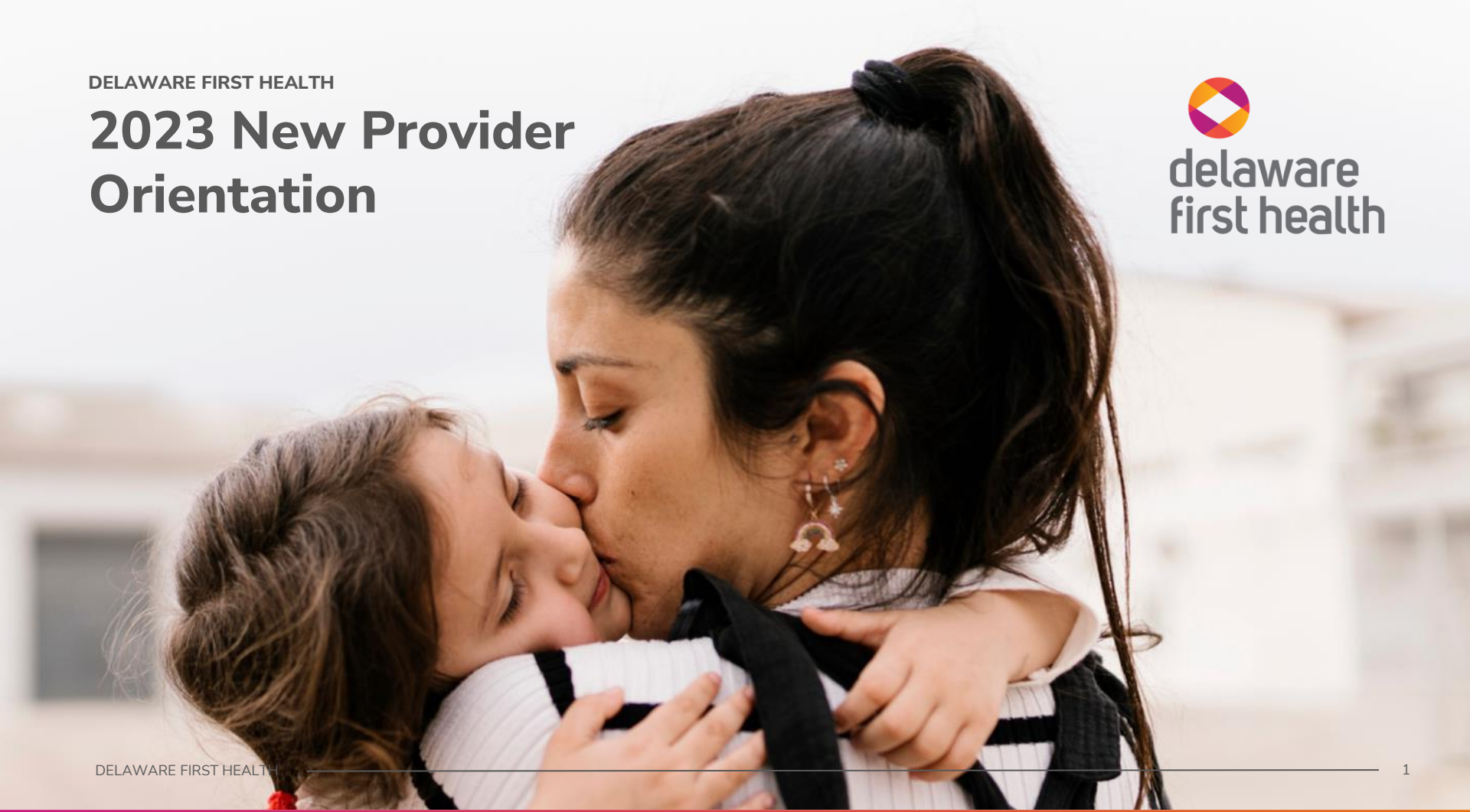
DELAWARE FIRST HEALTH

2023 New Provider Orientation



Agenda

01— About Delaware First Health

02— Our Partnership

03— Provider Resources + Training

04— Member Benefits + Eligibility

05— Provider Responsibilities, Access, and Availability

06— Prior Authorization

07— Billing + Claims

08— Medical Management

09— Q + A

01—

About Delaware First Health

Welcome to Delaware First Health! Thank you for being part of our network of healthcare professionals. We look forward to working with you to improve the health of our communities, one person at a time.

Hello, Delaware. So nice to meet you.

A Local Health Approach from a National Leader

Delaware First Health offers a local, community centric approach to healthcare, all backed by the nation's largest Medicaid Managed Care Organization: Centene Corporation.

With Centene's deep experience serving more than 15 million Medicaid members in 30 states, Delaware First Health also brings established best practices and a wealth of knowledge to Delaware's Medicaid Managed Care program and our provider partnerships.

Centene At-A-Glance

Transforming the health of the community, one person at a time.

#26 FORTUNE 500® (2021)

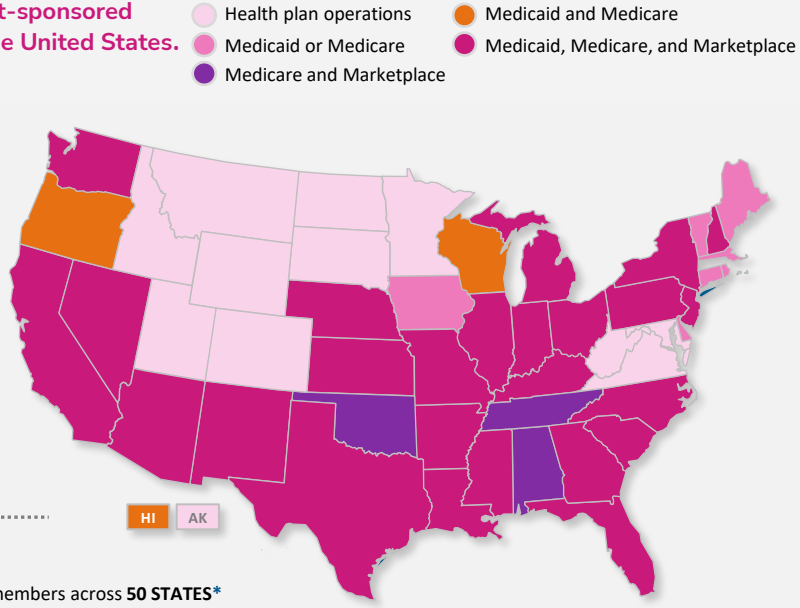
#57 FORTUNE GLOBAL 500® (2021)

82,000+ diverse and dedicated employees

Serving **1 in 15** Individuals

26.4 million managed care members

Leading government-sponsored healthcare across the United States.



15.4M Medicaid members across **30 STATES***

1.4M Medicare members across **36 STATES***

2.0M Marketplace members across **28 STATES***

4.2M Prescription Drug Plan members across **50 STATES***

**As of January 1, 2023.*

OUR PURPOSE

Transform the health of the community, one person at a time.

OUR APPROACH

Delaware First Health strives to improve the health of Delaware members through **focused, compassionate and coordinated care.**

Our approach is based on the core belief that quality healthcare is best delivered locally.

OUR PILLARS

Local

Whole Health

Focus on the Individual

UPDATE:

Medicaid Redetermination is Resuming This Year
Let your patients know:

- They should receive a letter a few months before their Medicaid anniversary date with instructions for verifying their eligibility. They can also check renewal information online.
- It's very important that they follow through on these instructions or they risk having their coverage canceled.
- If their eligibility is confirmed, they can continue their existing coverage. If they are no longer eligible for Medicaid, they can explore Marketplace and Medicare options.

For more information about Medicaid redeterminations, please visit medicaid.gov

UPDATE:

DFH Reinstates Prior Authorization Requirements Effective May 1, 2023,

•The waiver on prior authorizations for certain services will expire on May 1, 2023.

•Providers must obtain prior authorization for certain services that occur on or after May 1, 2023, including:
-Out of network services
-All non-emergent, advanced, outpatient imaging, cardiac, and interventional pain management (IPM) services managed by NIA.
-Please utilize DFH's preauthorization tool on our website to check for authorization requirements

Reminder: participating providers must refer members to in-network providers for services, including but not limited to labs, specialists, etc.

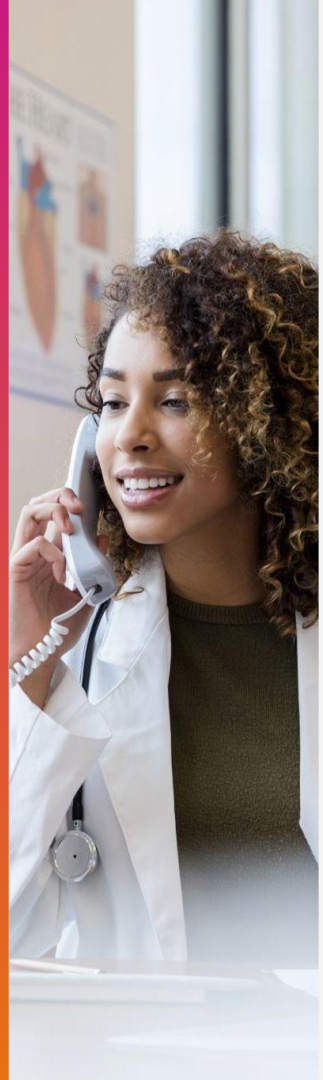
02—
Our Partnership

We're proud to be your

Managed Medicaid Partner

As our partner, you can count on Delaware First Health to provide:

- Fast and accurate claims payments
- Transparent data sharing to improve health outcomes
- Efficient and convenient processes for providing care to our members
- Responsive Provider Relations representatives to assist with all your needs
- A strong working partnership to ensure your patients receive the quality, affordable healthcare they deserve

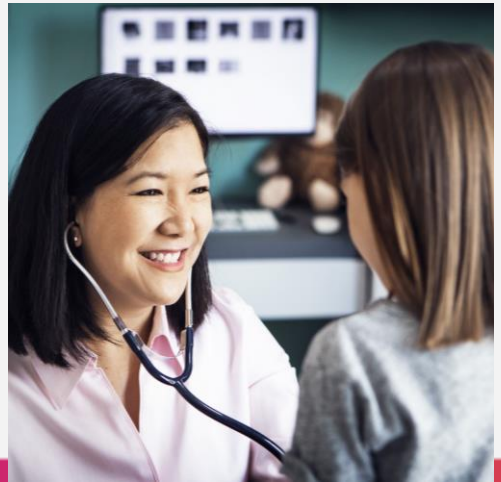


ABOUT DELAWARE FIRST HEALTH

Our Commitment to our Partners

Our goal is to help each and every Delaware First Health member achieve the highest possible levels of wellness and quality of life, while demonstrating positive clinical results. We do that through:

- **Integrated Care** – Strong support for service integration of physical, behavioral, and Long-Term Services and Support through a high degree of healthcare collaboration and communication.
- **Coordination of Care** – Organized member care that requires the involvement of all personal, community and healthcare stakeholders to facilitate the appropriate delivery of health care services.
- **Continuity of Care** – Healthcare driven by relationships between member, health providers, and community services to ensure ongoing health care management through shared goals and multiple care settings to produce high quality, cost-effective care.



03—
Provider Resources + Training

KEY CONTACT INFORMATION

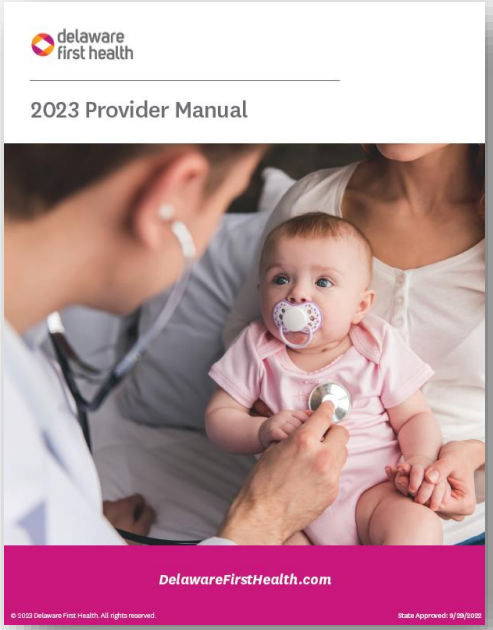
Delaware First Health

PHONE
1-877-236-1341

TTY/TDD
711

WEB + PORTAL
WWW.DELAWAREFIRSTHEALTH.COM

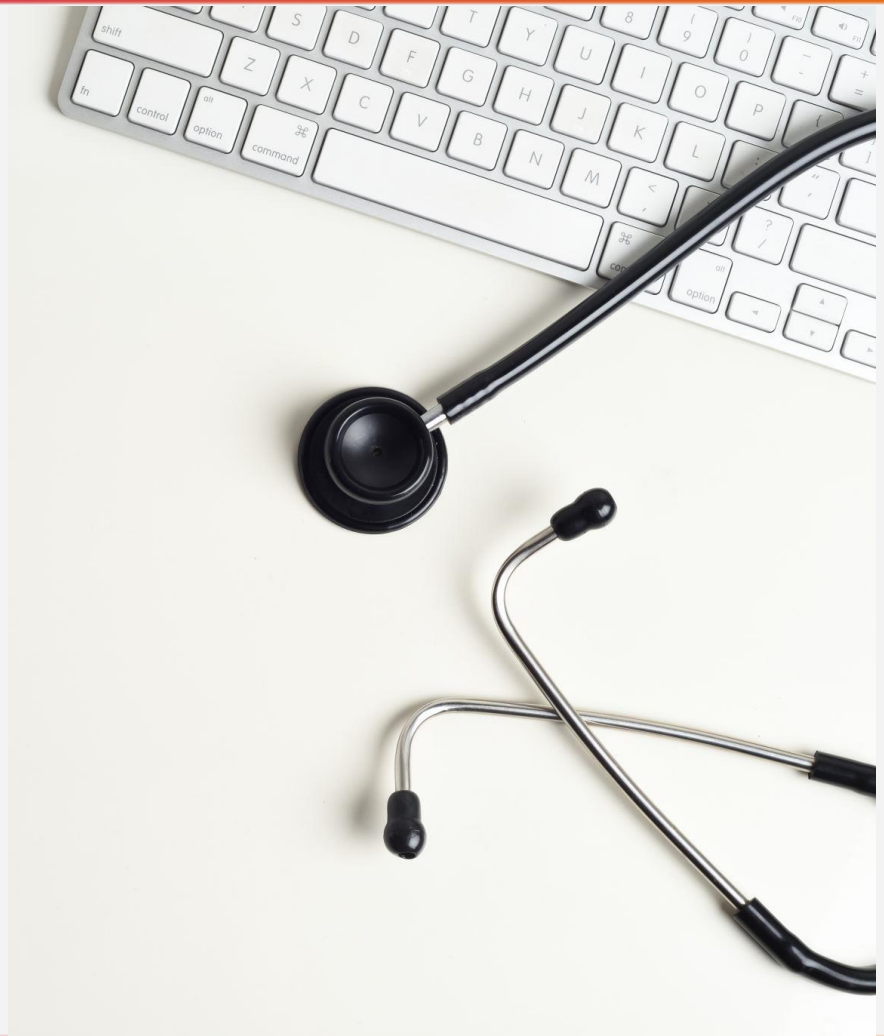
Your Manuals

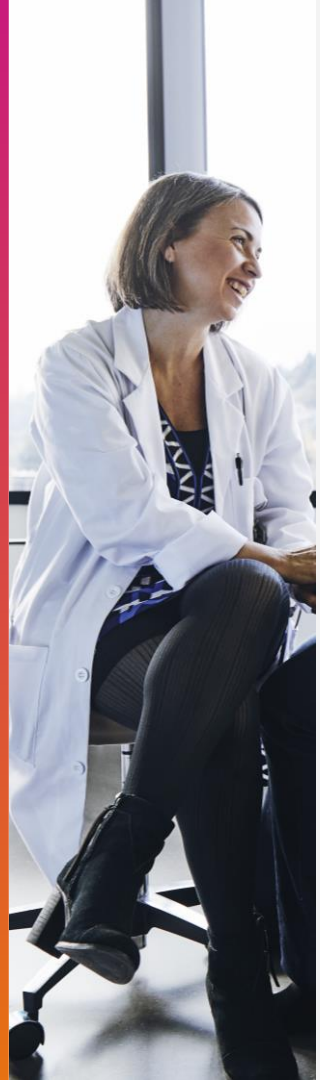


The Provider Manual and Provider Billing Manual are your comprehensive guides to doing business with Delaware First Health.

- The Manuals includes a wide array of important information relevant to providers including, but not limited to:
  - Network information
  - Billing guidelines
  - Claims information
  - Regulatory information
  - Key contact list
  - Quality initiatives
  - And much more!
- The Provider Manual and Provider Billing Manual can be found in the “For Providers” section of the DFH website at www.DelawareFirstHealth.com

- The Delaware Frist Health Provider Services department includes trained Provider Services staff who are available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
  - Member Eligibility
  - Claims Status
  - General Questions
- By calling Provider Services at 1-877-236-1341, providers will be able to access real time assistance for all their service needs
- Hours: Monday – Friday, 8 am – 5 pm





Provider Relations

- As a Delaware First Health provider, you will have a dedicated Provider Engagement Administrator available to assist you
- Our Provider Engagement Administrator serve as the primary liaisons between our health plan and provider network
- Your Provider Engagement Administrator is here to help with things like:

- ✓ Inquiries related to administrative policies, procedures, and operational issues
- ✓ Performance pattern monitoring
- ✓ Contract clarification
- ✓ Membership/provider roster questions
- ✓ Secure Portal registration and Pay Span
- ✓ Provider education
- ✓ HEDIS/Care gap reviews
- ✓ Financial analysis
- ✓ EHR Utilization
- ✓ Demographic information updates
- ✓ Initiate credentialing of a new practitioner

PROVIDER RESOURCES

The Public Website

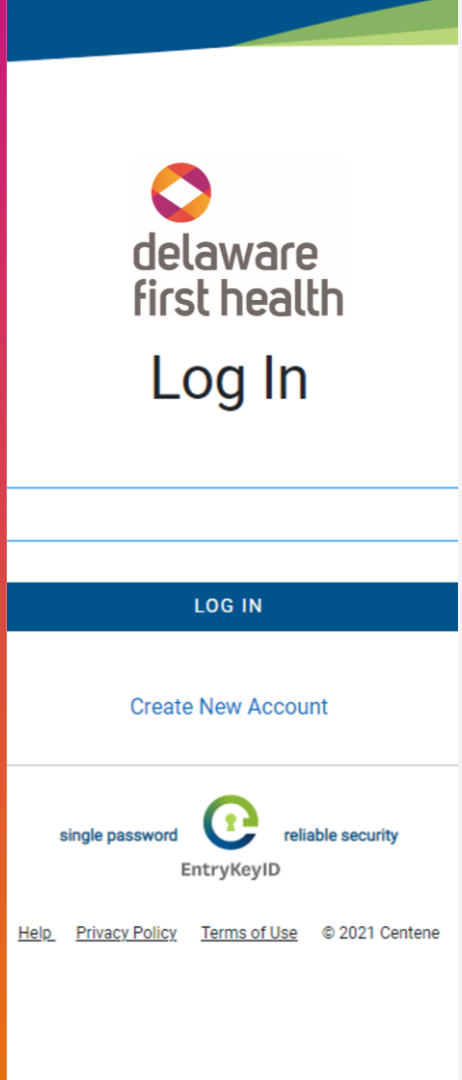
What's on the Delaware First Health Website?

- The Provider Manual
- The Provider Billing Manual
- Provider Trainings
- Clinical & Payment Policies
- Important Forms including:
    - Notification of Pregnancy
    - Prior Authorization Fax forms
    - Complaints and Disputes
    - Appeals forms
- The Pre-Auth Check Tool
- The Pharmacy Preferred Drug Listing
- Provider News
- And much more!

Provider Trainings

Delaware First Health offers multiple ongoing training opportunities for providers, including:

- New Provider Orientation
- Virtual Provider Forums
- Provider Portal Webinars
- And more!



PROVIDER RESOURCES

The Secure Provider Portal

What's on the Secure Provider Portal?

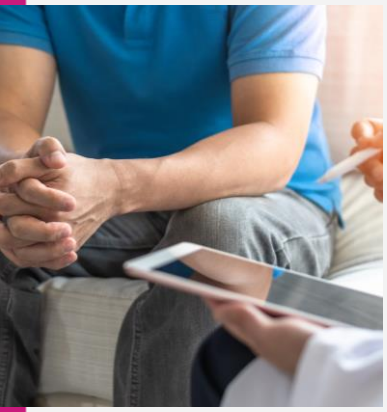
- Member eligibility & patient listings
- Health records & care gaps
- Authorizations
- Claims submissions & status
- Corrected claims & adjustments
- Payment history

Insightful Reports

- PCP reports available on secure provider portal are generated on a monthly basis and can be exported into a PDF or Excel format.

PCP Reports Include:

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High-Cost Claims



04—
Member Benefits + Eligibility

Member Population and Benefits

- Delaware First Health provides health coverage for enrollees of:
  - Diamond State Health Plan
  - Diamond State Health Plan-Plus (DSHP-Plus)

- Core Medicaid benefits are covered, and all services are subject to benefit coverage, limitations, and exclusions, as described in the Provider Manual
  - Link to Member Handbook: https://www.delawarefirsthealth.com/members/medicaid/resources/handbooks-forms.html
  - Link to Provider Manual: https://www.delawarefirsthealth.com/providers/resources/forms-resources.html

Verification of Eligibility, Benefits and Cost Share

Providers MUST Verify Member Eligibility

- Every time a member schedules an appointment
- When the member arrives for the appointment

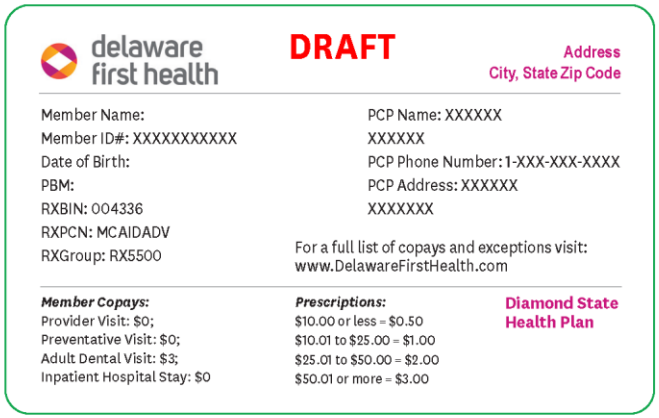
Panel Status

- Primary Care Physicians (PCPs) should confirm that a member is assigned to their patient panel
- This can be done via our Secure Provider Portal
- PCPs can still administer service if the member is not on their panel, and they wish to have member assigned to them for future care

Verification of Eligibility, Benefits and Cost Share

Eligibility, benefits and member cost shares can be verified in 3 simple ways:

- ✓ Secure Provider Portal: www.DelawareFirstHealth.com If you are already a registered user of the Delaware First Health secure portal, you do NOT need a separate registration!
- ✓ 24/7 Interactive Voice Response System: Enter the Member ID Number and the month of service to check eligibility
- ✓ Contact Provider Services: 1-877-236-1341


delaware first health

DRAFT

Address
City, State Zip Code

Member Name:
Member ID#: XXXXXXXXXXX
Date of Birth:
PBM:
RXBIN: 004336
RXPCN: MCAIDADV
RXGroup: RX5500

PCP Name: XXXXXX
XXXXXX
PCP Phone Number: 1-XXX-XXX-XXXX
PCP Address: XXXXXX
XXXXXXX

For a full list of copays and exceptions visit:
www.DelawareFirstHealth.com

Member Copays:
Provider Visit: $0;
Preventative Visit: $0;
Adult Dental Visit: $3;
Inpatient Hospital Stay: $0

Prescriptions:
$10.00 or less = $0.50
$10.01 to $25.00 = $1.00
$25.01 to $50.00 = $2.00
$50.01 or more = $3.00

Diamond State Health Plan


IMPORTANT CONTACT INFORMATION

www.DelawareFirstHealth.com

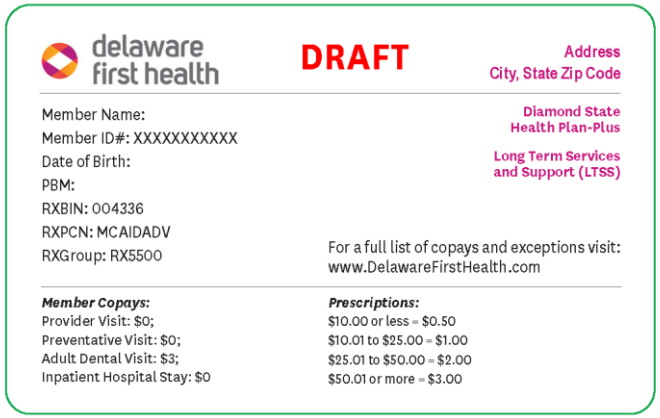
- **Member Services, 24/7 Nurse Line, Behavioral Health Line:** 1-877-236-1341 (TTY: 711)
- **Providers:** X-XXX-XXX-XXXX
- **Pharmacy Provider Support:** 1-833-236-1887 (TTY: 711)
- **Dental:** 1-877-236-1341 (TTY: 711)

DRAFT

Medical Claims:
Delaware First Health
PO BOX XXX
[city], [state] [zip]

Pharmacy Paper Claims:
Pharmacy Services
Member Reimbursements
P.O. Box 989000
West Sacramento, CA 95798

In case of an emergency, call 911 or go to the closest emergency room.
After treatment, call your PCP within 24 hours or as soon as possible.


delaware first health

DRAFT

Address
City, State Zip Code

Member Name:
Member ID#: XXXXXXXXXXX
Date of Birth:
PBM:
RXBIN: 004336
RXPCN: MCAIDADV
RXGroup: RX5500

Diamond State Health Plan-Plus

Long Term Services and Support (LTSS)

For a full list of copays and exceptions visit:
www.DelawareFirstHealth.com

Member Copays:
Provider Visit: $0;
Preventative Visit: $0;
Adult Dental Visit: $3;
Inpatient Hospital Stay: $0

Prescriptions:
$10.00 or less = $0.50
$10.01 to $25.00 = $1.00
$25.01 to $50.00 = $2.00
$50.01 or more = $3.00


IMPORTANT CONTACT INFORMATION

www.DelawareFirstHealth.com

- **Member Services, 24/7 Nurse Line, Behavioral Health Line:** 1-877-236-1341 (TTY: 711)
- **Providers:** X-XXX-XXX-XXXX
- **Pharmacy Provider Support:** 1-833-236-1887 (TTY: 711)
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Diamond State Health Plan-Plus

Long Term Services and Support (LTSS)

Medical Claims:
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PO BOX XXX
[city], [state] [zip]

Pharmacy Paper Claims:
Pharmacy Services
Member Reimbursements
P.O. Box 989000
West Sacramento, CA 95798

DRAFT

In case of an emergency, call 911 or go to the closest emergency room.
After treatment, call your PCP within 24 hours or as soon as possible.

Find-A-Provider

Choosing a doctor is important for our members. Delaware First Health has created a way for our members to have quick and easy access to finding a doctor in three ways.

These resources are also a great way for finding other in-network providers to assist in a member's care journey.

Online Find-A-Provider Tool	Provider Directory	Member Services
• Quick and Easy • LINK	• Updated Weekly • LINK	1-(877)-236-1341

Value-Added Services

Start Smart for Your Baby®

- Prenatal and Postpartum program
- Care management to extend the gestational period and reduce pregnancy-related risks

24/7 Nurse Advice Line

- 24-hour service by calling1-877-236-1341
- Registered Nurse available to provide health education and nurse triage for complex health issues

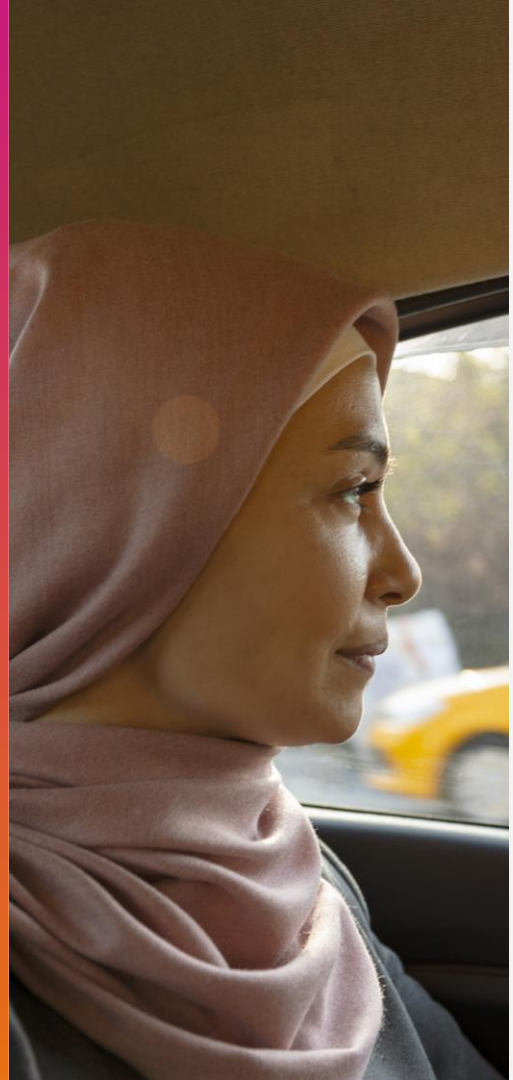
My Health Pays™

- A healthy rewards account program
- Innovative approach to encourage health behaviors through financial incentives

SafeLink Wireless

- No cost to Delaware First Health members
- Free smartphone
- Up to 350 minutes a month
- Unlimited texting

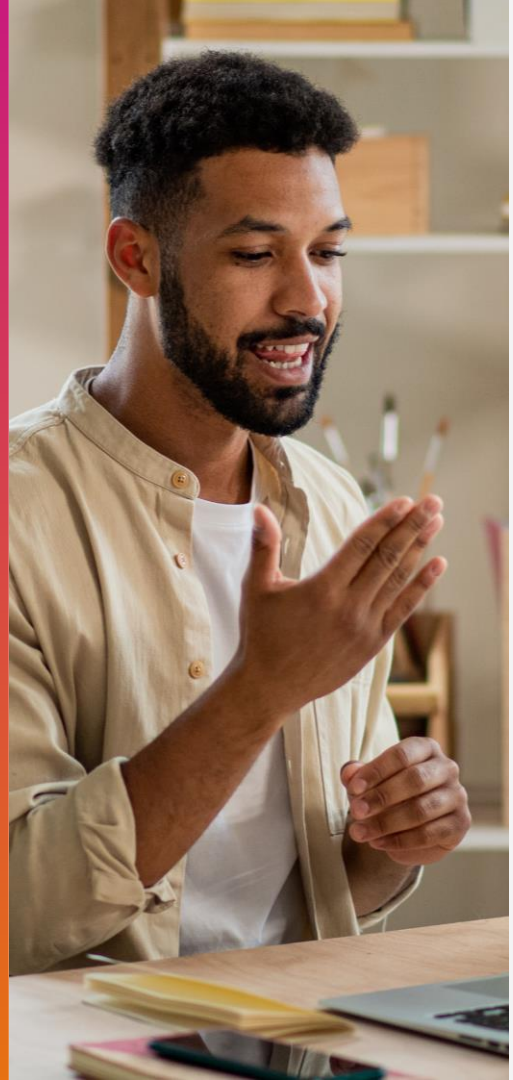
To learn more about all of our Value-Added Services, go to www.delawarefirsthealth.com and the "For Members" section.



BENEFITS + ELIGIBILITY

Whole Health Transportation

- Delaware First Health screens for transportation needs when members fill out their Health Risk Screening.
- Members identified with transportation needs will be offered transportation services through Modivcare, Lyft or DART vouchers.
- Members need to work with Member Services to receive these services.
- No prior authorization or copays will be required.
- See the table located in the Provider Manual for more details on the type of covered transportation services.



Telehealth Services

- Delaware First Health treats telehealth services with in-network providers in the same way as face-to-face visits with in-network providers.
- Telehealth visits with an in-network provider are subject to the same co-payments, co-insurance, and deductible amounts as an in-person visit with an in-network provider.
- ***Please note**: An originating site fee is not available if the member site is the member's home.*
- Providers interested in providing telemedicine, telemonitoring and telehealth services to eligible Delaware First Health members should reference the Delaware Medicaid Provider Procedures Manual.

State Covered Services

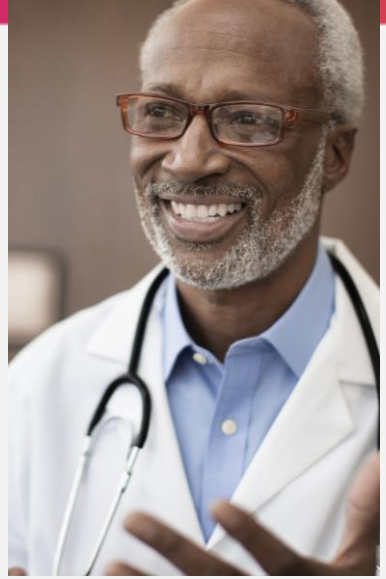
Some services are carved-out and covered by the State's fee-for-service (FFS) program instead of Diamond State Health Plan and Diamond State Health Plan-Plus (DSHP-Plus). While Delaware First Health does not cover these services, providers and specialists are required to provide referrals and assist in setting up these services. These include:

- Services included in the Program of All Inclusive Care for the Elderly (PACE)
- School-based services provided by the area education or local education agencies
- Dental services provided outside a hospital setting
- State of Delaware Veterans Home services

For details on how and where to access these services, members can call the Delaware Medicaid Health Benefits Manager toll-free at 1-800-996-9969 Monday-Friday from 8:00am – 5:00p EST.

Member Grievances and Appeals

- Member grievances and appeals may be filed by the member, a member's authorized representative, or a member's provider.
- Written consent must be obtained from the Member or their authorized representative on the designated Authorized Representative Designation form located at https://www.delawarefirsthealth.com/members/medicaid/resources/complaints-appeals.html
- Refer to the Provider Manual for information on how to file a member grievance, appeal, and State Fair Hearing, along with details on timely filing deadlines.



05—
Provider Responsibilities, Access, and Availability

Provider Responsibilities

- Treat members with fairness, dignity, and respect.
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- Respect members' Advance Directives and include these documents in the members' medical record.
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
- Follow all state and federal laws and regulations related to patient care and patient rights.

**A full list of our Provider Responsibilities can be found in the Provider Manual.*

Provider Responsibilities *(cont'd)*

- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
- Office hours of operation offered to Medicaid members will be no less than those offered to commercial members.
- Review clinical practice guidelines distributed by Delaware First Health.
- Disclose overpayments or improper payments to Delaware First Health.
- Not deny services to a member due to inability to pay the copayment if the household income is at or below 100% FPL.
- Reimburse copayments to members who have been incorrectly overcharged.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Obtain and report to Delaware First Health information regarding other insurance coverage.
- Notify Delaware First Health in writing if the provider is leaving or closing a practice.
- Update their enrollment information/status with the Delaware Medicaid program if there is any change in their location, licensure or certification, or status via the Delaware Medicaid's Provider Web Portal.

**A full list of our Provider Responsibilities can be found in the Provider Manual.*

Non-Discrimination of Members

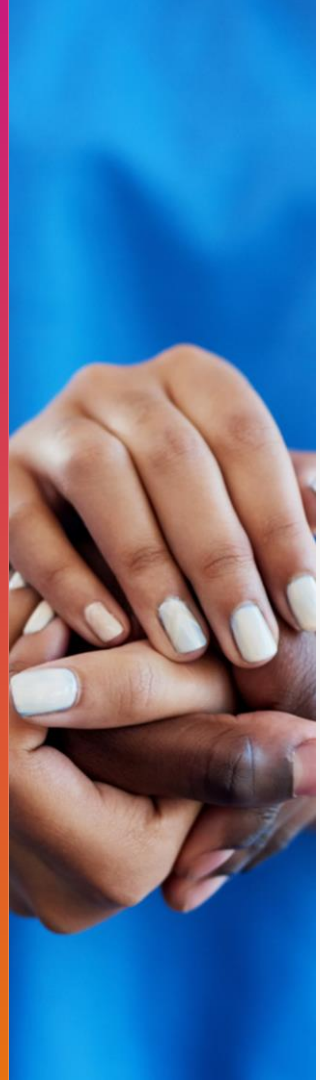
> Delaware First Health participating providers may not intentionally segregate members in any way from other individuals receiving services.

This discrimination can include:

- Denying or not providing to a Delaware First Health member any covered service or availability of a facility
- Providing a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large
- Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service
- Assigning service times based on the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, program enrollment, or physical or mental handicap of the member
- Restricting Medicaid members to a clinic practice when a participating provider has office appointments for non-Medicaid patients

Cultural Competency

Delaware First Health believes it is our responsibility, along with our partnering providers, to ensure inclusiveness and fairness is part of all of our activities, and that meeting the unique needs of our diverse membership in a culturally competent manner promotes the best outcomes in the delivery of healthcare to our members regardless of race, ethnicity, or language.



PROVIDER RESPONSIBILITIES

Cultural Competency

- When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care.
- Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.
- Delaware First Health will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist providers in developing culturally competent and culturally proficient practices.
- The U.S. Department of Health and Human Services' Office of Minority Health has published a suite of online educational programs to advance health equity at every point of contact through development and promotion of culturally and linguistically appropriate services.
- Visit Think Cultural Health at www.thinkculturalhealth.hhs.gov to access these free online resources.

Cultural Competency and the Patient Experience

Providers should note that the experience of a member begins at the front door. Failure to use culturally competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely.
- Reluctance and fear of making future contact with the office.
- Confusion and misunderstanding.
- Treatment non-compliance.
- Feelings of being uncared for, looked down on, and devalued.
- Parents resisting to seek help for their children.
- Unfilled prescriptions.
- Missed appointments.
- Misdiagnosis due to lack of information sharing.
- Wasted time.
- Increased grievances or complaints.

Appointment Access and Availability Standards

Appointment Access & Availability Standards

Network providers must comply with all access standards. *For a complete list of standards, refer to the provider manual.*

Hospital Emergency Availability

- 24 hours / 7 days a week

Primary Care Physician Availability

- Urgent: within 24 hours
- Routine Appointment: four (4) to six (6) weeks from the date of patient's request

Behavioral Health Availability

- Urgent: within one (1) hour of presentation at service site or within twenty-four (24) hours of telephone contact with provider or Delaware First Health
- Routine Appointment: within three (3) weeks of request for an appointment

Specialty Provider Availability

- Urgent: within 24 hours
- Routine care: within thirty (30) days

Reporting Critical Incidents

Delaware First Health Providers shall report critical incidents to Delaware First Health immediately upon occurrence and no later than within twenty-four (24) hours after detection or notification. The Incident Report Form can be found at DelawareFirstHealth.com. Delaware First Health shall ensure suspected cases of abuse, neglect and/or exploitation are reported to DSAMH Risk Management. Critical incidents include but are not limited to the following incidents:

- Unexpected death of a member;
- Suspected physical, mental, or sexual mistreatment, abuse and/or neglect of a member;
- Suspected theft or financial exploitation of a member;
- Severe injury sustained by a member when source of injury is unknown, and injury is suspicious, or
- injury requires transfer to acute care;
- Medication or treatment error or omission that jeopardizes a member's health or safety; or
- Inappropriate/unprofessional conduct by a provider involving a member.

Reporting Child and Dependent Adult Abuse

Mandatory Reporting of Suspected Child and Dependent Adult Abuse

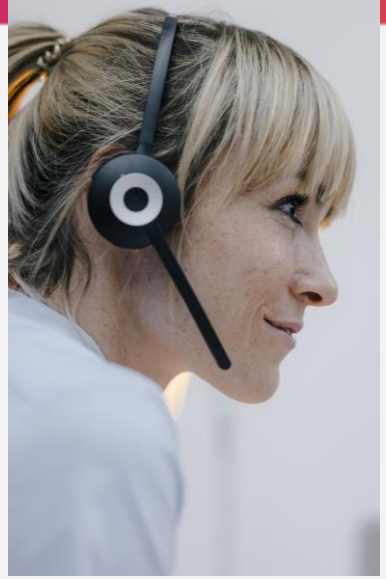
Reporting requirements apply to providers who are mandatory reporters under Delaware law

Providers have a responsibility to report known or suspected child or dependent adult abuse

To report suspected child (under age 18) abuse or neglect, call the Child Abuse Hotline at 1-800-292-9582	**Additional Information:** dhss.delaware.gov/dhss/dmma/medicaid.html.
To report abuse, neglect, exploitation, or self-neglect of a dependent adult, call 1-800-223-9074	**Additional Information:** https://dhss.delaware.gov/dhss/dsaapd/index.html

Advance Medical Directives

- Delaware First Health providers are required to provide adult members with written information about the members' right to have an Advance Directive as defined in 42 C.F.R. 489.100.
- An advance directive will help the PCP understand the member's wishes about their health care in the event they become unable to make decisions on their own behalf. Examples include:
  - Living will
  - Health care power of attorney
  - "Do Not Resuscitate" orders
- Execution of an advance directive must be documented on the member's medical records.
- Providers must educate staff on issues concerning advance directives and maintain written policies that address a member's right to make decisions about their own medical care.
- A full outline of Delaware First Health's requirements around Advanced Medical Directives can be found in the Provider Manual.

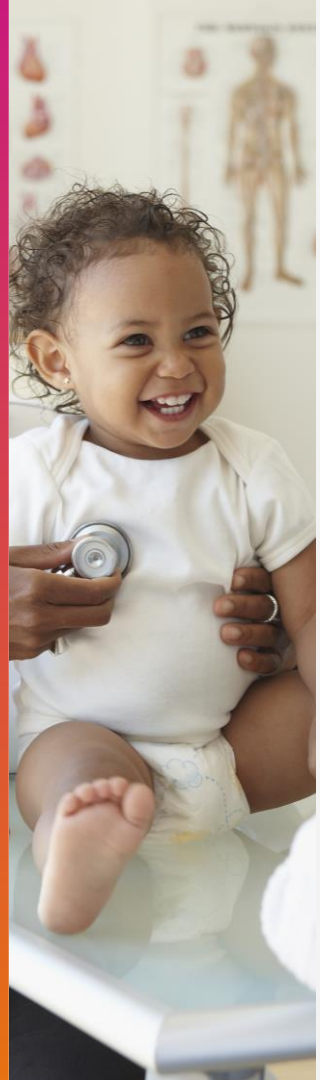


06—

Utilization Management + Authorizations

Utilization Management

- Delaware First Health Utilization Management Program (UMP) is designed to ensure members receive access to the right care at the right place and right time.
- Delaware First Health UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends.
- The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and that meet professionally recognized standards of care
- Our program is comprehensive and applies to all eligible members, age categories, and range of diagnoses.
- It provides for aggregate and individual analysis and feedback of providers and plan performance in providing access to care, the quality of care provided to members, and utilization of services.
- The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, Health Homes, maternity care, and ancillary care.



Utilization Management

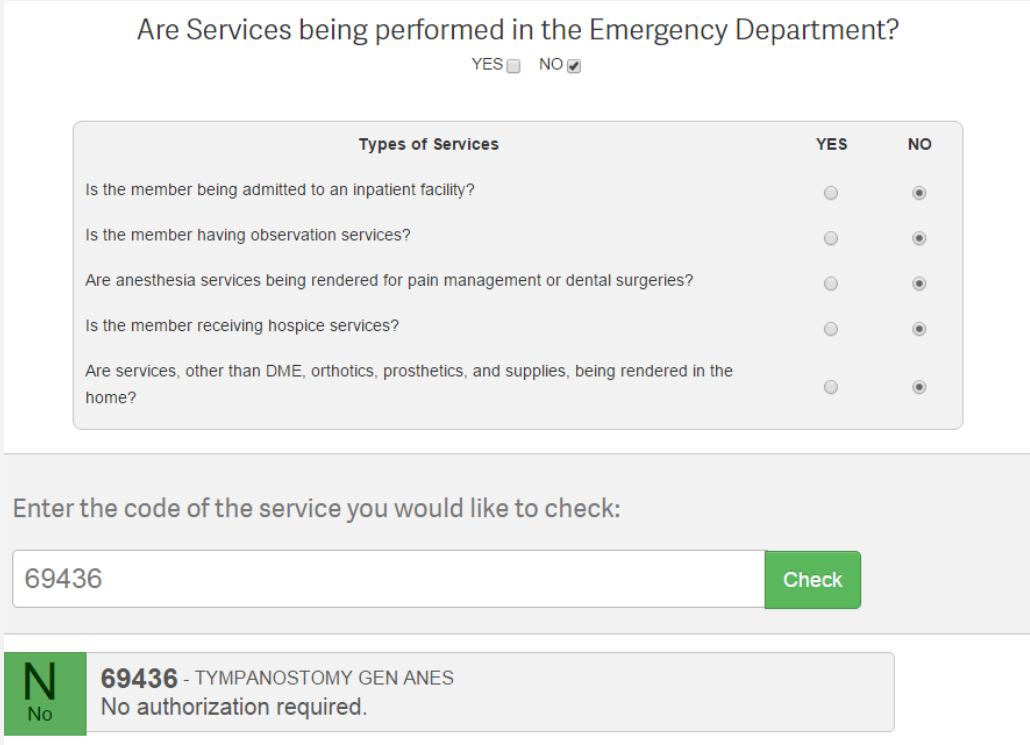
Our program goals include:

- Monitoring utilization patterns to guard against over- or under- utilization.
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction.
- Identification and provision of care and/or population management for members at risk for significant health costs or ongoing care.
- Development of an infrastructure to ensure members establish relationships with their PCPs to obtain preventive care.
- Implementation of programs that encourage preventive services and chronic condition self-management.
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals.

PRIOR AUTHORIZATION

Is Prior Authorization Needed?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Available on the provider section of the Delaware First Health website at: https://www.delawarefirsthealth.com/providers/preauth-check.html



How To Secure Prior Authorization

Need prior authorization? It can be requested in the following ways:

- ✓ **Secure Web Portal** *This is the preferred and fastest method!*

  www.DelawareFirstHealth.com

- ✓ **Phone**

  1-877-236-1341

- ✓ **Fax**
  - Medical Fax: 1-833-967-0502
  - Behavioral (Inpatient) Fax: 1-833-967-0499
  - Behavioral (Outpatient) Fax: 1-833-967-0498

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned via phone, fax or web.

Procedures / services that need Prior Authorization include*:

- Potentially cosmetic
- Experimental or investigational
- Outpatient radiology (e.g., CT, MRI, PET)
- Infertility
- Obstetrical ultrasound
    - One standard first trimester ultrasound and one standard second or third trimester ultrasound allowed in a 9-month period.
    - An additional detailed anatomic ultrasound is allowed per pregnancy with a high risk diagnosis, if billed by a new provider.
    - No authorization is required for these ultrasounds or any follow-up limited ultrasound (76815 or 76816) assessments for suspected concerns.
    - For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- Pain management

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Inpatient Authorization is required for the following*:

- All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral health/substance use
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
- Emergency Admissions and/or Observation Stay (notification within 1 business day of admission)
- Observation Services (outpatient)
- Newborn deliveries must include birth outcomes
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Ancillary Services that require Prior Authorization include*:

- All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral health/substance use
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
- Emergency Admissions and/or Observation Stay (notification within 1 business day of admission)
- Observation Services (outpatient)
- Newborn deliveries must include birth outcomes
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five (5) days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five (5) days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one (1) business day
Observation – 24 hours or less	Notification within one (1) business day for non-participating providers
Observation – greater than 24 hours	Requires inpatient prior authorization within one (1) day
Emergency room and post stabilization, urgent care and crisis intervention	Notification within one (1) calendar day
Maternity admissions	Notification within three (3) calendar days
Newborn admissions	Notification within two (2) business days
Neonatal Intensive Care Unit (NICU) admissions	Notification within one (1) business day
Outpatient Dialysis	Notification within two (2) business days

Utilization Determination Timeframes

Type	Timeframe
Expedited Pre-Service/Urgent[1]	72 hours
Standard Pre-Service/Non-Urgent[2]	Within 7 calendar days
Concurrent Review	24 hours
Retrospective	30 calendar days

[1] Delaware First Health may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if Delaware First Health justifies (to the State upon request) a need for additional information and how the extension is in the member's interest.
[2] For standard service authorization decisions, Delaware First Health shall provide notice as expeditiously as the member's health condition requires and within seven calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if: (1) The member, or the provider, requests extension; or (2) Delaware First Health justifies (to the State upon request) a need for additional information and how the extension is in the member's interest.

Correct Coding Prior Authorization

Prior Authorization will be granted at the CPT code level

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.
- It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission, or the claim will deny.
- Delaware First Health will update authorizations but will **not** retro-authorize services.
  - The claim will deny for lack of authorization.
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

Medical Necessity Determination

- Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or on an exception basis, **must be documented in writing**.
- The determination is based on medical information provided by the member, the member's family/caretaker, and the PCP, as well as any other providers, programs, and agencies that have evaluated the member.
- All such determinations must be made by qualified and trained healthcare providers.

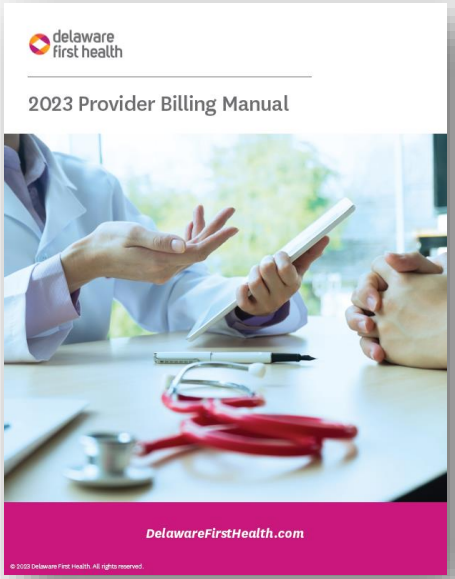
What happens if Medical Necessity is not established?

- When medical necessity cannot be established, a peer-to-peer conversation is offered.
- Denial letters will be sent to the member and provider.
- The clinical basis for the denial will be indicated.
- Member appeal rights will be fully explained.

07—
Billing + Claims

BILLING + CLAIMS

The Provider Billing Manual



The Provider Billing Manual includes essential information on Delaware First Health's billing guidelines and claims, including:

- Encounter data submission guidelines
- Claims submission protocols and standards, including timeframe requirements
- Instructions/information for clean claims
- Claims dispute process
- Payment policies
- Client participation requirements
- Cost sharing requirements
- Third party liability and other instructions

- The Provider Billing Manual can be found in the "For Providers" section of the DFH website at www.DelawareFirstHealth.com

General Billing Guidelines

- It is important that providers ensure Delaware First Health has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:
  - Provider name (as noted on current W-9 form)
  - National Provider Identifier (NPI)
  - Tax Identification Number (TIN)
  - Medicaid Number
  - Taxonomy code
  - Physical location address (as noted on current W-9 form)
  - Billing name and address
- Providers must bill with their NPI number in box 24Jb.
- We require providers to also bill their taxonomy code in box 24Ja and the Member's Medicaid number in box 1a on the CMS-1500 form (also known as the HCFA), to avoid possible delays in processing.

General Billing Guidelines

- Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays; such claims are not considered “clean” and therefore cannot be accepted into our system.
- We recommend that providers notify Delaware First Health 30 days in advance of changes pertaining to billing information.
- Please submit this information on a W-9 form; Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.
- Providers must notify Delaware First Health in writing at least 30 days in advance of his/her inability to accept additional Medicaid covered persons under Delaware First Health agreements.
- Delaware First Health will not accept more than 97 service lines per UB-04 claim.
- Delaware First Health will not accept more than 50 service lines per CMS 1500 claim

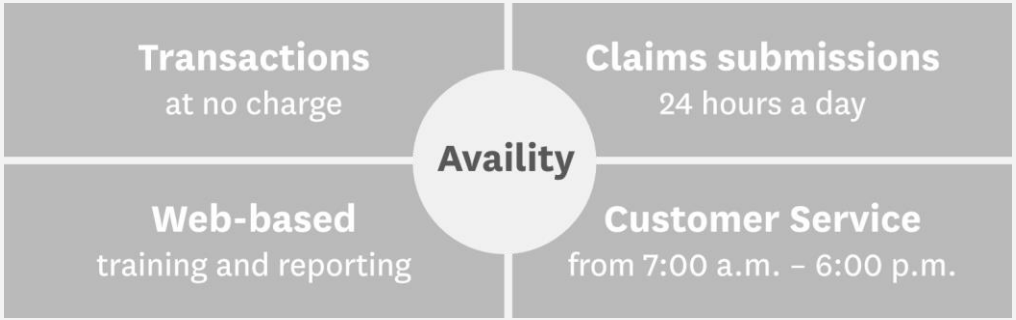
Claims Submissions

- The Delaware First Health Payor ID is 68069.
- Claims eligible for payment must meet the following requirements:
  - The member must be effective on the date of service.
  - The service provided must be a covered benefit under the member's contract on the date of service.
  - Referral and prior authorization processes must be followed, if applicable.
- Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the Provider Billing Manual.

PAPER CLAIMS	Mail to: Delaware First Health Attn: Claims Department P.O. Box 8001, Farmington MO 63640-8001
ELECTRONIC CLAIMS	The preferred clearinghouse vendor is Availity, but providers may use their own contracted clearinghouse to submit claims to Delaware First Health.

Our Claims Clearinghouse

- Availity is the preferred clearinghouse, offering the following value services:



- Providers may use their own contracted clearinghouse to submit claims to Delaware First Health.

For questions or more information on electronic filing please contact:
Delaware First Health
c/o Centene EDI Department
1-800-225-2573 ext. 6075525
EDIBA@centene.com

The following tables outline claim submission and payment timings:

Claim Type	Submission Timing
New clean claim	120 calendar days from date of service
Retroactive eligibility claims	365 calendar days from the notice date
Secondary payer	365 calendar days from primary payer claim determination
Third-party submission and no reply	After 30 calendar days of no reply, claims accepted for 12 months from date of service

Claim Type	Payment Timing
New clean claim	90% within 30 calendar days of receipt
	95% within 45 calendar days of receipt
	99% within 90 calendar days of receipt

Claim Type	Payment Timing
Claim Reconsiderations	90 day from the date of on the EOP or PRA

payspan

Payspan Contact Information:

- **Phone: (877) 331-7154 x 1** ***(available M-F 7am-7pm)***
- **Email:** providersupport@payspanhealth.com
- **Website:** www.Payspan.com

Improve cash flow
by getting payments faster

Settle claims electronically
through Electronic Fund Transfers (EFTs) and Electronic Remittance Advices (ERAs)

Maintain control over bank accounts
by routing EFTs to the bank account(s) of your choice

Match payments to advices quickly
and easily re-associate payments with claims

Manage multiple payers,
including any payers that are using Payspan to settle claims

Eliminate re-keying of remittance data
by choosing how you want
to receive remittance details

Create custom reports
including ACH summary reports, monthly summary reports, and payment
reports sorted by date

Claim Payment Reconsideration

A claim payment dispute involves a finalized claim in which a provider disagrees with the outcome.

1st DISPUTE STEP - RECONSIDERATION

Provider can request to have the outcome of the finalized claim be reviewed by paper or Provider Portal

Submission of request must be within 90 calendar days from the date of EOP (Explanation of Payment) or PRA (Provider Remittance Advice)

2nd DISPUTE STEP – APPEAL

Submission of request must be within 120 days of the date of service or no later than 60 calendar days after the reconsideration decision, whichever is latest.

Include as much information as possible to assist with determination review

Mailing address for disputes:

Delaware First Health
ATTN: Claims Disputes
P.O. Box 8001
Farmington, MO 63640-8001

Provider Complaints: Non-Claims Related

Providers have the right to file a complaint with Delaware First Health.

- Provider complaints can be filed regarding policies, procedures or administrative processes in place by Delaware First Health.
- Provider(s) may file a complaint in writing that is non-claims related within forty-five (45) calendar days of the date of the dissatisfaction.
- Provider complaints will be acknowledged within three (3) days of receipt and be resolved within 90 calendar days.
  - If the provider(s) complaint is not resolved within thirty (30) calendar days, documentation why and a written notice of the status to the provider will be provided every thirty (30) calendar days thereafter until the complaint is resolved.

MAIL:

Delaware First Health
Attn: Complaints
P.O. Box 10353
Van Nuys, CA 90410-0353

PORTAL:

www.DelawareFirstHealth.com

Provider Complaints: Claims Related

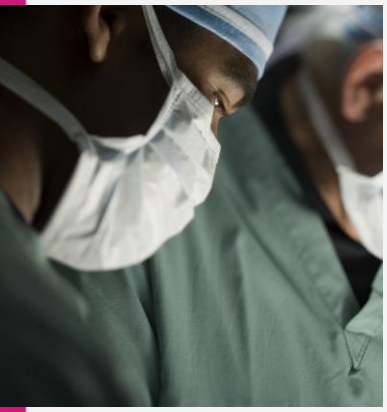
- Complaints related to claims, may file a written complaint within twelve (12) months from the date of service or sixty (60) calendar days after the payment or denial of a timely claim submission.
- Provider complaints will be acknowledged within three (3) days of receipt, and be resolved within 90 calendar days.
  - If the provider(s) complaint is not resolved within thirty (30) calendar days, documentation why and a written notice of the status to the provider will be provided every thirty (30) calendar days thereafter until the complaint is resolved.

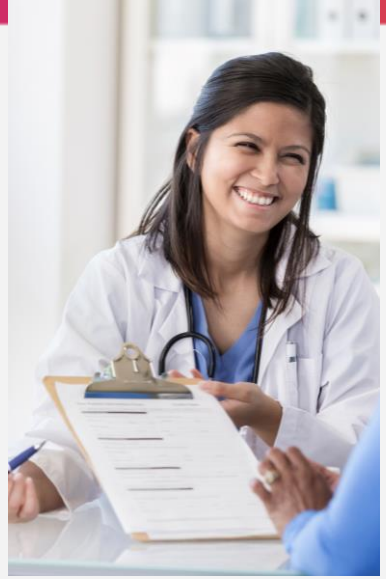
MAIL:

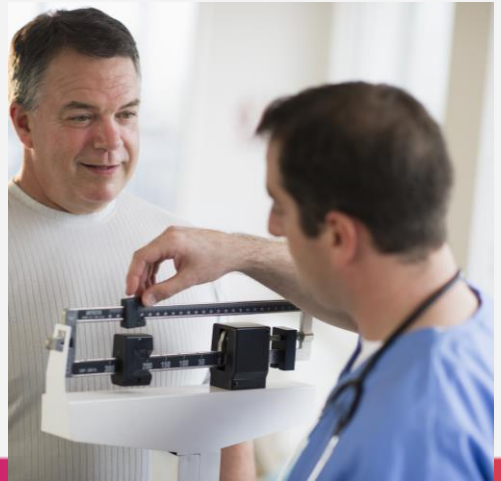
Delaware First Health
Attn: Complaints
P.O. Box 8001
Farmington, MO 63640-8001

PORTAL:

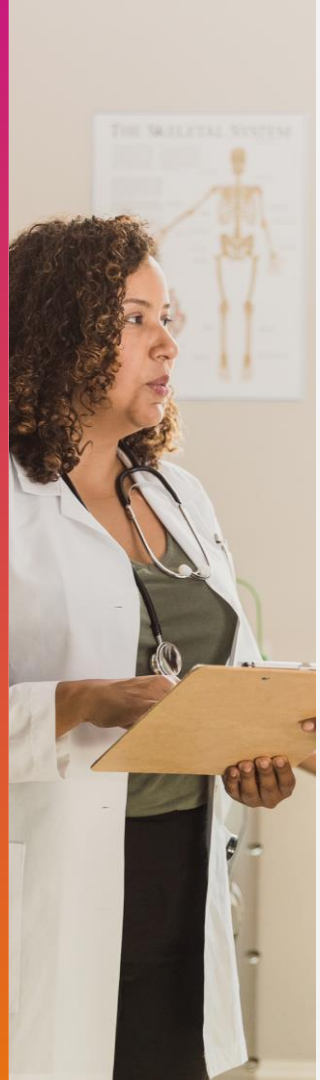
www.DelawareFirstHealth.com







08— Medical Management



The Primary Care Provider

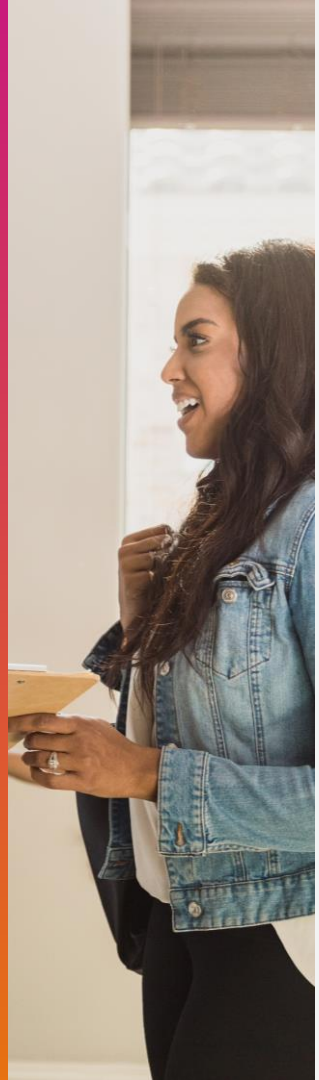
PCPs are the cornerstone of Delaware First Health service delivery model. The PCP serves as the "Medical Home" for the member.

- The Medical Home concept assists in establishing a member/provider relationship, supports continuity of care, and patient safety.
- This leads to elimination of redundant services, cost effective care, and better health outcomes.
- Delaware First Health offers a robust network of PCPs to ensure every member has access to a Medical Home within 30 miles or 45 minutes within the member's primary address.
- LTSS members will have access to a Medical Home within 30 miles or 45 minutes between the appropriate facility placement.

Provider Types That May Serve as PCPs

A PCP shall be a medical Practitioner in our network including:

- Family Practitioner
- General Practitioner
- Internal Medicine
- Pediatrician
- Advanced Registered Nurse Practitioner (ARNP)
- Obstetrician or Gynecologist (OB/GYN)
- Physician Assistant

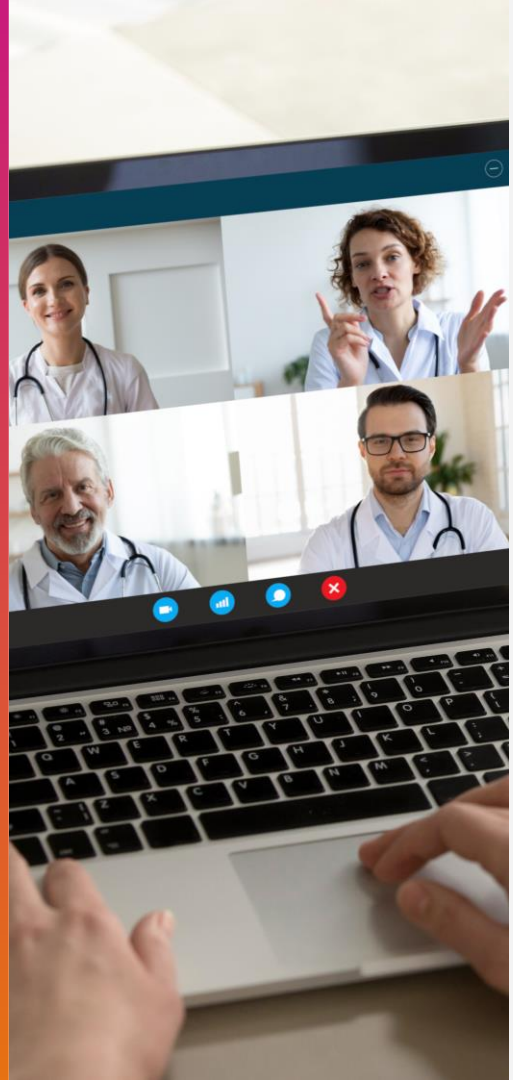


PCP Assignment

- Delaware First Health members have the freedom to choose a PCP from our comprehensive provider network.
- Within ten (10) days of enrollment, Delaware First Health will send new members a letter encouraging them to select a PCP.
- For those members who have not selected a PCP during enrollment or within thirty (30) calendar days of enrollment, Delaware First Health will use a PCP auto-assignment algorithm to assign an initial PCP.
    - The algorithm assigns Members to a PCP according to the following criteria:
        - Member's geographic location.
        - Member's previous PCP, if known.
        - Other family Members' PCPs, if known.
        - Special healthcare needs, including pregnancy, if known.
        - Special language and cultural considerations, if known.
- Members reserve the right to change their PCP at any time. PCP's can be updated by calling our Member Services toll free at 1-877-236-1341.

Member Panel Capacity

- All PCPs reserve the right to determine the number of members they are willing to accept into their panel.
- Delaware First Health does not guarantee any provider will receive a certain number of members.
- The PCP to member ratio shall not exceed **2500** members to a single PCP.
- If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact Delaware First Health Provider Services toll-free at 1-877-236-1341.
- A PCP cannot refuse to treat members as long as the provider has not reached their requested panel size.
- PCPs cannot close panels to Medicaid members alone. If a provider's panel is closed, it must be closed to all patients. If a provider's plan reopens, the provider must accept patients on a first-come, first-served basis.
- Providers must notify Delaware First Health in writing at least forty-five (45) in advance of his or her inability to accept additional Medicaid covered persons under Delaware First Health agreements.
- Any established patient who becomes a Delaware First Health member cannot be considered a new patient.



MEDICAL MANAGEMENT

Integrated Health Services

- Integrated Health Services include the areas of utilization management, care management, population management, and quality review.
- Delaware First Health uses a multi-disciplinary Integrated Care Team to offer and coordinate care.
- Our staff coordinates care with all the necessary individuals on the member's care team, including the member's primary and specialty providers, other care team members, and those identified as having a significant role in the member's life, as appropriate.
- Our goal is to help each, and every Delaware First Health member achieve the highest possible levels of wellness, functioning, and quality of life, while demonstrating positive clinical results.

Clinical Practice Guidelines

> Adherence to the guidelines will be evaluated at least annually as part of our Quality Management Program

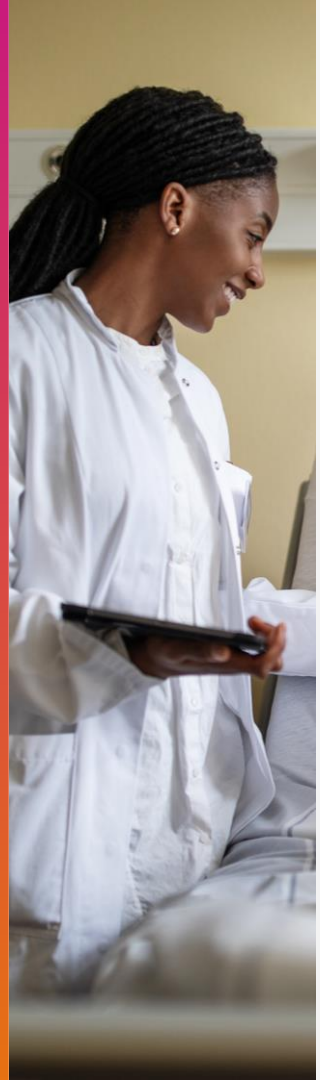
Examples of clinical practice guidelines adopted by Delaware First Health include:

- American Academy of Pediatrics: Recommendations for Preventative Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health
- American Psychiatric Association

All clinical practice guidelines can be found at:
https://www.delawarefirsthealth.com/providers/quality-improvement/practice-guidelines.html

Care Management Program

- Delaware First Health will assign a specific Care Manager to each member who, when determined by assessment, would benefit from such services.
- A member may be assigned to Care Coordination, Care Management, or Disease Management, as applicable.
- Services provided under varying levels of Care Management may include:
  - Care Coordination
  - Care Management
  - Complex Care Management



MEDICAL MANAGEMENT

Care Management Program

Care Coordination

- For members with a number of uncomplicated issues/issues related to social determinants of health such as housing, food insecurity, financial, etc., with need for referrals to community resources or assistance with accessing health care services.
- Services involve non-clinical activities performed by non-clinical staff under the direction of a care manager or other designee; clinical staff may provide assistance if minor medical or behavioral health concerns arise.

Care Management

- For members needing a moderate level of support based on physical or behavioral health or multiple/complicated psychosocial needs and/or unusually high utilization of services based on their condition.
- Services included at this level of care management include coordination of care, identification of goals, identification of interventions, and tracking of progress meeting goals.

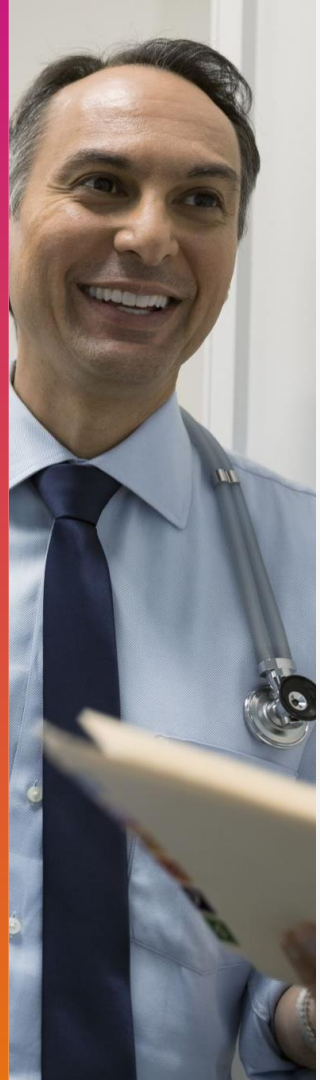
Complex Care Management

- For members with highly complex needs and/or limited supports, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life.
- Services are more intensive at this level of care management and include coordination of care, identification of goals, identification of interventions, and tracking of progress meeting goals.

DSHP Plus Long-Term Services and Supports (LTSS)

Long-Term Services and Support (LTSS) benefits include:

- Home and Community Based Services (HCBS) – Provides services and supports through the waiver and Habilitation programs to help members remain as independent as possible in their home and community.
- Facility – Provides long-term care in an inpatient setting
- Home Health – provides services and supports in the member's home as part of the Medicaid State Plan of services
- Hospice – provides services and care to terminally ill members with a life expectancy of 6 months or less.



MEDICAL MANAGEMENT

Contact Our Team

- Providers can contact the Delaware First Health Medical Management department toll-free at 1-877-236-1341.
- Hours of operation are Monday through Friday from 8:00am – 5:00pm EST (excluding holidays).
- After normal business hours, our 24/7 nurse advice hotline staff is available to provide health education and nurse triage for complex health issues.

Our Clinical Leadership

- Clinical services are overseen by the Delaware First Health Medical Director.
- The Vice President of Medical Management (VPMM) has responsibility for direct supervision and operation of the department.
- To reach the Medical Director or VPMM, please contact Medical Management toll-free at 1-877-236-1341.

Changes:

Provider Medical Appeals Fax Number: Changed to 1-833-525-0054
(Provider Manual, page 85 has been updated)

2023 NEW PROVIDER ORIENTATION

Q+A

Thank you.

2023 NEW PROVIDER ORIENTATION