV compliance requires:

- Ensuring accurate visit verification
- Maintaining readiness for compliance reviews
- Training staff and CDS employers
- Staying updated with EVV policy revisions
- Monitoring system changes issued by HHSC, TMHP, and MCOs

Provider Quick Reference Guide

COMMUNITY FIRST PROVIDER SERVICES & PROVIDER PORTAL

210-358-6030

CommunityFirstHealthPlans.com/ProviderPortal

CALL PROVIDER SERVICES FOR ASSISTANCE WITH:

- Member benefits and eligibility
- Authorizations
- Scheduling medical transportation for a patient
- Service Coordination
- Claims inquiries
- Provider relations, contracts, portal issues, other inquiries

COMMUNITY FIRST PROVIDER PORTAL:
Create an account and log in to the Provider Portal to verify eligibility, streamline claims management, submit auth requests, view auth status/other documents, and find tip sheets and training materials.

CORPORATE CONTACT INFORMATION

Corporate Office Mailing & Physical Address
Community First Health Plans /
Community First Insurance Plans
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

Website: CommunityFirstHealthPlans.com
Phone: 1-800-434-2347

AUTHORIZATIONS

AUTH TYPE	FAX
General	210-358-6040
Medical Inpatient ONLY	210-358-6388
Behavioral Health ONLY	210-358-6387
Long Term Service and Supports (PCS/PAS, DAHS, Meals, ERS, Adaptive Aid, Minor Home Modifications)	210-358-6274
AUTH APPEALS	210-358-6384

PHARMACY AUTHORIZATIONS

	FAX
Navitus (Pharmacy Benefits)	855-668-8553
Clinician Administered Drugs (CAD)	210-358-6385

PROVIDER RELATIONS / NETWORK MANAGEMENT

	EMAIL	FAX
Primary	providerrelations@cfhp.com	210-358-6199

SELF-REFERRALS
No Prior Authorization Needed

PRIOR AUTHORIZATION IS NOT REQUIRED WHEN A PARTICIPATING NETWORK PROVIDER IS UTILIZED FOR:

- Routine obstetrical and/or gynecological services
- Behavioral health (subject to program benefits and limitations)
- EPSDT/Texas Health Steps (Medicaid ONLY)
- Urgent care services provided in a network urgent care facility
- Emergency care provided in a hospital (Community First must receive notification of ER to inpatient setting admission within 24 hours of occurrence)
- Early Childhood Intervention
- Behavioral Health Targeted Care Management

Current authorization lists can be found on the Community First Provider Portal or online at CommunityFirstHealthPlans.com.

BILLING/CLAIMS

ELECTRONIC CLAIMS	PAPER CLAIMS MAILING ADDRESS	PAPER CLAIMS APPEALS MAILING ADDRESS
Availity Payor ID: COMMF	Community First Health Plans / Community First Insurance Plans P.O. Box 240969 Apple Valley, MN 55124	Community First Health Plans / Community First Insurance Plans Attn: Claim Appeals P.O. Box 240969 Apple Valley, MN 55124

CLAIM APPEALS

- Appeal requests must be clearly identified and received by Community First within the appeal deadline specified below.
- Providers should use a Claim Appeal Submission Form when submitting appeals.
- A copy of the EOP and/or other supporting documentation may be required. If an EOP is submitted, de-identify information of other Members on the EOP.
- Appeals must be mailed to the claim appeal address listed above (addressed to "Claim Appeals") or submitted via the Community First Provider Portal.
- All Medicaid claims must be finalized within 24 months from the date of service, discharge date, or inpatient claims.
- If you disagree with an appeal decision, a second appeal must be received by the deadline specified below:

	Commercial/ UFCP	CHIP	STAR/STAR Kids/ STAR+PLUS	Medicare Adv & D-SNP	Marketplace (UCCP)
Filing Deadline	95 days	95 days	95 days	120 days	95 days
Appeal Deadline	90 days	90 days	120 days	60 days	120 days
2nd Appeal	30 days	30 days	120 days	60 days	120 days
COB Deadline	95 days	95 days	95 days	120 days	95 days

NEW PORTAL FEATURE: AUTHORIZATION PRE-CHECK TOOL

We are excited to introduce a **NEW** tool available on the Community First Provider Portal: **Authorization Pre-Check**.

How It Works:

The Authorization Pre-Check tool performs a quick review based on preliminary information to determine whether an authorization is required. If the tool shows that authorization is needed, your pre-check information will automatically transfer to the submission form.

How To Find It:

Log in to the Community First Provider Portal using your existing credentials. Navigate to the Referral & Authorizations dashboard and enter required information.

For step-by-step instructions, read the Authorization Pre-Check Guide available on the portal under Community First U.

We appreciate your partnership as we improve our tools and workflows. Questions? Call Provider Services at 210-358-6030 for support. Additional prior authorization information is also available on our website:

- Prior Authorization - Information For Providers
- Prior Authorization Exemptions - Commercial & Marketplace Provider FAQ

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 select your 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.

4. For the most up-to-date version of the Medicaid PDL, please visit **Medicaid Pharmacy Prior Authorization and PDL.**
5. To obtain a paper copy, please contact Provider Services at **210-358-6030**.

INTERDISCIPLINARY CARE TEAM (ICT) MEETINGS: SUPPORTING CARE COORDINATION FOR PCPS

At Community First, we understand the critical role Primary Care Providers (PCPs) play in coordinating and sustaining high-quality care for Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Members. To support you and your patients, our Medicare Advantage D-SNP program facilitates Interdisciplinary Care Team (ICT) meetings for Members with complex medical, behavioral, or social needs.

Why ICT Meetings Matter

ICT meetings are structured case conferences that bring together a coordinated team of clinicians that includes care coordinators, nurses, pharmacists, behavioral health specialists, and social workers who support the Member's treatment plan.

How ICT Meetings Benefit PCPs

- Reinforce care plan adherence by aligning specialists, behavioral health, and supportive services.
- Address barriers such as medication access, care coordination challenges, and non-medical drivers of health (NMDOH).
- Improve communication between all treating Providers and the health plan.
- Streamline follow-up, reducing duplicated efforts and supporting better continuity of care.
- Support high-risk patients, especially those with chronic conditions, recent hospitalizations, or ongoing social needs.

PCP clinical insight is highly valued and directly influences care plan development.

How We Support Your Practice

Community First has dedicated Case Managers who coordinate ICT meetings and maintain follow-up documentation. PCP participation may be requested when:

- Your input is essential to the patient's care plan.
- A change in treatment or medication management is being considered.
- There is a need to align goals across specialties.
- The Member has complex, ongoing clinical needs.

Our goal is to reduce administrative burden while strengthening collaboration.

To learn more about ICT meetings or to request additional support for one of your Medicare Advantage D-SNP patients, contact us at chelp@cfhp.com.

Together, we can enhance coordination, improve outcomes, and ensure comprehensive, patient-centered care for our shared Medicare Advantage D-SNP Members.

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**
  Lifestyle Management Program
- **HEALTHY EXPECTATIONS**
  Maternity Program
- **HEALTHY HEART**
  Blood Pressure Management Program

A PRESCRIPTION FOR WELLNESS

Community First Health & Wellness Programs offer personalized guidance, one-on-one support, and incentives to help Members improve their health outcomes.

Please explore our program offerings and share these valuable resources with your Community First patients.

COMMUNITY FIRST HEALTH PLANS

HEALTH & WELLNESS 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 can get an asthma kit, pillow cover, mattress protector, gift cards for: participating in Asthma Matters: Asthma Management Program, completing asthma education, receiving a flu shot, and completing three home visits with San Antonio Kids BREATHE.**

Diabetes in Control

Diabetes Management Program

- Diabetes education, self management, and healthy cooking classes
- In-person and virtual fitness classes
- Home visit from a nurse
- Tips to better communicate with providers
- Smart mat that checks foot temperature to help catch complications from diabetes early*
- Referral to YMCA Diabetes Prevention Program (including YMCA membership)*
- Diabetes Garage classes for men with diabetes*

*Members in Diabetes in Control may qualify for gift cards for participating and completing diabetes education, receiving a dilated eye exam, and submitting A1C results (once every six months).**

Healthy Expectations Maternity Program

- Prenatal and postpartum education
- Information about labor and delivery
- Breastfeeding education
- Home visits for high-risk pregnancies*
- In-person or virtual Mommy & Me Baby Shower
- Fourth trimester classes

*Members in Healthy Expectations may qualify for gift cards for each of the following: completing the 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. Members can also receive a gift card toward a pregnancy item or birthing classes.**

Healthy Mind

Behavioral Health Program

- Help determining the type of behavioral health assistance needed
- Mental health resources and education
- Help choosing the right professional, counselor, or doctor
- Case Management for high-risk Members

*Caregivers or parents of qualifying Members or qualifying Members caring for a child/teen with a mental health condition may qualify for a gift card for completing NAMI Basics, a six-class series on mental health.**

Healthy Living

Lifestyle Management Program

- Education on managing and monitoring blood pressure for better heart health
- Referral to YMCA Y Weightloss Program (including YMCA membership)
- Case Management for high-risk Members

Healthy Heart

Blood Pressure Management Program

- Education on managing and monitoring your blood pressure for better heart health
- Referral to YMCA Blood Pressure Management Program (including YMCA membership)*
- 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 patients 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. These programs support and enhance your clinical care.

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

2026 MEDICAID MENTAL HEALTH CARE PROVIDER INCENTIVE PROGRAM

Below is a description of Community First's Incentive/Level 2 Alternative Payment Program effective January 1, 2026 for Mental Health Care Providers and other qualifying Providers based on HEDIS® technical specifications and the provision of services.

Follow-Up After Hospitalization for Mental Illness (FUH)

Mental Health Care Providers and other qualifying Providers* can be awarded up to $100 for each 7-day Follow-Up After Hospitalization for Mental Illness for STAR, STAR Kids and STAR+PLUS. Members, in addition to regular fees for service reimbursement.

Providers that provide 7-day Follow-Up After Hospitalization for Mental Illness 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 for STAR, STAR Kids, and STAR+PLUS Members** with verified eligibility on the date of service in addition to the contracted payment for rendered services.**

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.
Your efforts toward this measure reduce readmission rates and enhance mental health outcomes.

Thank you for prioritizing patient care during a vulnerable time in your patient's life.

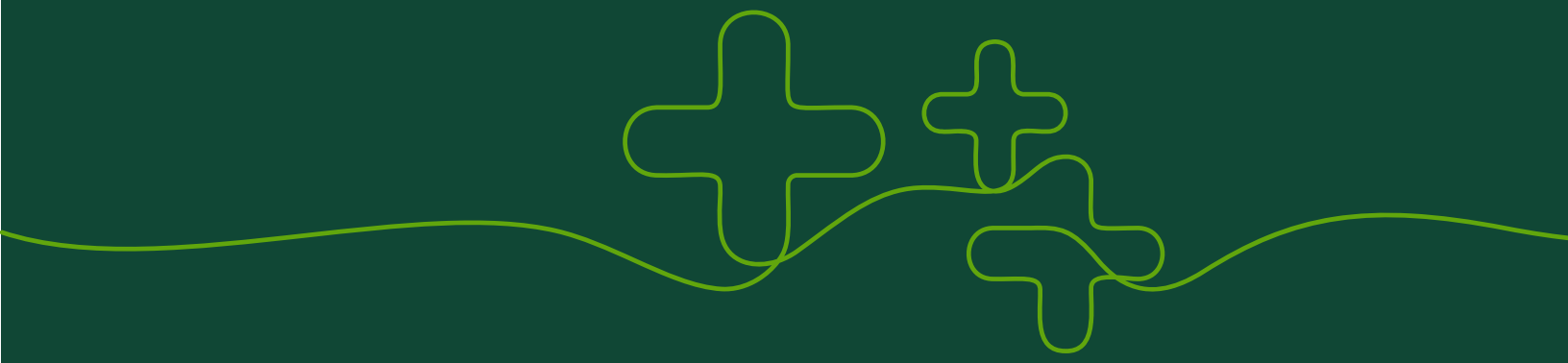
We encourage you to participate in this Medicaid Mental Health Care Provider Incentive Program. If you have any questions about this program or other Community First provider incentive programs, please contact **Narkunan Kesavaram** at nkesavaram@cfhp.com or 210-358-6268.

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.

** Follow-up visit must meet FUH HEDIS technical specifications.*

*** Financial rewards will be distributed quarterly through this program, with payments commencing 90 days after the close of each quarter.*

HEDIS® Tip Sheets



The following HEDIS Tip Sheets and billing guidance are designed by Community First to assist providers, their clinical team, and billing staff with information to improve HEDIS performance. If you have any questions related to HEDIS measures, please contact Provider Services at 210-358-6030.

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, and 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 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

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

INFANT AND EARLY CHILDHOOD DEVELOPMENTAL SCREENINGS UP TO AGE 3

PROVIDER TIP SHEET

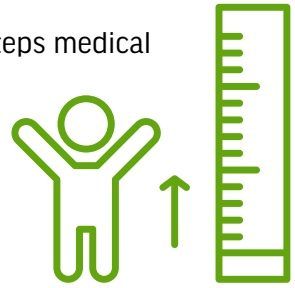
Early screenings for children from birth through age 3 is crucial to ensuring the best possible health outcomes. It's equally important to educate parents about the importance of these screenings so that they schedule them on time and follow through.

This Provider Tip Sheet was created with guidelines on well-child exams and Texas Health Steps from the American Academy of Pediatrics (AAP) and Health and Human Services Commission (HHSC). It should serve as a quick reference for when to screen children in their first few years of life using standardized screening tools for the risk of developmental, behavioral, and social delays.

Age Ranges

A total of eight developmental screenings are allowed up to age 6 with a Texas Health Steps medical checkup/well-child exam within the following age ranges:

- Two screenings from birth to 11 months
- Three screenings from ages 12 to 23 months
- Two screenings from ages 24 to 35 months
- One screening at 3 years of age



Clinical Recommendations

1. The AAP recommends developmental and behavioral screenings for all children during regular Texas Health Steps checkups/well-child visits at 9 months, 18 months, and 30 months.
2. In addition, the AAP recommends that all children be screened specifically for autism spectrum disorder (ASD) during regular Texas Health Steps checkups/well-child visits at 18 months and 24 months.
3. Developmental surveillance should be a component of every preventive care visit. Educate staff to schedule office visits within recommended time frames.
4. Standardized developmental screening tools should be used when surveillance identifies concerns about a child´s development.

Texas Health Steps/Well Child Checkup Recommended Standardized Screening Tools

Screening Ages	Developmental Screening Tools	Autism Screening Tools
9 months	ASQ or PEDS	
12 months	ASQ or PEDS if not completed at 9 months or if provider/parental concern	
18 months	ASQ or PEDS	M-CHAT
24 months	ASQ or ASQ-SE or PEDS	
30 months	ASQ or PEDS if not completed at 24 months or if provider/parental concern	
3 years	ASQ or ASQ-SE or PEDS	
4 years	ASQ or ASQ-SE or PEDS	

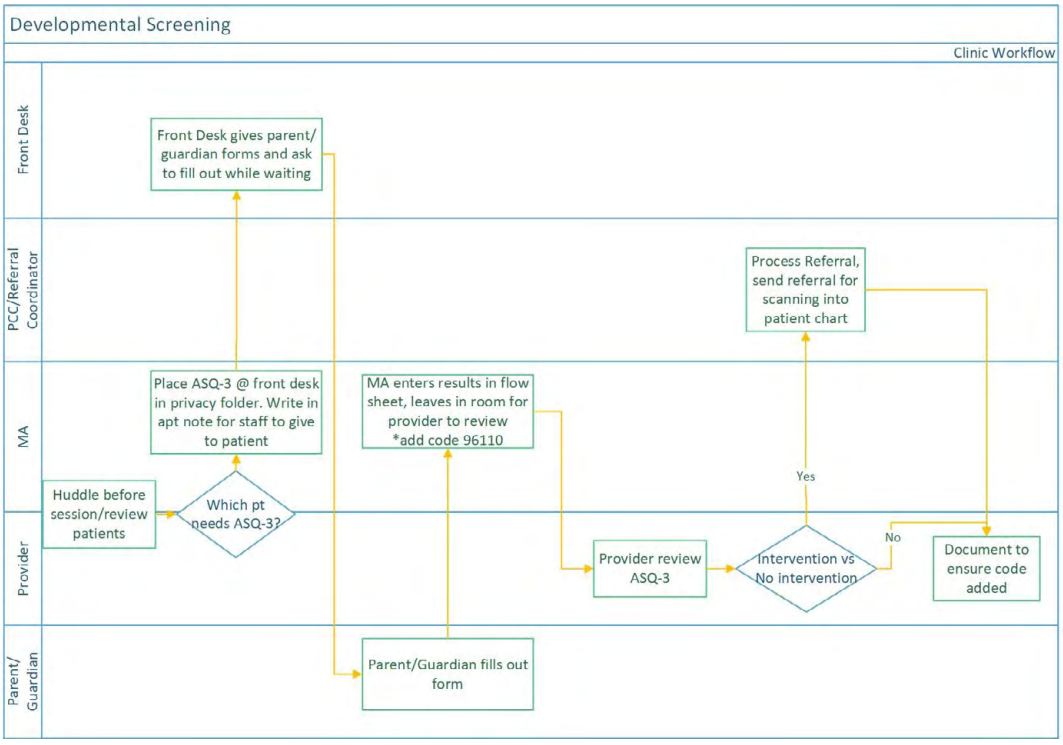
CPT Codes

- **CPT Code 96110:** Use for developmental testing, with an interpretation and report, billed twice in a 12-month period.
- **CPT Code 96110 with modifier U6:** Use when additional screenings are performed for the screening of autism. This billing will not count toward the twice-yearly allowable regular screenings.

Best Practices

- Integrate screening protocols into routine pediatric care to enhance detection of developmental delays during subsequent assessments (American Academy of Pediatrics, AAP.org).
- Perform developmental observation and screenings during each health visit using a validated tool at 9, 18, and 30 months of age (AAP). Framing developmental surveillance as "monitoring" may facilitate understanding when discussing it with families.
- Increase screening frequency for children with additional risk factors such as preterm birth, low birth weight, and exposure to lead, among others.
- Actively solicit and address parental concerns regarding their child's development.
- Screen for maternal depression at 1, 2, 4, and 6-month visits, recognizing its impact as an adverse childhood experience affecting infants and children (AAP).
- Assess parents/guardians for non-medical drivers of health (NMDOH) (formerly social determinants of health, SDOH) and other risks such as food insecurity or housing instability at each patient encounter.
- Conduct regular screenings for social-emotional development at recommended intervals.
- Follow the developmental screening workflow below.

Developmental Screening Workflow



Sources:

- Texas Health Steps Anticipatory Guidance Provider Guide
- Texas Health Steps Periodicity Schedule

Coding for Controlling Blood Pressure (CBP)

PROVIDER TIP SHEET

Coding for Controlling Blood Pressure (CBP)

As part of Community First's ongoing efforts to improve care and ensure compliance with the Healthcare Effectiveness Data and Information Set (HEDIS®) measures, we want to remind our network of Providers about the importance of accurate coding and documentation. Accurate coding and documentation are essential for meeting HEDIS requirements and ensuring timely and proper reimbursement.

HEDIS Measure Description

Coding for Controlling Blood Pressure (CBP) tracks the percentage of adults aged 18 to 85 with a hypertension diagnosis, who were screened for CBP according to established guidelines, and whose blood pressure is controlled. Blood pressure is considered controlled if the most recent reading during the measurement year is <140/90mm Hg.

Recommended Screening Guidelines

Clinical practical guidelines recommend screening patients within this population who meet these restrictions or requirements during the measurement year or in the previous years.

Coding Guidelines

Systolic Blood Pressure:	
Description	**CPT II Code**
<130 mm Hg	**3074F**
130-139 mm Hg	**3075F**
≥ 140 mm Hg	**3077F**

Diastolic Blood Pressure:	
Description	**CPT II Code**
<80 mm Hg	**3078F**
80-89 mm Hg	**3079F**
≥ 90 mm Hg	**3080F**

ICD-10 Code I10 - Essential (Primary) Hypertension

HEDIS Best Practices

Key requirements for HEDIS compliance: Documentation of the lowest systolic and diastolic blood pressure reading from the most recent blood pressure notation in the medical record during the measurement year.

- Document exact blood pressure readings (no rounding).
- Take blood pressure and record it in the patient's medical record at every office visit, telehealth visit, e-visit, or other virtual check-in.
- If the initial readings are ≥140/90, recheck at the end of the visit.
- Communicate and provide specific goals regarding management of medical condition(s).
- Schedule follow-ups for uncontrolled blood pressure.
- Encourage patients to use a validated digital device to track and report their blood pressure values. If the reading is captured with a digital device, patient-reported data is acceptable to document in the medical record.
- Ranges and thresholds do not meet the criteria for this measure. A distinct numeric result for both the systolic and diastolic blood pressure readings is required.
- Educate on what to do to maintain compliance with medications and lifestyle, especially during special circumstances like traveling or celebrations.
- Provide information/education about different blood pressure medications (printed materials, videos, self-study programs, referrals to community organizations, etc.).

Community First Resources

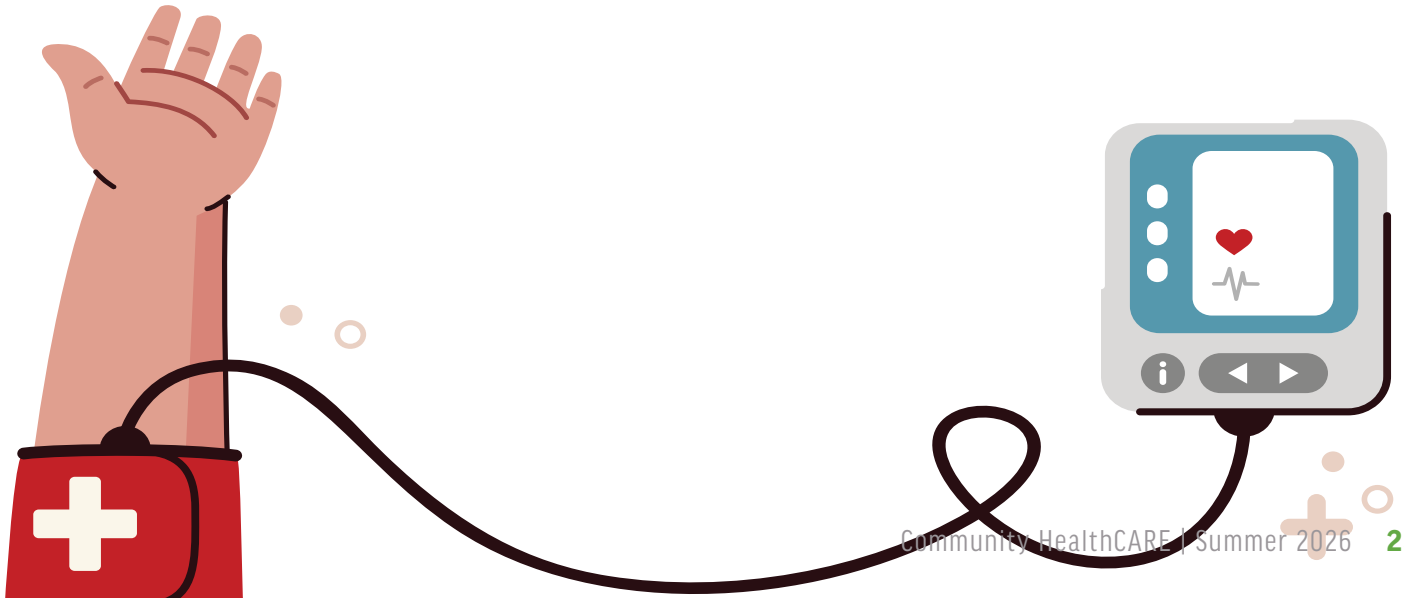
Refer Community First Members to these additional no-cost resources:

» Healthy Heart: Blood Pressure Management Program: This program offers Members education and resources to help them manage their high blood pressure by making healthy lifestyle changes

» YMCA Blood Pressure Self-Monitoring Program: Participating Members may be eligible for a 4-month YMCA family membership and a blood pressure cuff, while supplies last

References

1. Centers for Disease Control and Prevention (2024, December 13). *Managing High Blood Pressure*. CDC. https://www.cdc.gov/high-blood-pressure/living-with/index.html
2. Centers for Disease Control and Prevention (2024, December 13). *Team-Based Care to Improve Blood Pressure Control*. CDC. https://www.cdc.gov/high-blood-pressure/php/data-research/team-based-care/index.html



PROVIDER TIP SHEET

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH) WITHIN 7 AND 30 DAYS

Why is the FUH HEDIS® Measure important?

Evidence suggests that individuals who receive follow-up care after a psychiatric hospitalization experience a reduction in readmission rates to inpatient facilities. Additionally, delivering consistent continuity of care can lead to better mental health outcomes and facilitate a patient's return to their baseline functioning in a less-restrictive care setting.

What does the FUH Measure assess?

The FUH measure assesses the percentage of discharges for Members ages six and above who were hospitalized for treatment of a mental health or intentional self-harm diagnosis and who had a follow-up visit with a mental health provider within **seven days** of their discharge, but no later than **30 days** from the discharge date.

What population is included in the measure?

Members hospitalized with a primary diagnosis of mental illness or intentional self-harm. This measure applies to Members ages six and up across the Commercial. Medicaid, and Medicare lines of business.

When does a Member "pass" the measure?

Providers should document the date of the first follow-up visit that is at least one calendar day after discharge.

This measure calculates two rates for the first follow-up visit:

- **Within 7 days**
- **Within 30 days**

If the first follow-up visit is within seven days after discharge, then both rates are counted for this measure.

A follow-up visit is with a mental health provider, or with any practitioner for any diagnosis of a mental health disorder.

Which services qualify to meet the measure?

Follow-up claims, including claims for any of the following services, qualify to meet this measure:

- Outpatient visit with a mental health Provider
- Medication management with a Psychiatrist/APN/PA with a mental health license or certificate
- Community support team (CST)
- Psychosocial rehabilitation (PSR)
- Intensive outpatient program (IOP)
- Partial hospitalization (PH)
- Opioid treatment/SA non-medical community residential treatment
- Targeted case management (TCM)
- Behavioral health day treatment
- Electroconvulsive therapy (ECT)
- Mental health and/or substance use assessments, screenings, treatment planning
- Community-based wrap-around and/or day treatment services
- Telehealth or telephone visit with a mental health provider
- Psychiatric collaborative care management
- Peer support services (PSS)

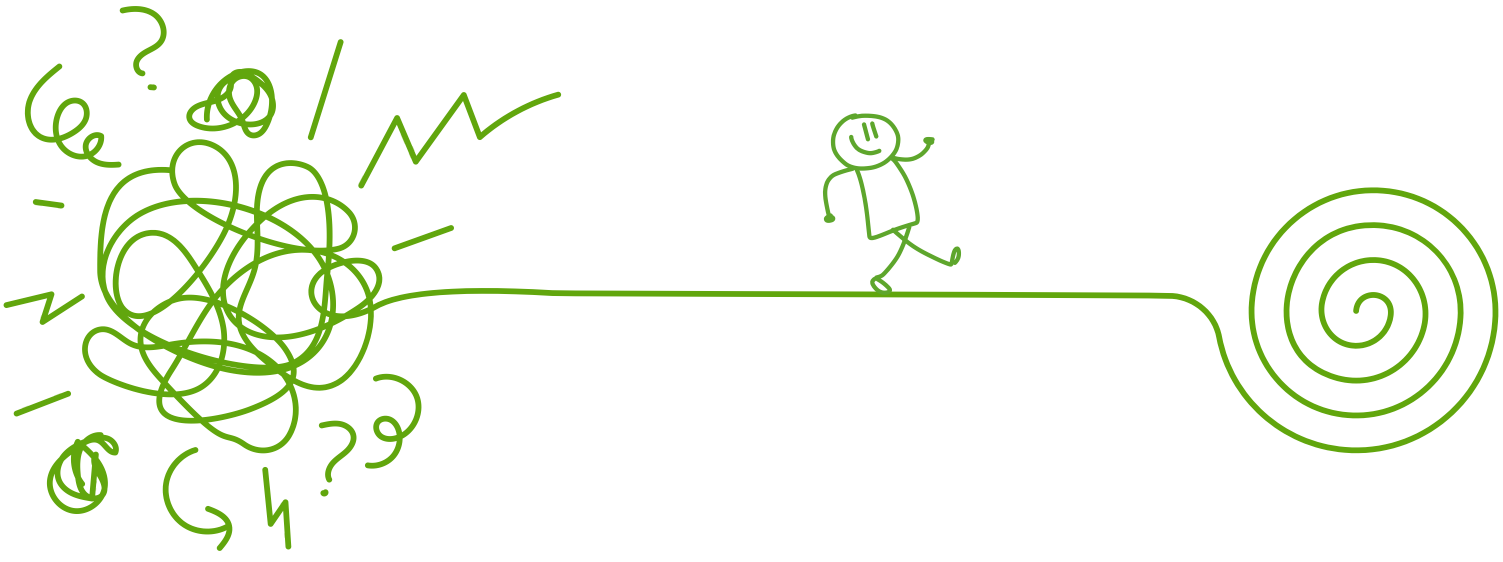
Best Practice Recommendations

Inpatient Providers

- Initiate discharge planning upon admission, maintaining its continuous and tailored progression.
- Schedule the patient's post-discharge appointment in advance.
- Engage the patient and family in all stages of discharge planning.
- Ensure Members have adequate access to prescribed medications.
- Attempt to address and mitigate barriers hindering post-discharge appointment attendance.
- Develop local referral sources of outpatient providers who can provide aftercare to patients within seven days of discharge.
- Ensure the prompt transmission of the Member's discharge documentation to both the outpatient provider and Community First within 24 hours.
- Invite care coordinators to meet Members to facilitate the process or aftercare planning.

Outpatient Providers

- Offer telehealth and phone visits.
- Ensure flexibility when scheduling appointments for patients who are being discharged from acute care to allow for appointments to be scheduled within seven days of discharge.
- Make reminder calls to Members before appointments and after a missed appointment to reschedule.
- Review medications with patients to ensure they understand the purpose, appropriate frequency, and method of administration.
- Educate staff on local resources to assist with barriers such as transportation needs.
- Establish communication pathways with inpatient discharge coordinators at local facilities.
- Coordinate care between behavioral health and primary care physicians by sharing progress notes and updates.
- Use complete and accurate value set codes.
- Submit claims in a timely manner.



FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH) WITHIN 7 AND 30 DAYS, continued

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 99252 99253 99254 99255	N/A	03 05 07 09 11 12 13 14 15 16 17 18 19 20 22 33 49 50 71 72	N/A
BH Outpatient	98000 98001 98002 98003 98004 98005 98006 98007 98960 98961 98962 99078 99202 99203 99204 99205 99211 99212 99213 99214 99215 99242 99243 99244 99245 99341 99342 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 G0560 H0002 H0004 H0031 H0034 H0036 H0037 H0039 H0040 H2000 H2010 H2011 H2013 H2014 H2015 H2016 H2017 H2018 H2019 H2020 T1015	N/A	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
Psychiatric Collaborative Care Management	99492 99493 99494	G0512	N/A	N/A
Community Mental Health Center	N/A	N/A	53	N/A
Electroconvulsive Therapy	90870	N/A	24 52 53	N/A
Behavioral Healthcare Setting	N/A	N/A	N/A	0513 0900 0901 0902 0903 0904 0905 0907 0911 0912 0913 0914 0915 0916 0917 0919 1001
Transitional Care Management Services	99495 99496	N/A	N/A	N/A
Telephone Visits	98008 98009 98010 98011 98012 98013 98014 98015 98966 98967 98968 99441 99442 99443	N/A	02 10	N/A
Residential Behavioral Health Treatment	N/A	H0017 H0018 H0019 T2048	56	N/A
Peer Support Services	N/A	G0140 G0177 H0024 H0025 H0038 H0039 H0040 H0046 H2014 H2023 S9445 T1012 T1016 T1017	N/A	N/A

*Refer to the current year ICD-10 CM manual for additional codes and guidelines.

UPCOMING POLICY CHANGES RELATED TO IMPROVEMENTS IN CLAIMS PROCESSING

Effective August 3, Community First will enhance its existing claims processing program to improve the overall accuracy of claim processing in partnership with Cotiviti.

The goals of this endeavor are to implement, to the extent possible, claim payment policies that are broad in scope, simple to understand, and that come from regulatory guidance. We believe that this will enable you and your billing staff to more readily understand our payment of claims given the widespread use of these policies.

Industry Standards Driving These Updates

Community First's payment policies are based on nationally accepted methodologies for claims payment, including:

- American Medical Association (AMA) CPT® coding guidelines
- National and regional Medicare policies
- National specialty academy guidelines
- State Medicaid guidelines, as applicable

Key Areas of Focus

These enhancements align with established coding and billing practices, including:

- CPT® procedure code definitions and guidelines
- National Correct Coding Initiative (NCCI) edits
- Appropriate modifier usage
- ICD-10-CM diagnosis coding guidelines
- Global surgery periods
- Evaluation and Management (E/M) guidelines
- Add-on code usage
- Professional, technical, and global billing rules
- Diagnosis-to-procedure alignment
- Place of service requirements
- Age-appropriate services
- CMS National and Local Coverage Determinations (NCDs and LCDs)
- Revenue code validation

Beginning August 3, 2026, Providers may receive claims denials or payment changes based on these enhanced claim editing concepts on your Explanation of Benefits or electronic remittances. For additional information on the specifics of your claim submission payment decisions, or to file a grievance or appeal, please contact Provider Services at 210-358-6030 or use our online directory to contact your Provider Relations representative directly.

Please review the following coding guidance on pages 32-35 to minimize the chance of claims denials or payment changes based on our new, enhanced claim editing concepts effective August 3.

Servicing Facility Location Reporting on Professional Claims (837P):

Correct Use and Coding Guidance

Community First is providing guidance on the correct reporting of Servicing Facility Location information on professional claims submitted using the 837P electronic claim format. Accurate reporting of the Servicing Facility is required when services are rendered at a location different from the billing Provider's address and is necessary to support proper claim adjudication.

Effective August 1, 2026, claims that do not include required Servicing Facility Information, when applicable, may be rejected.

When Servicing Facility Reporting Is Required

Servicing Facility information must be reported only when both of the following apply:

1. Services were rendered at a location different from the billing Provider's address, and
2. Identification of the Servicing Facility is required for accurate claims processing.

If services are rendered at the billing Provider's address, the Servicing Facility Loop should not be populated.

How to Report the Servicing Facility (837P Claims)

When submitting professional claims electronically using the 837P format, Providers must report Servicing Facility information in the Service Facility Location Loop (Loop 2310C), as outlined below.

Segment/Element	Value	Description
NM101	77	Entity Identifier (Service Location)
NM103	Name	Full legal name of the servicing facility
NM109	NPI	Servicing facility NPI is required and must be enrolled in the Provider Enrollment Management System (PEMS) or NPPES. Missing NPI will result in a claim rejection
N3 Segment	Street Address	Physical address (No P.O. Boxes)
N4 Segment	City/State/ZIP	Must include 9-digit ZIP code (ZIP+4)

Claims submitted without all required elements in Loop 2310C, when applicable, will be rejected.

Important Reminders

- The Servicing Facility Loop should only be populated when appropriate.
- The NPI submitted must belong to the facility where services were rendered, not the billing Provider.
- Claims submitted without a valid 9-digit ZIP code in Loop 2310C may be rejected.

When services are rendered at a location other than the billing Provider's address, accurate Servicing Facility reporting on 837P claims is required. Claims that do not meet these requirements may be rejected.

Community First Resources

- The **Community First Provider Resource Page** offers additional tip sheets and resources to support your practice and help you stay current on state news and training opportunities.

Additional Resources

- The **National Correct Coding Initiative (NCCI) Page** provides CMS guidance on correct coding methodologies, including procedure-to-procedure edits and modifier use.

- The **American Medical Association (AMA) Current Procedural Terminology (CPT®) page** offers official CPT® coding definitions, guidelines, and modifier instructions used across payers.

- The **Center for Medicare and Medicaid Services Medicare Learning Network® (MLN) page** offers educational materials for health care Providers on CMS programs, policies, and initiatives.

LABORATORY MODIFIERS 59 AND 91: CORRECT USE AND CODING GUIDANCE

Community First is providing clarification on the appropriate use of laboratory modifiers 59 and 91. These modifiers are valid for many laboratory services and may be required when multiple laboratory services described by a single CPT® code are performed for the same patient on the same date of service by the same provider.

Modifier 59 – Distinct Procedural Service

Modifier 59 is used to indicate that a laboratory service is separate and distinct from another laboratory service billed on the same date of service, even when the same CPT® code is reported.

Appropriate use includes situations such as:

- The same laboratory test performed on different specimens
- Testing performed on different species or strains
- Distinct laboratory services that produce separately reportable results

CPT® guidance notes that modifier 59 may be reported when the same procedure code is used for testing different specimens, species, or strains, and when separate results are reported for each.

Modifier 59 should not be used:

- When a more specific modifier is available
- To routinely bypass National Correct Coding Initiative (NCCI) edits
- When services are duplicative and not distinct

Think: Different service, Different circumstance.

Modifier 91 – Repeat Clinical Diagnostic Laboratory Test

Modifier 91 is used when the same laboratory test is repeated on the same patient, same date of service, to obtain subsequent results that are medically necessary for patient management.

Appropriate use applies only when all criteria are met:

- Same CPT® code
- Same patient
- Specimen collected more than once on the same day
- Repeat testing is medically necessary and clearly documented

Examples include repeated laboratory tests performed at different intervals during the same day for ongoing monitoring, such as serial blood glucose or electrolyte testing.

Think: Same test, repeated for a valid clinical reason.

When Modifiers 59 or 91 Should Not Be Used

According to CPT® guidance, modifiers 59 and 91 should not be appended to laboratory codes in the following circumstances:

- Reruns performed to confirm test results
- Testing repeated due to specimen or equipment issues
- When another procedure code describes a series or panel test
- When the procedure code itself represents a series of tests
- When a one time result is required and no subsequent result is clinically necessary

Documentation Requirements

For both modifiers, documentation must clearly support use of the modifier, including:

- Medical necessity
- Distinct specimens or collection times, when applicable
- Clinical rationale for distinct or repeat testing

Key Takeaway

- Modifier 59: Use for distinct laboratory services
- Modifier 91: Use for a medically necessary repeat of the same laboratory test

Modifiers should only be applied when documentation clearly supports their use.

Community First Resources

The **Community First Provider Resource page** offers additional tip sheets and resources to support your practice and help you stay current on state news and training opportunities.

Additional Resources

- The **National Correct Coding Initiative (NCCI) page** provides CMS guidance on correct coding methodologies, including procedure-to-procedure edits and modifier use.
- The **American Medical Association (AMA) Current Procedural Terminology (CPT®) page** offers official CPT® coding definitions, guidelines, and modifier instructions used across payers.
- The **American Academy of Professional Coders (AAPC) "What Are Medical Coding Modifiers" page** explains the purpose and appropriate use of modifiers to support accurate medical coding and claims submission.

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 health care provider.**

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.

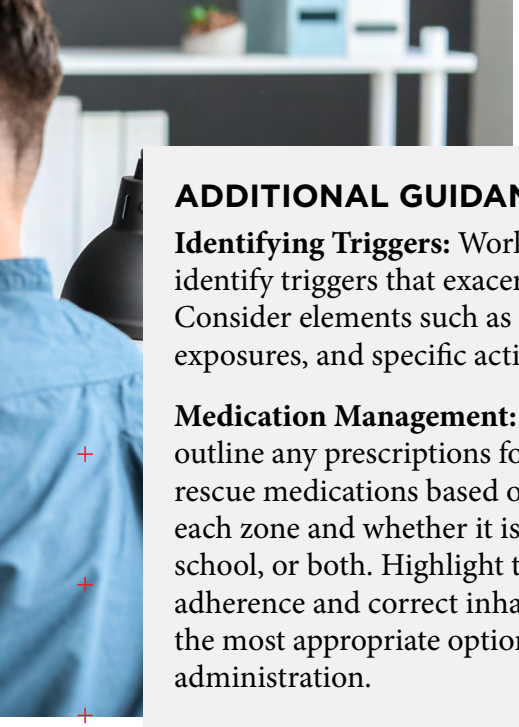
INSTRUCTIONS

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 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 and allergy-free pillow protector
- $10 gift card for completing asthma education

**Limitations and restrictions apply.*

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.

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.

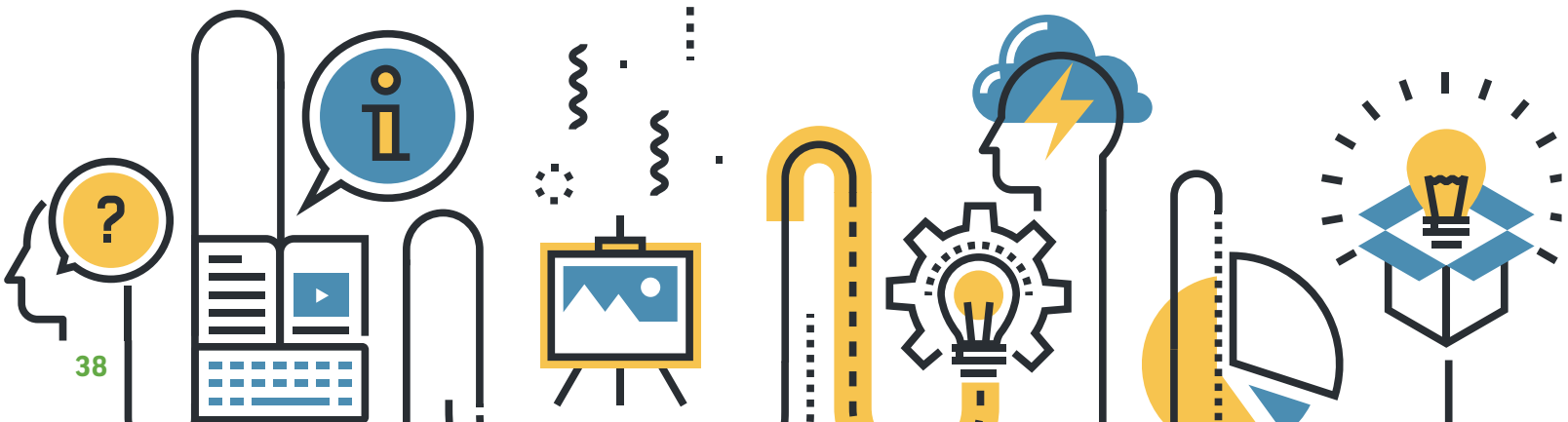
Appeals

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 **210-358-6030** and press "2" 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.



SUPPORTING CARE: WORKING TOGETHER TO CONNECT PHYSICAL AND BEHAVIORAL HEALTH

At Community First, we recognize the essential role Primary Care Providers (PCPs) play in supporting Behavioral Health (BH). As often the first point of contact, PCPs serve as a critical link between Members' physical and mental health needs. We also understand that effective collaboration can be challenging—especially when Providers operate across different Electronic Health Record (EHR) systems. That's why we are committed to simplifying communication and supporting more seamless coordination of care.

WHAT HAPPENS WHEN CARE IS CONNECTED?

- Improved quality of care
- Reduction in health care costs
- Enhanced patient safety
- Greater patient care experience
- Efficient delivery of care

SIMPLE STEPS FOR STRONGER CARE CONNECTIONS

Here are some requirements and tips to facilitate the flow of communication between different health care settings and Providers.

- A release of information form must be on record for information to be shared between the PCP and the BH Provider.
- BH Providers and PCPs are required to send each other initial and updated (quarterly or more frequently, if clinically indicated) summary reports of a Member's physical and BH status (as agreed to by the PCP team members and with the consent of the Member or the Member's legal guardian).
- BH Providers are required to refer Members with known or suspected and untreated physical health problems or disorders to their PCP (with the consent of the Member or the Member's legal guardian).

COMMUNICATION FORM

Community First has developed a standardized communication form to help facilitate information sharing between physical and BH Providers.

Our Quality Management clinical staff monitors for the presence of release forms and indication of communication between BH Providers and PCPs during medical record documentation audits.

When PCPs and BH Providers work together, patients receive more consistent, comprehensive support. We're committed to working alongside you to simplify processes, strengthen connections, and most importantly, help every Member get the care they deserve.

NAMI Basics

National Alliance on Mental Illness
Greater San Antonio

Education and support for parents and caregivers of children and teens with mental illness

What is NAMI Basics?

Community First is partnering with the National Alliance on Mental Illness (NAMI) Greater San Antonio to offer NAMI Basics, a free, six-week class created to provide education, support, and resources for caregivers of children, teens, and young adults diagnosed with a behavioral health condition. * NAMI Basics is available to parents/caregivers of Members with a diagnosed mental health condition or substance use disorder or Members who are caregivers for children and teens with a mental health condition or substance use disorder.

NAMI Basics Class Topics

I. Mental Health Conditions Are No One's Fault

II. Brain Biology & Getting A Diagnosis

III. Treatment

IV. Communication Skills & Crisis Prevention

V. Navigating Mental Health, School, & Juvenile Systems

VI. Advocacy, Self-Care, & Evaluation

Those who attend the six-week NAMI Basics class may be eligible to receive rewards for participating, including a $50 gift card (one gift card per eligible Member or parent/caregiver of an eligible Member). Limitations and restrictions apply.

Recovery is a journey, and there is hope. You are not alone! The group setting of NAMI Basics provides mutual support and helpful information for shared positive impact. Experience compassion and gain strength and knowledge from people who understand your situation because they have lived through it.

About NAMI Greater San Antonio: NAMI Greater San Antonio provides advocacy, education, support, and public awareness to help individuals and families affected by mental illness build better lives.

*Age range eligibility depends on the individual health care plan.

Community First Members or their parent/caregiver can register for NAMI Basics by scanning the QR code or online at CommunityFirsthealthPlans.com/NAMI-Basics-Education-Program-Form.
Call 210-358-6055 or email healthyhelp@cfhp.com for help.

If you are not a Community First Member and would like to register, contact NAMI Greater San Antonio at 210-256-2421.

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 symptoms.

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. and Texas.

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/PeriPAN.
- 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.

RESPONDING TO RISING RATES: NEW SUPPORT FOR CONGENITAL SYPHILIS PREVENTION

Texas continues to see rising rates of congenital syphilis, highlighting the continued vigilance in prenatal care. Early screening, timely diagnosis, and appropriate treatment during pregnancy are critical to preventing transmission and improving outcomes for infants.

To support Providers in these efforts, the Texas Department of State Health Services (DSHS) has released new resources designed to help with both prevention and clinical management. Community First is sharing these tools to help strengthen care delivery and support better outcomes for patients

Congenital Syphilis Consultation Hotline:

The Congenital Syphilis Consultation Hotline is available to support Providers caring for pregnant women and infants with suspected or confirmed syphilis.

- **Phone: 833-623-6327 (833-62-END-CS)**
- **Hours: Monday through Friday, 8:00 a.m. – 5:00 p.m. (expanded evening hours expected in the future)**

This resource provides direct access to clinical experts and offers support for complex cases, including case-specific guidance and referrals to regional prevention and treatment services. Providers are encouraged to use the hotline when additional clinical input is needed.

Additional details are available on the Congenital Syphilis Hotline Flyer *(Texas Health and Human Services).*

Congenital Syphilis Prevention Training

DSHS has also launched an online training module, Congenital Syphilis Prevention: Screening, Diagnosis, and Treatment for Pregnant Women in Texas, that offers practical guidance on:

- **Prenatal screening recommendations**
- **Diagnosis and treatment protocols**
- **Strategies to reduce barriers to care**
- **Information on health disparities impacting congenital syphilis rates in Texas**

The activity is approved for 1.25 continuing education hours, including credit in the medical ethics/professional responsibility category for CME. Continuing education credits are also available for multiple disciplines, including nurses, certified health education specialists, and social workers.
Providers may review the training flyer or visit the DSHS Training Website for more information. (PDF)

We encourage Providers to take advantage of these resources to support early detection, improve care coordination, and help reduce the impact of congenital syphilis for mothers and infants across Texas.

REFUNDING OVERPAYMENT MAILING ADDRESS – IMPORTANT REMINDER

THIS INFORMATION APPLIES TO PROVIDER REFUNDS ONLY.

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

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

Please mail this information to:
Community First Health Plans
P.O. Box 2409
San Antonio, TX 78298

If you have questions, please reach out to our Provider Relations team at 210-358-6030 or email ProviderRelations@cfhp.com.

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 Provider Services at 210-358-6030.

HEDIS® The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

NOTES:

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 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 by phone, fax, or email at:

Community First Compliance Coordinator
Phone: 210-227-2347 | 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 de 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 ni 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 formatos)

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

— Intérpretes calificados
— Información escrita en otros idiomas

Si usted necesita recibir estos servicios, comuníquese con Servicios para Miembros de Community First al número que aparece en el reverso de su tarjeta de Miembro o al 1-800-434-2347. Si tiene dificultades auditivas, por favor llame al 711. Si usted cree que Community First no le proporcionó servicios lingüísticos gratuitos o que fue discriminado/a de cualquier otra manera por motivos de su raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género u orientación sexual, usted puede comunicarse con Community First por teléfono, fax o correo electrónico:

Coordinador de Cumplimiento Regulatorio de Community First
Teléfono: 210-227-2347 | TTY: 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 | TTY: 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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-434-2347 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-434-2347 (TTY: 711) o hable con su proveedor.

پاملرنه: که چېرې تاسو په پښتو ژبه خبرې کوئ، په وړیا ډول د ژبې د مرستې خدمتونه ستاسو لپاره د لاسرسي وړ دي. د لاسرسي وړ بڼو کې د معلوماتو د وړاندې کولو لپاره مناسبې مرستې او خدمتونه په وړیا ډول د لاسرسي وړ دي. له 1-800-434-2347 (TTY: 711) شمېرې سره اړیکه ونیسئ یا د خپلو خدمتونو له چمتو کوونکي سره اړیکه ونیسئ.

تنبيه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-434-2347 (TTY: 711) أو تحدث إلى مزوّد الخدمة.

ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-434-2347 (TTY : 711) ou parlez à votre fournisseur.

توجه: اگر به فارسی صحبت می کنید، خدمات رایگان کمک زبانی در دسترس شماست. کمک‌ها و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس نیز به صورت رایگان در دسترس هستند. با شماره 1-800-434-2347 (TTY: 711) تماس بگیرید یا با ارائه دهنده خدمات خود صحبت کنید.

توجه: اگر شما دری صحبت می کنید، خدمات کمک زبان رایگان برای شما در دسترس است. کمک ها و خدمات کمکی مناسب برای ارائه معلومات در فارمت های قابل دسترس نیز به صورت رایگان در دسترس است. با 1-800-434-2347 (TTY: 711) تماس بگیرید یا با ارائه کننده خود صحبت کنید.

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-434-2347（文本电话：711）或咨询您的服务提供商。

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-434-2347 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ICYITONDERWA: Niba uvuga Ikinyarwanda, ufite serivisi z'ubufasha bw'ururimi ku buntu. Ibikoresho na serivisi byunganira bitangwa ku buntu kugira ngo amakuru atangwe mu buryo bworoshye kumva. Hamagara 1-800-434-2347 (TTY: 711) cyangwa uvugishe umuganga wawe.

DÍYAN DO: Zodi oñne Rohingya hotá hoo, toíle oñnolla maana zubani modot ókkol ase. Lootfaíbade formeth ót maalumat dibolla munasef modotgorede caíjjo adde hédmot oñnolla taíbo. Kool goró 1-800-434-2347 (TTY: 711) ót yá oñnor dekbal doya loí hotá hoo.

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-800-434-2347 (TTY: 711) au zungumza na mtoa huduma wako.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-434-2347 (TTY: 711) o makipag-usap sa iyong provider.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-434-2347 (TTY: 711) или обратитесь к своему поставщику услуг.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-434-2347 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

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