COMMUNITY FIRST
HEALTH PLANS

COMMUNITY FIRST MEDICARE ADVANTAGE BEXAR DUAL (D-SNP HMO) PROVIDER MANUAL



PROVIDER SERVICES 210-358-6030

CommunityFirstMedicare.com

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SECTION I. INTRODUCTION TO COMMUNITY FIRST FIDE D-SNP

Welcome to the Community First Health Plans, Inc. (Community First) Medicare Advantage Bexar Dual (HMO D-SNP) Network, a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP). This FIDE-SNP product is designed to deliver seamless, coordinated care to individuals eligible for both Medicare and Medicaid, ensuring access to the full spectrum of covered services.

This Provider Manual contains important information about Community First Medicare Advantage Bexar Dual (HMO D-SNP) plan policies and procedures, claims submission and adjudication requirements, and guidelines used to administer the health plans. Other policies and procedures are posted on the Community First website and Provider Portal. State-specific Medicaid Provider Manuals are also available online and may contain additional information. This Provider Manual replaces and supersedes any other previous versions and is located on the Community First website. A paper copy may be requested at any time upon written request to Community First. Any capitalized terms not otherwise defined herein shall have the meaning as outlined in the agreement.

Except as may otherwise be set forth in the agreement, Providers are contractually required to comply with all provisions contained in this Provider Manual. However, in the event of a conflict between the obligations, terms, conditions of the participation agreement and this manual, the obligations, terms, and conditions in the agreement shall take precedence.

Variations in applicable laws, regulations, and governmental agency guidance including, but not limited to, state or federal laws, regulations and/or changes to such laws, regulations, or guidance may create certain requirements related to the content in this manual that are not expressly set forth in this Provider Manual. Revisions to this Provider Manual constitute revisions to Community First's policies and procedures. Any requirements under applicable law, regulation, or guidance that are not expressly set forth in this Provider Manual's content are incorporated herein by this reference and shall apply to Providers.

About Community First Health Plans

Community First Health Plans, Inc. (Community First) was established in 1995 by University Health to provide health care coverage to the citizens of Bexar and the surrounding seven counties. As the only locally owned and managed non-profit health plan in our service area, we are committed to providing great health care benefits backed by outstanding service delivered by people who live right here in Bexar County. Our goal is to provide individuals and families opportunities for successful health outcomes by putting our community first.

For nearly 30 years, Community First has provided affordable health coverage for families, children, expectant mothers, and individuals with special health care needs.

What is a FIDE D-SNP?

In May 2022, the Centers for Medicare & Medicaid Services (CMS) finalized regulatory requirements for states participating in the Medicare-Medicaid Financial Alignment Initiative. These requirements mandate that states either end their demonstration programs by December 31, 2025, or transition to an integrated Dual Eligible Special Needs Plan (D-SNP) model.

In response to this guidance, Texas Health and Human Services (HHS) has transitioned its existing program to a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP). A FIDE-SNP is a specific type of Medicare Advantage plan designed to serve individuals who are dually eligible for both Medicare and Medicaid. It provides coordinated delivery of Medicare and Medicaid benefits, including long-term services and supports (LTSS) and behavioral health services through a single managed care organization.

Community First, in partnership with the Texas Health and Human Services Commission, is dedicated to improving care delivery for low-income seniors and individuals with disabilities who are eligible for both Medicare and Medicaid. This commitment will be fulfilled through the implementation of a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), with the primary goal of ensuring continuity of benefits and maintaining high standards of care.

To facilitate a smooth and effective transition, Community First has adopted the Integrated Care Transition Pillars established by the Centers for Medicare & Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO), supported by the Resources for Integrated Care (RIC) initiative. These pillars serve as guiding principles for providing high-quality, person-centered, and equitable care within the FIDE-SNP model.

FIDE Program Goals

Integrated Care Transition Platform

Foster Integration and Continuity: Texas FIDE-SNP program is designed to fully integrate Medicare and Medicaid services, improving access and care quality for dually eligible individuals. The model bridges gaps between physical health, behavioral health, and LTSS. Upon enrollment, Members will maintain access to their existing Providers and services – without changes in amount, scope, or duration – until a comprehensive assessment is completed.

Reduce Racial and Ethnic Disparities: HHS uses a data-driven approach to identify and address health disparities. The FIDE-SNP model emphasizes culturally and linguistically appropriate services, ensuring equitable access to care for individuals with limited English proficiency and those from diverse backgrounds. These efforts align with broader state and federal health equity initiatives.

Improve Care Delivery: FIDE-SNPs use a person-centered care model that prioritizes the holistic needs of each Member. Care coordination will be central, ensuring seamless transitions across care settings and Providers. Interdisciplinary care teams support individualized care planning and service delivery.

Promote Self-Determination: Texas' FIDE-SNPs empower Members to take an active role in directing their care, particularly in LTSS. The program supports flexible, enrollee-directed care models that respect individual preferences, values, and goals.

Build a Culture of Quality: Continuous quality improvement is embedded throughout the FIDE-SNP program. Plans use integrated data systems to monitor performance, identify gaps, and improve outcomes. Key focus areas include care coordination, person-centered planning, health equity, and value-based payment reform.

SECTION 2. PROVIDER RESPONSIBILITIES

Role of the Primary Care Provider (Medical Home)

Primary Care Providers (PCPs) play a central role in the delivery of integrated, person-centered care for Members enrolled in the Community First FIDE D-SNP. The Community First FIDE D-SNP Model of Care is designed to coordinate Medicare and Medicaid benefits through a comprehensive, interdisciplinary approach that promotes improved health outcomes, independence, and quality of life.

The PCP serves as the Member's medical home and primary point of contact for healthcare services. The PCP is responsible for providing, coordinating, and overseeing medically necessary healthcare services while supporting preventive care, chronic disease management, behavioral health integration, and care transitions. PCPs collaborate with Community First Service Coordinators, Care Managers, specialists, behavioral health providers, Long-Term Services and Supports (LTSS) providers, caregivers, and other members of the Interdisciplinary Care Team (ICT) to ensure Members receive coordinated care across the healthcare continuum.

The medical home model promotes an ongoing relationship between the Member and PCP and emphasizes preventive healthcare, early intervention, person-centered care planning, and integrated service delivery rather than episodic management of acute health events. Community First encourages Members to actively participate in their care and wellness goals through collaboration with their healthcare team.

PCP Responsibilities

The PCP is responsible for providing and coordinating primary care services for assigned Members, including but not limited to:

- Supervising, coordinating, and providing primary care services.
- Assessing, diagnosing, treating, and monitoring acute and chronic health conditions.
- Maintaining continuity of care.
- Initiating referrals for medically necessary specialty services and coordinating follow-up care.
- Coordinating healthcare services across Medicare-covered, Medicaid-covered, LTSS, behavioral health, and supplemental benefit programs.
- Maintaining complete, accurate, and current medical records.

Reviewing information received from specialists, hospitals, behavioral health providers, nursing facilities, and other treating practitioners.

- Screening for behavioral health, substance use disorder, psychosocial, functional, and cognitive concerns and initiating appropriate referrals when indicated.
- Promoting preventive services, including age-appropriate screenings and immunizations.
- Facilitating access to medically necessary services and community-based supports.
- Participating in care transitions and post-discharge follow-up activities.
- Collaborating with Community First Service Coordinators and Care Managers regarding Member needs and care planning activities.
- Certifying medical necessity for applicable waiver, LTSS, and other covered services when required.
- Assisting with the identification of social determinants of health and barriers to care.

PCP Responsibilities within the FIDE Model of Care

As participants in the Community First FIDE D-SNP Model of Care, PCPs are expected to support integrated care management activities by:

- Collaborating with Community First Service Coordination and Care Management staff.
- Participating in Interdisciplinary Care Team (ICT) activities when requested.
- Contributing to the development, implementation, and review of Individualized Care Plans (ICPs).
- Reviewing and addressing findings identified through Health Risk Assessments (HRAs) and Comprehensive Assessments when appropriate.
- Providing clinical input regarding Member goals, interventions, and care coordination needs.
- Supporting transitions of care and discharge planning activities.
- Identifying Members who may benefit from additional care management, behavioral health, LTSS, or community support services.
- Communicating significant changes in Member condition that may affect care planning or service needs.
- Supporting person-centered decision-making and Member self-determination.

Availability and Access to Care

The PCP must provide or arrange for covered services and telephone consultation during normal office hours and ensure access to urgent and emergent medical guidance twenty-four (24) hours per day, seven (7) days per week.

The PCP is responsible for contacting Community First to verify Member eligibility and obtain prior authorization for covered services when required.

Interpreter and Language Assistance Services

Community First provides access to interpreter and language assistance services at no cost to Members or Providers. Interpreter services are available twenty-four (24) hours per day, seven (7) days per week and include spoken language interpretation, sign language interpretation, and other language assistance services.

Providers may access interpreter services through Community First Member Services during business hours. After-hours requests may be coordinated through Community First's Nurse Advice Line. Providers are expected to utilize interpreter services as necessary to ensure effective communication and culturally competent care delivery.

Referral Requirements

Members should be encouraged to seek routine healthcare services through their designated PCP whenever possible. The following services may be accessed without PCP referral requirements, subject to applicable benefit and network requirements:

- Emergency Services
- Behavioral Health Services
- Obstetrical and Gynecological Services
- Family Planning Services
- Department of State Health Services Case Management Services
- Local Mental Health Authority Services
- Routine Vision Services as applicable under the Member's benefit package

The PCP is responsible for coordinating referrals, communicating with treating providers, and documenting all referrals in the Member's medical record. PCPs may collaborate with Community First Service Coordinators regarding medically necessary referrals and community support services.

Provider Request for Member Transfer

A PCP requesting reassignment of a Member must submit the applicable Community First Provider Request for Member Transfer form and comply with Community First policies and procedures governing provider reassignment. Questions regarding Member transfer requests should be directed to the Community First Network Management Department.

PCP Panel Capacity

PCPs wishing to limit or expand panel capacity should contact Community First Network Management. Community First reserves the right to establish and monitor panel capacity standards in accordance with applicable regulatory requirements and network adequacy standards.

Specialist as a PCP

Members with disabilities, special healthcare needs, chronic conditions, or complex medical conditions may request designation of a specialist to serve as their PCP when medically appropriate. A specialist may serve as a PCP only upon approval by Community First and in accordance with applicable regulatory requirements.

To qualify as a PCP, the specialist must:

- Meet Community First credentialing requirements for PCP designation.
- Maintain participation in the Community First provider network.
- Agree to assume responsibility for coordinating all healthcare services provided to the Member.
- Fulfill all PCP responsibilities described within this Provider Manual, including participation in care coordination, care planning, and transition management activities.

Requests for specialist designation as PCP must be submitted using Community First's Specialist as PCP Request Form.

Community First will review and approve or deny requests within required regulatory timeframes and will provide written notification to the Member of the determination and applicable appeal rights.

Role of the Specialty Care Physician

Specialists are responsible for providing medically necessary specialty healthcare services to Members referred by their PCP or otherwise authorized under Community First policies and

applicable benefit requirements. Specialists must verify Member eligibility prior to rendering services.

Specialists shall:

- Communicate evaluation findings, treatment recommendations, and outcomes to the PCP.
- Coordinate care with the PCP and other treating providers.
- Support implementation of the Member's Individualized Care Plan when applicable.
- Participate in Interdisciplinary Care Team activities when requested.
- Notify the PCP and Community First of significant changes in Member health status that may impact care planning or service needs.
- Obtain authorization for additional services when required.

Documentation of referrals, consultation reports, and treatment recommendations must be maintained within the Member's medical record.

Role of the Long-Term Services and Supports (LTSS) Provider

LTSS providers play a critical role in supporting Community First FIDE D-SNP Members who require assistance with activities of daily living, functional limitations, chronic conditions, disabilities, or ongoing supportive services. LTSS providers support Community First's goal of helping Members remain independent and safely reside in the least restrictive setting appropriate to their needs.

Examples of LTSS services may include:

- Personal Assistance Services
- Private Duty Nursing
- Adult Foster Care
- Home Delivered Meals
- Habilitation Services
- Respite Services
- Home Modifications
- Nursing Facility Services
- Other Medicaid LTSS services as covered under the Member's benefit package
- LTSS providers are responsible for:
- Verifying Member eligibility and authorization requirements.

- Delivering authorized services in accordance with applicable requirements.
- Providing continuity of care.
- Coordinating with Community First Service Coordinators.
- Participating in care planning activities as requested.
- Reporting significant changes in Member condition.
- Reporting health, safety, abuse, neglect, exploitation, or other critical incidents in accordance with Community First policy.
- Supporting transitions between care settings.
- Coordinating Medicare and Medicaid service delivery to support integrated care.

Role of the Service Coordinator

Community First Health Plans Service Coordination program offers personalized care management for Members with complex or high-risk conditions. The program is designed to improve health outcomes through proactive care planning and service coordination. FIDE D-SNP Members will receive one service coordinator that will coordinate their care between both their Medicare Advantage D-SNP and STAR+PLUS benefits. Service Coordinators will identify the needs, including medical, psychosocial, cognitive, functional and LTSS services for FIDE SNP Members and develop a service plan of care.

Service Coordinators are responsible for:

- Conducting or coordinating Health Risk Assessments and reassessments.
- Facilitating comprehensive assessments.
- Supporting development and implementation of Individualized Care Plans.
- Facilitating Interdisciplinary Care Team activities.
- Coordinating Medicare and Medicaid benefits and services.
- Monitoring Member progress and care plan goals.
- Assisting Members with access to community resources and supplemental benefits.
- Supporting care transitions and discharge planning.
- Coordinating LTSS, behavioral health, medical, and social support services.
- Promoting self-management and Member engagement.

Interdisciplinary Care Team (ICT)

Community First utilizes an Interdisciplinary Care Team approach for Members with complex medical, behavioral, functional, social, or LTSS needs. The ICT supports the development and

implementation of person-centered care plans that coordinate services across Medicare and Medicaid programs.

The ICT may include:

- The Member and/or authorized representative
- Primary Care Provider
- Specialists
- Behavioral Health Providers
- LTSS Providers
- Pharmacists
- Service Coordinators
- Care Managers
- Caregivers and family members as appropriate
- Other healthcare professionals involved in the Member's care

Participating providers may be requested to contribute clinical recommendations, collaborate in care planning activities, and communicate relevant information necessary to support quality outcomes and coordinated care delivery.

This version would be substantially more aligned with CMS FIDE expectations and a D-SNP Model of Care than the current STAR+PLUS language while preserving Community First operational requirements.

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 and 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:

- Provider Name
- Address
- Phone Number
- Office Hours
- Days of Operation
- Practice Limitations
- Languages Spoken
- Provider Type / Provider Specialty
- Wait Times for Appointment (as defined in this Provider Manual)
- Closed or Open Panel (PCPs only)
- 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.

SECTION 3. ELIGIBILITY, ENROLLMENT, AND MEMBER TRANSITIONS

The Community First Fully Integrated Dual Eligible Special Needs Plan (FIDE D-SNP) serves individuals who are entitled to Medicare benefits, eligible for Medicaid benefits, and meet applicable enrollment requirements established by the Centers for Medicare & Medicaid Services (CMS) and the Texas Health and Human Services Commission (HHSC). The Community First FIDE D-SNP integrates Medicare and Medicaid benefits through a coordinated care model designed to improve access, quality, Member experience, and health outcomes.

Providers are responsible for verifying Member eligibility prior to rendering services and should understand how enrollment, eligibility changes, continuity of care protections, and transition requirements may impact the delivery of services.

Member Eligibility Requirements

To be eligible for enrollment in Community First FIDE D-SNP, an individual must:

Be entitled to Medicare Part A.

Be enrolled in Medicare Part B.

Be eligible for and maintain Medicaid eligibility as required for FIDE D-SNP enrollment.

Reside within the Community First service area.

Meet all CMS and HHSC eligibility criteria applicable to the product.

Not have End-Stage Renal Disease (ESRD) limitations except as otherwise permitted under current CMS regulations.

Eligibility requirements are subject to change based on federal and state regulations.

Verification of Eligibility

Providers are responsible for verifying Member eligibility prior to rendering services and before each date of service.

Eligibility verification may be completed through:

- The Community First Provider Portal
- Electronic eligibility verification systems
- Community First Member Services

Possession of a Community First identification card does not guarantee eligibility or coverage. Eligibility status may change due to enrollment, disenrollment, Medicaid eligibility changes, or other regulatory actions. Providers should verify eligibility each time services are rendered.

NOTE: A copy of the Medicare enrollment form can serve as verification of eligibility for Medicare Members who have not received their Member ID card at the time of service. Members may not be denied covered, medically necessary services.

Member Identification Cards

Community First issues identification cards to enrolled Members. Member identification cards contain information necessary to facilitate access to covered services and identify the Member's plan enrollment.

Providers should request the Member's identification card at the time services are rendered and verify eligibility through Community First systems.

Enrollment Effective Dates

Enrollment generally becomes effective on dates established by CMS and HHSC based upon the Member's enrollment election, eligibility status, and enrollment processing requirements.

Providers should verify enrollment effective dates prior to delivering non-emergent services.

Community First is not responsible for payment of services provided outside of applicable enrollment periods except where continuity of care protections or regulatory requirements apply.

New Member Transition and Continuity of Care

When a Member enrolls in the Community First FIDE D-SNP, Community First will work to ensure continuity of medically necessary services and minimize disruptions in care.

Community First may honor prior authorizations, treatment plans, and ongoing services during applicable transition periods when required by CMS, HHSC, or Community First policy. Transitional protections may apply to:

- Ongoing courses of treatment
- Active prior authorizations
- Behavioral health services
- Long-Term Services and Supports (LTSS)
- Home health services
- Durable Medical Equipment (DME)

- Prescription medications
- Specialty services
- Nursing facility services

Providers are expected to cooperate with Community First in obtaining records, sharing treatment plans, and coordinating continuity of care for new Members.

Continuity of Care Requirements for Providers

To promote continuity of care, providers shall:

- Submit medical records and treatment information as requested.
- Cooperate with Community First staff regarding prior authorization reviews.
- Coordinate care with Community First Service Coordinators and Care Managers.
- Participate in transition planning activities when requested.
- Continue treatment during applicable transition periods as required by federal and state regulations.
- Coordinate with receiving providers when a transfer of care is necessary.

Members Who Lose Medicaid Eligibility/Status

Members may temporarily lose Medicaid eligibility while keeping Medicare eligibility. Under CMS rules, they may still qualify for certain D-SNP protections for a limited time, known as the Deeming Period, up to six months. During this time, Members with cost-share protection will have claims paid at 100% of the Medicare allowable rate, and providers must accept this as full payment without balance billing. However, Medicaid services are not covered during the Deeming Period.

During a deeming period:

- Community First may continue to provide Medicare-covered benefits in accordance with CMS requirements.
- Community First will attempt outreach and assistance to support restoration of Medicaid eligibility, when appropriate.
- Providers should continue to verify eligibility and benefit coverage before rendering services.

Changes in Medicaid status may affect coverage of Medicaid-covered services, LTSS benefits, cost-sharing protections, and supplemental benefits.

Health Risk Assessment and Initial Member Outreach

Following enrollment, Community First conducts outreach to identify healthcare needs, service needs, and social support needs.

Community First may perform or coordinate:

- Health Risk Assessments (HRAs)
- Comprehensive assessments
- Functional assessments
- Behavioral health screenings
- LTSS evaluations
- Social Determinants of Health (SDOH) assessments

Providers may be contacted to support these activities and are expected to cooperate with Community First Care Management and Service Coordination staff.

Assignment to a Primary Care Provider

Members are generally assigned a Primary Care Provider (PCP) upon enrollment if a PCP selection is not made during the enrollment process.

Members may request a PCP change in accordance with Community First policies and applicable regulatory requirements.

The assigned PCP serves as the Member's medical home and coordinates healthcare services across Medicare and Medicaid programs.

Enrollment Changes and Disenrollment

Enrollment may end due to:

- Voluntary disenrollment by the Member.
- Loss of Medicare eligibility.
- Loss of required Medicaid eligibility.
- Relocation outside the service area.
- Death of the Member.
- CMS or HHSC-directed disenrollment.
- Other circumstances permitted under federal or state regulations.

Providers should continue medically necessary treatment during applicable transition periods and assist Community First with continuity of care activities when a Member experiences an enrollment change.

Member Transitions Between Care Settings

Community First utilizes a coordinated transition of care process to support Members moving between healthcare settings, including:

- Hospital admissions and discharges
- Skilled nursing facility admissions and discharges
- Nursing facility transitions
- Home health admissions and discharges
- Emergency department visits
- Community re-entry following institutional stays
- Behavioral health facility admissions and discharges

Providers are expected to:

- Notify Community First of significant care transitions as appropriate.
- Share discharge plans and treatment recommendations.
- Coordinate medication reconciliation.
- Participate in discharge planning activities when requested.
- Collaborate with Community First Service Coordinators regarding follow-up care and community support needs.

Provider Responsibilities Related to Member Transitions

Providers play an important role in preventing gaps in care and reducing avoidable hospital readmissions.

Providers should:

- Communicate significant changes in Member condition.
- Participate in Interdisciplinary Care Team activities when requested.
- Coordinate with Community First Service Coordinators.
- Assist with implementation of Individualized Care Plans.
- Support Member access to medically necessary services during transitions.
- Promote safe discharge planning and continuity of care.

Coordination with Service Coordination and Care Management

Community First Service Coordinators and Case Managers work with Members, providers, caregivers, LTSS providers, hospitals, nursing facilities, and community organizations to coordinate care across Medicare and Medicaid services.

Providers are expected to collaborate with Service Coordination and Care Management staff to:

- Address barriers to care
- Improve care transitions
- Support care planning
- Coordinate LTSS and community-based services
- Facilitate access to behavioral health services
- Improve quality outcomes and Member experience

SECTION 4. MODEL OF CARE (MOC)

Model of Care Overview

The Model of Care (MOC) provides the basic framework under which Community First Health Plans will meet the needs of our Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) Members. The MOC is used to coordinate Medicare and Medicaid services for our FIDE D-SNP Members, so care is organized between both the Medicare and STAR+PLUS benefits. It is designed to identify Members' clinical, behavioral, functional, and social needs; stratify risk; assign an Interdisciplinary Care Team; complete and update a Health Risk Assessment and individualized care plan; and support smooth care transitions across settings. CMS requires D-SNPs to have evidence-based MOC approved through the SNP structure and to implement it in ways that coordinate the delivery of all covered Medicare and Medicaid benefits for the dual-eligible population.

Through a coordinated and interdisciplinary approach to care delivery, Community First FIDE D-SNP integrates:

- Medicare-covered services
- Medicaid-covered services
- Long-Term Services and Supports (LTSS)
- Behavioral Health Services
- Pharmacy Benefits
- Home and Community-Based Services (HCBS)
- Supplemental Benefits
- Community Support Services

The Model of Care is designed to:

- Identify Members' clinical, behavioral, functional, and social needs.
- Stratify Members according to risk and care coordination needs.
- Conduct and maintain Health Risk Assessments (HRAs).
- Develop and update Individualized Care Plans (ICPs).
- Facilitate Interdisciplinary Care Team (ICT) participation.
- Coordinate Medicare and Medicaid services and benefits.
- Promote continuity of care and successful transitions between settings.
- Improve quality outcomes and Member experience.
- Support person-centered care and Member self-determination.

Community First implements its Model of Care in accordance with CMS, NCQA, and Texas Health and Human Services Commission (HHSC) requirements.

Model of Care Training

Community First Health Plans requires Model of Care (MOC) training for providers who serve Members enrolled in the plan's Fully Integrated Dual Eligible Special Needs Plan (FIDE D-SNP) and other Special Needs Plan products, as applicable. The purpose of this policy is to ensure participating providers understand the plan's MOC, their role in interdisciplinary care coordination, and the operational expectations that support high-quality, integrated, Member-centered care for dual eligible Members.

Provider MOC training will be conducted at initial participation and at least annually thereafter. Additional training will be conducted when there are material changes to the MOC, applicable regulatory or contractual requirements, care coordination workflows, provider responsibilities, or plan operations affecting delivery of services to the SNP population.

MOC training explains:

- The purpose and structure of the MOC
- Characteristics and needs of the SNP population served by the plan
- Provider responsibilities in supporting the MOC
- Interdisciplinary Care Team participation and coordination expectations
- Health Risk Assessment, individualized care planning, and care transition processes
- Escalation pathways and coordination with plan care management staff
- Any other operational expectations relevant to the provider's role

Community First will send out annual notifications to complete this required training. Each provider serving our D-SNP population must attest that the training has been completed. Providers or delegated entities that fail to complete required MOC training within established timeframes may be subject to follow-up, escalation, corrective action, or other contractually permitted interventions. The plan may also require targeted re-education when deficiencies are identified through monitoring, audits, complaints, quality reviews, or operational oversight.

To complete the training Providers can go to Medicare.communityfirsthealthplans.com/providers/model-of-care/ to review and attest.

Failure to complete required training may result in follow-up activities, corrective action, or other interventions consistent with provider contractual obligations.

Population Health Management

Community First utilizes a population health management strategy to identify health risks, manage chronic conditions, address gaps in care, improve preventive service utilization, and coordinate care for vulnerable Members.

Population health activities include analysis of:

- Claims and encounter data
- Pharmacy utilization
- Health Risk Assessments
- Hospitalization and readmission trends
- Emergency Department utilization
- LTSS utilization
- Behavioral Health utilization
- Preventive care compliance
- Quality performance measures
- Social Determinants of Health (SDOH) indicators

This information is used to identify care opportunities, support proactive interventions, and improve health outcomes across the entire FIDE D-SNP population.

Identification of High-Risk Members

Community First employs a systematic process to identify Members who may benefit from enhanced care management services.

Members may be identified through:

- Health Risk Assessments
- Claims and utilization data
- Prior authorization activity
- Provider referral
- Service Coordinator referral
- Hospital admission, discharge, and transfer notifications
- Pharmacy utilization indicators
- Caregiver referral
- Self-referral
- Community-based organization referral

Examples of high-risk Members may include:

- Members with multiple chronic conditions
- Members with frequent hospitalizations
- Members with repeated Emergency Department visits
- Members receiving LTSS services
- Members with serious behavioral health conditions
- Members with significant functional limitations
- Members with complex medication regimens
- Members experiencing significant social barriers to care

Members identified as high-risk may be enrolled in enhanced care management and service coordination programs.

Target Populations

Community First recognizes that certain Members face increased risks related to healthcare access, health outcomes, and social support needs.

Vulnerable populations may include:

- Nursing Facility residents.
- Members receiving LTSS.
- Members with intellectual or developmental disabilities.
- Members with physical disabilities.
- Members with serious mental illness.
- Members with substance use disorders.
- Members experiencing homelessness or housing instability.
- Members with transportation barriers.
- Members with food insecurity.
- Members with limited caregiver support.
- Members with limited health literacy.
- Members with language or communication barriers.

Community First uses person-centered interventions and targeted care coordination strategies to address the unique needs of these populations.

Care Management Program

The Community First Care Management Program supports Members whose health status, functional limitations, behavioral health needs, or social circumstances require coordinated interventions beyond routine clinical care.

Health Risk Assessments (HRA)

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandate a Health Risk Assessment, care plan, qualifying face-to-face encounter, and an interdisciplinary care team for FIDE SNP Members as well as an evaluation of care effectiveness by Community First Health Plans. Service Coordination starts with the Health Risk Assessment (HRA) for all D-SNP Members to include Members in our FIDE plan. The risk level indicates the Member's needs and appropriate level of Service Coordination services. Initial assessments are conducted within 90 days of enrollment and annual reassessments are conducted within one year of the initial assessment.

Community First conducts Health Risk Assessments to identify medical, behavioral, functional, psychosocial, and social support needs.

Assessments may evaluate:

- Physical health conditions
- Behavioral health conditions
- Medication utilization
- Functional status
- LTSS needs
- Social Determinants of Health
- Transportation needs
- Housing stability
- Food insecurity
- Caregiver support availability

Assessment findings are used to support risk stratification and individualized care planning.

Comprehensive Assessments

Members identified as high-risk may receive comprehensive assessments to evaluate:

- Clinical needs
- LTSS needs

- Behavioral health needs
- Functional limitations
- Cognitive status
- Caregiver supports
- Community resource needs

Comprehensive assessments support development of person-centered care plans.

Individualized Care Plans (ICP)

Each FIDE SNP Member will receive an Individualized Care Plan (ICP) based on the Member's HRA responses. Once the Member, and/or caregiver completes the health risk assessment, an ICP is generated that reflects the Member's specific problems, prioritized goals, and interventions. The ICP generated tracks dates and goal progress. The frequency of contact will vary depending on the risk level of the Member and specific goal timeframes. The ICP is shared with the Member and their caregiver, the PCP, and as appropriate, other Members of the care team for input and updates. If unable to reach a Member or if a Member declines to complete an HRA then a standard care plan is developed based on available Member data.

The Individualized Care Plan may include:

- Member goals
- Clinical objectives
- Behavioral health goals
- LTSS interventions
- Community resource referrals
- Preventive health goals
- Transition planning activities
- Assigned responsibilities

Care plans are reviewed and updated as needed based upon Member condition, needs, and preferences.

Interdisciplinary Care Team (ICT)

Providers identified as part of a Member's Interdisciplinary Care Team (ICT) are encouraged to actively participate in the care planning process. The ICT collaborates with the Member and their support team to ensure care is coordinated, person-centered, and aligned with the Member's unique goals, preferences, and needs.

The ICT may include:

- The Member and/or authorized representative
- Primary Care Provider
- Specialists
- Behavioral Health Providers
- LTSS Providers
- Pharmacists
- Service Coordinators
- Care Managers
- Caregivers and family members
- Community support organizations

The ICT collaborates to develop, implement, and monitor the Individualized Care Plan and address barriers to achieving Member goals.

Face-to-Face Encounters

Community First Health Plans ensures that Members are provided a face-to-face encounter either in person or virtually within the first 12 months of their enrollment and annually thereafter. The face-to-face encounter is completed for the purpose of delivering healthcare, Service Coordination, or Care Coordination services and can be completed with an in-network treating Provider on the Member's interdisciplinary care team or with the Service Coordinator.

Care Transition Management

Community First supports Members during transitions between care settings, including:

- Hospital admissions and discharges
- Skilled Nursing Facility admissions and discharges
- Nursing Facility transitions
- Home Health transitions
- Behavioral Health facility transitions
- Community reentry following institutional stays

Community First Health Plans Service Coordinator will facilitate transitions of care for all FIDE D-SNP Members through communication and coordination with the Member, caregiver, treating Providers, and their primary care practitioner. Any changes to the Member's health status and any resulting changes to the care plan are discussed. The Member's primary care Provider will be notified of the transition and informed of any needs to assist with a smoother transition process.

Care Coordination Framework

The Community First Care Coordination Framework integrates Medicare and Medicaid services through collaboration among Members, providers, care managers, service coordinators, caregivers, and community organizations.

Care coordination activities include:

- Coordination of Medicare and Medicaid benefits
- LTSS coordination
- Behavioral Health integration
- Pharmacy management support
- Care transition support
- Community resource referrals
- Social Determinants of Health interventions
- Collaboration among treating providers

The goal of the care coordination framework is to improve continuity of care, reduce fragmentation, and support Members in maintaining health and independence in the least restrictive setting appropriate to their needs.

Provider Participation Expectations

Participating providers are critical partners in the successful implementation of the Community First FIDE D-SNP Model of Care.

Providers are expected to:

- Coordinate care with Community First Service Coordinators and Care Managers.
- Participate in ICT activities when requested.
- Support development and implementation of Individualized Care Plans.
- Communicate significant changes in Member condition.
- Participate in transition planning and discharge activities.
- Assist in identifying Members who may benefit from care management services.
- Address preventive care opportunities and gaps in care.
- Support behavioral health integration efforts.
- Cooperate with Community First quality improvement initiatives.
- Complete required Model of Care training and annual attestation requirements.
- Maintain compliance with all Community First FIDE D-SNP policies and applicable CMS and HHSC requirements.

Provider participation is essential to delivering coordinated, integrated, and person-centered care for the dual-eligible population served by Community First.

SECTION 5. LONG-TERM SERVICES AND SUPPORTS (LTSS)

LTSS Program Overview

Long-Term Services and Supports (LTSS) are an essential component of the Community First Health Plans Fully Integrated Dual Eligible Special Needs Plan (FIDE D-SNP). LTSS services are designed to assist Members who require ongoing support due to chronic illness, disability, functional limitations, cognitive impairment, or age-related conditions. The Community First FIDE D-SNP integrates Medicare and Medicaid services to ensure Members receive coordinated care that supports independence, promotes quality of life, and allows Members to remain safely in the least restrictive setting appropriate to their needs.

LTSS services are coordinated through Community First's integrated care model and are delivered in collaboration with Primary Care Providers (PCPs), specialists, behavioral health providers, Service Coordinators, caregivers, and community-based providers. The goal of the LTSS program is to address the Member's medical, functional, behavioral, and social support needs through a person-centered approach that emphasizes care coordination, continuity of care, and Member choice.

Community First's LTSS program supports Members receiving services in their homes, community settings, assisted living settings, nursing facilities, and other approved care environments. Services are coordinated as part of the Member's Individualized Care Plan (ICP) and are reviewed periodically to ensure continued medical necessity and alignment with the Member's goals and preferences.

Home and Community-Based Services

Home and Community-Based Services (HCBS) are intended to support Members who require assistance with activities of daily living, instrumental activities of daily living, or ongoing health-related services but who can safely remain in a home or community setting. Community First recognizes that many Members prefer to receive services in their homes and communities whenever clinically appropriate, and the FIDE D-SNP model promotes community integration and independence whenever possible.

Community First coordinates HCBS in accordance with applicable Medicaid requirements and Member eligibility criteria. Depending upon the Member's needs and authorized service plan, HCBS may include services such as personal assistance services, private duty nursing, respite services, home-delivered meals, habilitation services, home modifications, personal emergency

response systems, adaptive aids, and other supports that enable Members to safely reside in the community.

HCBS services are coordinated through Community First Service Coordination and are incorporated into the Member's care planning process. Service Coordinators work with Members, caregivers, Providers, and LTSS organizations to ensure services are delivered in a manner that supports Member choice, dignity, and independence. Members receiving HCBS may be reassessed periodically to determine whether changes to services are necessary due to evolving healthcare or functional needs.

Personal Assistance Services

Personal Assistance Services (PAS) provide support to Members who require assistance with activities of daily living or instrumental activities of daily living due to physical, cognitive, behavioral, or functional limitations. PAS are intended to help Members remain safely in their homes and communities while maximizing independence and quality of life.

Services may include assistance with personal care activities such as bathing, grooming, dressing, eating, mobility, toileting, meal preparation, light housekeeping, and other activities necessary to support the Member's health and safety. Services are provided according to an approved service plan and must be delivered in accordance with applicable state and federal requirements.

Community First works closely with LTSS providers and caregivers to monitor service delivery, identify changes in Member needs, and ensure services continue to support the Member's goals as outlined in the Individualized Care Plan. Service levels may be adjusted as warranted based on reassessment findings and changes in the Member's condition.

Nursing Facility Services

Community First supports Members who require nursing facility services through integrated service coordination, care planning, and transition management activities. Nursing facility services are intended for Members whose physical, medical, or functional needs require a level of care that cannot be safely met in a community setting.

Nursing facilities serve as important partners within the Community First FIDE D-SNP Model of Care. Community First Service Coordinators collaborate with nursing facility staff, treating providers, Members, and caregivers to support care planning activities, identify opportunities for community reintegration when appropriate, and coordinate transitions between care settings.

Nursing facilities are expected to notify Community First of significant events affecting enrolled Members, including hospitalizations, emergency department visits, discharge planning activities, hospice enrollment, adverse changes in condition, and Member deaths. Community First may participate in interdisciplinary care planning activities and nursing facility care conferences when appropriate to support coordination of services and transitions of care.

Community First remains committed to supporting Members in the least restrictive setting possible while ensuring access to medically necessary nursing facility services when such services are clinically appropriate.

LTSS Authorizations

Most LTSS services require prior authorization by Community First before services may be initiated, expanded, modified, or renewed. Authorization determinations are based upon medical necessity, Member eligibility, applicable benefit coverage, clinical documentation, assessment findings, and state and federal program requirements.

Providers requesting LTSS services must submit sufficient clinical and functional documentation to support the requested service. Community First may require supporting assessments, physician documentation, care plans, or additional information necessary to evaluate the request. Authorization reviews are conducted in accordance with applicable Medicare, Medicaid, and Community First utilization management policies.

Authorizations are subject to periodic review and may be modified based on reassessment findings, changes in the Member's condition, service utilization patterns, achievement of care plan goals, or other factors affecting medical necessity. Authorization approval does not guarantee payment, which remains subject to Member eligibility and benefit coverage at the time services are rendered.

LTSS Provider Responsibilities

LTSS providers are integral participants in the Community First FIDE D-SNP integrated care model. Providers delivering LTSS services are expected to support person-centered care, collaborate with Community First Service Coordinators and healthcare providers, and contribute to achievement of Member care plan goals.

LTSS providers are responsible for verifying Member eligibility and applicable service authorizations prior to delivering services. Providers must furnish authorized services in accordance with contractual requirements, established standards of care, and applicable state and federal regulations. Providers must maintain appropriate documentation to support services

rendered and cooperate with Community First monitoring, auditing, quality improvement, and reporting activities.

LTSS providers must promptly communicate significant changes in a Member's condition, functional status, living situation, caregiver support system, or service needs. Providers are also expected to notify Community First when Members experience hospitalization, nursing facility admission, emergency department utilization, health or safety concerns, changes in eligibility, or other events that may affect care planning or service delivery.

As Members of the interdisciplinary care team, LTSS providers may be asked to participate in assessments, care planning discussions, transition planning activities, and service coordination efforts to promote continuity of care and support achievement of Member-centered goals.

Service Suspension and Resumption Procedures

Community First recognizes that temporary service interruptions may occur due to hospitalization, nursing facility admission, relocation, incarceration, changes in eligibility, or other circumstances affecting a Member's ability to receive authorized LTSS services. LTSS providers are required to notify Community First as soon as they become aware that services must be suspended. Notification should occur no later than the first business day following the suspension of services.

The suspension notice should include the reason for the suspension, the effective date of the suspension, and the anticipated duration if known. Community First uses this information to coordinate care, update service records, and support transition planning activities as necessary.

When a Member becomes eligible to resume services, LTSS providers are expected to reinitiate services as quickly as possible and in accordance with Community First authorization requirements and care planning expectations. Providers should coordinate with the Member's assigned Service Coordinator to ensure services resume safely and appropriately. Confirmation of service resumption should be submitted to Community First within the required timeframes established by policy and contractual requirements.

These processes help ensure continuity of care and reduce the risk of gaps in services following hospitalizations, institutional stays, or other care transitions.

Reporting Requirements

Community First requires LTSS providers to comply with all applicable reporting requirements established by federal regulations, Texas Health and Human Services Commission (HHSC),

Community First policies, and contractual obligations. Timely and accurate reporting supports care coordination, quality oversight, program integrity, and Member safety.

LTSS providers must report significant events that may affect Member health, safety, service delivery, or eligibility. Reportable events may include hospitalization, nursing facility admission or discharge, changes in condition, service interruptions, suspected abuse, neglect, exploitation, medication errors, injuries, critical incidents, complaints, grievances, and other circumstances identified by Community First policy.

Providers are expected to cooperate fully with Community First investigations, quality reviews, audits, corrective action activities, and requests for documentation. Reporting obligations include compliance with encounter data submission requirements, Electronic Visit Verification (EVV) requirements when applicable, and any HHSC cost reporting requirements applicable to LTSS providers.

Community First may provide additional guidance regarding reporting processes, reporting timeframes, critical incident requirements, and regulatory updates through provider communications, training materials, and provider portal resources. LTSS providers are responsible for maintaining awareness of current reporting requirements and ensuring compliance with all applicable standards.

SECTION 6. BEHAVIORAL HEALTH INTEGRATION

Behavioral Health Benefits

Community First Health Plans recognizes behavioral health as a critical component of overall health and well-being. The Community First FIDE D-SNP provides integrated access to medically necessary behavioral health services, including mental health services, psychiatric care, counseling, substance use disorder treatment, medication management, crisis intervention, and other covered behavioral health services available through Medicare and Medicaid benefits.

Behavioral health services are coordinated through Community First's integrated Model of Care to support whole-person, person-centered treatment and improved health outcomes.

Integrated Behavioral Health Model

The Community First FIDE D-SNP utilizes an integrated behavioral health model that promotes coordination among Primary Care Providers, behavioral health providers, Service Coordinators, LTSS providers, caregivers, and other Members of the Interdisciplinary Care Team (ICT). Behavioral health needs are incorporated into Health Risk Assessments, Comprehensive Assessments, Individualized Care Plans, and care management activities when appropriate.

This integrated approach supports early identification of behavioral health needs, reduces fragmentation of care, and improves coordination between physical health, behavioral health, LTSS, and community-based services.

Coordination Expectations

Providers are expected to collaborate in the delivery of coordinated behavioral healthcare and share information necessary to support treatment planning, continuity of care, and Member safety in accordance with applicable privacy requirements.

Primary Care Providers should screen for behavioral health concerns and facilitate referrals when appropriate. Behavioral health providers should communicate significant findings, treatment recommendations, medication changes, and safety concerns to other treating providers when clinically appropriate. Community First Service Coordinators and Care Managers assist with care coordination, transition planning, and integration of behavioral health services into the Member's care plan.

Crisis Services

Community First supports timely access to behavioral health crisis services for Members experiencing psychiatric emergencies or other urgent behavioral health needs. Providers should

assess Members for situations that may require immediate intervention and facilitate access to emergency or crisis services when clinically appropriate.

Following a crisis event, Community First may coordinate follow-up care, discharge planning, medication reconciliation, and ongoing care management activities to support continuity of care and reduce future crises.

Substance Use Disorder Services

Community First supports access to medically necessary substance use disorder (SUD) services through an integrated care model that coordinates treatment across medical, behavioral health, and community support settings. Covered services may include screening, assessment, counseling, medication-assisted treatment, outpatient treatment, inpatient treatment, and recovery support services, as applicable.

Providers are encouraged to routinely screen for substance use concerns and coordinate treatment with Community First Service Coordinators, behavioral health providers, and other members of the care team. Community First promotes a coordinated, recovery-oriented approach that supports long-term health, stability, and quality of life.

SECTION 7. UTILIZATION MANAGEMENT

Utilization Management Program

The Community First Health Plans Utilization Management (UM) Program supports the delivery of medically necessary, appropriate, and cost-effective healthcare services for Members enrolled in the Community First FIDE D-SNP. The UM Program is designed to ensure Members receive the right care, at the right time, in the most appropriate setting while supporting coordination of both Medicare and Medicaid benefits.

Community First uses evidence-based clinical criteria, applicable Medicare and Medicaid requirements, national coverage determinations (NCDs), local coverage determinations (LCDs), and nationally recognized clinical guidelines when making utilization management decisions. Medical necessity determinations are made by qualified healthcare professionals and are based on the Member's individual clinical circumstances.

Prior Authorization

Certain services, procedures, medications, and Long-Term Services and Supports (LTSS) require prior authorization before services are rendered. Prior authorization allows Community First to evaluate medical necessity, appropriateness of care, and benefit coverage prior to service delivery.

Providers should submit authorization requests as far in advance as possible but at least 14 days in advance of the service date and include all relevant clinical documentation necessary to support medical necessity. Requests may be submitted through the Community First Provider Portal or by contacting Provider Services at 210-358-6030.

Providers may review current authorization requirements and authorization lists on the Community First provider website at Medicare.CommunityFirstHealthPlans.com/Providers. Authorization requirements are subject to change and providers are responsible for verifying current requirements prior to rendering services.

Emergency and urgently needed services do not require prior authorization. However, Community First should be notified of inpatient admissions within 24 hours of hospital admission and provide supporting documentation within 48 hours of admission.

If prior authorization is required and not obtained, it may result in a reduction or denial of payment.

How to Request Prior Authorization

To initiate prior authorization or a notification request, a Provider may:

Submit a prior authorization request online via the Community First Provider Portal. Providers must attach relevant clinical information to the request. You will be notified when prior authorization is approved.

Call Member Services at 1-833-434-2347 as soon as practicable to facilitate care coordination and discharge planning activities.

Approval of an authorization request does not guarantee payment. Payment remains subject to Member eligibility, benefit coverage, and all applicable contractual and regulatory requirements at the time services are rendered.

Required Documentation

Information required for a prior authorization request or notification may include, but is not limited, to:

- Member name and date of birth
- Member ID number
- Relationship to the subscriber
- Date of actual service or hospital admission
- Type of service
- Place of service
- Service quantity
- Procedure codes
- Date of the proposed procedure, if applicable
- ICD 10 Diagnosis codes (primary and secondary), up to a maximum of six per authorization request
- Service location
    - Inpatient
        - Acute hospital
        - Skilled nursing
        - Hospice
    - Outpatient
        - Telehealth
        - Office

        - Home
        - Ambulatory surgery center
- Type of authorization (inpatient or outpatient)
- Referral
- Tax ID number and NPI of requesting Provider
- Tax ID number and NPI of treatment facility where service is being rendered
- Tax ID number and NPI of Provider performing the service
- Name and phone number of all Providers indicated
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will facilitate a quicker determination. If additional clinical information is required, a Community First representative will request the specific information needed to complete the authorization process.

Expedited Requests

Providers may request expedited review when applying standard review timeframes could seriously jeopardize the Member's life, health, or ability to regain maximum function. Expedited requests should include clinical documentation supporting the need for urgent review.

Community First processes expedited requests in accordance with applicable Medicare and Medicaid requirements and notifies Providers and Members of determinations within required regulatory timeframes.

Concurrent Review

Concurrent review is conducted when Members are actively receiving services, including inpatient hospital care, skilled nursing facility care, behavioral health services, rehabilitation services, and other ongoing treatment episodes.

The purpose of concurrent review is to evaluate continued medical necessity, support care coordination, facilitate discharge planning, and ensure Members receive care at the most appropriate level. Community First clinical staff may collaborate with treating Providers, facility staff, Service Coordinators, and discharge planners to obtain updated clinical information and coordinate transition planning.

Providers are expected to submit timely clinical updates when requested to support continued authorization of services.

Retrospective Review

Retrospective review may be conducted after services have been rendered to evaluate medical necessity, appropriateness of care, benefit coverage, quality concerns, coding accuracy, or compliance with authorization requirements.

Providers may be asked to submit medical records and supporting documentation as part of the review process and are expected to cooperate with all requests for information.

Denials and Peer Review

If Community First determines that a requested service does not meet medical necessity, authorization, coverage, or benefit requirements, an adverse determination may be issued. Adverse determinations are made by appropriately qualified healthcare professionals using applicable clinical criteria and regulatory requirements.

Written notification of adverse determinations will be provided in accordance with Medicare and Medicaid requirements and will include the reason for the decision and available appeal rights.

Prior to an adverse determination, or when otherwise permitted, the requesting Provider may be offered the opportunity to discuss the request with a Community First Medical Director or qualified clinical reviewer through a peer-to-peer review process.

Providers may submit appeals or reconsideration requests in accordance with Community First policies and applicable regulatory requirements. Additional information regarding appeals and grievances is available in Section 15 of this Provider Manual.

Second Medical Opinions

Members have the right to obtain a second medical opinion regarding the medical necessity or appropriateness of a proposed treatment plan, surgical procedure, diagnosis, or other healthcare service. Community First will facilitate access to second opinions in accordance with applicable Medicare and Medicaid requirements.

Clinical Review Criteria

Community First utilizes nationally recognized clinical guidelines, CMS coverage policies, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and evidence-based clinical resources when making utilization management decisions. Community

First may also use internally developed clinical policies consistent with current standards of care and regulatory requirements.

Providers may request information regarding the clinical criteria used to make a specific utilization management determination by contacting Community First.

SECTION 8. CLAIMS AND BILLING

Claims Submission

Unless applicable law provides that submissions can be in paper format, Providers must submit all claims, encounters, and clinical data to Community First by electronic means. Those electronic means accepted as industry standard may include claims clearinghouses or electronic data interface companies.

Providers using electronic submission must submit all claims to Community First or its designee, as applicable, using the Health Insurance Portability and Accountability Act (HIPAA)-compliant EDI 837 electronic format. When submitting claims — whether electronically via the 837 format or on paper — Providers must include a taxonomy code for each Provider. The taxonomy code must be the code most appropriate for that Provider and the services delivered.

NOTE: No claim is complete for a covered service and/or no reimbursement is due for a covered service unless the Provider's performance of that covered service is fully and accurately documented in the Member's medical record prior to the claim's initial submission.

Prompt Payment of Claims

A claim is deemed to have been promptly adjudicated if it has been paid, pended for review (when applicable under state guidelines), or denied within the time established by the applicable state or federal prompt payment statutes and/or regulations. To ensure that a claim is processed promptly and within a timely manner, the following criteria must be satisfied upon the claim's submission to Community First:

- The claim must be submitted either electronically or by paper if permitted by applicable law.
- The claim must be "complete" and must qualify as a "clean claim."
    - "Complete" – the information provided in the claim must be sufficient to substantiate the services rendered to the covered patient.
    - "Clean claim" – the claim must satisfy the description set forth in state or federal law, as applicable, based on the type of plan.

A Member's original signature or a "signature on file" (or "assignment on file") stamp is required for payments made directly to the Provider.

NOTE: The Provider must maintain a valid written assignment of benefits from the Member on file. This will serve as evidence that the Provider is entitled to all payments for service.

Community First reserves the right to review the original, signed assignment document at any time.

Separate charges must be itemized on separate lines. Medical record documentation must validate the scope of services provided and billed.

The time frame for submitting claims is listed below, if not otherwise specified by the agreement or applicable state or federal law:

Initial Submission of Claim: 120 days from the date of service

- 1st Level Appeal: 60 days from Explanation of Payment (EOP)
- 2nd Level Appeal: 60 days from initial appeal Explanation of Payment (EOP)

Providers should have a timely process in place to refund patients any difference between their copayment and the allowable amount for the office visit (in instances when the allowed amount is less than the copay collected) when Community First processes the claim. For assistance, call Member Services.

Claims Processing

Community First will process accurate and complete Provider claims in accordance with Community First's normal claims processing procedures, including, but not limited to, claims processing edits, claims payment policies, and applicable state and/or federal laws, rules and regulations.

Such claims processing procedures include a review of the interaction of a number of factors. The result of Community First's claims processing procedures will be dependent upon the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures.

Examples of the most commonly used procedures, including, but not limited to, are:

- The complexity of a service.
- Whether a service is one of multiple same-day services such that the cost of the service to the Provider is less than if the service had been provided on a different day. For example: Two or more surgeries performed the same day.
- Two or more therapy services performed the same day.
- Whether an assistant surgeon, surgical assistant, or any other Provider who is independently billing is involved.

- When a charge includes more than one claim line, whether any service is part of, or incidental to, the primary service that was provided or if these services cannot be performed together.
- Whether the service is reasonably expected to be provided for the diagnosis reported.
- Whether a service was performed specifically for the Member.
- Whether services can be billed as a complete set of services under one billing code.

Community First develops claims processing procedures based on a review of one or more of the following sources, including, but not limited to:

- Medicare laws, regulations, manuals, and other related guidance.
- Federal and state laws, rules and regulations, including instructions published in the Federal Register.
- National Uniform Billing Committee (NUBC) guidance, including the UB-04 Data Specifications Manual.
- American Medical Association (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services.
- The Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services.
- International Classification of Diseases (ICD).
- American Hospital Association's (AHA) Coding Clinic Guidelines.
- Uniform Billing Editor.
- American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services.
- Food and Drug Administration (FDA) guidance.
- Medical and surgical specialty societies and associations.
- Industry-standard utilization management criteria and/or care guidelines.
- Community First medical and pharmacy coverage policies.
- Generally accepted standards of medical, behavioral health, and dental practice based on credible scientific evidence recognized in published, peer-reviewed literature.

Changes to any one of the sources may lead Community First to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records prior to or after payment, or the recoupment or refund request of a previous reimbursement.

An adjustment in reimbursement as a result of claims processing procedures is not an indication that the service provided is a non-covered service. Providers may submit an appeal request of any adjustment produced by these claims processing procedures by submitting a timely request to Community First. For additional information, see the *Provider Claim Appeals, Member Appeal/Grievances,* and *Provider Termination Appeal Processes* sections of this Provider Manual.

SECTION 9. APPEALS, GRIEVANCES, AND COVERAGE DETERMINATIONS

Organization Determinations

An Organization Determination is a decision made by Community First Health Plans regarding a Member's Medicare-covered services, benefits, payment, or authorization of healthcare services. Organization Determinations may involve requests for prior authorization, payment for services already received, continuation of services, or determinations regarding whether a service is covered under the Member's benefit plan.

Community First processes Organization Determinations in accordance with applicable Centers for Medicare & Medicaid Services (CMS) requirements and established regulatory timeframes. Members, authorized representatives, and Providers acting on behalf of Members may request an Organization Determination when permitted by applicable regulations.

Coverage Determinations

Coverage Determinations are decisions regarding whether a requested healthcare service, item, treatment, or medication is covered under the Member's Medicare and/or Medicaid benefits and whether Community First will authorize or pay for the requested service. Coverage Determinations are based on the Member's benefits, applicable coverage requirements, medical necessity criteria, and supporting clinical documentation.

Providers should submit sufficient clinical information to support requests for coverage determinations. Community First reviews requests using applicable Medicare and Medicaid requirements, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), evidence-based clinical guidelines, and established medical necessity criteria.

If a requested service is not approved, Community First will issue written notification explaining the reason for the determination and available appeal rights.

Provider Claim Appeals

If a Provider disagrees with how Community First has adjudicated a claim, the Provider should submit the Community First Claim Appeal Form, a copy of the EOP, plus any substantive information for the claim appeal, and follow the procedures set forth by Community First or any applicable state laws.

NOTE: If an authorization number is not obtained prior to the delivery of services, the claim may be denied. The Member may not be billed for the balance for this type of denied claim.

Requests for Review of Denied Claims

Providers may request a review of claim payment denials by the plan(s). To obtain a review, Providers must submit an appeal via the Provider Portal.

Claim Appeals Process

For more efficient processing, please complete the Claim Appeal Form electronically available on the secure Community First Provider Portal. For assistance navigating the portal or to create an account, please email ProviderRelations@cfhp.com or call 210-358-6300 to contact Provider Services.

Providers can request an appeal/reopening of the issue by calling or writing to Community First at:

Community First Health Plans P.O.
Box 240969
Apple Valley, MN 55124
Phone: 210-358-6300

When submitting a request for an appeal/reopening in writing, include the following information:

- Provider name
- Tax ID
- Member name and identification number
- Date of service
- Relationship of the Member to the patient
- Claim number
- Charge amount
- Payment amount
- Proposed correct payment amount
- Difference between the amount paid and the proposed correct payment amount
- Brief description of the basis for the request
- Relevant supporting documentation (medical records, copy of the invoice, etc.)

Community First must receive claim appeals within 60 calendar days from the date of the notice of the initial determination or the claim will not be reopened.

Visit Medicare.CommunityFirstHealthPlans.com/Providers for claim payment policies and further information about claim appeals.

NOTE: Appeals submitted without the Claim Appeal Form will be rejected.

NOTE: The above provisions of this section are to be considered separate and distinct from the arbitration provisions set forth in the Provider agreement.

Pass-Through Billing

Community First prohibits pass-through billing. Pass-through billing occurs when a Provider bills for a service not performed by that Provider or any individual under that Provider's direct employment. Pass-through billing services will not be eligible for reimbursement from Community First. The Provider shall not bill, charge, seek payment, or have any recourse against Members for any amounts related to the pass-through billing provision.

Reimbursement

Payment terms are defined in the agreement. Additionally, the amount of payment for services provided may be affected by one or more of the following factors, including, but not limited, to:

- Member eligibility at the time of service
- Whether services provided are covered by the Member's plan
- Whether services provided are medically necessary, as required by the Member's plan
- Whether services provided require prior authorization by the Member's plan
- The amount of the Provider's billed charges
- Member copayments, coinsurance, deductibles, and other cost-sharing amounts due from the Member
- Coordination of benefits with third-party payers, as applicable
- Adjustment of payments based on claims processing procedures described in Claim Submission and Processing section of this Provider Manual
- Adjustments of payments based on Provider payment integrity policies, as described online at CommunityFirstMedicare.com

A Provider who receives reimbursement for services rendered to a Community First Medicare and Medicaid covered patient must comply with all federal laws, rules, and regulations applicable to individuals and entities receiving federal funds, including without limitation Title VI of the Civil Rights Act of 1964, Rehabilitation Act of 1973, Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990.

Nothing contained in the agreement or this Provider Manual is intended by Community First to be a financial incentive or payment that directly or indirectly acts as an inducement for Providers to limit medically necessary services.

Electronic Claims Payment

Community First partners with Zelis for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA).

Balance Billing

Pursuant to Law, Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payor is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Community First. Providers may not bill Members for covered services, also known as "balance billing," regardless of whether they believe the amount they were paid or will be paid by Community First is appropriate or sufficient. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable Member Liability towards covered Medicaid services such as Nursing Facility. Section 1902(n)(3)(B) of the Social Security Act (42 USC 1396a(n)(3)(b)); 42 CFR §422.504(g)(1)(iii).

Providers must accept as payment-in-full from Community First payment for covered services provided to health plan Members in accordance with the reimbursement terms outlined in the agreement. Members are responsible for applicable copayment, coinsurance, and deductible amounts. For covered services, Providers may not balance-bill Members for an amount other than their applicable copayment, coinsurance, and/or deductible responsibilities.

Subject to the limitation for services provided to a Member, a Provider is not prohibited by the agreement from collecting from health plan Members for a service not covered under the terms of the applicable Member's plan. A reduction in payment due to claims processing procedures is not an indication that the service provided is a non-covered service.

NOTE: A Provider may only collect for a service not covered under the terms of the applicable Member plan if the Provider followed the procedures outlined in the Utilization Management/Prior Authorization section of this Provider Manual. To verify covered services, please review plan documents at CommunityFirstMedicare.com.

Services That Are Not Medically Necessary

When Community First determines that rendered services covered under the terms of the applicable Member plan were not medically necessary, the Provider shall not bill, charge, seek payment, or have any recourse against the Member for such services.

Physician or Other Health Care Professional Surgical Payments

Professional reimbursement for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care. Claims processing procedures apply to surgical procedures and related services. Visit Medicare.CommunityFirstHealthPlans.com/Providers for a more detailed explanation of claim payment policies and/or code edit notifications.

Community First Special Investigative Unit

Community First Special Investigative Unit (SIU) The Special Investigative Unit (SIU) at Community First is a dedicated team focused on upholding integrity, accuracy, and compliance throughout claims processing. Committed to protecting both Members and Providers, the SIU is integral in detecting, preventing, and resolving issues related to payment errors, fraud, waste, and abuse. Through meticulous reviews, comprehensive audits, and collaborative efforts, the SIU ensures that all payments are accurate and transparent, building trust across the health care system.

SIU Review Process

As part of its commitment to detecting, preventing and correcting fraud, waste, and abuse, the SIU also operates a thorough review program. This process is essential for validating claims accuracy and ensuring compliance. For additional details on the medical record review or to request the SIU Audit Plan, please contact the Community First SIU team at SIURequests@cfhp.com.

Overpayments

The SIU prioritizes accuracy in claim payments, identifying any overpayments or errors through a comprehensive review process. When discrepancies are found, Community First may initiate a refund request to resolve issues promptly, ensuring the integrity and reliability of payment processes.

To Report Suspected Fraud, Waste, or Abuse

Community First encourages Providers, Members, and stakeholders to report any suspected instances of fraud, waste, or abuse. Prompt reporting helps ensure the integrity of our health care system and supports efforts to maintain accurate claims processing.

- Call 210-358-6338 or 1-877-225-7152
- Email SIURequests@cfhp.com
- Complete our online Suspicious Activity Report Form at CommunityFirstHealthPlans.com/Fraud-Waste-Abuse.

When reporting, please provide as much detail as possible, including names, dates, claim numbers, and a description of the suspected activity. All reports are taken seriously and reviewed by the SIU to ensure appropriate action. Community First is committed to safeguarding the integrity of health care services, ensuring accountability, and protecting the resources of our Members and Providers.

Contacts, General Inquiries, and Escalation Process

For more information on how to resolve recoupment concerns, such as overpayments, payment integrity reviews, disputes, and medical record requests, please review the SIU Audit Plan, available upon request by contacting the SIU Manager at **210-510-2455** or SIURequests@cfhp.com.

Member Appeals/Grievances

A Member, their Provider, or an authorized representative may express orally or in writing dissatisfaction or disagreement regarding an Adverse Benefit Determination. Community First regards any expression of dissatisfaction or disagreement as a request to appeal the Adverse Benefit Determination within 60 days from the date of the denial notification letter. Community First may accept a request for a standard or expedited level 1 appeal after the 60-day timeframe if a filing party shows good cause. Community First will accept and process any additional evidence or allegations of law and fact related to the disputed issue.

Community First will identify and remove any communication barrier that might impede Members or representatives from effectively making appeals, and facilitate the request to file an appeal for a Member who has a communication challenge affecting their ability to communicate or read through the following means:

- A toll free TTY line (711) for the hearing impaired.

- Free translation services for Members who do not speak English.
- Additional accommodations for any Member with special needs who is unable to follow the standard process.

Community First will conduct a full and fair review of the appeal, including specialty review for clinical appeals. Appeals must be submitted within 60 calendar days from the date of the adverse determination notice unless the Member can demonstrate good cause.

Notification of the decision will be issued within the following time frames from the date the request is received (with the exception of Medicare Part B drugs):

- Expedited – As expeditiously as the Member's health condition requires, but no later than 72 hours.
- Preservice – As expeditiously as required based on the Member's health, but no later than 30 calendar days.
- Payment – 60 calendar days from the receipt of the request.

The time frames for Medicare Part B drugs are:

- Expedited – No later than 24 hours (no extensions permitted).
- Standard Preservice – No later than seven (7) days (no extensions permitted).

Time frames for decisions might be extended for expedited and preservice appeals up to 14 calendar days if the:

- Member requests the extension.
- Community First justifies the necessity for additional information and documents, in the best interest of the Member.

The extension notification to the Member must occur prior to the expiration of the decision time frame and must include the right to file an expedited appeal if the Member disagrees with the extension.

NOTE: If the initial determination is upheld during the appeal process, the resolution letter from Community First will provide information on next-level appeals.

Reconsiderations

A Reconsideration is the first level of appeal for Medicare-related adverse determinations. During the reconsideration process, Community First conducts an independent review of the original

decision and any additional information submitted by the Member, authorized representative, or Provider.

Reconsiderations may involve review of medical necessity, benefit coverage, authorization requirements, clinical documentation, or payment determinations. If the original denial is upheld, the Member may have additional appeal rights available through subsequent levels of the Medicare appeals process.

Providers may be asked to submit additional medical records or supporting documentation during the reconsideration process and are expected to cooperate with all requests for information.

Grievances

A grievance is a complaint or expression of dissatisfaction regarding any aspect of Community First operations, customer service, access to care, quality of care, provider interactions, or other concerns that are not related to a coverage determination or payment decision.

Members have the right to file a grievance when they believe Community First or a participating Provider has failed to meet expectations regarding service delivery or quality. Community First investigates grievances promptly and works to resolve concerns in accordance with applicable Medicare and Medicaid requirements.

Providers are expected to cooperate with grievance investigations and provide requested information within required timeframes. Community First may use grievance findings to identify opportunities for quality improvement and provider education.

Expedited Reviews

Members, authorized representatives, and Providers may request an expedited review when waiting for a standard determination or appeal could seriously jeopardize the Member's life, health, ability to regain maximum function, or subject the Member to unmanaged pain that cannot be adequately controlled.

Community First evaluates requests for expedited processing based on clinical information provided by the treating Provider and applicable regulatory requirements. When criteria for expedited review are met, Community First processes the request within accelerated timeframes established by CMS and other applicable regulatory agencies.

If Community First determines that expedited review is not warranted, the request may be processed under standard review procedures, and the Member will be informed of the decision and applicable rights.

Provider Responsibilities

Participating Providers play an important role in the appeals and grievance process and are expected to submit requested medical records, clinical documentation, and supporting information within required timeframes. Providers should cooperate with Community First review activities and assist Members in understanding available appeal and grievance options when appropriate.

Timely submission of complete and accurate documentation helps ensure compliance with regulatory requirements and supports prompt resolution of Member concerns.

SECTION 10. QUALITY IMPROVEMENT

Quality Improvement Program

Community First Health Plans maintains an ongoing Quality Improvement (QI) Program designed to monitor, evaluate, and improve the quality, safety, effectiveness, and accessibility of healthcare services provided to Members enrolled in the Community First Fully Integrated Dual Eligible Special Needs Plan (FIDE D-SNP). The Quality Improvement Program supports Community First's commitment to delivering coordinated, person-centered care that improves health outcomes, enhances Member experience, and promotes appropriate utilization of healthcare services.

The Quality Improvement Program utilizes clinical performance measures, quality studies, Member feedback, utilization data, patient safety initiatives, and regulatory requirements to identify opportunities for improvement. Program activities focus on preventive care, chronic disease management, care coordination, behavioral health integration, Long-Term Services and Supports (LTSS), care transitions, and Member satisfaction.

Providers play an important role in supporting Community First's quality goals through the delivery of evidence-based care, timely documentation, participation in quality initiatives, and collaboration with Community First quality improvement activities.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Healthcare Effectiveness Data and Information Set (HEDIS®) measures are used to evaluate the quality of care and services provided to Members. Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS measures assess performance across a variety of clinical and preventive care areas, including screenings, immunizations, chronic disease management, medication adherence, and follow-up care.

Community First monitors HEDIS performance throughout the year and works collaboratively with Providers to improve quality outcomes. Providers may be asked to submit medical records, participate in chart reviews, close identified gaps in care, and support outreach efforts to improve measure performance. Accurate and timely documentation remains essential to ensuring that quality performance is appropriately captured and reported.

CAHPS

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures Member experience and satisfaction with healthcare services. Survey results provide valuable

feedback regarding access to care, communication with Providers, customer service, care coordination, and overall satisfaction with the health plan.

Community First uses CAHPS results to identify opportunities to improve Member experience and strengthen provider and health plan interactions. Providers are encouraged to support positive Member experiences through effective communication, timely access to care, responsive service, and patient-centered treatment approaches.

Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) measures Members' perceptions of their health status and evaluates the impact of healthcare interventions on quality of life over time. The survey focuses on physical and mental health functioning and helps assess the effectiveness of care delivered to Medicare beneficiaries.

Community First reviews HOS results to identify opportunities for improving health outcomes, care management programs, chronic disease management strategies, and care coordination efforts. Providers can contribute to improved outcomes by emphasizing preventive care, managing chronic conditions proactively, and encouraging Member engagement in health and wellness activities.

Medicare Star Ratings

The Medicare Star Ratings Program is administered by the Centers for Medicare & Medicaid Services (CMS) and evaluates Medicare Advantage plans based on quality and performance measures. Star Ratings assess a broad range of factors, including clinical quality, medication adherence, preventive services, Member experience, customer service, care coordination, and operational performance.

Community First actively monitors Star Ratings performance and implements quality improvement initiatives to enhance outcomes across all measured domains. Provider performance and engagement significantly contribute to Star Ratings success. Timely preventive care, medication management, chronic disease monitoring, accurate documentation, and effective care coordination all support improved Star Ratings results and Member outcomes.

Provider Participation Expectations

Participating Providers are expected to actively support Community First's Quality Improvement Program and related quality initiatives. Provider participation may include cooperating with medical record requests, supporting HEDIS data collection activities, addressing gaps in care,

participating in performance improvement initiatives, and implementing evidence-based clinical practices.

Providers are also expected to collaborate with Community First Service Coordinators, Care Managers, and Quality Improvement staff to support preventive care, chronic disease management, behavioral health integration, care transitions, and population health initiatives. Timely documentation, accurate coding, and complete medical record maintenance are essential to measuring quality outcomes and demonstrating compliance with regulatory standards.

Community First may periodically share quality performance reports, educational materials, and opportunities for quality improvement collaboration with participating Providers. Providers are encouraged to review performance information and participate in activities designed to improve Member outcomes, quality of care, and overall healthcare experience.

SECTION 11. COMPLIANCE PROGRAM

Community First Health Plans maintains a comprehensive Compliance Program designed to promote ethical conduct, prevent fraud and abuse, and ensure compliance with applicable federal and state laws, regulations, contractual requirements, and program guidance governing Medicare and Medicaid programs. The Compliance Program applies to all Community First employees, contracted Providers, delegated entities, vendors, and downstream entities participating in the Community First Fully Integrated Dual Eligible Special Needs Plan (FIDE D-SNP).

The Compliance Program is designed to support the delivery of high-quality, person-centered healthcare services while ensuring adherence to requirements established by the Centers for Medicare & Medicaid Services (CMS), the Texas Health and Human Services Commission (HHSC), and other applicable regulatory agencies. Participating Providers are expected to maintain effective compliance practices within their organizations and cooperate with Community First compliance activities, audits, investigations, monitoring activities, and corrective action initiatives.

Fraud, Waste, and Abuse

Community First is committed to preventing, detecting, and correcting fraud, waste, and abuse (FWA) in Medicare and Medicaid programs. Fraud, waste, and abuse can increase healthcare costs, compromise program integrity, and negatively affect Member access to care. Participating Providers are responsible for complying with all applicable Medicare and Medicaid program requirements and maintaining safeguards to prevent inappropriate billing, coding, documentation, and reimbursement practices.

Examples of potentially fraudulent or abusive practices may include billing for services not rendered, falsifying medical records, submitting duplicate claims, upcoding, misrepresenting diagnoses, offering inducements prohibited by law, or knowingly submitting inaccurate information for payment. Providers are expected to educate workforce members regarding FWA requirements and cooperate with audits, investigations, and corrective action efforts when requested by Community First or regulatory agencies.

HIPAA

Providers must protect the privacy, confidentiality, integrity, and security of Member Protected Health Information (PHI) and comply with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) and related federal and state privacy laws. PHI may

only be used, disclosed, or accessed as permitted by law and for purposes related to treatment, payment, healthcare operations, or other authorized activities.

Providers are responsible for implementing appropriate administrative, technical, and physical safeguards to protect Member information. Suspected privacy or security incidents involving Community First Members should be reported promptly in accordance with applicable legal, contractual, and regulatory requirements.

Exclusion Screening

Federal regulations prohibit participation in Medicare and Medicaid programs by individuals and entities excluded from federally funded healthcare programs. Providers are responsible for screening employees, contractors, temporary staff, vendors, and other downstream entities against applicable federal and state exclusion databases, including the Office of Inspector General (OIG) List of Excluded Individuals and Entities and applicable state exclusion lists.

Providers must take appropriate action if an excluded individual or entity is identified and must notify Community First in accordance with applicable contractual requirements. Failure to comply with exclusion screening requirements may result in corrective action, recoupment, termination of participation, or referral to regulatory authorities.

Reporting Compliance Concerns

Community First encourages Providers and their workforce members to report suspected compliance violations, fraud, waste, abuse, unethical conduct, privacy concerns, or other regulatory issues. Reports may be made through Community First's Compliance Department, Compliance Hotline, or other reporting mechanisms established by Community First.

Reports may be submitted anonymously when permitted by law. Community First prohibits retaliation against any individual who reports a compliance concern in good faith or participates in an investigation. Providers are expected to cooperate fully with compliance reviews, audits, investigations, and requests for information related to reported concerns.

Record Retention

Providers must maintain complete, accurate, and accessible records in accordance with applicable federal and state laws, CMS and HHSC requirements, accreditation standards, and Community First contractual obligations. Records must be retained for the period required by law and must be made available to Community First and authorized regulatory agencies upon request.

Records subject to retention requirements may include medical records, billing records, authorization documentation, encounter data, quality records, compliance records, pharmacy documentation, credentialing records, and other materials related to the provision of healthcare services. Providers are responsible for ensuring records remain secure, retrievable, and protected from unauthorized access, alteration, or destruction.

Timely access to records supports quality improvement, utilization management, appeals and grievances, claims review, compliance oversight, program integrity activities, and regulatory audits. Providers are expected to respond promptly to requests for records and supporting documentation from Community First or authorized governmental agencies.

SECTION 12. CRITICAL INCIDENT REPORTING AND EVV

Community First Health Plans requires timely reporting of critical incidents involving Members receiving Long-Term Services and Supports (LTSS), Home and Community-Based Services (HCBS), or other Medicaid-funded services. Critical incident reporting supports Member safety, quality oversight, regulatory compliance, and coordination of appropriate interventions when serious events occur. This reporting requirement applies to all participating providers responsible for delivering LTSS or HCBS services to Community First FIDE D-SNP Members.

Providers are expected to take immediate action to protect the health and safety of Members, ensure appropriate medical attention is obtained when necessary, and notify Community First of any reportable incident. Community First may conduct follow-up reviews, request additional documentation, coordinate corrective actions, and collaborate with regulatory agencies when appropriate. The reporting process is intended to support early identification of risks and prevent future adverse events.

Reportable Events

Critical incidents include events that may place a Member's health, safety, welfare, or rights at risk. Reportable events include, but are not limited to, abuse, neglect, exploitation, medication errors resulting in harm or requiring intervention, serious injury, unexpected hospitalization related to service delivery, suicide attempts, suicidal ideation with immediate safety concerns, and the unexpected death of a Member receiving services.

Providers should also report incidents involving suspected financial exploitation, criminal activity affecting a Member, significant health and safety concerns, or circumstances that may require intervention by Adult Protective Services, law enforcement, HHSC, or another regulatory entity.

Community First reserves the right to request reporting of additional events based on contractual, regulatory, or operational requirements.

Notification Timeframes

Providers must notify Community First as soon as reasonably possible upon discovery of a critical incident and no later than twenty-four (24) hours after the incident is identified. Initial notification should include all known information regarding the event, individuals involved, immediate actions taken, and current Member status.

When immediate danger exists, Providers must first ensure Member safety by contacting emergency services, law enforcement, Adult Protective Services, or other appropriate authorities

before submitting notification to Community First. Notification to Community First does not replace a Provider's responsibilities to comply with mandatory reporting requirements under federal or state law.

Providers may be required to submit follow-up information, corrective action plans, investigation findings, or additional documentation within timelines established by Community First or applicable regulatory agencies.

Provider Investigation Requirements

Providers are responsible for investigating incidents involving their employees, contractors, subcontractors, caregivers, or service delivery activities. Investigations should be conducted promptly and include appropriate documentation of the event, witness statements when available, corrective actions taken, and measures implemented to prevent recurrence.

Providers must cooperate fully with Community First investigations and monitoring activities. Community First may request medical records, personnel documentation, service records, training records, background screening information, corrective action plans, or other information necessary to evaluate the incident.

When warranted by the severity of the incident, Community First may require the Provider to implement corrective actions, additional staff training, enhanced supervision, or other quality improvement measures.

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is required for applicable Medicaid-funded Personal Care Services (PCS), Home Health Care Services (HHCS), and other services designated by the Texas Health and Human Services Commission (HHSC). EVV is used to electronically document and verify service delivery and ensure that services authorized for Members are accurately provided and billed.

EVV records capture information including the type of service provided, the individual receiving services, the individual delivering services, the date of service, service location, and the time services begin and end. EVV requirements support program integrity, service accountability, and compliance with federal mandates established under the 21st Century Cures Act.

All Providers furnishing EVV-required services must utilize an HHSC-approved EVV system and comply with applicable state requirements.

EVV Compliance Requirements

Providers are responsible for ensuring that EVV data is accurate, complete, and properly documented prior to claim submission. Claims for EVV-required services must be supported by verified EVV records and must comply with all HHSC and Community First requirements.

Providers should monitor EVV records regularly and correct visit exceptions, documentation discrepancies, and missing information within required timeframes. Failure to maintain compliant EVV documentation may result in claim denials, payment delays, corrective action requirements, or additional review activities.

Community First may conduct monitoring, audits, and compliance reviews related to EVV documentation and service delivery. Providers are expected to cooperate with these reviews and maintain all required EVV records in accordance with applicable state and federal requirements.

COMMUNITY FIRST MEDICARE ADVANTAGE BEXAR DUAL (D-SNP HMO) PROVIDER MANUAL

COMMUNITY FIRST HEALTH PLANS

12238 Silicon Drive, Ste. 100
San Antonio, Texas 78249
CommunityFirstMedicare.com