COMMUNITY FIRST HEALTH PLANS

TEXAS STAR PLUS Your Health Plan ★ Your Choice | TEXAS Health and Human Services

2024 STAR+PLUS NURSING FACILITY PROVIDER MANUAL

COMMUNITY FIRST PROVIDER RELATIONS

LOCAL 210-358-6403

TOLL FREE 1-855-607-7827

CommunityFirstMedicaid.com

Atascosa • Bandera • Bexar • Comal • Guadalupe • Kendall • Medina • Wilson

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COMMUNITY FIRST
HEALTH PLANS

Community First Health Plans, Inc.

STAR+PLUS Nursing Facility Provider Manual

Member Services: 210-358-6403

Toll-Free: 1-855-607-7827

Covering residents of Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson counties.

CommunityFirstMedicaid.com

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I. INTRODUCTION

Welcome to Community First Health Plans, Inc. (Community First) STAR+PLUS program for Medicaid Nursing Facility Managed Care Members. Thank you for participating in our network of Providers.

Community First is a Managed Care Organization (MCO), contracted by Texas Health and Human Services Commission (HHSC), to provide health care services to Members enrolled in the STAR+PLUS program. Community First also works with HHSC to ensure that benefits to Nursing Facility residents are timely and appropriately provided and available.

This manual is a reference guide for Nursing Facility Providers and their staff providing services to Members who participate in our STAR+PLUS program. Nursing Facility services are a covered benefit for qualifying STAR+PLUS Members age 21 and older, who need acute health care services and long-term care services. Please review the Community First Provider Manual for complete program details.

COMMUNITY FIRST OBJECTIVES

Community First conducts its business affairs in accordance with the standards and rules of ethical business conduct and abides by all applicable federal and state laws. Community First's policies are designed to assist HHSC in achieving an integrated delivery system of acute care and Long-Term Services and Supports (LTSS) through the following objectives:

- Improved access to care
- Improved quality of care
- Improved Member health status
- Improved Provider and Member experience

STAR+PLUS PROGRAM

STAR+PLUS is a Texas Medicaid program integrating the delivery of acute care services and LTSS to Medicaid recipients who are aged, blind, and disabled, through a managed care system. The STAR+PLUS program is designed to assist Medicaid recipients with chronic and complex conditions who require more than acute care services.

The STAR+PLUS program operates under the federal Medicaid waiver for Home and Community-Based Services (HCBS) in order to mandate participation and to provide Home and Community-Based Services. HHSC is the oversight agency for the STAR+PLUS program.

Mandatory Members

The following Medicaid-eligible individuals MUST enroll in the STAR+PLUS program:

- Supplemental Security Income (SSI) eligible 21 and over.
- Individuals 21 and over who are Medicaid eligible because they are in a Social Security exclusion program. These individuals are considered Medical Assistance Only (MAO) for purposes of HCBS STAR+PLUS (c) waiver eligibility.
- Dual Eligible individuals 21 and over who are covered by both Medicare and Medicaid.
- Individuals 21 and over who reside in a Nursing Facility.

Voluntary Members
The following Medicaid-eligible individuals may opt to enroll in the STAR+PLUS program:

- Nursing Facility resident, age 21 and over, who is federally recognized as a tribal member.
- Nursing Facility resident, age 21 and over, who receives services through the Program of All Inclusive Care for the Elderly (PACE).

Excluded Individuals
The following Medicaid-eligible individuals are excluded from participation in the STAR+PLUS program:

- Nursing Facility residents in a state veterans' home.
- Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).
- Residents of Institutions of Mental Disease or State Hospitals.
- Children in the conservatorship of the Texas Department of Family and Protective Services (DFPS).
- Dual Eligible (individuals who have both Medicare and Medicaid) who are residents of Intermediate Care Facilities for Persons with IID (ICF/IID) Community Living Assistance and Support Services.
- Persons enrolled in a waiver program other than the HCBS STAR+PLUS(c) Nursing Facility waiver program.
- Individuals not eligible for full Medicaid benefits (e.g., frail elderly program, Qualified Medicare Beneficiary [QMB], Service Limited Medicare Beneficiary [SLMB], Qualified Disabled Working Individual [QDWI], undocumented immigrants).
- Individuals receiving long-term care services through non-Medicaid funded programs.

Dual Eligible Members
Dual Eligible Members have both Medicare and Medicaid health insurance coverage. Medicare or the Member's Medicare Health Maintenance Organization (HMO) is the primary payer and will reimburse all Medicare-covered services. The state Medicaid program serves as a secondary payer and will continue to reimburse Medicare co-insurance and deductibles for Dual Eligible Members unless enrolled in a Community First Medicare Advantage Plan (HMO).

The Member's Community First Medicare Advantage Plan will coordinate the payment of the Medicare Advantage cost-sharing amounts for Dual Eligible Members up to the Medicaid fee schedule. Under the Member's Community First Medicare Advantage Plan, there is no copayment for services received at a Skilled Nursing Facility. Community First will reimburse Long-Term Services and Supports (LTSS) covered under the STAR+PLUS Nursing Facility program. Community First STAR+PLUS Nursing Facility benefits will not change or reduce any Medicare benefits for which a Member is eligible.

Members with traditional Medicare coverage may choose to use their existing Primary Care Provider (PCP) and may access specialty services without prior approval from Community First. Dual Eligible Members do not have to select a separate PCP through Community First for their LTSS services. The Service Coordinator will communicate and coordinate services with the Member's Medicare PCP to ensure continuity of care.

Dual Eligible Members should notify their Service Coordinators that they have Medicare coverage and provide the name of their chosen PCP.

Dual Eligible Members have an identification card that indicates Long-Term Care (LTC) services only, and must show their ID card each time they receive Community First STAR+PLUS covered services. Dual Eligible Members enrolled in a Community First Medicare Advantage Plan (HMO) must show their ID card each time they receive physician or hospital services. Dual Eligible Members do not receive the unlimited prescription drug benefit because the delivery of primary and acute care services are beyond the scope of the Medicaid managed care program.

For Dual Eligible Members, claims will process according to the Member's Medicare insurance, and as per CMS guidance on processing Medicare Part D and/or Part B pharmacy claims. Medicare (part B or D) covered drugs and/or products must be billed to Medicare and/or commercial insurance (if there is commercial insurance on file) prior to billing Medicaid.

For medications which are exclusions to CMS Medicare coverage, if the medications are included under the Medicaid formulary, they will be adjudicated under the Medicaid benefit as a "wrap-around" drug. "Wrap-around" drugs/products include non-prescription (over-the-counter medications), some products used in symptomatic relief of cough and colds, limited home health supplies (LHHS), and some prescription vitamins and mineral products, which are identified on the HHSC Drug Exception file. However, these wrap-around drugs/products must also follow Medicaid Texas Vendor Drug Program (TXVDP) formulary.

PLEASE NOTE:

- If a Member has a Medicare Advantage plan, itwill not affect the coverage of wrap benefits.
- Over-the-counter "wrap-around" drugs require a prescription for Medicaid payment (these drugs will not be covered by Medicaid without a prescription).

PLEASE NOTE: If a STAR+PLUS Dual Eligible Member has Medicare, Medicare is responsible for most primary, acute, and behavioral health services. Therefore, the PCP's name, address and telephone number are not listed on the Member's ID card.

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights:

1. Members have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that their medical records and discussions with Providers will be kept private and confidential.
2. Members have the right to a reasonable opportunity to choose a health care plan and Primary Care Provider (PCP). This is the doctor or health care Provider Members will see most of the time and who will coordinate their care. Members have the right to change to another plan or Provider. That includes the right to:
   a. Be told how to choose and change health plans and PCPs.
   b. Choose any health plan that is available in the Member's area and choose a PCP

from that plan.

c. Change PCPs.

d. Change health plans without penalty.

e. Be told how to change health plans or PCPs.

3. Members have the right to ask questions and get answers about anything they do not understand. That includes the right to:
   a. Have their Provider explain their health care needs to them and talk about the different ways their health care problems can be treated.
   b. Be told why care or services were denied and not given.
4. Members have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with Providers in deciding what health care is best for them.
   b. Say yes or no to the care recommended by Providers.
5. Members have the right to use each available complaint and appeal process through Community First and through Medicaid, and get a timely response to complaints, internal health plan appeals, External Medical Reviews, and State Fair Hearings. That includes the right to:
   a. Make a complaint to Community First or to the state Medicaid program about health care, Providers or their health plan.
   b. Get a timely answer to complaints.
   c. Use the Community First appeal process and be told how to use it.
   d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   e. Ask for a State Fair Hearing with or without an External Medical Review from the state Medicaid program and get information about how that process works.
6. Members have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, seven days a week to get any emergency or urgent care needed.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care Provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with Providers and when talking to Community First. Interpreters include people who can speak in a Member's native language, help someone with a disability, or help a Member understand the information.
   e. Be given information Members understand about their health plan rules, including the health care services they can get and how to get them.
7. Members have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force the Member to do something they do not want to do or is to punish them.
8. Members have a right to know that doctors, hospitals, and others who care for them

can advise them about their health status, medical care, and treatment. Community First cannot prevent them from giving Members this information, even if the care or treatment is not a covered service.

9. Members have a right to know that they are not responsible for paying for covered services. Doctors, hospitals, and others cannot require Members to pay copayments or any other amounts for covered services.
10. Members have the right to make recommendations about Community First's Member Rights and Responsibilities Policies.

Member Responsibilities:

1. Members must learn and understand each right they have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand their rights under the Medicaid program.
   b. Ask questions they do not understand about their rights.
   c. Learn what choices of health plans are available in their area.
2. Members must abide by Community First and Medicaid policies and procedures. That includes the responsibility to:
   a. Learn and follow Community First and Medicaid rules.
   b. Choose their health plan and a PCP quickly.
   c. Make any changes in their health plan and PCP in the ways established by Medicaid and by Community First.
   d. Keep scheduled appointments.
   e. Cancel appointments in advance when they cannot keep them.
   f. Always contact their PCP first for non-emergency medical needs.
   g. Be sure they have approval from their PCP before going to a specialist.
   h. Understand when they should and should not go to the emergency room.
3. Members must share information about their health with PCPs and learn about service and treatment options. That includes the responsibility to:
   a. Tell their PCP about their health.
   b. Talk to their Providers about their health care needs and ask questions about the different ways their health care problems can be treated.
   c. Help their Providers get their medical records.
4. Members must be involved in decisions relating to service and treatment options, make personal choices and take action to maintain their health. That includes the responsibility to:
   a. Work as a team with their Provider in deciding what health care is best for them.
   b. Understand how the things they do can affect their health.
   c. Do the best they can to stay healthy.
   d. Treat Providers and staff with respect.
   e. Talk to their Provider about all of their medications.
5. Members of Community First Health Plans can ask for and get the following information each year:

a. Information about Community First and our network Providers—at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, languages spoken (other than English), identification of Providers that are not accepting new patients and qualifications for each network Provider such as:
   - Professional qualifications
   - Specialty
   - Medical school attended
   - Residency completion
   - Board certification status
   - Provider demographics

b. Any limits on the Member's freedom of choice among network Providers.

c. Member rights and responsibilities.

d. Information on complaint, appeal, and State Fair Hearing procedures.

e. Information about Community First's Quality Improvement Program. To request a hard copy, call Member Services at **210-358-6105**.

f. Information about benefits available under the Medicaid program including the amount, duration, and scope of benefits. This is designed to make sure Members understand the benefits to which they are entitled.

g. How Members can get benefits, including authorization requirements or family planning services, from out-of- network Providers and/or limits to those benefits.

h. How Members get after hours and emergency coverage and/or limits to those kinds of benefits, including:
   - What makes up emergency medical conditions, emergency services and post-stabilization services.
   - The fact that Members do not need prior authorization from their PCP for emergency care services.
   - How to get emergency services, including instructions on how to use the **911** telephone system or its local equivalent.
   - The addresses of any places where Providers and hospitals furnish emergency services covered by Medicaid.
   - A statement saying Members have the right to use any hospital or other settings for emergency care.
   - Post-stabilization rules.

i. Policy on referrals for specialty care and for other benefits you cannot get through the Member's PCP.

j. Community First's practice guidelines.

MEMBER EDUCATION

Community First abides by state contractual agreements to ensure we provide appropriate cultural and linguistic services to our Members. Materials are made available in large print, Braille, and on compact disc (CD) when requested.

A variety of sources are used to inform Community First Members, in a culturally sensitive manner, about the health plan and the services available to them. This includes,

but is not limited to:

- Community First STAR+PLUS Nursing Facility Member Handbook
- Community First website at CommunityFirstMedicaid.com
- Community First Provider Directory
- Biannual newsletters
- Monthly e-newsletters
- Special mailings

To obtain a sample of any of the materials listed above, contact Member Services. All educational materials are available in written text, both English and Spanish, and can be made available in other languages or formats such as Braille or large print, if needed. All Member materials are written at or below a 6th grade reading level, as measured by the appropriate score on the Flesch-Kincaid Readability Scale.

You may also refer your residents to our Member Services Department at **210-358-6105** for personalized Member education or to request information or materials.

CONTACTING COMMUNITY FIRST

Community First has staff to assist you with your day-to-day operations, questions, and concerns. Every Nursing Facility Provider will have a designated representative that can coordinate an in-service/training for facility staff, provide face-to-face support in the facility, and assist with answering questions about Community First's policies and procedures.

You may also contact Community First's Provider Relations Department at **210-358-6294**, Monday through Friday 8 a.m. to 5 p.m. (CST), for inquiries including program information or assistance with claims. After hours or on federal and state-approved holidays and weekends, the Provider Relations line will direct to Community First's 24-hour Nurse Advice Line. The Nurse Advice Line can provide assistance with eligibility and authorizations for needed services.

QUICK REFERENCE GUIDE

DEPARTMENT	CONTACT INFORMATION
Member Services Member Services Fax	1-844-382-2347 210-358-6099
Population Health Management Preauthorization Fax	210-358-6055 210-358-6274
Urgent Care	210-227-2347
Behavioral Health Authorization/Case Management Behavioral Health Fax	210-358-6105 210-358-6387
Member Services Eligibility/Benefits Verification	1-844-382-2347
Interpreter Services (sign and language)	1-844-382-2347 1-800-246-2686
TTY (for the hearing impaired)	711

Network Management Network Management Fax	210-358-6294 210-358-6199
Claims Information Claims Fax Electronic Claims	210-358-6200 210-358-6014 Availity Payor ID: COMMF
Nurse Advice Line After Hours (After-hours calls to Community First are forwarded to the Nurse Advice Line.)	1-844-382-2347
Preventive Health & Disease Management Preventive Health & Disease Management Fax	210-356-6105 210-358-6099
Community Outreach Agencies	XXX-XXX-XXX
Pharmacy - Navitus Health Solutions	1-877-908-6023
Vision - Envolve Benefit Options	1-800-334-3937
Dental Inquiries	1-844-382-2347

II. PROVIDER ROLES

The Primary Care Provider (PCP) is responsible for monitoring the quality of care of Community First Members. PCPs and Specialty Care Providers must maintain the appropriate privileges with Community First contracted Nursing Facilities to provide care to Members.

THE ROLE OF THE NURSING FACILITY PROVIDER

Nursing Facility Providers provide institutional care to Medicaid recipients whose medical condition regularly requires the skills of licensed nurses. Nursing Facilities provide for the medical, social, and psychological needs of each resident, including room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid program or Medicare Part D), medical supplies, rehabilitative services, and personal needs items.

General Responsibilities

Providers must comply with each of the items listed below:

- To coordinate with Member's assigned Primary Care Provider (PCP).
- To provide availability 24 hours a day, 7 days a week.
- To submit updates to Provider's contact information, if and when, there are changes. Network Providers must inform both Community First and HHSC of any changes to their address, telephone number, group affiliation, etc.
- To provide Community First with access to medical records and access to the facility.
- To comply with the timelines, definitions, formats, and instructions specified by HHSC.
- To provide records requested within three business days of the request.
    - PLEASE NOTE: If, at the time of the request for access to medical records, HHSC or the Office of Inspector General (OIG) or another state or federal agency believes records have been altered or destroyed, the Nursing Facility must provide records at the time of the request or in less than 24 hours.
- To provide notice to Community First of plan termination per requirements in the agreement with Community First.
- To provide notice to Community First's designated Service Coordinator via phone, fax, email, or other electronic means no later than one business day after the following events, unless the table below indicates otherwise:

Event	Notification
A significant adverse change in the Member's physical or mental condition or environment that could lead to hospitalization	One business day
An emergency room visit	One business day
Death of a Member	72 hours

An admission to or discharge from the Nursing Facility, including admission or discharge to a hospital or other acute care facility, skilled bed, LTSS Provider, non-contracted bed, or another nursing or long-term care facility, or involuntary discharge of a Member initiated by the facility	One business day

- To submit Form 3618 or Form 3619, as applicable, to HHSC administrative services contractor.
- To submit Minimum Data Set (MDS) assessments, as required, to federal Centers for Medicare and Medicaid Services (CMS) and associated MDS Long-term Care Medicaid Information to HHSC's administrative services contractor.
- To complete and submit Preadmission Screening and Resident Review (PASRR) Level I screening information to HHSC's administrative services contractor.
- To coordinate with Local Authorities (LA) and Local Mental Health Authorities (LMHA) to complete a PASRR Level 2 evaluation when an individual has been identified through the PASRR Level 1 screen as potentially eligible for PASRR specialized services.
- To respect the Member's right to designate a specialist as their PCP as long as the specialist agrees.
- To respect the Member's right to select and have access to, without a PCP referral, a network ophthalmologist or therapeutic optometrist to provide eye health care services other than surgery.
- To respect a Member's right to obtain medication from any network pharmacy.
- To respect a Member's Advance Directives and Power of Attorney and include these documents in their medical record.
- To inform Members of covered services and the costs for non-covered services prior to rendering these services by obtaining a signed Private Pay Form from the Member.
- To refer Members to specialists and health-related services and documentation of coordination of referrals and services provided between PCP and specialist.
- To provide behavioral health-related services within the scope of practice.
- To make a referral to network facilities and contractors, including access to a second opinion.
- To ensure medical records reflect all aspects of Member care including ancillary services.
- To ensure the use of electronic medical records conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.
  - PLEASE NOTE: Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through portals or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.
- To ensure proper justification to Community First regarding out-of-network referrals, including partners not contracted with Community First.
- To inform Members on how to report abuse, neglect and exploitation.
- To train staff on how to recognize and report abuse, neglect and exploitation.
- To make reasonable efforts to collect applied income, document those efforts and notify the Service Coordinator or Community First's designated representative when the Provider has made two unsuccessful attempts to collect applied income in

a month.
- To maintain enrollment status with Texas Medicaid.

PLEASE NOTE: Texas Medicaid will deny claims for prescriptions, items, and services ordered, referred, or prescribed for any Medicaid, Children with Special Health Care Needs Services Program (CSHCN), or Healthy Texas Women Member when the Provider who ordered, referred, or prescribed the items or services is not enrolled in Texas Medicaid. This applies to both in-state and out-of-state Providers.

KEY INFORMATION FOR NURSING FACILITY PROVIDERS

The following are some helpful tips for Nursing Facility Providers:

- Verify Member eligibility to ensure the first date of enrollment with the plan.
- Ensure necessary authorizations have been obtained from Community First for all add-on services.
- Use in-network Providers for add-on services.
- Adhere to HHSC clean claim rules, as found in the Code of Federal Regulations, Title 42, §447.45(b).
- Notify the Service Coordinator whenever there is a change in the Member's physical or mental condition, an inpatient admission, or an emergency room visit.
- Ensure that covered Medicare services are billed to Medicare as primary for Members who are eligible for both Medicare and Medicaid.
- File claims for PASRR and hospice directly to the administrative services contractor for Medicaid fee-for-service.
- Continue submitting your MDS 3618 and 3619 forms through the LTC online portal.

Coordination with Entities Providing Non-Capitated Services

Community First is required, through its contractual relationship with HHSC, to coordinate with public health entities regarding the provision of services for essential public health services or for services not directly provided by Community First. Providers must assist in these efforts. The Texas Medicaid Provider Procedures Manual (TMPPM) includes the following services:

- Tuberculosis (TB) services provided by DSHS-approved Providers (directly observed therapy and contact investigation).
- Hospice services provided by Home and Community Support Service Agencies contracted with HHSC.
- Long-Term Care and Supports for individuals who have IDD provided by HHSC-contracted Providers.

PASRR Level 1 screenings, Level 2 evaluations, and specialized services are provided by HHSC-contracted LA and DSHS-contracted LMHA. Specialized services provided by the LA include:

- Service coordination, alternate placement, and vocational training.
- Mental health rehabilitative services and targeted case management.
- Specialized services provided by a Nursing Facility or Long-Term Care and Supports for individuals identified with intellectual and developmental disabilities (IDD), including physical therapy, occupational therapy, speech therapy, and customized adaptive aids.

Hospice
When additional or ongoing care is necessary, the Nursing Facility should coordinate with Community First's Service Coordinator to plan the Member's discharge to an appropriate setting for extended services such as hospice. The Nursing Facility should contact Community First's Service Coordinator within one business day of unplanned admission or discharge to a hospital or other acute facility, skilled bed, or nursing home.

Hospice services are provided for STAR+PLUS Members by Home and Community Service Agencies contracted with HHSC. HHSC manages the hospice program through Provider enrollment contracts with hospice agencies that are licensed by the state and are Medicare-certified as hospice agencies. The hospice program provides palliative care to Community First Members who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illness runs its normal course. For Dual Eligible Members, hospice services are provided through a Medicare-contracted agency and all services related to the Member's terminal illness are also provided through a Medicare hospice agency.

Members enrolled in hospice waive their rights to all other Medicaid services related to their terminal illness. Members who are Dual Eligible must elect hospice for both Medicare and Medicaid.

Policy and program questions may be directed to HHSC at 512-438-3161. Questions regarding billing, claims, and authorizations should be directed to HHSC at 512-438-3550 or Providers can refer to the TMPPM for further coordination.

Preadmission Screening and Resident Review (PASRR)
PASRR is a review process that is federally mandated and requires all individuals wishing to be admitted to a Medicaid-certified Nursing Facility be screened for mental illness, developmental disability (or related condition), or intellectual disability.

The PASRR Evaluation (PE) is also used to determine if the Nursing Facility is the appropriate placement for the Member and if the Member could benefit from specialized services. The evaluation can only be performed face-to-face by a member of the Local Authorities (LA), and must be completed within 72 hours and submitted through the Long Term Care Online Portal within seven days from the time that the request for the PE was received. A Member cannot be admitted to a Nursing Facility until an evaluation is completed, submitted through the portal, and the result confirms that the facility can meet the needs of the Member.

PASRR Level 1 screenings, Level 2 evaluations, and specialized services are provided by HHSC-contracted LA and DSHS-contracted Local Mental Health Authority (LMHA). Specialized services provided by the LA include:

- Service coordination, alternate placement, and vocational training.
- Specialized services provided by the LMHA, including mental health rehabilitative services and targeted case management.
- Specialized services provided by a Nursing Facility or LTSS for individuals identified as IDD, including physical therapy, occupational therapy, speech therapy, and customized adaptive aids.

All PASRR specialized services are non-capitated, fee-for-service so should be billed directly to Texas Medicaid & Healthcare Partnership (TMHP). Refer to the TMPPM for further instructions.

ABUSE, NEGLECT, OR EXPLOITATION

Reporting Abuse, Neglect, or Exploitation (ANE)

Community First Members and Providers must report any allegation or suspicion of Abuse, Neglect, or Exploitation (ANE) that occurs within the delivery of LTSS to the appropriate entity. The managed care contracts include MCO and Provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and Provider requirements continue to apply.

Report to HHSC if the victim is an adult or child who resides in or receives services from:

- Nursing facilities
- Assisted living facilities
- Adult day care centers
- Home and Community Support Services Agencies
- Licensed adult foster care Providers

Report to HHSC by calling **1-800-458-9858**. If it's an emergency, call **911**.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
  - Home and Community Support Services Agencies (HCSSAs).
  - Unlicensed adult foster care Provider with three or fewer beds.
- An adult with a disability or child residing in or receiving services from one of the following Providers or their contractors:
  - Local Intellectual and Developmental Disability Authority (LIDDA), LMHAs, community center, or mental health facility operated by the Department of State Health Services (DSHS).
  - A person who contracts with a Medicaid Managed Care Organization (MCO) to provide behavioral health services.
  - A managed care organization.
  - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above.
- An adult with a disability receiving services through the Consumer Directed Services option.

Contact DFPS at **1-800-252-5400** or, in non-emergency situations, online at txabusehotline.org.

Report to Local Law Enforcement

If a Provider is unable to identify state agency jurisdiction, but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Report to Community First Health Plans

- In addition to reporting to HHSC and DFPS, a care Provider must report the findings within one business day to Community First.
- Providers should submit a copy of the ANE findings and the individual remediation

within one business day of receiving the findings from DFPS.

Failure to Report or False Reporting

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHSC, or a law enforcement agency (See Texas Human Resources Code, Section 48.052; Texas Health & Safety Cod,e, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHSC, or a law enforcement agency regarding ANE (See Texas Human Resources Code, Sec. 48.053; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS-licensed foster parent, or accredited child placing agency for a foster home, DFPS-licensed general residential operation, or at a childcare center.

Fraud, Waste and Abuse Prevention

Community First is committed to identifying, investigating, sanctioning, and prosecuting suspected fraud and abuse. It is your responsibility as a participating Provider to report any Member or Provider suspected of fraud and abuse. All reports will remain confidential.

Reporting Fraud, Waste, and Abuse

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care Providers, or a person getting benefits is doing something wrong. Doing something wrong could be fraud, waste, or abuse, which is against the law.

For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid.
- Using someone else's Medicaid.
- Not telling the truth about the amount of money or resources they have to get benefits.

Information Needed to Report Fraud, Waste, and Abuse

To report fraud, waste or abuse, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184**;
- Visit https://oig.hhs.gov/fraud/report-fraud/
  - Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- Call Community First at **210-358-6105** or **1-844-382-2347** (toll free). TTY users can call **711**.
- Contact Community First's Special Investigative Unit directly at:
  Community First Health Plans
  Attention: SIU
  12238 Silicon Drive, Suite 100
  San Antonio, TX 78249

To report fraud, waste, or abuse, gather as much information as possible.

- When reporting about a Provider (a doctor, dentist, counselor, etc.) include:

  - Name, address, and phone number of Provider.
  - Name and address of the facility (hospital, nursing home, home health agency, etc.).
  - Medicaid number of the Provider and facility, if you have it, and type of Provider (doctor, dentist, therapist, pharmacist, etc.).
  - Names and phone numbers of other witnesses who can help in the investigation.
  - Dates of events.
  - Summary of what happened.
- When reporting about someone who gets benefits, include:
  - The person's name.
  - The person's date of birth, Social Security number, or case number if you have it.
  - The city where the person lives.
  - Specific details about the fraud, waste or abuse.

Practitioner Right to Review and Correct Information
All practitioners participating within the network have the right to review information obtained by Community First to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank Healthcare Integrity and Protection Data Bank, Council for Affordable Quality Healthcare, Inc. (CAQH), malpractice insurance carriers, and state licensing agencies. This does not allow a Provider to review references, personal recommendations or other information that is peer review protected. Should a Provider believe any of the information used in the credentialing/ recredentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a Provider, they have the right to correct erroneous information.

To request release of such information, a written request must be submitted to the Community First Credentialing Department. Upon receipt of this information, the Provider will have 10 days to provide a written explanation detailing the error or the difference in information to Community First. Community First's credentials committee will then include this information as part of the credentialing/recredentialing process and will also include it in the practitioner's file. If no response is received within 10 days, the Credentialing Department, on behalf of Community First, assumes the Provider does not dispute the accuracy of the information collected, and the file is presented to the Medical Director and/or the Credentials Committee.

Community First will notify the practitioner if information obtained during the credentialing process varies substantially from the information provided.

Practitioner Right to Be Informed of Application Status
All practitioners who have submitted an application to join the Community First network have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the Provider Relations Department at **210-358-6294**.

THE ROLE OF A PRIMARY CARE PROVIDER (PCP)

The PCP is the cornerstone of Community First and serves as the "medical home" for the Member. The "medical home" concept should assist in establishing a Member-Provider relationship and ultimately better health outcomes.

The PCP is responsible for the provision of all primary care services to Community First Member. This includes providing behavioral health-related services within the scope of their practice. In addition, the PCP is responsible for referring and obtaining authorization for services requiring authorization.

PLEASE NOTE: Dual Eligible (Medicare/Medicaid) Members will not be assigned a PCP. For Dual Eligible Members (either fee-for-service or covered under a Medicare Advantage plan), Medicare continues to be responsible for all acute care services, including physician claims.

Who Can Serve as a PCP?

Credentialed Providers in the following specialties can serve as a PCP:

- Certified Nurse Midwife
- Family Practitioner
- Obstetrics and Gynecology (OB/GYN)
- General Practitioner
- Physician Assistant
- Internal Medicine Practitioner
- Specialist (when appropriate, as described below)
- Nurse Practitioner
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Pediatricians
- Geriatricians

Specialist as PCP

Members with disabilities, special health care needs, and chronic or complex conditions have the right to designate a specialist as their PCP. A specialist may serve as a PCP only under certain circumstances, and with approval of Community First's Chief Medical Officer. To be eligible to serve as a PCP, the specialist must:

- Meet Community First's requirements for PCP designation, including credentialing.
- Contract with Community First as a PCP.

All requests for a specialist to serve as a PCP must be submitted to Community First on the Specialist as PCP Request Form located on the Community First website. The request should contain the following information:

- Certification by the specialist of the medical need for the Member to utilize the specialist as a PCP.
- A statement signed by the specialist that they are willing to accept responsibility for the coordination of all of the Member's health care needs.
- Signature of the Member on the completed Specialist as PCP Request Form.

Community First will approve or deny the request for a specialist to serve as a PCP and provide notification to the Member of the decision no later than 30 days after receiving

the request. The effective date of the designation of a specialist as a Member's PCP may not be applied retroactively. If the request is denied, Community First will provide a written notification to the Member, which will include the reasons for the denial. The Member may file an appeal if their request to have a specialist as a PCP is denied.

Role of Specialty Care Providers
The specialist partners with the PCP to deliver specialty care to Members. A key component of the specialist's responsibilities is to maintain ongoing communication with the Member's PCP. Community First prefers that specialists are board-certified in their area of expertise, but it is not required. Specialty Care Providers and facilities are responsible for ensuring that necessary referrals/authorizations have been obtained prior to the provision of services. To ensure continuity and coordination of care for the Member, every Specialty Care Provider must:

- Verify Member eligibility or authorization of services such as hospitalization, facility transfer, pregnancy information, when a Member moves out of the service area, and when a pre-existing condition is not imposed.
- Be available for or provide on-call coverage through another source 24 hours a day for management of Member care.
- Provide medical records that reflect all aspects of patient care including ancillary services.
    - PLEASE NOTE: The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.
- Provide justification to Community First regarding out-of-network referrals, including partners not contracted with Community First.
- Providers are required to inform Members on how to report Abuse, Neglect, or Exploitation (ANE) as described in this Provider Manual.
- Providers are required to train staff on how to recognize and report ANE as described in this Provider Manual.

ROLE OF THE MCO SERVICE COORDINATOR

The Service Coordinator focuses on maximizing a Member's health, well-being, and independence in a holistic manner. Service Coordinators work with the Member's PCP and Specialty Care Providers to coordinate all covered services, non-capitated services, and non-covered services, to include utilization management and case management (including behavioral health and substance abuse services). Service Coordinators are experienced in meeting the needs of vulnerable populations who have chronic or complex conditions and are solely dedicated to serving STAR+PLUS Members. Service Coordinators are responsible for discharge planning and continuity of care transition planning.

ROLE OF THE PHARMACY

The pharmacy is responsible for providing pharmaceutical services to Community First STAR+PLUS Members. Pharmacies must verify the eligibility of the Member prior to rendering services. Pharmacies are responsible for:

- Performing prospective and retrospective drug utilization reviews.
- Adhering to the Formulary and Preferred Drug List (PDL).
- Coordinating with the prescribing physician.
- Ensuring Members receive all medications for which they are eligible.

- Coordinating benefits when a Member also receives Medicare Part D services or other insurance benefits.

MEMBER'S RIGHT TO DESIGNATE AN OB/GYN

Community First Members have the right to designate an OB/GYN, whether that doctor is in the same network as the Member's PCP or not.

Attention Female Members

Members have the right to pick an OB/GYN without a referral from their PCP. An OB/GYN can give the Member:

- Care related to pregnancy.
- One well-woman checkup each year.
- Care for any female medical condition.
- A referral to a specialist doctor within the network.

NETWORK LIMITATIONS

Community First Members must receive covered Medicaid services from Community First contracted Providers. There may be exceptions where a Provider is not accessible within Community First's contracted network of Providers. To ensure appropriate receipt of covered service, a non-contracted or "out-of-network" Provider may be approved on an exception basis.

PLEASE NOTE: Except for emergency services, post-stabilization services, and services provided to during an approved inpatient admission, all services from an out-of-network Provider must be prior authorized.

NEWLY ENROLLED MEMBERS

Acute Care Services

Community First will consider an initial timeframe of up to a 90-day initial continuity of care period to allow time for the transition to a Community First Health Plans participating Provider.

- Continuity of care will no longer apply after the initial 90-day period or until Community First has evaluated and assessed the Member and issued or denied a new authorization.
- If covered services are not available within Community First's network, Community First may authorize or continue authorizing services to a non-participating Provider for as long as those services are necessary and not available in the Network.

Members Diagnosed with a Terminal Illness

Continuity of care also applies to Members diagnosed with a terminal illness. A Member can continue receiving care from their current Provider for a period of nine months from the date the Member became enrolled with Community First.

Community Based Long-Term Services & Supports (LTSS)

Community First will consider an initial time frame of up to six months for LTSS or until a new assessment is completed and new authorizations issued, whichever comes first.

Members Who Move Out of the Service Area

Community First will continue to provide and coordinate services for Members who

move out of the service area until such time the Member is disenrolled from Community First. Community First will be responsible for providing and coordinating services for the Member until the Member's eligibility with the new MCO is effective.

NETWORK TERMINATION

A Provider may terminate from the Community First network in accordance with the Provider's Participation Agreement. Providers should refer to their Community First contract for written notification time frames and/or contact Provider Relations. All termination requests must be received in writing. Please include the TIN, NPI, termination date and the reason for the termination. Your Provider Relations Representative can help you facilitate a termination.

In the event of a Nursing Facility Change of Ownership (CHOW), please contact your Provider Relations Representative for assistance in coordinating the CHOW and termination of the previous tax ID number.

III. ELIGIBILITY AND DISENROLLMENT

HEALTH PLAN ENROLLMENT

HHSC is responsible for determining Medicaid and CHIP eligibility. Contact Community First Member Services if you need to locate an HHSC eligibility office.

The state's Enrollment Broker, Maximus, is responsible for enrolling individuals into the Medicaid and CHIP programs. The Enrollment Broker can be contacted at the Medicaid Managed Care help line at **1-800-964-2777**.

When a Member's application is approved for Medicaid or CHIP, the state's Enrollment Broker sends the Member an enrollment packet, informing the Member of the health plan choices in their area. The packet will also instruct the Member to select a health plan and a PCP within 15 days. Members applying for CHIP will need to select a plan and a PCP within 15 days of gaining eligibility.

VERIFYING MEMBER MEDICAID ELIGIBILITY

Each person approved for Medicaid benefits receives a "Your Texas Benefits Medicaid" card. However, having a card does not always mean a person has current Medicaid coverage. A Provider should verify the Member's eligibility for the date of service before rendering services. There are three ways to do this:

- Call Community First at **210-358-6105** or **1-844-382-2347** (toll free). TTY users should call **711**.
- Log in to the secure Community First Provider Portal at CommunityFirstHealthPlans.com/ProviderPortal
- Use TexMedConnect on the Texas Medicaid and Healthcare Partnership (TMHP) website at TMPH.com.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at **1-800-925-9126** or **512-335-5986**.
- Your Texas Benefits Medicaid Card
  1. Temporary ID (Form 1027-A).
  2. Community First Member ID Card.
     - If the Member also receives Medicare health insurance coverage (Dual Eligible), Medicare is responsible for most primary, acute and behavioral health services. Therefore, the PCP's name, address and telephone number are not listed on the Member's Community First ID card. The Member only receives long-term services and supports through Community First.

Pharmacies

Electronic eligibility verification (e.g., NCPDP E1 Transaction) is available to check eligibility when rendering a prescription.

Involuntary Disenrollment Due to Member Non-Compliance
There may be instances when a PCP feels that a Member should be removed from their panel. Community First requires notification of such requests so educational outreach can be arranged with the Member. All notifications to remove a patient from a panel must:

- Be made in writing;
- Contain detailed documentation; and
- Be directed to Community First's Compliance Department. Upon receipt of a request, Community First may:
  - Interview the Provider or their staff requesting the disenrollment, as well as any additional Providers who are relevant to the request;
  - Interview the Member; or
  - Review any relevant medical records.

Examples of reasons why a PCP may request to remove a Member from their panel could include, but are not limited to:

- If a Member is disruptive, unruly, threatening, or uncooperative to the extent that the Member seriously impairs the Provider's ability to provide services to the Member, or to other patients, and the Member's behavior is not caused by a physical or behavioral condition.
- If a Member refuses to comply with managed care guidelines, such as repeated emergency room use, combined with refusal to allow the Provider to treat the underlying medical condition.

A PCP cannot request a Member be disenrolled for any of the following reasons:

- Adverse change in the Member's health status or utilization of services which are medically necessary for the treatment of a Member's condition.
- On the basis of the Member's race, color, national origin, sex, age, disability, political beliefs, or religion.

Under no circumstances can a Provider take retaliatory action against a Member due to disenrollment from either the Provider or a plan. HHSC will make the final decision.

Disenrollment
When a Member becomes ineligible for Texas Medicaid, the Member is disenrolled from the STAR+PLUS program and from Community First. HHSC is solely responsible for determining if and when a Member is disenrolled from the Medicaid program. Members can be disenrolled from Community First, but still be eligible for Medicaid through another health plan or program, so it is important to check eligibility before considering a Member as eligible or ineligible.

A Member can request disenrollment from Community First. Their request will require medical documentation from the PCP, or documentation that indicates sufficiently compelling circumstances that merit disenrollment. The Member's request must be submitted to HHSC for review and a final decision.

Community First and network Providers are expressly prohibited from taking any retaliatory action against a Member who requests disenrollment either from the plan or from their care, respectively.

Renewal

Members who receive SSI benefits from the Social Security Administration (SSA) are categorically eligible for SSI Medicaid and, therefore, do not have to re-certify with HHSC each year. To maintain SSI benefits, the SSA may require information from the Member related to their SSI benefits. The Member or their representative payee may call the SSA. HHSC does not play a role in determining SSI eligibility. Providers are encouraged to remind Members to keep their information current with SSA.

If a Community First Member becomes temporarily ineligible (for six months or less) for Medicaid, but regains Medicaid eligibility within the six month time frame and resides in the same service area, the Member will be automatically re-enrolled by HHSC in Community First. Community First and the state's Enrollment Broker will make every effort to re-enroll the Member with the previous PCP. The Member will also have the option to switch plans.

Members Who Move to a Facility Outside of the Service Area
Members may transfer to another Nursing Facility at any time. Members are required to notify the State Enrollment Broker of their change of address. The Member may transfer to a Nursing Facility in a different geographic area.

Span of Coverage
Community First must accept all persons who choose to enroll as Members in the MCO or who are assigned as Members in the MCO by HHSC, without regard to the Member's previous coverage or any other factor.

IV. COVERED BENEFITS AND SERVICES

DIRECT ACCESS TO CARE - MEDICAID MEMBERS ONLY

Members have direct access to the following services and Providers without first accessing care through the PCP:

- Behavioral health services.
- Obstetric or gynecologic services for female Members.
- Routine vision services, to include eye exams and eyewear.
- Network ophthalmologists or therapeutic optometrists to provide health care services other than surgery.

Members with special health care needs can access specialist services as needed. If the specialist is of a specialty which requires prior authorization (PA), per the current Community First Prior Authorization List, an authorization will be provided as appropriate for the Member's condition.

TELEMEDICINE AND TELEHEALTH SERVICES

Any Provider in the Community First network can offer telehealth services to Community First Members (except for STAR+PLUS Dual Eligible Members) for certain health care needs. "Telehealth services" are virtual health care visits with a Provider through a mobile app, online video or other electronic method. These may include, but are not be limited to telemedicine, telemonitoring, and telehealth services.

Community First treats telehealth services with in-network Providers in the same way as face-to-face visits with in-network Providers.

- A telehealth visit with an in-network Community First Provider does not require prior authorization.
- A telehealth visit with an in-network Community First Provider is subject to the same co-payments, co-insurance, and deductible amounts as an in-person visit with an in-network Provider.

Providers may be reimbursed for a patient site facility fee when services are performed by a:

- County Indigent Health Care Program
- Physician
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Outpatient Hospital

PLEASE NOTE: A facility fee is not available if the patient site is the patient's home.

- Providers interested in providing telemedicine, telemonitoring, and telehealth services to eligible Community First Members should reference the Texas Medicaid Provider Procedures Manual, located at TMHP.com.

For more information, contact Member Services at **210-358-6105**.

STAR+PLUS NURSING FACILITY SPELL OF ILLNESS LIMITATION

The Medicaid spell of illness limitation is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of an inpatient care admission, reimbursement for additional inpatient care is not considered until the patient has been out of an acute facility for 60 consecutive days.

Exceptions to the spell of illness limitation for inpatient admissions are listed below:

- A prior approved solid organ transplant. The 30-day spell of illness for transplants begins on the date of the transplant, allowing additional time for the inpatient stay.
- Applicable diagnoses, including the following, as described in the DSM-V (parenthetical codes are corresponding ICD-10 codes):
  - Schizophrenia (F20)
  - Schizoaffective disorder (F25)
  - Schizophreniform (F20)
  - Bipolar I and Bipolar II Disorder (F31) with any severity or status
  - Major Depressive Disorder (F32 and F33) with any variation or subtype

However, the diagnosis must be a specific condition rather than a general behavioral health condition. For example, MCOs are not required to exempt "unspecified" or "not classified" diagnoses. Examples of diagnoses that are unspecified include (but are not limited to):

- F31.9 (bipolar disorder, unspecified)
- F20.9 (schizophrenia, unspecified type)
- F20.89 (other specified types of schizophrenia, unspecified)

NURSING FACILITY ADD-ON SERVICES

Nursing Facility add-on services are services provided in the facility setting by a Provider or another network Provider that are not included in the Nursing Facility Unit Rate. Nursing Facility add-on services are emergency dental services, physician-ordered rehabilitative services, customized power wheelchairs, and augmentative communication devices.

Add-on services are limited to the following:

Ventilator care add-on service
To qualify for supplemental reimbursement, a Nursing Facility Member must require artificial ventilation for at least six consecutive hours daily and the use must be prescribed by a licensed physician.

Tracheostomy care add-on service
To qualify for supplemental reimbursement, a Nursing Facility Member must be less than 22 years of age; require daily cleansing, dressing, and suctioning of a tracheostomy; and be unable to do self-care. The daily care of the tracheostomy must be prescribed by a licensed physician.

Physical Therapy (PT), Speech Therapy (ST), Occupational Therapy (OT) add-on services
Rehabilitative services are physical therapy, occupational therapy, and speech therapy services not covered under the Nursing Facility Unit Rate, for Medicaid Nursing Facility

Members who are not eligible for Medicare or other insurance. The cost of therapy services for Members with Medicare or other insurance coverage or both must be billed to Medicare or other insurance or both. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions that have been impaired by illness. Rehabilitative services must be provided with the expectation that the Member's functioning will improve measurably in 30 days.

The Provider must ensure that rehabilitative services are provided under a written plan of treatment based on the physician's diagnosis and orders, and that services are documented in the Member's clinical record.

Rehabilitative services only include acute benefits. Therapy services for chronic conditions are not a covered benefit for Nursing Facility add-on services.

Initial therapy evaluation requests should originate directly from the office of the Member's PCP, specialist or Nursing Facility and should include:

- An evaluation order signed and dated within the last 30 days by the member's PCP (MD, DO, PA or NP) or other appropriate specialist involved in the Member's care. The evaluation order must specify the discipline(s) to be evaluated.
- Correct procedure codes and diagnoses codes corresponding to the service(s) to be provided.
- Documented medical necessity reason for therapy initial evaluation.

Reevaluation request may originate from the Nursing Facility or servicing Provider and should include:

- A reevaluation order signed within the last 30 days by the PCP or specialist involved in the Member's care.
- If the request is made greater than 30 days from the end of the existing treatment authorization documentation from the PCP or specialist involved in the Member's care identifying the medical necessity for reevaluation.

Initial treatment requests should include:

- Date of evaluation.
- Member's age and birthdate.
- A brief statement of the Member's medical history, including onset date of the illness, injury, or exacerbation that requires the therapy services and any prior therapy treatment.
- Relevant review of systems.
- Pertinent physical assessment including a description of the Member's current deficits and the severity level documented using objective data. This may include current standardized assessment scores, percentage of functional impairment, criterion-referenced scores, or other objective information as appropriate for the Member's condition or impairment.
- A clear diagnosis and reasonable prognosis including the Member's potential for meaningful and significant progress.
- A description of the Member's functional impairment with a comparison of prior level of function to current level of function.
- A statement of the prescribed treatment modalities and their recommended frequency/duration.
- Proposed patient and/or caregiver education.

- Functional treatment goals which are specific to the Member's diagnosed condition or impairment. Functional treatment goals must be specific, measurable, attainable and time-based.
- Treatment plan may not be more than 90 days old.
- If the treatment plan is part of a medically necessary program to maintain or prevent a significant functional regression, it must document skilled services to be provided and have goals that address maintenance.

Requests for continued treatment should include all of the above elements, in addition to:

- Number of therapy visits authorized, and number of therapy visits attended.
- A clear diagnosis and reasonable prognosis including the Member's potential for meaningful and significant progress.
- A description of the Member's current deficits and the severity level documented using objective data. This may include current standardized assessment scores, percentage of functional impairment, criterion-referenced scores, or other objective information as appropriate for the Member's condition or impairment.
- Objective demonstration of the Member's progress towards each prior functional treatment goal.
  - For all unmet functional treatment goals, baseline and current function must be submitted so that the Member's progress towards goals may be measured. As the treating therapist has set the functional treatment goals for a specified time period, it would be expected that functional treatment goals would be met within the specified time frame. If the functional treatment goals are unmet, it is the treating therapist's responsibility to objectively describe any barriers to progress that were encountered and appropriate modifications to the treatment plan in order to meet the Member's needs.
- An updated statement of the prescribed treatment modalities and their recommended frequency/duration.
- A brief prognosis with clearly established discharge criteria.
- Updated functional treatment goals which are specific to the Member's diagnosed condition or impairment. Functional treatment goals must be specific, measurable, attainable, and time-based.
- Updated treatment plan/progress summary may be no older than 90 days old.
- Treatment plan must be signed and dated by the treating therapist.

PLEASE NOTE: Therapy orders signed by doctors of philosophy are not accepted.

Customized Power Wheelchair (CPWC) add-on services
To be eligible for a CPWC a resident must be:

- Medicaid eligible.
- 21 years of age or older.
- Residing in a licensed and certified Nursing Facility that has a Medicaid contract with HHSC.
- Eligible for and receiving Medicaid services in a Nursing Facility.
- Unable to ambulate independently more than 10 feet.
- Unable to use a manual wheelchair.
- Able to safely operate a power wheelchair.
- Able to use the requested equipment safely in the Nursing Facility.
- Unable to be positioned in a standard power wheelchair.

- Mobility status would be compromised without the requested CPWC.
- Certified by a signed statement from a physician that the CPWC is medically necessary.

Augmentative Communication Device (ACD) add on services
A speech-generating device system available to Nursing Facility Members. A physician and a licensed speech therapist must determine if the ACD is medically necessary.

PLEASE NOTE: For Nursing Facility add-on therapy services, Community First will accept claims received from (1) the Nursing Facility on behalf of the employed or contracted therapists; and (2) directly from therapists who are contracted with Community First. All other Nursing Facility add-on Providers must contract directly with and directly bill Community First. Nursing Facility add-on Providers, except Nursing Facility add-on therapy Providers, should refer to the STAR+PLUS Provider Manual for information on credentialing and re-credentialing.

UTILIZATION MANAGEMENT CRITERIA

Utilization Management decisions are made in accordance with currently accepted medical or health care practices. The criteria used for review of medical necessity, Provider peer-to-peer review takes into account the special circumstances of each case that may require an exception to the standard, as stated in the screening criteria. The medical director may review all potential adverse determinations for medical necessity; and the vice president of medical management, or a designee, assesses the consistency with which reviewers apply the criteria.

InterQual criteria are used to determine medical necessity. InterQual was developed by generalist and specialist physicians representing a national panel from academic as well as community-based practice, both within and outside the managed care industry. These criteria provide a clear and consistent platform for care decisions to appropriately balance resources. A Community First Utilization Management clinician will review clinical documentation to determine medical necessity and the appropriateness for Nursing Facility add-on and acute care services, including setting of care, are met according to the InterQual criteria. Community First also utilizes the Texas Medicaid Provider Manual (TMPPM) as a guideline for Medicaid covered services. Utilization review decision making is based on appropriateness of care and service and the existence of decision. Community First does not reward Providers or other individuals for issuing medically necessary denials. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

PLEASE NOTE: Utilization Management reporting requirements are specified by individual mental health service types.

COORDINATION WITH OTHER STATE PROGRAM SERVICES

Coordination with Public Health
Community First coordinates with other State Health and Human Services Commission

(HHSC) programs regarding the provision of essential public health services. Providers must assist Community First in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in notifying or referring to the local public health entity, as defined by state law, any communicable disease outbreaks involving Members.
- Reporting Tuberculosis (TB) and all confirmed cases of STD/HIV to the public health entity for investigation and evaluation, and preventive treatment of persons whom the Member has come into contact within one business day of identification:
  1. Bill all TB-related services to TMHP.
  2. Reporting to the local public health entity for TB contact investigation and evaluation, and preventive treatment of persons whom the Member has come into contact within one business day of identification.
  3. Ensure all Members who have TB or are at-risk are screened for TB.
  4. Access procedures for reporting TB and appropriate DSHS forms from www.dshs.state.tx.us/idcu/disease/tb/forms.
- Properly maintaining confidential information about Members who have received STD/HIV services.
- Properly referring for Women, Infant, and Children (WIC) services and information sharing for the purposes of eligibility determination.
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.
- Referring lead screening tests to the HHSC laboratory.
- Reporting of immunizations provided to the statewide ImmTrac Registry, including parental consent to share data.
- Cooperating with activities required of public health authorities to conduct the annual population and community-based needs assessment.
- Identifying Members who are less than three years of age and suspected of having a developmental delay or disability, and referring to Early Childhood Education (ECI) Providers for screening and assessment within two business days from the day the Member is identified.
- Using materials from HHSC available at https://hhs.texas.gov/services/disability or by calling 1-877-787-8999.
- Complying with the release of records within 45 days so that screening may be completed.

For coordination of services not directly provided through Community First, all network Providers are encouraged to refer to and coordinate services with the agencies listed below. However, if more information or assistance is required, contact Community First Member Services or complete and submit a Request for Care Management Services Form located on the Community First website at CommunityFirstMedicaid.com.

- Access procedures for reporting TB and appropriate DSHS forms at www.dshs.state.tx.us/idcu/disease/tb/forms or by contacting Community First Member Services.
- Access required forms for STD/HIV reporting at http://www.dshs.texas.gov/hivstd/healthcare/reporting.shtm or by calling Community First Member Services.
- Refer to the TMPPM for further coordination.

ADDITIONAL BENEFITS

Prescriptions
All STAR+PLUS Non-Dual Eligible Medicaid Members receive unlimited prescriptions. Members who receive Medicare as their primary health care insurance coverage will continue to receive their prescriptions through their Medicare Part D benefit.

Pharmacy Compounds
Providers must bill for compounds using the drug code and metric decimal quantity for each National Drug Code in the compound. Compounds should contain medication(s) that are covered by the Texas Vendor Drug formulary.

Providers should bill a compound using the compound indicator code.

Roles of a Pharmacy
Community First Members receive pharmacy services through Community First's contracted Pharmacy Benefit Manager (PBM). The PBM has a statewide network of contracted pharmacies enrolled in the Texas Vendor Drug Program (VDP), including many long-term care pharmacies such as but not limited to Pharmerica, Omnicare, and Pharmascript and VDP-enrolled independent and chain pharmacies. In addition, in-house pharmacies and/or those affiliated with a Nursing Facility are contracted with the VDP and our PBM. Contracting for in-house or affiliated pharmacies are handled via our PBM. The PBM will also work with any pharmacy Provider should there be any concerns related to contracting.

Community First is required to adhere to the Preferred Drug List (PDL) which is created and maintained by the Texas VDP. Members have the right to obtain Medicaid covered medications from any Community First network pharmacy. These pharmacies are located on the Community First website at CommunityFirstMedicaid.com. Providers and Members can also call Community First Member Services to locate a network pharmacy.

Network pharmacies are required to perform Prospective and Retrospective Drug Utilization Reviews, coordinate with the prescribing physician, ensure Members receive all medications for which they are eligible and ensure adherence to the state mandated Medicaid formulary PDL. The pharmacy must coordinate the benefits when a Member also receives Medicare Part D services or has other benefits.

Behavioral Health
Community First manages behavioral health services (mental health and substance use disorders) for Community First Members. Community First is responsible for the provision of medically necessary behavioral health services and maintains a robust network of behavioral health and substance use disorder Providers including psychiatrists, nurse practitioners, psychologists, social workers, licensed professional counselors, hospitals and Local Mental Health Authority (LMHA) Facilities.

Behavioral Health Providers agree to:

- Refer Members with known or suspected physical health problems or disorders to the PCP for examination and treatment.
- Only provide physical health services if such services are within the scope of the

network Provider's clinical licensure.
- Send initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the consent of the Member or the Member's legal guardian.
- Schedule outpatient follow up and/or continuing treatment prior to discharge for all Members that have received inpatient psychiatric services.
- Ensure outpatient treatment occurs within 7 days from the date of hospital discharge, inpatient psychiatric facility discharge, or Nursing Facility discharge.
- Contact Members who have missed appointments within 24 hours to reschedule appointments.
- Coordinate with LMHA and state psychiatric facilities.
- Complete training and become certified to administer Adult Needs and Strengths Assessment (ANSA).
- Use Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG) and the Uniform Managed Care Manual, Chapter 15 as the medical necessity criteria for Mental Health Rehabilitative services (MHR) and Mental Health Targeted Case Management (TCM) services.
- As part of the credentialing process, provide an attestation to Community First that Provider/facility has the ability to provide, either directly or through sub-contract, Community First Members with the full array of MHR and TCM services as outlined in the RRUMG and the Uniform Managed Care Manual, Chapter 15.
- Abide by the Qualified Mental Health Professionals for Community Services (QMHP-CS). The requirement minimums for a QMHP-CS are as follows:
  - Demonstrate competency in the work to be performed; and medical record documentation and referral information must be documented using the Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications.

Value-Added Services

Community First offers coverage beyond traditional Medicaid benefits. Collectively, this additional coverage is referred to as Value-added Services (VAS). VAS may be actual health care services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve health outcomes. Community First contracts with other companies to provide VAS. Those companies bill Community First directly for the services they provide.

For a complete list of current Community First STAR+PLUS Nursing Facility VAS, please refer to:

- Community First STAR+PLUS Nursing Facility Member Handbook.
- Community First website at CommunityFirstMedicaid.com.
- Community First Population Health Management Department at **210-358-6055**.

V. SERVICE COORDINATION

The goals of managed care include an emphasis on preventive care, improved access to care, appropriate utilization of services, improved client and Provider satisfaction, improved health outcomes, quality of care, and cost-effectiveness. Community First Service Coordinators partner with Nursing Facility staff to ensure a Member's care is holistically integrated and coordinated by finding ways to avoid preventable hospital admissions, readmissions, and emergency room visits, resulting in shared savings to benefit both the Nursing Facility and Community First, and most importantly the Members.

The Service Coordinator participates in person and family-centered service planning with the Nursing Facility staff, Primary Care Provider, vendors and other state and community agencies to coordinate managed and non-managed services, including non-Medicaid community resources. In addition, the Service Coordinator attends meetings, assists in the development of the Nursing Facility's plan of care for the Member, and serves as the primary resource or advocate for the Member ensuring that the Member, the Member's family or representative, Nursing Facility staff, and other Members of the interdisciplinary team are involved. On a quarterly basis, the Service Coordinator conducts a face-to-face visit with the Nursing Facility Member, or more frequently, as determined by the Member's condition, situation, and level of care.

Providers may request a Service Coordinator by calling Members Services at **210-358-6105**, Monday through Friday 8 a.m. to 5 p.m. (CST). During after hours, state-approved holidays and weekends the Member Services line is answered by Community First's 24-hour Nurse Advice Line. The Nurse Advice Line can provide assistance with eligibility and authorizations for needed services.

SERVICE COORDINATOR RESPONSIBILITY

The Service Coordinator is responsible for:

- Coordinating services when a Member transitions into a Nursing Facility.
- Developing a service plan that includes services provided through the Nursing Facility, add-on services, acute medical services, behavioral health services, and primary or specialty care.
- Participating in Nursing Facility care planning meetings telephonically or in person, provided the Member does not object.
- Comprehensively reviewing the Member's service plan, including the Nursing Facility plan of care, at least annually, or when there is a significant change in condition.
- Visiting Members living in Nursing Facilities at least quarterly.
    - Visits should include, at a minimum, a review of the Member's service plan and, when possible, a person-centered discussion with the Member about the services and supports the Member is receiving, any unmet needs or gaps in the Member's service plan and any other aspect of the Member's life or situation that may need to be addressed.
- Promoting a meaningful quality of life and autonomy for Members.
- Assisting with the collection of applied income when a Nursing Facility has

documented unsuccessful efforts, per the state-mandated Nursing Facility requirements.
- Cooperating with representatives of regulatory and investigating entities including HHSC Regulatory Services, the LTC Ombudsman program, Adult Protective Services, the Office of the Inspector General, and law enforcement.
- Fulfilling requirements of the Texas Promoting Independence Initiative (PII) as described in UMCC Section 8.3.9.2. The quarterly in-person visits required can include assessments required under the PII, and the Service Coordinator can serve as the designated point of contact for an individual referred to return to the community under PII.
- Coordinating with the Nursing Facility discharge planning staff to plan discharge and transition from the Nursing Facility.
- Notifying the Nursing Facility within 10 days of a change to a Member's assigned service coordinator.
- Returning a call from a Nursing Facility within 24 hours after the call is placed by the Nursing Facility.

NURSING FACILITY RESPONSIBILITY

The Nursing Facility staff will partner with Community First Service Coordinators to ensure the member's plan of care meets the Member's needs in the least restrictive setting. The Nursing Facility is responsible for:

- Inviting the Member's Community First Service Coordinator to attend scheduled meetings with the interdisciplinary team and including the Service Coordinator's input on the development of the Nursing Facility care plan which is subject to the Member's right of refusal. Nursing Facility care planning meetings should be contingent on Community First's Service Coordinator participation.
- Notifying the Member's Community First Service Coordinator within one business day of unplanned admission or discharge to a hospital or other acute facility, skilled bed, or another nursing home.
- Notifying the Community First Service Coordinator if a Member moves into hospice care.
- Notifying the Community First Service Coordinator within one business day of an adverse change in a Member's physical or mental condition or environment that could potentially lead to hospitalization.
- Coordinating with the Community First Service Coordinator to plan discharge and transition from a Nursing Facility.
- Notifying Community First's Service Coordinator within one business day of an emergency room visit.
- Notifying the Community First Service Coordinator within 72 hours of a Member's death.
- Notifying the Community First Service Coordinator of any other important circumstances such as the relocation of Members due to a natural disaster.
- Providing the Community First Service Coordinator access to the facility, Nursing Facility staff, and Member's medical information and records.

VI. ROUTINE, URGENT, AND EMERGENCY SERVICES

ROUTINE, URGENT, AND EMERGENCY CARE DEFINITIONS

Community First requires that medically necessary health services are safely provided in the most appropriate and least restrictive setting without adversely affecting a Member's physical health or their quality of life. Members are encouraged to contact their Primary Care Provider (PCP) prior to seeking care. In the case of a true emergency, Members are encouraged to visit their nearest emergency department. The following are definitions for routine, urgent and emergency care:

Routine Care
Health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent, designed to prevent disease altogether, to detect and treat it early or to manage its course most effectively. Some examples of routine care include immunizations and regular screenings like pap smears or cholesterol checks.

Urgent Condition
A health condition, including an urgent behavioral health situation that is not an emergency but is severe or painful enough to cause a PCP or practitioner to believe that a Member's condition requires medical treatment evaluation or treatment within 24 hours to prevent serious deterioration of the Member's condition or health. Medicare Members in need of urgent care services should be treated immediately in order to avoid the likely onset of an emergency medical condition.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity including severe pain, such that a PCP or practitioner could reasonably expect the absence of immediate medical care could result in:

- Placing the Member's health in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- With respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

ACCESS TO ROUTINE, URGENT, AND EMERGENT CARE

Community First requires the hours of operation that Providers offer to Medicaid Members be no less than those offered to commercial patients. Members must have access to covered services within the timelines specified by HHSC and Texas Department of Insurance (TDI). "Day" is a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first.

Covered Services	Timelines
Routine primary care	14 days
Routine specialty care	21 days
Initial outpatient behavioral health visits	14 days
Urgent care, including urgent specialty care	24 hours
Emergency services, including at non-network out-of-area facilities	Must be provided upon Member presentation at the service delivery site

EMERGENCY PHARMACY SERVICES - MEDICAID ONLY

A 72-hour emergency supply of a prescribed drug may be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to drugs requiring a PA, either because they are non-preferred drugs on the Preferred Drug List (PDL) or because they are subject to a clinical prior authorization. Emergency supplies are NOT available for medications that do not appear on the VDP formulary.

The 72-hour emergency supply should be dispensed when a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the Member's medical condition. This short-term supply does not apply to Drug Efficacy Study Implementation (DESI) drugs, when the drug could be contraindicated to the Member's condition or when starting and abruptly stopping the medication would be medically contraindicated. If the prescribing Provider cannot be reached or is unable to request a PA, then the pharmacy should provide an emergency 72-hour prescription as long as the above concerns are not noted.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable such as albuterol inhaler as a 72-hour emergency supply. To be reimbursed for a 72-hour emergency prescription supply, pharmacies should contact Navitus Health Solutions Provider Hotline at **1-877-908-6023**. For more information about the 72-hour emergency prescription supply policy, call the Community First Provider Relations Department at **210-358-6294**.

EMERGENCY TRANSPORTATION

An emergency ambulance transport is reimbursable when the Member has an emergency medical condition. Nursing Facilities should utilize a participating Provider for all emergency transportation.

Reimbursement is limited to basic life support ambulance services. Emergency transportation does not require prior authorization.

NON-EMERGENCY AMBULANCE TRANSPORTATION

The Nursing Facility is responsible for providing routine non-emergency transportation services. The cost of such transportation is included in the Nursing Facility unit rate.

Transports of Nursing Facility Members for rehabilitative treatment (e.g., physical therapy) to outpatient departments or to physicians' offices for recertification examinations for Nursing Facility care are not reimbursable services by Community First.

Community First is responsible for authorizing non-emergency ambulance transportation for a Member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contraindicated).

Community First is required to cover emergency and medically necessary non-emergency ambulance services.

- Non-emergency ambulance transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the client's home after discharge when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation.
- Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in 1 TAC §353.2 (relating to definitions), is not available at the first facility and Community First has not included payment for such transports in the hospital reimbursement.

All ambulance transports which do not meet the definition of an emergency medical condition as per 1 TAC §353.2 require prior autorization, including:

- All facility-to-facility transports.
- All out-of-state transports.
- All air, ground, and water transport.

Authorization
Nursing Facility Providers must follow the steps below to obtain prior authorization for non-emergency ambulance transportation for STAR+PLUS Nursing Facility Members:

1. A physician or physician extender writes an order for non-emergency transport.
2. Nursing Facility staff should contact Community First Member Services, Utilization Management, or the Member's assigned Service Coordinator to find an ambulance company that is in-network.
3. The Nursing Facility staff contacts the ambulance company to get their necessary information to complete the Prior Authorization form. Necessary information supplied by the ambulance company is limited to company name, fax number, NPI and other business information.
4. The ambulance Provider will document the request was initiated by the Nursing Facility staff and include name, time, and date.
5. The Nursing Facility must sign and submit the form to Community First for review along with documentation to support medical necessity.
6. The ambulance company and Nursing Facility will coordinate the scheduling of the appointment.

Approvals/Denials
Approved Utilization Management criteria will be used by Community First to review requests for medical necessity. Community First will provide an approval or denial letter for the prior authorization to the requesting entity, as well as the ambulance Provider. If a request for recurring transports is approved, Community First will include the number of one-way transports in the approval. Appeals for denials of medical necessity follow the standard Provider appeal process. Refer to the Appeals section in this Provider Manual.

The ambulance Provider is ultimately responsible for ensuring that a prior authorization has been obtained prior to transport. Non-payment may result for services provided without a prior authorization or when the authorization request is denied.

STAR+PLUS NON-EMERGENCY MEDICAL TRANSPORTATION

Non-Emergency Medical Transportation (NEMT)
Community First Health Plans Non-Emergency Medical Transportation Services are designed to serve community-based STAR+PLUS Members that have no other means of transportation for medical appointments. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips.

What services are part of NEMT services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible-vans, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) to a covered health care service. The ITP can be the Member, a responsible party, a family member, a friend, or a neighbor.
- If the Member is 20 years old or younger, they may be able to receive the cost of meals associated with a long-distance trip to obtain health care services. The daily rate for meals is $25 per day, per person.
- If the Member is 20 years old or younger, they may be able to receive the cost of lodging associated with a long-distance trip to obtain health care services. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
- If the Member is 20 years old or younger, they may be able to receive funds in advance of a trip to cover authorized NEMT services.

If a Member needs an attendant to travel to an appointment with them, NEMT services will cover the transportation costs of the attendant.

How can I help a Member schedule a ride?
Community First Health Plans will provide you with information on how to request NEMT services. You should request NEMT services as early as possible, and at least 48 hours before you need the NEMT service. In certain circumstances you may request the NEMT service with less than 48 hours notice. These circumstances include:

- Being picked up after being discharged from a hospital;
- Trips to the pharmacy to pick up medication or approved medical supplies; and
- Trips for urgent conditions. (An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.)

You must notify Community First prior to the approved and scheduled trip if your medical appointment is canceled.

To schedule a ride, please call:
NEMT Member Reservation Line: **1-888-444-0307** (TTY: **711**)
Monday through Friday, from 8 a.m. to 5 p.m.
Information available in both English and Spanish. Interpreter services available.

When you call, please be ready to provide:

- Medicaid ID number (from Your Texas Benefits Medicaid ID card).
- The name, address, and phone number of the place you are going.
- The medical reason for your visit.

Your driver will call, give you your pickup time, and provide you with his or her direct phone number. Keep this number with you. If you need help after hours or are unable to contact your driver, please call:

Where's My Ride?: **1-888-444-0824** (TTY: **711**)
24 hours a day, 7 days a week

Information available in both English and Spanish. Interpreter services available.

EMERGENCY DENTAL SERVICES - MEDICAID ONLY

Community First is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. Community First will also pay for hospital, physician and related medical services such as anesthesia and drugs for covered emergency dental procedures.

Covered emergency dental procedures include, but are not limited to:

- Alleviation of extreme pain in oral cavity associated with serious infection or swelling.
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration).
- Open or closed reduction of fracture of the maxilla or mandible.
- Repair of laceration in or around oral cavity.
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts.
- Incision and drainage of cellulitis.
- Root canal therapy. However, payment is subject to dental necessity review and pre- and post-operative x-rays are required.
- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

NON-EMERGENCY DENTAL SERVICES

Community First is not responsible for paying for routine dental services provided to Medicaid Members. However, Community First is responsible for paying for treatment and devices for craniofacial anomalies.

VII. PRIOR AUTHORIZATION

Community First's Population Health Management Department works with its network Providers to facilitate quality care through its refined Medical Management program. This program includes utilization management, care management/complex care management, and disease management components, as well as other features such as 24-hour nurse triage, referrals, second opinions, prior authorization/pre-certification, concurrent review, retrospective review, and discharge planning.

This section of the Provider Manual focuses on prior authorization, notifications, and referrals.

PRIOR AUTHORIZATION REQUIREMENTS

Requesting Providers must initiate a prior authorization (PA) of non-emergency services and all add-on services prior to providing the requested service. It is recommended that requests be submitted five business days prior to the desired start date in order to allow time for processing. All add-on services require PA and should be submitted via the secure online Community First Provider Portal. Contact Community First's Population Health Management Department for detailed instructions about this process.

Community First has adopted a PA process for specific procedures and/or services. These procedures and/or services are listed on the Community First Prior Authorization List. The Authorization list is available on Community First's website at CommunityFirstMedicaid.com.

Failure to obtain PA for services that require PA will result in an administrative denial. PA requests that do not include essential information will be returned as incomplete and not processed.

If you have any questions about prior authorizations, contact Population Health Management at **210-358-6105.** For prescriber assistance, please call Navitus at 1-877-**908-6023**.

CLINICAL PRIOR AUTHORIZATION EDITS

Community First will utilize the Texas Vendor Drug Program prior authorization criteria for non-preferred medication requests. A copy of the criteria is available online at the PA XPRESS website via https://paxpress.txpa.hidinc.com. It is helpful to include all pertinent medical information in the original request to facilitate this process.

In addition, the Texas VDP provides clinical prior authorization criteria to managed care organizations to ensure medications follow the latest FDA-approved product labeling, and peer-reviewed literature via evidence-based clinical criteria. Please refer to our website for a link to the Clinical Prior Authorization criteria applied to Community First Members, as well as forms to assist Providers with prior authorization requests at CommunityFirstMedicaid.com.

SECOND OPINIONS

A second opinion may be requested when there is a question concerning diagnosis, options for surgery, other treatment of a health condition, or when requested by any

member of the Member's health care team, including the Member, parent and/or guardian, or a social worker exercising a custodial responsibility.

Authorization for a second opinion shall be granted to a network Provider or an out-of-network Provider if there is not an in-network practitioner available. The second opinion will be provided at no cost to the Member.

If the Provider who will see the Member for a second opinion is not in-network, an authorization is required. An authorization can be obtained via the secure online Community First Provider Portal at CommunityFirstHealthPlans.com/ProviderPortal. Contact Population Health Management Department at **210-358-6105** for detailed instructions.

CONTINUITY OF CARE

There are situations that arise when Community First may need to approve services out-of-network. Community First may need to provide authorization for continuity in the care of a Member whose health condition could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted.

Prior Authorization (PA) for services may be requested in one of three ways:

1. Calling the Prior Authorization Department at 210-358-6105.
2. Faxing the Prior Authorization form to 210-358-6274.
3. Submitting the request via via the secure online Community First Provider Portal at CommunityFirstHealthPlans.com/ProviderPortal.

Acute Care and Add-On Services

In the case of a newly enrolled Member who is receiving a service that did not require authorization from the prior plan, we will authorize services in the same amount, duration, and scope until the shorter of:

- 90 calendar days
- The time it takes for us to evaluate and assess the Member and issue or deny a new authorization.

For Members enrolling on the operational start date of an HHSC program or on the start date of a new service area, Community First will honor existing acute care authorizations for the earlier of 90 days or the expiration of the current authorization. We will honor existing long-term services and supports authorizations for up to six months or until we have completed a new assessment for the Member and issued new service authorizations.

For new Members who have been diagnosed with a terminal illness, we will approve out-of-network care by existing Providers for up to nine months while enrolled with Community First.

We pay a Member's existing out-of-network Providers for medically necessary covered services, including inpatient and Nursing Facility services, until the Member's records, clinical information and care can be transferred to a network Provider or until the Member is no longer enrolled with us, whichever is shorter.

Member Moves Out of Service Area

Community First will provide or pay out-of-network Providers for medically necessary

covered services to Members who move out of the service area. Members are covered through the end of the period for which they are enrolled in Community First.

When a Member's Nursing Facility address is not located in the Member's enrolled service area, Community First will pay out-of-network Providers for medically necessary covered services while working with the Member, their legal guardian, HHSC, and the Nursing Facility to determine on a case-by-case basis if updates are needed to the Member's plan enrollment or if transfer to an in-network facility is necessary.

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

Hospitalizations
There is no prior authorization requirement for Community First STAR+PLUS Nursing Facility residents admitted or readmitted to nursing facilities for residential care following hospitalization. Emergency services, including emergency transportation, do not require prior authorization from Community First.

Skilled Nursing Facility Admission and Discharge
Prior authorization from Community First is always required for admission to a skilled Nursing Facility (SNF) for Non-Dual Eligible (Medicaid only) Members. SNF stays for Non-Dual Members are excluded from the authorization waiver period for acute care services. Admissions or readmissions to residential Nursing Facility care following discharge from a SNF do not require prior authorization from Community First.

Pre-existing Condition not Imposed
Community First does not impose any pre-existing condition limitations or exclusions. Community First does not require evidence of insurability to provide coverage to any Member.

VIII. CLAIMS AND ENCOUNTERS ADMINISTRATION

A claim is a request for reimbursement for any health care service provided. The claims process begins when a Member's eligibility for coverage is determined and Community First provides benefits for specific services.

Community First Providers are encouraged to submit a claim or encounter for each service rendered to a Community First Member.

Community First will not accept claims submitted to an address or through a method not described in this section.

Please note the important claims information below:

- Clean claims for Nursing Facility (NF) unit rate and NF Medicare Coinsurance submitted for Medicaid Members are adjudicated within 10 days from the date the Provider submits a clean claim. Clean claims not adjudicated within 10 days of submission by us are subject to interest payments. Claims must be filed within 365 days of the date of service.
- Clean claims for NF add-on services or other services negotiated into the Provider's contract and submitted for Medicaid Members are adjudicated within 30 days from the date we receive a clean claim. Clean claims not adjudicated within 30 days of receipt by us are subject to interest payments. Claims must be filed within 95 days of the date of service.
- Adjudication edits are based on the Member's eligibility, benefit plan, authorization status, HIPAA coding compliance, and our claim processing guidelines. Claim coding is subject to review using code-editing software.
- Claim reimbursement is based on the Provider's contract. We are responsible for paying qualified Providers their liability insurance and an enhanced fee to NF Providers who are part of the HHSC Direct Care Staff Rate Enhancement Payment program. The fees will be built into the Provider's unit rate payment fee schedule.
- Claims submitted by an NF must meet the HHSC criteria for clean claims submission as described in UMCM Chapter 2.3, Nursing Facility Claims Manual.

CLAIMS SUBMISSION

Providers have the following options for submitting claims to Community First:

- Electronic Data Interchange (EDI) using the Availity EDI Gateway
- Availity Provider Portal
- TMHP website claim portal
- Paper (for claims filed by Providers other than a Nursing Facility)

NURSING FACILITY CARVED-IN SERVICES

The following services are reimbursable by Community First for STAR+PLUS Nursing Facility Members:

Nursing Facility Unit Rate

Daily unit rate services include services traditionally provided by the NF as defined by HHSC Vendor Payment Services. The following service categories are included in the NF unit rate and are not reimbursable separately:

- Computation of the NF daily unit rate = direct care staff + other resident care +

dietary + general and administration costs + fixed capital
- Full or partial ventilator services
- Child tracheostomy for adults ages 21-22
- Liability insurance
- Direct care staff rate enhancement

Individual NF rates are established by HHSC and supplied to Community First regularly from TMHP. Claims submitted for the daily unit rate will continue to be authorized by TMHP. Community First will not reassess or authorize services resulting from the MDS and covered under the daily unit rate.

Providers should contact Community First's Provider Relations Department at **210-358-6300** for questions related to claims procedures.

Add-On Services
The following add-on services are covered benefits for STAR+PLUS Nursing Facility Members:

- Tracheostomy care for Members age 21
- Ventilator care
- Physician-ordered rehabilitative therapy services (including assessments) provided by therapists who are either employed by the Nursing Facility or subcontracted by the facility:
  - Rehabilitative therapy services should be billed by the Nursing Facility when authorized by Community First and provided in the Nursing Facility.

The following add-on services are covered benefits that must be billed by the rendering Provider of the service and not by the Nursing Facility:

- Emergency dental services
- Augmentative communication devices
- Customized power wheel chairs

Services
The following list of services is carved out of our responsibility and should be billed to fee-for-service Medicaid:

- PASSR specialized services
- Hospice services
- Nursing Facility daily care for a veterans' home
- Hospice care for a veterans' home

Medicare SNF Coinsurance
Medicare SNF coinsurance amounts should be billed by the Nursing Facility to Community First.

Other Negotiated Services
Other negotiated services contained in the Nursing Facility Provider's contract should be billed to Community First.

Cost Reporting to HHSC
The Nursing Facility Provider must submit cost reports to HHSC or its designee in the manner and format required by HHSC. If the Provider fails to comply with this requirement, Community First will hold payments to the Provider as directed by HHSC until HHSC instructs Community First to release payments.

CLAIM FILING GUIDELINES

All Nursing Facility Providers must follow and meet HHSC's criteria for clean claims submissions as described in UMCM Chapter 2.3, "Nursing Facility Claims Manual" and as noted below.

HHSC Clean Claim Criteria:

- The Nursing Facility resident must be Medicaid eligible for the dates of service billed.
- The Nursing Facility resident must be in the Nursing Facility for the dates of service billed.
- The Nursing Facility resident must have a current Medicaid necessity determination for the dates of service billed.
- The Nursing Facility Provider has to have been in good standing for the dates of service billed (i.e., not on vendor payment hold for any reason).

Any claim that does not meet the definition of a clean claim is considered a "non-clean claim." Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate the claim.

Nursing Facility Providers are encouraged to participate in Community First's electronic claims/encounter filing directly through the secure online Community First Provider Portal at CommunityFirstHealthPlans.com/ProviderPortal.

Providers should contact Community First's Provider Relations Department at **210-358-6030** for questions related to claims procedures, filing complaints or appeals.

Timely Filing Requirements

Nursing Facilities must file room and board first time claims within 365 days from the date of service. If a claim is not received by Community First within the 365 days, Community First will deny the claim unless there is an exception from the filing deadline.

If the Nursing Facility files with the wrong health plan or the wrong HHSC portal within the required 365 days and produces documentation demonstrating timely filing, Community First will honor the initial filing date and process the claim without denying for the sole reason of passed timely filing.

The Nursing Facility must file the claim with Community First within: (1) 365 days after the date of service, or (2) 95 days after the date on the Remittance and Status (R&S) Report or explanation of payment from the other carrier or contractor.

When a service is billed to a third-party insurance resource other than to Community First, the claim must be refiled and received by Community First within: (1) 365 days from the date of service, or (2) 95 days after the room and board first time claim date on the R&S Report or explanation of payment from the other carrier or contractor. Community First will require that the Nursing Facility file their claim with a copy of the third-party payor's R&S Report or explanation of payment.

A claim should not be filed with different resource utilization group (RUG) or split authorized service levels. Each claim must only bill for one RUG or service authorized

date span which may result in a separate claim. If a filing deadline falls on a weekend or holiday, the filing deadline shall be extended to the next business day following the weekend or holiday.

Clean Claim
A clean claim is one submitted for medical care or health care services rendered to a Member with the data necessary for the MCO or its subcontracted claims processor to adjudicate and accurately report the claim.

A clean claim other than a Nursing Facility unit rate clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837 (claim type) encounter guides as follows:

- 837 Institutional Combined Implementation Guide
- 837 Professional Combined Implementation Guide
- 837 Institutional Companion Guide
- 837 Professional Companion Guide

Claims submitted by a Nursing Facility for Nursing Facility unit rate or Medicare coinsurance must meet the HHSC criteria for clean claims submission as described in UMCM Chapter 2.3, Nursing Facility Claims Manual.

A clean claim is a request for payment for a service rendered by a Provider that:

- Is accurate.
- Is submitted in a HIPAA-compliant format or using the standard claim form, including a CMS-1450 (UB-04), CMS-1500 (02-12) or successor forms thereto, or the electronic equivalent of such claim form.
- Requires no further information, adjustment or alteration by the Provider or by a third party to be processed and paid by us.
- For a Nursing Facility unit rate or Medicare coinsurance claim, is submitted including all data as defined in the HHSC criteria for clean claims submission as described in UMCM Chapter 2.3, Nursing Facility Claims Manual.

CMS-1450 (UB-04) and CMS-1500 (02-12) forms must include the following information (HIPAA-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- CPT-4 codes/HCPCS procedure codes
- Modifiers
- Diagnosis pointers
- Itemized charges
- Days or units
- Provider's tax ID number
- Total charge
- Provider's name according to the contract
- NPI of billing Provider
- Billing Provider's taxonomy codes

- NPI of rendering Provider
- Rendering Provider taxonomy codes
- State Medicaid ID number (optional)
- COB/other insurance information
- Authorization number or copy of authorization
- Name of referring physician
- NPI of ordering/referring/supervising Provider when applicable
- Any other state-required data
- National drug codes (NDCs)

A claim that is deemed unclean is returned to the Provider or submitter along with the reason for rejection.

For STAR+PLUS Nursing Facility daily unit rate and Medicare Coinsurance claims, clean claims are adjudicated within 10 calendar days of initial clean claim submission.

All other clean claims are adjudicated within 30 calendar days of receipt (18 days for electronic pharmacy claims submission, 21 days for non-electronic pharmacy claims). If we do not adjudicate the clean claim within the time frames specified above, we will pay all applicable interest as required by law.

We produce and distribute Explanation of Payments (EOPs) on a daily basis except Sundays for our Nursing Facility Providers. EOPs for other Provider claims are produced on a biweekly basis. The EOP delineates the status of each claim that has been adjudicated during the payment cycle. EOPs are available in a format of the Provider's choice, paper or electronic, and are available for printing and/or download.

Payment Requirements
Community First must administer an effective, accurate, and efficient claims payment process in compliance with federal laws and regulations, applicable state laws and rules, and the contract, including Uniform Managed Care Manual Chapter 2.3. Community First may not directly or indirectly charge or hold a Member or network or non-network Provider responsible for a fee to adjudicate a claim.

Community First may deny a claim submitted by a Provider for failure to file in a timely manner as described in the Uniform Managed Care Manual Chapter 2.3. Community First may withhold all or part of a payment for a claim submitted to a Provider:

- Excluded or suspended from Medicare, Medicaid or CHIP programs for fraud, waste or abuse.
- On full or partial payment hold under the authority of HHSC or its authorized agent(s) with debts, settlements, or pending payments due to HHSC or the state or federal government.
- If the Provider's claim for Nursing Facility unit rate does not comply with all clean claim criteria.

A claim should not be filed with different RUG or split authorized service levels. Each claim must only bill for one RUG or service authorized date span which may result in a separate claim.

No later than 10 days after the submission received date of a clean first time claim, Community First must:

1. Pay the total amount due of the claim or part of the claim, or
2. Deny the entire claim or part of the claim and notify the Provider defining the reasons why the claim will not be paid.

Payment is considered paid on the date of:

1. The date of issue of a check for payment and its corresponding Explanation of Payment, or
2. Electronic transmission, if payment is made electronically.

PARTICIPATING, IN-NETWORK PROVIDER REIMBURSEMENT

Claim reimbursement is based on the Provider's contract. Community First cannot pay Providers or assign Medicaid Members to Providers for Medicaid services unless they are included on the state master file as provided by the Texas Medicaid & Healthcare Partnership (TMHP), which includes the state master file for nursing facilities. State master files are updated weekly.

Community First will automatically adjust previously adjudicated daily care claims within 30 days from the date of receipt of a change in data from the state to reflect adjustments to such items as Nursing Facility daily rates, Provider contracts, service authorizations, applied income, and level of service. Any adjustments, besides the ones listed previously and some denials, may require a corrected claim by the Nursing Facility Provider.

ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE (ERA) (835)

The 835 eliminates the need for paper remittance reconciliation. Use Availity to register and manage ERA account changes by following these three steps:

1. Log into Availity
2. Select "My Providers"
3. Select "Enrollments Center" and then "Transaction Enrollment"

PLEASE NOTE: If you use a clearinghouse or vendor, please work with them on ERA registrations and receiving your ERAs.

Electronic Funds Transfer (EFT)
Electronic claims payment through EFT is a secure and fast way to receive payments and reduce administrative processes. An EFT deposit is assigned a trace number that is matched to the 835 electronic remittance advice for simple payment reconciliation.

Contact Availity
For help with ERA or EFT questions, contact Availity Client Services at 800-Availity **(800-282-4548**).

REPORTING OVERPAYMENTS TO COMMUNITY FIRST

A Provider may identify an overpayment as result of multiple reasons, but may include:

- Erroneous billing by a Provider using incorrect NPI or taxonomy, or incorrect Member identification number.
- Payment to the Provider by a primary insurance payer, previously unknown or unreported to Community First.
- Duplicative billing by a Provider for services previously billed or paid.

- Erroneous billing by a Provider for services not rendered.

A Provider has an obligation to notify Community First in writing immediately upon identification of an overpayment, but no more than 30 days from the date of discovery. Providers must submit the notification of overpayment in writing to Community First. The overpayment can be remediated through refund to Community First, or a Provider may request Community First recoup the payment issued in error.

Refund
If a Provider wishes to refund the overpayment by issuing a check to Community First, the refund check must be submitted to Community First within 30 days of notification of the overpayment, or 60 days from the date of the discovery of the overpayment, whichever is less.

Each claim overpayment should be accompanied with a copy of the EOP indicating the overpaid claim or claims for which the refund is being submitted, along with the following:

- A check issued to Community First in the amount of the overpayment
- Member Name, date of birth, and Member Medicaid or CHIP identification number
- Claim date(s) of service
- Brief description of the reason for the overpayment
- Other supporting documentation

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

Alternatively, if a copy of the EOP is not available, a Provider may submit the following information with the refund check:

- Provider Name, Tax ID, and NPI
- Member Name, date of birth, and Member Medicaid or CHIP identification number
- Claim date(s) of service
- Brief description/reason for the overpayment
- Other supporting documentation

If a refund check is not received within 30 days of notification of the overpayment, or 60 days from the date of the discovery of the overpayment, whichever is less, Community First will proceed with recoupment of the overpayment(s).

Recoupment
If a Provider requests Community First recoup the overpayment, the prior erroneous payment(s) will be reversed by Community First within 30 to 60 days of receipt of the request. When the overpayment is recouped, the reversal of the prior payment will be reflected on the Provider's EOP after the claim is adjusted, and the monies prior paid will be deducted from the net amount due for claim payments as documented on the current EOP.

OVERPAYMENTS IDENTIFIED BY COMMUNITY FIRST

Community First may also identify overpayments made to a Provider, that may occur as result of HHSC's retroactive disenrollment of a Member who was eligible with Community First at the time of service/submission and payment of the claim, claims processing errors, retroactive Medicaid or CHIP program or benefit changes, or identification of a primary insurance payer responsible for payment of a portion or full payment of the claim. For retroactive loss of enrollment where the date of service falls outside of the 24 month period and there have been no updates to HHSC SAS data removing authorization/coverage, recoupment cannot take place.

In these circumstances, Community First will typically reverse the prior payment of the claim and recoup the monies paid in error, unless the Provider contract requires, or the Provider has previously requested that Community First allow the Provider the opportunity to refund the overpayment prior to recoupment.

If a Provider receives notification of overpayment, and request for refund, the Provider should include a copy of the notification of overpayment letter with the refund check, and mail to:

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

If the overpayment is recouped, the reversal of the prior payment will be reflected on the Provider's EOP after the claim is adjusted, and the monies prior paid will be deducted from the net amount due for claim payments as documented on the current EOP.

If a Provider has requested, or the Provider's contract requires prior notification and opportunity to submit a refund as result of an overpayment identified by Community First, the Provider will receive a letter explaining the reason for the overpayment, and requesting a refund be submitted within the appropriate timeframe as documented in the overpayment notice to the Provider. If the refund is not received within that timeframe, Community First will proceed with reversal of the erroneous payment, recouping the payment prior issued.

DURABLE MEDICAL EQUIPMENT (DME) AND OTHER COMMON PHARMACY PRODUCTS

Community First reimburses for covered DME and products commonly found in a pharmacy and not covered under the Nursing Facility Unit Rate. DME covered under the Nursing Facility Unit Rate includes medically necessary items such as:

- Nebulizers, ostomy supplies, or bed pans and medical accessories.
- Cannulas, tubes, masks, catheters, ostomy bags, and supplies.
- Intravenous (IV) fluids, IV equipment, and equipment that can be used by more than one person.
- Wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars and walkers.
- Oxygen equipment, tanks, concentrators, tubing, masks, valves, and regulators.

NURSING FACILITY UNIT RATE

Nursing Facility Unit Rates will continue to be authorized by HHSC. Community First will not reassess or authorize services resulting from the Minimum Data Set (MDS) and covered under the Nursing Facility Unit Rate. Nursing Facilities must submit an electronic version of the Medicare Remittances and Advice Form.

The Nursing Facility Unit Rates are the types of services included in the HHSC daily rate for Nursing Facility Providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. This also includes applicable Nursing Facility rate enhancements and professional and general liability insurance. Nursing Facility Unit Rates exclude add-on services.

It is important to note that HHSC will continue to authorize the daily rate as well as make the medical necessity determinations. Nursing Facilities are required to submit the MDS form to Centers for Medicare and Medicaid Services (CMS) and the Long-Term Care Medicaid Information (LTCMI) form via the LTC Online Portal. For additional information on Texas Minimum Data Set, visit https://hhs.texas.gov/doing-business-hhs/Provider- portals/long-term-care-providers/nursing-facilities-nf/texas-minimum-data-set-mds.

Providers should contact Community First's Provider Relations Department at **210-358-6294** for questions related to claims procedures.

PLEASE NOTE: SAS information is obtained by Community First after it is posted to the TMHP website. Delays can be expected between data appearing on the TMHP website and the secure online Community First Provider Portal. The uniform billing requirements can be found in the HHSC Uniform Managed Care Manual (UMCM), Chapters 2 Texas Claims Procedures: https://www.hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management/texas-medicaid-chip-uniform-managed-care-manual.

ADJUSTED CLAIMS - DAILY UNIT RATE

There may be occasions in which a claim, which is in a paid status, may require a payment adjustment. Community First will monitor and re-adjudicate a claim through the daily Service Authorization (SAS) file. Adjustments are identified by the health plan, and Nursing Facility Providers are not required to take any action. Some of the reasons a claim may require an adjustment are due to changes in:

- Nursing Facility daily rates
- Provider contracts
- Service authorizations
- Applied income
- Level of service/Resource Utilization Group (RUG)
- Non-compliance with spending and staffing requirements as dictated by HHSC's Direct Care Rate Enhancement Program

In each of these instances, Community First will re-adjudicate claims affected by the change. Payment on adjusted claims will be made within 30 days from receipt of the adjustment reason.

When a subsequent claim submission is necessary as result of a SAS-related claim denial,

please submit as a corrected claim within 120 days of the applied SAS denial (vs. a first time claim).

APPLIED INCOME - NURSING FACILITY UNIT

Within three business days after the effective date of the Nursing Facility Member, Community First will provide the name and contact information of a Service Coordinator or designated representative who will assist with the collection of applied income from the Nursing Facility Member. Community First will notify the Provider within 10 days of any change to the assigned Service Coordinator or designated representative. The Provider must make reasonable efforts to collect applied income, document those efforts. The Provider should notify Community First's Service Coordinator or designated representative when they have made two unsuccessful attempts to collect applied income in a month. This provision in no way subrogates the Provider's existing regulatory and licensing responsibilities related to the collection of applied income, including the requirements of 40 TAC § 19.2316.

COORDINATION OF BENEFITS FOR STAR+PLUS MEMBERS WITH MEDICARE

Dual Eligible Members have both Medicare and Medicaid health insurance coverage. Medicare is the primary payor and will reimburse for all acute care services, including behavioral health as well as the Skilled Nursing Facilities (SNF) approved amounts. The Nursing Facility is responsible for filing claims for Medicare coinsurance. Community First is responsible for paying the Medicare deductibles and coinsurance for services provided by Nursing Facilities.

To receive payment on a claim for tracheostomy care or ventilator services, it is not necessary to provide the R&S report from Medicare for the Nursing Facility unit costs. However, for all other services provided by the Nursing Facility, if Community First is not the Member's Medicare payor, then the electronic copy of the R&S report from Medicare will need to be filed with the claim.

In the event Community First is the Member's Medicare carrier, no Medicare R&S is required. Claims will deny if services billed that require a copy of the Medicare R&S are not submitted with the initial claim. The denial status of the claim will not change until the Medicare R&S is received.

The Nursing Facility must file a room and board first time claim with Community First: (1) 365 days after the date of service or (2) 95 days after the date on the R&S report or explanation of payment (EOP) from the other carrier or contractor.

Claims for SNF services require that one claim be filed to the Medicare carrier for the SNF allowable and a second, distinct claim be filed to Community First for the Medicaid coinsurance reimbursement. Appropriate and required revenue codes must be used for each separate claim. Nursing Facilities must submit an electronic version of the Medicare Remittances and Advice form (ERA) (835). The 835 eliminated the need for paper remittance reconciliation.

Dual Eligible Acute Care Services

For Community First Members that are Dual Eligible, Medicare is the primary payor for all acute care services (e.g. PCP, hospital and outpatient services), SNF services and skilled nursing stay days one through 20 at 100% of the level of service.

For Community First Members that have Medicaid only, Community First covers acute care services (e.g., hearing aids, orthotics or prosthetics, and non-emergent ambulance transportation), add-on services, and the Nursing Facility Unit Rate.

Providers that provide acute care services have 95 days from the date of service to submit a claim. Providers are required to bill two separate claims for Medicare acute services: (1) for Member compensation and (2) for Medicaid co-pay.

COORDINATION OF BENEFITS FOR STAR+PLUS MEMBERS WITH OTHER INSURANCE

Some Members with Medicaid may have other health coverage that must pay before Medicaid pays its share of the bill. These health insurance coverages are always primary to Medicaid coverage. When there's more than one payor, "coordination of benefits" rules decide who pays first. It is important that Providers verify if Members have health coverage in addition to Medicaid as this will help ensure that claims are submitted to the correct payer to avoid delays.

If a Member has other insurance, please submit your claim to the primary insurance for consideration. Claims filed to Community First for Members who have another insurance carrier should include a copy of the Explanation of Benefits (EOB), an Explanation of Payment (EOP), or a rejection letter from the other insurance carrier. If this information is not received with the initial claim, then the claim will deny until the appropriate documentation is received.

PLEASE NOTE: If a Member has more than one primary insurance carrier and Medicaid is the third payor, then a claim cannot be submitted through the Electronic Data Interchange (EDI) or the secure online Community First Provider Portal, a paper claim must be submitted.

OUT-OF-NETWORK REIMBURSEMENT

Nursing Facilities that have not signed a contract to provide care for Community First Members are considered out-of- network. In such cases where an out-of-network Nursing Facility provides care to a Community First Member, Community First will reimburse the out-of-network, in-area service Provider the Medicaid fee-for-service (FFS) rate whereby Community First will pay for services rendered, less five percent per rules found in 1 Texas Administrative Code (TAC) § 353.4 with the exception to the Medicare coinsurance.

CLAIMS FILING GUIDELINES FOR ADD-ON SERVICES

A clean claim must include Community First published requirements for adjudication such as the appropriate Medicaid number, TIN number, NPI, and taxonomy or medical records.

Please use the ANSI ASC X12 837P 5010 format for PT, OT, ST, Customized Power Wheelchairs (CPWC) and Augmentative Communication Devices (ACD). Use the ANSI ASC X12 8371 5010 format for Ventilator and Tracheostomy Care add-on services. Claims filed for add-on services must conform to national billing standards and Medicaid billing guidelines.

Claims may be filed by:

1. Submitting an ANSI X12N 837 professional transaction through an EDI partner. PLEASE NOTE: Submission of a claim to the clearinghouse does not guarantee that the claim was transmitted or received by Community First. Providers are responsible for monitoring their error reports to ensure all transmitted claims and encounters appear on reports.
2. Providers may also submit claims directly to Community First through the secure online Provider Portal.
3. Claims for add-on services can be submitted on paper to:
   Community First Health Plans, Inc.
   Attn.: Claims Department
   P.O. Box 240969
   Apple Valley, MN 55124

PLEASE NOTE: Paper claims must be filed on the approved claim form UB-04/CMS 1450. The only acceptable claim form is the one in FLINT OCR Red, J6983, or exact match ink.

Timely Filing Requirements
Claims for add-on services must be filed with Community First within: (1) 95 days after the date of service, or (2) 95 days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor.

However, if a filing deadline falls on a weekend or holiday, the filing deadline shall be extended to the next business day following the weekend or holiday.

Payment Requirements
All clean claims (including professional and institutional claims submissions) will be processed within 30 days of receipt. Each claim payment check will be accompanied by an EOP, which itemizes your charges for services rendered and the amount paid by Community First.

Billing Codes
Please reference to the most current LTSS Crosswalk for the list of codes and modifiers located in the HHSC MMC: https://hhs.texas.gov/doing-business-hhs/Provider-portals/long-term-care-providers/resources/long-term-care-bill-code-crosswalks.

CLAIMS RECONSIDERATIONS

A corrected claim is the replacement of a previously submitted claim and occurs when a Provider has submitted a claim and received a denial due to incorrect or missing information. A corrected claim must be received within 120 days of the initial claim disposition. To submit a claim form on paper, please use the required standard red and white UB-04 or HCFA 1500 claim form.

- Adjustment: An adjustment to a previously finalized clean claim.
- Appeal: In accordance with the appeal process, a clean claim that has been adjudicated where the Provider is appealing the disposition through written notification to Community First. The following are examples of supporting documentation which must be included with an appeal:
  - A letter from the Provider stating why they feel the claim payment is

incorrect (required).
  - A copy of the original claim.
  - A copy of the Community First EOP (required).
  - An EOP from another insurance company.
  - Documentation of eligibility verification, such as copy of the Member's "Your Texas Benefits" Medicaid card (formerly Medicaid form 3087), TMHP documentation or call log, etc.
  - Overnight or certified mail receipt as proof of filing date.
  - EDI acceptance report showing the claim was accepted by Community First.
  - Prior authorization number and/or form or fax.

PLEASE NOTE: If a Provider disputes the disposition of a claim, the Provider may appeal the decision.

Submitting a Claims Appeal

A claims appeal is a request for reconsideration of a previous claim denial. This excludes claims for medical necessity or that would require review of medical records to make a determination.

Upon receipt of denial, all claim appeals regarding the amount reimbursed or regarding a denial for a particular service must be initiated in writing or through the secure online Community First Provider Portal with the necessary documentation. Any adjustments that result from a claim appeal will be provided by check with an EOP that reflects the claim adjustment.

When submitting appeals please follow these guidelines:

- All appeals of claims and adjustment requests must be received by Community First within 120 days from the date of the last denial of and/or adjustment to the original claim.
- Claims appeals must be submitted via the secure online Community First Provider Portal or in writing to:

  Community First Health Plans, Inc.
  Attn.: Claims Department
  P.O. Box 240969
  Apple Valley, MN 55124

Corrected Claim

A corrected claim is a correction or change of information to a previously finalized clean claim in which corrected information from the Provider is required to perform the adjustment and is unrelated to MESAV/SAS changes. A corrected claim can be the result of:

- An original claim that was either denied or rejected as being deficient, as it did not contain all required elements to appropriately process the claim.
- An original clean claim that was previously adjudicated and included all elements necessary to process the claim, but one or more elements included in the original claim submission were erroneous.
- Providers may correct, but are not limited to, the following:
  - Patient control number (PCN)
  - Date of birth

- Place of service (POS)
- Quantity billed
- Date of service (DOS)
- Modifier missing or incorrect

Filing a Corrected Claim

Corrected paper claims should clearly indicate the corrections. Electronic or paper corrected claims must be submitted within 120 days of the initial claim disposition. When a subsequent claim submission is necessary as result of a SAS-related claim denial, please submit as a corrected claim vs. first time claim.

Corrected claims can be submitted via EDI or mailed to:

Community First Health Plans
Attn.: Claims Appeal
P.O. Box 240969
Apple Valley, MN 55124

IX. COMPLAINT PROCEDURES

In Medicaid, a complaint is defined as an expression of dissatisfaction expressed by a complainant, orally or in writing to the MCO, about any matter related to the MCO other than an action. As provided by 42 C.F.R. §438.400, possible subjects for complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Medicaid Member's rights.

FILING A PROVIDER COMPLAINT

Community First recognizes that there are times when providers may not be satisfied with a matter handled by Community First. Providers have the right to file a complaint related to that matter in accordance with regulations afforded by the Texas Department of Insurance and Texas Administrative Code. This section describes in detail the process to filing a complaint, the response timeframes, and the complainant's rights during the process.

Providers are able to file a complaint through a variety of mediums.

- Calling Provider Relations to file a complaint orally.
- Expressing their dissatisfaction during face-to-face contact with a Community First employee.
- Completing the Provider Complaint Form on the Community First website at CommunityFirstMedicaid.com.
- Mailing a written complaint to:
  Community First Health Plans
  Attn: Network Management
  12238 Silicon Drive, Ste. 100
  San Antonio, TX 78249

Resolving a Complaint

It is Community First's goal to resolve all complaints in a timely manner. Community First has 30 days to investigate and provide response to a complaint. When a complaint is received, written acknowledgement of the complaint is sent to the Provider within 5 business days. The resolution is provided to the complainant in the form of a letter which contains a full explanation of the resolution as well as what further action could be taken if the Provider is not satisfied with the resolution of the complaint.

Appealing a Resolution

If a resolution/response is not satisfactory, a Provider may ask that their appeal be reviewed and settled in accordance with the commercial arbitration rules of the American Arbitration Association or the arbitration or litigation provisions as noted in the individual Provider's contract with Community First.

Additional Filing Rights

After exhausting Community First's complaint procedures, Medicaid Providers may also file a complaint with HHSC by submitting the complaint to:

Texas Health and Human Services
HPM Complaints
P.O. Box 85200, MC H-320
Austin, TX 78758

FILING A MEMBER COMPLAINT

Community First offers a number of ways a Member can file a complaint.

- Calling Member Services to file a complaint orally.
- Expressing their dissatisfaction during face-to-face contact with a Community First employee.
- Filing a complaint by writing to us at
  Community First Health Plans
  Attention: Member Services Resolution Unit
  12238 Silicon Drive, Suite 100
  San Antonio, TX 78249

What a Member Can Expect When Filing a Complaint

When a complaint is received, a written acknowledgment letter is sent to the complainant within five business days of receipt of the complaint. Community First then has 30 days to resolve the complaint. The response to the complaint will be provided in writing in the form of a resolution letter. If Community First denies services, the Member will receive a letter at the same time the denial is made. If the resolution/response is not satisfactory, a complaint appeal may be filed.

Member Appeal of a Complaint Resolution

Complaint appeals must be submitted no later than 30 days of the complaint resolution response. The complaint appeal involves the review by a complaint appeal panel during a scheduled meeting. The appeal panel is composed of an equal number of Members, Providers, and Community First employees. The doctors or other Providers will be specialists in the area of care related to the complaint, and will not have reviewed the issue before. The meeting will be at a time and place that is acceptable and convenient to the Member. The Member may choose to send an authorized or designated representative in their place and have the right to submit written documentation that can be presented during the panel hearing. The panel reviews all of the information presented and makes a recommendation to Community First. The recommendation is presented to Community First for a final decision. Community First will mail the complaint appeal response letter to the Member no later than 30 days from receipt of the complaint appeal panel request.

Additional Filing Rights

If a Medicaid Member is not satisfied with the outcome of Community First's resolution of the complaint, they may file a complaint with HHSC at 1-877-787-8999 or by mail at the address below.

Texas Health and Human Services Commission
ATTN: Office of the Ombudsman
P.O. Box 13247
Austin, Texas 78711-3247

How Community First Can Assist the Member with Filing Complaints or Appeals

Community First Member Advocates are available to assist Members with the complaint or appeal process. A Member Advocate can be reached by calling Member Services at **210-358-6105**.

X. ADVERSE BENEFIT DETERMINATIONS AND APPEALS

Community First's Utilization Management program outlines the process the Member, a Member's authorized representative, or a Provider must follow when a covered service is denied.

Adverse Benefit Determination is the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner; the failure of STAR+PLUS to act within the required timeframes for the standard resolution of Appeals and Grievances, the denial of a Member's request to obtain out-of-network services, or the denial of a Member's request to dispute a financial liability.

For the processing of requests for initial and continuing authorizations of services, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, is made by an individual who has appropriate expertise in addressing the Member's medical, behavioral health, or long-term services and supports needs.

The Member and requesting Provider are notified in writing of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.

ADVERSE BENEFIT DETERMINATIONS

Adverse benefit determinations occur when a service is denied for not meeting medical necessity. Community First will request all necessary information, including pertinent clinical information and consult with the physician providing treatment as appropriate in making Utilization Management determinations.

A peer-to-peer discussion is available to the ordering physician at any time during the prior authorization, adverse determination or appeal process. A Medical Director will review all potential medical necessity adverse determinations and render a final decision. Authorizations for medications may be reviewed by a pharmacist.

The review may include a discussion with the ordering physician in order to obtain any information that may not have been submitted with the request. If the final decision is to deny the service request, then a adverse benefit determination is rendered.

STAR+PLUS will notify the Member and Provider of the adverse determination in writing. The notification describes the services that are being denied, the full clinical explanation for the adverse determination and the steps a Member or authorized representative can take to appeal the decision and how to access subsequent steps of the appeal process which includes a State Fair Hearing with or without External Medical Review.

Medicaid Peer-To-Peer Discussion and Opportunity to Discuss
For Medicaid covered services that require prior authorization, a peer-to-peer discussion is offered to the requesting Provider prior to an adverse determination, and an opportunity to discuss is available to the Member's requesting or servicing Provider after the adverse determination has been rendered. Contact Provider Relations for more information.

Provider Contractual Denials
Contractual (administrative) denials are not determined based on medical necessity. Upon notice of a contractual denial to a Provider for failure to comply with the plan's authorization requirements, the opportunity to submit documentation as evidence for reconsideration of the contractual denial is offered.

Providers have 60 days from the date of the contractual denial to submit written documentation of the Provider's compliance with authorization requirements. The required documentation for reconsideration of the contractual denial must be specific to address and remediate the reason for the contractual denial and may include evidence of the Provider's timely request for prior authorization or notification of inpatient admission. If the dispute of the contractual denial and associated documentation and evidence to support reconsideration is not received within 60 days, the Provider may forfeit the right for reconsideration of the denial.

Non-Covered Benefits Denials
Request for authorization of a service that is not a covered Medicaid state plan service will be denied as not a covered Medicaid benefit. Medicaid non-covered benefit denials that are not based on medical necessity review are eligible for internal appeal, State Fair Hearing, and Member complaint rights but are not eligible for External Medical Review rights.

Medical Necessity Denial Claim Disputes for Contracted Providers
Community First contracts with out-of-network physicians to review claims disputes related to medical necessity denials that remain unresolved subsequent to a Provider appeal. The physician resolving the dispute is not an employee of Community First. The determination of the physician resolving the dispute is binding on Community First and our contracted Provider. The physician resolving the dispute is licensed in the State of Texas and the same specialty or a related specialty as the appealing Provider.

Appeal of an Adverse Benefit Determination
STAR+PLUS Nursing Facility Members have the right to appeal an adverse benefit determination in whole or in part, for any of the following reasons:

- They believe the requested services are necessary.
- They believe the services should be authorized.
- When Community First has not paid a hospital bill they feel should be paid.
- When Community First limits a request for a covered service that the Member believes should be allowed.

A person authorized by the Member to act on their behalf, or their Provider or other health care Provider may request an appeal of an adverse benefit determination.

STAR+PLUS Nursing Facility Member Medicaid internal health plan appeal requests can be requested orally or in writing, within 60 days from the receipt of the Adverse Benefit

Determination letter. Community First will acknowledge an internal appeal request within 5 business days of receipt. Community First must complete the entire appeal process within 30 days after receipt of the initial written or oral request for appeal. Any additional information that may be used in consideration of the appeal will be requested, and must be submitted to Community First, within the requested timeframe.

Members or their authorized representative may request an extension of the appeal time frame, for an additional 14 days, or if Community First shows that there is a need for additional information and how the delay is in the Member's interest. The extension would be in the best interest of the Member. The extension of the timeframe to resolve the appeal will be confirmed in writing to the Member or Member's authorized representative.

Medicaid Members, a person acting on their behalf with the Member's written consent, or their physician or other health care Provider may request an expedited appeal of an Adverse Benefit Determination if waiting 30 days for a standard resolution could seriously jeopardize the Member's life or health. Call Community First Member Services at **210-358-6105** for assistance filing an emergency appeal.

Community First will review the request to expedite the appeal review. If the request to expedite the appeal review is not medically necessary, Community First will transfer the appeal to the standard appeal timeframe of 30 days and provide notice to the Member and appellant of the decision, including complaint rights to dispute the denial of the expedited review.

An expedited appeal for emergency care, or continued hospitalization, will be resolved and notification sent of the resolution within one business day, but no later than 72 hours of the request. Expedited appeals that are not for emergency care or continued hospitalization will be resolved within 72 hours of the request.

If the internal appeal is denied, Nursing Facility Members, an authorized representative or the Member's Provider have External Appeal Rights through the CMS Independent Review Entity (IRE) for Medicare covered services, or the HHSC State Fair Hearing office for Medicaid covered services.

Continuing Services
To continue services while the appeal is pending, the denial must involve the termination, suspension or reduction of a previously authorized course of treatment and have been ordered by an authorized Provider.

- The Member or their representative must submit a request for an appeal on or before the later of 10 calendar days from the postmarked date of the Community First denial notice or the day your service will be reduced or end.
- The time period covered by the original authorization must not have ended.

If the above are met, the services will continue until any of the following happen:

- The Member cancels the appeal.
- The denial is upheld on internal health plan appeal, unless the Member requests external review.
- The time period covered by the original authorization has ended.

EXTERNAL APPEALS

After a STAR+PLUS Nursing Facility Member has completed the internal health plan appeal process related to an adverse benefit determination, more appeal rights are available to a Member if they are not satisfied with the health plan's appeal decision. After the health plan's appeal decision is completed, Members have additional external appeal rights, including a State Fair Hearing, with or without an External Medical Review for STAR+PLUS Nursing Facility Members, and External Appeal Rights through the CMS Independent Review Entity (IRE), or the HHSC State Fair Hearing office for STAR+PLUS Nursing Facility Members. The details for External appeal rights and procedures are included in the sections below.

External Medical Review

If you, as a Member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for an External Medical Review. These include State Fair Hearing, with or without External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A Provider may be the Member's representative. A Member cannot request only an External Medical Review. The Member must exhaust the internal health plan appeal process prior to requesting an External Medical Review. The Member or the Member's representative, including the Member's Provider, must ask for the External Medical Review within 120 days of the date Community First mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the State Fair Hearing and External Medical Review Request Form provided as an attachment to the Member Notice of Internal Appeal Decision Letter and mail or fax it to Community First by using the address or fax number on the form; or
- Call Community First at **1-844-382-2347**; or
- Email Community First at Member_Services@cfhp.com

If the Member asks for an External Medical Review within 10 days from the time Community First mails the appeal decision, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from Community First the service Community First denied will be stopped.

The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail or fax; or (2) orally, by phone or in person.

An Independent Review Organization is a third-party organization contracted by HHSC

that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Emergency External Medical Review
If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Community First. To qualify for an emergency External Medical Review and emergency State Fair Hearing the Member must first complete Community First's internal appeals process.

STATE FAIR HEARINGS

State Fair Hearings
If a Member, as a Member of Community First, disagrees with the decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent them by contacting Community First giving the name of the person the Member wants to represent him or her. A Provider may be the Member's representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 days of the date on the appeal decision notice that tells of the decision being challenged.

If the Member does not ask for a State Fair Hearing, the Member or the Member's representative should either call Member Services at **210-358-6105** or send a letter to Community First at:

Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

If the Member asks for a State Fair Hearing within 10 days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service denied, at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within 10 days from the time the Member gets the

hearing notice, the service the health plan denied will be stopped.

If the Member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most State Fair Hearings are held by telephone. At the time, the Member or the Member's representative can tell why the Member need the service the health plan denied.

HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.

Expedited State Fair Hearing
Medicaid Members, or their authorized representatives, may request an expedited State Fair Hearing if they believe that waiting for a standard State Fair Hearing could seriously jeopardize the Member's life or health. However, in order to qualify for an expedited State Fair Hearing, the Member must have exhausted Community First's internal appeal procedures. If the final decision is adverse to the Member, it is possible that the Member may be required to pay the cost of continued services while the appeal is in progress.

An expedited State Fair Hearing can be requested verbally or by calling Community First Member Services, or in writing to:

Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

PLEASE NOTE: Verbally expedited State Fair Hearing requests must be confirmed in writing and signed by the Member or the Member's authorized representative.

RESOLVING A LEVEL OF CARE DETERMINATION

Medical necessity determinations for the daily unit rate are the responsibility of the HHSC's administrative services contractor, Accenture. Accenture will review the information received on the MDS form and use the information to assign a Resource Utilization Groups (RUG) level. The MDS form will provide a comprehensive summary of the Member's mental and physical issues which should be completed by the fifth day after admission to a Nursing Facility. Community First also assesses the Member in the Nursing Facility upon initial admission (within 30 days and then 90 days thereafter). After each assessment, Community First reviews the MDS from Accenture and utilizes the MDS to assist in meeting the needs of the Member during their stay or at relocation.

The determination of the RUG level is based on facility considerations, including facility needs, nursing care and the amount of therapy provided per week. The RUG level determines the amount of money per day that Medicare will pay for a Member's stay at the Nursing Facility. If a Member is informed that medical necessity is denied by an Accenture physician, the Member has the right to appeal that decision. The Member or the Member's licensed authorized representative (LAR) or physician may file an appeal directly to Accenture:

Texas Health and Human Services
HHSC Administrator Contract Management
P.O. Box 204077, Mail Code 91-X
Austin, Texas 78720-4077

OTHER AVAILABLE PROVIDER AND MEMBER RESOURCES

Consumer Rights and Services

Consumer Rights and Services (CRS) is an area at HHSC that receives complaints regarding long term care services provided to individuals in any type of facility or setting. Complaints come from a variety of sources and in several formats.

- A complaint allegation is an assertion that a requirement of licensure or certification has been violated. This allegation can be reported orally or in writing and can come directly from individuals or residents, family members, health care Providers, advocates, law enforcement or other state agencies.
- A self-reported incident is an official notification to the state survey and licensing agency from an HHSC-regulated Provider that the physical or mental health or welfare of an individual or resident has been, or may be adversely affected by mistreatment, neglect or abuse. These reports may also include injuries of unknown source and exploitation or misappropriation of individual or resident property. In addition, reports are required to be filed on staff drug diversions or situations that pose a threat to residents, employees or the public, including calling the police or the local fire authority to maintain safety.

Contact information:

- CRS website: https://hhs.texas.gov/about-hhs/your-rights/consumer-rights-services
- Phone: **1-800-458-9858**

Long-Term Care Ombudsman

The LTC Ombudsman identifies, investigates and resolves complaints that adversely affect the health, safety, welfare or rights of people who live in nursing facilities and assisted living facilities to ensure they receive optimal quality of care and achieve high quality of life. STAR+PLUS Members can file a complaint through the Office of Long-Term Care Ombudsman.

Contact information:

- Phone: **1-800-252-2412**.
- LTC Ombudsman website: https://apps.hhs.texas.gov/news_info/ombudsman/

A list and contact information of the 28 Area Agencies on Aging can be found at: https://apps.hhs.texas.gov/contact/aaa.cfm

Health Plan Management

Health Plan Management (HPM) at HHSC in the managed care division receives complaints, inquiries, or disenrollment requests either directly from Providers and Members or via secondary sources, such as the Office of the Ombudsman, Legislative offices (External Relations Division), Member Advocates (family), Vendor Drug Program, Department of Family and Protective Services or other stakeholders.

HHSC Office of the Ombudsman

The HHSC Office of the Ombudsman serves as a central point of assistance in identifying appropriate programs and departments for problems and complaints. The Office of the Ombudsman assists the Member when the agency's normal complaint process cannot or does not satisfactorily resolve an issue. They also conduct independent reviews of complaints concerning agency policies or practices, ensure policies and practices are consistent with the goals of HHSC, ensure individuals are treated fairly, respectfully and

with dignity and make referrals to other agencies as appropriate. If there is a problem or complaint, it is recommended that the person, program or office involved contact the Office of the Ombudsman to see if they can explain a specific policy or correct the problem immediately. If the agency's normal complaint process cannot or does not satisfactorily resolve the issue, there are ways to send a question or file a complaint:

Contact information:

- Online submission form: https://www.hhs.texas.gov/services/your-rights/hhs-office-ombudsman.
- Phone: **1-877-787-8999**
- Relay Texas/TTY (hearing impaired): **1-800-735-2989**

XI. QUALITY MANAGEMENT

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

Community First is committed to the provision of a well-designed and well-implemented Quality Assessment and Performance Improvement (QAPI) program. Community First's culture, systems and processes are structured around its mission to improve the quality of services delivered to our Providers and to our Members. The purpose of the QAPI program is to plan, implement and monitor ongoing efforts that demonstrate improvements in Member safety, overall health, and care experience.

Community First is accredited by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to improving health care quality. The NCQA seal is a widely recognized symbol of quality. NCQA health plan accreditation surveys include rigorous, on-site and off-site evaluations standards and selected HEDIS measures. A national oversight committee of physicians analyzes the survey findings and assigns an accreditation level based on the performance level of each plan being evaluated to NCQA's standards. This recognition is the result of Community First's long-standing dedication to provide quality health care service and programs to our Members. Community First requires all practitioners and Providers to cooperate with all Quality Improvement (QI) activities, as well as allow the plan to use practitioner and/or Provider performance data to ensure success of the QAPI Program.

Goals and Objectives

The following are Community First's goals and objectives for its QAPI program:

- Safety - Care doesn't harm Members.
- Member Experience - Members feel valued.
- Efficiency - Resources are used to maximize quality and minimize waste.
- Eliminating Disparities - Quality care is reliably received regardless of geography, income, language, or diagnosis.

In support of the QAPI program, the QI Department monitors the quality of health care services provided to Community First Members, addressing two basic areas:

- Quality of service
- Quality of care

To monitor the quality of services provided to Community First Health Plans Members, the QI Department reviews the availability of appointments for emergencies, urgent care and preventive care. Community First also monitors availability for after-hours calls from Members, as well as how satisfied Members are with services provided by you and your office staff. Community First will report all add-on services to HHSC.

To monitor quality of service, Community First's QI Department may assess:

- Satisfaction levels from Community First Providers and Members utilizing both satisfaction surveys and complaints.
- Turn-around time in responding to Provider issues.
- Appropriate claims payment and adjustment timeframes.
- Customer service performance with incoming Provider calls.

To monitor quality of care, Community First's review processes may include:

- Review and distribution of practice guidelines for diseases and conditions most likely to impact Community First's Members, as well as pediatric and adult preventive health care guidelines, including compliance with practice guidelines.
- Targeted audits of primary care practices to promote the confidentiality of medical information and compliance with standards for appropriate medical record documentation, when necessary.
- Monitoring and support of communication systems that promote continuity and coordination of care.
- Investigation of potential quality of care complaints, including the tracking and trending of complaints.

The QI Department also monitors reports of Abuse, Neglect and Exploitation (ANE). Such reports are submitted to applicable agencies in accordance with state rules and regulations. Quarterly, Community First will submit the number of critical incidents and abuse report for Members receiving LTSS. Below are the types of ANE that Community First will report:

- Physical Abuse: any knowing, reckless, or intentional act or failure to act, including unreasonable confinement, corporal punishment, inappropriate or excessive force, or intimidation, which caused physical injury, death, or emotional harm by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Sexual Abuse: nonconsensual sexual activity, which may include, but is not limited to, any activity that would be a sexually-oriented offense per Texas Penal Code, Chapters 21, 22, or 43 by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Emotional/Verbal Abuse: any act or use of verbal or other communication to threaten violence that makes a reasonable person fearful of imminent physical injury; communication that is used to curse, vilify, humiliate, degrade, or threaten and that results in emotional harm; or of such a serious nature that a reasonable person would consider it emotionally harmful by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Neglect: failure to provide the protection, food, shelter or care necessary to avoid emotional harm or physical injury; or a negligent act or omission that caused or may have caused emotional harm, physical injury, or death by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Exploitation: the illegal or improper act or process of using, or attempting to use, the resources of the alleged victim, including the alleged victim's social security number or other identifying information, for monetary or personal benefit, profit, or gain without the informed consent of the alleged victim by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Emergency: any abuse, neglect, or financial exploitation, which, without immediate intervention, would result in the victim being in a state of, or at risk of, immediate and serious physical harm.

PRACTICE GUIDELINES

Community First's Practice and Preventive Health Guidelines are based on the health needs of its membership. Selected guidelines are evidence-based, adopted from

recognized sources and promoted to Providers in an effort to ensure health care quality and uniformity of care provision to Community First's enrolled Members. Community First's QI Department reviews all guidelines annually for updating and/or when new scientific evidence or national standards are published. All guidelines are approved by Community First's Quality Improvement Committee (QIC) annually and disseminated to Providers via the Provider e-newsletter, targeted mailings and other media sources.

Community First's Quality Assessment and Performance Improvement (QAPI) program assures that practice guidelines meet the following:

- Adopted guidelines are approved by Community First's QIC annually.
- Adopted guidelines are evidence-based and include preventive health services.
- Guidelines are reviewed on an annual basis and updated accordingly, but no less than annually.
- Guidelines are disseminated to Providers in a timely manner via the following appropriate communication settings:
  - Targeted mailings
  - Provider e-newsletters
  - Online via the secure online Community First Provider Portal
  - Online at CommunityFirstMedicaid.com.
  - Provider orientations and other group sessions

PLEASE NOTE: QI initiatives, including focus studies, are designed and implemented in accordance with national QI standards and benchmarks (e.g., NCQA, HEDIS®, CAHPS®, as applicable). Focus studies utilize sound research design and appropriate statistical analysis.

XII. CULTURAL COMPETENCY

Community First places great emphasis on the wellness of its Members. A large part of quality health care delivery is treating the whole patient and not just the medical condition. Community First encourages Providers to provide culturally competent care that aligns with the National Standards on Culturally and Linguistically Appropriate Services (CLAS). Community First maintains policies which emphasize the importance of culturally and linguistically competent care to Community First's membership of all cultures, races, languages, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual enrollees while protecting and preserving the dignity of each Member. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a Provider's relationship with patients and, in the long run, the health and wellness of the patients themselves.

The following is a list of principles for health care Providers to include knowledge, skills and attitudes related to cultural competency in the delivery of health care services to Community First Members.

Knowledge

- Provider's self-understanding of health disparities, as related to race, ethnicity or influence and the critical link between quality health care and the clinical encounter.
- Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns and the importance of building physician, patient-centered relationships.
- Understanding of the particular psycho-social stressors relevant to minority patients including war trauma, migration, acculturation stress and socioeconomic status.
- Understanding of the cultural differences within minority groups and how cultural dynamics influence cross- cultural behaviors.
- Understanding of the health service resources for minority patients.
- Understanding of the minority patient within a family life cycle and intergenerational conceptual framework in addition to a personal developmental network.
- Understanding of the difference between culturally acceptable behaviors and characteristics of different minority groups.
- Understanding indigenous healing practices and the role of religion in the treatment of minority patients.
- Understanding of cultural factors that can affect decision-making based on cultural beliefs, lack of trust or other behavior patterns within minority groups.
- Understanding of the public health policies and its impact on minority patients and communities.

Skills

- Ability to facilitate and assess minority patients based on a psychological, social, biological, cultural, political, or spiritual model.
- Ability to enhance patient communication effectively with the use of cross-cultural interpreters.
- Ability to diagnose minority patients with an understanding of cultural differences in pathology.

- Ability to avoid under diagnosis or over diagnosis.
- Ability to apply treatment methods that enhance clinical assessment processes and adherence.
- Ability to utilize community resources (church, community-based organizations [CBOs], self-help groups).
- Ability to provide therapeutic and pharmacological interventions with an understanding of the cultural differences in treatment expectations and biological response to medication.
- Ability to ask for consultation.

Attitudes

- Respect the "survival merits" of immigrants and refugees.
- Respect the importance of cultural forces.
- Respect the holistic view of health and illness.
- Respect the importance of spiritual beliefs.
- Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines.
- Be aware of transference and counter transference issues.

RESOURCES FOR CULTURAL COMPETENCY

Community First provides CLAS-related educational opportunities for Providers through the secure online Community First Provider Portal. Providers are able to participate in Community First's Cultural Competency Health Literacy Training, as well as participate in training opportunities administered by the State or nationally recognized organizations.

Providers are also encouraged to participate in training provided by other organizations. For additional information regarding resources and trainings, visit:

- The Health and Human Services Culturally Effective Health Care online course at https://www.txhealthsteps.com/674-culturally-effective-health-care.
- "A Physician's Practical Guide to Culturally Competent Care," developed by the U.S. Department of Health and Human Services, Office of Minority Health at https://cccm.thinkculturalhealth.hhs.gov.
- The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) site at https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy.

Providers can find free online courses on topics such as addressing health literacy, cultural competency and limited English proficiency.

Community First also provides ongoing Provider training, which includes topics of health equity, including cultural competence, bias, diversity and inclusion, and is conducted through monthly webinars, quarterly and refresher trainings on an as-needed-basis, during routine on-site visits, and upon request. Providers can register to attend a webinar on the online secure Community First Provider Portal. In addition, your local, state and national Provider organizations are likely to have information resources available as well. Providers may request information and resources by contacting their Provider Relations Representative.

INTERPRETER/TRANSLATION SERVICES

Community First has interpretive services available for its STAR+PLUS Members to ensure effective communication regarding treatment, medical history, or health education. These interpretive services are available on an "on-call" basis. Our contracted interpretive services provide STAR+PLUS Members access to professionals trained to help with technical, medical or treatment information.

To arrange for a sign interpreter or language interpreter for a Community First STAR+PLUS Member, please contact Community First Member Services at **210-358-6105**.

Community First is committed to ensuring that staff and subcontractors are educated about, remain aware of and are sensitive to the linguistic needs and cultural differences of our membership. Information about cultural and linguistic competency and interpreter and translation services are included in a variety of communications media via this Provider Manual, the Community First Provider Newsletter, and the Community First Provider Portal.

Providers are also informed of their ability to request assistance with professional interpreter and translation services with the utilization of Community First's interpreter and translation partners, 24-Hour Nurse Advice Line, and Telephone Interpreter Services Vendors to assist with Community First's membership when language or hearing impairment is a barrier to communication.

XIII. COMMUNITY FIRST PROVIDER PORTAL

Community First has a secure online Provider Portal that Providers can use to access resource information, file claims, request authorizations, and verify eligibility. The Provider Portal makes online transactions easier and faster.

REGISTERING FOR THE PROVIDER PORTAL

In order to use our secure online Provider Portal, you must register at CommunityFirstHealthPlans.com/ProviderPortal. You will be asked to enter your tax identification number, first name, last name, email address and create a password. Your email address will also serve as your username.

Once you submit the registration form, you will receive an email confirmation to validate your account.

After your email address has been validated, your request for access will be reviewed and additional validation will be sent to Provider Relations Department for confirmation.

Logins and passwords are unique, requiring each staff member within one office or group to register separate user accounts. Sharing accounts between staff is not permitted.

BENEFITS OF THE PROVIDER PORTAL

The following features are available on the Provider Portal:

- Verify Member Eligibility: Determine a Member's coverage by simply entering the necessary search criteria, such as date of birth, Member number, and Member name.
- Online Claims Submission features:
  - Individual Claim Submissions: Submit both professional claims for add-on services and institutional claims for the daily unit rate.
  - Copy Claim Feature: Recreate claims without entering data twice.
  - Recurring Claims Tool: Quick and easy way to submit repetitive, long-term care claims for multiple Members.
  - Corrected Claims: Resubmit corrected claims
  - Batch Claim Submissions: Avoid paying clearinghouse fees and submit batch claims online. (Currently, formatted 837 claims files are only accepted. We apply Health Insurance Portability and Accountability Act (HIPAA) level five edits. Files must be .dat, .edi or .txt formats and no larger that 25MB.)
  - Attachments for Claims: Ability to attach additional documentation during the online claims process or when submitting a Request for Reconsideration.
  - Check Claims Status Online: Confirm the status of submitted claims and easily reconcile to your resident accounts.
  - Online Claims Appeal: Submit claim appeals and attach necessary documentation.
  - Explanation of Payment (EOP): View EOPs
  - Update Demographic Information: Update Provider demographics, such as address, phone number, and office hours.
- Submit and Review Online Authorizations: Avoid the fax machine and submit acute service and add-on service authorization requests directly to us online.
- Check on status of authorizations by Member, authorization, or web reference

number and dates of service.

Other valuable content is made available at CommunityFirstMedicaid.com. This website includes a Provider Resources section, Frequently Asked Questions (FAQs), a link to the digital version of this Provider Manual, an online look-up feature to find contracted Providers, a Provider Directory available for download, training presentations, Provider forms, and more.

2024

STAR+PLUS NURSING FACILITY PROVIDER MANUAL

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CommunityFirstMedicaid.com