COMMUNITY FIRST HEALTH PLANS

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

2024 | STAR+PLUS PROVIDER MANUAL

COMMUNITY FIRST PROVIDER RELATIONS

LOCAL 210-358-6105

TOLL FREE 1-844-382-2347

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 Provider Manual

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

CommunityFirstMedicaid.com

September 2024

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I. INTRODUCTION

Welcome to the Community First Health Plans, Inc. (Communit First) STAR +PLUS Network. Community First STAR+PLUS is a managed care option of the STAR (State of Texas Access Reform) Program for Medicaid clients.

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

STAR+PLUS PROGRAM BACKGROUND

- The 74th Texas Legislature implemented the State of Texas Access Reform Plus (STAR+PLUS) program to create a cost-neutral managed care system to combine acute care with long-term services and supports (LTSS). The STAR+PLUS program does not change Medicaid eligibility or services. It does change the way Medicaid services are delivered.
- The STAR+PLUS program combines acute care and LTSS, such as assisting in a Member's home with activities of daily living (ADLs), home modifications, respite (short-term supervision) and personal assistance services (PAS). These services are delivered through providers contracted with managed care organizations (MCOs).
- The STAR+PLUS program provides a continuum of care with a wide range of options and increased flexibility to meet individual needs. The program has increased the number and types of providers available to Medicaid Members.
- Service coordination, available to all Members, is the main feature of the STAR+PLUS program. It is a specialized case management service for program Members who need or request it. Service coordination means that plan Members, family Members, and providers can work together to help Members get acute care, LTSS, Medicare services for dually-eligible Members and other community support services.
- The STAR+PLUS Home and Community Based Services (HCBS) program is a program approved for the managed care delivery system, designed to allow individuals who qualify for nursing facility (NF) care to receive LTSS in order to be able to live in the community.

STAR+PLUS PROGRAM OBJECTIVES

The objectives of the STAR+PLUS program are to:

- Prevent or delay the institutionalization of Members through an effective use of Long-Term Services and Supports (LTSS) services.
- Provide comprehensive service coordination which includes assessing, service planning, monitoring and coordinating care for Members with complex, chronic or high cost health care or social support needs.
- Assign Medicaid-only Members to a medical home and integrate primary, acute and long-term care services into one consumer-driven managed care system.
- Ensure Members receive the appropriate level of care in the least restrictive setting, consistent with their personal health and safety needs.
- Improve access to health care needs and improve Members' current quality of care.
- Create accountability and control on costs and outcomes of care.
- Promote provider and Member satisfaction by coordination of services.
- Coordinate Medicare services between Medicaid and Medicare for Members who

are dual eligible.
- Provide comprehensive, community-based education to Members regarding STAR+PLUS, while ensuring access to services for persons with physical or mental disabilities and persons with limited English proficiency.

Services are to be provided in a manner that promotes:

- Meaningful quality of life and autonomy for Members.
- Maximum dignity and respect for all Members.
- Member participation in care decisions by self-determination and/or person-centered planning.
- Member satisfaction
- Independent living in Members' homes and other community settings.
- Preservation and support of Members' family and community support systems.
- Cost-effective, quality health care delivery
- Accessibility to covered services when needed by Member.
- Coordination with services outside the scope of Medicaid for true service integration.

Community First's network comprises physicians (primary care physicians and specialists), allied and ancillary health care providers, hospitals, and other facilities selected to provide quality health care to our STAR+PLUS Members. The Member's Primary Care Provider (PCP) is responsible for managing the overall medical care of patients and for coordinating referrals to specialists and inpatient/outpatient facilities. A Community First STAR+PLUS PCP is a provider with one of the following specialties/ practice areas:

- General Practice
- Family Practice
- Internal Medicine
- Obstetrics and Gynecology
- Geriatrics
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)

In addition, Community First STAR+PLUS Members can access contracted Advance Practice Nurses (APN), Physician Assistants (PA), and Certified Nurse-Midwives (CNM), practicing under the supervision of a physician for appropriate covered services.

This Provider Manual is designed to assist you and your staff in working with us to deliver quality health care to Community First STAR+PLUS Members. It provides information regarding our utilization and quality management programs, preauthorization and referral notification procedures, claims filing processes, and our appeals process. We encourage you and your staff to review this manual carefully and contact your Community First Provider Relations Representative if you have any questions, comments, or concerns. We welcome suggestions from you and/or your staff for enhancing this Manual.

In addition, Community First publishes a bi-annual newsletter to all network physicians and Providers. The newsletter includes information such as STAR+PLUS services, policies and procedures, statutes, regulations, and claims processing information. Community First also uses fax alerts, banner messages, special mailings, and our website

as additional means to communicate changes/updates to you and your staff.

Following the initial orientation session for Community First STAR+PLUS network Providers, Community First will have ongoing training sessions when requested by the Provider or deemed necessary by Community First or the Texas Health and Human Services Commission (HHSC). Prior to the effective date of the renewal of our agreement with HHSC, Community First will schedule Provider orientations for existing Providers to review STAR+PLUS Program requirements, including changes to covered services, authorization requirements, and claims submission procedures and/or appeal timeframes.

QUICK REFERENCE PHONE LIST

Listed below are important Community First phone numbers

DEPARTMENT	CONTACT INFORMATION
Member Services	210-358-6105
	Toll-Free: 1-844-382-2347
Member Services Fax	210-358-6099
Population Health Management	210-358-6055
Population Health Management Fax	210-358-6274
Service Coordination	210-358-6105
Transition Specialist	210-358-6105
Preauthorization Fax	210-358-6274
Behavioral Health Authorization/Case Management	210-358-6105
Behavioral Health Fax	210-358-6387
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	210-358-6294
Network Management Fax	210-358-6199
Claims Information	210-358-6200
Claims Fax	210-358-6014
Electronic Claims	Availity Payor ID: COMMF
Nurse Advice Line After Hours (After-hours calls to Community First are forwarded to the Nurse Advice Line.)	1-800-434-2347
Preventive Health & Disease Management	210-356-6105
Preventive Health & Disease Management Fax	210-358-6099
Pharmacy - Navitus Health Solutions	1-877-908-6023
Vision - Envolve Benefit Options	1-800-334-3937
Dental Inquiries	
DentaQuest	1-800-516-0165
MCNA Dental	1-855-691-6262
United Healthcare Dental	1-877-901-7321

ROLE OF THE PRIMARY CARE PROVIDER (MEDICAL HOME)

Primary care providers (PCPs) play an integral role in helping meet the objectives of the STAR+PLUS Program. The program places its main focus on the total well-being of the Member, while providing a "medical home" where the Member can readily access preventive health care services and treatment, as opposed to episodic health crisis management. The "medical home" concept should assist in establishing a Member and provider relationship and, ultimately, better health outcomes. Members are encouraged to become more involved in their own health care and maintain their own wellness. In addition, the PCP is responsible for referring and obtaining authorization for Members needing specialty services to network providers, as well as certifying medical necessity for Waiver programs and LTSS services.

The PCP is responsible for providing all primary care services for Members including but not limited to:

- Supervision, coordination, and provision of care to each assigned Member.
- Initiation of referrals for medically necessary specialty care.
- Maintaining continuity of care for each assigned Member.
- Maintaining the Member's medical record, including documentation for all services provided to the Member by the PCP, as well as any specialists, behavioral health, or other referral services.
- Screening for behavioral health needs at each visit and when appropriate, initiating a behavioral health referral.

Who can serve as a Primary Care Provider (PCP)
Credentialed providers in the following specialties can serve as a PCP:

- Advanced Family Practice Nurse
- Family Practitioner
- General Practitioner
- Internal Medicine Practitioner
- OB/GYN
- Geriatrician
- Certified Nurse Midwife
- Physician Assistant
- Specialist (when appropriate)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)

The PCP is responsible for contacting Community First to verify Member eligibility and to obtain authorizations for covered services as appropriate.

The PCP will provide, or arrange for the provision of, covered services and/or telephone consultations during normal office hours as well as on an emergency basis, 24 hours a day, seven days a week.

Community First has contracted with an interpreter service for any Provider's office that does not have bilingual employees or sign language interpreters. Services are available for sign language, Spanish, English, and other languages that may be spoken by our STAR+PLUS Members. The service is accessible 24 hours a day, seven days a week. Providers can use the service during normal business hours by calling Member Services at **210-358-6105**. Requests for interpreter services after hours and on weekends are

answered by and arranged for through Community First's Nurse Advice Line.

It is important to educate STAR+PLUS Members to seek services from their designated PCP before accessing other specialty health care services, with the following exceptions:

- Emergency services
- Behavioral Health services
- Obstetric/Gynecological services
- Family Planning
- Department of State Health Services (DSHS) Case Management
- Mental Health Authorities
- Routine vision services

The PCP is responsible for the appropriate coordination and referral of STAR+PLUS Members for the following services and may work with the Member's assigned Service Coordinator to assist with the necessary referrals:

- Texas Commission for the Blind Case Management Services
- Community First pharmacy benefits through Navitus

Provider Request for Member Transfer
The PCP must submit a Provider Request for Member Transfer form. Questions regarding this process may be directed to Community First Network Management Department.

PCP STAR+PLUS Member Capacity (PCPs Only)
If a PCP wishes to limit or expand panel capacity, the PCP must contact Community First Network Management Department. PCPs do not have panel size limitations.

Specialist as a 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 THE SPECIALTY CARE PHYSICIAN

The specialty care physician (Specialist) is responsible for providing medically necessary services to Community First STAR+PLUS Members who have been referred by their PCPs for specified treatments and/or diagnostic services. Specialists must verify the eligibility of the referred Member prior to rendering services. If additional visits or services are necessary, the specialist may request authorization to provide these services or arrange for services by contacting Community First Population Health Management Department. The specialist must communicate with the PCP regarding services rendered, results, reports, and recommendations to ensure the continuity and quality of care. Referrals from the PCP must be documented in both the PCP's and specialist's medical records.

ROLE OF THE LONG-TERM SERVICES AND SUPPORTS PROVIDER

The Long-Term Services and Supports (LTSS) Provider serves certain Members participating in the STAR+PLUS Program. A LTSS Provider assists the Member by providing a variety of medical and non-medical services, such as, private duty nursing, adult foster care, home delivered meals, personal care services, habilitation services, home modifications, and respite services. All LTSS services require a prior authorization.

LTSS providers deliver a continuum of care and assistance such as in home and community-based services for elderly people, providing assistance to individuals with disabilities to allow them to maintain their independence, persons with disabilities who need assistance in maintaining their independence, to institutional care for those who require that level of support, seeking to maintain independence for individuals whole providing the support required.

LTSS providers have certain responsibilities for the STAR+PLUS program and the Members they serve, such as:

- Contacting Community First to verify Member eligibility and/or authorizations for service.
- Providing continuity of care.
- Coordination with Medicare and Medicaid.
- Notifying Community First of any change in Member's physical condition or eligibility.

LTSS providers are required to provide covered health services to Members within the scope of their Community First agreement and specialty license. In accordance with 1 Tex. Admin. Code Chapter 355, including Subchapter A (Cost Determination Process) and 1 Tex. Admin. Code §355.403 (Vendor Hold), Community First must require that LTSS providers submit periodic cost reports and supplemental reports to Texas Health and Human Services Commission (HSCC). If an LTSS provider fails to comply with these requirements, HHSC will notify Community First to hold payments to the LTSS provider until HHS instructs Community First to release the payments. HHSC will forward notices directly to LTSS providers about such cost reports and information that is required to be submitted.

LTSS providers must verify the eligibility of the STAR+PLUS Member prior to rendering services as well as obtain authorization for provision of those services from Community First.

ROLE OF THE 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 use disorder 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 AN OB/GYN

Female Members may select an obstetrician/gynecologist (OB/GYN) without a referral from their PCP.

An OB/GYN can provide a Member:

- One well-women checkup each year
- Care related to pregnancy
- Care for any female medical condition
- Referral to a specialist within the network

Female Members may:

- Go to any OB/GYN in the network for all women's care services. Neither a referral nor prior authorization is required.
- Receive family planning services from an in or out-of-network provider without a referral or prior authorization.

ROLE OF A NURSING FACILITY

Nursing facilities are residential facilities that provide care for people 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), medical supplies and equipment, rehabilitative services, and personal needs items.

The Nursing Facility (NF) staff will partner with Community First's Service Coordinators to ensure a Member's plan of care meets their needs in the least restrictive setting.

The NF is responsible for:

- Inviting the Service Coordinator to provide input for the development of the NF plan of care by notifying the Service Coordinator when the interdisciplinary team is scheduled to meet. NF plan of care meetings should not be contingent on the Service Coordinators participation.
- Notifying the Service Coordinator within one business day of unplanned admission or discharge to the hospital or other acute facility, skilled bed, or another nursing home.
- Notifying the Service Coordinator if a Member moves into hospice care.
- Notifying the 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 Service Coordinator to plan discharge and transition from a NF.
- Notifying the Service Coordinator within one business day of an emergency room visit.
- Notifying the Service Coordinator within 72 hours of a Member's death.
- Notifying the Service Coordinator of any other important circumstances such as the relocation of Members due to a natural disaster; and providing the Service Coordinator access to the facility, NF staff, and Members' medical information and records.

Please see the Community First STAR+PLUS Nursing Facility Provider Manual for more information about Nursing Facility billing.

ROLE OF ANCILLARY PROVIDERS

Ancillary providers cover a wide range of services from therapy services to laboratory. The following is a sample of ancillary providers:

- Durable Medical Equipment
- Home Health
- Hospice Care
- Laboratory
- Prosthetics and Orthotics
- Radiology
- Therapy (physical, occupational, speech)

NETWORK LIMITATIONS

A STAR+PLUS Member may be assigned to a PCP who is part of a Limited Provider Network (an association of health professionals who work together to provide a full range of health care services). If a STAR+PLUS Member selects a PCP or is assigned to a PCP in a Limited Provider Network, the PCP will arrange for services through a specific group of specialists, hospitals and/or ancillary Providers who are part of the PCPs network. In such a case, a STAR+PLUS Member may not be allowed to receive service from any physician or health care professional that is not part of the PCPs network (excluding OB/GYN and Behavioral Health Providers).

NONDISCRIMINATION BY THE PARTICIPATING PROVIDER

According to Community First's Provider contract, network Providers agree to comply with the following requirements:

- Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the American with Disabilities Act of 1990, and all the requirements set forth by the regulations in carrying out these acts and all amendments to the laws and regulations.
- Medical records comply with Texas Health and Safety Code Section 85.113 (relates to workplace and confidentiality guidelines regarding AIDS and HIV).
- Regulations of the United States Department of Labor recited in 20 Code of Federal Regulations, Part 741, and the Federal Rehabilitation Act of 1973.

MEDICAL RECORD STANDARDS

Community First requires all Providers to create and keep appropriate medical records in compliance with generally accepted medical records standards. All medical records must be kept for at least five years from the date of service or until all audit questions, appeal hearing, investigations, or court cases are resolved. Freestanding Rural Health Clinics (RHC) must be kept for a period of six years from the date of service and Hospital-based RHC, which must be kept for a period of 10 years from the date of service.

The Provider agrees to provide, at no cost to the MCO, records requested for the purpose of HEDIS audits or Special Investigation Unit audits. Upon receipt of the request, Provider must provide the records within the time frame and manner listed in the notification of audit.

Failure to supply the requested information may result in recovery of the payment for the services and/or submission to the OIG for failure to supply records.

The Provider agrees to provide HHSC the following, at no cost:

- All information required under Community First managed care contract with HHSC, including, but not limited to, the reporting requirements and other information related to the Provider's performance of its obligations under the contract.
- Any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations.
- All information in accordance with the timelines, definitions, formats, and instructions specified by HHSC.

Upon receipt of a record review request, a Provider must comply at no cost to the requesting agency, HHSC, Office of the Inspector General (OIG), or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions. The records must be provided within three (3) business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request and/or in less than 24 hours, the Provider must provide the records requested at the time of the request and/or in less than 24 hours.

The request for record review includes, but is not limited to, clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other Health and Human Services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items, equipment, or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data; and/or contracts with Providers and subhealth plans. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in OIG imposing sanctions against the Provider as described in 1 Tex. Admin. Code § 371.1701-371.1719.

The records must reflect all aspects of patient care, including ancillary services. These standards must, at a minimum, include the following documentation requirements:

- Written policy regarding confidentiality and safeguarding of Member information; records are protected through secure storage with limited access.
- Records are organized, consistent and easily retrieved at the time of each visit. Written procedure for release of information and obtaining consent for treatment.
- Each page in the record contains the patient's name or ID number.
- Personal/biographical data includes address, age, sex, employer, home and work telephone numbers, and marital status as well as assessment of cultural and/or linguistic needs (preferred language, religious restrictions) or visual or hearing impairments.
- All entries in the medical record contain author identification, are legible (to someone other than the writer), in ink and dated.
- The history and physical exam records appropriate subjective and objective information for presenting complaints.
- Problem list documenting significant illnesses, behavioral health and/or medical conditions; unresolved problems from previous office visits are addressed in subsequent visits.
- Medication list includes instructions to Member regarding dosage, initial date of prescription, and number of refills.
- Medical allergies and adverse reactions are prominently documented in a uniformed location in the medical record; if no known allergy, NKA or NKDA is documented.
- An appropriate history is made in chart for adults regarding immunization records.
- Past medical history (for patients seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.
- Physical, clinical findings, and evaluation for each visit are clearly documented including appropriate treatment plan and follow-up schedule as indicated.
- Consultation lab/imaging reports and other studies are ordered, as appropriate. Abnormal lab and imaging study results have explicit notations in the record for follow up plans. All entries are initialed by the ordering practitioner (or other documentation of review) to signify review.
- All working diagnoses, and treatment plans are consistent with findings. Ancillary tests and/or services (diagnostic and therapeutic) ordered by practitioner are documented; encounter forms or notes include follow-up care, calls, or visits., with specific time of return noted in weeks, months, or PRN, and include follow up of outcomes and summaries of treatment rendered elsewhere.
- No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (does the care appear to be medically appropriate?).
- Health teaching and/or counseling is documented. If a consultation is requested, there is a note from the consultant in the record.
- For Members 10 years of age and over, appropriate notations concerning use of tobacco, alcohol, and substance use (for Members seen three or more times, substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Evidence that an Advance Directive has been discussed with adults 18 years of age and older.

Additional Behavioral Health Documentation Standards:

- For Members receiving behavioral health treatment, documentation is to include "at risk" factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social history).
- For Members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment progress. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased, or unchanged during treatment period.
- For Members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in treatment planning and therapy sessions, when appropriate.
- For Members who receive behavioral health treatment, documentation shall include evidence of attempts by treating providers to communicate and coordinate behavioral health treatment with primary care providers and other behavioral health providers. This should include, at a minimum, the documentation of attempts to provide Members' behavioral health diagnosis(es), current symptoms, behavioral health medications, any pertinent lab work, assessment and current treatment plan.

Providers should obtain from STAR+PLUS Members a signed authorization for release of information. The Provider may use the standard CMS 1500/UB04 or develop their own form. If developing their own form, the release should allow the Provider to disclose information to Community First and DSHS. This will enable Community First to process claims and perform utilization management and quality management functions.

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.

ROLE OF THE MAIN DENTAL HOME

Dental plan Members may choose their main dental homes. Dental plans will assign each Member to a main dental home if they do not choose one in a timely manner. Whether chosen or assigned, each Member who is six months or older must have a designated main dental home.

A main dental home serves as the Member's main dentist for all aspects of oral health care. The main dental home has an ongoing relationship with that Member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The main dental home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers and individuals who are general dentists serve as a main dental home.

Dental plan Members may choose their main dental home. Dental plans will assign each

Member to a main dental home if they do not choose one. Whether chosen or assigned, each Member who is six months or older must have a designated main dental home.

Helping Members Find Dental Care
The dental plan Member ID card lists the name and phone numbers of a Member's main dental home provider. The Member can contact the dental plan to select a different main dental home provider at any time. If the Member selects a different main dental home provider, the change is reflected immediately in the dental plan's system, and the Member is mailed a new ID card within five business days.

CONFIDENTIALITY

Providers must treat all information that is obtained through the performance services included in the Provider contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC programs.

The Provider must protect the confidentiality of Member Protected Health Information (PHI), including patient records and electronic medical records (EMR). Providers must comply with all applicable federal and state laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of protected health information.

II. LEGAL AND REGULATORY

LAWS, RULES, AND REGULATIONS

The Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Provider contract and Community First's contract with HHSC, the HMO Program, and all persons or entities receiving state and federal funds. The Provider understands and agrees that any violation by a Provider of a state or federal law relating to the delivery of services pursuant to the Provider contract, or any violation of Community First's contract with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

The Provider understands and agrees that the following laws, rules, and regulations, and all subsequent amendments or modifications thereto, apply to the Provider contract:

1. **Environmental Protection Laws**
   a. National Environmental Policy Act of 1969 (42 U.S.C. § 4321 et seq.) and Executive Order 11514, "Protection and Enhancement of Environmental Quality," relating to the institution of environmental quality control measures.

   b. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to federal Contracts, Grants, and Loans").

   c. State Clean Air Implementation Plan (42 U.S.C. § 740 et seq.) regarding conformity of federal actions to state Implementation Plans under §176(c) of the Clean Air Act.

   d. Safe Drinking Water Act of 1974 (21 U.S.C. § 349; 42 U.S.C. § 300f to 300j-9) relating to the protection of underground sources of drinking water.

2. **State and Federal Anti-Discrimination Laws**
   a. Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.) and, as applicable, 45 C.F.R. Part 80 or 7 C.F.R. Part 15.

   b. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.).

   c. Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107).

   d. Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688).

   e. Food Stamp Act of 1977 (7 U.S.C. § 200 et seq.).

   f. Executive Order 13279 and its implementing rules for equal protection of the laws for faith-based organizations.

LIABILITY

In the event Community First becomes insolvent or ceases operations, the Provider understands and agrees that its sole recourse against Community First will be through Community First's bankruptcy, conservatorship, or receivership estate.

The Provider understands and agrees that Community First Members may not be held liable for Community First's debts in the event of Community First's insolvency.

Provider understands and agrees that the Texas Health and Human Services Commission (HHSC) does not assume liability for the actions of, or judgments rendered against, Community First, its employees, agents, or subhealth plans. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to the Provider by Community First, or any judgment rendered against Community First. HHSC's liability to the Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Prac. & Rem. Code § 101.001 et seq.).

MEDICAL CONSENT REQUIREMENTS

Providers must comply with medical consent requirements in FAM § 266.004 which require the Member's Medical Consenter to consent to the provision of medical care. Providers must notify the Medical Consenter about the provision of emergency services no later than the second business day after providing emergency services, as required by FAM § 266.009.

MEMBER COMMUNICATION

Community First is prohibited from imposing restrictions upon the Provider's free communication with a Member about the Member's medical conditions, treatment options, Community First referral policies, and other Community First policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts.

ABUSE, NEGLECT, OR EXPLOITATION

Report Suspected Abuse, Neglect, and Exploitation (ANE)
Community First 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 (Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, 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 (Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, or DFPS licensed general residential operation.

III. COVERED SERVICES

PROGRAM BENEFITS

Community First Health Plans, Inc. is required to provide specific, medically necessary services to its STAR+PLUS Members. Please refer to the current Texas Medicaid Provider Procedures Manual and the bi-monthly Texas Medicaid Bulletin for a more inclusive listing of limitations and exclusions.

Community First Health Plans, Inc. will not impose any pre-existing condition limitations or exclusions, or require evidence of insurability to provide coverage to any Members enrolled in the STAR+PLUS program.

MEMBER HANDBOOK

Every Community First STAR+PLUS Member receives a Member Handbook when enrolled. Each handbook includes important information about Community First, including their health plan benefits.

SPELL OF ILLNESS AND ANNUAL MAXIMUM LIMITATION

In the traditional Medicaid program, the 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. This limitation applies to Community First STAR+PLUS Members; however does not apply to STAR+PLUS Members who are admitted to an inpatient facility with a diagnosis of bipolar disorder, major depressive disorder, recurrent depressive disorder, schizoaffective disorder, or schizophrenia as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). These diagnoses will remove the SOI limitation for the entire inpatient hospital stay. Also, the $200,000 annual limit on inpatient services does not apply.

COORDINATION WITH OTHER STATE PROGRAM SERVICES

Coordination with Public Health

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. 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 to the local public health entity for Tuberculosis (TB) contact investigation and evaluation and preventive treatment of persons whom the Member has come into contact within one business day of identification:
  - Ensuring all Members who have TB or are at-risk are screened for TB.
  - Accessing procedures for reporting TB and appropriate DSHS forms from www.dshs.state.tx.us/idcu/disease/tb/forms.
- Reporting all confirmed cases of STD/HIV to the local public health entity for STD/HIV contact investigation, and evaluation and preventive treatment of persons

whom the Member has come into contact:
    - Accessing required forms for reporting from http://www.dshs.texas.gov/hivstd/reporting/ or by calling Community First Member Services Department.
    - Keeping information confidential about Members who have received STD/HIV services.
- 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.
- Using material from HHSC available at https://www.hhs.texas.gov/services/disability.
- Complying with the release of records within 45 days so that screening may be completed.

Coordination for Services Not Directly Provided Through Community First
There are several services that are available to Community First Members based on their eligibility and are accessed outside of Community First provider network. In addition, the services are not a part of the managed care program. These services are found in the Texas Medicaid Provider Manual (TMPPM) and include the following:

- Court-ordered commitments to inpatient mental health facilities as a condition of probation.
- PASRR screenings, evaluations,and specialized services for STAR+PLUS Members.
- HHSC-contracted providers of Long-Term Services and Supports (LTSS), Case Management, or service coordination for individuals who have intellectual or developmental disabilities.
- Mental health rehabilitation services.
- Tuberculosis services provided by HSHS-approved providers (directly observed therapy and contact investigation).
- HHS hospice care.
- HHSC or DSHS HCBS Waiver programs, including CLASS, DBMD, HCS, and TxHmL.

All network providers are encouraged to refer to and coordinate services with the above agencies. If more information or assistance is required, contact Community First Member Services Department.

BENEFITS OVERVIEW

Medicaid Members participating in the STAR+PLUS program receive all the benefits of the traditional Texas Medicaid program.

Community First will provide functionally necessary community LTSS services to all STAR+PLUS Members beginning on the Member's date of enrollment regardless of pre-existing condition, prior diagnosis and/or receipt of any prior health care services. Community First will not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Members enrolled in the STAR+PLUS program.

All adult Members in STAR+PLUS who are not covered by Medicare or are dual eligible and receiving STAR+PLUS Waiver services receive unlimited medically necessary prescription drugs. Dual eligible STAR+PLUS Members will continue to receive pharmacy benefits from their Medicare Part D pharmacy plan.

Long-Term Services and Supports (LTSS)
Below is a list of the community based LTSS included under the STAR+PLUS Medicaid managed care program. Additional information on LTSS can be found online at https://hhs.texas.gov/.

The HHSC uniform managed care contract terms and conditions is the final authority on STAR+PLUS.

LTSS State Plan Benefits

- Private Duty Nursing
- Day Activity and Health Services (DAHS)
- Personal Care Services (PCS) (with and without nurse delegation)
- Financial Management Services to Support the Consumer-Directed Services Delivery Model Services
- Primary Home Care (PHC)

Other services under the STAR+PLUS Home and Community-Based Services Waiver include:

- Personal Assistance Services
- Adaptive aids
- Adult foster care home services
- Assisted living
- Emergency response services
- Home delivered meals
- Medical Supplies
- Minor home modifications (making changes to your home so you can safely move around)
- Nursing services
- Respite care (short-term care to provide a break for caregivers)
- Therapies (occupational, physical, and speech-language)
- Transitional assistance services

Key Information for Long-Term Services and Supports Providers
The following list includes important tips when providing LTSS services:

- Verify Member eligibility with Community First before performing services.
- Ensure necessary referral/authorizations have been obtained from Community First prior to provision of services.
- Use the HHSC provider ID given to you by Community First or your NPI and taxonomy code when filing claims for LTSS services.
- Bill and report LTSS services in compliance with the HHSC Billing Matrix for LTSS HCPC codes and STAR+PLUS Modifiers Matrix.
- Notify the Member's service coordinator whenever there is a change in the Member's physical or mental condition, upon knowledge of an inpatient or nursing facility admissions, all Member complaints or grievances, or if you identify a Member needs services outside the Community First contracted scope of services

with the provider.
- Ensure for Members who are eligible for both Medicare and Medicaid that covered Medicare services are billed to Medicare as primary prior to accessing services under Medicaid or HCBS STAR+PLUS (c) waiver services.
- Refer to the LTSS bulletin(s) posted on the Texas Medicaid Health care Partnership (TMHP) website at www.tmhp.com for additional information.

Medicaid facility and community-based LTSS benefits available include the following:

Personal Assistant Services (PAS)
Provides in-home assistance to individuals as authorized on their Individual Service Plan (ISP) with the performance of activities of daily living, household chores and delegated nursing tasks that have been delegated by a registered nurse (RN). PAS are subject to Electronic Visit Verification (EVV). See the Electronic Visit Verification section in this Provider Manual for more information.

There are three options available to STAR+PLUS Members desiring the delivery of PAS:

- **Consumer-Directed Services** - In the consumer-directed model, the Member or the Member's legally authorized representative is the employer of record and retains control over the hiring, management, and termination of an individual providing PAS. The Member is responsible for assuring that the employee meets the requirements for PAS, including the criminal history check. Member uses a Financial Management Services Agency (FMSA) to handle the employer-related administrative functions such as payroll, substitute (back-up) attendant in place and filing tax-related reports of PAS. To participate as a Community First FMSA providing services under the consumer-directed model, a FMSA must be specifically identified to provide consumer direct services by HHSC.

- **Service Responsibility Option** - In the service responsibility option, the Member or the Member's legally authorized representative chooses an agency in the Community First provider network who is the employer of record. In this model, the Member selects the personal attendant from the agency's personal attendant employees. The schedule is set up based on the Member input, and the Member manages the PAS. The Member retains the right to supervise and train the personal attendant. The Member may request a different personal attendant and the agency would be expected to honor the request. The agency establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up) and filing tax-related reports of PAS.

- **Agency Model** - In the agency model, the Member chooses an agency to hire, manage and terminate the individual providing PAS. The agency is selected by the Member from a list of agencies within Community First's provider network. The Service Coordinator and Member develop the schedule and send it to the agency. The Member retains the right to supervise and train the personal attendant. The Member may request a different personal attendant and the agency is expected to honor the request. The agency establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up) and filing tax-related reports of PAS.

To participate as a PAS network provider with Community First, the provider must have an executed agreement with Community First, be licensed by HHSC for the delivery of PAS services, and must comply with the Texas Administrative Code (TAC) in Title 40, Part 1, Chapter 41, Sections 41.101, 41.103, and 41.105 and Chapter 43.

Day Activity and Health Services (DAHS)
DAHS is LTSS offered to individuals residing in the community, Monday-Friday except holidays, for a maximum of 10 hours/day. Services include nursing and personal care services, nutrition services, transportation services, social and recreational activities and other supportive services. These services are provided at adult day care facilities licensed by the Department of State Health Services (DSHS) and certified by HHSC.

Providers submitting requests for initial authorization of DAHS services can utilize the HHSC forms 3050 and 3055, or submit the following clinical elements:

1. A list of all active diagnoses related to the Member's need for DAHS.
2. A description of any functional disability related to the Member's medical diagnoses.
3. A current medication list, including any PRN medications.
4. A record of the Member's vital signs as obtained at the time of the assessment, to include blood pressure, pulse, respiration, height, weight and blood sugar, if applicable.
5. An indication of the Member's dietary needs, specifying whether the Member has no special dietary requirements, or needs (for example, a bland diet, diabetic diet, low sodium diet, etc.).
6. A description of the Member's personal care requirements, to include an indication of the degree of assistance required (no setup or physical assistance, one-person physical assistance or two-person physical assistance), in the following areas:
   a. Transfer
   b. Ambulation
   c. Eating
   d. Toileting
7. A description of the Member's potential to stabilize, maintain or improve functioning from attending DAHS.
8. A list of the interventions to be performed by the nurse at the DAHS facility, to include the nature of the intervention as well as the frequency. For example, this may include:
   a. Occupational therapy, physical therapy, or speech therapy
   b. Respiratory therapy
   c. Medication administration
   d. Wound care
   e. Meal setup
   f. Health teaching/training
   g. Other
9. Physician's orders indicating the need for LVN or RN care/supervision, along with the above elements.

Minimum Wage Requirements for STAR+PLUS Attendants
Persons providing attendant services must be paid at the prevailing minimum wage rate as set by HHSC. Community First must ensure that facilities and agencies that provide attendant services in community settings pay attendants at or above the minimum rates

described below. This requirement applies to the following types of services, whether or not the Member chooses to self direct these services:

- Day Activity Health Care Services (DAHS);
- Personal Assistance Services (PAS);
- Habilitation (under CFC)

This requirement does not apply to attendant services provided by non-institutional facilities, such as assisted living, adult foster care, residential care, and nursing facilities.

Title 40 Texas Administrative Code §§49.312 requires that persons working as personal attendants in the services/ programs listed above, whether as employees or contractors of a provider or as employees or contractors of subcontractors, be paid at or above a specified hourly base wage.

In addition, providers are required to notify persons hired as personal attendants of the required base wage.

Newly employed or contracting attendants hired on or after September 1, 2013, must be notified of the required base wages within three days of being hired.

Community First may require providers to submit annual attestations and sample notices to employees/contracted employees ensuring that the minimum wage requirements were paid at or above the required hourly base wages as specified above.

HCBS STAR+PLUS Waiver (SPW) Services
Community First will provide an array of services under the HCBS STAR+PLUS waiver (SPW). This includes the following benefits:

- **Adaptive Aids and Medical Supplies:** Includes devices, controls or medically necessary supplies that enable individuals with functional impairments to perform activities of daily living or control the environment in which they live.

- **Adult Foster Care (AFC):** Provides a 24-hour living arrangement in an HHSC-contracted foster home for persons who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, minimal help with personal care, nursing tasks, supervision, companion services, help with activities of daily living, and provision of or arrangement for transportation. The unit of service is one day.

- **Assisted Living Facility (ALF):** Provides 24-hour living arrangement for persons who, because of physical or mental limitations, are unable to continue independent functioning in their own home. Services are provided in personal care facilities licensed by HHSC. Participants are responsible for their room and board costs and, if applicable, copayments for ALF services.

- **Dental Services:** Services provided by a licensed dentist such as dentures, routine cleaning, emergency procedures, preventive care, and treatment of injuries. Services are capped at $5,000 per waiver plan year but may be extended an additional $5,000 when oral surgeon services are required.

- **Emergency Response Services (ERS):** Provided through an electronic monitoring

system for use by functionally impaired individuals who live alone or are isolated in the community. In an emergency, the individual can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven days a week monitoring capability, helps ensure that the appropriate person or service agency responds to an alarm call from the individual.

- **Employment Assistance:** Provides identification of Member's preferences, skills and work setting/condition needs, locating available jobs that match the Member's criteria/needs and negotiating the Member's potential employment with the employer. PLEASE NOTE: Employment Assistance is not available to Members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.
- **Financial Management Services:** Services provided by Certified Financial Management Services Agencies (FMSA) to support Members who hire their own service providers under the Consumer Directed Services (CDS) option.
- **Home Delivered Meals:** Meal services provide hot, nutritious meals delivered to an individual's home. The benefit limitation is one meal per day, and the need for a home delivered meal must be part of the individual service plan. Home delivered meals will be provided to individuals who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet individual requirements. Menu plans will be reviewed and approved by a registered dietician licensed by the Texas State Board of Examiners of Dietitians or has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management. Any agency providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation, handling, and serving of food.
- **In-Home Skilled Nursing Care:** Direct delivery of skilled tasks/procedures by a registered or practical nurse based on an assessment of the Member's health care needs, guidance by professional practice standards and physician order if required. The Texas Board of Nurse Examiners allows delegation of nursing tasks to unlicensed persons following the development of a care plan and education on proper health maintenance.
- **Mental Health Rehabilitative Services:** Services are defined as age-appropriate services determined by HHSC and federally-approved protocol as medically necessary to reduce a Member's disability resulting from severe mental illness for adults, or serious emotional, behavioral or mental disorders, and to restore the Member to their best possible functioning level in the community.
- **Mental Health Targeted Case Management:** Assist Members with gaining access to needed medical, social, educational, and other services and supports. Members are eligible to receive these if they have been assessed and diagnosed with a severe and persistent mental illness (SPMI) or a severe emotional disturbance (SED) and they are authorized to receive Mental Health Rehabilitative Services.
  - SPMI is defined as a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental disorders, 5th Edition (DSM-5) accompanied

by:
    - Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or
    - Impaired emotional or behavioral functioning that interferes substantially with the Member's capacity to remain in the community without supportive treatment or services.
  - SED is defined as psychiatric disorders in adults which cause severe disturbances in behavior, thinking, and feeling.

- **Minor Home Modifications:** Includes services that assess the need for, arrange for and provide home modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security and accessibility within their home.

- **Personal Assistant Services (PAS):** Provides in-home assistance to individuals as authorized on their Individual Service Plan (ISP) with the performance of activities of daily living, household chores and nursing tasks that have been delegated by a registered nurse (RN). PAS is subject to Electronic Visit Verification (EVV).

- **Respite Care Services:** Available on an emergency or short-term basis to relieve those persons normally providing unpaid care for a STAR+PLUS waiver (SPW) Member unable to care for themselves. In-home respite care services are subject to EVV.

- **Supported Employment:** Service available to Members who earn at least minimum wage, that provides employment adaptations, supervision, and additional training to sustain employment.

- **Therapy (Occupational, Physical, Speech):** Includes the evaluation, examination, and treatment of physical, functional, speech and hearing disorders and/or limitations. A full range of services are provided in the Member's home or a rehabilitative center by a licensed therapist or an assistant under the direction of a licensed therapist.

- **Transitional Assistance Services (TAS):** Assists individuals who are discharging from a nursing facility to the community and set up their household. A maximum of $2,500 is available on a one-time basis to help offset the costs associated with setting up their household. Some examples of what TAS money provides payment for are security deposits, moving expenses, essential furnishings, and set-up fees for utilities.

- **Supplemental Transition Services (STS):** Service offered through Medicaid MCOs to assist Members who are transitioning from a Nursing Facility (NF) into the community, along with the support of a home and community-based services program authorized by a 1915(c) or 1115 waiver. Form H1746-A NF resident discharged from the facility into a home and community-based services program is eligible to receive up to $2,500 in STS for assistance with moving and setting up a household. STS is available on a one-time only basis and only after TAS has been exhausted.

ADDITIONAL BENEFITS

Adult Well Check

An adult well check is an annual adult physical exam and additional benefit for STAR+PLUS non-dual Members 21 years of age and older. The annual adult well exam may be received in addition to the Member's annual OB/GYN visit for females. Members can self-refer to an OB/GYN provider without a referral from their PCP. All newly enrolled Members should obtain a well checkup within 90 days of enrollment.

Communicable/Infectious Diseases

- Community First Providers must report all conditions on the Infectious Disease Report as indicated as when to report each condition. Suspected cases of illness considered to be public health emergencies, outbreaks, exotic diseases, and unusual group expressions of disease must be reported to the local health department or DSHS immediately. Other diseases for which there must be a quick public health response must be reported within one working day. All other conditions must be reported to the local health department or DSHS within one week.

- Community First Providers must report notifiable conditions, or other illnesses that may be of public health significance, directly to the local or health service regions by using Infectious Disease Report. Paper reporting forms can be obtained by calling your local or health service region. As a last resort or in case of emergency, reports can be made by telephone to the state office at **1-800-252-8239** and after hours will reach the physician/epidemiologist on-call.

Community First Choice (CFC)

Community First Choice (CFC) is a Medicaid benefit that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities. The services available under CFC are:

- **Personal Assistance Services (PAS):** Help with daily living activities and health-related tasks.

- **Habilitation:** Services to help Members learn new skills and care for themselves.

- **Emergency Response Services (ERS):** Help Members who live alone or are alone for most of the day.

- **Support Management:** Training to help Members learn how to select, manage and dismiss attendants.

Who Can Receive CFC Services?

To be eligible for Community First Choice services through Community First, an individual must:

- Be eligible for Medicaid and enrolled in either STAR Kids, STAR Health, or STAR+PLUS.

- Need an institutional level of care such as a hospital, an Intermediate Care Facility (ICF) for Individuals with an Intellectual Disability (IID), nursing facility (NF), or Institution for Mental Disease (IMD).

- Need services provided in the CFC program.

Assessments for CFC Services

- For STAR+PLUS Members with physical disabilities, Community First will complete the Medical Necessity Level of Care assessment (MN/LOC) and CFC Assessment. MN/LOC will be transmitted to TMHP who determines MN for the NF LOC.
- For STAR+PLUS Members with an IDD diagnosis or a related condition, the Local Intellectual and Developmental Disability Authority (LIDDA) will complete the Intellectual Disability/Related Condition (ID/RC) assessment and the CFC assessment for Members 21 and over. The LIDDA will transmit the ID/RC to HHSC who makes the determinations on the ICF LOC.
- All CFC assessments will be person-centered and will result in a plan of care reflecting the needs and goals of the Member.
- Assessments will be conducted initially and at least annually.

Authorizations for CFC Services

- Upon completed and approved assessments, a plan of care will be created and presented to the Member.
- Member and/or their LAR and/or medical consenter will accept the plan of care and select their providers/ provider agencies for their approved CFC services.
- Community First will create and issue authorizations that will be valid for up to one year from the date of the initial/ annual assessment.
- If a Member already receiving PAS becomes eligible for habilitation services, the Member may desire to switch to a habilitation-contracted provider if necessary, or decline habilitation services.
- PAS Only:
  - Members with no identified habilitation service need will select a Community First contracted PAS provider.
  - Authorization will utilize the CFC PAS-only codes/modifiers and rate.
- PAS with HAB:
  - Members with any identified habilitation service need will select a Community First contracted HAB/PAS provider.
  - Must use a single provider for HAB and PAS services.
  - Single Authorization will utilize the habilitation codes/ modifiers and rate.
- HAB Only:
  - Members with a habilitation service need, but no PAS need, will select a Community First contracted HAB provider.
  - Authorization will utilize the habilitation codes/modifiers and rate.
- Non-CFC PAS and ERS:
  - Continue to use existing LTSS codes/modifiers and rates.

CFC Standards

- CFC services must be provided in accordance with HHSC rule 1 TAC, Part 15, Chapter 354, Subchapter A, Division 27 and includes the following:
  - CFC PAS/HAB assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision, and/

or cueing and acquisition, maintenance and enhancement of skills necessary for the Member to accomplish ADLs, IADLs and health-related tasks;
    - CFC ERS: Electronic devices to ensure continuity of services and supports; and

- Support Management: Voluntary training on how to select, manage and dismiss attendants.The CFC services must be delivered in accordance with the Member's service plan.

- Provider must have current documentation, which includes the Member's service plan, ID/RC when applicable, staff training documentation, service delivery logs (documentation showing the delivery of the CFC services),medication administration record (if applicable) and nursing assessment (if applicable).

- Provider must ensure that the rights of the Members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).

- Provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies and any other needs specific to the Member which are required to ensure the Member's health, safety and welfare. The provider must maintain documentation of this training in the Member's record.

- Provider must ensure that the staff Members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when, from the time they are notified that a DFPS investigation has begun, through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect and exploitation and the DFPS hotline at www.txabusehotline.org or 1-800-252-5400.

- Provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.

- Provider must not retaliate against Community First, a staff member, service provider, Member (or someone on behalf of a Member) or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect or exploitation.

- Provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/ GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure

that the provider of ERS has the appropriate licensure.

- Per the CFR §441.565 for CFC, the provider must ensure that any additional training requested by the Member/LAR of CFC PAS/HAB service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The provider must adhere to Community First's billing guidelines as outlined in Section XIV. In addition, proper procedure codes and CFC modifiers must be used when billing. Furthermore, all attendant services and habilitation providers/ provider agencies must use an HHSC-approved Electronic Visit Verification (EVV) vendor to submit their timesheets
- The provider must prevent conflicts of interest between themselves, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member or service provider could financially benefit.
- The provider must prevent financial impropriety toward a Member including unauthorized disclosure of information related to a Member's finances and the purchase of goods that a Member cannot use with the Member's funds.
- Agencies that provide attendant care are required to conduct unannounced home visits to validate services are being rendered and billed correctly.

Cognitive Rehabilitation Therapy (CRT) for CFC Members
CRT is a service that assists an individual in learning or re-learning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. CRT has been proven to help individuals with an acquired brain injury (ABI) recover or compensate for cognitive skills that have been lost or altered as a result of damage to brain cells or brain chemistry.

To qualify for CRT, the services must be deemed medically necessary, the Member must be enrolled in the STAR+PLUS HCBS program and have:

- Medicaid eligibility.
- A need for at least one HCBS service.
- An approved medical necessity/level of care MN/LOC.

Establishing Medical Necessity for CRT
One of the two following assessment tests must be performed on a qualifying Member, and indicate the need for CRT. These tests are a covered benefit.

- Neurobehavioral Assessment - performed by a physician, nurse practitioner or physician assistant.
- Neuropsychological Assessment - performed by a psychiatrist, psychologist, neuro-psychologist or licensed psychological associate.

For dual eligible Members receiving acute care through Medicare, Community First will still help establish medical necessity and coordinate the assessment test with the Member's Medicare provider.

Providers of CRT
Treatment is provided in an outpatient setting or in the Member's home and is overseen by a physician or neuro- psychologist and requires judgment, knowledge and skills of a speech and language pathologist or occupational therapist.

Dental Services for CFC Members
Services provided by a licensed dentist such as dentures, routine cleaning, emergency procedures, preventive care and treatment of injuries are a benefit available to STAR+PLUS waiver Members. Services are capped at $5,000 per waiver plan year, but may be extended an additional $5,000 when oral surgeon services are required.

Durable Medical Equipment for CFC Members
Community First reimburses for covered durable medical equipment (DME) and other products commonly found in a pharmacy. For all qualified Members, this includes medically necessary items such as, but not limited to, nebulizers, ostomy supplies, bed pans, other supplies, and equipment, etc.

Please consult the "Texas Medicaid Provider Procedures Manual" (Durable Medical Equipment (DME) and Comprehensive Care Program (CCP) sections), the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form, in addition to this Provider Manual for information regarding the scope of coverage of durable medical equipment and other products commonly found in a pharmacy. Community First encourages your pharmacy's participation in providing these items to Medicaid clients.

Call Community First Member Services at 210-358-6105 for information about DME and other covered products commonly found in a pharmacy.

Claims for CFC Members
Electronic Claims

- Direct electronic submission is available via the secure online Community First Provider Portal at CommunityFirstHealthPlans.com/ProviderPortal.
  - Community First also accepts EDI claims submitted claims through Availity. Claims filed electronically must be filed using the 837P or 837I format. Billing instructions can be found at the Availity website. Electronically submitted claims must be transmitted through Availity using Community First's Payor Identification as indicated below:

EDI Electronic Data Interface

- Availity Payor ID: COMMF
- Availity Receiver Type: F

Provider Portal Electronic Billing

- Claim MD
- Availity

Providers must be certain that all information is accurate.

Cancellation of Product Orders for CFC Members
A Provider that offers delivery services for covered products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products must reduce, cancel, or stop delivery if the Member or the Member's

authorized representative submits an oral or written request. The Provider must maintain records documenting the request.

Call 210-358-6105 for information about DME and other covered products commonly found in a pharmacy.

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

Financial Management Services for CFC Members
Financial Management Services (FMS) are a benefit available to STAR+PLUS waiver Members. Certified Financial Management Services Agencies (FMSA) provide assistance to Members to manage funds associated with services elected for self-direction and is provided by a Consumer-Directed Service option. The FMSA must meets necessary qualifications to provide financial management services, including completing the mandatory FMSA enrollment training provided by HHSC and meeting eligibility requirements for an HHSC FMSA contract.

Examples of FMS include, but are not limited to:

- Providing required initial orientation, ongoing training, assistance and support for employer-related responsibilities;
- Verifying qualifications of applicants before services are delivered and monitoring continued eligibility of service providers;
- Approving and monitoring budgets for services delivered through the CDS option;
- Managing payroll, including calculations of employee withholdings and employer contributions, and depositing these funds with appropriate agencies (FMSAs are not allowed to use a payroll agent);
- Complying with applicable government regulations concerning employee withholdings, garnishments, mandated withholdings and benefits;
- Preparing and filing required tax forms and reports;
- Paying allowable expenses incurred by the employer;
- Providing status reports concerning the individual's budget, expenditures and compliance with CDS option requirements;
- Responding to the employer or designated representative as soon as possible, but at least within two business days after receipt of information requiring a response from the CDS Agency.

HOSPICE SERVICES

HHSC manages the Hospice Program through Provider enrollment contracts with hospice agencies. These agencies must be licensed by the state and Medicare-certified as hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services unrelated to the treatment of the client's terminal illness and for certain physician services (not the treatments).

Medicaid Hospice provides palliative care to all Medicaid-eligible clients (no age restriction) who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illnesses run their normal courses.

Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

When clients elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness. Medicare and Medicaid clients must elect both the Medicare and Medicaid Hospice programs. Individuals who elect hospice care are issued a Texas Benefits Medicaid Card with "HOSPICE" printed on it. Clients may cancel their election at any time.

HHSC pays the Provider for a variety of services under a per diem rate for any particular hospice day in one of the following categories:

- Routine home care
- Continuous home care
- Respite care
- Inpatient care

For HHSC Hospice billing questions, visit https://hhs.texas.gov/services/health/palliative-care/hospice-care

When the services are unrelated to the terminal illness, Medicaid (TMHP) pays its Providers directly. For questions about hospice billing, call TMHP at **1-800-626-4117**. Providers are required to follow Medicaid guidelines for prior authorization when filing claims to TMHP for hospice clients. Fax authorization requests to **512-514-4209**.

Non-hospice Providers may be reimbursed directly by TMHP for services rendered to a Medicaid hospice client.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (IDD)

Members with Intellectual and Developmental Disabilities (IDD) or Related Conditions (RC) who do not qualify for Medicare, and receive services through the Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF-IID) Program or an IDD Waiver can receive Acute Care Services through Community First STAR+PLUS. Authorization will be required for applicable medically necessary acute care or behavioral health services managed through Community First.

PLEASE NOTE: These individuals will not be eligible for HCBS STAR+PLUS Waiver services while enrolled in the ICF-IID Program or an IDD Waiver.

MEDICAID FOR BREAST AND CERVICAL CANCER (MBCC) PROGRAM

Effective September 1, 2017, women in the Medicaid for Breast and Cervical Cancer (MBCC) program will receive all of their Medicaid services, including cancer treatment, through a Managed Care Organization that offers STAR+PLUS. After selecting and transitioning into a STAR+PLUS health plan, women who receive MBCC services will have the same Medicaid benefits they have currently. In addition STAR+PLUS Members receive:

- Unlimited prescriptions.
- A service coordinator to help them find the right providers for their needs.
- A primary care provider to make sure all of their needs are addressed.

- Value-added Services which are extra services like respite, extra vision services, and health and wellness services.

Women who get MBCC services will have a nurse as their service coordinator. The service coordinator can help:

- Identify and address medical needs
- Understand Medicaid benefits
- Ensure access to needed specialty services
- Coordinate community supports including services that might be non-medical or not covered by Medicaid.

To make sure materials are mailed to the right address, individuals may visit YourTexasBenefits.com or call 2-1-1 to confirm the address on file is correct.

If providers have questions about MBCC services changing to managed care, please email Managed_Care_Initatives@HHS.state.tx.us.

For more information, please visit: https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs-services/medicaid-breast-cervical-cancer-program

MENTAL HEALTH TARGETED CASE MANAGEMENT

Community First, working with the Member's PCP through the Local Mental Health Authority (LMHA), will assess the Member's eligibility for rehabilitative and targeted DSHS case management. The Texas Medicaid Program provides the following service coordination and case management services:

- Service coordination for adults with mental retardation or related condition.
- Case Management Services for adults with severe and persistent mental illness
- Individual Community Support Services Service Coordination for adults with mental retardation or related condition.
- Routine Case Management for adults.

An MHMR service coordination reimbursable "contact" is the provision of a service coordination activity by an authorized service coordinator during a face-to-face meeting with an individual-eligible for service coordination. To bill and be paid for one unit of service coordination per month, at least one face-to-face meeting between the service coordinator and the eligible individual must occur during the month billed.

An MHMR case management reimbursable "contact" is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual authorized to receive that specific type of case management. A billable unit of case management is 15 continuous minutes of contact.

Individual Community Support Services

Service	Proc Code	Modifier	Limitations
Service Coordination for people with mental retardation or related condition	G9012		Once per calendar month

Routine Case Management (Adult)	T1017	TF	32 units (8 hours) per calendar day for people 21 years of age or older

Mental Health Rehabilitation

Service	Proc Code	Modifier	Limitations
Skills Training and Development, Adult, Individual	H2014		16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Skills Training and Development, Adult, group	H2014	HQ	16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Psychosocial Rehabilitative Services, individual	H2017		16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Psychosocial Rehabilitative Services, ACT or ACT alternative consumer, individual	H2017	HK	16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Psychosocial Rehabilitative Services, by RN, individual	H2017	TD	16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Psychosocial Rehabilitative Services ACT or ACT alternative consumer, by RN, individual	H2017	HK and TD	16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Psychosocial Rehabilitative Services, group	H2017	HQ	16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Psychosocial Rehabilitative Services, ACT or ACT alternative consumer, group	H2017	HQ and HK	16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Psychosocial Rehabilitative Services, by RN, group	H2017	HQ and TD	16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Psychosocial Rehabilitative Services, ACT or ACT alternative consumer, by RN, group	H2017	HQ and HK and TD	16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Psychosocial Rehabilitative Services, Individual, Crisis	H2017	ET	96 units (24 hours) per calendar day, in any combination
Psychosocial Rehabilitative Services, ACT or ACT alternative consumer, individual, crisis	H2017	HK and ET	16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older

NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES

What are Non-Emergency Medical Transportation (NEMT) services?
NEMT services provides transportation to covered health care services for Medicaid Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips.

What services are part of NEMT?

- 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 service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is $25 per day for the Member and $25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If a Member needs assistance while traveling to and from their appointment, NEMT services will cover the costs of an attendant. The Member may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature.

Providers can help schedule both routine and life-sustaining appointments for patients through MTM.

How to help patients schedule a ride
Community First partners with MTM for non-emergency medical transportation for our STAR+PLUS Members. Providers can help Community First Members request NEMT services. NEMT services should be requested as early as possible, and at least 48 hours in advance. In certain circumstances, NEMT services can be requested 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.

Members must notify MTM prior to the approved and scheduled trip if your medical appointment is canceled.

To schedule a ride, please call or go online:

Phone: MTM Member Reservation Line: 1-888-444-0307 (TTY 711)
Website: MedicalTrip.net
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:

- Patient's Medicaid ID number (from Your Texas Benefits Medicaid ID card).
- Name, address, and phone number of location Member is traveling to/appointment setting
- The medical reason for the visit.

If Members need help after hours or are unable to contact their driver, call:

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

PHARMACY PROGRAM

General Guidelines

Prescription drugs must be ordered by a licensed prescriber within the scope of the prescriber's practice. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. The Preferred Drug List (PDL) gives information about the drugs covered by Community First. For the most current and up-to-date version of the PDL, go to CommunityFirstMedicaid.com.

All STAR+PLUS Medicaid only (non-dual)Members 21 years of age and older receive unlimited prescriptions as part of the Medicaid Managed Care program.

Brand Medications

Brand-name medications that are listed on the PDL are designated in all CAPS and are covered by the plan. The PDL may cover the brand and generic versions of certain medications.

Pharmacy Prior Authorization (PA)

Pharmacy prior authorization may be required if:

- Prescriptions exceed recommended doses.
- Highly specialized drugs are prescribed which require certain established clinical guidelines be met before consideration for prior approval.
- Quantity limits are exceeded.

Procedure for Obtaining Pharmacy Prior Authorization

Navitus Health Solutions is the pharmacy benefit manager for Community First Health Plans. Navitus processes Texas Medicaid pharmacy prior authorization for Community First.

The Texas Vendor Drug Program (VDP) retains accountability for making formulary decisions which includes establishing quantity limits and prior authorization criteria.

Prescribers can access prior authorization (PA) forms online at Navitus.com under the "Providers" section or request they be faxed by Customer Care to the Prescriber's office. Prescribers will need to enter their NPI and select their state from the dropdown menu in order to access the portal.

Completed PA forms can be faxed 24/7 to Navitus at **1-855-668-8553**. Prescribers can also call Navitus Customer Care at **1-877-908-6023** to speak with the Prior Authorization department from 8:00 a.m. to 5:00 p.m., Monday through Friday (CST) to submit a PA request over the phone. After hours, Providers will have the option to leave voicemail.

Decisions regarding prior authorizations will be made within 24 hours from the time Navitus receives the PA request. The Provider will either be notified of the outcome by fax or verbally, if an approval can be established during a phone request.

Pharmacies will submit pharmacy claims to Navitus. Medications that require prior authorization will undergo an automated review to determine if the criteria are met. If all criteria are met, the claim is approved and paid, and the pharmacy continues with the dispensing process. If the automated review determines that all criteria are not met, the claim will be rejected, and the pharmacy will receive a message indicating that the drug requires prior authorization. At that point, the pharmacy should notify the prescriber and the above process should be followed.

When a prior authorization is required and the Provider is not available to submit the PA request, HHSC encourages pharmacies to dispense a 72-hour supply as long as the Member will not be harmed. This procedure should not be used for routine and continuous overrides but can be used more than once if the Provider remains unavailable. If a pharmacy is not complying with the 72-hour emergency fill requirement, they can be reported to the HHSC Office of the Inspector General. They can also be reported to Navitus' Network Department byc alling **1-877-908-6023**.

Providers may initiate prior authorization through the secure online Community First Provider Portal or via fax at **210-358-6274**.

PLEASE NOTE: If the prior authorization request comes back "PA Not Required," it means that the medication does not require prior authorization. However, "PA Not Required" does not mean that service is covered. Please contact Community First Member Services at 1-844-382-2347 should you have questions regarding covered services.

Texas Medicaid Preferred Drug List
Many preferred drugs are available without prior authorization (PA). To find out if a medication is on the Texas Medicaid Preferred Drug List, check the list of covered drugs at:

- Texas Drug Non-PA PDL Search
- PDL/PA Status Search

The Texas Medicaid preferred drug list is now available on the Epocrates drug

information system at Online.Epocrates.com/Home. The service is free and provides instant access to information on the drugs covered by the Texas formulary on a handheld device.

Formulary Drug List
The Texas Drug Code Formulary located at TXVendorDrug.com/Formulary covers more than 32,000 line items of drugs including single source and multi-source (generic) products. You can check to see if a medication is on the state's formulary list. Remember, before prescribing these medications to your patient(s), the medication may first require PA.

If you would like to request a drug to be added to the formulary, please contact HHSC at TXVendorDrug.com/About/Contact-Us

Over-the-Counter Drugs
Community First also covers certain over-the-counter drugs if they are on the list. Like other drugs, over-the-counter drugs must have a prescription written by the Member's physician. Review the list of covered drugs at TxVendorDrug.com/Formulary/Preferred-Drugs

All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

Mail Order Form for Members
You can assist a Member in completing a mail order form if you are prescribing a maintenance medication. Instructions and helpful links for the mail order process can be found online in Community First Member Resources at Medicaid.CommunityFirstHealthPlans.com/Resources/Pharmacy.

PRESCRIPTIONS

All STAR+PLUS Medicaid Only (non-dual) Members 21 years of age and older receive unlimited prescriptions as part of the Medicaid Managed Care program.

TEXAS COMMISSION FOR THE BLIND CASE MANAGEMENT

Texas Commission for the Blind Case Management is a rehabilitation agency that assists persons with a visual impairment with finding and maintaining a job. They offer case management, counseling, referrals, physical and mental restoration, visual aids, and mobility programs.

Resource categories include:

- Employment and financial assistance
- Mobility and transportation
- Communication
- Assistive technology
- Psychological and counseling services
- Post-secondary education services

Members can apply for services and get more information on any Division for Blind Services program and Providers can help Members apply for services at HHS.Texas.gov/Services/Disability/Blind-Visually-Impaired or call **1-877-787-8999**.

TUBERCULOSIS SERVICES PROVIDED BY DSHS-APPROVED PROVIDERS

- Community First Providers must report all confirmed or suspected cases of TB for a contact investigation and directly observed therapy (DOT) to Local Tuberculosis Control Health Authority (LTCHA) within one (1) working day of identification, using the procedures and forms for reporting TB adopted by DSHS located online at DSHS.Texas.gov/Tuberculosis-TB/Texas-DSHS-TB-Program-TB-Forms-Resources
- Community First Providers must coordinate with LTCHA and report any Community First STAR+PLUS Member who is noncompliant, drug resistant, or who is or may be posing a public health threat.

SERVICE COORDINATION

The Community First Service Coordinator provides a specialized level of care management service that includes but is not limited to:

- Identification of needs, including physical health, mental health services, and LTSS services for STAR+PLUS Members.
- Assessment of Member's risk factors.
- Development of an integrated plan of care in coordination with the Primary Care Provider (PCP) and other managing providers, that considers the Member's and caregiver's goals, preference and desired level of involvement in the plan of care.
- Identification of barriers to meeting goals or complying with the plan of care.
- Application of appropriate interventions to remove barriers to meeting goals included in the plan of care.
- Active coordination of care linking enrollees to providers, medical services, residential, social and other support services where needed.
- Continuity and coordination of care.
- Development and communication of Member self-management plans.
- Addressing the Member's right to decline participation in the service coordination program or disenrollment at any time.
- Accommodating the specific cultural and linguistic needs of all Members.
- Conducting all service coordination procedures in compliance with HIPPA and state law.
- Completing mandatory telephonic or face-to-face contacts with Members.

Service Coordination services provided to Members include:

- The review of assessments and development of a plan of care utilizing input from the Member, family, and providers.
- Coordination with the Member's PCP, Specialist, and LTSS Providers to ensure the Member's health and safety needs are met in the least restrictive setting.
- The referral of Members to support services such as disease management and community resources.
- Authorization of LTSS services.

Service Coordination utilizes a multidisciplinary approach in meeting the Member's needs, including behavioral health.

Discharge Planning

The Service Coordinator or Care Manager collaborates in concurrent review with Community First nurses who follow Members while they are in a hospital setting in

order to schedule needed assessments and work with the Member, family, attending physician, discharge planner, PCP, and other relevant providers to coordinate services and equipment required at discharge. If a Member was receiving any LTSS prior to admission to a hospital, once a Member is discharged, Service Coordination staff notifies LTSS providers to resume services. If an LTSS provider becomes aware of a Member that is admitted to a hospital, the provider should alert the Service Coordinator when services cease after the admission and resume once the Member returns home from the hospital.

Transition Planning
Community First Continuity of Care Transition Plan ensures consistent, unduplicated care without disruption for all new Members receiving care at the time of enrollment from in-network and out-of-network providers including, but not limited to PCPs, specialists, behavioral health (BH), LTSS, and home health providers. We identify new Members receiving care from out-of-network providers in multiple ways such as: current service files and information from the transferring MCO or HHSC, provider authorization requests, completed Health Risk Screening (HRS), outreach to LTSS providers, PCPs, BH and/or other specialty providers not reflected on transfer files, and other Member or Provider contact or referrals.

Community First staff contacts the Provider to ensure the Member continues to receive services ordered prior to the Member's enrollment, (e.g., medical equipment, supplies, or home modifications approved but not completed prior to enrollment). The Service Coordinator will contact the Member to ensure there are no gaps in services. LTSS providers should contact Service Coordination for current service authorizations at the time of enrollment with Community First.

Members entering into a nursing facility will receive an assessment within 30 days of admission by their Service Coordinator. The Service Coordinator works with the Member, family, and providers to develop/implement a transition plan that includes necessary community LTSS and transition services. Members interested in transitioning out of the nursing facility will receive an assessment and education regarding the transition process from the Service Coordinator.

Community First STAR+PLUS Members are assigned a Service Coordinator upon enrollment. Any Member or provider may request a Service Coordinator by calling **210-358-6105**.

Members receiving Service Coordination are assigned a Service Coordinator and will be provided contact information within five business days. Community First will post Service Coordinator assignments to the secure online Community First Provider Portal as well as notify the Member of any changes. Community First must notify Members within five business days of the name and phone number of their new Service Coordinator, if their Service Coordinator changes.

Support Consultation Services
Support Consultation Services (SCS) are optional services offered to STAR+PLUS waiver Members who receive services through the Consumer Directed Service (CDS) option. Support consultation, delivered by an HHSC-certified support advisor, provides coaching and training for employer-related issues such as interviewing, hiring, or managing of providers.

Financial management services (FMS) are provided by financial management service agencies (FMSAs). An FMSA must have a sufficient number of certified support advisors available as an independent employee hired by the individual using the CDS option or through a contract to provide services when requested by an employer.

A certified support advisor may provide services as an independent employee or through an entity (not providing other program or Care Management services to the individual receiving services) or through employment or contract with a FMSA. Support consultation may be provided over the phone or in person. An applicant must be able and willing to fulfill the requirements of Texas Administrative Code, Title 40, Part 1, Chapter 41, Consumer Directed Services (CDS).

Support Consultation is not a separate billable service to Community First. If SCS is needed for Members who choose the CDS option, it can be built into the Member's budget. Providers should refer to the HHSC rate analysis for LTSS to determine rates that are allowed to be used for determining the Member's budget.

VALUE-ADDED SERVICES

Community First STAR+PLUS Members also have access to other services in addition to Medicaid-covered benefits and services, depending on their health needs. Collectively, this additional coverage is referred to as Value-Added Services (VAS). Some of those extra services include:

- A 24-hour Nurse Advice Line staffed by registered nurses.
- Online mental health resources.
- Emergency response services that ensure Members have access to emergency help while home alone.
- Access to household, personal care, and oral care items.
- Access to dental services such as exams, cleanings, and x-rays.
- Extra vision services to help cover the cost of eyeglasses.
- Extra services and benefits for pregnant women.
- Home delivered meals following discharge from a hospital or nursing facility.
- Respite care services to help while a Member's family or other unpaid caregiver is taking a break.

*This not a comprehensive list of all Value-Added Services available to STAR+PLUS Members. For the most up-to-date list of services, please visit CommunityFirstMedicaid.com. Value-Added Services may vary based on whether or not a Member also has Medicare, HCBS STAR+PLUS Waiver coverage, or based on where the Member lives. Restrictions and limitations may apply. For more information about these or other extra services, please call 210-358-6055.

The following is a list of STAR+PLUS covered services.

- Ambulance services
- Audiology services, including hearing aids
- Behavioral health services, including:
  - Inpatient mental health services
  - Outpatient mental health services
  - Psychiatry services
  - Home health services

    - Attention Deficit Hyperactivity Disorder (ADHD) services
    - Counseling services for adults (21 years of age and over)
    - Outpatient substance use disorder treatment services including:
        - Assessment
        - Detoxification services
        - Counseling treatment
        - Medication assisted therapy
- Birthing services provided by a licensed birthing center
- Birthing services provided by a physician or advanced practice nurse in a licensed birthing center
- Breast pump coverage
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dental and vision services
- Dialysis
- Doctor and clinic visits
- Durable medical equipment and supplies
- Emergency services
- Family planning services
- Home health-care services
- Hospital services, including inpatient and outpatient
- Immunizations
- Laboratory
- Mastectomy, breast reconstruction and related follow up procedures including:
    - **I**npatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed
    - Surgery and reconstruction on the other breast to produce symmetrical appearance
    - Treatment of physical complications from the mastectomy and treatment of lymphedema; prophylactic mastectomy to prevent the development of breast cancer
    - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
- Medical supplies and equipment
- Mental health care
- Podiatry
- Prenatal care
- Prescription drugs
- Primary care services
- Preventive services, including an annual adult well check for patients 21 years of age and over
- Radiology, imaging and X-rays
- Residential substance use disorder treatment services including:
    - Detoxification services
    - Substance use disorder treatment (including room and board)
- Specialty physician services

- Therapies (physical, occupational and speech)
- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction, which cannot be accomplished by glasses.)

For a full list of benefits and services including exclusions, please see the Texas Provider Procedures Manual at THMP.com.

In addition to the standard covered benefits, Community First STAR+PLUS Members are eligible for the following benefits:

- Annual adult well checks
- Removal of the Spell of Illness limitation
- Unlimited prescriptions for adults

FAMILY PLANNING SERVICES

Family planning services are preventive health, medical, counseling, and educational services, which help individuals in managing their fertility and achieving optimal reproductive and general health.

If a Member requests contraceptive services or family planning services, the Provider must also provide the Member counseling and education about family planning and available family planning services.

Providers cannot require parental consent for Members who are minors to receive family planning services. Providers must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.

Rules and Regulations

The Social Security Act governing Texas Temporary Assistance for Needy Families (TANF) mandates offering and promptly providing family planning services to prevent and reduce unplanned and out-of-wedlock births for appropriate adults and youths, including minors, who may be considered sexually active.

- Family planning Members must have freedom of choice in the selection of contraceptive methods, as medically appropriate.
- Family planning Members must have the freedom to accept or reject services without coercion.
- Family planning services must be provided without regard to age, marital status, sex, race/ethnicity, parenthood, disability, religion, national origin, or contraceptive preferences.
- Only the STAR+PLUS Member, not the parents, spouse, or any other individual may consent to the provision of family planning services. Counseling, however, may be offered to adolescents, which encourages them to discuss family planning needs with a parent, an adult family member, or another trusted adult.
- Federal regulations require safeguarding a STAR+PLUS Member's confidential choice of birth control and family planning services. Seeking information from third-party insurance resources may jeopardize the STAR+PLUS Member's confidentiality; therefore, prior insurance billing is not a requirement for billing family planning.

Access to Services
STAR+PLUS Members may select any Texas Medicaid Provider to perform their family planning services. The Provider's participation with Community First is not mandatory.

Family Planning Visits
A family planning annual visit is allowed once a year, within the state's fiscal year, September 1 through August 31. If a Provider inadvertently bills a second annual exam, the procedure code automatically will be changed to 99213, and reimbursed at the lesser of the current Medicaid fee schedule or the contracted rate.

Specific Family Planning Procedure Codes and Definitions
To be reimbursed for an annual visit, the Provider must perform a comprehensive health history and physical examination, provide indicated laboratory evaluations, assess the STAR+PLUS Member's problems and needs, and set up an appropriate management plan. The history and physical examination must include the following:

Female Members
Health History

- Gynecologic history including sexual history and STD/HIV risk
- Menstrual history
- Contraceptive history
- Obstetric history
- Medical and surgical history
- Family/genetic history
- Social history, to include tobacco, substance abuse, alcohol, and domestic violence

Physical Examination

- Height (annually for Members until they are five years' post-menarchal)
- Weight
- Blood pressure
- Head, neck (including thyroid)
- Lymph nodes
- Heart
- Lungs
- Breasts (including instruction in self-examination, reinforcement annually)
- Abdomen
- Back
- Extremities
- Pelvic examination
- Rectal examination, as indicated

Male Members
The history and physical examination must include the same general elements as female Members, but should be specific for males.

Office or Member Visit (Follow-up)
A follow-up visit is allowed for routine contraceptive surveillance, family planning counseling/education, contraceptive problems, and suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

During any visit for a medical problem (related to a family planning annual visit) or follow-up visit, the following must occur:

- An update of Member's history
- Physical exam, if appropriate
- Laboratory tests, if appropriate
- Referral to PCP, if appropriate
- Education/counseling, if appropriate

After a contraceptive method is initially provided, the first routine follow-up visit must be scheduled in accordance with the following (unless specifically indicated otherwise):

- Between three and four months for oral contraceptive users (visit must include blood pressure and weight).
- One week and three to four months for implantable contraceptive capsules users, according to protocols (visits must include blood pressure and weight).
- After the next normal menses, or no more than six weeks after an IUD is inserted.
- Two and one-half to three months for Depo Provera users.

1-99429 Initial Member Education
This visit is to assist in the effective selection of a contraceptive method and will only be reimbursed once for a new STAR+PLUS Member, per Provider. The Provider may repeat the visit no more than once per state fiscal year, per Provider. An initial STAR+PLUS Member education visit may be billed in conjunction with an annual or follow-up visit.

The visit must be performed as follows: Every new STAR+PLUS Member requesting contraceptive services or family planning must be provided with STAR+PLUS Member education verbally, in writing, or by audiovisual materials. Over-the-counter contraceptive methods may be provided before the STAR+PLUS Member receives education but must be accompanied by written instructions for correct use.

The Provider may alter the following initial STAR+PLUS Member education, according to the educator's evaluation of the STAR+PLUS Member's current knowledge:

- General benefits of family planning services and contraception.
- Information on male and female basic reproductive anatomy and physiology.
- Information regarding particular benefits, potential side effects, and complications of all available contraceptive methods.
- Information concerning all the Member's available services, the purpose and sequence of procedures, and a routine schedule of return visits.
- Breast self-examination rationale and instructions, unless provided during the physical exam for females.
- Information on HIV/STD infection, prevention, and safe sex discussion.

1-99401 - Method-Specific Education/Counseling
This visit should give the STAR+PLUS Member information about the contraceptive chosen by the Member, and include proper use, possible side effects, complications, reliability, and reversibility. The Provider should provide these services when initiating a method, changing contraceptive methods, or if the STAR+PLUS Member is having difficulty with their current method. This visit can occur along with an annual or follow-up visit. The number of occurrences for this visit will be determined by the number of contraceptive methods chosen by the STAR+PLUS Member.

Education counseling must include the following:

- Verbal and written instructions for correct use and self-monitoring of the method chosen.
- Information regarding the method's mode of action, safety, benefits, and effectiveness.
- Back-up method review when appropriate and instructions on correct use.
- Demonstration of appropriate insertion and removal of a diaphragm or cap at the time of fitting.

1-99402 Problem Counseling
This visit deals with situations that do not relate to a contraceptive method. Examples include pregnancy, sexually transmitted diseases, social and marital problems, health disorders, sexuality concerns, and preconception counseling (for an identified problem that could jeopardize the outcome of a pregnancy). This visit may be billed along with an annual or follow-up visit. STAR+PLUS Members who become pregnant (assessment reveals potential pregnancy) must be provided preconception counseling regarding the modification and reduction of that risk.

If a STAR+PLUS Member requests information about options for an unintended pregnancy or nondirective counseling, then an appropriate referral must be provided for the following:

- Prenatal care and delivery
- Infant care, foster care, or adoption
- Pregnancy termination (not required of natural family planning agencies)

1-S9445 Introduction to Family Planning in Hospital Setting/Auspice
This encounter provides an overview of family planning services available to the STAR+PLUS Member and encourages pregnant or postpartum women to use such services following their delivery.

1-H1010 Instruction in Natural Family Planning Methods (per session)
This visit is for either a couple or individual and may consist of two sessions. When the Provider is billing for these services, they must indicate a quantity of two in block 24G of the CMS-1500, or next to the description in field locator 46 on the UB-04, when billing two sessions together.

Annual Family Planning Exam and Office Visit

Procedure Code	Description
1-99203	Office or other outpatient visit for the E&M of a new patient which requires these three key components: a detailed history; a detailed examination; a medical decision making of low complexity, counseling, and/or coordination of care with other providers or agencies.
OR	

1-99214	Office or other outpatient visit for the E&M of an established patient which requires at least two of these three components: a detailed history; a detailed examination; a medical decision making of moderate complexity, counseling, and/or coordination of care.
WITH	
Modifier FP	Service provided as part of Medicaid Family Planning Program or FP diagnosis.
1-99213	Office or other outpatient visits.

Family Planning Diagnosis and Procedure Codes
Several diagnosis codes are acceptable for billing family planning services, however, to simplify the process Providers are encouraged to use a single diagnosis with all family planning procedures and services. **The recommended diagnosis code is "V25.09 - Encounter for contraceptive management, other."**

The following procedure codes are authorized for use when billing family planning services:

Family Planning Visits:
1-99213

Laboratory in Provider's Office:
TITLE V and XX

5-80061	5-81002	5-81015	5-81025	5-81099
5-82465	5-82947	5-83020	5-84478	5-85013
5-85018	5-85025	5-85660	5-86580	5-86592
5-86701	5-86762	5-87070	5-87205	5-87797
5-88150	5-88230	5-88262		

TITLE XIX

5-80061	5-81000	5-81002	5-81015	5-81025
5-81099	5-82465	5-82947	5-83020	5-83718
5-83719	5-83721	5-84478	5-84702	5-84703
5-85013	5-85014	5-85018	5-85025	5-85660
5-86317	5-86403	5-86580	5-86592	5-86689
5-86701	5-86702	5-86703	5-86762	5-86781
5-86850	5-86900	5-86901	5-87070	5-87076
5-87077	5-87086	5-87088	5-87110	5-87205
5-87797	5-88142	5-88150	5-88230	5-88262

5-99000 with modifier FP

PLEASE NOTE**:** Only the office that performs the laboratory procedure(s) may bill for the laboratory procedure(s). Providers may be reimbursed one lab handling fee per day, per STAR+PLUS Member, unless the Provider obtains multiple specimens and sends them to different laboratories. Lab handling fees will be paid for specimens obtained by venipuncture or catheterization only.

All Providers of laboratory services must comply with the rules and regulations of the

Clinical Laboratory Improvement Amendments (CLIA). If Providers do not comply with CLIA, Community First will not reimburse them for laboratory services.

Laboratory Outside Provider's Office
When it is necessary to send a STAR+PLUS Member out of the Provider's office for laboratory services, the Provider must direct the STAR+PLUS Member to a laboratory identified as a Community First Provider.

Radiology in Provider's Office:

4-74000
4-74010
4-76815

PLEASE NOTE**:** Only the office that performs the radiology procedure(s) may bill for the radiology procedure(s).

Radiology Outside Provider's Office
When it is necessary to send a STAR+PLUS Member out of the Provider's office for radiology services, the Provider must direct the Member to a radiology facility identified as a Community First Provider.

Contraceptive Devices and Related Procedures:

9-A4261	9-A4266	1-J7300	1-J7302	2-11976
2-57170	2-58300	2-58301		

Drugs and Supplies:

9-A4261	9-A4266	1-A4267	1-A4268	1-A4269
1-A9150 with modifier FP		1-J1055	1-J1056	1-J3490
1-S4993				

Medical Education/Counseling:

1-H1010
1-S9445 with modifier FP
1-S9470*
1-99401 with modifier FP
1-99402 with modifier FP
1-99411**
1-99429 with modifier FP
* Title V only
** Title XX only

Sterilization Services (global fees):

Complete:	1-55250*	1-58600*

*Global fee

Title V and Title XX only
For incomplete procedures, one of the following diagnoses must be present on the claim in addition to the diagnosis for sterilization:

V641	V642	V643

Tubal Ligation: 58600
Vasectomy: 55250

PLEASE NOTE: Prior to performing any sterilization procedures, a Sterilization Consent Form must be completed in accordance with its instructions. This form and instructions can be found online at TMHP.com/Resources/Forms.

Medical Conditions
If the family planning provider is not the Member's PCP and the STAR+PLUS Member presents with a "medical condition," the family planning provider must refer the Member to their PCP for the appropriate treatment and/or referral for specialty services.

ACCESS TO TELEMEDICINE, TELEMONITORING, AND TELEHEALTH

STAR+PLUS Members have access to Providers who offer telemedicine, telemonitoring, and telehealth services. To be eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in Texas Government Code - GOV'T § 531.0217.

As a second option to face-to-face visits, any provider in the Community First network can offer telehealth services to Community First Members (except for STAR+PLUS dual 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 delivering telemedicine, telemonitoring and telehealth services to eligible Community First Members should reference the Texas Medicaid Provider Procedures Manual, for billing guidance and applicable modifiers.

BREAST PUMP COVERAGE IN MEDICAID AND CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother's Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must

be obtained under the infant's Medicaid client number.

Pregnancy and Postpartum Coverage			
Coverage in prenatal period	**Coverage at delivery**	**Coverage for newborn**	**Breast pump coverage & billing**
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	
STAR Health	STAR Health	STAR Health	

Pregnancy and Postpartum Coverage			
Coverage in prenatal period	**Coverage at delivery**	**Coverage for newborn**	**Breast pump coverage & billing**
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 Days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

**These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.

IV. BEHAVIORAL HEALTH

DEFINITIONS

Behavioral Health Services means covered services for the treatment of mental or emotional disorders and treatment of chemical dependency disorders.

An **emergency behavioral health condition** means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention without which a STAR+PLUS Member would present an immediate danger to themselves or others or which renders the STAR+PLUS Member incapable of controlling, knowing or understanding the consequences of their actions.

An **urgent behavioral health situation** is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the Member is not an immediate danger to himself or herself or others and is able to cooperate with treatment.

Severe and Persistent Mental Illness (SPMI) means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by

- impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or
- impaired emotional or behavioral functioning that interferes substantially with the Member's capacity to remain in the community without supportive treatment or services.

Severe Emotional Disturbance (SED) means psychiatric disorders in adults which cause severe disturbances in behavior, thinking, and feeling.

BEHAVIORAL HEALTH SERVICES DEFINED

Behavioral health services are covered services for the treatment of mental or emotional disorders and for the treatment of substance use disorders. Community First has defined "behavioral health" as encompassing both acute and chronic psychiatric and substance use disorders as referenced in the most recent ICD-10-CM/PCS. Community First reviews, authorizes, and pays medically necessary claims for behavioral health providers when the primary diagnosis is for behavioral health services.

Community First will authorize, review, and pay claims for medically necessary treatment, including inpatient hospital services. Community First's clinical program focuses on individualized treatment strategies that promote resiliency and recovery using evidence-based practices. The goal of this program is to support the provision and maintenance of a quality-oriented patient care environment, and to provide easy access to quality mental health and substance use disorder, treatment services.

PRIMARY CARE PROVIDER'S ROLE IN BEHAVIORAL HEALTH

Primary Care Providers (PCPs) are responsible for coordinating the Member's physical and behavioral health care including making referrals to behavioral health practitioners

when necessary. However, the Member does not need a referral to access mental health or substance use disorder treatment with a participating Community First provider. The PCP serves as the "medical home" for the patient.

In addition, PCPs must adhere to screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. Practitioners should follow generally-accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health. PCPs can also reference Community First's website, CommunityFirstMedicaid.com for more information. PCPs may provide behavioral health-related services within the scope of their practice.

COORDINATION BETWEEN BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES

Community First recognizes that communication is the link that unites all the service components and is a key element in any program's success. To advance this objective, providers are required to obtain a consent for disclosure of information from the Member, permitting exchange of clinical information between the behavioral health provider and the Member's physical health provider.

If the Member refuses to release the information, they should indicate their refusal on the release form. In addition, the provider will document the reasons for declination in the medical record. Community First monitors compliance of the behavioral health providers to ensure a consent and an authorization to disclose information form has been signed by the Member. Community First also ensures that regular reports are sent to the PCP, for Members agreeing to the disclosure.

Community First promotes the development of Integrated Primary Care (IPC) at the Member's Medical Home (Primary Care) and involves the integration of behavioral health services into primary care during the regular provision of primary care services where appropriate. IPC occurs at the same time and by the same provider ideally, or by the behavioral health provider seeing the Member in tandem with the PCP. The IPC is a model distinct from co-location of services, which is considered to be parallel care rather than integrated care. IPC is also distinct from sequential care, which denotes behavioral health care that occurs either before or after the primary care and at the same or different location.

PCP Requirements for Behavioral Health

A PCP may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of his practice.

PCP must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Primary Care Providers are required to:

- Send the behavioral health provider initial and quarterly (or more frequently if clinically indicated or court ordered) summary reports of the Member's physical and behavioral health status. The report must include, at a minimum:

  - Behavioral health medications prescribed.
  - Behavioral health medication effects reported during PCP visits and information about physical health conditions and treatments that may affect behavioral health conditions and treatments.
- Administer a screening tool at intake, and at least annually thereafter, to identify Members who need behavioral health referrals. Behavioral health assessment tools, if available, may be utilized by the PCP.
- Send a copy of the physical health consultation record and the behavioral health screening tool results to the behavioral health provider who referred the Member.

Behavioral Health Provider Requirements

Behavioral health providers agree to:

- Refer Members with known or suspected physical health problems or disorders to the PCP for examination and treatment, with the consent of the Member or the Member's legal guardian.
- Only provide physical health services if such services are within the scope of the network practitioner'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. Contact Members who have missed appointments within 24 hours to reschedule appointments.
- Network Facilities and Community Mental Health Centers must ensure Members who are discharging from inpatient care are scheduled for outpatient follow-up and/or continuing treatment prior to the Member's discharge. The outpatient treatment must occur within seven days from the date of discharge.
- Coordinate with state psychiatric facilities and Local Mental Health Authorities
- Provide an attestation to MCO that organization has the ability to provide, either directly or through sub-contract, the Members with the full array of Mental Health Rehabilitative (MHR) and Targeted Case Management (TCM) services as outlined in the Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG) and the Uniform Managed Care Manual, Chapter 15 (as part of Credentialing process).
- Annually complete training and become certified to administer Adult Needs and Strengths Assessment (ANSA) assessment tools if providing MHR and TCM.
- Use RRUMG as the medical necessity criteria for MHR and TCM services.
- Qualified Mental Health Professionals for Community Services (QMHP-CS) requirement minimums are as follows:
  - Demonstrated competency in the work to be performed; and
  - Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, or be a Registered Nurse (RN);
  - An LPHA is automatically certified as a QMHP-CS. A Community Services Specialist (CSSP), a Peer Provider, and a Family Partner can be a QMHP-CS if acting under the supervision of an LPHA. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA. A Peer Provider must be a certified peer specialist, and a Family Partner must be a certified Family Partner.
  - The name of a performing provider is not required on claims submitted to

Community First, if that provider is not a type that enrolls in Medicaid (such as CSSPs, PPs, FPs, non-LPHA QMHPs and Targeted Case Managers).

- A qualified provider of Mental Health Rehabilitative and Targeted Case Management services must:
  - Demonstrate competency in the work performed.
  - Possess a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology,
  - Be a Registered Nurse (RN).
  - Follow HHSC established qualification and supervisory protocols.
- Community First is prohibited from establishing additional supervisory protocols with respect to the providers of TCM or MHR
- Training and certification to administer the Adult Needs and Strength Assessment (ANSA) for Members.
- Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG).
- Attestation from provider entity to MCO that organization has the ability to provide, either directly or through sub-contract, the Member with the full array of MHR and TCM services as outlined in the RRUMG.
- HHSC-established qualification and supervisory protocols.

Reimbursement
Claims billed by a physical health provider will be considered for reimbursement when billed with an ADHD diagnosis code. Reimbursement will be based on the prevailing Texas Medicaid fee schedule and the contracted reimbursement agreement with Community First.

ICD-10 Diagnostic Codes for Behavioral Health Claims
Medical record documentation and referral information must be documented using the ICD-10 classifications, as well as the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications.

Laboratory Services
Behavioral health providers should facilitate the provision of in-office laboratory services for behavioral health Members whenever possible or at a location that is within close proximity to the behavioral health provider's office.

BEHAVIORAL HEALTH COVERED SERVICES

- Screening
- Inpatient mental health and substance abuse hospitalization (free standing hospital and general acute-care hospital and Department of State Health Services licensed facilities)
- Treatment by psychiatrists, psychologists, LPCs, LCSW-ACPs, LMFTs, and LCDCs
- Outpatient Behavioral Health counseling services
- Attention Deficit Hyperactivity Disorder (ADHD)
- Health Home
- Self-referral (any network Behavioral Health provider)
- PCP referral

- Target Case Management and Rehabilitative Services
- Substance use disorder services

Member Access to Behavioral Health Services
A STAR+PLUS Member can access behavioral health services by:

- Self-referral to any network behavioral health provider.
- Calling Community First at 210-358-6105 and obtaining the names of network behavioral health providers.

Community First does not require STAR+PLUS Members have a PCP referral to obtain an initial consultation visit with a network behavioral health provider. Outpatient behavioral health services **beyond** the first 20 visits must be preauthorized by sending a Behavioral Health Request for Authorized Services and Treatment Plan to Community First's Population Health Management Department via fax to **210-358-6387**. Medical necessity documentation must be submitted prior to the 20th visit.

A registered nurse is available to receive calls 7 days a week, 24 hours a day, including holidays to provide:

- Initial/concurrent review of Members admitted to the hospital or receiving services to determine coverage
- Assistance with obtaining information and checking eligibility
- Provision of preauthorization determinations as requested

Consultation regarding the appropriateness of the level of care is available through Community First's Care Management staff. Psychological/Neuropsychological testing requires preauthorization. Providers must fax a completed Psychological Testing Request Form to **210-358-6387**.

Community First Care Management staff is available to assist you in identifying and accessing behavioral health providers that can meet the needs of your STAR+PLUS Members. We encourage you to call us with any questions regarding behavioral health services at **210-358-6105**.

Medical Records Documentation and Referral Information
When assessing a STAR+PLUS Member for behavioral health services, Providers must use the DSM-IV multi-axial classification and report axes I, II, II, IV and V. Community First may require use of other assessment instruments/outcome measures in addition to the DSM-IV. Providers must document DSM-IV and the assessment/outcome information in the STAR+PLUS Member's medical record.

All network PCPs must ensure all STAR+PLUS Members receive a screening, evaluation, and referral and/or treatment for any identified behavioral health problems or disorders.

Consent for Disclosure of Information. A written medical record release must be obtained from the STAR+PLUS Member, or a parent or legal guardian of the STAR+PLUS Member, before the Provider can send the STAR+PLUS Member's Behavioral Health Report to the PCP. The STAR+PLUS Member will be advised that they are not required to sign the release and treatment will not be denied if the STAR+PLUS Member objects to signing the form. The Provider will place a copy of the signed release in the STAR+PLUS Member's record.

Court Ordered Commitments

Community First will provide covered Medicaid inpatient services to members, birth through 20 years of age and 65 years of age and older, who has been ordered to receive inpatient psychiatric services under court of competent jurisdiction including services ordered pursuant to the Texas Health and Safety Code Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. Community First cannot deny, reduce, or controvert the medical necessity of inpatient psychiatric services provided pursuant to a court-ordered commitment for Members, birth through 20 years of age and 65 years of age and older. Community First will not deny, reduce, or controvert the court orders for Medicaid inpatient mental health covered services for Members of any age if the court ordered services are delivered in an acute care hospital. Community First may not limit substance use disorder treatment or outpatient mental health services for Members of any age provided pursuant to a court order or a condition of probation. The Member can only appeal the commitment through the court system. These requirements are not applicable when the Member is considered incarcerated, as defined by Uniform Managed Care Manual (UMCM) Chapter 16.

To ensure services are not inadvertently denied, providers must contact Community First and provide telephonic or written clinical information as well as a copy of the court order.

Any professional services provided that are part of a court order must be billed with an H9 modifier as described in the Texas Medicaid Provider Procedures Manual. Court-ordered services that require authorization or notification per Community First's prior authorization list must also have an authorization.

Facilities providing court-ordered services should bill using the appropriate code (8 or 08 per the Texas Medicaid Provider Procedures Manual) in the Source of Admission field of the UB-04 claim form. Community First will make best efforts to authorize services from the court order once provided.

COORDINATION WITH THE LOCAL MENTAL HEALTH AUTHORITY

Providers rendering behavioral health services who believe STAR+PLUS Members qualify for target case management or rehabilitation services through the Local Mental Health Authority (LMHA) may refer the Member to the nearest LMHA office. The LMHA will assess the STAR+PLUS Member to determine if they meet criteria for Severe and Persistent Emotional Disturbance (SPMI) or Severe Emotional Disturbance (SED). For LMHA information, call the Center for Healthcare Services **210-713-1300**.

A Provider, with written consent from the STAR+PLUS Member, should inform the LMHA providing rehabilitation services or targeted case management that the STAR+PLUS Member is receiving behavioral health services.

COORDINATION WITH THE DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

Behavioral health providers and/or physical health providers who are treating a behavioral health condition are responsible for appropriate referrals to the Department of Family and Protective Services (DFPS) for suspected or confirmed cases of abuse.

To report concerns of abuse, neglect, or exploitation of the elderly or people with disabilities, contact the Texas Abuse/Neglect Hotline at 1-800-252-5400 or go to TXAbuseHotline.org.

Assessment Instruments for Behavioral Health Available for PCP Use. Community First requires, through provisions in its Professional Provider Agreement, that a Member's PCP have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. PCPs may provide any clinically appropriate behavioral health services within the scope of their training and practice.

Community First will provide or arrange for training for network PCPs on how to screen and identify behavioral health disorders, the referral process for behavioral health services, and clinical coordination requirements for such services. Community First will also provide general assessment tools for PCPs as they are developed.

Focus Studies and Utilization Management Reporting Requirements. As part of the utilization management report submitted to HHSC on a quarterly basis, Community First includes behavior health utilization data. Each report has a standardized reporting format and detailed instructions that DSHS may periodically update to include new codes, which will allow for better communication between Community First and HHSC.

To meet this reporting requirement, Community First might include Providers who render behavioral health services to STAR+PLUS Members in a behavioral health medical record audit.

Procedures for Follow-up on Missed Appointments. Community First requires that all Providers contact STAR+PLUS Members if they miss a scheduled appointment to reschedule such appointment within 24 hours of the missed appointment.

Discharge Planning and Aftercare. Providers must notify a Community First Case Manager when they discharge a STAR+PLUS Member from an inpatient, residential treatment, partial hospitalization, or intensive outpatient setting. STAR+PLUS Members should have a copy of the discharge plan, which includes an aftercare appointment or entry into a lesser level of care.

Providers who provide inpatient psychiatric services to a Member must schedule the Member for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact Members who have missed appointments within 24 hours to reschedule appointments.

Summary Reports to Primary Care Providers. All Providers rendering behavioral health services to STAR+PLUS Members must send completed behavioral health reports to the Member's PCP upon beginning behavioral health services, every three months that the STAR+PLUS Member remains in treatment, and/or upon discharge. A copy of the report will be placed in the STAR +PLUS Member's permanent record.

Inpatient Authorization. Community First is responsible for authorized inpatient hospital services including services provided in freestanding psychiatric facilities.

BEHAVIORAL HEALTH SCREENING AND ASSESSMENT

When assessing STAR+PLUS Members for behavioral health services, Providers must use the DSM-IV multi-axial classification and report axes I, II, III, IV, and V. Community First may require assessment instruments/outcome measures in addition to the DSM-IV. Providers must document DSM-IV and assessment/outcome information in the STAR+PLUS Member's medical record.

All network PCPs must ensure all STAR+PLUS Members receive a screening, evaluation, and referral and/or treatment for any identified behavioral health problems and disorders.

EMERGENCY AND URGENT BEHAVIORAL HEALTH SERVICES

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention/medical attention. In an emergency and without immediate intervention/medical attention, the Member would present an immediate danger to themselves or others, or would be rendered incapable of controlling, knowing or understanding the consequences of his or her actions.

Emergency behavioral health conditions include Emergency Detentions as defined under Tex. Health & Safety Code § 573.0001-573.026 and under Tex. Health & Safety Code § 462.001-462.081.

In the event of a behavioral health emergency, the safety of the Member and others is paramount. The Member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 9-1-1 should be contacted if the Member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the Member is any of the following:

- Suicidal
- Homicidal
- Violent towards others
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living
- Alcohol or drug-dependent, with signs of severe withdrawal

Community First does not require precertification or notification of emergency services, including emergency room and ambulance services. If the Member cannot be seen within six hours of initial contact, then the Member should be referred to the ED.

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the Member is not an immediate danger to themselvesor others and is able to cooperate with treatment.

MENTAL HEALTH TARGETED CASE MANAGEMENT

STAR+PLUS Members may qualify for Targeted Case Management. Targeted Case Management is designed to assist Members with gaining access to needed medical,

social, educational, and other services and supports. Members are eligible to receive these based on a standardized assessment, Adult Needs and Strengths Assessment (ANSA), and other diagnostic criteria used to establish medical necessity. Targeted Case Management does not require prior authorization through Community First for participating providers.

MENTAL HEALTH REHABILITATIVE SERVICES

STAR+PLUS Members may qualify to receive Mental Health Rehabilitative Services. Mental Health Rehabilitation Services are defined as age-appropriate services determined by HHSC and federally-approved protocol as medically necessary to reduce a Member's disability resulting from severe mental illness for adults, or serious emotional, behavioral or mental disorders, and to restore the Member to their best possible functioning level in the community.

Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a Member achieve a rehabilitation goal as defined in the Member's rehabilitation plan. Mental Health Rehabilitation services do not require prior authorization through Community First for participating providers.

V. LONG-TERM SERVICES AND SUPPORTS

SERVICE COORDINATION

Service Coordination is a model of care coordination that encourages a collaborative process which assesses a Member from a physical, functional, social, and environmental point of view. Then, through a person-centered and directed perspective, service coordination builds, and implements plans, coordinates, monitors, and evaluates options and services to meet an individual's health needs, using communication and available resources to promote access, quality, and cost-effective outcomes. Service Coordination is Member-centered, goal-oriented, and culturally relevant, and is a logically managed process to help ensure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

Community First Service Coordination teams support the Member and their physicians by tracking compliance with the Member's Individual Service Plan (ISP), and facilitating communication between the PCP, specialist, Member, managing care team(s), and the Service Coordinator. The Service Coordinator also facilitates referrals and links to community Providers, such as local health departments and school-based clinics. The managing physician maintains responsibility for the Member's ongoing care needs. The Community First Service Coordinator will contact the PCP, and/or, managing physician, if the Member is not following the plan of care or requires additional services. Members with needs may be identified via Community First outreach, clinical rounds, referrals from other Community First staff Members, hospital census, direct referral from Providers, self-referral, or referral from other Providers.

Providers may contact a Community First Service Coordinator by calling **210-358-6105**.

ROLE OF THE SERVICE COORDINATOR

The role of 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. This includes utilization management and care management (including behavioral health and substance abuse services), and Texas Health Steps. 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. Services Coordinators are responsible for discharge planning and continuity of care transition planning.

LONG-TERM CARE OMBUDSMAN

The State Long-Term Care Ombudsman Program operated through HHSC advocates for the rights of people who live in nursing homes and assisted living facilities so they receive optimal quality of care and achieve high quality of life. The Long-Term Care Ombudsman identifies, investigates, and resolves complaints that may adversely affect the health, safety, welfare, or rights of people who live in nursing facilities or assisted living facilities.

For more information, visit the Long-Term Ombudsman website at Apps.HHS.Texas.gov/News_iIfo/Ombudsman/

OMBUDSMAN SERVICES

The mission of the Ombudsman is to serve as an impartial and confidential resource, assisting our Members with Health and Human Services-related complaints and issues. The HHSC's Office of the Ombudsman helps people when the agency's normal complaint process cannot or does not satisfactorily resolve the issue.

The Office of the Ombudsman

- Conducts independent reviews of complaints concerning agency policies or practices.
- Ensures policies and practices are consistent with the goals of the Texas Health and Human Services Commission.
- Ensures individuals are treated fairly, respectfully and with dignity.
- Makes referrals to other agencies as appropriate.

Providers or Members can contact the Office of the Ombudsman at **1-877-787-8999 (TTY 711)** or **1-800-735-2989** for assistance. For additional information on the Ombudsman Complaint Process, visit Apps.HHS.Texas.gov/News_iIfo/Ombudsman/

OTHER HHSC LTSS PROGRAMS AND PROGRAM DEFINITIONS

1915(i) Home and Community Based Services-Adult Mental Health (HCBS-AMH). Home and Community Based Services-Adult Mental Health (HCBS-AMH) is a state-wide program that provides home and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each Member's needs, to enable him or her to live and experience successful tenure in their chosen community. Services are designed to support long term recovery from mental illness.

Community Living Assistance and Support Services (CLASS) Waiver Program. The Community Living Assistance and Support Services (CLASS) program provides home and community-based services to people with related conditions as a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). A related condition is a disability, other than an intellectual disability, that originated before age 22 that affects the ability to function in daily life.

Deaf Blind with Multiple Disabilities (DBMD) Waiver Program. The Deaf Blind with Multiple Disabilities (DBMD) program provides home and community-based services to people who are deaf blind and have another disability. This is a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). The DBMD program focuses on increasing opportunities for consumers to communicate and interact with their environment.

Dual-Eligible. Dual-eligible Members are Medicaid recipients who are also eligible for Medicare.

Home and Community-based Services (HCS) Waiver Program. The Home and Community-based Services (HCS) program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.

Long Term Services and Supports (LTSS). Long Term Services and Supports provide assistance with daily health care and living needs for individuals with a long-lasting illness or disability.

Texas Home Living (TxHmL) Waiver Program. The Texas Home Living (TxHmL) program provides selected essential services and supports to people with an intellectual disability or a related condition who live in their own home or their family's home.

VI. ELECTRONIC VISIT VERIFICATION (EVV)

Electronic Visit Verification (EVV) applies to providers in the STAR+PLUS program providing Texas Medicaid attendant or attendant-like services or habilitation services. EVV is a computer-based system that electronically verifies when service visits occur and documents that precise time service provision begins and ends. The purpose of EVV is to verify that individuals are receiving the services authorized for their support and for which the state is being billed.

Effective April 1, 2016, EVV was set as required by HHSC for LTSS-designated providers with STRA+PLUS, STAR Health, and Dual Eligible Integrated Care Demonstration. This includes Personal Assistance Services (PAS), Flexible Family Support Services (FFSS) and In-home Respite Care.

Providers who contract with Community First on or after April 1, 2016, and provide services required to use EVV, must select and enroll with an HHSC approved EVV vendor prior to furnishing services to Community First Members.

EVV REQUIREMENTS

As a part of EVV compliance, providers must ensure Electronic Visit Verification data, including any necessary visit maintenance within 95 days from the date of service is accurately documented in the EVV vendor system, in order to be properly reimbursed by Community First. EVV compliance and claim submissions are independent processes. EVV data must be captured and confirmed in the vendor systems prior to billing.

Providers can verify that their visits have been transmitted to Community First by utilizing the EVV Visit Log in the EVV vendor portal. The EVV Visit Log is used to verify the hours of services delivered by whom and to whom as well as to verify that all the visits were complete and accurate prior to the submission of a visit for billing. Additional reports are available in the EVV vendor portal to check for unsent transmissions and/or inaccurate visit data.

GENERAL INFORMATION ABOUT EVV

What is EVV?

EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a Member. The EVV System documents the following:

- Type of service provided (Service Authorization Data);
- Name of the Member to whom the service is provided (Member Data);
- Date and times the visit began and ended;
- Service delivery location;
- Name of the service provider or CDS Employee who provided the service (Service Provider Data); and
- Other information HHS determines is necessary to ensure the accurate adjudication of Medicaid claims.

Is there a law that requires the use of EVV?
Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section 531.024172, requires HHS to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHS required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. More recently, HHS required the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2024.

Which services must a service provider or CDS Employee electronically document and verify using EVV?
The EVV required services that must be electronically documented and verified through EVV are listed on the HHS EVV website. Refer to the Programs, Services and Service Delivery Options Required to Use Electronic Visit Verification.

Check the EVV Service Bill Codes Table on the HHS EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services.

To learn more, please review the EVV Service Bill Codes Table found on the HHS website: HHS.Texas.gov/Providers/Long-Term-Care-Providers/Long-Term-Care-Provider-Resources/Electronic-Visit-Verification.

Who must use EVV?
The following must use EVV:

- Provider: An entity that contracts with Community First to provide an EVV service.
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a provider or a CDS Employer.
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with Community First to provide financial management services to a CDS Employer as described in Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, § 41.103(25), Consumer Directed Services Option.
- CDS Employer: A Member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

EVV SYSTEMS

Do providers and FMSAs have a choice of EVV Vendors?
Yes. A provider or FMSA must select one of the following two EVV Systems:

- **EVV vendor system.** An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHS, that a provider or FMSA may opt to use instead of an EVV proprietary system. For additional information, please visit: TMHP.com/Topics/EVV/EVV-Vendors
- **EVV proprietary system.** An EVV proprietary system is an HHS-approved EVV system that a provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
  - Is purchased or developed by a provider or an FMSA,
  - Is used to exchange EVV information with HHS or Community First, and

- Complies with the requirements of Texas Government Code Section 531.024172 or its successors.

More information on proprietary systems can be found at TMHP: TMHP.com/Topics/EVV/EVV-Proprietary-Systems

Does a CDS Employer have a choice of EVV Systems?
No. A CDS Employer must use the EVV System selected by the CDS Employer's FMSA.

What is the process for a provider or FMSA to select an EVV System?

- To select an EVV vendor from the state vendor pool, a provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor's website.
- To access state approved vendors and contact information, please visit: TMHP.com/Topics/EVV/EVV-Vendors. To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHS EVV Proprietary System approval process.
- For more information about the EVV proprietary system and onboarding process, please visit: TMHP.com/Topics/EVV/EVV-Proprietary-Systems

What requirements must a provider or FMSA meet before using the selected EVV System?
Before using a selected EVV System:

- The provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor. To see state approved vendor information, please visit: TMHP.com/Topics/EVV/EVV-Vendors.
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
  - An EVV Proprietary System Request Form
  - EVV PSO Detailed Questionnaire (DQ)
  - TMHP Interface Access Request
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHS to use an EVV proprietary system to comply with HHS EVV requirements.
- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
  - Complete all required EVV training as described in the answer in the EVV Training section below; and
  - Complete the EVV System onboarding activities:
    - Manually enter or electronically import identification data;
    - Enter or verify Member service authorizations;
    - Setup Member schedules (if required); and
    - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

Does a provider or FMSA pay to use the selected EVV System?

- If a provider or FMSA selects an EVV vendor system, the provider or FMSA uses the system free of charge.

- If a provider or FMSA elects to use an EVV proprietary system, the provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

Can a provider or FMSA change EVV Systems?
Yes. A provider or FMSA may:

- Transfer from an EVV vendor to another EVV vendor within the state vendor pool;
- Transfer from an EVV vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an EVV vendor; or
- Transfer from one EVV Proprietary system to another EVV Proprietary system.

What is the process to change from one EVV System to another EVV System?
To change EVV Systems, a provider or FMSA must request a transfer as follows:

- To request a transfer to an EVV vendor, a provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV vendor.
- To request a transfer to an EVV proprietary system, a provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 days before the desired effective date of the transfer.
- If a provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the provider or FMSA and the newly selected EVV vendor agree on an earlier date.
- If a provider or FMSA is transferring to an EVV proprietary system, the provider or FMSA, TMHP, and HHS will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
- An FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A provider or FMSA must complete all required EVV System training before using the new EVV System.
- A provider or FMSA who transfers to a new EVV vendor or proprietary system:
  - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement; and
  - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.
- After a provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

Are the EVV Systems accessible for people with disabilities?
The EVV vendors provide accessible systems, but if a CDS Employer, service provider or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the provider or FMSA is using a proprietary system, the service provider, CDS Employer or CDS Employee must contact the provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV SERVICE AUTHORIZATIONS

What responsibilities do Providers and FMSAs have regarding service authorizations issued by Community First for an EVV required service?

A provider and FMSA must do the following regarding service authorizations issued by Community First for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
  - Name of the MCO;
  - Name of the Provider or FMSA;
  - Provider or FMSA Tax Identification Number;
  - National Provider Identifier (NPI) or Atypical Provider Identifier (API);
  - Member Medicaid ID;
  - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
  - Authorization start date; and
  - Authorization end date.
- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System; and
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV CLOCK IN AND CLOCK OUT METHODS

What are the approved methods a service provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a Member in the home or in the community?

A service provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a Member in the home or in the community. A service provider or CDS Employee may use one method to clock in and a different method to clock out.

1. Mobile method
   - A service provider must use one of the following mobile devices to clock in and clock out:
     - The service provider's personal smart phone or tablet; or
     - A smart phone or tablet issued by the provider.
   - A service provider must not use a Member's smart phone or tablet to clock in and clock out.
   - A CDS Employee must use one of the following mobile devices to clock in and clock out:
     - The CDS Employee's personal smart phone or tablet;
     - A smart phone or tablet issued by the FMSA; or
     - The CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
   - To use a mobile method, a service provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the service provider or CDS Employee has downloaded to the smart phone or tablet.
   - The mobile method is the only method that a service provider or CDS Employee may use to clock in and clock out when providing services in the community.
2. Home phone landline

- A service provider or CDS Employee may use the Member's home phone landline, if the Member agrees, to clock in and clock out of the EVV System.
- To use a home phone landline, a service provider or CDS Employee must call a toll-free number provided by the EVV vendor or the Proprietary System Operator (PSO) to clock in and clock out.
- If a Member does not agree to a service provider's or CDS Employee's use of the home phone landline or if the Member's home phone landline is frequently not available for the service provider or CDS Employee to use, the service provider or CDS Employee must use another approved clock in and clock out method.
- The provider or FMSA must enter the Member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

3. Alternative device
   - A service provider or CDS Employee may use an HHS-approved alternative device to clock in and clock out when providing services in the Member's home.
   - An alternative device is an HHS-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
   - An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
   - The alternative device codes are active for only seven days after the date of service and must be entered into the EVV system before the code expires.
   - The service provider or CDS Employee must follow the instructions provided by the provider or CDS Employer to use the alternative device to record a visit.
   - An alternative device must always remain in the Member's home even during an evacuation.

What actions must the provider or FMSA take if a service provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a service provider does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the provider must manually enter the visit in the EVV System.
- If a service provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to correct the inaccurate service delivery information in the EVV System.
- After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if Community First approves a Visit Maintenance

Unlock Request.
- The EVV Policy Handbook requires the provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV VISIT MAINTENANCE

Is there a timeframe in which providers, FMSAs, and CDS Employers must perform Visit Maintenance?
In general, a provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHS EVV Policy Handbook.

Please Note: the standard Visit Maintenance timeframe as set in EVV Policy Handbook may be changed by HHS to accommodate providers impacted by circumstances outside of their control.

Are providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?
Yes. Program providers, FMSAs or CDS Employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

- Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.
- For more information, please review the Current HHSC EVV Reason Codes found on the HHS website: HHS.Texas.gov/Providers/Long-Term-Care-Providers/Long-Term-Care-Provider-Resources/Electronic-Visit-Verification.

EVV TRAINING

What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:
  - EVV System training provided by the EVV vendor or EVV PSO;
  - EVV Portal training provided by TMHP; and
  - EVV Policy training provided by HHS or Community First.
- CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities:
  - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked in the EVV System;
    - EVV System training provided by the EVV vendor or EVV PSO;
    - Clock in and clock out methods; and
    - EVV Policy training provided by HHS, Community First or FMSA.
  - Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
    - EVV System training provided by EVV vendor or EVV PSO; and
    - EVV Policy training provided by HHS, Community First or FMSA.

  - Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
    - Overview of EVV Systems training provided by EVV Vendor or EVV PSO; and
    - EVV policy training provided by HHS, Community First or FMSA.
- Providers and CDS Employers must train service providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.
- For more information on Community First's EVV Training Requirement, please attend a vistual EVV Training session. Register on the secure online Community First Provider Portal.

EVV COMPLIANCE REVIEWS

What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by Community First to ensure providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.
- Community First will conduct the following reviews and initiate contract or enforcement actions if providers, FMSAs, or CDS Employers do not meet any of the following EVV compliance requirements:
  - EVV Usage Review: meet the minimum EVV Usage Score;
  - EVV Required Free Text Review: document EVV required free text; and
  - EVV Landline Phone Verification Review: ensure valid phone type is used.
- The Community First EVV Compliance Plan can be found online at Medicaid.CommunityFirstHealthPlans.com/Providers/EVV.

All Providers providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

- The HHSC Compliance Plan located at https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-termcare/evv/evv-compliance-oversight-reviews-policy.pdf
- The Community First EVV Compliance Plan located at Medicaid.CommunityFirstHealthPlans.com/Providers/EVV.
- Providers must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
- Providers must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
- Providers should notify Community First or HHSC within 48 hours of any ongoing issues with EVV vendor or issues with EVV systems.
- Any corrective action plan required by Community First is required to be submitted by the Provider to Community First within 10 calendar days of receipt of request.
- Failure of a Provider to comply with the HHSC EVV Program Initiative – Provider Compliance Plan and/or the guidelines of the Community First Agreement and Provider Manual will result in contractual action up to and including possible termination from the Community First network and report of the Provider to HHSC.
- Complaints regarding EVV vendor and general HHSC questions may be emailed to Electronic_Visit_Verification@hhsc.state.tx.us
- Complaints regarding EVV and Community First may be emailed to

HPM_Complaints@hhsc.state.tx.us

EVV CLAIMS

Are Provider and FMSAs required to use an EVV System to receive payment for EVV required services?
Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by Community First. Community First may deny or recoup an EVV claim that does not match an accepted visit transaction.

Where does a Provider or FMSA submit an EVV claim?
Providers and FMSAs must submit all EVV claims to the HHS Claims Administrator in accordance with Community First's submission requirements.

Providers must follow the standards outlined within the existing appeals process and include supporting EVV attendant data as applicable in order to substantiate claims payment. All EVV claims being appealed must be submitted to TMHP. Please see Claim Appeal Process within section XIV for more information.

EVV Claims Matching

What happens if a provider or FMSA submits an EVV claim to Community First instead of the HHS Claims Administrator?
If a provider or FMSA submits an EVV claim to Community First instead of the HHS Claims Administrator, Community First will reject or deny the claim and require the provider or FMSA to submit the claim to the HHS Claims Administrator.

What happens after the HHS Claims Administrator receives an EVV claim from a provider or FMSA?
The HHS Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHS Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHS Claims Administrator forwards the claim to Community First for final processing.

How does the automated EVV claims matching process work?
The claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to Community First once the claims matching process is complete. The following data elements from the claim line item and EVV transaction must match:
- Medicaid ID;
- Date of service;
- National Provider Identifier (NPI) or Atypical Provider Identifier (API);
- Healthcare Common Procedure Coding System (HCPCS) code;
- HCPCS modifiers; and
- Billed units to units on the visit transaction, if applicable.

Please Note: No unit match is performed on CDS EVV claims and unit match is not

performed on visit transactions against the billed units on the claim line item for specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch
- EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. Community First will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHS implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- Community First will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- Community First may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by HHS, Community First may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

How can a provider and FMSA see the results of the EVV claims matching process?
Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and Community First's system. Community First's Provider Portal also provides additional claims status information, such as whether Community First has paid or denied the claim. In addition, Community First provides an Explanation of Payment (EOP) to providers and FMSAs to inform them of whether Community First paid or denied the claim, and if denied, the reason for denial.

For more information, please review the EVV Portal Job Aids section on the TMHP EVV Training webpage at TMHP.com/Topics/EVV/EVV-Training.

Could Community First deny payment of an EVV claim even if the EVV claim

successfully matches the EVV visit transaction?
Yes. Community First may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a Member's loss of program eligibility or the provider's or FMSA's failure to obtain prior authorization for a service.

Is EVV Required for CDS Employers?
With the passage of the 21st Century Cures Act, the use of EVV will be required for individuals using the SRO/CDS option effective January 1, 2021. CDS employers have the option to choose from the following three options:

- Phone and Computer (Full Participation): The telephone portion of EVV will be used by your CDS employee(s) and you will use the computer portion of the system to perform visit maintenance.
- Phone Only (Partial Participation): This option is available to CDS employers who can participate in EVV, but may need some assistance from the FMSA with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS employee will call in when they start work and call out when they end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.
- No EVV Participation: If you do not have access to a computer, assistive devices or other supports, you do not feel you can fully participate in EVV, or you do not feel you can fully participate in EVV, you may choose to use a paper time sheet to document service delivery.

EVV Due Process Procedures for Recoupment of Overpayments: Missing EVV Information
Community First may periodically perform audits of EVV claims for a rolling 24 month lookback period.

In the event Community First identifies EVV claim overpayments Community First will provide written notice of the intent to recoup to the provider or FMSA within 30 days from the completion of the audit. If the provider or FMSA intends to dispute Community First's findings, a response to the written notice must be received by Community First within 30 business days.

Providers and FMSAs have 60 calendar days from the notice date to correct and explain the deficiencies related to EVV claims identified in the audit before Community First may begin recovery effort for the identified overpayments. Community First may only recover for claims where deficiencies have not been corrected within 60 calendar days.

PROVIDERS OF HOME HEALTH SERVICES RESPONSIBILITIES

All Providers, providing the mandated services, must use the EVV system and must maintain compliance. The HHSC Compliance Plan, including compliance standards and EVV guidelines as they relate to claims, training, reports, equipment, and corrective action plans, can be found at: HHS.Texas.gov/Providers/Long-Term-Care-Providers/Long-Term-Care-Provider-Resources/Electronic-Visit-Verification-EVV

Use of Reason Codes
Providers must use the most appropriate reason code to explain why each change was made when information is added or changed in the EVV system. For more information, please visit: HHS.Texas.gov/Providers/Long-Term-Care-Providers/Long-Term-Care-

Provider-Resources/Electronic-Visit-Verification-EVV

OTHER EVV QUESTIONS AND ANSWERS

How do Providers with assistive technology (ADA) needs use EVV?
If you use assistive technology and need to discuss accommodations related to the EVV system or materials, please contact these HHSC-approved EVV vendors:

DataLogic (Vesta) Software, Inc.	First Data Government Solutions/AuthentiCare
Phone: 1-888-880-2400 Sales & Training info@vestaevv.com Tech Support support@vesta.net Website: VestaEVV.com	Phone: 1-877-829-2002 Tech Support AuthentiCareTXSupport@firstdata.com Website: Solutions.Fiserv.com/Authenticare-TX

Will training be offered to Providers?
Providers should contact the following EVV vendors for training:

Vesta EVV
Website: VestaEVV.com/Training/
Phone: 956-412-1424
Fax: 956-412-1464
Email: info@vestaevv.com

First Data Government Solutions/AuthentiCare
Website: Solutions.Fiserv.com/Authenticare-TX
Phone: 1-877-829-2002
Email: AuthentiCareTXSupport@firstdata.com

Will claim payment be affected by the use of EVV?
Yes, claims can be denied and/or reduced in units and payment based on a Provider's compliance with the EVV guidelines.

- Providers must adhere to EVV guidelines in the Provider Compliance Plan when submitting a claim.
- Claims must be submitted within 95 calendar days of the EVV visit.

What if I need assistance?
Providers may contact Vesta EVV or First Data.

VII. QUALITY MANAGEMENT

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 QAPI 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 Quality Management (QM) 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's Members, the QM 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 Providers and their office staff.

To monitor quality of service, Community First's QM 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 Members, as well as 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 QM 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. Annually, Community First will submit the number of service coordinators receiving CDS training. 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.

OTHER PROGRAM ACTIVITIES

QM initiatives (clinical and non-clinical Performance Improvement Projects [PIPs], focus studies, medical record audits, etc.) are selected:

- Based on having the greatest potential for improving health outcomes or the quality of service delivered to Community First's Members and network providers;
- To test an innovative strategy; and
- To reflect distinctive regional emphasis on populations and cultures.

Community First's PIPs, focused studies and other QM initiatives are selected, designed and implemented in accordance with principles of sound research design and appropriate statistical analysis.

PARTICIPATION IN THE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

There are several ways that providers can participate in Community First's QAPI program. Providers can participate by:

- Volunteering for committee service. Community First has an active Quality Improvement Committee (QIC) structure that is comprised of physician peers. The QIC and its subcommittees provide the voice of the provider in determining the current community standard of care and in providing direction to the plan on clinical and non-clinical issues that are most relevant to Community First's Members. Stipends are usually provided for attendees.

- Being vocal. We are here to help providers. If there is a problem we do not know about, Community First wants to hear why you are not happy with the plan, as well as your suggestions for how to fix the problem. Community First would also like to hear about things we do well, to model other processes after our successes.

- Responding to surveys and requests for information. If we do not hear your opinion, it cannot be a factor in our decision making.

The Quality Improvement Committee (QIC)

This committee is an important link between Community First and its network providers. The QIC is comprised of contracted providers representing most geographic areas and a variety of specialties. Community First's Chief Medical Director appoints providers to the committee. Once appointed, Members are asked to serve a minimum of one year.

This committee advises the plan regarding proposed quality improvement activities and projects, evaluates the design as well as the results of clinical studies, reviews and approves clinical practice and preventive health-care guidelines and oversees the activities of the Utilization Management Committee (UMC). The QIC also serves as the Peer Review Committee (PRC) when reviewing significant quality of care issues involving network providers.

The Utilization Management Committee

The UMC is a subcommittee of the QIC. This committee focuses on evaluation and monitoring of the Utilization Management Program and reporting requirements, which includes review of criteria used for decision making as well as oversight of the denial and appeal processes. This committee reviews specific issues related to over-and under-utilization and assists in the development of interventions or processes to improve the

appropriateness of services available to and received by Community First's Members.

Committee Meeting Schedules
The QIC and UMC meet every other month, on alternating months. Meetings are scheduled at a time agreed upon by the committee Members and generally last one hour. Meetings are held at the Austin Community First office. Those Members unable to easily travel to the Austin location may participate by telephone.

If you have an interest in taking an active role on the QIC or UMC, please contact Provider Services.

PROVIDER PROFILING

In accordance with our HHSC contract, Community First adopted a formal profiling process as a tool to partner with PCPs, high-volume specialists and hospitals to improve care and services provided to Community First Members. The profiling process is intended to increase provider awareness of their performance, identify areas for process improvement and expand opportunities for Community First to work closely with providers in development, implementation and ongoing monitoring of site-based practice performance improvement initiatives. The Chief Medical Director has final authority and responsibility for the provider profiling program.

Program Goals
The following are Community First's goals for the provider profiling program:

- Increase provider awareness of performance in areas identified as key indicators.
- Motivate providers to establish measurable performance improvement processes in their practice sites relevant to Community First's Member populations.
- Identify the best practices of high-performing providers by comparing findings to the state average, other providers of the same type and (when possible) other comparable data.
- Increase opportunities for Community First to partner with providers to achieve measurable improvement in health outcomes.

Program Objectives
The following are Community First's objectives for the provider profiling program:

- Produce and distribute provider-specific reports containing meaningful, reliable and valid data for evaluation by the plan monthly for PCPs, and annually for acute care hospitals and high volume OB/GYNs and specialists.
- Establish and maintain an open dialogue related to performance improvement initiatives with identified providers.

Program Scope
Community First's provider profiling program includes monthly review of high-volume PCPs and annual reviews of high volume OB/GYNs, specialists and acute care hospitals.

On average, high-volume providers deliver services to 70 percent of Community First's membership. High-volume providers who participate in the STAR+PLUS program are included in the profiling activities.

PCP Provider Profiling Process
Community First provides PCP's monthly data through the 3M Health Information

Systems (HIS) dashboard which provides insight into actual patterns of care of their patients. 3M HIS provides data analytics to transform healthcare. 3M uses Community First claims data, risk adjusted, to provide providers with detail on, as available, gaps in care, emergency department information, inpatient admissions and readmissions, PCP visits for the providers attributed Members and potentially preventable events. The 3M Potentially Preventable Events (PPE) logic is included in the dashboard and provides a dynamic information for providers and Community First to understand and manage patients at risk of PPE. Further, 3M has a Value Index Score that captures provider quality in six domains: chronic and follow-up care, primary and secondary prevention, tertiary prevention, continuity of care, population health status and patient experience.

High-Volume OB/GYN, High-Volume Specialists, and Acute Care Hospital Provider Profiling Process

High-volume OB/GYNs, specialists, including behavioral health specialist providers, and hospitals are identified annually by Community First. Specific inclusion criteria are outlined in the table below.

Provider Type	Criteria	Data Source
High-Volume OB/GYNs	OB/GYN groups who served 50 or more Members during the reporting year.	Claims data.
High-Volume Specialists	Specialists who served 50 or more Members during the reporting year.	Claims data.
Acute Care Hospitals	Hospitals with 100 or more admissions during the reporting year.	Claims data.

When evaluating inclusion criteria or claims, the provider's total experience in all program types is used. Providers may be included in the profiles individually or as part of a group or system. Determination of providers included in the provider profiling process is the joint responsibility of select staff from the Quality Improvement, Medical Management, and Account Management departments.

All indicators are reviewed and approved by the QIC annually. Additionally, Community First disseminates all approved inclusion criteria, indicators and performance benchmarks to providers through the Provider Portal before each measurement cycle. All indicators selected for inclusion in the process must have the following characteristics:

- Indicator data must be reliable and valid.
- Reliable comparative data must be available.
- Indicator topics must be meaningful to the provider, the plan and the membership.
- The provider must have the capability to effect improvement in performance.

Once identified, Community First will continue reporting indicators over multiple cycles to identify measurable performance improvement at both the system and provider levels.

Quality Indicator Data Source

The analytical software that is used by Community First applies the concept of a peer definition to make comparisons. All peer definitions start with a specialty designation and include all providers of the same specialty for purposes of comparison. Thus, for the set of episodes or population a provider is attributed to, their performance is compared

to all participating same specialty providers in Community First's provider database.

Community First uses evidence-based medicine rules that can be measured in claims. These apply at the Member level. Performance is determined by comparing the compliance rate for the quality rules attributed to a provider to the compliance rate of the other providers in the peer definition for that exact same mix of attributed rules. A quality index is calculated by dividing a provider's compliance rate for the attributed rules by the compliance rate for the exact same mix of rules by their peers. Thus, an index greater than one would indicate that a compliance rate is greater than peers for the exact mix of attributed rules.

Provider Profile Analysis
Aggregate data on provider profiles is analyzed by the Community First's QIC. Select staff from the Quality Improvement, Medical Management and Account Management departments analyzes individual data. Analysis includes identification of outliers, generally defined as those providers in the top and bottom five percent of the aggregate scoring for their peer group.

Provider Practice Profiles in Recredentialing
A copy of each provider profile may be utilized as the quality report in the provider recredentialing process and may be filed with select credentialing files.

Provider Profile Distribution
The PCP profile is refreshed monthly and available through the provider's assigned log-in to the 3M HIS portal. The High-Volume OB/GYN, Specialist and Acute Care Hospital profile is mailed to select providers. Staff from the Clinical Engagement Team (CET) are available to assist with review of performance detailed in the provider profile. The service area Medical Director, Quality Practice Advisor and Chief Medical Director may accompany CET staff in visiting those providers identified as outliers. Standards used to measure the provider are available to the provider.

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 enrolled Members. Community First's QM 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 QIC annually and disseminated to providers via the provider e-newsletter, targeted mailings, and other media sources. The most up-to-date list of approved guidelines are available on the secure online Community First Provider Portal.

Community First's 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:
  - Provider orientations and other group sessions

- Provider e-newsletters
- Targeted mailings
- Guidelines are posted on Community First's website or paper copies are available upon request.

Office Site Survey
Community First's QIC has adopted guidelines for office sites. Community First may conduct a site visit to the office of any physician or provider at any time for cause. Community First will conduct the site visit to evaluate any complaints or other precipitating events, which may include an evaluation of any facilities or services related to the complaint and an evaluation of any/all of the following:

- Physical accessibility (provider offices are required to be accessible to Members with disabilities);
- Physical appearance;
- Adequacy of waiting and examining room space;
- Adequacy of medical/treatment record keeping;
- Appointment availability; and
- Equipment.

The survey will be conducted by Community First Account Management staff or designee or through a contracted vendor.

Once the survey is completed, it is scored. If the score is less than 80%, or if any elements in the "access for the disabled" section of the form are not met, the provider office is required to submit a corrective action plan to Community First within 30 days. Following submission of the corrective action plan, a second survey is scheduled within six months to evaluate compliance with office site guidelines.

If Community First receives another complaint about the same aspect of the performance for the office site within six months after completing the site visit, Community First will determine whether the practitioner's previous office site visit met the plan's standards and thresholds. If that is the case, Community First will follow up on the complaint and a subsequent visit is not required.

Survey Results
At the conclusion of an office site survey, the results will be reviewed with the Provider and/or a designated staff member. The provider may make a copy of the survey for their records. If there are deficiencies, the Provider may be asked to submit a corrective action plan.

Medicare Star Ratings
The Centers for Medicare and Medicaid Services (CMS) developed the Medicare Star Ratings system in order to provide information to consumers about Medicare Plans and to reward top-performing health plans. CMS developed a set of Quality Performance Ratings for Health Plans that includes specific clinical, Member perceptions and operational measures. The Star Ratings are drawn from various data sources including but not limited to: Healthcare Effectiveness Data and Information Set (HEDIS); Consumer Assessment of Healthcare Providers and Systems (CAHPS®); Healthcare Outcomes Survey (HOS).

How Can Providers Help to Improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Continue to talk to patients and document interventions regarding topics such as fall prevention, bladder control, and the importance of physical activity.
- Create office practices to identify noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all Members.
- Review the gap in care files listing Members with open gaps.
- Identify opportunities for Providers and office staff to make an impact.

Medicare Health Outcomes Survey

The Medicare Health Outcomes Survey (HOS) is a patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather data to help target quality improvement activities and resources by monitoring health plan performance and rewarding top-performing health plans and helping Medicare beneficiaries make informed health-care choices. Community First must participate in the Medicare HOS.

VIII. PROVIDER RESPONSIBILITIES

PCP (MEDICAL HOME) RESPONSIBILITIES

PCPs function as the medical home for Community First STAR+PLUS Members.

Primary Care Provider (or PCP) means a physician or Provider who has agreed with the MCO to provide a Medical Home to Members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Health Home means a primary care provider practice or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under Medicaid. The role of the Health Home is to provide Members with multiple chronic physical and emotional conditions with a team-based approach to care while covering a holistic array of services and supports extending beyond what can be provided by the Member's PCP. Health Homes operate in conjunction with two other entities; a primary care practice and/or a specialty care practice. Health Homes are designed to provide easy access to care between providers while ensuring quality of care continues.

To participate in the Medicaid Program, a Provider, with an agreement with HHSC or its agent, must have a Texas Provider Identification Number (TPIN). Medicaid providers also must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2008).

PROVIDER RIGHTS

1. To be treated by their patients, who are Community First Members, and other health care workers with dignity and respect.
2. To receive accurate and complete information and medical histories for Members' care.
3. To have their patients, who are Community First Members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital or other offices running smoothly.
4. To expect other network providers to act as partners in Members' treatment plans.
5. To expect Members to follow their health-care instructions and directions, such as taking the right amount of medication at the right times.
6. To make a complaint or file an appeal against Community First and/or a Member.
7. To file a grievance on behalf of a Member, with the Member's consent.
8. To have access to information about Community First quality improvement programs, including program goals, processes, and outcomes that relate to Member care and services.
9. To contact Provider Services with any questions, comments or problems.
10. To collaborate with other health-care professionals who are involved in the care of Members.
11. To not be excluded, penalized or terminated from participating with Community

First for having developed or accumulated a substantial number of patients in Community First with high cost medical conditions.

12. To collect Member copays, coinsurance and deductibles at the time of the service.

ROLE OF HEALTH HOME

The role of the health home is to provide Members with multiple chronic, physical, and emotional conditions with a team-based approach to care while covering an array of services and supports extending beyond what can be provided by the Member's PCP. Health homes operate in conjunction with two other entities: a primary care practice and/or a specialty care practice. Health Homes are designed to provide easy access to care between providers while ensuring quality of care.

Health homes must provide six core services:

1. Patient self-management education
2. Provider education
3. Evidence-based models and minimum standards of care
4. Patient-centered and family-centered care
5. Patient and family support (including authorized representatives)
6. Service Coordination

PROVIDER RESPONSIBILITIES

Providers must comply with each of the items listed below:

- Provide Community First's Members with a professionally recognized level of care and efficacy consistent with community standards, compliant with Community First's clinical and non-clinical guidelines, and within the practice of their professional license.
- Abide by the terms of your Community First Provider Participation Agreement.
- Comply with all of Community First's policies, procedures, rules and regulations, including those found in this Provider Manual.
- Facilitate inpatient and ambulatory care services at in-network facilities.
- Arrange referrals for care and service within the Community First network.
- Verify Member eligibility for authorizations or services.
- Ensure Member understands their right to obtain medication from any network pharmacy.
- Maintain confidential medical records consistent with Community First medical records guidelines and as applicable to HIPAA regulations.
  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.
- Maintain a facility that promotes patient safety.
- Participate in Community First's Quality Improvement program initiatives.
- Participate in provider orientations and continuing education.
- Abide by the ethical principles of their profession.
- Notify Community First if the Provider is undergoing an investigation, or has agreed to written orders by the state licensing agency.
- Notify Community First if a Member has a change in eligibility status by contacting Provider Services.

- Maintain professional liability insurance in the amounts that meet Community First credentialing requirements and/or state-mandated requirements.
- Notify Community First if there is a change in office address, tax ID number, or any other demographic changes.
- Inform Members on how to report abuse, neglect, and exploitation.
- Train staff on how to recognize and report abuse, neglect, and exploitation.
- Maintain enrollment status with Texas Medicaid.
- Comply with the requirements of Texas Government Code §531.024161 regarding the submission of claims involving supervised providers.
- Maintain the Participating Provider Conflict of Interest and Health Care Entity Financial Interest Policy and Disclosure statements to reflect current status. Further details about the designees and types of requests can be found within network provider contracts.
- Provide at no cost to HHSC or its delegates any requested records in accordance with the timelines, definitions, formats and instructions specified by HHSC.

PLEASE NOTE: Texas Medicaid will deny claims for prescriptions, items and services ordered, referred or prescribed for any Medicaid, 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 instate and out-of-state providers.

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, 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. Practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner. To request release of such information, a written request must be submitted to the Credentialing department. Upon receipt of this information, the practitioner will have 30 days from the initial notification to provide a written explanation detailing the error or the difference in information to the Credentialing Committee. The credentialing Committee will then include this information as part of the credentialing or re-credentialing process.

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 Community First Network Management Department at **210-358-6294**.

Practitioner Right to Appeal Adverse Initial and Re-credentialing Determinations
Applicants who are existing providers and who are declined continued participation due to adverse recredentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an

appeal must be made in writing within 14 days of the date of the notice.

New applicants who are declined participation may request reconsideration within 30 days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than 60 days from the receipt of the additional documentation.

INTEGRATING PHYSICAL HEALTH/BEHAVIORAL HEALTH IN HEALTH HOMES

Medicaid health homes provide states with an important opportunity to integrate physical and behavioral health care for beneficiaries with complex care needs. Although states have considerable flexibility to define health home services and Provider qualification as they see fit, effective integration of physical and behavioral health services is a critical aspect of program design.

PCPs are responsible for arranging and coordinating appropriate referrals to other providers and specialists within the network, and for managing, monitoring, and documenting the services of other providers.

- PCPs must comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations, and
- Otherwise conduct themselves in a businesslike and professional manner.
- A PCP is required to refer a Member to a specialist when medically necessary care is needed beyond the scope of the PCP.
- A Member should be referred to a specialist by their PCP.
- A specialist cannot refer to another specialist. All Member care should be coordinated through the PCP.
- PCPs are required to request authorization for services requiring authorization.
- PCPs must document the coordination of referrals and services provided between the PCP and specialist.

PCPs are responsible for the appropriate coordination and referral of Community First STAR+PLUS Members for the following services:

- CPW Case Management Services
- ECI Case Management Services
- MR Targeted Case Management
- Texas Commission for the Blind Case Management Services
- Tuberculosis services
- Community First's pharmacy program through Navitus

AVAILABILITY AND ACCESSIBILITY

Network PCPs must be accessible to STAR+PLUS Members 24 hours a day, 7 days a week, or make other arrangements for the provision of availability and accessibility. The following are acceptable and unacceptable phone arrangements for network PCPs after normal business hours.

Acceptable:

1. Office phone is answered after hours by an answering service, which meets language

requirements of the major population groups, and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.

2. Office phone is answered after normal business hours by a recording in the language of each of the major population groups served directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's phone. A second recorded message is not acceptable.
3. Office phone is transferred after hours to another location where someone will answer the phone and be able to contact the PCP or another designated provider.

Unacceptable:

1. The office phone is only answered during office hours.
2. The office phone is answered after hours by a recording, which tells patients to leave a message.
3. The office phone is answered after hours by a recording, which directs patients to go to an emergency room for any services needed.
4. The answering machine is not bilingual (English and Spanish).
5. Returning after-hours calls outside of 30 minutes.

Please Note: If after hours urgent care or emergent care is needed, the PCP or their designee should contact the urgent care or emergency center to notify the facility.

Updates to contact information. Network Providers must inform both Community First and TMHP of any changes to the Provider's address, telephone number, and/or group affiliation.

Access and Availability Standards. The purpose of these guidelines is to ensure that health services are available and accessible to Community First Members. Because Community First contracts with a closed panel of practitioners, it is essential that we have a sufficient number of practitioners in our network who are conveniently located to serve our enrollees. By monitoring compliance with these guidelines, Community First can identify opportunities to improve our performance, and to develop and implement intervention strategies to affect any necessary improvement.

Community First has PCPs available throughout the service area to ensure that no Member must travel more than 30 miles, or 45 minutes, whichever is less, to access the PCP.

Community First Providers must be available to Members by telephone 24 hours a day, 7 days a week for consultation and/or management of medical concerns.

The following standards are established regarding appointment availability:

- A full-time practice is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week.
- Emergency services must be provided upon the Member's presentation at the service delivery site, including at non-network and out-of-area facilities.
- Urgent care, including urgent specialty care, must be provided within 24 hours.
- Routine primary care must be provided within 14 days.

- Initial outpatient behavioral health visits must be provided within 14 days.
- Routine specialty care referrals must be made on a timely basis, based on the urgency of the Member's medical condition, but no later than five days.
- Prenatal care must be provided within 14 days, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists.
- Preventive health services for adults must be offered within 90 days of the request. Community-Based LTSS Enrollees must be initiated within seven days from the start date on the ISP or the eligibility effective date for non-waiver LTSS unless the referring provider, enrollee or STAR+PLUS handbook states otherwise.

Please Note: Providers are prohibited from restricting or limiting their office hours for Medicaid or Medicare Members.

Type of Care	Example	Appointment Availability	Primary Provider Type
"Emergency Care" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in: • Death, placing the Member's health in serious jeopardy, permanent impairment of bodily functions, serious dysfunction of any bodily organ or part. • With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.	Radiating chest pain, severe shortness of breath.	Services must be provided upon Member presentation at the service delivery site.	PCP, Specialist, Hospital.
"Urgent Care" is defined as a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that their condition requires medical evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health. "Urgent Behavioral Health Situation" is defined as a behavioral health condition that requires attention and assessment within 24 hours but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.	Fever, persistent vomiting, wants to hurt or has thoughts about hurting themselves or others.	Appointment must be offered within 24 hours of the request, including urgent specialty care.	PCP, Specialist.

Type of Care	Example	Appointment Availability	Primary Provider Type
"Routine Primary Care" is defined as health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.	Services designed to prevent disease, to detect disease and treat early, or to manage the course of disease effectively.	Within 14 days of request.	PCP
Routine Specialty Care.	Referral for non-urgent condition.	Within 21 days of request.	Specialist.
Preventive Health Services for Adults.	Annual physical, well women examination.	Within 90 days of request	PCP, Gynecologist.
Prenatal Care.	Routine prenatal care visits.	Within 14 days of request.	Obstetrical services providers.
High risk pregnancy or new Member in the third trimester.	Bleeding, no previous prenatal care.	Within 5 days of request or immediately if an emergency exists.	Obstetrical services providers.
Routine Initial Visits and Follow-Up Behavioral Health Care.	Acute/chronic psychiatric and substance use disorders.	Within 14 days of request.	Behavioral Health Care Provider, Psychologist

Covering Providers. PCPs must arrange for coverage with another Community First contracted provider during scheduled or unscheduled time off. Covering providers must have an active National Provider Identifier (NPI) number in order to receive payment. For provision of services to Medicaid Members, providers must also be actively enrolled in Texas Medicaid.

Member Education. Community First abides by state contractual agreements to ensure we provide appropriate cultural and linguistic services for our Members. Materials are also made available in large print, braille and on 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:

- Member Handbooks
- Member biannual newsletter
- Member monthly e-newsletters
- Targeted Disease Management brochures
- Provider Directories
- Community First website
- Special mailings

PLAN TERMINATION PROCESS

Community First or the participating provider may terminate their contractual agreement as of any date by giving written notice of at least sixty (60) days in advance. The parties may, however, agree to an earlier termination date. Community First may also terminate this agreement immediately upon notice to the Provider in the event of Community First's determination that the health, safety, or welfare of any STAR+PLUS Member may be in jeopardy if the agreement is not terminated. Providers may refer to the Term and Termination section of their Professional Provider Agreement for more information.

The Provider's contract contains Community First's process for termination.

Community First follows the procedures outlined in INS § 843.306 if terminating a contract with a Provider, including an STP. At least 90 days before the effective date of the proposed termination of the Provider's contract, Community First will provide a written explanation to the Provider of the reasons for termination. Community First may immediately terminate a Provider contract in a case involving:

1. Imminent harm to patient health.
2. An action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency, that effectively impairs the Provider's ability to practice medicine, dentistry, or another profession.
3. Fraud or malfeasance.

Not later than 30 days following receipt of the termination notice, a Provider may request a review from Community First proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a license, or fraud or malfeasance. The advisory review panel must be composed of physicians and providers, as those terms are defined in INS § 843.306, including at least one representative in the Provider's specialty or a similar specialty, if available,

appointed to serve on the standing quality assurance committee or utilization review committee from Community First. The decision of the advisory review panel must be considered by Community First but is not binding of Community First. Within 60 days following receipt of the Provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and Community First will communicate its decision to the Provider. Community First will provide to the affected Provider, upon request, a copy of the recommendation of the advisory review panel and Community First's determination.

Termination for Gifts or Gratuities. Providers may not offer or give anything of value to an officer or employee of HHSC or the state of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Community First may terminate the provider contract at any time for violation of this requirement.

MEMBER'S RIGHT TO DESIGNATE AN OB/GYN

Community First does not limit the selection of an OB/GYN to the PCP's network.

Female Members have the right to select an OB/GYN without a referral from their PCP. The access to health care services of an OB/GYN includes:

- One well-woman checkup per year
- Care related to pregnancy
- Care for any female medical condition
- Referral to special doctor within the network

ADVANCE DIRECTIVES

The Provider must comply with the requirements of state and federal laws, rules, and regulations relating to advance directives. Providers must inform Members, 18 years of age and older, of their right to refuse, withhold, or withdraw medical and mental treatment, and the rights of the Member or Member's representative to facilitate medical care or make treatment decisions when the Member is unable to do so as stipulated in the Advance Directives Act, Chapter 166, Texas Health and Safety Code: http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.166.htm.

It's the Member's right to accept or refuse medical care. Advance directive can protect this right if they ever become mentally or physically unable to choose or communicate their wishes due to an injury or illness. To request additional information or to request a brochure about advance directives the Member can contact Member Services at **210-358-6105** or toll-free at **1-844-382-2347**.

REFERRAL TO SPECIALISTS AND HEALTH-RELATED SERVICES

PCPs are responsible for assessing the medical needs of STAR+PLUS Members for referral to specialty care providers and to provide referrals as needed. The PCP must coordinate Member's care with the specialty care providers after referral. Community First will assess PCPs actions in arranging and coordi¬nating appropriate referrals to other providers and specialists, and for managing, monitoring, and documenting the

services of other Providers.

PCP AND BEHAVIORAL HEALTH SERVICES

A PCP may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of his training and/or practice.

REFERRAL TO NETWORK FACILITIES AND CONTRACTORS

The PCP or specialist may directly refer a Member for services that do not require preauthorization. All referrals must be to a Community First Network Provider. Community First's Provider network may occasionally change. Contact the Network Management Department at **210-358-6294** for current provider information. Use of a non-participating provider requires preauthorization by Community First. The specialist must communicate with the PCP regarding services rendered, results, reports, and recommendations to ensure the continuity and quality of care.

Please Note: Payment for services requiring notification or preauthorization is contingent upon verification of current eligibility and applicable contract specifications at the time of service. For verification of eligibility call **210-358-6105**.

ACCESS TO A SECOND OPINION

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 participant in 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 will 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.

SPECIALTY CARE PROVIDER RESPONSIBILITIES

Availability and Accessibility. Network specialists must be accessible to STAR+PLUS Members 24 hours a day, 7 days a week, or make other arrangements for the provision of availability and accessibility. The following are acceptable and unacceptable phone arrangements for network specialists after normal business hours.

Acceptable:

1. Office phone is answered after hours by an answering service, which meets language requirements of the major population groups, and who can contact the specialist or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
2. Office phone is answered after normal business hours by a recording in the language of each of the major population groups served directing the patient to call another number to reach the specialist or another Network Provider designated by the

specialist. Someone must be available to answer the designated Network Provider's phone. A second recorded message is not acceptable.

3. Office phone is transferred after hours to another location where someone will answer the phone and be able to contact the specialist or another designated Network Provider.

Unacceptable:

1. The office phone is only answered during office hours.
2. The office phone is answered after hours by a recording, which tells patients to leave a message.
3. The office phone is answered after hours by a recording, which directs patients to go to an emergency room for any services needed.

Members with disabilities, special health care needs, and chronic or complex conditions are allowed to have direct access to a specialist. The network specialist must agree to perform all PCP duties, and such duties must be within the scope of the participating specialist's certification. Please refer to the Specialist as a Primary Care Provider in the Introduction section of this Provider Manual for further information.

ACCESS STANDARDS	
Appointment Type	**Appointment Availability**
Emergency care, including behavioral health	24 hours a day, 7 days a week, upon Member presentation at the delivery site, including non-network and out-of-area facilities
Urgent care (PCP) (Specialist) (Behavioral health)	Within 24 hours of request Within 24 hours of request Within 24 hours of request
Routine care (PCP) (Specialist) (Behavioral health) Routine/scheduled inpatient/outpatient care	Within 14 days of request Within 14 days of request Within 14 days of request
Behavioral health discharge planning/ aftercare	Members discharged from an impatient setting must have a scheduled follow-up outpatient appointment within seven (7) days after discharge. Members should be strongly encouraged to attend and participate in aftercare appointments.
Initial outpatient behavioral health visits	Within 14 days of request
Routine specialty care referrals	Within 21 days of request
Physical examinations	56 days or less (4 to 8 weeks)

ACCESS STANDARDS	
Appointment Type	**Appointment Availability**
Prenatal care (Initial)	14 calendar days or less or by the 12th week of gestation. Members who express concern about termination will be addressed as urgent care.
High-risk pregnancies or new Members in the third trimester	Within five (5) days or immediately if an emergency exists.
Preventive health services for adults	Within 90 days of request in accordance with US Preventive Service Task Force recommendations
Physical Therapy	Within 24 hours (urgent) 3 days or less (routine) 14 days or less (follow-up)
Radiology	Within 24 hours (urgent) 7 days or less (MRI/CT Scan) 10 days or less (IVP/UGI) 21 days or less (Mammogram)
Home Health/DME/Supplies (OT, PT, ST SNV, etc.)	Within two (2) hours for IV therapy or oxygen therapy. Within 24 hours for standard nursing care and delivery of non-urgent equipment. Significant changes in health status of the patient are to be relayed to the attending physician within four (4) hours of detection.
Provider office waiting time	Within 30 minutes of scheduled appointment time
Requests for feedback from pharmacy related to prescriptions	Within 24 business hours

VERIFYING MEMBER ELIGIBILITY AND/OR AUTHORIZATION FOR SERVICES

All reimbursement is subject to eligibility and contractual provisions and limitations.

Each STAR+PLUS Member is issued a Your Texas Benefits Medicaid Card and a plan (i.e., Community First) ID card. We instruct the STAR+PLUS Member to present both ID cards when requesting services. The Community First Member ID card shows important Member information and important Community First telephone numbers.

At the time of the visit, ask the Member to show both forms of ID. The Your Texas Benefits Medicaid Card will verify coverage for the current month only, identify if the cardholder is a STAR+PLUS Member, and state the name of the plan. The Community First ID card and Medicaid ID forms do not guarantee eligibility for coverage. To verify eligibility, log on to the secure online Community First Provider Portal at CommunityFirstHealthPlans.com/ProviderPortal or call Member Services at **1-844-382-2347.**

Eligibility may also be obtained through TMHP's Automated Inquiry System (AIS) or TMHP's Electronic Data Interchange (EDI). If conflicting PCP information is found, please contact Community First Member Services for assistance. Providers must document this verification in their records and treat the client as usual.

PCP information is not shown on the Texas Benefits Medicaid Card and is only printed on the Community First ID card (for non-dual Members). Listed below are helpful ways to verify eligibility:

- Call Community First Member Services at **210-358-6105** or toll-free **1-844-382-2347**.
- Log in to the Community First Provider Portal.
- Review the temporary ID (Form 1027A), which is issued when the Member's Texas Benefits Medicaid Card is lost or stolen, or temporary emergency Medicaid is granted.
- Call the AIS Line at **512-345-5949** or **1-800-925-9126.**

If a Member has questions about benefit coverage or wants to change to a different PCP, please ask them to call our Member Services at **1-844-382-2347**.

Community First will arrange for all covered services for the period STAR+PLUS Members are eligible with Community First, except as follows:

- **Inpatient admissions prior to enrollment with Community First.** Community First is responsible for physician and non-hospital services from the date of enrollment with Community First. Additionally, Community First is not responsible for any hospital charges for Members admitted prior to enrollment with Community First.
- **Inpatients after enrollment with Community First.** Community First is responsible for services until they discharge the Member from the hospital, unless the STAR+PLUS Member loses Medicaid or STAR+PLUS eligibility.
- **Discharge after voluntary disenrollment from Community First and re-enrollment into a new STAR+PLUS HMO.** Community First remains responsible for hospital charges until the STAR+PLUS Member is discharged from the facility. The new STAR+PLUS HMO is responsible for physician and non-hospital charges beginning on the effective date of enrollment into the new STAR+PLUS HMO.
- **Hospital Transfers.** Discharge from one hospital and readmission or admission to another hospital within 24 hours for continued treatment should not be considered as discharged under this section.
- **Psychiatric Care.** Inpatient psychiatric care, in a freestanding psychiatric facility for STAR+PLUS Members, is Community First's responsibility from the Member's date of enrollment with Community First.

Please Note: Community First's responsibilities shown above are subject to the contractual requirements between Community First and Provider (i.e., referral and claims submission requirements).

The PCP is responsible for initiating all referrals to specialty care providers.

Community First currently requires preauthorization for services listed on the authorization list at Medicaid.CommunityFirstHealthPlans.com/Provider-Prior-Authorizations.

The list of services requiring preauthorization is subject to change. Community First will provide at least 90 days notice of changes in the list of authorized services.

If the Provider seeking authorization is a specialty physician, communication must be provided to the PCP regarding services rendered, results, reports, and recommendations to ensure continuity of care.

Please Note: Pre-authorizations are generally valid for 30 days from the date issued; this timeframe may be extended based on the type of request. Hospital confinements and inpatient or outpatient surgeries are valid only for the requested and approved days. If preauthorization expires, call Community First. All services listed on the preauthorization list will be subject to medical necessity review in advance of the services being rendered. Failure to obtain preauthorization in advance of the service being rendered will result in an administrative denial of the claim. Providers cannot bill STAR+PLUS Members for covered services.

PCPs and specialists may request preauthorization as follows:

- Call Community First Population Health Management Department at **210-358-6055**.
- Fax the completed Texas Standard Prior Authorization Request Form for Health Care Services to **210-358-6274**.
- Submit secure electronic requests using the secure online Community First Provider Portal. (To create an account, go to CommunityFirstHealthPlans.com/ProviderPortal)

The Population Health Management Department is available to answer the preauthorization telephone lines from 8:30 a.m. to 5:00 p.m. (CST), Monday through Friday. After hours and on weekends or holidays we will accept either your fax or phone message as meeting notification requirements, however, authorization of the services listed on the preauthorization list will need to meet eligibility, medical necessity review, and benefit criteria prior to issuance of an authorization number. You may call Community First to check on the status of your preauthorization request at **210-358-6105** during regular business hours.

Please have the following information available when requesting pre-authorization:

- Member's name and ID number
- Primary diagnosis with ICD-10 Code, if known
- Surgery/Procedure with CPT Code, or purpose and number of visits
- Anticipated date of service or admission date
- Name of consultant/facility
- Clinical information to support the requested service
- Expected length of stay (inpatient only)

The Population Health Management Department will issue an authorization number for approved requests after eligibility, medical necessity, and benefit criteria has been determined. Faxed requests will be faxed back to the requesting provider including the authorization number if the service/s has been approved. Telephone requests will receive an authorization telephonically if the service/s is being approved.

If a request is pended because information is incomplete, the Provider will be contacted.

Once we receive the required information, we will either approve the request or send the information to the Community First Medical Director for final review. If we do not receive the required information, the services will be denied by the Medical Director or Clinical Consultant for lack of requested information.

Community First will deny requests that do not meet eligibility, benefit criteria, or medical necessity criteria. Community First will afford the requesting provider reasonable opportunity to discuss with the Medical Director or Clinical Consultant the plan of treatment and the clinical basis for the decision, as well as the opportunity to provide additional information that may be pertinent prior to the issuance of an adverse determination. We will notify the Provider by phone and letter, either by fax or mail, within 48 hours. The STAR+PLUS Member is sent a denial letter by mail. If the authorization request is denied based on medical necessity, the Provider can appeal the decision on behalf of the Member. The appeal information will be on the denial letter.

Verifying Member Eligibility
Each Member approved for STAR+PLUS benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the Member has current coverage. It is imperative that providers verify the Member's eligibility for the date of service prior to services being rendered. There are two ways to do this:

HHSC Resources
Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.

- Use TexMedConnect on the TMHP website at TMHP.com.
- Call Provider Services at the patient's medical or dental plan.

Member Identification Card
All STAR+PLUS Members will receive a Community First Member identification card. Below are samples of STAR+PLUS Member identification cards.

Please Note: Presentation of a Member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

TRANSITION AND CONTINUITY OF CARE

Continuity of Care
Community First will ensure newly enrolled Members will continue to have access to medically necessary items, services, and prescription drugs as well as medical, behavioral

health, and LTSS providers during the transition period.

- Members will be allowed to maintain their current providers for 90 days from the date of enrollment.
- Members will be allowed to maintain their current LTSS providers for up to 6 months after initial enrollment or until the Comprehensive Health Risk Assessment has been completed and the enrollee has signed the Integrated Plan of Care. Members who have a terminal illness at the time of enrollment have up to nine months.
- Members will be allowed to maintain their preauthorized services for the duration of the prior authorization or six months from enrollment, whichever is sooner. Members who have a terminal illness will also be allowed to maintain their preauthorized services for the duration of the prior authorization or nine months from enrollment, whichever is sooner.

Community First will also advise, in writing, both Members and Providers, when a Member has received care that would not otherwise be covered at an in-network level. Community First will contact Non-Contracted Providers to inform them of the procedure for becoming an In-Network Provider.

Special Situations
There are situations that arise when Community First may need to approve services that are out-of-network. Community First may need to provide authorization for continuity in the care of a Member whose health condition has been treated by a specialty care provider or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted. In these cases, Community First may provide authorization to a non-contracted provider to provide the medically necessary until the transition to a network provider may be completed.

The following are circumstances in which continuity of care apply. Pre-existing conditions are not imposed.

- **Individuals Residing in a Nursing Facility Prior to Effective Date.** Individuals residing in Nursing Facilities prior to their effective date with Community First may remain in the facility as long as they continue to meet HHSC criteria for nursing home care, unless they or their families prefer to move to a different nursing facility or return to the community. During the transition period, a change from the existing Provider can only occur in the following circumstances:
  - The Member requests a change.
  - The Provider chooses to discontinue providing services to a Member as currently allowed by Medicare or Medicaid.
  - Community First, CMS, or HHSC identifies Provider performance issues that affect a Member's health and welfare.
  - The Provider is excluded under state or federal exclusion requirements.

- **Pregnant Women.** Continuity of care for pregnant Members with 12 weeks or less remaining before the expected delivery date extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery. The Member will be allowed to stay under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the Provider is out-of-network. If the Member wants to change her OB/GYN to one who is in the plan, she will be allowed to do so if the Provider to whom she wishes to transfer agrees to

accept her in the last trimester using the "Request for Continuity/Transition of Care Form" (Exhibit 1).

- **Community-Based Long-Term Care Services.** At the time of new program implementation, Community First will provide continued authorization for services prior authorized for a period not to exceed six months or until a new assessment iscompleted and a new authorization is issued, whichever comes first.
- **A Member that Moves Out-of-Area.** Community First will reimburse out-of-network providers for covered services rendered to STAR+PLUS Members who move out of Community First's service area through the end of the period for which a premium has been paid for the Member. Preauthorization must be obtained for all out-of-network services. Requests for preauthorization can be submitted by fax to Community First's Population Health Management Department at 210-358-6274 or requested by phone at 210-358-6105.
- **Pre-existing Conditions.** Community First is responsible for arranging for the provision of all covered STAR+PLUS services to each eligible Community First STAR+PLUS Member beginning on the STAR+PLUS Member's date of enrollment, regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services; health status; confinement in a health care facility; or for any other reason. All arrangements for covered STAR+PLUS services will be in accordance with contractual requirements between Community First and the Provider.

Community First is also responsible for arranging the provision of all necessary, covered STAR+PLUS services (including services not available in-network)for each eligible STAR+PLUS Member, including Members receiving Community-based Services or any other service on the STAR+PLUS Operational Start Date.

Transition of Care

A transition in care for a Member is defined as a point at which the Member's care is transferred from one Provider to another or from a facility to another level of care. Examples of transitions in care include the following:

- A referral from a PCP to a specialist
- An admission to a hospital or a discharge from a hospital to home care or a skilled nursing facility

When a Member experiences a transition in care, it is the responsibility of the transferring Provider to do the following:

- Notify the Member in advance of a planned transition.
- Provide documentation of the care plan to the receiving institution or provider within 24 hours of the transition.
- Communicate with the member about the transition process.
- Communicate with the member about their health status and plan of care.
- Notify the Member's usual practitioner of the transition within three business days after notification of the transition.
- Provide a treatment plan/discharge instructions to the member prior to discharge
- Notify the Member's Community First Service Coordinator.

The provider is an integral part of effectively managing transitions. Communication is

the key with both the member and other treating providers. To prevent duplicate testing and provide critical information about the member, the following processes should be followed:

- The referring physician or provider should provide the relevant patient history to the receiving provider.
- Any pertinent diagnostic results should be forwarded to the receiving provider.
- The receiving provider should communicate a treatment plan back to the referring provider.
- Any diagnostic test results ordered by the receiving provider should be communicated to the referring provider.

Transition Plan for New Members
Community First will provide a transition plan for a member newly enrolled with Community First who is already receiving long-term services and supports, including nursing facility services.

HHSC, or the previous STAR+PLUS MCO, will provide Community First with information such as detailed care plans and names of current providers. Community First will ensure that current providers are paid for medically necessary and functionally necessary covered services that are delivered in accordance with the member's existing care plan beginning with the member's date of enrollment with Community First until the transition plan is developed and implemented.

The transition planning process will include the following:

- Review of existing care plans prepared by HHSC or another STAR+PLUS MCO
- Preparation of a transition plan that ensures continuous care under the member's existing care plan during the transfer into Community First's network while conducting an appropriate assessment and development of a new plan (if needed)
- If durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the date of enrollment, Community First will coordinate and follow through to ensure that the member receives the necessary supportive equipment and supplies without undue delay
- Payment to the existing provider of service under any existing authorization for up to six months, until we have completed the assessment and service plan and issued a new authorization

Community First will review any existing care plan for a new member and develop a transition plan within 30 days of receiving notice of the member's enrollment. The transition plan will remain in place until we contact the member or the member's representative, and we coordinate modifications to the member's current care plan. We will ensure that existing services continue and there is no break in services. A transition plan will include the following:

- The member's history
- A summary of current medical, behavioral health and social needs and concerns
- Short-term and long-term needs and goals
- A list of services required and their frequency
- A description of who will provide the services

The transition plan may include information about services outside the scope of covered services such as how to access affordable, integrated housing. Community First will ensure the member or the member's representative is involved in the assessment process and fully informed about options, is included in the development of the transition plan, and is in agreement with the plan when completed.

PCPs and specialists can call the Population Health Management Department at 210-358-6055 to address any continuity/transition of care issues or fax a completed Request for Continuity/Transition of Care form to 210-358-6274.

MEDICAL RECORDS DOCUMENTATION GUIDELINES

Community First has established guidelines for medical record documentation. Individual medical records for each family member are to be maintained. The medical records must be handled in a confidential manner and organized in such a manner that all progress notes, diagnostic tests, reports, letters, discharge summaries, and other pertinent medical information are readily accessible, and that the events are documented clearly and completely. In addition, each office should have a written policy in place to ensure that medical records are safeguarded against loss, destruction, or unauthorized use.

Community First follows guidance from the Centers for Medicare and Medicaid regarding 1997 CMS documentation and coding guidelines; the National Correct Coding Initiative; Global Surgical Period; Physician Signature Guidelines; and current American Medical Association (AMA) Current Procedural Terminology (CPT) and International Classification of Diseases (ICD-10). The Texas Medicaid Provider Procedures Manual also recognizes guidelines from the Centers for Medicare and Medicaid regarding medical record documentation standards for coding and billing.

The Administrative Simplification Act of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that AMA's CPT and ICD-10 CM systems be used to report professional services, including physician services and diagnoses. Correct use of CPT and ICD-10 coding requires using the most specific code that matches the services provided and illnesses based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

Amendment to Medical Records. Community First follows guidelines for the amendment of medical records as outlined in 22 Tex. Admin. Code § 165.1.

- The Provider must have specific recollection of the services provided which is documented.
- A Provider may add a missing signature without a time restriction if the Provider created the original documentation him/herself.
- The above does not restrict or limit the Provider's ability to document or amend

medical records at any time to more accurately describe the clinical care provided to the patient.
- For medical record review/audit and reimbursement purposes, documentation is not considered appropriate and/or timely documented if originally completed after 30 days of the date of service.

Definitions

Late entry means the addition of information that was omitted from the original entry. The late entry is added as soon as possible, reflects the current date, and is documented and signed by the performing provider who must have total recollection of the service provided.

Addendum means the provision of additional information that was not available at the time of the original entry. The addendum should be timely, reflect the current date, Provider signature and the rational for the addition or clarification of being added to the medical record.

Correction means revisions of errors from the original entry, which make clear the specific change made, the date of the change and the identity of the person making the revision. Errors must have a single line through the incorrect information that allows the original entry to remain legible. The correct information should be documented in the next line or space with the current date and time, referring back to the original entry.

Medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of HIPAA and other federal and state laws.

JUSTIFICATION FOR OUT-OF-NETWORK AUTHORIZATIONS

Community First's requirements concerning treatment of Members by out-of-network providers are as follows:

1. Community First will allow referral of its Member(s) to an out-of-network provider; issue the proper authorization for such referral in a timely manner; and timely reimburse the out-of-network provider for authorized services provided when:
   - Medicaid covered services are medically necessary and these services are not available through a Network Provider.
   - A Provider currently providing authorized services to the Member requests authorization for such services by an out-of-network provider.
   - The authorized services are provided within the time period specified in the authorization issued by Community First. If the services are not provided within the required time period, a new request for preauthorization from the requesting Provider must be submitted to Community First prior to the provision of services.
2. Community First may not refuse to reimburse an out-of-network provider for emergency or post-stabilization services provided as a result of the Community First failure to arrange for and authorize a timely transfer of a Member to an in-network facility.
3. Community First's requirements concerning emergency services are as follows:
   - Community First must allow its Members to be treated by any emergency

services provider for emergency services and/or for services to determine if an emergency condition exists.
- Community First is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists.

4. Community First may be required by contract with HHSC to allow Members to obtain services from out-of-network providers in circumstances other than those described above.

Reasonable Reimbursement Methodology. Community First reimburses out-of-network providers in accordance with 1 Tex. Admin. Code, Part 15, Chapter 355:

- For a date of service on or after 02/20/2010, out-of-network/in-area providers were reimbursed at Medicaid minus 5 percent in accordance with the change in 1 Tex. Admin. Code, Part 15, Chapter 355.
- Out-of-network/out-of-area providers requesting reimbursement at 100 percent of Medicaid rates are considered if a timely request for authorization is obtained, which includes the requirement to request 100 percent of the Medicaid rate at the time of the request for authorization. If the service(s) are approved, the request for the 100 percent Medicaid rate will be forwarded to Network Management to address the requested rate with the Provider.

OPTOMETRY AND OPHTHALMOLOGY SERVICES

Members have the 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.

ACCESS TO MEDICATION

Members have the right to obtain medication from any network pharmacy.

HOW TO HELP A MEMBER FIND DENTAL CARE

The Member's Dental Plan Member ID card will list the name and phone number of a Member's Main Dental Home Provider. The Member can contact the dental plan to select a different Main Dental Home Provider at any time. If the Member selects a different Main Dental Home Provider, the change is reflected immediately in the dental plan's system, and the Member is mailed a new ID card within 5 business days.

If a Member does not have a dental plan assigned or is missing a card from their dental plan, the Member can contact the Medicaid enrollment broker's toll-free telephone number at **1-800-964-2777**.

CONFIDENTIALITY

The Provider must treat all information that is obtained through the performance of the services included in the Provider contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs.

The Provider may not use information obtained through the performance of the Provider contract in any manner except as is necessary for the proper discharge of obligations and securing of rights under the contract.

FRAUD, WASTE, AND ABUSE

The Medicaid programs include an important element of fraud, waste and abuse prevention, which requires the cooperation and participation of Community First's contracted providers in prevention and reporting of potential fraud, waste or abuse. Community First has a fraud, waste and abuse plan that complies with state and federal law, including Texas Government Code § 531.113, Texas Government Code § 533.012, 1 Tex. Admin. Code §§ 353.501- 353.505, and 1 Tex. Admin. Code §§ 370.501-370.505. It is your responsibility as a participating provider to report any Member or Provider suspected of potential fraud, waste or abuse. All reports will remain confidential.

Reporting Fraud, Waste, or Abuse

Let Community First 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 waste, abuse, or fraud, which is against the law. For example, tell Community First if you think someone is:

- Getting paid for services that were not provided or necessary.
- Upcoding for services provided to receive higher reimbursement.
- Unbundling when billing for services provided.
- Using someone else's Medicaid ID.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Not telling the truth about the amount of money or resources they have to get benefits.

Information Needed to Report Fraud, Waste, or Abuse

When reporting a provider (doctor, dentist, therapist, pharmacist, etc.) include as much information as possible, such as:

- Name, address and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- NPI of the provider.
- Dates of events.
- Type of provider (physician, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can aid in the investigation.
- Summary of what happened.

When reporting a Member (a person who receives benefits), include:

- The person's name.
- The program in which the Member is/was enrolled (STAR+PLUS).
- The city where the person resides.
- The person's date of birth, social security number or case number if available.
- Specific details about the fraud, waste or abuse.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government. The Act prohibits:

1. Knowingly presenting, or causing to be presented a false claim for payment or approval;
2. Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;

3. Conspiring to commit any violation of the False Claims Act;
4. Falsely certifying the type or amount of property to be used by the Government;
5. Certifying receipt of property on a document without completely knowing that the information is true;
6. Knowingly buying Government property from an unauthorized officer of the Government; and
7. Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims Act, please visit CMS.HHS.gov.

The Provider understands and agrees to the following:

1. HHSC Office of Inspector General (OIG) and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Providers and their employees, agents, health plans, and patients.
2. Requests for information from such entities must be complied with, in the form and language requested.
3. Providers and their employees, agents, and health plans must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at the Provider's own expense.
4. Compliance with these requirements will be at the Provider's expense.
5. Providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care or dental care and the Medicaid Programs, as applicable.
6. Providers must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud, waste, or abuse.
7. Providers must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free of charge.
8. If the Provider places required records in another legal entity's records, such as a hospital, the Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
9. Providers must report any suspected fraud or abuse including any suspected fraud and abuse committed by Community First or a Member to the HHSC Office of Inspector General.

If the Provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the Provider must:

1. Establish written policies for all employees, managers, officers, health plans, subhealth plans, and agents of the Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and

whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act.

2. Include as part of such written policies detailed provisions regarding the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and the Provider's policies and procedures for detecting and preventing fraud, waste and abuse.

Provider under Investigation. Community First will not pay STAR+PLUS claims submitted for payment by a Provider who is under investigation, or has been excluded or suspended from the Medicare or Medicaid programs for fraud and abuse, when Community First has been notified of such investigation, exclusion or suspension.

INSURANCE

The Provider must maintain, during the term of the Provider contract, Professional Liability Insurance of $100,000 per occurrence and $300,000 in the aggregate, or the limits required by the hospital at which the Provider has admitting privileges.

Please Note: This provision will not apply if the Provider is a state or federal unit of government, or a municipality, that is required to comply with, and is subject to, the provisions of the Texas and/or federal Tort Claims Act.

MARKETING

The Provider agrees to comply with state and federal laws, rules, and regulations governing marketing. In addition, Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in HHSC's Uniform Managed Care Manual.

The Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

PROVIDER NETWORK REQUIREMENTS

Under Medicaid agreements, the TPI and NPI for acute care providers serving Medicaid Members must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid Program, and must have a Texas Provider Identification Number (TPIN). All Medicaid providers must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D.

CREDENTIALING AND RE-CREDENTIALING

All applicants for participation undergo a careful review of their qualifications, including education, training, licensure status, board certification, hospital privileges, and work and malpractice history. Providers who meet the criteria and standards of Community First are presented to the Credentials Committee for final approval of their credentials.

Re-credentialing is performed at least every three years. In addition to the verification of current license, DEA, malpractice insurance, National Practitioner Data Bank query, and

current hospital privileges, the process may also include:

- Member survey results
- Complaints and grievances
- Utilization data
- Compliance of Community First policies & procedures
- An office site review and evaluation
- A medical record audit

Advance Nurse Practitioner Requirements. To be a provider of Medicaid covered services, an Advance Nurse Practitioner must:

- Be licensed by the Texas State Board of Nurse Examiners.
- Be licensed by the licensing authority as an Advance Nurse Practitioner.
- Comply with all applicable federal and state laws and regulations governing the services provided.
- Be enrolled and approved for participation in the Texas Medical Assistance Program.
- Sign a written provider agreement with the department or its designee.
- Comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards, and guidelines published by the department or its designee.
- Bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the department or its designee.

Advance Nurse Practitioner Benefits and Limitations. Subject to the specifications, conditions, requirements, and limitations established by the department or its designee, services performed by Advance Nurse Practitioners are covered if the services:

- Are within the scope of practice for Advance Nurse Practitioners, as defined by state law.
- Are consistent with rules and regulations promulgated by the Texas State Board of Nurse Examiners or other appropriate states licensing authority.
- Would be covered by the Texas Medical Assistance Program if provided by a licensed physician (MD or DO).

To be payable, services must be reasonable and medically necessary as determined by the department or its designee.

Advance Nurse Practitioners who are employed or remunerated by a physician, hospital, facility, or other provider must not bill the Texas Medical Assistance Program directly for their services, if that billing would result in duplicate payment for the same services. If the services are coverable and reimbursable by the program, payment may be made to the physician, hospital, or other provider (if the Provider is approved for participation in the Texas Medical Assistance Program) who employs or reimburses Advance Nurse Practitioners. The basis and amount of Medicaid reimbursement depend on the services actually provided, who provided the services, and the reimbursement methodology determined by the Texas Medical Assistance Program as appropriate for the services and the Providers involved.

These policies and procedures do not apply to Certified Registered Nurse Anesthetists and Certified Nurse-Midwives. Coverage of services provided by Certified Nurse-Midwives and Certified Registered Nurse Anesthetists are described in 1 Tex. Admin.

Code § 354.1251 (relating to Nurse-Midwife services) and 1 Tex. Admin. Code § 354.1301 (relating to Certified Registered Nurse Anesthetists services).

On-Site Reviews. As part of our QIP, Community First conducts periodic facility and medical record audits for PCPs who have 50 or more Community First Members, and to research cases of potential quality issue. The reviews are used in the re-credentialing process, to substantiate the quality of the services provided to health plan Members, to augment and improve Healthcare Effectiveness Data and Information Set (HEDIS) quality data, and to confirm the services billed to Community First. Record reviews are considered an essential method of identifying potential quality of care issues and opportunities for Practice Guideline development.

Community First has adopted medical record standards that assist with evaluating patient care to ensure conformance with Quality-of-Care Standards. Providers must conform to the standards to remain a Network Provider. Providers will be evaluated at least every three years and will be notified of the scheduled audit by the Quality Management Department prior to the review. The audit routinely consists of three components:

- Documentation
- Continuity of Care
- Preventive Care

Providers can refer to the Medical Record Review Tool and Preventive Services for Adults. You will receive written feedback on the results of the record review along with any recommendations regarding documentation. Those areas with scores below the established benchmarks will be required to adopt a Corrective Action Plan. The Community First Quality Management Department may provide educational assistance with medical record documentation, if desired. Repeat audits are performed if problems are identified. Results of medical record audits are trended and reported to the Quality Improvement Committee to identify areas needing improvement or follow-up action needed based on peer review guidance.

UPDATES TO CONTACT INFORMATION

Providers must inform both Community First and HHSC's administrative services health plan of any changes in the Provider's profile information, such as address, telephone number, or group affiliation. Medicaid enrolled providers providing Medicaid only covered services and LTSS must also notify TMHP of any changes in organizational structure or demographic information.

MANDATORY CHALLENGE SURVEY

Community First is required to develop and implement a mandatory challenge survey to verify Provider information and monitor adherence to Provider requirements. Community First must design the survey so that on a periodic, randomized basis, a Provider's input is required before accessing Community First's Provider Portal functionalities. At a minimum, the challenge survey will include verification of the following elements:

1. Provider Name
2. Address
3. Phone Number

4. Office Hours
5. Days of Operation
6. Practice Limitations
7. Languages Spoken
8. Provider Type / Provider Specialty
9. Wait Times for Appointment (as defined in this Provider Manual)
10. Closed or Open Panel (PCPs only)
11. THSteps Provider (PCP only)

Community First collects, analyzes, and submits survey results as specified in UMCM Chapter 5.4.1.10, "Provider Network Examination."

Community First will enforce access and other network standards required by the contract and take appropriate action with Providers whose performance is determined by Community First to be out of compliance.

LONG-TERM SERVICES AND SUPPORTS PROVIDER RESPONSIBILITIES

LTSS providers deliver a continuum of care and assistance such as in home and community-based services for elderly people, providing assistance to individuals with disabilities to allow them to maintain their independence, persons with disabilities who need assistance in maintaining their independence, to institutional care for those who require that level of support, seeking to maintain independence for individuals while providing the support required. LTSS providers have certain responsibilities for the STAR+PLUS program and the Members they serve. This includes, but is not limited to:

- Contacting Community First to verify Member eligibility or obtain authorizations for service.
- Continuity of care.
- Medicare/Medicaid coordination.
- Coordination of benefits for Dual Eligibles as applicable.
- Notifying Community First of change in Member's physical condition or eligibility.

LTSS providers are required to provide covered health services to Members within the scope of their Community First agreement and specialty license. Community First offers LTSS providers access to necessary supports and resources, access to emergency services for their safety and protection and a means to communicate grievances.

Community First must require that LTSS providers submit periodic cost reports and supplemental reports to HHSC in accordance with 1 Tex. Admin. Code Chapter 355, including Subchapter A (Cost Determination Process) and 1 Tex. Admin. Code § 355.403 (Vendor Hold). If an LTSS provider fails to comply with these requirements, HHSC will notify Community First to hold payments to the LTSS provider until HHSC instructs Community First to release the payments. HHSC will forward notices directly to LTSS providers about such cost reports and information that is required to be submitted.

The following LTSS services are eligible for enhanced payments:

- Personal Assistant Services (PAS) both waiver and non-waiver
- Day Activity and Health Services (DAHS) both waiver and non-waiver

- Assisted Living and Residential Care Services (ALRC)
- Habilitation (under CFC)

Community First Choice (CFC) Provider Responsibilities

- CFC services must be delivered in accordance with the Member's service plan.
- The program provider must maintain current documentation which includes the Member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable).
- The HCS or TxHmL program provider must ensure that the rights of the Members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the Member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken from the time they are notified that an Adult Protective Services investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the Adult Protective Services hotline at **1-800-252-5400**. The program provider must provide Community First with a copy of the Abuse, Neglect, and Exploitation report findings within one business day of receipt of the findings from Adult Protective Services.
- The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (e.g., age; high school diploma/GED or competency exam; three references from non-relatives; current Texas driver's license and insurance if transporting; criminal history check; employee misconduct registry check; nurse aide registry check; OIG checks). For CFC ERS, the program provider must ensure

that the provider of ERS has the appropriate licensure.

- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per 42 C.F.R. § 441.565, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member's finances and the purchase of goods that a Member cannot use with the Member's funds.

Provider Responsibilities for Employment Assistance (EA) and Supported Employment (SE)

Employment Assistance (EA) is provided as an HCBS STAR+PLUS Waiver service to a Member to help the Member locate competitive employment or self-employment. EA services include, but are not limited to, the following:

- Identifying a Member's employment preferences, job skills and requirements for a work setting and work conditions;
- Locating prospective employers offering employment compatible with an Member's identified preferences, skills and requirements; and
- Contacting a prospective employer on behalf of a Member and negotiating the Member's employment.

SE services provide assistance as HCBS Waiver service to a Member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform in a work setting at which Members without disabilities are employed. SE provides the supports necessary in order to sustain paid employment. SE services include, but are not limited to, the following:

- Employment adaptations, supervision and training related to a Member's diagnosis;
- If the Member is 21 years of age, ensure provision of SE, as needed, if the services are not available through the local school district; and
- If the Member is 21 years of age, SE may be provided through the STAR+PLUS Waiver (SPW) if documentation is maintained in the Member's record, that the service is not available to the Member, under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq).

The provider must develop and update quarterly a plan for delivering EA/SE including documentation of the following information:

- Name of the Member;

- Member's employment goal;
- Strategies for achieving the Member's employment goal, including those addressing the Member's anticipated employment support needs;
- Names of the people, in addition to the Member, whose support is or will be needed to ensure successful employment placement, including the corresponding level of support those persons are providing or have committed to providing;
- Any concerns about the effect of earnings on benefits, and a plan to address those concerns;
- Progress toward the Member's employment goal; and
- If progress is slower than anticipated, an explanation of why the documented strategies have not been effective, and a plan improve the effectiveness of the Member's employment search.

PHARMACY PROVIDER RESPONSIBILITIES

- Adhere to the Formulary
- Adhere to the Preferred Drug List (PDL)
- Coordinate with the prescribing physician
- Ensure Members receive all medications for which they are eligible
- Coordination of benefits when a Member also receives Medicare Part D services or other insurance benefits

COORDINATION WITH TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS)

The Provider must cooperate and coordinate with DFPS and foster parents for the care of an elderly person who is receiving services from or has been placed in the conservatorship of DFPS, including:

- Report any confirmed or suspected cases of abuse and neglect to DFPS.
- Provide medical records at the time the records are requested.

Community First will continue to provide all covered services to a STAR+PLUS Member receiving services from or in the protective custody of DFPS until the STAR+PLUS Member has been disenrolled from Community First as a result of loss of eligibility or placement into foster care.

The Provider must coordinate with DFPS and Member who is receiving services from or has been placed in the conservatorship of DFPS and must respond to requests from DFPS, including:

- Providing medical records.
- Recognizing abuse and neglect and appropriate referral to DFPS.

IX. ROUTINE, URGENT AND EMERGENCY SERVICES

DEFINITIONS OF ROUTINE, URGENT, AND EMERGENCY CARE

Medically necessary health services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided. Medically necessary health services must also be provided at the most appropriate level or supply of service which can safely be provided and could not be omitted without adversely affecting the Member's physical health or the quality of life.

Except for emergency care in a true emergency, Members are encouraged to contact the PCP prior to seeking care. In the case of a true emergency, Members are encouraged to visit their nearest emergency department.

Routine care is 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. Examples of routine care include immunizations and regular screenings like pap smears or cholesterol checks.

An **urgent condition** is defined as a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that their condition requires medical treatment evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Emergency Care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that their condition, sickness, or injury is of such matter that failure to get immediate care could result in:

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

Community First covers services for a medical emergency anywhere in the United States, 24 hours a day. If a medical emergency occurs, whether in or out of Community First's service area, STAR+PLUS Members are instructed to seek care at the nearest hospital emergency room or comparable facility. The necessary emergency care services will be provided to covered STAR+PLUS Members, including transportation, treatment and stabilization of an emergency medical condition, and any medical screening examination or other evaluation required by state or federal law which is necessary to determine if a medical emergency exists.

When the condition of the STAR+PLUS Member requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, the ambulance is an emergency service. If a STAR+PLUS

Member needs to be transferred to another facility and the medical condition of the STAR+PLUS Member requires immediate medical attention, the transfer may be considered as an emergency transfer.

Community First should be notified of admissions or procedures within 24 hours, or the next business day.

If it is determined that a medical emergency does not exist (emergency care is not rendered), the STAR+PLUS Member must contact his or her PCP to arrange any non-emergency care needed. If the STAR+PLUS Member is hospitalized in a non-participating hospital as a result of an emergency medical condition, the STAR+PLUS Member may be transferred to a network hospital as soon as stabilization occurs, and the attending provider deems it medically appropriate. Once the patient/Member is stabilized, the treating provider is required to contact Community First to obtain authorization for any necessary post-stabilization services. Community First will process all requests for authorization of post-stabilization services within one (1) hour of receiving the request.

An **urgent condition** means a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine to believe that their condition requires medical treatment evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Urgent Admission Notification Process

- Unplanned Admissions Requirements – Community First requires urgent admission notification within 24 hours of admission. Facilities are to submit supporting clinical information within 48 hours of the admission. Observation stays do not require authorization.
- Documentation Requirements – Supporting documentation includes but is not limited to the physician's history and physical, progress notes, and orders. In some instances, vital signs, medication administration records, laboratory/imaging results, and other information may be required.

If additional information is later required for concurrent review, facilities are to submit requested information within 24 hours of request.

For after-hours urgent care, and certain instances during normal office hours, Community First has arrangements with Urgent Care Clinics listed in the Provider Directory. In addition, we offer a 24-hour Nurse Advice Line at **1-800-434-2347** staffed by registered nurses who provide advice according to written protocols and assist STAR+PLUS Members in accessing treatment.

Services provided at the Urgent Care Clinics are limited to:

- **After-hours Urgent Care**

Weekdays/Weekends & Holidays	5:30 p.m. to 8:30 a.m.
Day Preceding a Holiday	After 5:00 p.m.
Day Following a Holiday	Before 8:30 a.m.

- **During Normal Office Hours.** You may refer a patient to an Urgent Care Clinic during normal office hours only if the PCP is unavailable, and a triage nurse has determined that the patient requires urgent care, **not hospital emergency** care. The PCPs nursing staff should triage the patient or refer to the Nurse Advice Line if the PCPs nursing staff is unavailable.
- **Requirements for Scheduling Appointments/Referrals to the Urgent Care Clinic.** When referring a STAR+PLUS Member to an Urgent Care Clinic, the PCP or PCP's nursing staff should call the clinic and notify the clinic they are referring the patient. If a STAR+PLUS Member goes to one of the clinics without approval, the clinic must contact the PCP. If the PCP does not respond within a reasonable length of time, depending on the medical situation, the clinic should call Community First's Population Health Management Department or the Nurse Advice Line.

If the examining physician determines that a **true medical emergency exists**, the STAR+PLUS Member will be admitted to the nearest hospital emergency department appropriate for the patient's condition. If a **medical emergency does not exist**, but the examining physician determines that hospitalization is necessary for further evaluation and/or treatment, the PCP will be contacted to affirm concurrence in admitting the patient. It will then be the PCP's responsibility to arrange admission to a Community First network hospital.

ACCESS TO ROUTINE, URGENT, AND EMERGENT CARE

Members must have access to covered services within the timelines specified by HHSC and Texas Department of Insurance (TDI). "Day" is defined as a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first. In coordination with the definitions above, this includes the following:

- Routine primary care must be provided within 14 days (unless requested earlier by DFPS)
- Routine specialty care referrals must be made on a timely basis, based on the urgency of the Member's medical condition, but no later than five days.
- Initial outpatient behavioral health visits must be provided within 14 days.
- Urgent care, including urgent specialty care, must be provided within 24 hours.
- Emergency services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities.

NON-EMERGENCY SERVICES

Non-emergency primary care services are not covered benefits for Members of Medicaid managed care health plans when those services are delivered in the hospital-based emergency department (ED). A PCP and/or specialist physician in a physician office and/or clinic setting primarily provides these services. When a Member seeks services that are not considered a covered benefit in the hospital-based ED, the provider of those services can bill a Member if the Member has been properly informed in advance of their potential financial liability. The determination of an emergency condition is based on the prudent layperson definition as described above under emergency medical condition.

Below are examples of non-emergency situations:

- Routine follow up care
- Removal of sutures

- Immunizations, including tuberculosis
- Other non-emergency primary care services

HOSPITAL EMERGENCY DEPARTMENT CLAIMS

Hospital ED claims are coordinated in accordance to the rate schedule included in the Medicare contract agreement between Community First and the hospital. For out-of-network providers, hospital emergency department claims are coordinated in accordance with CMS and state guidelines.

Emergency Service Claims Appeals
Providers may appeal determinations made during this emergency department claims adjudication process. Emergency department denials are based on a prudent lay person's determination, and are therefore not Adverse Benefit Determinations. Emergency department claims denied as not meeting the prudent layperson definition of emergency care are considered non-covered benefits, and the Member can be held financially responsible for the denied services, if the appropriate financial responsibility documents have been signed by the Member. Community First recognizes that it is not in the Member's best interest to receive routine (non-emergency) episodic care in the emergency department and Members are best served by receiving care from their PCP. Community First has an education process for its Members and providers through several modes of communication. The goal is to form a clear understanding of what constitutes covered emergency benefits, what access standards are contractually required for all PCPs and how improved access to appropriate levels of care will result in improved health outcomes.

EMERGENCY TRANSPORTATION

According to 1 Tex. Admin. Code § 354.1111, an emergency transport is a service provided by a Medicaid-enrolled ambulance provider for a Medicaid client whose condition meets the definition of an emergency medical condition. Conditions requiring cardiopulmonary resuscitation (CPR) in transit or the use of above routine restraints for the safety of the client or crew are also considered emergencies. Facility-to-facility transfers are appropriate as emergencies if the required emergency treatment is not available at the first facility.

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, and loss of consciousness, semi consciousness, and seizure, or with receipt of CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Emergencies include medical conditions for which the absence of immediate medical attention could reasonably be expected to result in serious impairment, dysfunction, or failure of one or more organs or body parts, and the required emergency treatment is not available at the first facility. Claims for such transports must document the aforementioned criteria.

Emergency transports do not require prior authorization.

Urgent/Emergent Hospital-to-Hospital Transportation
Community First is required to cover emergency ambulance transportation services. Urgent/emergency hospital-to-hospital transportation does not require prior

authorization. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition is not available at the first facility and Community First has not included payment for such transports in the hospital reimbursement. Emergency air transportation providers must notify Community First within one business day of providing emergency air transportation.

NON-EMERGENCY TRANSPORTATION SERVICES

Non-Emergency Medical Transportation (NEMT) services are available to eligible Medicaid clients who have no other means of transportation. These services are detailed in the "Non-Emergency Transportation Services" section of this Provider Manual.

In addition, as a value-added service, Community First can provide extra help getting a ride for medical and behavioral visits, Community First sponsored events, health classes, and Member Advisory Group meetings.

Community First is required to cover 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 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 authorization, including:

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

MEMBER/CLIENT ACKNOWLEDGMENT STATEMENT

A Provider may not bill a STAR+PLUS Member for covered services, which Community First determines are not medically necessary, unless the Provider obtains the Member's prior, written, informed consent. The Member's consent will not be considered informed, unless the Provider explains to the Member before services are rendered that Community First will not pay for the services, and that the Member will be financially responsible.

A Provider may bill the STAR+PLUS Member for a service if both of the following conditions are met:

- The patient requests the specific service.
- The Provider obtains a Member/Client Acknowledgment Statement signed by the patient and the Provider.

The Provider must obtain and keep a written Member/Client Acknowledgment Statement signed by the client that states:

"I understand that, in the opinion of (Provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas

Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

"Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicaid no cobra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determinan la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

Please Note: A Provider is allowed to bill the following to a client without obtaining a signed Client Acknowledgment Statement:

- Any service that is not a benefit of the Texas Medicaid Program (e.g., personal care items).
- All services incurred on non-covered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-covered days. Spell of illness limitations do not apply to medically necessary stays for THSteps-eligible clients younger than age 21 years.
- All services provided as a private pay patient. If the Provider accepts the client as a private pay patient, the Provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying for all services received. In this situation, HHSC strongly encourages the Provider to ensure that the client signs written notification so there is no question how the client was accepted.

PRIVATE PAY FORM AGREEMENT

A participating physician and/or provider may bill a STAR+PLUS Member only if:

- A specific service or item is provided at the STAR+PLUS Member's request.
- The Provider has obtained and kept a written Private Pay Agreement form signed by the client. This form is available on our website at CommunityFirstMedicaid.com.

The Provider must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed Private Pay Agreement from the STAR+PLUS Member. Without written, signed documentation that the STAR+PLUS Member was properly notified of the private pay status, PCP and/or participating provider cannot seek payment from an eligible STAR+PLUS Member.

If the Member is accepted as a private pay patient pending Medicaid eligibility determination and the Member does not become eligible for Medicaid retroactively. The PCP and/or participating provider are allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactive, the Member will notify the Provider of the change in status. Ultimately, the Provider is responsible for filing claims timely to Community First. If the Member becomes eligible, the Provider must refund any money paid by the client and file claims for all services

rendered to Community First , if appropriate.

A Provider attempting to bill or recover money from a Member in violation of the above conditions may be subject to exclusion from the Texas Medicaid Program and termination from network participation with Community First.

Please Note: Ancillary services must be coordinated, and pertinent eligibility information must be shared. The PCP is responsible for sharing eligibility information with others.

EMERGENCY PRESCRIPTION SUPPLY

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a PA, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time 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. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable (e.g., an 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**.

EMERGENCY AND NON-EMERGENCY DENTAL SERVICES

Emergency and non-emergency dental services are available to eligible Medicaid clients.

Community First is responsible for emergency dental services provided to STAR+PLUS Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts, and
- Treatment of oral abscess of tooth or gum origin.

DURABLE MEDICAL EQUIPMENT AND OTHER PRODUCTS NORMALLY FOUND IN A PHARMACY

Durable Medical Equipment (DME) is available to eligible Medicaid clients. Community First reimburses for covered DME and products commonly found in a pharmacy. For all qualified Members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment.

DBMD ESCALATION HELP LINE

What is the DBMD escalation help line?

The DBMD escalation help line assists people with Medicaid who get benefits through the Deaf-Blind with Multiple Disabilities (DBMD) program.

The escalation help line can help solve issues related to the STAR+PLUS managed care program. Help can include answering questions about External Medical Reviews, State

Fair Hearings, and continuing services during the appeal process.

When should Members call the escalation help line?
A Member should call when they have tried to get help but have not been able to get the help they need. If a Member does not know who to call, they can call **1-844-999-9543** and they will work to connect the Member with the right people.

Is the escalation help line the same as the HHSC Office of the Ombudsman?
No. The DBMD Escalation Help Line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached by calling **1-866-566-8989** or online at hhs.texas.gov/managed-care-help. The DBMD escalation help line is dedicated to individuals and families that receive benefits from DBMD program.

Who can call the help line?
A Member, their authorized representative(s), or their legal representative can call.

Can Members call any time?
The escalation help line is available Monday through Friday from 8 a.m. to 8 p.m. After these hours, Members should leave a message and trained on-call staff will return their call.

X. PROVIDER COMPLAINTS/APPEALS PROCESS

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.

A complaint is an expression of dissatisfaction communicated by a complainant, orally or in writing, about any matter related to Community First, other than an action/ Adverse Benefit Determinations. As provided by 42 C.F.R. §438.400, possible subjects for complaints include, but are not limited to:

1. The quality of care or services provided.
2. Aspects of interpersonal relationships such as rudeness of a provider or employee.
3. The failure to respect the Medicaid Member's rights.

PROVIDER COMPLAINTS TO COMMUNITY FIRST

Community First has a process to address Provider complaints in a timely manner, which is consistent for all network providers. Community First and the Provider have an obligation under their mutual contract provisions to make a good faith effort to resolve any disputes arising under the agreement. In the event a dispute cannot be resolved through informal discussions, the Provider must submit a complaint to Community First which specifically sets forth the basis of the complaint along with a proposed resolution. 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

Retain the following documentation:

- Fax cover pages.
- Emails to and from Community First.
- A log of telephone communication.

Upon receipt of a written Provider complaint, the Network Management Department will send a letter acknowledging receipt of the complaint within five (5) working days from the date of receipt. Following investigation of the complaint, the Network Management Department will send a letter to communicate Community First's resolution of the complaint to the Provider within thirty (30) calendar days from the receipt of the written complaint. Following investigation of the complaint, the Network Management Department will send a letter to communicate Community First's resolution of the complaint to the Provider within thirty (30) calendar days from the

receipt of the written complaint or completed "Provider Complaint" form.

If the Provider and Community First are unable to resolve the complaint, the Provider may submit an appeal, orally or in writing, to Community First. Provider complaint appeals must be submitted no later than 30 days of the complaint response letter. Upon receipt of a written appeal, Community First will send a letter acknowledging the request for an appeal within five (5) working days from the date of receipt.

Community First will send written notification within thirty (30) calendar days from the receipt of the appeal to the Provider of the acceptance, rejection, or modification of the Provider's appeal and proposed resolution. This notification will constitute Community First's final determination. The notification will advise the Provider of his or her right to submit the complaint to binding arbitration. Any binding arbitration will be conducted in accordance with the rules and regulations of the American Arbitration Association, unless the Provider and Community First mutually agree to some other binding arbitration procedure.

PROVIDER APPEALS TO COMMUNITY FIRST

If a Provider wishes to appeal a decision made by Community First that the health care services furnished or proposed to be furnished to a STAR+PLUS Member are not medically necessary, the Provider or the Member may appeal orally, followed up with a written appeal.

- Members: Orally **210-358-6105** or **1-844-382-2347**
- Providers: Orally **210-358-6105** or **1-844-382-2347**
- Fax: **210-358-6099** (Please include appeal form)
- Online: Community First's secure Provider Portal at https://communityfirsthealthplans.com/providerportal/ (click the "Contact Us" link).

Retain the following documentation:

- Fax cover pages
- Emails to and from Community First
- A log of telephone communication

Provider Appeals Process

1. Within (5) working days from receipt of the appeal, Community First will send the appealing party a letter acknowledging the date of Community First's receipt of the appeal. This letter will include a reasonable list of documents that need to be submitted to Community First for the appeal.
2. When Community First receives an oral appeal, Community First will send the appealing party a one-page appeal form.
3. Emergency care denials, denials for care of life-threatening conditions, and denials of continued stays for hospital patients may follow an expedited appeal procedure. This procedure will include a review by a health care provider who has not previously reviewed the case, and who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. The time frame in which such an expedited appeal must be completed will be based on the medical immediacy of the condition, procedure, or treatment, but not to exceed one (1) working day following the date that the appeal, including all necessary information to complete the appeal, is made to Community First.

4. After Community First has sought review of the appeal, we will provide written notification to the Member, Member's representative, and the Member's physician or health care provider explaining the resolution of the appeal. Community First will provide written notification to the appealing party as soon as practical, but no later than thirty (30) days after we receive the oral or written request for appeal. The notification will include:
   a. A clear and concise statement of the specific medical or contractual reason for the resolution.
   b. The clinical basis for such decision.
   c. The specialty of any physician or other provider consultant.
   d. If the appeal is denied, the written notification will include notice of the appealing party's right to seek a State Fair Hearing (See Member Complaint and Appeals section).

Please Note: This decision affects coverage only and does not control whether to render medical services.

PROVIDER COMPLAINT PROCESS TO HHSC

A Provider who believes they did not receive full due process from Community First may file a complaint with HHSC. HHSC is only responsible for the management of complaints. Appeal, hearing, or dispute resolutions are the responsibility of Community First. Providers must exhaust the appeals/complaint process with Community First before filing a complaint with HHSC.

Complaints must be received by HHSC. Providers should refer to the Texas Medicaid Provider Manual for specific information on complaint requirements.

The Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.

Complaints should be mailed to the following address:

Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
P.O. Box 85200
Austin, TX 78708

Providers can also file a complaint with HHSC via email to HPM_Complaints@hhsc.state.tx.us.

PROVIDER APPEAL PROCESS TO HHSC (RELATED TO CLAIM RECOUPMENT)

Upon notification of a claim payment recoupment, the first step is for the Provider to recheck Member eligibility to determine if a Member eligibility change was made to Fee-for-Service or to a different managed care organization on the date of service.

1. **Member eligibility was changed to Fee-for-Service on the date of service.** The Provider may appeal claim recoupment by submitting the following information to HHSC:
   - A letter indicating that the appeal is related to a managed care disenrollment/

recoupment and that the Provider is requesting an Exception Request.
- **The Explanation of Payment (EOP) showing the original payment.** This is also used when issuing the retro-authorization as HHSC will only authorize TMHP to grant an authorization for the exact items that were approved by the plan.
- **The EOP showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOP.
- **Completed clean claim.** All paper claims must include both the valid NPI and TPI number. In cases where issuance of a prior authorization (PA) is needed, the Provider will be contacted with the authorization number and will need to submit a corrected claim that contains the valid authorization number.

Please Note: Label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed prior to eighteen (18) months from the date of service.

Mail Fee-for-Service-related appeal requests to:

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

Prepare a new paper claim for each claim that was recouped and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recouped.

Submission of the new claims is not required before sending the administrative appeal letter. However, if a Provider appeals prior to submitting the new claims, the Provider must subsequently include the new claims with the administrative appeal.

HHSC Claims Administrator Contract Management only reviews appeals that are received within 18 months from the date of service. In accordance with 1 TAC §354.1003, Providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management and all claims must be finalized within 24 months from the date of service.

2. **Member eligibility changed from one Managed Care Organization (MCO) to another on the date of service.**
   Providers may appeal claims payment recoupments and denials of services by submitting the following information to the appropriate MCO to which the Member eligibility was changed on the date of service:
   - A letter indicating that the appeal is related to a managed care disenrollment/ recoupment and that the Provider is requesting an Exception Request.
   - **The Explanation of Payment (EOP) showing the original payment.** The EOP showing the recoupment and/or the MCO's "demand" letter for recoupment must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOP.
   - **Documentation must identify** the client name, identification number, DOS,

recoupment amount, and other claims information.

Please Note: Label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

Submit appeals to Community First online via the Provider Portal.

Mail Fee-for-Service-related appeal requests to:

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

XI. MEMBER COMPLAINT AND APPEAL PROCESS

MEMBER COMPLAINT PROCESS

STAR+PLUS Members may file a complaint with Community First at any time. A complaint means an expression of dissatisfaction expressed by a Complainant, orally or in writing, to Community First about any matter related to the MCO other than an Adverse Benefit Determination. Complaint has the same meaning as grievance, as provided by 42 C.F.R. § 438.400(b). Possible subjects for complaints include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. A complaint includes the Member's right to dispute an extension of time (if allowed by law) proposed by the MCO to make an authorization decision. If the Member wishes to file a complaint, Community First is here to help. Please direct them to call Member Services at **210-358-6105** or toll-free at **1-844-382-2347**.

Members may contact Community First Member Services to request assistance in filing a complaint. Community First designates Member ADvocates to support and assist Members who want to file a complaint and monitor the complaint through Community First's complaint process until the issue is resolved. Community First will mail a letter to the complainant within five (5) days to inform them that we have received their complaint. Following investigation of the complaint, we will send a letter to communicate Community First's resolution of the complaint within thirty (30) calendar days from the receipt of the complaint. If the response is not satisfactory, a complaint appeal may be filled.

If a Member is not satisfied with the resolution of the complaint, after they have used the Community First complaint process, they may file a complaint with HHSC by calling **1-866-566-8989**. If the Member would like to file a complaint in writing, it may be addressed to:

Texas Health and Human Services Commission
Attn: Resolution Services
Health Plan Operations, H-320
P.O. Box 85200
Austin, TX 78708-5200

HHSC also accepts complaints via email at HPM_Complaints@hhsc.state.tx.us.

MEMBER APPEAL PROCESS

If Community First denies or limits a request for a covered service, the Member will be notified by mail. The Member will receive a formal letter from Community First explaining the decision.

The Member may than request an appeal. The Member can appeal denial of payment for services in whole or part.

If a Member wishes to appeal, the Member or the Member's authorized representative must file the appeal on or before the later of

- 30 days following Community First's mailing of the notice of the action,
- or the intended effective date of the proposed action, in order to ensure continuity of current authorized services.

Community First Member Services can assist a STAR+PLUS Member or a Member's authorized representative in filing an appeal. A Member or the Member's authorized representative can call **1-844-382-2347** to request an appeal form or assistance with understanding Community First's appeal process.

Appeals can be made orally or in writing at the address below:

Community First Health Plans
Attn: Resolution Unit
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

Timeframe of the Appeal Process
The entire standard appeals process must be completed by Community First within 30 days after receipt of the initial written or oral request for appeal. This deadline may be extended for up to 14 days at the request of a Member or if Community First shows that there is a need for additional information and how the delay is in the Member's interest. If Community First needs to extend, the Member must receive written notice of the reason for delay.

Community First will send the Member an acknowledgement of the appeal within five (5) days and a decision on the appeal within 30 days.

The Member may be required to pay cost of services furnished while appeal is pending, if the final decision is adverse to the Member.

External Medical Review and State Fair Hearing
STAR+PLUS Members have external appeal rights to both CMS and HHSC, depending on the type of service being appealed; whether a traditional Medicare service, a Medicaid only service, or services that overlap both Medicare and Medicaid services.

Appeal of Community First 's adverse decision on appeal for traditional Medicare A and B services not fully in favor of the Member are automatically forwarded to the Medicare Independent Review Entity (IRE) by Community First. Appeals for services covered by Medicaid only, including, but not limited to, LTSS, Texas Medicaid-covered drugs excluded from Medicare Part D, and some Behavioral Health Care Services, may also be appealed to the HHSC Appeals Division for a State Fair Hearing. For services for which Medicare and Medical overlap, including, but not limited to, Home Health, Durable Medical Equipment and skilled therapies, adverse benefit determinations made by Community First that are not fully in favor of the Member are automatically sent to the IRE by Community First. A Member may also file a request for a State Fair Hearing for these services. If an Appeal is both sent to the IRE and requested to the State Fair Hearing office by the Member, any determination in favor of the Member binds Community First to that decision, and results in an overturn of Community First 's denial, in whole or in part.

CMS Independent Review Entity (IRE). If, on internal Appeal, Community First does not decide fully in the Member's favor within the relevant time frame, Community first automatically forwards the case file regarding Medicare services to the CMS Independent Review Entity (IRE) for a new and impartial review.

For standard External Appeals, the CMS IRE will send the Member and Community First a letter with its decision within thirty (30) calendar days after it receives the case, or at the end of up to a fourteen (14) calendar-day extension, and a payment decision within sixty (60) calendar days. If the CMS IRE decides in the Enrollee's favor and reverses Community First's adverse decision, Community First will authorize the service under dispute as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Community First receives the notice reversing the decision.

State Fair Hearings. Appeals for services covered by Medicaid only, including, but not limited to, LTSS, Texas Medicaid-covered drugs excluded from Medicare Part D, and some Behavioral Health Care Services, may also be appealed to the HHSC Appeals Division for a State Fair Hearing. 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 Community First's decision to deny the Member's appeal. If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose their right to a State Fair Hearing. If Community First continues or reinstates benefits and the request for continued services is not approved by the State Fair Hearing officer, Community First will not pursue recovery of payment for those services without written permission from HHSC.

If the Member asks for a State Fair Hearing by the later of 10 days from the date the appeal was denied, or the day the health plan's letter says the service will be reduced or end, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the Member does not request a State Fair Hearing by this date, 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 that time, the Member or the Member's representative can tell why the Member needs the service the health plan denied. HHSC will give the Member a final decision within ninety (90) days from the date the Member asked for the hearing.

If a Member is not satisfied with the appeal decision, they can request an External Medical Review and State Fair Hearing no later than 120 days after the date Community First Health Plans mails the appeal decision notice.

MEMBER EXPEDITED APPEAL PROCESS

Community First STAR+PLUS Members may request an expedited appeal if the STAR+PLUS Member is not satisfied with the denial covered benefit. Community First STAR+PLUS Members may request an expedited appeal orally or in writing when Community First is required to make a decision quickly based on the Member's health status and taking the time for a standard appeal could jeopardize the Members health such as a denial of emergency care, a life-threatening condition, or an inpatient hospitalization.

Community First Member Services can assist a STAR+PLUS Member who would like to file an expedited appeal.

The time frame in which such an expedited appeal must be completed will be based on the medical immediacy of the condition, procedure, or treatment, but is not to exceed one (1) to three (3) days following the date that the appeal is made to Community First.

The timeframe may be extended up to 14 calendar days if Member requests an extension or if Community First can show that there is a need for additional information and how the delay is in the Member's interest.

If the Member's request for an Expedited Appeal is denied, the request will then be moved to the regular appeal process. Community First will send the Member written notice of this change by mail within two (2) calendar days.

Expedited internal appeals that are adverse determinations made by Community First will be forwarded to the CMS Independent Review Entity (IRE) to be processed by the IRE as expedited. The CMS IRE will send the Member and Community First a letter with its decision within 72 hours after it receives the case from Community First, or at the end of up to a 14 calendar-day extension. Members, or their authorized representatives, may also 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. In order to qualify for an expedited State Fair Hearing the Member must first complete Community First's expedited appeal process.

For expedited External Appeals, the CMS IRE will send the Member and Community First a letter with its decision within 72 hours after it receives the case from Community First, or at the end of up to a 14 calendar-day extension. If Community First or the Member disagrees with the CMS IRE's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review. Community First must comply with any requests for information or participation from such further Appeal entities.

STATE FAIR HEARING INFORMATION

Can a Member ask for a State Fair Hearing?
If a Member, as a Member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent them by contacting the health plan giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative if the provider is named as the Member's authorized representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either call **210-358-6105** or **1-844-382-2347** or send a letter to the health plan at:

Community First Health Plans, Inc.
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 the health plan denied, based on previously authorized services 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 that time, the Member or the Member's representative can tell why the Member needs 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.

EXTERNAL MEDICAL REVIEW INFORMATION

Can a Member of Community First ask for an External Medical Review?
If a Member, as a Member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an 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 Community First 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 External Medical Review within 120 days of the date the health plan 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 MCO Internal Appeal Decision letter and mail or fax it to Community First by using the address or fax number at the top of the form; or
- Call Community First at **1-844-382-2347**

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, 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 the health plan, the service the health plan 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 Entity or while the Independent Review Entity 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, email, or fax; or (2) orally, by phone or in person.

An Independent Review Entity 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 Entity 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. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Entity be present at the State Fair Hearing. The Member can make both of these requests by contacting Community First at **1-844-382-2347** or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

Can a Member ask for an 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.

XII. MEMBER ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

HHSC and Centers for Medicare and Medicaid Services (CMS) are responsible for determining STAR+PLUS eligibility. The state's Enrollment Broker, Maximus, is responsible for enrolling individuals into the STAR+PLUS program. The Enrollment Broker can be contacted at the Medicaid Managed Care help line at **1-800-964-2777**.

When a Member gains eligibility, 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 inform the Member to select a health plan and a PCP within 15 days.

Individuals who meet all of the following criteria will be eligible for STAR+PLUS:

- Age 21 or older at time of enrollment.
- Entitled to benefits under the Medicare Part A and enrolled under Medicare Part B.
- Required to receive their Medicaid benefits through the Community First STAR+PLUS.
- Reside in Bexar, or surrounding counties, including Atascosa, Bandera, Comal, Guadalupe, Medina, Kendall, or Wilson.

Certain Community First STAR+PLUS populations excluded from participation in the STAR+PLUS demonstration include those who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions and individuals with developmental disabilities who get services through one of these waivers:

- Community Living Assistance and Support Services (CLASS)
- Home and Community-based Services (HSC)
- Deaf Blind with Multiple Disabilities program (DBMD)
- Texas Home Living program (TxHmL)

Plan Enrollment

Enrollment for eligible individuals into STAR+PLUS may be conducted (when no active choice has otherwise been made) using a seamless, passive enrollment process that provides the opportunity for individuals to make a voluntary choice to enroll or disenroll from STAR+PLUS at any time. Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted STAR+PLUS MCOs no less than 60 days prior to the effective date of enrollment, and will have the opportunity to opt-out until the last day of the month prior to the effective date of enrollment. Disenrollment from STAR+PLUS MCOs and enrollment from one STAR+PLUS MCO to a different STAR+PLUS MCO will be allowed on a month-to-month basis any time during the year. However, coverage for these individuals will continue through the end of the month. As mutually agreed upon, CMS and the State will utilize an Enrollment Broker, independent of the STAR+PLUS MCO, to facilitate all enrollment into the STAR+PLUS program. STAR+PLUS enrollments, including enrollment from one STAR+PLUS MCO to a different STAR+PLUS MCO, and opt-outs, shall become effective on the same day for both Medicare and Medicaid. For those who lose Medicaid eligibility during the month, coverage and Federal Financial Participation (FFP) will continue through the end of that month.

Members who do not participate in STAR+PLUS will remain enrolled in Community First STAR+PLUS and will continue to receive their Long-Term Service and Supports

(LTSS) through Community First.

Accountable Care Organizations (ACOs)
Members enrolled in a Medicare Accountable Care Organization (ACO) are considered to be fee-for-service (FFS) Medicare and may also be eligible for enrollment in the STAR+PLUS program. To preserve the infrastructure of existing ACOs in the counties in which the demonstration will operate, HHSC will reduce the number of Members who will be passively enrolled from an ACO. Further, HHSC has required participating STAR+PLUS programs to contract with ACOs to develop shared savings and/or quality incentives. However, these arrangements will not count as enrollment in a Medicare ACO for purposes of shared savings with Medicare. This will be an ongoing process that only applies to ACOs that were in operation prior to the Dual Demonstration implementation on March 1, 2015.

HHSC will work with STAR+PLUS in an attempt to limit passive enrollment for Members in an ACO with the following attributes:

- Operating in a demonstration county (Bexar, Dallas or Hidalgo).
- Fewer than 9,000 Members.
- Established by March 1, 2015.

However, Members can elect to participate. Members in an ACO that are excluded from passive enrollment will receive notification about the option to enroll in the STAR+PLUS program. If a Member of an ACO elects to participate in the demonstration, they can continue to receive services from their primary care provider (PCP) aligned with the ACO once enrolled if the PCP is a Community First STAR+PLUS network provider.

Please Note: The Enrollment Broker will not facilitate PCP assignment. Members enrolled in Community First will be assigned through the plan's PCP auto-assignment process and not through the state Enrollment Broker. Members are encouraged to select their own PCP and are able to call Member Services and change their PCP assignment at any time. PCP assignments are effective the first of the month after they are received.

As with all dual-eligible demonstrations, Members will be able to opt-out of the program and will be enrolled back into STAR+PLUS.

Members who opt into STAR+PLUS will be enrolled based on when their request is provided to the Enrollment Broker. For enrollment requests received through the 12th of the month, the effective date of coverage will be the first day of the next month. Enrollment requests received after the 12th of the month will be effective the first day of the second month following initial receipt of the request.

Required Involuntary Disenrollment
Texas and CMS will terminate a Member's enrollment in STAR+PLUS upon the occurrence of any of the conditions listed below:

- Change in residence makes the individual ineligible to remain enrolled in the STAR+PLUS program.
- The Member loses entitlement to either Medicare Part A or Part B.
- The Member dies.
- The Member loses Medicaid eligibility or additional State-specific eligibility requirements.

- When Community First verifies the Member as having third-party coverage with Community First or with another carrier.
- Upon incarceration in a county jail, Texas Department of Corrections facility or Federal penal institution.
- Upon the occurrence of any of the conditions described in this section.

Community First will be responsible for ceasing the provision of covered services to a Member upon the effective date of disenrollment. Community First must first provide documentation, satisfactory to Community First, that the Member meets one of the disenrollment criteria. Termination of the coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which Community First determines that the Member is no longer eligible.

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.
- 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.
- Review any relevant medical records.

Examples of reasons 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.

A Member will receive an Advance Notice and Notice of Intent as described in the 2013 Medicare –Medicaid Plan Enrollment and Disenrollment Guidance. Termination of a Member's enrollment shall take effect at 11:59 p.m. on the last day of the month following the month the disenrollment is processed.

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 for

Member disenrollment.

Renewal
Members who receive SSI benefits from the Social Security Administration (SSA) are categorically eligible for SSI Medicaid and, therefore, do not have to recertify with HHSC each year. To maintain SSI benefits, the SSA may require information from the person related to their SSI benefits. The person or their representative 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 timeframe and resides in the same service area, the Member will be automatically re-enrolled by HHSC. 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.

VERIFYING ELIGIBILITY

Each STAR+PLUS Member is issued a Texas Benefits Medicaid and a health plan (i.e., Community First) ID Card. However, having a card does not always mean the Member has current coverage. We instruct the STAR+PLUS Members to present both ID Cards when requesting medical services. It is imperative that providers verify the Member's eligibility for the date of service prior to services being rendered. There are two ways to do this:

- Use TexMedConnect on the TMHP website at TMHP.com
- Call Provider Services at the patient's medical or dental plan.

The Community First ID Card shows important Member information such as Community First's telephone numbers and the Member's assigned PCP. Providers may contact Community First to verify Member eligibility by calling **210-358-6105** or **1-844-382-2347**.

If the Member also received Medicare benefits, Medicare is responsible for most primary and acute services and some behavioral health services; therefore, the primary care provider's name, address, and telephone number are not listed on the Member's ID card. The Member receives long-term services and supports through Community First.

A Member who appears on a PCP's monthly Member Roster is considered to be an existing Member from the first month that he/she appears on the roster and therefore cannot be refused services while assigned to that PCP.

The Your Texas Benefits Medicaid Card. At the time of the visit, ask the Member to show both forms of ID. The Texas Benefits Medicaid Card will verify coverage for the current month only, identify if the holder is a STAR+PLUS Member, and name of the plan. The Community First ID Card and Texas Benefits Medicaid Card do not guarantee eligibility for coverage. Other ways to verify eligibility include TMHP's Automated Inquiry System (AIS), TexMedConnect, or the Community First Provider Portal.

- To verify eligibility using the secure online Community First Provider Portal, visit CommunityFirstHealthPlans.com/ProviderPortal
- Provider must document verification in their records and treat the client as usual.

Temporary ID (Form H1027-A). Form 1027-A is an additional form used to verify Medicaid eligibility. The form is acceptable as evidence of eligibility during the eligibility period of the letter unless the letter contains limitations that effect eligibility for the intended services. Providers must accept either Your Texas Benefits Medicaid card or Form 1027-A as valid proof of eligibility. If the Member is not eligible for medical assistance or certain benefits, the Member is treated as a private pay patient.

Although the temporary Medicaid Eligibility Verification Form 1027-A identifies eligible clients when the client's Your Texas Benefits Medicaid Card is lost or has not yet been issued, Form 1027-A does not indicate periodic eligibility for medical checkup services. Providers should call the TMHP Contact Center at **1-800-925-9126** or check the TMHP website at TMHP.com to verify a client's periodic eligibility for medical checkup services.

Verifying Member Medicaid Eligibility and Community First Enrollment. Providers should verify the patient's Medicaid eligibility and Community First enrollment for the date of service prior to services being rendered.

There are several ways to do this:

- Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.
- Use TexMedConnect on the TMHP website at TMHP.com.
- Log into your TMHP user account and accessing Medicaid Client Portal for Providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at **1-800-925-9126** or **512-335-5986**
- Pharmacies may use AIS for eligibility verification (e.g., NCPDP E1 transaction)
- Call Provider Services at the patient's medical or dental plan.
- Call the Your Texas Benefits Provider helpline at **1-855-827-3747**.

Please Note: Do not send patients who forgot or lost their Texas Benefits Medicaid cards to an HHSC benefits office for a paper form. Members can request a new card by calling **1-800-252-8263**. Medicaid Members also can go online to order new cards or print temporary cards at YourTexasBenefits.com. On the website, Members can also see their benefit and care information, view and set up THSteps Alerts, and more.

Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients or proof of client eligibility. A copy is required during the appeal process if the client's eligibility becomes an issue.

Provider Access to Medicaid Medical and Dental Health Information. Medicaid Providers can log into their TMHP user account and access the Medicaid Client Portal for Providers at TMHP.com. This portal aggregates data (provided from TMHP) into one central hub – regardless of the plan (FFS or Managed Care). This information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be.

The specific functions available are:

- Access to a Medicaid patient's medical and dental health information, including medical diagnosis, procedures, prescription medicines and vaccines on the Medicaid Client Portal through "My Account."

- Enhances eligibility verification available on any device, including desktops, laptops, tablets, and smart phones with print functionality.
- THSteps and benefit limitations information.
- A viewable and printable Medicaid Card.
- Display of the Tooth Code and Tooth Service Code for dental claims or encounters.
- Display of the dental anesthesia procedure date.

Additionally, an online portal is available to patients at YourTexasBenefits.com where they can:

- View, print, and order a Your Texas Benefits Medicaid card.
- See their medical and dental plans.
- See their benefit information.
- See THSteps alerts.
- See broadcast alerts.
- See diagnosis and treatments.
- See vaccines.
- See prescription medicines.
- Choose whether to let Medicaid doctors and staff see their available medical and dental information.

Please Note: YourTexasBenefits.com Medicaid Client Portal displays information for active patients only. Legally Authorized Representatives can view anyone who is part of their case.

BENEFITS

Community First must provide covered services as described in the most recent Texas Medicaid Provider Procedures Manual, the THSteps Manual (a supplement to the Provider Procedures Manual), and in all Texas Medicaid Bulletins, which update the Provider Procedures Manual except for those services identified as non-capitated services. Covered services are subject to change due to changes in federal and state law, changes in Medicaid policy, and changes in medical practice, clinical protocols, or technology.

In addition to the standard covered benefits, Community First STAR+PLUS Members are eligible for the following benefits:

- Annual adult well checks
- Removal of the Spell of Illness limitation
- Unlimited prescriptions (Benefit is only available for Members who are not covered by Medicare)
- The $200,000 annual limit on inpatient services does not apply.

VALUE-ADDED SERVICES

Community First Network Providers may visit CommunityFirstMedicaid.com for a current list of Value-Added Services available to STAR+PLUS Members. Members are informed through the HHSC health plan comparison charts and in the STAR +PLUS Member Handbook.

CONTINUOUS INPATIENT STAY

Span of Coverage (Hospital) - Responsibility during a Continuous Inpatient Stay. If a Member is disenrolled from Community First and enrolled in another STAR+PLUS MCO during an inpatient stay, then Community First will pay all facility charges until the Member is discharged from the hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, or until the Member loses Medicaid eligibility. The new STAR+PLUS MCO will be responsible for all other covered services on the Effective Date of Coverage with the STAR+PLUS MCO.

	Scenario	Hospital Facility Charge	All Other Covered Services
1	Member moves from FFS to STAR+PLUS	FFS	New MCO
2	Member moves from STAR, STAR Health or STAR+PLUS to STAR+PLUS	Former MCO	New MCO
3	Member moves from CHIP to STAR+PLUS	New MCO	New MCO
4	Adult Member moves from STAR+PLUS to STAR or STAR+PLUS	Former STAR+PLUS MCO	New STAR or STAR+PLUS MCO
5	Member moves from STAR+PLUS to STAR+PLUS	Former STAR+PLUS MCO	New STAR Health MCO
6	Member Retroactively Enrolled in STAR+PLUS	New MCO	New MCO
7	Member moves between STAR+PLUS MCOs	Former MCO	New MCO

XIII. MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

1. You 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 your medical records and discussions with your Providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or Provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider.
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your Provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.
   c. Be given information about your health, plan, services, and providers.
   d. Be told about your rights and responsibilities.
4. You 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 your Provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your Provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your Provider, or your health plan.
   b. DBMD escalation help line for Members receiving Waiver services via the Deaf/Blind Multi-Disability Program.
   c. Get a timely answer to your complaint.
   d. Use Community First's appeal process and be told how to use it.
   e. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   f. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You 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, 7 days a week to get any emergency or urgent care you need.

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 your Providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you 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. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan's rules and Medicaid rules.
   b. Choose your health plan and a primary care provider quickly.
   c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your primary care provider first for your non-emergency medical needs.
   g. Be sure you have approval from your primary care provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.
   b. Talk to your Providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your Providers get your medical records.
4. You must be involved in decisions relating to service and treatment options,

make personal choices, and take action to keep yourself healthy. That includes the responsibility to:

a. Work as a team with your Provider in deciding what health care is best for you.
b. Understand how the things you do can affect your health.
c. Do the best you can to stay healthy.
d. Treat Providers and staff with respect.
e. Talk to your Provider about all of your medications.

5. You can ask for and get the following information each year:
   - 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:
     a. Professional qualifications
     b. Specialty
     c. Medical school attended
     d. Residency completion
     e. Board certification status
     f. Provider demographics
   - Any limits on the Member's freedom of choice among network providers.
   - Member rights and responsibilities.
   - Information on complaint, appeal and State Fair Hearing procedures.
   - 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.
   - How Members can get benefits, including authorization requirements, family planning services, from out-of-network providers and/or limits to those benefits.
   - How Members get after hours and emergency coverage and/or limits to those kinds of benefits, including:
     a. What makes up emergency medical conditions, emergency services and post-stabilization services.
     b. The fact that Members do not need prior authorization from their PCP for emergency care services.
     c. How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
     d. The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
     e. A statement saying the Member has the right to use any hospital or other settings for emergency care.
     f. Post-stabilization rules.
   - Policy on referrals for specialty care and for other benefits a Member cannot get through their PCP.
   - Community First's practice guidelines.

Additional Member Responsibilities While Using Community First's Where's My Ride Program (NEMT Services):

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT Services.

3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT Services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the NEMT Service Provider, who helped you arrange your transportation as soon as possible.

SELF-REFERRALS

STAR+PLUS Members may self-refer for the following services:

- Emergency Care
- Family Planning Services
- Obstetrical and/or Gynecological Services (OB/GYN)
- MHMR Services
- Behavioral Health
- Additional eye health care services provided by an in-network optometrist or ophthalmologist (other than surgery) can be provided without a referral from the Member's PCP. Covered surgical/laser care requires prior authorization.

The PCP is encouraged to provide or coordinate referrals for the services shown above.

MEMBER'S RIGHT TO DESIGNATE AN OB/GYN

Community First allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member's primary care provider or not.

ATTENTION FEMALE MEMBERS

Members have the right to select an OB/GYN without a referral from their primary care provider. An OB/GYN can give the Member:

- One well-woman checkup per year
- Care related to pregnancy
- Care for any female medical condition
- Referral to special doctor within the network

MEMBER'S RIGHT TO DESIGNATE A SPECIALIST AS A PCP

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

- Meet Community First requirements for PCP participation, including credentialing.
- Contract with Community First as a PCP.

FRAUD, WASTE, AND ABUSE

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable Federal or State Law (42 CFR §455.2).

"Waste" means Practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services (RULE §371.1)

"Abuse" means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs (42 CFR § 455.2).

Examples of Fraud, Waste, and Abuse
Examples of Fraud, Waste, and Abuse by a health care provider include:

- Billing for services, procedures, or supplies that were not provided or needed
- Billing a claim for a more expensive procedure or service than what was performed
- Billing for a covered service when the service provided was not covered
- Omitting or misrepresenting information about a condition, symptom, or service performed
- Unbundling charges (taking an overall procedure and billing each part separately to receive higher reimbursement)
- Accepting money for patient referrals
- Waiving patient copays or deductibles for services that were prepaid or paid in full by the health insurer

Examples of Fraud, Waste, and Abuse by a Member or patient include:

- Sharing their Member ID card with someone else
- Adding someone to their insurance policy who is not eligible for coverage
- Receiving narcotic prescriptions from several different doctors or pharmacies, dishonestly
- Forging or altering bills or receipts
- Filing claims for services or medications not received
- Lying about their physical address to obtain coverage

Reporting Fraud, Waste, or Abuse by a Provider or Client
Community First Members, Providers, and others can report fraud, waste, or abuse by following the steps outlined below.

1. **Do you want to report Fraud, Waste, or Abuse?**

   Let Community First 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 Community First if you think someone is:
   - Getting paid for services that weren't given or necessary.
   - Upcoding for services provided to receive higher reimbursement.
   - Unbundling when billing for services provided.
   - Not telling the truth about a medical condition to get medical treatment.

- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources they have to get benefits.

2. **To report Fraud, Waste, or Abuse, choose one of the following:**

   - Call the OIG Hotline at **1-800-436-6184**
   - Visit OIG.HHS.Texas.gov/Report-Fraud-Waste-or-Abuse to complete IG's Fraud Reporting Form
   - Report directly to Community First at:
     Community First Health Plans, Inc.
     Attention: Special Investigations Unit
     12238 Silicon Drive, Suite 100
     San Antonio, TX 78249

- Call Community First Provider Services at **1-844-382-2347** or the Community First Anti-Fraud Hotline at 210-358-6332 (toll-free 1-877-225-7152)

3. **To report Fraud, Waste, or Abuse, gather as much information as possible.**

   When reporting a Provider (a doctor, dentist, counselor), include:

   - Name, address, and phone number of the Provider
   - Name and address of facility (e.g., hospital, nursing home, home health agency)
   - Medicaid number of the Provider and facility (if you have it)
   - Type of Provider (e.g., doctor, dentist, therapist, pharmacist)
   - Contact information of other witnesses who can help in the investigation.
   - Dates of events
   - Summary of what happened.

   When reporting abuse by someone who gets benefits, include:

   - The person's name.
   - The program in which the Member is/was enrolled (STAR+PLUS).
   - 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.

Community First Providers can also report Fraud, Waste, and Abuse directly to Community First using our online Suspicious Activity Report forms. Submit the Member and/or Provider Suspicious Activity forms either:

- Online: CommunityFirstHealthPlans.com/Fraud-Waste-Abuse
- Fax: 210-358-6405
- Email: SIURequest@cfhp.com

SPECIAL INVESTIGATIONS UNIT

Community First is committed to protecting and preserving the integrity and availability of health care resources to our recipients, our health care partners, and the general community. Community First performs several activities through its in-house Special Investigation Unit (SIU) to detect, prevent, and eliminate fraud, waste, and abuse at the provider, recipient, and health plan level to include coding and documentation audits,

pre and post payment review, verification of services through member outreach, and utilization of claims editing software. Community First trains employees, contractors, and agents to identify and report possible acts of fraud, waste, and abuse. When such acts are identified, Community First seeks effective remedies to identify overpaid amounts; prevent future occurrences of fraud, waste, and abuse; and report offenses to the appropriate agencies. The Special Investigation Unit (SIU) follows the requirements of the Texas Administrative Code §353.505 and §370.505 regarding the recovery of overpayments

Community First considers previous educational efforts when determining intent. Intentional misrepresentation, intent to deceive and or attempting to obtain unjustly benefit payments are not considered unless there is documented previous education in writing or in person by Community First regarding the same or similar adverse audit findings or there are obvious program violations.

To report Providers, use this address:

Office of Inspector General
Medicaid Provider Integrity
Mail Code 1361
P.O. Box 85200
Austin, TX 78708-5200

To report clients, use this address:

Office of Inspector General
General Investigations
Mail Code 1362
P.O. Box 85200
Austin, TX 78708-5200

Claims Review and Auditing
Community First utilizes established industry claims adjudications and/or clinical practices, National Correct Coding Initiative Edits (NCCI), State and Federal guidelines, and/or Community First's policies and data to determine the appropriateness of billing, coding, and reimbursement.

The Provider acknowledges Community First's right to conduct prepayment and post payment billing audits. The Provider shall cooperate with Community First's Special Investigation Unit (SIU) and audits of claims and payments by providing requested claims information, including supporting medical records, Provider's charging policies, and other related information or data as deemed applicable to support the services billed.

Providers are required to submit, or provide access to, medical records upon Community First's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment. Failure to respond or submit the necessary documentation for the specified claim(s) and date(s) of service(s) may result in recoupment of the claim. An appeal will not be accepted for recoupments or overpayments related to missing medical records or late submissions.

Community First may select a statistically valid random sample, or smaller subset of the statistically valid random sample, depending on the type of audit or monitoring being conducted. This sample gives an estimate of the proportion of claims Community First may have paid in error. The estimated percentage, or error rate, may be projected across all claims to determine the amount of overpayment. Provider audits may be telephonic, an on-site visit, internal claims review, regulatory investigation and/or compliance reviews.

If Community First's Special Investigation Unit suspects that there is fraudulent or abusive activity, an on-site audit without notice may be conducted. Should the Provider refuse to allow access to their facilities, Community First reserves the right to recover the full amount paid or due to the Provider.

XIV. ENCOUNTER DATA, BILLING, AND CLAIMS ADMINISTRATION

CLAIMS INFORMATION

A **claim** is a request for reimbursement, either electronically or by paper, for any health care service provided. A claim must be filed on the approved claim form such as the CMS-1500 Health Insurance Claim Form or UB-04 CMS-1450 Claim Form. Any UB-04-CMS 1450 or CMS 1500 paper claim forms received that do not meet the CMS printing requirements will be rejected back to the provider upon receipt.

A **clean claim** is a claim submitted on an approved standardized claim format (CMS 1500 or UB-04 CMS 1450) that contains all data fields required by Community First, as specified in this section for adjudication of the claim as a clean claim. The required data fields must be complete and accurate. A clean claim must include all published clean claim requirements including Tax Identification Number (TIN), National Provider Identifier (NPI), and taxonomy.

Processing and 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 Chapter 2 of the HHSC Uniform Managed Care Manual. In addition, STAR+PLUS claim requirements are exempt from the Texas Insurance and Administrative Code claims Prompt Pay requirements.

Community First and its subcontractors cannot directly or indirectly charge or hold a Member or provider responsible for claims adjudication or transaction fees.

Community First may deny a claim submitted by a provider for failure to file in a timely manner, as provided for in the HHSC Uniform Managed Care Manual Chapter 2.

Community First will not pay any claim submitted by a provider:

- Excluded or suspended from the Medicare or Medicaid programs for fraud, waste, or abuse.
- On payment hold under the authority of HHS or its authorized agent(s).
- For neonatal services provided on or after September 1, 2017, if submitted by a hospital that does not have a neonatal level of care designation from HHSC.*
- For maternal services provided on or after September 1, 2019, if submitted by a hospital that does not have a maternal level of care designation from HHSC.*

*In accordance with the Texas Health and Safety Code § 241.186, the restrictions on payment identified for neonatal and maternal services above do not apply to emergency services that must be provided or reimbursed under state or federal law.

Community First validates the following when adjudicating a claim:

- Institutional claims must contain Present on Admission (POA) indicators.
  - Community First utilizes the POA information submitted on claims to reduce and/or deny payment for provider preventable conditions.
  - For per diem hospital payments, Community First utilizes a methodology for reduction and/or denial of payment for services related to a provider preventable condition that was not POA.

Upon receipt of a clean claim, Community First will adjudicate the claim for payment or denial within the 30-day claim processing timeframe. If denied in whole or in part, Community First will notify the provider of why the claim will not be paid.

Community First must receive a provider's appeal of a claim within 120 days from the date of disposition (date of the EOP). Community First will process the claim appeal within 30 days from the date of receipt of the claim appeal.

The date of a claim payment is the date of issue of a check for payment, or the date of Electronic Funds Transmission (EFT) if payment is made electronically.

The Patient Protection and Affordable Care Act (PPACA) was amended by Section 1202 of the Health Care and Education Reconciliation Act. This amendment requires that Medicaid payment rates to Primary Care Providers (family medicine, general internal medicine, or pediatric medicine) for furnishing primary care services in 2013 and 2014 be at least 100% of Medicare payment rates under both fee-for-service plans and managed-care plans.

HHSC will make supplemental payments to Community First for these rate increases, and Community First will pass through the full amount of the supplemental payments to qualified providers no later than 30 days after receipt of HHSC' supplemental payment report, contingent upon receipt of the allocation.

Providers must bill compounded drugs using the drug code and metric decimal quantity for each National Drug Code in the compound.

WHERE TO SEND CLAIMS/ENCOUNTER DATA

Submitting Electronic Claims

- **Provider Portal**
  Providers may submit batch claims or individual claims electronically using the secure online Community First Provider Portal at CommunityFirstHealthPlans.com/ProviderPortal.

- **Availity - Clearinghouse**
  Community First accepts electronically submitted claims through Availity. Claims filed electronically must be filed using the 837P or 837I format. Billing instructions can be found at the Availity website. Electronically submitted claims must be transmitted through Availity using Community First's Payor Identification as indicated below:
  - Community First Payor ID: COMMF
  - Community First Receiver Type: F

- **Electronic Claims**
  - **Provider Portal Electronic Billing:**
    - Claim MD
    - Availity

Claims submissions for STAR+PLUS Members services may only be submitted directly to Community First.

- Claims for all LTSS services.

- Daily rate claims for services rendered in a nursing facility or Individuals with Intellectual Disabilities (ICF/IDDs) or other related conditions.
- Claims for custom DME or augmentative devices when the Member changes health plans and the authorizing health plan is not the Member's health plan on the date of delivery.
  Submit Paper Claims to:

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

Community First requests that if you are submitting paper claims the following steps should be followed to expedite payment:

- Use 10 x 13-inch envelopes; send multiple claims in one envelope.
- Do not staple, paper clip or fold claim forms or attachments.
- Do not use red ink.
- Whenever possible generate your claims on a computer or typewriter (handwritten claims are difficult to read and scan).

CLAIM FORMS

Physician and other health care providers must file paper claims on a CMS-1500 Health Insurance Claim Form. Federally Qualified Health Centers (FQHC) can file on either a CMS 1500 or a UB-04 Claim Form.

Community First should be billed a Provider's normal (usual and customary billed) charges only. We will make the necessary adjustments and will show the adjustments made on the Explanation of Payment (EOP) sent to the Provider with their reimbursement check.

Hospitals, Rural Health Clinics (RHC), and Other Facilities must bill on a UB-04 Claim Form.

Please Note: Only claims including all required information will be considered clean claims. Newborn claims should be submitted with all of the required elements above. However, if a Medicaid number for the newborn is unavailable, use the mother's Medicaid ID number with the correct date of birth for the newborn.

MONTHLY CAPITATION SERVICES

Some providers may receive a monthly capitation for services. These services may vary per each individual provider, and if applicable, will be listed in the provider's contract with Community First. Providers that receive monthly capitation for services must file a proxy claim on a CMS 1500 for each service provided. This is referred to as an "encounter."

Capitated services are adjudicated to reflect zero dollar payment amounts. It is mandatory that a capitated provider submit encounter claims to Community First, in order for Community First to utilize the encounter data to evaluate all aspects of quality and utilization management.

The following is a list of capitated services that Community First is responsible for

providing to STAR+PLUS Members:

- Ambulance services
- Audiology services, including hearing aids for adults
- Behavioral Health Services, including:
  - Inpatient and outpatient mental health services
  - Inpatient and outpatient chemical dependency services.
  - Detoxification services
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)
- Birthing center services if available within the service area
- Chiropractic services
- Dialysis
- Medical equipment and supplies
- Emergency services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Optometry, glasses, and contact lenses, if medically necessary
- Podiatry
- Prenatal care
- Primary care services
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision

For a full list of benefits and services, including exclusions, please see the "Texas Provider Procedures Manual" at TMHP.com.

Providers may call Community First with questions about what services are included in monthly capitation.

COINSURANCE CLAIMS

The payment of the Medicare Part A coinsurance and deductibles for Medicaid Members who are Medicare beneficiaries is based on the following:

- If the Medicare payment amount equals or exceeds the Medicaid payment rate, Medicaid does not pay the Medicare Part A coinsurance/deductible on a Medicare crossover claim.
- If the Medicare payment amount is less than the Medicaid payment rate, Medicaid pays the Medicare Part A coinsurance/deductible, but the amount of the payment is limited to the lesser of the coinsurance/deductible or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.

EMERGENCY SERVICE CLAIMS

Community First's policies and procedures, covered services, claims adjudication methodology and reimbursement levels for Emergency Services comply with all applicable state and federal laws, rules and regulations including 42 C.F.R. 438.114,

whether the Provider is a participating provider or out-of-network. Community First's policies and procedures are consistent with prudent layperson definition of an Emergency Medical Condition and the claims adjudication processes required under the contract with HHSC and C.F.R. 438.114.

Community First will pay for the professional, facility, and ancillary services that are medically necessary to perform the medical screening examination and stabilization of a Member presenting as an Emergency Medical Condition or an Emergency Behavioral Health Condition to a hospital emergency department, 24 hours a day, 7 days a week, rendered by either a participating provider or out-of-network.

Community First does not require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, or labor and delivery. Nor does Community First hold the Member liable for the payment of subsequent screening and treatment to diagnose the specific condition or stabilize the Member who had an Emergency Medical Condition.

PCPs should become actively involved in educating STAR+PLUS Members regarding the appropriate use of the emergency room and other emergency services. PCPs should notify Community First of any Member who may need further education by calling Member Services at Community First.

If a Member has an emergent condition, the emergency room must treat the Member until the condition is stabilized or until the client can be admitted or transferred. Once the Member is stabilized, the Emergency Room staff must notify Community First to arrange for medically necessary hospital admission or follow-up care with the Member's PCP.

PHARMACY CLAIMS

- Clean claims submitted electronically will be adjudicated within 18 days of receipt. Clean claims submitted non-electronically will be adjudicated within 21 days of receipt.
- Claims must be submitted within 95 days.
- Approved claim forms.

NO COPAYMENTS FOR MEDICAID MANAGED CARE MEMBERS

In Medicaid Managed Care programs, Members may assume a responsible role in achieving their personal health care by choosing a PCP, actively participating with their PCP to access preventive, primary care services. This collaborative approach to health care delivery does not require or allow the collection of a copayment from the STAR+PLUS Member.

BILLING MEMBERS

By entering into an agreement with Community First, the Provider has agreed to accept payment directly from us. Reimbursement from Community First constitutes payment in full for the services rendered to Members. **By contract, Providers cannot bill Members for the difference between their normal charge and the payment rate that was negotiated with Community First for rendering covered services.**

The Provider has also agreed that in no event, including, but not limited to non-payment by Community First or our insolvency or breach of our agreement with the Provider, will the Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member, the state of Texas, or any persons other than us for services provided pursuant to your agreement with Community First.

In addition, Providers may not bill a Member if any of the following circumstances occur:

- Failure to submit a claim, including claims not received by Community First.
- Failure to submit a claim to Community First for initial processing within the 95-day filing deadline.
- Failure to submit a corrected claim within the 120-day filing re-submission period.
- Failure to appeal a claim within the 120-day appeal period.

Payment for Services. The Provider is prohibited from billing or collecting any amount from a Medicaid Member for "health care services" rendered pursuant to the Provider contract. Federal and state laws impose severe penalties for any Provider who attempts to bill or collect any payment from a Medicaid recipient for a covered service.

The Provider understands and agrees that HHSC is not liable or responsible for payment of covered services rendered pursuant to the Provider contract.

TIME LIMIT FOR SUBMISSION OF CLAIMS

Providers are required to submit claims to Community First within 95 days from the date of service. Claims received after the filing date will be denied payment. Questions regarding claims should be directed to Community First Health Plan's Claims Provider Services Unit at **210-358-6200**.

Proof of Timely Filing. Community First accepts the following as proof of timely filing:

- Returned receipt (Certified Mail)
- Electronic confirmation from Community First vendor
- Receipt of claim log signed by Community First employee

CLAIMS SUBMISSION

See Community First Health Plans Provider Billing Guidelines to review certain aspects and expectations regarding the 837P Professional Health Care Claim transactions.

Community First will provide the Provider at least 90 days notice prior to implementing a change in the above-referenced claims guidelines unless the change is required by statute or regulation in a shorter timeframe.

Providers are required to submit claims to Community First within 95 days from the date of service. Claims received after the filing date will be denied payment. Questions regarding claims should be directed to Community First Health Plan's Claims Provider Services Unit at **210-358-6200**.

1. Community First will adjudicate all clean claims within 30 days from the date Community First receives the clean claim(s).
2. Community First will notify Providers within 30 days from the date we receive the

claim(s) if we will deny or pend the claim(s) and the reason(s) for the denial.

3. Community First will pay Providers interest on any clean claim(s) we do not adjudicate within 30 days from the date Community First receives the clean claim(s). Community First will pay the interest at a rate of 1.5 percent per month (18 percent annually) for each month we do not adjudicate within 30 days.

Unless otherwise specified in the Professional Provider Agreement, the payment methodology applicable to the Provider is:

- 100% of the current State of Texas Medicaid Fee Schedule, as may be amended from time to time.
- Providers who are considered out-of-network for Community First , the applicable payment methodology is defined by HHSC and is equal to 95% of the current State of Texas Medicaid Fee Schedule, as may be amended from time to time.
- Providers who are considered out-of-network and out of the Bexar Service Delivery Area, the applicable payment methodology is defined by HHSC and is equal to 100% of the current State of Texas Medicaid Fee Schedule, as may be amended from time to time.

The Texas Medicaid Fee Schedule is available at TMHP.com or by calling **1-800-925-9126**.

Program Violations. Arising out of performance of the contract are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG) as specified in 1 Tex. Admin. Code § 371.1651-1669.

Supervised Providers. Providers must comply with the requirements of GOV'T § 531.024161, regarding the submission of claims involving supervised Providers.

EOP, DUPLICATE CHECKS, AND CANCELED CHECK REQUESTS

Community First receives a significant number of requests each month from Providers for additional copies of EOPs and canceled checks. The Provider is sent a copy of the EOP with each check issued by Community First. Each Provider's office is responsible for keeping this information available for use in posting payments and submitting appeals. Community First recommends that you make a copy of the check, both front and back, as well as a copy of the EOP, so you have it available should you need in the future.

Please Note: Check printing errors that result in duplicated checks should be reported to Community First as soon as identified. Provider assumes responsibility for keeping an accurate record of checks received to ensure that a duplicate check is not deposited or cashed. Any bank fees that Provider accrues after Provider deposits or cashes a duplicate check will not be reimbursed by Community First.

Community First will provide the first request for an additional EOP at no charge. Any requests beyond the first request will be assessed a charge of $15.00 per EOP and $20.00 per check. The request for a copy of the EOP and/or check must be submitted in writing along with the appropriate fee. The request must include the date of the EOP, the name of Provider, and date of the check. Send the request to:

Community First Health Plans, Inc.
Attention: Claims Department
12238 Silicon Drive, Suite 100

San Antonio, TX 78249

SPECIAL BILLING

- The name on the claim should be the same name as it appears on the Your Texas Benefits Medicaid card.
- Make sure the sex of the Member listed on the claim is accurate.
- Value-added services do not require billing.
- Non-Emergency Medical Transportation (NEMT) services do not require billing.

BILLING AND CLAIMS ADMINISTRATION

Coordination of Benefits. Any other insurance, including Medicare, is always primary to Medicaid coverage. If a STAR+PLUS Member has other insurance, providers must submit claims to the primary insurance for consideration. For Community First payment consideration, file the claim with a copy of the EOB, EOP or rejection letter from the other insurance. If this information is not sent with an initial claim filed for a Member with other insurance, the claim will pend and/or deny until this information is received. If a Member has more than one primary insurance (Medicaid would be the third payer), the claim can be submitted through EDI, the Secure Provider Portal or on paper.

Third Party Recovery. Third Party Recovery (TPR) means the recovery of payments on behalf of a Member by Community First from an individual or entity with the legal responsibility to pay for the covered service. Community First providers are requested to provide Community First with any TPR information that they obtain from the Member. TPR information should be reported to Community First's Network Management Department.

The Your Texas Benefits Medicaid card (formerly Medicaid Form 3087) also contains a TPR column. The TPR column will indicate if other insurance has been reported by including an "M" (Medicare) and/or a "P" (Other Insurance).

The Provider understands and agrees that it may not interfere with or place any liens upon the state's right or Community First's right, acting as the state's agent, to recovery from third party resources.

Explanation of Payment (EOP). Providers will receive an EOP. The EOP will include the following information:

- Amount billed
- Allowed (contracted) amount
- Other insurance payment
- Total benefit paid to the Provider
- All reasons for the denial if payment is not made

Billing Codes. It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in denial/rejection of the claim and a consequent delay in payment. Claims should be billed using the following coding:

- Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-10 codes.
- Submit institutional claims with valid revenue codes and CPT-4 or HCPCS (when applicable), ICD- 10 codes and DRG codes (when applicable).

Claims must comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 11-148), regarding mandatory state use of National Correct Coding Initiatives, including all applicable rules, regulations and methodologies implemented as a result of this initiative.

Community First requires the use of valid ICD-10 diagnosis codes to the ultimate specificity, for all claims. See the ICD-10 coding manual for details.

The highest degree of detail can be determined by using the tabular list (volume one) of the ICD-10 coding manual in addition to the alphabetic list (volume two), when locating and designating diagnosis codes. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

The tabular list gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to ultimate specificity if appropriate.

Ancillary providers (e.g., labs, radiologists, etc.) and those physicians interpreting diagnostic testing may use appropriate and most current V codes for laboratory exam, radiological exam, NEC and other specified exam as the principal diagnosis on the claim. Please consult your ICD-10 Manual for further instruction.

Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

Medicare Part B Services and Supplies Billing
When billing for Medicare Part B services and supplies, Community First reimburses the provider the lesser of:

- The Medicare Part B coinsurance and deductible payment
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service. If this amount is less than the deductible, then the full deductible is reimbursed.

If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, Community First does not make a payment for coinsurance.

Private Duty Nursing Billing
Home Health agencies must bill Private Duty Nursing (PDN) services to clients, from birth through age 20, who have either had a tracheostomy or are ventilator-dependent. Community First requires providers to bill procedure code C-T1000 with modifiers TD UA (services performed by a RN) or TE UA (services performed by a LVN) or procedure codes C-T1002 and C-T1003 with the modifier UA in addition to one of the diagnosis codes in the grid below for these services.

Community First requires providers to bill the modifier or modifier combinations noted above AND the most appropriate higher-tier diagnosis codes from the list below in the first DX position on the claim form.

Diagnosis Codes

J9500	J9501	J9502	J9503	J9504	J9509	Z930
Z990	Z9911	Z9912	J95850	Z9989	Z430	

National Drug Code
The National Drug Code (NDC) is an 11-digit number on the package or container from which the medication is administered. All providers must submit an NDC for professional or outpatient claims submitted with provider-administered prescription drug procedure. Codes in the "A" code series do not require an NDC. N4 must be entered before the NDC on claims. Units of measurement are required for each NDC code submitted. The codes to be used for all claim forms are:

- F2 – International unit
- GR – Gram
- ME – Milligram
- ML – Milliliter
- UN – Unit

Unit quantities are also required for each NDC code submitted.

Community First will reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the Centers for Medicare and Medicaid Services (CMS) Drug Rebate program and that show as active on the CMS list for the date of service the drug is administered. CMS maintains a list of participating manufacturers and their rebate-eligible drug products, which is updated quarterly on the CMS website.

When providers submit claims for clinician-administered drug procedure codes, they must include the National Drug Code of the administered drug as indicated on the drug packaging. Community First will deny claims for drug procedure codes under the following circumstances:

The NDC submitted with the drug procedure code is not on the CMS drug rebate list that was current on the date of service.

The NDC submitted with the drug procedure code has been terminated.

The drug procedure code is submitted with a missing or invalid NDC.

To avoid claim denials, providers must speak with the pharmacy or wholesaler with whom they work to ensure the product purchased is on the current CMS list of participating manufacturers and their drugs.

Coding Auditing
Community First uses code auditing software to assist in improving accuracy and efficiency in claims processing, payment, reporting and to meet HIPAA compliance. The code auditing software will detect, correct and document coding errors on provider claims prior to payment. Community First's software will analyze CPT-4 codes, HCPCS Level II codes, industry standard modifiers and location to compare against rules that have been established by AMA and CMS.

In order to maintain its high standard of clinical accuracy, credibility and physician

acceptance, our code auditing software is updated regularly to keep current with medical practices, coding practices, annual changes to the CPT Manual and other industry standards. Community First conducts regular reviews to focus on the annual changes to the CPT Manual and the specialty sections of the CPT Manual.

When a change is made on a provider's submitted code(s), we will provide a general explanation of the reason for the change on the provider's EOP (or remittance advice). The following list gives examples of conditions where code-auditing software will make a change on submitted codes:

- Unbundling - Submitting a comprehensive procedure code along with multiple incidental procedure codes that are an inherent part of performing the procedure.
- Fragmentation - Billing all incidental codes or itemizing the components of procedures separately when a more comprehensive code is available.
- Age/Gender – Submitting codes inappropriate for the Member's age or gender because of the nature of the procedure.

Community First may request medical records or other documentation to assist in the determination of medical necessity, appropriateness of the coding submitted or review of the procedure billed.

Electronic Filing
Community First encourages all providers to file claims and/or encounters electronically.

Electronic claims have the same filing deadlines as paper claims (please see Claims Information in this section). Electronic claims submissions are required within 95 days of the date of service for participating providers and 365 days from the date of service for non-participating providers.

Billing the Member
Providers may not bill Members directly for STAR+PLUS covered services. Community First reimburses only those services that are medically necessary and a covered benefit in the STAR+PLUS program. This information can be found in your provider contract with Community First.

Community First STAR+PLUS Members do not have copayments.

Claims Reconsideration. If you disagree with the manner in which the claim was adjudicated, send the corrected claim and/or letter with a copy of the EOP to the claims address listed at the beginning of this section.

Appeals of "For Cause " HMO Agreement Termination. Community First must follow the procedures outlined in INS § 843.306 if terminating a contract with a Provider, including an STP. At least 30 days before the effective date of the proposed termination of the Provider's contract, Community First must provide a written explanation to the Provider of the reasons for termination. Community First may immediately terminate a Provider contract if the Provider presents imminent harm to patient health, actions against a license or practice, fraud, or malfeasance.

Within 60 days of the termination notice date, a Provider may request a review of Community First's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a private license,

fraud, or malfeasance. The advisory review panel must be composed of physicians and Providers, as those terms are defined in INS § 843.306, including at least one representative in the Provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Community First. The decision of the advisory review panel must be considered by Community First but is not binding on Community First. Community First must provide to the affected Provider, on request, a copy of the recommendation of the advisory review panel and the Community First's determination.

According to the Provider's agreement with Community First, the Provider is entitled to 60 days advance written notice of our intent to terminate your agreement for cause. The agreement also states that it will terminate immediately and without notice under certain circumstances. If Community First gives the Provider a 60 day notice of intended termination or if the Provider agreement terminates immediately without notice, and the cause for termination is based on concerns regarding competence or professional conduct as the result of formal peer review, the Provider may appeal the action pursuant to this procedure. This procedure is available only if we are terminating the Provider's agreement for the reasons stated above.

Providers may not offer or give anything of value to an officer or employee of HHSC or the state of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Community First may terminate the Provider's contract at any time for violation of this requirement.

Notice of Proposed Action. Community First will give the Provider notice that their agreement has terminated or is about to terminate, and the reason(s) for the termination. The notice will either accompany the Provider's 60 day notice of termination or be given at the time the agreement terminates immediately without notice.

Upon termination of the Provider's agreement, the Provider may request reinstatement by special notice (registered or certified mail) within 30 days of receiving the notice of termination to Community First's Medical Director. The Provider should include any explanation or other information with their request for reinstatement. Community First's Medical Director will appoint a committee to review their request, and any information or explanation provided within 30 days of receipt. The committee will recommend an initial decision to the Board of Directors either to terminate their membership and reaffirm their agreement, reaffirm with sanctions, or to revoke.

Decision. Within 10 days of receiving the committee's recommendations Community First will, by special notice in registered or certified mail, inform you of Community First's decision on your request for reinstatement. This decision will be final.

CLAIMS QUESTIONS/APPEALS

Providers have the right to appeal the denial of a claim by Community First. The Provider has **120 days** from the date of the most recent Community First EOP to appeal the denial. Community First will not accept any appeal submitted after the appeal deadline or appeals older than two (2) years.

Claim appeals must be submitted via the secure online Community First Provider Portal or in writing to:

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

Please direct any claim questions regarding appeals to Community First Claims Department at **210-358-6200**.

ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE

Community First is partnered with Zelis for EFT and ERA.

Additional Information for Claims Filing and Encounters Administration

Long-Term Services and Supports

All providers rendering LTSS services, with the exception of atypical providers, must use the CMS-1500 Claim Form or the HIPAA 837 Professional Transaction when billing claims. Atypical providers are LTSS providers that render non-health or non-medical services to STAR+PLUS Members.

- Examples include pest control services and building and supply services. Atypical providers will submit appropriate documentation to Community First to accurately populate an 837 Professional Encounter.

Providers will bill and report LTSS in compliance with the STAR+PLUS LTSS HCPC and STAR+PLUS Modifiers Matrix. The uniform billing requirements and billing Matrix can be found in the STAR+PLUS Handbook Appendices at https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-appendices.

LTSS providers must use the designated position of the modifiers as indicated on the matrix when filing claims.

Nursing Facility

For complete nursing facility claims filing guidelines for STAR+PLUS Members, see the STAR+PLUS Nursing Facility Provider Manual posted at CommunityFirstMedicaid.com.

Providers Using Paper CMS 1500

Providers billing on paper will provide complete information about the service event and will use the HHSC state assigned provider identification (provider ID) or NPI and taxonomy to represent the provider(s) involved in the service event. The provider ID or NPI (billing and/or rendering) will be located in block 33 on the paper form.

For providers billing NPI, taxonomy code should be located in block 24J.

If the billing provider and the rendering provider are the same, then the provider ID or NPI will be populated in block 33 and 24 ZZ qualifier, 24 (Ja) (ZZ) taxonomy (Jb) NPI.

If the rendering provider is different than the billing provider, then the billing provider ID or NPI will be populated in block 33, and the rendering provider ID or NPI will be populated in block 24 (Ja) (ZZ) taxonomy (Jb) NPI.

Under specific scenarios, the additional usage of block 17, name, 17a (ZZ) taxonomy, 17b NPI (referring provider), and block 24 J can be used to report additional information on providers that are involved in the service event.

Providers Using the Electronic HIPAA 837
Providers billing electronically will comply with HIPAA 837 guidelines including the accurate and complete conveyance of information pertaining to the provider(s) involved in the service event.

ATTENDANT CARE ENHANCED PAYMENT METHODOLOGY

LTSS providers contracted with Community First may participate in the STAR+PLUS attendant care enhanced payment program if they currently participate in the attendant compensation rate enhancement program with HHSC. The following LTSS services are eligible for enhanced payments:

- Personal Assistant Services (PAS) both waiver and non-waiver
- Day Activity and Health Services (DAHS)
- Assisted Living (AL)
- Habilitation (under CFC)

Community First will reimburse providers at the same participation level as they are assigned by HHSC. Community First will increase the fee schedules for the codes included in the enhancement program for Community First contracted providers who are contracted to participate in Community First's Attendant Care Enhanced Payment program. For providers who are enrolled and subsequently do not continue participation in HHSC, the level will remain the same throughout the duration of their participation in the program. For assisted living facilities that do not hold an HHSC contract, Community First will establish an additional amount to be added on to the unit rates by type of service. If Community First's review of quality measures determines a change to the provider's level, Community First will supply appropriate advance notice to such providers.

There are two distinct processes that encompass Community First's Rate Enhancement program which is in place for participating providers. These processes are Annual Attestation and Rate Level Changes. Non-participating providers cannot participate in rate enhancement through Community First.

Annual Attestation Process
Annually, Community First conducts outreach to providers in its Rate Enhancement program to obtain an affidavit attesting to their participation in the Rate Enhancement program for STAR+PLUS and the pass through of enhanced payments to their direct care staff. Towards the end of each year, these providers will be asked to submit a new attestation for the following calendar year.

Each affidavit is effective for a specific calendar year. However, any affidavit received on or after September 1 will be processed for both the current and upcoming calendar year.

Providers who contract during the plan year, and are participating in rate enhancement, should submit an affidavit that would be good for the existing plan year.

Rate Level Changes

Providers may communicate changes to their rate enhancement level at any time during the year. For providers that are assigned a new participation level by HHSC for PAS or DAHS services, these providers must submit the updated level in writing to Community First requesting a change in participation level.

Community First will verify new participation levels using the list as published on the HHSC website under the Attendant Compensation Rate Enhancement webpage. All rate enhancement level changes are effective the month following the month the notice was provided to Community First. Rate enhancement level changes are made prospectively, and will not be made retrospectively.

Please Note: Without an affidavit on file, Community First cannot process a rate change. Providers will need to submit an affidavit with their level change for the remaining plan year, if there is none on file.

XV. MEMBER ENROLLMENT & DISENROLLMENT

ENROLLMENT

Babies born to Medicaid eligible mothers who are enrolled in Community First will be enrolled into Community First for 90 days following the date of birth. The mother of the newborn may change her newborn to another Plan during the first 90 days but may only do so through the enrollment broker.

AUTOMATIC RE-ENROLLMENT

Community First STAR+PLUS Members who are disenrolled because they are temporarily ineligible for Medicaid will be automatically re-enrolled into the same health plan with the same PCP. Temporary loss of eligibility is defined as a period of six (6) months or less. Member has the option to switch plans at this time.

DISENROLLMENT

HHSC must approve any request by Community First for disenrollment. The STAR+PLUS Member may request the right to appeal the decision. The PCP will be responsible for directing the STAR+PLUS Member's care until the disenrollment is made. A request to disenroll a Community First STAR+PLUS Member **is acceptable** under the following circumstances:

- The STAR+PLUS Member misuses or lends their Community First Membership ID card to another person to obtain services.
- The STAR+PLUS Member is disruptive, unruly, threatening, or uncooperative to the extent that the STAR+PLUS Member seriously impairs Community First's or a Provider's ability to service the STAR+PLUS Member. However, this only occurs if the STAR+PLUS Member's behavior is not due to a physical or behavioral health condition.
- The STAR+PLUS Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow Community First to arrange for the treatment of the underlying medical condition.
- Member's disenrollment request from managed care will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment.
- A Provider cannot take retaliatory action against a Member.
- HHSC makes the final disenrollment decision.

STAR+PLUS MEMBER PCP CHANGE

If a STAR+PLUS Member requests a PCP change before the 15th day of the month, the change becomes effective on the first day of the following month. Changes received after the 15th day of the month will become effective the first day of the second month following the change request.

XVI. SPECIAL ACCESS REQUIREMENTS

EMERGENCY AND NON-EMERGENCY AMBULANCE TRANSPORTATION

Community First covers ambulance transportation under the following circumstances:

Emergency. When the condition of the STAR+PLUS Member is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, the ambulance transport is an emergency service and does not require preauthorization.

Non-Emergency. Any ambulance services ground or air not considered an emergency (see above) must be preauthorized by Community First prior to rendering transportation services.

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.

COMMUNITY FIRST AND PROVIDER COORDINATION

Community First will make every effort to communicate with and coordinate the delivery of covered services with a STAR+PLUS Member's PCP. Community First will provide each PCP and their staff with a current Provider Manual and revisions within five (5) days of becoming network participants. Provider orientations will be completed within 30 days of the PCP becoming a network participant. Additionally, routine office visits will be made by assigned Network Management staff to answer any questions or concerns and to review critical elements with the physician and his/her staff.

Community First operates a toll-free telephone line **1-844-382-2347** for Providers from 8:00 a.m. to 5:00 p.m. (CST), Monday through Friday. The Provider Hotline is staffed with personnel who are knowledgeable about covered services for Medicaid, about non-capitated services, and general health plan operations to assist the Provider.

READING/GRADE LEVEL CONSIDERATION

Community First writes all STAR+PLUS Member materials in both English and Spanish at a sixth grade reading level or below.

CULTURAL SENSITIVITY

Community First recognizes the diversity of the population in the STAR+PLUS Program and has programs to support a multi-cultural membership. We staff Community First's Member Services with knowledgeable, bilingual (English/Spanish) Member Service representatives to help STAR+PLUS Members with questions.

ACCESS TO TELEMEDICINE, TELEMONITORING, AND TELEHEALTH

STAR+PLUS Members have access to Providers who offer telemedicine, telemonitoring and telehealth services. To be eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in GOV'T § 531.0217.

Access to School-Based Telemedicine Services. As required by GOV'T § 531.0217, school-based telemedicine medical services are a covered service for Members. Community First will reimburse the distant site physician providing treatment even if the physician is not the patient's primary care physician/Provider or is an out-of-network physician. To be eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in GOV'T § 531.0217 (c-4).

Community First does not require prior authorization for school-based telemedicine medical services.

XVII. UTILIZATION MANAGEMENT

Community First's Utilization Management program determines whether proposed or rendered medical services and/or supplies are medically necessary and appropriate, are of a generally acceptable high quality and appropriate frequency, done in the appropriate setting, and covered in the STAR+PLUS Member's benefit plan. Program components include preauthorization, concurrent stay review, discharge planning, retrospective review, disease management, and case management.

Providers may initiate prior authorization through the Provider Portal or fax to **210-358-6274**.

Please Note: Determinations only affect payment for services by Community First. The decision to provide treatment is between the STAR+PLUS Member and the attending physician.

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. Community First does not specifically award practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

Utilization management decisions are made in accordance with currently accepted medical or health-care practices, taking into account the special circumstances of each case that may require an exception to the standard, as stated in the screening criteria. Criteria are used for the review of medical necessity, as well as provider peer-to-peer review. The medical director reviews all potential Adverse Benefit Determinations for medical necessity. At least annually, the vice president of medical management, or a designee, assesses the consistency with which reviewers apply the criteria. Utilization review decision making is based on appropriateness of care and service and the existence of coverage. Community First does not reward providers or other individuals for issuing medically necessary denials. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

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 practices, both within and outside the managed care industry. These criteria provide a clear and consistent platform for care decisions to appropriately balance resources. Community First also utilizes 28 T.A.C. §3.8001 et seq. for substance use disorders.

Besides processing requests for authorizations, Utilization Management analyzes utilization patterns, and provides an appeal process to address disputes in a timely manner.

All reimbursement is subject to eligibility and contractual provisions and limitations.

"Prior Authorization Not Required" does not mean that the service is covered. Please contact Member Services at **210-358-6105** with any questions regarding covered services.

Successful operation of our Utilization Management program depends upon the Provider's cooperation by:

- Accepting and returning our phone calls concerning our STAR+PLUS Members.
- Providing Community First with complete medical documentation to support any preauthorization requests.
- Allowing us to review medical and billing records concerning care rendered to our STAR+PLUS Members to validate delivery of care against claims data.
- Participating with us in discharge planning, disease management, and case management.
- Participating with our Community First's committee proceedings when appropriate.

Community First currently requires preauthorization for services. You can find authorization requirements on our website at Medicaid.CommunityFirstHealthPlans.com/Provider-Prior-Authorizations.

The list of services requiring preauthorization is subject to change. Community First will provide at least 90 days' notice of changes in the list of authorized services.

XVIII. PREVENTIVE HEALTH AND DISEASE MANAGEMENT

Members who feel empowered to become knowledgeable partners in their health care are better able to accept responsibility for appropriate utilization of health care resources. With that in mind, Community First has developed programs that work within the continuum of health to promote health, primary prevention, early detection and treatment, and disease management. The goal is to promote a collaborative relationship between our Members and their health care providers and to create a supportive environment for the development and maintenance of healthy lifestyle behaviors.

Provider Referral. Providers are encouraged to inform STAR+PLUS Members about the health education services available through Community First. When an education or social need is identified, one can refer a STAR+PLUS Member to the Preventive Health and Disease Management Department one of several ways:

1. Mail a completed Member Education Request form to:

   Community First Health Plans, Inc.
   Attention: Network Management
   12238 Silicon Drive, Suite 100
   San Antonio, TX 78249
2. Fax the Member Education Request form to **210-358-6099**.
3. Contact a Community First Health Educator at **210-358-6055** or email healthyhelp@cfhp.com.

Community First New Member Assessment Program. Outreach is initiated to each new STAR+PLUS Member to detect health risk factors, potential participation in population-based initiatives or disease management programs, and to assess barriers to care. Educational information and resource information is given to Members, including social services resources. Common STAR+PLUS Member concerns include transportation, utilities, and nutritional resources. Although not all social concerns are directly related to their medical care, frequently these issues affect access to care, continuity of care and compliance with treatment plan. Community First works to assist STAR+PLUS Members in addressing these concerns to promote wellness. Information gathered from the Member is forwarded to the primary care physician for review, potential outreach, and inclusion in the medical record.

Health Education Services. Health education is available through classes, educational mail outs, and individualized outreach visits. Several initiatives have been developed to educate STAR+PLUS Members and promote involvement in self-care behaviors. Participation in disease management and health promotion initiatives is free-of-charge and Members may opt out at any time. Overall program goals include increased education regarding disease processes and management, establishment of a collaborative physician-patient relationship, appropriate utilization of health care resources, increased quality of life, and STAR+PLUS Member satisfaction and retention. Program participation information is routinely mailed to the primary care physician for review and inclusion in the STAR+PLUS Member's medical record.

DIABETES IN CONTROL: DIABETES MANAGEMENT PROGRAM

Per the CDC's National Diabetes Statistics Report of 2020, (https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf), 34.1 million adults

ages 18 and older in the United States have diabetes (13 percent of the U.S. population). More than 7.3 million of these are undiagnosed (21.4 percent of people with diabetes are undiagnosed). In Bexar County in 2018, 15.5 percent of the population had been diagnosed with diabetes.

Accessible to the entire membership, Community First developed a diabetes disease management program, **Diabetes in Control**, to promote a collaborative approach to diabetes self-management. The goals of the program include identification of Members with diabetes, increase awareness and understanding of diabetes, increase risk reduction behaviors, improve access to quality diabetes education and health care services, and to promote diabetes standards of care, in coordination with the Texas Diabetes Council's Minimum Standards for Diabetes Care in Texas.

Members are identified via pharmacy management records, claims and encounter utilization data, physician referral, case management, utilization management, health promotion, Member Services, and referrals and information gathered through self-reported Member health assessments. Case Managers screen Members for possible referral to **Diabetes in Control** by reviewing claims histories.

Members enrolled in the **Diabetes in Control** program receive ongoing information, including how to control their blood sugar, tips for talking to the doctor, routine diabetes screening tests, the Member's role in preventing complications, blood sugar testing and supplies, and self-management during an illness. Members are eligible to attend community-based diabetes education classes. Higher risk Members are referred to one-on-one intensive education, which provides education on the importance of regular checkups, checking blood sugar at home, exercising regularly, following a meal plan, taking necessary medication, maintaining recommended weight, taking care of skin and feet, and management of their diabetes in conjunction with other current acute or chronic conditions. Because depression is a well-documented component of this chronic condition, potential behavioral health needs are taken into consideration and incorporated into the plan of care.

ASTHMA MATTERS: ASTHMA MANAGEMENT PROGRAM

Asthma Matters is an initiative developed by Community First to improve the health, well-being, and productivity of our Members with asthma. Through ongoing review and oversight of this comprehensive disease management program, Community First works to provide quality health promotion and education services, in collaboration with our Members, Providers, and community organizations. A key element of the program is to promote the development of a strong, collaborative relationship between our Members and their primary care providers, and the use of nationally accepted care standards for asthma, to help Members achieve long term control of their disease, which will result in the appropriate utilization of health care services.

The Asthma Matters program targets Members identified to have asthma via pharmacy management records, claim and encounter utilization data, and information received via the completion of Member health surveys. Routinely, utilization patterns are assessed and targeted interventions are implemented to coordinate health care delivery and measures to improve Members' clinical, quality of life, and economic status. Clinical outcomes may include a decrease in the use of beta-agonists, an increase in use of asthma-controlling medications and an increase in the number of outpatient visits.

Improvement in quality-of-life factors may include increased productivity and activity without asthma episodes, decreased absences from work or school, sleeping through the night without asthma episodes, increased knowledge about the disease, and overall asthma control with a decrease in acute asthma episodes. Economic outcome measures include decreased hospital admissions and emergency room events and/or unscheduled visits.

Upon identification of prospective Members, steps are taken to assess asthma severity levels and implement appropriate education and outreach services for each Member. Prospective Asthma Matters Members are sent an asthma health risk appraisal form. Key areas assessed include current symptoms, treatment protocols, and perception of quality of life. Upon receipt of the survey, Members are stratified into one of three risk categories: low, moderate, and high risk. For each risk category, health promotion outreach activities include:

Low Risk	Send education literature bimonthly
Moderate Risk	Send education literature quarterly Provide an age-appropriate peak flow meter and OptiChamber kit Follow-up call/recommend asthma class
High Risk	Send education literature quarterly Provide and age-appropriate peak flow meter, OptiChamber kit and allergy-free pillow cover Refer to Case Management for further evaluation Possible health assessment and education

Asthma education is coordinated with existing community education programs to promote utilization of services currently available. Members who are categorized in the moderate risk category are mailed a roster of up-to-date classes available in the community. Follow-up calls are conducted for Members who continue to accrue potentially preventable utilization of the emergency room and/or hospitalization to assess for possible barriers to care and compliance.

Members who require intensive assessment and education are referred to asthma disease management education. Education is provided on an individualized basis, over several visits, to promote Member control and knowledge about their disease. The home environment is assessed, and recommendations are given to decrease the risk of an acute asthma episode.

Our goal is to provide programs which encourage our Members to actively participate in their asthma management in collaboration with their physician. As part of the initiative, the primary care physician receives a copy of the Members' health assessment tool, with a summary of the assigned risk status, and educational outreach Community First has initiated for each Member. Information regarding home assessment and education is also sent to the primary care provider for inclusion in the medical record. Providers whose patients are stratified as high-risk through utilization data, receive utilization and pharmacy profiles for inclusion in Member's medical record.

HEALTHY EXPECTATIONS MATERNITY PROGRAM

The percentage of women seeking and obtaining prenatal care during the first trimester has increased over the years. Many high-risk women, however, continue to experience difficulty in accessing early prenatal care. This is a significant problem in south and central Texas and of significant concern for pregnant teens in Bexar County.

Community First is committed to addressing these issues at large, through our **Healthy Expectations** maternity program, because of the opportunity for a "win-win" situation: health outcomes are improved, and the cost of prenatal care is reduced. The Healthy Expectations program employs two phases to reach out and educate prenatal Members.

Access to early prenatal care is a hallmark of quality health care. Community First has worked with the Health and Human Services Commission and STAR+PLUS health plans across the state to expedite the Medicaid eligibility determination and the enrollment of pregnant women into Medicaid managed care. As a result, Medicaid eligibility has been simplified and a process is in place to expedite enrollment within 30 days of application. Health plans receive the names of newly enrolled Members on a daily basis, to promote immediate access to prenatal care.

The Population Health Management staff collaborates with health plan providers to offer comprehensive perinatal services, as we believe education is an important factor in changing behaviors and improving the overall health of our Members. Outreach to pregnant Members includes:

- Completion of a prenatal health risk assessment.
- Referral to educational or community resources, as needed.
- Education regarding the importance of early prenatal care.
- Education regarding the importance of the six-week postpartum visit.

An assessment program for identified pregnant women provides opportunity to identify risk factors. Social and behavioral health education and referral are typical outcome strategies at the initial assessment phase. When completed, the risk tool allows staff time to outreach to those at increased risk for complications. Those at lower risk are sent educational materials and encouraged to attend community sponsored prenatal education classes. Pregnant Members who elect to enroll into the program are routinely reassessed at 20-24 weeks gestation to evaluate for changes in prenatal health.

The phases of the **Healthy Expectations** prenatal program provide numerous opportunities to assess Member health, pregnancy status, to promote compliance with appropriate perinatal guidelines, and provide Member education. Programs such as our **Healthy Expectations** have been recognized by the American Association of Health Plans as best practices in case management for prenatal care.

HEALTHY MINDS: BEHAVIORAL HEALTH PROGRAM

Community First's staff aids Members in need of behavioral health services. Professional counselors are contracted and ready to help with areas such as aggressive behavior, anxiety, grief, depression, stress, eating disorders, emotional and physical abuse, and much more.

In response to such staggering statistics, Community First developed, **Healthy Minds**, a behavioral health program to better meet the needs of Members and Providers, increase

awareness of mental and behavioral health services, and impact the overall health of our Members.

Members: Improve Members' adherence to their physicians' treatment plans by addressing underlying behavioral concerns and facilitating life behavior changes to better manage medical health. Goals include:

- Empowering Members to manage their behavioral symptoms.
- Guiding Members in identifying sustainable solutions to their symptoms.
- Educating Members about their illness(es) and effective treatments.
- Connecting Members with other available care management benefit providers to foster continued improvement.
- Advocating for each Member's needs and goals by understanding and respecting the Member's value system while searching for necessary funding, appropriate treatment, and treatment alternatives.
- Integrating medical and behavioral components of treatment to produce long-lasting results.

Providers: Facilitate continuity and coordination of care among physicians and other health care providers by collecting data on:

- Exchange of information.
- Appropriate diagnoses, treatment, and referrals of BH disorders commonly seen in primary care.
- Appropriate use of psychotropic medications.
- Management of treatment access and follow-up for Members with coexisting medical and behavioral disorder.
- Identifying the special needs of Members with severe and persistent mental illness.

HEALTHY LIVING: HEALTHY LIFESTYLE MANAGEMENT PROGRAM

Healthy Living, a healthy lifestyle management program was developed to address healthy eating, active living, and tobacco avoidance, and aligns with the U.S. Preventive Services Task Force (USPSTF) Recommendations. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. Recommendations can be found at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics

The 2019 Bexar County Community Health Assessment Report reflected

- **Healthy Eating:** Recent surveys showed that just 19.1 percent of Bexar County adults consumed fruits and vegetables five or more times per day.
- **Physical Activity:** The percent of Bexar County adults reporting participating in 150 minutes or more of aerobic physical activity per week has remained flat in recent years, estimated at 44.8 percent.
- **Obesity:** Approximately 68.8 percent of adults report a height and weight that puts their Body Max Index (BMI) in the overweight or obese range.

Members enrolled in the Lifestyle Management program receive ongoing, age-appropriate information on stress management, quitting smoking, exercise, and a heart-healthy lifestyle. They are also provided a list of community resources offering nutrition, smoking cessation, and exercise classes.

Higher risk Members are also referred to one-on-one intensive education, which provides education on the importance of regular checkups; exercising regularly; following a meal plan; taking necessary medication; and maintaining recommended weight in conjunction with other current acute or chronic conditions.

HEALTHY HEART: BLOOD PRESSURE MANAGEMENT PROGRAM

Community First's hypertension program, **Healthy Heart**, is designed to promote effective management of the chronic disease through the provision of disease management education and case management assistance. The program enables Members diagnosed with hypertension to maintain their health and optimally manage their chronic disease condition by preventing health problems, protecting from health threats, and promoting health of self and others.

According to the "City of San Antonio's Metropolitan Health District's Mortality in Bexar County, 2017 Report," chronic diseases were responsible for six out of every 10 deaths in Bexar County. Hypertension is a common chronic health condition that can cause catastrophic harm to a patient's body, leading to potential disability, diminished quality of life, stroke, heart attack, heart failure, and kidney disease. There are many risk factors associated with high blood pressure to include age, family history, race, ethnicity, sex, and an unhealthy lifestyle.

The program incorporates a comprehensive multi-disciplinary, continuum-based process to health care delivery. Community First proactively identifies populations with, or at risk for, chronic illnesses and provides person-based education and interventions to advance Member well-being and quality of life. It allows for a patient-centered approach that holistically addresses the disease management needs of Community First Members and:

- Supports the physician/patient relationship and plan of care.
- Emphasizes prevention of exacerbations and complications using cost-effective, evidence-based practice guidelines, and patient empowerment strategies, such as disease self-management.
- Meets the needs of individuals with specific chronic conditions.
- Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health.

Members enrolled in the **Hypertension** program receive ongoing, age-appropriate education on high blood pressure; appropriate use of medication; exercise; and kidney disease. They are also provided a list of community resources offering blood pressure, nutrition, and fitness programs.

XIX. SUBSTANCE USE DISORDER

SUBSTANCE USE DISORDER DEFINITION

The "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)," no longer uses the terms substance abuse and substance dependence, rather it refers to Substance Use Disorders (SUD), which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

SPECIALIZED SERVICE COORDINATION

The role of a Service Coordinator is to maximize a Member's health, well-being, and independence. Service Coordination should consider and address the Member's situation as a whole, including their medical, behavioral, social, and educational needs. All Members have access to a named Service Coordinator as well as an experienced team supporting them and the Member.

In some cases, Member's require a Specialized Service Coordinator who has special expertise or experience in that Member's condition. Community First will provide Members with Specialized Service Coordinators as appropriate and in accordance with the Member's needs. Two categories of STAR+PLUS Members are automatically assigned Specialized Service Coordinators: (1) Members who are 15-20 years old and assigned to a Transition Specialist in addition to their named Service Coordinator, and (2) Members with a substance use disorder.

TREATMENT FOR SUD

Treatment for SUD is a benefit of Texas Medicaid for persons who meet the criteria for a substance related disorder, as outlined in the current edition of the American Psychiatric Association's (APA) Diagnostic Statistical Manual of Mental Disorders (DSM). SUD treatment services are individualized, age-appropriate medical and psychosocial interventions designed to treat a person's problematic use of alcohol or other drugs, including prescription medication. SUD services include:

- Withdrawal management services.
- Individual and group SUD counseling in an outpatient setting.
- Residential treatment services.
- Medication assisted treatment.
- Opioid Use Disorder Treatment
- Evaluation and treatment (or referral for treatment) for co-occurring physical and behavioral health conditions

Level of care (e.g., outpatient, residential, inpatient hospital) and specific services provided must adhere to current evidence-based industry standards and guidelines for SUD treatment, such as those outlined in the current edition of the American Society of Addiction Medicine's Treatment Criteria for Addictive Substance-Related and Co-Occurring Conditions, as well as the licensure requirements outlined in 25 TAC §448 pertaining to standards of care. SUD outpatient or residential treatment services may only be delivered

in a licensed chemical dependency treatment facility (CDTF). Medication assisted treatment (MAT) may also be delivered in the office setting by appropriately trained physicians, physician assistants (PAs), and advanced practice registered nurses (APRNs) who are recognized by the Texas Board of Nursing as either nurse practitioners (NPs), clinical nurse specialists (CNSs), nurse anesthetists (CRNAs), or nurse midwives (CNMs), provided that the APRN is a qualifying practitioner and possesses the Drug Addiction Treatment Act (DATA) waiver. SUD withdrawal management in an inpatient hospital setting may be provided for persons who meet hospital level of care requirements as a result of the severity of their withdrawal syndrome or the severity of their co-occurring conditions. These services may be reimbursed as general hospital inpatient services. The treatment setting and the intensity or level of services will vary depending on the severity of the person's SUD and what is clinically appropriate. The intensity or level of services refers to the number of hours of services per week, as well as the types of services the person receives.

SUD TELEMEDICINE AND TELEHEALTH SERVICES

Providers of SUD services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered and primarily driven by the person's choice and not provider convenience.

Providers must provide SUD services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT

Screening, Brief Intervention, and Referral to Treatment (SBIRD) is a comprehensive, public health approach to the delivery of early intervention and treatment services for persons who are 10 years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders. SBIRT services can be provided by physicians, registered nurses, advanced practice nurses, physician assistants, psychologists, licensed clinical social workers, licensed professional counselors, certified nurse midwives, outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs). Non-licensed providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the scope of practice for that licensed provider. The same SBIRT training requirements apply to non-licensed providers.

A person may have a maximum of two screening only sessions per rolling year, and up to four combined screening and brief intervention sessions per rolling year. Providers must refer the person to treatment if the screening results reveal severe risk of alcohol or substance use.

Screening

Screening persons for problems related to alcohol or substance use identifies the person's level of risk and determines the appropriate level of intervention indicated for the person. Providers must explain the screening results to the person, and if the results are positive, be prepared to subsequently deliver, or delegate to another provider, brief intervention services. Screening must be conducted using a standardized screening tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, annoyed, guilty, eye-opener (CAGE) questionnaire
- Car, relax, alone, forget, family or friends, trouble (CRAFFT) questionnaire

- Binge drinking questionnaire

Results obtained through blood alcohol content (BAC) or through toxicology screening may also be used to screen for alcohol or substance use risk.

Brief Intervention

Brief intervention is performed following a positive screen or a finding of at least a mild to moderate risk for alcohol or substance use. During the session, brief intervention involves motivational interviewing techniques that are focused on raising the person's awareness of his or her alcohol or substance use and its consequences. Subsequent screening and brief intervention sessions within the allowable annual limitations may be indicated to assess for behavior change and further explore a person's readiness to make behavioral changes related to their alcohol or substance use.

Referral to Treatment

If the provider determines that the person is in need of more extensive treatment or has a severe risk for alcohol or substance use, the person must be referred to an appropriate substance use treatment provider. Referral is an essential component of the SBIRT intervention because it ensures that all persons who are screened have access to the appropriate level of care.

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STAR+PLUS PROVIDER MANUAL

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