

COMMUNITY FIRST
HEALTH PLANS

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) Provider Training

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What is a FIDE Plan?

A **Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)** is a Medicare Advantage plan that fully integrates Medicare D-SNP and Medicaid (STAR+PLUS dual) benefits for individuals who are eligible for both programs.

FIDE plans coordinate medical, pharmacy, behavioral health, and long-term care services through a single health plan, providing Members with streamlined access to care and support.

How Medicare and STAR+PLUS Benefits Work Together

Medicare Advantage D-SNP	STAR+PLUS Dual Eligible
Medicare-covered medical and prescription drug benefits	Medicaid-covered medical and long-term care benefits
Primary care, specialists, hospital services, preventive care	Personal attendant services, nursing facility care, home and community-based services
Additional supplemental benefits	Long-Term Services and Supports (LTSS) and Service Coordination
Coordinates Medicare benefits for dual-eligible Members	Coordinates Medicaid benefits and supports independence in the community

FIDE plans help provide comprehensive, coordinated care for individuals who qualify for both Medicare and Medicaid.

Community First Medicare Advantage Bexar Dual (HMO D-SNP)

Community First Medicare Advantage Bexar Dual (HMO D-SNP) is Community First's FIDE Plan.

COMMUNITY FIRST
MEDICARE ADVANTAGE PLAN
BEXAR DUAL

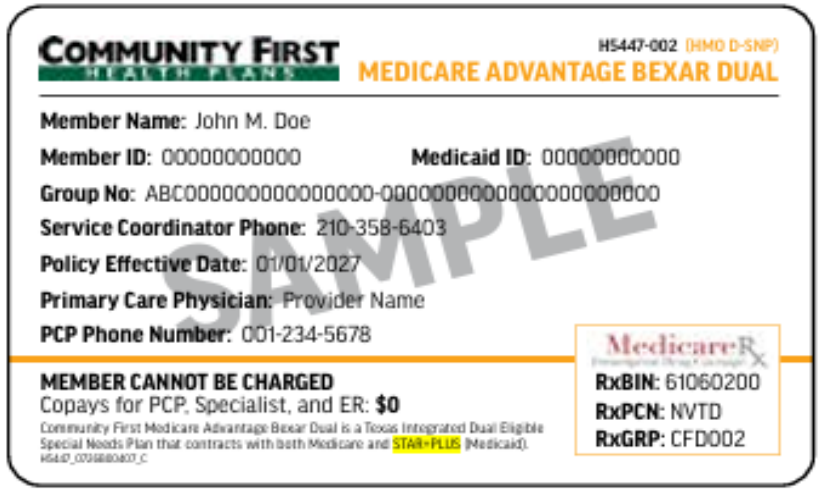
Bexar Dual is available to Medicare D-SNP and STAR+PLUS Dual Eligible Members in Bexar County, as of January 1, 2027.

Integrated Documents & Member ID Card

FIDE plans utilize integrated Member materials that combine Medicare D-SNP and STAR+PLUS dual benefit information into a single, easy-to-understand set of documents, creating a streamlined experience for Members and Providers.

Integrated Plan Documents

- Annual Notice of Change (ANOC)
- ANOC Cover Letter
- Evidence of Coverage
- Summary of Benefits
- Provider and Pharmacy Directory



Member ID Card

- Includes both Community First and and Medicaid ID numbers
- Specifically indicates that Members can not be charged copays for PCP, Specialist, or ER visits

Deeming Period

CMS requires FIDE-SNPs to provide a grace period of up to six months for Members who lose Medicaid eligibility or experience a change in eligibility status, allowing time to regain eligibility and maintain plan enrollment.

This period is called the **“deeming period.”**

During the deeming period, Members remain enrolled in their D-SNP and receive Medicare-covered benefits without interruption. Supplemental Medicaid-related benefits may be adjusted based upon CMS and state requirements.

Provider Responsibilities

Providers play a critical role in the success of FIDE plans by partnering with Community First to deliver coordinated, person-centered care that integrates Medicare and Medicaid benefits.

Through active engagement, providers help coordinate services, address non-medical drivers of health, and guide members in navigating their benefits to support improved health outcomes and a seamless care experience.

Provider Responsibilities

Key Provider Responsibilities

- Verify Member eligibility and benefits at each visit.
- Coordinate care with the Member's Primary Care Provider (PCP), specialists, and care management team.
- Participate in the Interdisciplinary Care Team (ICT) when requested.
- Follow the Member's Individualized Care Plan (ICP).
- Obtain prior authorization when required by the health plan.
- Submit claims accurately and timely according to plan requirements.
- Assist with referrals to in-network Providers and community resources.
- Educate Members on available benefits, including supplemental benefits and SSBCI services.
- Report changes in a Member's health status that may impact care needs.
- Support Members during Medicaid redetermination and renewal to help them maintain eligibility and coverage.

Model of Care

The **Model of Care (MOC)** is the framework used by FIDE plans to coordinate Medicare and Medicaid services and ensure Members receive comprehensive, person-centered care. The MOC includes these elements:

- **Health Risk Assessment (HRA):** Identifies Members' medical, behavioral, functional, and social needs.
- **Individualized Care Plan (ICP):** Develops goals and interventions tailored to each Member's needs.
- **Interdisciplinary Care Team (ICT):** Brings together Providers, care managers, caregivers, and other professionals to coordinate care.
- **Care Coordination:** Ensures Members receive the right care and services across settings.
- **Transitions of Care:** Supports Members during transitions between hospitals, skilled nursing facilities, home health, and community settings.

Prior Authorization

A **prior authorization** is a formal medical necessity determination request submitted to Community First by a Provider prior to a service being rendered.

Prior authorization may be obtained by the Member's PCP or by a treating specialist or facility to which they were referred.

Providers will only need to submit one authorization or clinical appeal and will receive a single decision.

Community First then will issue a decision to the Provider and Member/Member's representative within the following timeframes, as required by CMS guidelines:

- Expedited Request: within 72 hours.
- Standard Part B Request: within 7 calendar days.
- Standard Pre-Service Request: within 7 calendar days.
- Standard Post-Service Request: within 30 calendar days.

Inpatient Notification Requirements

Providers, including facilities, must notify Community First of all emergent admissions no later than the close of the next business day.

Prior authorization is not required for emergency services, urgent care services and post-stabilization services.

All non-emergency, elective inpatient admissions require a prior authorization.

Emergent inpatient admissions to any level of acute or sub-acute care, skilled nursing facilities, rehabilitation admission, behavioral health, and all other inpatient facility type require notification.

Failure to notify an emergent inpatient admission by the next business day will result in a late notification denial, unless otherwise stated within a contract with Community First.

Level I Integrated Appeals

An **appeal** is a request to review and reconsider an **adverse determination** for a service, item, Medicare Part B drug, or Medicaid drug.

Community First offers both **Standard and Expedited (Fast) appeal options**. Appeals may be submitted by the Member, the Member's authorized representative, or the Provider acting on the Member's behalf. **Providers may submit an appeal by following the instructions included in the Coverage Decision Letter.**

Appeals must be requested within **65 calendar days** of the date of the decision letter. To continue benefits during the appeal review process, an appeal should be requested within **10 calendar days** of the date on the decision letter or before the date the decision takes effect, whichever is later.

Level I Integrated Appeals

For integrated Medicare D-SNP and Medicaid (STAR+PLUS dual) appeals, Community First provides written notice of the appeal determination to the Provider and the Member/Member's authorized representative through a **single integrated Appeal Decision Letter**. Appeal decisions are issued within the following timeframes, as required by CMS guidelines:

- Expedited (Fast) Appeal Request: Within 72 hours.
- Standard Appeal Request (Drug): Within 7 calendar days.
- Standard Appeal Request (Medical Service/Item): Within 30 calendar days.

The Appeal Decision Letter includes information about next-level appeal rights, including a **Medicare Level 2 Appeal** and instructions for requesting a **Medicaid State Fair Hearing**, with or without an **External Medical Review**, when applicable.

Service Coordination

Service Coordination is a person-centered approach that helps ensure Members receive the right care, services, and support across both Medicare and Medicaid benefits.

Service Coordinator Responsibilities

Conduct mandatory telephonic or face-to-face contacts and assessments.

- Identification of medical, psychosocial, cognitive, functional and social determinate needs, and medical and behavioral health history for members.
- Development of a Service Plan of Care as appropriate to address identified needs.
- Provide the Service Plan to the Member and the Member's authorized representatives and Providers in the language and format requested.

Service Coordination

Service Coordinator Responsibilities, continued

Service Coordination services provided to Members include:

- Coordinate with the Member's PCP, S=specialist, and LTSS Providers to ensure that the Member's health and safety needs are met in the least restrictive setting.
- Refer Members to support services, such as disease management and community resources.
- Authorize LTSS services.
- Host ICT meetings.

Service Coordinators may contact Providers to:

- Participate in Member Integrated Care Team (ICT) meetings
- Coordinate or update a Member's plan of care.
- Confirm diagnoses or test results.
- Identify care gaps or non-compliance issues.
- Address behavioral health needs or non-medical drivers of health.

Claims Coordination and Appeals

Claims Coordination

Claims Coordination ensures services are billed and processed correctly across Medicare and Medicaid benefits, helping Providers receive accurate reimbursement and reducing Member responsibility for covered services.

Provider Responsibilities

- Verify Member eligibility and benefits prior to providing services.
- Submit claims accurately and within required filing deadlines.
- Use appropriate diagnosis, procedure, and billing codes.
- Maintain documentation supporting medical necessity and services rendered.
- Follow Medicare and Medicaid coordination of benefits (COB) requirements.
- Respond promptly to requests for additional information or claim corrections.