delaware first health

2025 Provider Manual

DelawareFirstHealth.com

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WELCOME

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.

About Us

Delaware First Health is a Managed Care Organization (MCO) health plan, contracted with the Delaware Department of Health and Social Services (DHSS), Division of Medicaid & Medical Assistance (DMMA) to serve Medicaid members enrolled in Diamond State Health Plan (DSHP), Diamond State Health Plan-Plus (DSHP-Plus), Diamond State Health Plan and Diamond State Health Plan-Plus Long Term Services and Supports (DSHP-Plus LTSS) and Delaware Healthy Children Program (DHCP).

As a subsidiary of Centene Corporation, Delaware First Health's mission is to improve the health of our members through focused, compassionate, and coordinated care, one person at time. Our approach is based on the core belief that quality healthcare is best delivered at the local level through regional and community-based care.

About This Manual

The Provider Manual contains comprehensive information about Delaware First Health's operations, benefits, policies, and procedures. The most up-to-date version may be viewed in the "For Providers" section of our website at DelawareFirstHealth.com. Providers will be notified of updates via notices posted on our website, bulletins and/or in Explanation of Payment (EOP) notices. To obtain a hard copy of this Manual, please contact Provider Services at 1-877-236-1341.

Billing Guidelines

Billing guidelines and information may be found in the Delaware First Health Provider Billing Manual, located in the For Providers section of our website at DelawareFirstHealth.com. The Provider Billing Manual includes information on:

- Encounter data submission guidelines
- Claim submission protocols and standards, including timeframe requirements and dispute process
- Coding rules and guidelines
- Payment policies
- Client participation requirements
- Cost sharing requirements
- Third party liability and other instructions

Discrimination

Delaware First Health complies with applicable federal civil rights laws and does not discriminate or treat people differently based on race, color, national origin, age, disability, or sex.

KEY CONTACTS

The following chart includes a list of important telephone and fax numbers. When calling Delaware First Health, please have the following information available:

- National Provider Identifier (NPI) number
- Tax ID Number (TIN)
- Member's ID number

HEALTH PLAN INFORMATION		
Delaware First Health	750 Prides Crossing Suite 200 Newark, DE 19713 Phone: 1-877-236-1341 TTY/TDD: 711 DelawareFirstHealth.com	
Department	Phone	Fax/Web Address
Provider Services	1-877-236-1341	N/A
Member Services		N/A
Member Eligibility		N/A
Medical Management Inpatient and Outpatient Prior Authorization		1-833-967-0502
Behavioral Health Prior Authorization		Inpatient: 1-833-967-0499 Outpatient: 1-833-967-0498
Admissions		1-833-967-0497
Concurrent Review/Clinical Information		1-833-967-0495
Medical Records Fax		1-833-967-0496
Face sheets		1-833-974-1203
Notification of Pregnancy and Health Risk Assessment		1-833-967-0503
Care Management		1-833-966-0517
24/7 Nurse Advice Line		N/A
Behavioral Health Crisis Services		N/A

HEALTH PLAN INFORMATION		
Interpreter Services		N/A
Non-Emergency Medical Transportation (NEMT)		1-833-974-1204
Pharmacy Services	1-833-236-1887	Retail & Specialty Prior Authorizations: 1-844-233-6130 Preferred Auth method: Covermymedsportal
Envolve Vision	1-833-236-1886	envolvevision.com
Envolve Dental		envolvedental.com
Advanced Imaging (MRI, CT, PET) (Evolent formerly NIA)		www.RadMD.com
Cardiac Imaging (Evolent formerly NIA)		www.RadMD.com
EDI Claims Assistance	1-800-225-2573 ext. 6075525	EDIBA@centene.com
Ethics and Compliance Helpline	1-800-345-1642	N/A
To report suspected fraud, waste and abuse	1-866-685-8664	N/A
State Ombudsman	1-800-223-9074	N/A
Northern Delaware Crisis Line	1-800-652-2929	N/A
Southern Delaware Crisis Line	1-800-345-6785	N/A
Department of Services for Children, Youth, and their Families (DSCYF) Crisis Hotline for Youth	1-800-969-4357	N/A
Crisis Text Line Text 'DE' to 741741		
National Suicide Prevention Lifeline 988		

POPULATIONS SERVED

Delaware First Health provides health coverage for enrollees of:

- Delaware Healthy Children Program (DHCP)
- Diamond State Health Plan
- Diamond State Health Plan-Plus (DSHP-Plus)
- Diamond State Health Plan-Plus Long Term Services and Supports (DSHP-Plus LTSS)

VERIFYING ELIGIBILITY

Delaware First Health providers are responsible for verifying member eligibility before every service is rendered, using one of the following methods:

1. Log on to our Secure Provider Web Portal at DelawareFirstHealth.com. Using our Secure Provider Portal, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medicaid ID and date of birth.

   Alternatively, you may use our new secure portal, Availity Essentials. You may also reach Provider Services at 1-877-236-1341 from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility verification system 24 hours a day. The automated system will prompt you to enter the Medicaid ID member and the month of service to check eligibility.

2. If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-877-236-1341 to speak to a live representative. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility prior to rendering services. Provider Services will need the member's name, member Medicaid ID, and member date of birth to check eligibility. Possession of a Delaware First Health member ID card is not a guarantee of eligibility. Use one of the above methods to verify member eligibility on the date of service.

The Delaware First Health Secure Provider Portal allows Primary Care Providers (PCPs) to access a list of eligible members who have selected the PCP and/or are assigned to them. The list of eligible members also provides other important information, including indicators for members whose claims data shows a gap in care, such as the need for an adult BMI assessment. To view this list, log on to DelawareFirstHealth.com.

Eligibility changes can occur throughout the month, and the member eligibility list does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify member eligibility on, or prior to the date of service.

Member Identification Card

All new Delaware First Health members receive a Delaware First Health member ID card. A new card is issued only when the information on the card changes, a member loses a card, or a member requests an additional card.

Members should present both their Delaware First Health member ID card and a photo ID each time they seek services from a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification.

If you suspect fraud, please contact Provider Services toll-free at 1-877-236-1341 immediately.

Members must also keep their state-issued Medicaid ID card to receive benefits that are not covered by Delaware First Health


delaware first health

Diamond State Health Plan-Plus

Long Term Services and Support (LTSS)

SAMPLE A SAMPLE
Member ID#: 12345678901
DOB: 01/01/1980
RXBIN: 003858
RXPCN: DSHP
RXGROUP: 2ECA

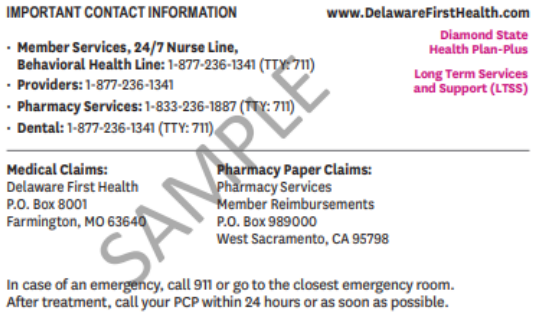
PCP Name:
Allison Smith
PCP Phone Number:
1-302-123-45

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

SAMPLE


IMPORTANT CONTACT INFORMATION

www.DelawareFirstHealth.com

Diamond State Health Plan-Plus

Long Term Services and Support (LTSS)

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

Medical Claims:
Delaware First Health
P.O. Box 8001
Farmington, MO 63640

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.

SAMPLE


delaware first health

Diamond State Health Plan

SAMPLE A SAMPLE
Member ID#: 12345678901
DOB: 01/01/1980
RXBIN: 003858
RXPCN: DSHP
RXGROUP: 2ECA

PCP Name:
Allison Smith
PCP Phone Number:
1-302-123-4567

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

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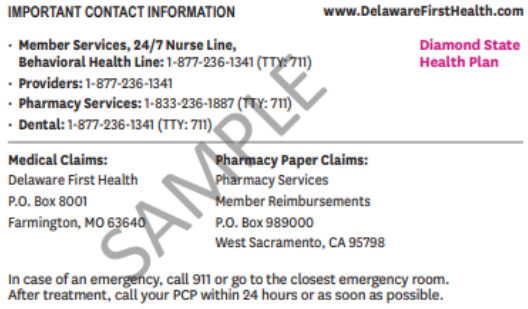
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www.DelawareFirstHealth.com

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delaware first health

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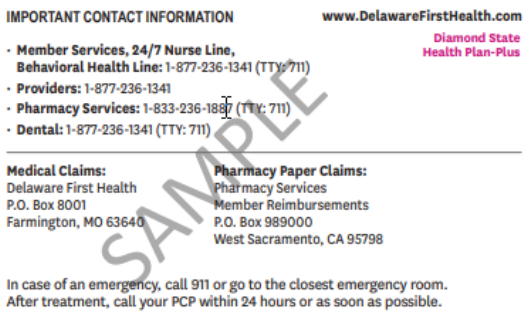
SAMPLE


IMPORTANT CONTACT INFORMATION

www.DelawareFirstHealth.com

Diamond State Health Plan-Plus

- **Member Services, 24/7 Nurse Line, Behavioral Health Line:** 1-877-236-1341 (TTY: 711)
- **Providers:** 1-877-236-1341
- **Pharmacy Services:** 1-833-236-1887 (TTY: 711)
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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.

SAMPLE

ONLINE RESOURCES

The Delaware First Health website allows 24/7 access to provider and member information.. Providers can find the following information on the website:

- Provider Manual
- Provider Billing Manual
- Provider Education & Training
- Communication Preferences
- Additional Resource Guides and Tools
- Clinical & Payment Policies
- Important Forms including:
    - Notification of Pregnancy
    - Prior Authorization Fax Forms
    - Appeals Form
    - Provider Data Update Forms
    - Annual Attestation Forms
    - General Feedback Form
- Pre Auth Tool
- Pharmacy Preferred Drug Listing
- Provider Engagement Account Manager Contact Information

Please contact your Provider Engagement Account Manager or Provider Services toll-free at 1-877-236-1341 with any questions or concerns regarding the website.

SECURE PROVIDER WEB PORTAL

The Delaware First Health Secure Provider Web Portal allows providers to check member eligibility and benefits, submit and check the status of claims, request authorizations and send messages to communicate with Delaware First Health staff.

Providers and designated office staff may register to use the Provider Web Portal in four easy steps. Once registered, tools are available that make obtaining and sharing information easy.

Go to DelawareFirstHealth.com to register. On the home page, select the “Login” link on the top right to start the registration process. A tutorial on how to register and use the Secure Provider Web Portal is available by contacting your Provider Engagement Account Manager.

Providers may use the Secure Provider Web Portal to:

- Check member eligibility
- View member health records
- View the PCP panel (patient list)
- View and submit claims and adjustments

- Verify claim status
- View payment history
- View and submit Prior Authorizations
- Check Prior Authorization requirements
- Verify Prior Authorization status
- View member gaps in care
- Contact us securely and confidentially
- Add/remove account users
- Determine payment/check clear dates
- View PCP Quality Incentive Report
- View and print Explanation of Payment (EOP)

Alternatively, you may use our new secure portal, Availity Essentials. You can log in to your existing Availity Essentials account to verify member eligibility and benefits, submit claims, check claim status, submit authorizations, and access health plan payer resources via Availity Essentials. Our current secure portal will still be available for other functions you may use today.

- If you are new to Availity Essentials, activating your Essentials account is the first step toward working with us in Availity.
- If you are a current use for other health plans, you may look for additional functionality in each health plan's payer space on Essentials and use the heart icon to add apps to My Favorites in the top navigation bar.
- Access Manage My Organization – Providers to save provider information. You can then auto-populate that information repeatedly to eliminate repetitive data entry and reduce errors.

Providers agree that all health information, including that related to patient conditions, medical utilization, and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

PROVIDER ENGAGEMENT SERVICES

Overview

Delaware First Health's Provider Engagement team is committed to supporting providers as they care for our members. Through provider orientation, ongoing training, and support of daily business operations, we will strive to be your partners in good care. Upon credentialing approval and contracting, each provider will be assigned a Provider Engagement Account Manager (PEAM). The PEAM will contact the provider to schedule an orientation.

Reasons to Contact a Provider Engagement Account Manager

- Report any changes to your practice (locations, NPI, TIN numbers)
- Initiate credentialing of a new Practitioner
- Schedule an in-service training for new staff
- Conduct ongoing education for existing staff
- Obtain clarification of policies and procedures
- Obtain clarification of a provider contract
- Request fee schedule information

- Obtain member roster
- Obtaining Provider Profiles
- Learn how to use electronic solutions on web authorizations, claims submissions and member eligibility
- Open/close patient panel

Provider Services

Provider Services is available toll-free at 1-877-236-1341 Monday – Friday 8:00am – 5:00pm EST and closed on state holidays.

NETWORK DEVELOPMENT AND MAINTENANCE

Delaware First Health maintains a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with the Delaware Department of Health and Social Services' (DHSS') access and availability requirements.

Delaware First Health offers a network of PCPs to ensure every member has access to a Medical Home within the required travel-distance standards.

In the event the our network is unable to provide medically necessary services required under the contract, Delaware First Health shall ensure timely and adequate coverage of these services through an out-of-network provider at no cost to the member, until such time a network provider is contracted and will ensure coordination with respect to Prior Authorization and payment issues in these circumstances.

For assistance in making a referral to an out-of-network specialist or subspecialist for a Delaware First Health member, please contact our Medical Management team at 1-877-236-1341 and we will identify a provider for the necessary referral.

Tertiary Care

Delaware First Health offers a network of tertiary care providers inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical subspecialties available 24-hours per day in the geographical service area. In the event our Delaware network is unable to provide the necessary tertiary care services required, Delaware First Health shall ensure timely and appropriate coverage of these services through an out-of-network provider who is enrolled with the Diamond State Health Plan and Diamond State Health Plan-Plus (DSHP-Plus) until such time a network provider is contracted and will ensure coordination of Prior Authorization and/or payment issues related to these circumstances.

Voluntarily Leaving the Network

Providers must give Delaware First Health advance notice of voluntary termination in accordance with timeframe terms in the Delaware First Health Participating Provider Agreement (PPA) following the notification time-period in the participating agreement with our health plan. For a termination to be considered valid, providers are required to send written termination notices via certified mail (return receipt requested) or overnight courier to:

Delaware First Health
Attn: Provider Engagement Department
750 Prides Crossing
Suite 200
Newark, DE 19713

In addition, and as requested, Providers must forward copies of medical records, at no cost, to the member's new provider and facilitate the seamless transfer of care accordingly.

Delaware First Health will send written notice to all impacted members of a provider's termination, within fifteen (15) calendar days of the receipt of the Provider's letter of termination, provided that such notice from the provider is timely.

PROVIDER GUIDELINES

Medical Homes

Delaware First Health is committed to supporting providers in achieving recognition as Medical Homes and will promote and facilitate the capacity of primary care practices to function as Medical Homes by using systematic, patient-centered and coordinated care management processes.

Delaware First Health will support providers in obtaining either NCQA's Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or the Joint Commission's Primary Care Medical Home Option for Ambulatory Care accreditation.

Medical Homes provide better healthcare quality, improves member self-management of their own care and reduce avoidable costs over time. Delaware First Health will actively partner with providers, community organizations, and groups representing our members to increase the number of providers who are recognized as Medical Homes.

Delaware First Health has dedicated resources to ensure its providers achieve the highest level of Medical Home recognition using a technical support model that will include:

- Readiness survey of contracted providers
- Education on the certification process
- Resources, tools, and best practice guidance

The Secure Provider Web Portal offers tools to help support PCMH accreditation elements. These tools include:

- Online care gap notification
- Member panel roster (including member detail information)

For more information on the Medical Home model or how to become a Medical Home, contact your Provider Engagement Account Manager (PEAM).

Referrals

Delaware First Health prefers the PCP to coordinate the Member's healthcare services. PCPs are encouraged to refer a member to another provider when medically necessary care is needed that is beyond the scope of what the PCP can provide. Referrals from the PCP are not required for specialty care as a condition of payment for services rendered.

The PCP must obtain Prior Authorization from Delaware First Health for referrals to certain specialty providers, as noted on the Prior Authorization list. All out-of-network services require Prior Authorization as further described in this manual, except for family planning, emergency room, and table-top x-ray services. Providers are also required to promptly notify Delaware First Health when prenatal care is rendered.

Delaware First Health encourages specialists to communicate with the PCP when there is the need for a referral to another specialist. This allows the PCP to better coordinate care and become aware of the additional service request.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.

PCP Lock-In Standards

Delaware First Health requires that members receive services from a specific PCP when Delaware First Health has identified utilization of unnecessary services or frequent occurrences of drug seeking behaviors. Prior to placing the member on PCP lock-in, Delaware First Health will inform the member of the intent to lock-in, including the reasons for imposing the PCP lock-in. Additionally, the member will be referred to Care Management for further support to properly manage their pain. Delaware First Health's grievance process will be made available to any member being designated for PCP lock-in.

The member will be removed from PCP lock-in when Delaware First Health has determined that the utilization problems have been solved and that recurrence of the problems is judged to be improbable. Delaware First Health will document, track, and report to the State on lock-ins and lock-in removals.

ACCESSIBILITY

Delaware First Health is committed to providing equal access to quality healthcare and services. In May 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards. One of the goals of the PAI is to improve the accuracy, completeness, and transparency of provider self-reported disability access data in Provider Directories so that members with disabilities have the most accurate, accessible, and up-to-date information possible related to a provider's disability access. To accomplish this, providers are asked to complete a self-report of disability access that will be verified by Delaware First Health through an onsite Accessibility Site Review (ASR).

Delaware First Health's expectation, as communicated through the provider contract, is full compliance with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). "Minimum accessibility," as defined in the ASR Tool, is not to be confused with, nor is it intended to replace, the obligation of full compliance with all federal and state disability access laws and regulations, which remains the legal responsibility of Delaware First Health providers.

APPOINTMENT AVAILABILITY AND ACCESS STANDARDS

Delaware First Health follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Delaware First Health monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization.

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Primary Care Providers & OB/GYN	Timeframe
Emergency Medical Condition	Same day
Urgent Medical Condition	Within two (2) calendar days
Routine Care Appointments	Not to exceed three (3) weeks
Specialists	Timeframe
Specialty Providers - Urgent	Within 48 hours
Specialty Providers - Routine	Within three (3) weeks
Maternity Care	Timeframe
First Trimester Care	Within three (3) weeks of member request
Second Trimester Care	Within seven (7) calendar days of member request
Third Trimester Care	Within three (3) calendar days of member request

High-Risk Pregnancies	Within three (3) calendar days of identification of high risk by Delaware First Health or maternity care provider, or immediately if an emergency exists.
Behavioral Health	Timeframe
Behavioral Health – Routine	Outpatient (OP) services within 7 calendar days of request with non-prescribing clinician for an initial assessment. Non-emergency OP services within 3 weeks of request for prescribing clinician
Behavioral Health – Non-Life-Threatening Emergency	Within 1 hour of request, or direct member to crisis center or ER
Behavioral Health – Mobile Crisis	Immediate treatment for members experiencing a behavioral health (BH) crisis, including a mobile team based on the acuity of the member and not to exceed 1 hour from the request
Outpatient Services	Timeframes
Follow-up Outpatient Services	Within 2 business days for: • Members being discharged from an inpatient (IP) or residential setting to a community placement, and; • Members seen in an ER, or by a BH crisis provider for a BH condition.
Routine Outpatient Services	Within seven (7) calendar days of request with a non-prescribing clinician for an initial assessment
Non-Emergency Outpatient Services	Within three (3) weeks of request of prescribing clinician services.

Office Waiting Times

Providers are to ensure that Delaware First Health members with appointments do not wait longer than one hour to be seen. Office visits can be delayed when a provider "works in" urgent cases, when a serious problem is found, or when a patient had an unknown need that requires more services or education than was described at the time the appointment was made. If a physician or other provider is delayed, members must be notified as soon as possible so they understand the delay. If the delay will result in more than a 90-minute wait, then the member must be offered a new appointment.

Covering Providers

PCPs and specialists must arrange for coverage with another provider during scheduled or unscheduled time off, preferably with another Delaware First Health network provider. In the event of unscheduled time off, please notify Provider Services of coverage arrangements as soon as possible. The covering provider is compensated in accordance with the fee schedule in their agreement, and, if not a Delaware First Health network provider, they will be paid as a non-participating provider.

Telephone Arrangements

PCPs and Specialists must:

- Respond to the members' telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and, when possible, reschedule cancelled and no-show appointments.
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
    - After-hours telephone care for non-emergent, symptomatic issues within thirty (30) minutes.
    - Same day for non-symptomatic concerns.
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method and then transferred to the member's medical record.

Delaware First Health will monitor appointment and after-hours availability on an on-going basis through its Quality Management/Quality Improvement (QM/QI) Program.

24-Hour Access

Delaware First Health PCPs and specialists are required to maintain sufficient access to facilities and personnel to provide covered services and shall ensure that such services are accessible to Members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.
- During after-hours, a provider must have arrangements for one of the following:
    - Access to a covering Practitioner
    - An answering service
    - Triage service
    - A voice message that provides a second phone number that is answered
    - Any recorded message must be provided in English and Spanish, if the Provider's practice includes a high population of Spanish speaking Members

Examples of unacceptable after-hours coverage include, but are not limited to:

- The provider's office telephone number is only answered during office hours.
- The provider's office telephone is answered after-hours by a recording that tells patients to leave a message.

- The provider's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed.
- A clinician returning after-hours calls outside 30 minutes.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, the PCP, specialist, or covering medical professional must return the call within thirty (30) minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Delaware First Health will monitor providers' offices after-hour coverage through surveys and through mystery shopper calls conducted by Delaware First Health Provider Network staff.

TELEHEALTH

Delaware First Health supports the appropriate and effective use of Telehealth services. Telehealth services are virtual health-care visits using information and communication technologies consisting of telephones, Remote Patient Monitoring devices or other electronic means to provide or support health-care delivery. Telehealth occurs when the patient is at an Originating Site and the health care provider is at a Distant Site.

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.

NOTE: If the originating site is the member's home, the originating site fee will not be paid.

Providers interested in providing telemedicine, telemonitoring and telehealth services to eligible Delaware First Health members should reference the Delaware Medicaid Provider Procedures Manual.

CONFIDENTIALITY REQUIREMENTS

Providers must comply with all federal, state, and local laws and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining to, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements. Providers are also contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential provider and member information, whether oral or written, in any form or medium. The following information is considered confidential:

All "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The privacy rule calls this information Protected Health

Information (PHI). "Individually identifiable health information," including demographic data, is information that relates to:

- The individual's past, present or future physical or mental health or condition.
- The provision of healthcare to the individual.
- The past, present, or future payment for the provision of healthcare to the individual.
- Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
- Many common identifiers (e.g., name, address, birth date, social security number).

The privacy rule excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g.

Provider offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Delaware First Health.

Release of data to third parties requires advance written approval from the Delaware Department of Health and Social Services, except for releases of information for the purpose of individual care and coordination among Providers, releases authorized by Members or releases required by court order, subpoena, or law.

Member Privacy Rights

Delaware First Health privacy policy assures that all members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. The Delaware First Health privacy policy complies with the applicable provisions in 45 C.F.R. §164 Subpart E regarding members' rights to access, and manage uses and disclosures of, their PHI.

Delaware First Health policy also assists our personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request including:

Use and Disclosure Guidelines

Delaware First Health is required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations

A privacy request may be subject to specific limitations or restrictions as required by law. Delaware First Health may deny a privacy request under any of the following conditions:

- Delaware First Health does not maintain the records containing the PHI.
- The requester is not the member and we're unable to verify his/her identity or authority to act as the member's authorized representative.
- The documents requested are not part of the designated record set (e.g., credentialing information).

- Access to the information may endanger the life or physical safety of or otherwise cause harm to the member or another person.
- Delaware First Health is not required by law to honor the particular request (e.g., accounting for certain disclosures).
- Accommodating the request would place excessive demands on us or our time and resources and is not contrary to HIPAA.

CULTURAL COMPETENCY

Delaware First Health believes it is our responsibility, along with our partnering providers, to ensure inclusiveness and fairness is part of all r 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.

Delaware First Health complies with all statutes and regulations to ensure eligible members have equal access to quality healthcare regardless of their race, color, creed, national origin, religion, disability, or age, including Title VI of the Civil Rights Act of 1964 (which prohibits discrimination on the basis of race, color and national origin); Section 504 of the Rehabilitation Act of 1973 (which prohibits discrimination on the basis of disability); The Age discrimination of 1975 (which prohibits discrimination on the basis of age) and the Americans with Disabilities Act.

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. 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.

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. Network providers must ensure:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them. Members or their representatives may request an interpreter be assigned to accompany them to any covered service at no additional charge. When the member has identified the need to have an interpreter accompany them to their appointment, the Delaware First Health Member Services Representative can make the arrangements for the member with the designee vendor. Members or their authorized representatives can contact Member Services for a list of translation vendors in their area. Member Services can access the use of the Language Services, TDD telephone line or the hearing-impaired relay service to assist in this matter.
- Member Advocates help members access care and navigate resources, engage difficult-to-reach members, work with community organizations, and staff healthy events. Case Management, and/or Member Advocate staff (Care Team staff) will support members who need appointment coordination and customized information. They will help address identified barriers like language and transportation by arranging for interpreters or coordinating transportation services. We have a "no wrong door" approach for assistance.

  To contact a Member Advocate, please call Delaware First Health at 1-877-236-1341
- Medical care is provided with consideration of the Member's race/ethnicity and language and its impact/influence on the member's health or illness.
- Office staff that routinely interact with members have access to and participate in cultural competency training and development.
- Office staff responsible for data collection make reasonable attempts to collect race and language information from the member. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental and physical abilities, heritage, culture, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on healthcare.
- Office sites have posted and printed materials in English and Spanish, and other prevalent non-English languages required by the Delaware Department of Health and Social Services.

Delaware First Health requires each Primary Care Provider (PCP) practice to complete an Annual Attestation Form confirming (i) each PCP's panel size across all payors (Medicaid, Medicare, Commercial), and (ii) completion of a Cultural Competency Course within the past 12 months. This supports our monitoring of PCP capacity and culturally competent care. Please access the PCP Annual Attestation Form on the Manuals, Forms, and Resources webpage.

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of the patients. Delaware First Health is committed to helping each provider reach this goal. The following questions should be considered as care is provided to Delaware First Health members:

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- Do you embrace differences as allies in your patients' healing process?

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 to access these free online resources.

Providers are also required to:

- Provide Interpretation Services in all languages, including American and Mexican Sign Language, at all key points of contact through a variety of formats, including but not limited to an in-person interpreter upon a member's request; telephone, relay, or video remote interpreting 24 hours a day seven days a week; or through other formats, such as real-time captioning or augmentative & alternative communication devices, that ensure effective communication. Interpreter services can be accessed by calling 1-877-236-1341 or the phone number on the back of the member's ID card. For your convenience, you can also request these services using the Interpreter Request Form available our Manuals, Forms, and Resources webpage.
- Provide member-informing materials (print documents, signage, and multimedia materials such as websites) translated into the currently identified threshold or concentration standard languages and provided through a variety of other means. This may include but not be limited to oral interpretation for other languages upon request; accessible formats (e.g., documents in Braille, large print, audio format, or websites with captioned videos and/or ASL versions) upon request; and easy-to-understand materials provided in a manner that takes into account different levels of health literacy.
- Provide reasonable accommodations that facilitates access for members. This includes but is not limited to accessible: medical care facilities, diagnostic equipment, and examination tables & scales; and modification of policies, practices, and procedures (e.g., modify policies to permit the use of service animals or to minimize distractions and stimuli for members with mental health or developmental disabilities).
- Inform members of the availability of these cultural, linguistic, and disability access services at no cost to members on brochures, newsletters, outreach and marketing materials, other materials that are routinely disseminated to members, and at member orientation sessions and sites where members receive covered services.
    - Delaware First Health and participating providers shall also facilitate access to these services and document a request and/or refusal of services in our Customer Relationship Management tool or the provider's member data system.

Call Provider Services toll-free at 1-877-236-1341 for more information.

MANDATORY REPORTING OF SUSPECTED CHILD AND DEPENDENT ADULT ABUSE

Delaware First Health providers who are mandatory reporters under Delaware law have a responsibility to report known or suspected child or dependent adult abuse in accordance with all applicable laws.

If you suspect a child under the age of 18 is abused or neglected, call the Child Abuse Hotline at 1-800-292-9582 or submit a formal report online at Reporter Portal (force.com). More information is available online at dhss.delaware.gov/dhss/dmma/medicaid.html.

To report abuse, neglect, exploitation, or self-neglect of a dependent adult, call 1-800-223-9074. More information is available at https://dhss.delaware.gov/dhss/dsaapd/index.html.

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 on the DHSS website under the Division of Services for Aging and Adults with Physical Disabilities webpage. Delaware First Health shall ensure suspected cases of abuse, neglect and/or exploitation are reported to DFHCriticalIncident@DelawareFirstHealth.com. 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.

ADVANCE 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 is a legal document, such as a living will or Durable Power of Attorney, where a member may provide directions or express preferences concerning their medical care and/or may appoint someone to act on their behalf. Members can use Advance Directives when the member is unable to make or communicate decisions about their medical treatment. Advance Directives are prepared before any condition or circumstance occurs that causes the member to be unable to actively make a decision about their medical care.

Delaware First Health is committed to ensuring that members are aware of and are able to avail themselves with information regarding their right to execute Advance Directives. Delaware First Health is equally committed to ensuring its providers and staff are aware of, and comply with, their responsibilities under federal and state law regarding Advance Directives.

Delaware First Health will provide and ensure that providers are sharing written information with all adult members

receiving medical care with respect to their rights under all applicable laws so members may make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.

Advance Directives are addressed by a provider with the member:

- When a member visits the provider's office.
- At a hospital at the time of a member's admission as an inpatient.
- At a skilled nursing facility at the time of a member's admission.
- Prior to or on the first visit when a member begins receiving care with a home health agency.
- At the time a member begins hospice care.

Neither Delaware First Health nor providers will condition the authorization or provision of care or otherwise discriminate against a member based on whether or not the member has executed an Advance Directive. Delaware First Health will facilitate communications between a member or member's authorized representative and the member's provider if the need is identified to ensure they are involved in decisions to withhold resuscitative services, or to forego or withdraw life-sustaining treatment.

Delaware First Health is aligned with the HEDIS Care of Older Adults measure, which includes annual review of advanced care planning, medication review, functional status, and pain assessment. Delaware First Health will annually assess and document the Advance Directive status in the Care Management systems for members who receive Long Term Services and Supports.

Providers must document that a member received information on Advance Directives that informed them of their right to execute and have one in the member's permanent medical record.

Delaware First Health recommends the following:

- The first point of contact for the member in the PCP's office should ask if the member has executed an Advance Directive and the member's response should be documented in the medical record.
- If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Advance Directive to the PCP's office and document this request in the member's medical record.
- An Advance Directive should be a part of the member's medical record and include mental health directives.

If an Advance Directive exists, the provider should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the Advance Directive and if available) and with the referring provider, if applicable. Any such discussion should be documented in the medical record.

Delaware First Health requires contracted providers to maintain written policies and procedures regarding Advance Directives and provide staff education related to it.

Members can file a grievance regarding noncompliance with Advance Directive requirements with Delaware First Health and/or with the Delaware DHSS. Delaware First Health provides information about Advance Directives to members in the Member Handbook, including the member's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or health care power of attorney, and general instructions.

COVERED SERVICES AND LIMITATIONS

Delaware First Health network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this Provider Manual, please contact Provider Services toll-free at 1-877-236-1341.

Delaware First Health covers, at a minimum, those core benefits and services which includes Fee-for-Service (FFS) services covered under the Delaware Medicaid program specified in our agreement with the State of Delaware Department of Health and Social Services as set forth below:

Standard DSHP Benefits Package

Services	Coverage and Limitations
Behavioral Health Services	
Inpatient behavioral health services	Covered for members ages 18 and older. Inpatient behavioral health services for members under age 18 are provided by the Delaware Department of Services for Children, Youth, and Families (DSCYF).
Medication-assisted treatment (MAT), including outpatient addiction services and residential addiction services	Covered for members ages 18 and older. Residential addiction services for members under the age of 18 are provided by DSCYF. For members participating in the PROMISE program (Promoting Optimal Mental Health for Individuals through Supports and Empowerment), these services are covered by the State.
Substance use disorder (SUD) treatment services	Covered for members ages 18 and older. 30-unit outpatient behavioral health benefit for members under the age of 18 (thereafter provided by DSCYF). For members participating in PROMISE, these services, except for medically managed intensive inpatient detoxification, are covered through the State.
Licensed behavioral health practitioner services (including licensed psychologists, clinical social workers, professional counselors, and marriage and family therapists)	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF). For members participating in PROMISE, these services are covered by the State.
Behavioral services to treat autism spectrum disorder (ASD) pursuant to EPSDT	Covered for members under age 21.
Crisis response and subacute mental health services	Covered.

Physicians' services	Physician oversight and direct therapy are considered to be a part of the following State-covered PROMISE services for participating members: • Assertive community treatment services. • Intensive case management services. • Supervision of group home services.
Dental Services	
Dental benefits	• Age 20 and under - Preventative care: Two dental exams per year, including cleanings, fluoride treatments, and sealants. • Restorative care: Care for cavities, fillings, crowns, and root canals. • Orthodontic screening: Exams by an orthodontist. • Orthodontic work (such as braces): Covered when medically necessary. Age 21 and older – Standard benefit, including $1,000 of coverage per year for dental services, such as cleanings, X-rays, cavity fillings, and more. Each visit has a $3 copay. Emergency dental, after $1,000 standard benefit used, members may get up to $1,500 of coverage per calendar year for dental work that meets the extended benefit criteria.
Fluoride varnish	Topical application of fluoride varnish one time in six months.
Durable Medical Equipment	
Medical equipment and supplies	Covered.
Diabetes equipment and supplies	Covered.
Hearing aids	Covered for members ages 0 to 20.
Orthotics and prosthetics	Covered.
Emergency Care	
Ambulance	Covered for emergency services only.
Freestanding emergency room	Covered.
Hospital emergency room	Covered.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services	
EPSDT services, including periodic preventive health screens and necessary diagnostic and treatment services	Covered for members under age 21.
EPSDT - Rehabilitative services, including community psychiatric support and treatment (CPST), psychosocial rehabilitation (PSR), crisis intervention, and family peer support services	Covered for members under 21. 30-unit outpatient behavioral health benefit for members under the age of 18 (thereafter provided by DSCYF)
Home Health, Home Visiting. and Nursing Facility Services	
Home health services, including: • Intermittent or part-time nursing • Home health aide services • Medical supplies, equipment, and appliances suitable for use in the home	Covered.

• Physical therapy, occupational therapy, and speech pathology and audiology services	
Nursing facility services	Covered for up to 30 calendar days, then services are covered as part of the DSHP Plus LTSS benefit package.
Pediatric respite (rest) services	Covered for members under age 21 with a physical health or behavioral health condition. Pediatric respite services are provided on a short-term basis to allow temporary relief from caretaking duties for a child's primary unpaid caregiver, parent, court-appointed guardian, or foster parent. The covered benefit is for a total of 285 hours or 15 days per year. Respite care can either be skilled or unskilled and at home or outside the home (for example, at a center). Emergency respite is limited to a maximum of six 72-hour episodes per year.
Private duty nursing	Covered.
Home visiting services	Covered.
Self-Directed Attendant Care for Children	Covered for members under age 21 who have a chronic medical condition, intellectual/developmental disability, or behavioral health condition that results in the need for assistance with age-appropriate activities of daily living.
Support for Self-Directed Attendant Care for Children	Covered for members approved to receive self-directed attendant care for children services.
Hospice	
Hospice Services	Covered.
Inpatient Hospital Services	
Room and Board	Covered.
Inpatient physician services	Covered.
Inpatient supplies	Covered.
Organ and tissue transplants	Covered.
Laboratory and Radiology Services	
Mammography	Covered.
Routine radiology screening and diagnostic services	Covered.
Sleep study testing	Covered.
Maternity Services	
Doula services	Covered for eligible members
Free standing birthing center services	Covered.
Licensed midwife services	Covered.
Postpartum nutrition supports	Covered for eligible members.
Medicare Co-insurance	
Medicare deductible/co-insurance and remainder up to Medicaid allowed amount.	Covered.
Outpatient Hospital Services	
Abortions	Federal regulations allow coverage so long as the pregnancy is the result of rape or incest, or if the

	individual suffers a life-endangering physical condition caused by or arising from the pregnancy itself.
Ambulatory surgical center	Covered.
Clinic services	Covered.
Dialysis	Covered.
Outpatient diagnostic lab and radiology	Covered.
Outpatient Therapy Services	
Occupational therapy	Covered.
Physical therapy	Covered.
Speech / language pathology	Covered.
Preventative Services	
Preventive services	Covered.
Routine check-ups	Covered.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Covered for children under age 21.
Immunizations	Covered.
Primary care provider Covered.	Covered.
Routine hearing exam	Covered under EPSDT for children under age 21.
Office visit	Covered.
Professional Office Services	
Allergy testing	Covered.
Birthing center (freestanding) services	Covered.
Certified nurse midwife services	Covered.
Chiropractor	Covered.
Contraceptive devices	Covered.
Face-to-face tobacco cessation counseling services	Covered.
Family planning and family planning-related services	Covered.
Federally Qualified Health Centers (FQHC)	Covered.
Laboratory tests	Covered.
Lactation counseling services	Covered.
Licensed midwife	Covered.
Office visit	Covered.
Optometrist	Covered.
Pediatric or family nurse practitioner's services	Covered.
Podiatry	Covered.
Routine patient cost in qualifying clinical trials	Covered.
Specialist office visit	Covered.
Tobacco cessation counseling services	Covered.
Vision Services	
Routine eye exam	Once every 12 months for members under 21 years of age.
Eyeglasses or contact lenses	Once every 12 months for members under 21 years of age.
Repairs	Covered for members under age 21.

Diamond State Health Plan (DSHP) Plus LTSS Benefit Package

The following is a list of covered benefits, services, and limitations for Diamond State Health Plan Plus LTSS members. Some services may require prior authorization. This is not a complete list of services. Please call Member Services at 1-877-236-1341 (TTY: 711) for full details.

Services	Coverage Details and Limitations
Adult day services	Offers supervised care and personal services during the day, overseen in a community-based setting. Therapies and meals may also be available.*
Attendant care	Helps members with daily tasks, like bathing, getting dressed, other personal hygiene (cleanliness), moving from one place to another, going to the bathroom, and eating.*
Cognitive services	Offered to members and their families who have problems with those close to them or cognitive deficits, such as those that may occur after a brain injury. These services include therapy or counseling, limited to 20 visits per year and an assessment.*
Community-based residential alternatives	Home-like settings, such as assisted living, that have services to support your needs and offers programs for socializing and recreation.
Day habilitation	Services to help members learn and develop skills to live on their own in and out of their home. These services take place in a nonresidential setting, away from the member's home. Day habilitation is for members who have problems with those close to them (also known as interpersonal conflict) or cognitive deficits, such as those that may occur after a brain injury. In some cases, meals and therapies may be included.**
Home-delivered meals	Offers up to two meals per day, fit for a well-balanced diet and delivered to the member's home.*
Independent activities of daily living	Offers help with daily tasks, like light cleaning, meal preparation (cooking), shopping, and more.*
Minor home modification	Based on medical necessity, changes can be made to the member's home to help them be able to live on their own. Changes include modifications such as widening doors for a wheelchair, tub cut outs, or putting in a wheelchair ramp or a grab bar. This benefit covers up to $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime. Service providers must be approved by Delaware First Health.*
Nursing facility	A setting where members get skilled nursing care and other services, such as rehabilitation services and health-related services.
Nutritional supplements for HIV/ AIDS	Help with HIV / AIDS - associated weight loss and malnutrition through oral supplements.*
Personal emergency response system (PERS)	An electronic device that is connected to the member's phone that gives the member access to a 24-hour emergency response service. When the button on the device is pushed, it sends a signal to someone who is available to help the member.*
Respite care	Personal care given to members in their home or at a nursing or assisted living facility to give unpaid caregivers time to rest.* This service is limited to 14 days per year. Please note: Assisted living facilities do not provide respite services.

Self-directed attendant care (SDAC) service	Offers members financial management and general support if they choose SDAC in the form of a Fiscal Employer Agent. SDAC is when the member serves as the legal employer of a paid caregiver; the member can also choose someone to fill this role for them, known as the member's Employer Representative. The member's Fiscal Employer Agent takes care of taxes, payroll withholding, and paychecks for the employee. They also help find and train an Attendant Care Employee, a worker to help the member with daily tasks.*
Specialized medical equipment	Help items are available to members, such as grabbers. This benefit covers only items that are not covered by the State.
Nursing facility transition (NFT) services	Offers help with the costs of moving from a nursing or assisted living facility to a community or home. These costs can include groceries, furniture, security deposit, telephone / internet connection fees, etc. Additional benefits may be available under Delaware First Health's value-added benefits (see below).

*These services are not available for members in assisted living or nursing facilities.

**Not offered to members living in non-acquired brain injury (ABI) assisted living or nursing facilities.

Urgent Care Services

Delaware First Health defines Urgent Care as the existence of conditions due to an illness or injury which are not life threatening but require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

If a member is unsure as to whether or not their situation is an emergency, they may contact their PCP or Delaware First Health's 24-hour Nurse Advice Hotline during regular or after business hours and on weekends; however, this is not a requirement to access these services. Members may access urgent care services at any time without Prior Authorization from Delaware First Health.

Emergency Services

In accordance with 42 CFR 438.114, emergency services are defined as covered inpatient and outpatient services furnished by a provider that is:

- Qualified to furnish these services under Delaware Medicaid; and
- Needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Care Services must be accessible 24 hours a day, seven days a week. They are provided in a hospital or comparable facility in order to stabilize the member and determine the severity of the condition and the appropriate treatment of acute symptoms.

Members may access emergency services at any time without Prior Authorization from Delaware First Health.

Emergency services are covered by Delaware First Health when provided by a qualified provider, including out-of-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Delaware First

Health. Delaware First Health will not deny payment for treatment obtained under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition; or
2. A representative from DE First Health instructs the member to seek emergency services.

STATE COVERED SERVICES

The Delaware Medicaid State Plan provides healthcare services and benefits that are not covered under the standard DSHP Plus LTSS benefits. To get help with these benefits, contact the Care Management Department at 1-877-236-1341 (TTY: 711).

These services include:

- Prescribed Pediatric Extended Care (PPEC).
- Non-emergency medical transportation (NEMT).
- Specialized services for nursing facility residents.
- Additional behavioral health services for children under the age of 18.

Service	Definition/Limitation
Prescribed pediatric extended care (PPEC)	PPEC is a package that includes: • Nursing. • Nutritional assessment. • Development assessment. • Speech. • Physical. • Occupational therapy services. These services are provided in an outpatient setting, as ordered by an attending physician. This is covered by the State.
Non-emergency medical transportation (NEMT)	Non-emergency medical transportation is available to all DSHP, DSHP Plus and DHCP members. This is covered by the State. Transportation arrangements should be made at least 72 hours in advance of a scheduled appointment. Modivcare will verify that the recipient is Delaware Medicaid eligible, and that transportation is required to a covered service. Once both criteria are confirmed, Modivcare will arrange for appropriate transportation to the covered medical service by one of their contracted transportation providers. Eligible Delaware Medicaid clients in need of non-emergency transportation should call Modivcare at 1-866-412-3778.

Specialized services for nursing facility residents not included in covered services	The State will provide specialized services as determined necessary by the State as part of the PASRR Level II process that are not included in the DSHP Plus LTSS benefit package.
Employment services and supports provided through Pathways	Services are available to members participating in Pathways to supplement covered services provided by Delaware First Health. The following services are covered by the State: • Career exploration and assessment. • Job placement supports. • Supported employment for individuals. • Supported employment for small groups. • Benefits counseling. • Financial coaching. • Non-medical transportation. • Personal care. • Orientation, mobility, and assistive technology.
Additional behavioral health services	Behavioral health services for children under the age of 18: • Behavioral health services provided to members under the age of 18 beyond those included in the DSHP benefit package are covered by the State. This includes outpatient services beyond what is included in the DSHP benefit package, as well as residential and inpatient behavioral health services. Behavioral health services for members ages 18 and older who participate in PROMISE: • As provided in the DSHP benefit package above, Delaware First Health will no longer cover the following services when a member is participating in PROMISE. For members participating in PROMISE, these services are covered by the State: – Substance use disorder (SUD) services other than medically managed intensive inpatient detoxification. – Licensed behavioral health practitioner services. • The following services are covered by the State and available to members participating in PROMISE to supplement covered services provided by Delaware First Health: – Care management. – Benefits counseling. – Community psychiatric support and treatment. – Community-based residential supports, excluding assisted living. – Community transition services. – Financial coaching. – IADL / chore. – Individual employment support services. – Non-medical transportation. – Additional nursing services. – Peer supports. – Personal care.

	– Psychosocial rehabilitation (PSR). – Respite. – Short-term small group supported employment.
Delaware Division of Developmental Disabilities (DDDS) lifespan waiver services	The following services are covered by the State and available to members participating in the DDDS lifespan waiver as a supplement to covered services provided by Delaware First Health: • Assistive technology. • Behavioral consultation. • Community participation. • Community transition. • Day habilitation. • Home or vehicle accessibility adaptations. • Nurse consultation. • Personal care. • Prevocational services. • Residential habilitation. • Respite. • Additional specialized medical equipment and supplies. • Supported employment. • Supported living.

VALUE-ADDED SERVICES

Delaware First Health members are eligible to receive value-added benefits (VABs) in addition to their covered benefits. Members can contact Member Services at 1-877-236-1341 (TTY: 711) for questions or to learn more about these services. Providers may visit our dedicated Provider Resources webpage for additional information and referral links.

Programs & Services	Description
Over-The-Counter (OTC) Program	$120 per household per year ($30 per quarter) to spend on select OTC items including diapers, period products (such as pads and tampons), and lots more. No prescription needed.
Tutoring Services	Up to $200 per year in tutoring for members in grades K-12 who are at risk of falling behind on one or more core subject areas.
GED Services	Members ages 16 and older not currently enrolled in school can get up to $200 in select GED testing and tutoring services.
Post-Discharge Home-Meal Delivery	Post-discharge meal delivery for members at high risk for readmissions. Eligible members can get three meals a day for seven days after being discharged from the hospital or other inpatient facility.

Connections Plus®	Free cell phone for high-needs members in Care Coordination or Case Management with qualifying needs.
Social Isolation Support Program and Application	Pyx Health social isolation support program for members 18 years and older. Pyx Health may call members ages 18 and up to invite them to join the program.
Behavioral Health Support App	Access to a mobile app to help manage stress, anxiety, chronic pain, and more. The mobile app provides personalized online learning to address common behavioral health conditions.
Vision Services for Adults	Members ages 21 and older are eligible for a routine comprehensive eye exam with refraction every 12 months and an eyewear allowance of up to $160 every year.
Whole Health Transportation	Transportation to value-added benefits (WeightWatchers®, GED testing, etc.), as well as transportation to additional health-related services such as SUD recovery support meetings, food pantries, and job interviews.
Community-Based Wellness Programs	Up to $250/year for programs to support population-specific wellness goals: • Children (5-18): Boys & Girls Clubs memberships and programs • Adults 18+ with BMI 25+: WeightWatchers®. • Seniors (age 60+): Senior center membership and additional programs and services. WeightWatchers® Referral form (For Provider Use)
Diabetes Prevention Program	Lifestyle change program on healthy eating and physical activity for members at high risk for diabetes. Members age 18+ who are not currently pregnant, have not been previously diagnosed with diabetes, and have a Body Mass Index (BMI) of 25 or higher (23 or higher if Asian American) may qualify for the program. Program Referral Link (For Provider Use)
Home-Based Interventions for Asthma	At-home, non-clinical asthma support. This includes $250 per year for non-clinical, home-based needs, such as hypoallergenic bedding, air purifiers, and pest control for qualifying members in Care Coordination or Case Management.
Housing Transition Allowance	Up to $2,500 per member per lifetime to help establish stable housing. For members 18+ in Case Management or Care Coordination experiencing

	homelessness, transitioning from foster care to independent living, or transitioning from a facility to community or independent living. This service is in addition to the standard $2,500 per transition benefit offered to LTSS members.
Practice Dental Visit	Practice dental visits with a new dentist to meet the dental team, discuss voice preferences and concerns, and understand what happens in a dental appointment before exams or treatments. All pediatric members (age 20 and younger) and adults (21+) with an intellectual or developmental disability (IDD).

My Health Pays® Rewards Program

With the My Health Pays rewards program, members can earn rewards when completing healthy activities, like going for an annual wellness visit, getting a flu shot, seeing a dentist, and more. Once the first qualifying healthy activity is completed, the member will get a My Health Pays Visa® prepaid card* from Delaware First Health. Rewards will be added to the card each time a qualifying activity is completed.

This card is issued by The Bancorp Bank, Member FDIC, pursuant to a license from Visa U.S.A. Inc. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage instructions.

2025 My Health Pays® Rewards:		
Activity	Reward	Reward Frequency
Register through the member portal.	$10	One time reward.
PCP confirmation within 30 days of enrollment.	$15	One time reward.
Complete health risk assessment (HRA).	$20	One time reward.
Complete notification of pregnancy (NOP).	$20	One per pregnancy.
Go to your prenatal visit in your first trimester or within 42 days of enrollment	$50	One per pregnancy.
Complete your third prenatal visit.	$20	One per pregnancy.
Complete your sixth prenatal visit.	$20	One per pregnancy.
Prenatal Tdap vaccine.	$15	One per pregnancy.
Prenatal RSV vaccine.	$15	One per pregnancy.
Go to your postpartum visit.	$40	One per pregnancy.
Attend 3 infant well visits for children 0 to 15 months old.	$50	This reward can be earned twice! Requires 3 visits or claims to receive $50 reward. $100 for both rewards.
Get a lead screening at 12 months	$25	One time reward
Get a lead screening at 24 months.	$25	One time reward.
Attend infant well visit for children ages 15-30 months.	$25	This reward can be earned twice! $25 per visit.

Get your asthma controller medication filled, for ages 18 and under.	$25/ prescription fill	Earn this reward up to 6 times per year. If you fill your asthma controller medication 6 times in a year, you will earn $150.
Attend adult well visit, for those ages 18 and up.	$25	Once per year.
Get your flu vaccination, for those ages 6 months and up.	$15	Once per year.
Go to annual adult dental visit, ages 21+.	$20	Once per year.
Complete diabetes HbA1c test, for members with diabetes ages 18 to 75.	$20	Once per year.
Complete a retina exam, for members with diabetes age 18-75.	$25	Once per year.
Complete breast cancer screening, for those ages 40 to 74.	$25	Every two years.
Complete cervical cancer screening, for those ages 21 to 64.	$30	Every three years.
Complete colorectal cancer screening, for those ages 50 to 75.	$20	One time reward.
Get your first tobacco cessation medication fill.	$20	Once per year.
Go to behavioral health hospitalization follow-up visit.	$20	Once per year.
Go to substance use disorder residential stay follow-up visit.	$20	Once per year.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

Medicaid offers its covered children and youth under age 21 a comprehensive benefit for preventive health and medical treatment. Delaware First Health adheres to and offers or arranges for the full scope of preventive and treatment services available within the federal EPSDT benefit. Preventive (wellness) services are offered without copays or other charges, per the nationally recognized periodic schedule established by Bright Futures. Early Periodic Screening services include physical exams, up to date health histories, developmental, behavioral and risk screens, vision, hearing and dental health screens and all vaccines recommended by the Advisory Committee on Immunization Practices.).

DFH requires all primary care providers (PCPs) to include the following components in each medical screening:

1. Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) “Guidelines for Health Supervision III” and described in “Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.”:

2. Comprehensive health and development history (including assessment of both physical and mental development and/or delays at each visit through the 5th year; and Autistic Spectrum Disorder [ASD] per AAP)
3. Comprehensive unclothed physical examination
4. Immunizations appropriate to age and health history, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
5. Assessment of nutritional status
6. Laboratory procedures appropriate for age and population groups, including blood lead screening. Blood lead screening is required for infants/toddlers at age 12 and 24 months. Blood lead screening is also appropriate whenever the provider suspects exposure or when they live in high-risk environments/areas.
7. Routine blood assay, including hemoglobin and hematocrit levels is required at 12 months and should be performed whenever clinical findings indicate medical necessity
8. Assessment of growth and development and administration of brief, scientifically validates developmental, emotional, behavioral, SDoH and risk screens during preventative visits
9. An ASD screen may be administered at a "catch-up" visit if the 18- or 24-month visit was missed. Providers may screen for developmental risk for ASD at ages greater than 30 months when the provider or caregiver has concerns about the child. Findings supporting use of a developmental screen for ASD may include:
    a. observed difficulties in responsiveness, age-appropriated interaction, or communication
    b. a report by parent or caregiver
    c. diagnosis of an ASD in a sibling
10. Vision screening and services, including at a minimum, diagnosis, and treatment for defects in vision, including eyeglasses
11. Dental screening (oral exam by primary care provider as part of comprehensive exam). Recommend that preventive dental services begin at age six (6) through 12 months and be repeated every six (6) months
12. Hearing screening and services, including at a minimum, diagnosis, and treatment for defects in hearing, including hearing aids; and
13. Health education and anticipatory guidance

PCP's must clearly document the provision of all components of EPSDT services in the medical records of each beneficiary.

EPSDT Guarantee

Delaware First Health does not require prior authorization for preventative care (early and periodic screens/wellness visits) for Medicaid Members less than twenty-one (21) years of age, however, prior authorization may be required for other diagnostic and treatment products and services provided under EPSDT. If a provider requests a service for a member that is not a covered benefit, providers are required to submit a prior authorization. (See section: "Prior Authorization and Notifications" for prior authorization details).

Upon receipt of the request, it will be reviewed for medical necessity under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements. The medical necessity criteria specific to EPSDT is defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and:

- Must be made on a case-by-case basis, taking into account the particular needs of the child.
- Should consider the child's long-term needs, not just what is required to address the immediate situation.
- Should consider all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders.
- May not contradict or be more restrictive than the federal statutory requirement
- Must correct or ameliorate a defect, physical or mental illness

Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap are not consistent with EPSDT requirements.

Upon conclusion of an individualized review of medically necessary services, DFH will cover medically necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. § 1396d(r), regardless of whether such services are covered under the Delaware Medicaid State Plan.

Medically necessary care and treatment to 'correct or ameliorate' health problems must be provided directly or arranged by referral, even when a Medicaid coverable service is not available under the Delaware Medicaid plan. DFH will provide referral assistance for non-medical treatment not covered by the plan but found to be needed due to conditions disclosed during screenings and diagnosis.

Delaware First Health requires that providers cooperate to the maximum extent possible with efforts to improve the health status of Delaware citizens, and to participate actively in the increase of percentage of eligible beneficiaries obtaining EPSDT services in accordance with the adopted periodicity schedules. Delaware First Health will cooperate and assist providers to identify and immunize all beneficiaries whose medical records do not indicate up-to-date immunizations.

For EPSDT and immunization billing guidelines please visit our website at DelawareFirstHealth.com for the Delaware First Health Provider Billing Manual.

PRIMARY CARE PROVIDER (PCP)

The Primary Care Provider (PCP) is a specific provider operating under the scope of his/her licensure, who is responsible for supervising, prescribing, and rendering primary care services; locating, coordinating, and monitoring all other medical care; rehabilitative service; and maintaining continuity of care on behalf of a member. 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, proactively outreaching and engaging with members and supports continuity of care, and patient safety. This model supports the elimination of redundant services, promotes cost-effective care, and leads to improved overall 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 of the member's primary residence. LTSS members will have access to a Medical Home within 30 miles or 45 minutes from the applicable facility placement.

Delaware First Health requires PCPs and specialists to conduct reasonable outreach to a member who misses a scheduled appointment and to document the outreach actions in the medical record. A reasonable outreach effort includes three (3) attempts to contact the member. Attempts may include but are not limited to written attempts, telephone calls, and/or home visits. At least one (1) such attempt must be a follow-up telephone call.

Provider Types That May Serve as PCPs

A PCP is a medical Practitioner in our network including:

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

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 across all payors. Delaware First Health requires each Primary Care Provider (PCP) practice to complete an Annual Attestation Form confirming (i) the panel size for each PCP with an assigned panel size across all payors (Medicaid, Medicare and Commercial). This form can be accessed on our website under the Manuals, Forms and Resources page.

PCPs interested in exceeding the member limit should contact their Provider Engagement Account Manager (PEAM) to discuss the criteria required to support the expansion request such as the use of physician extenders and/or extended office hours to accommodate additional members.

Should a PCP declare a specific capacity for his/her practice and wants to make a change to that capacity at any time, the PCP must contact Delaware First Health Provider Services toll-free at 1-877-236-1341. A PCP shall not refuse to treat members as long as the provider has not reached their requested panel size.

Providers shall notify Delaware First Health in writing at least forty-five (45) in advance of his or her inability to accept additional Medicaid covered persons enrolled with Delaware First Health. At no time shall an established patient, newly enrolled with Delaware First Health, be considered or treated as a new patient.

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 the selection of a PCP. For those members who do not select a PCP within thirty (30) calendar days of enrollment, Delaware First

Health will use a PCP auto-assignment algorithm to assign an initial PCP. Members reserve the right to change their PCP at any time. PCP selection can be updated by calling our Member Services toll free at 1-877-236-1341.The Delaware First Health algorithm assigns Members to a PCP according to the following criteria:

1. Member's geographic location.
2. Member's previous PCP, if known.
3. Other enrolled Members' in the same household selected PCPs, if known.
4. Special healthcare needs, including pregnancy, if known.
5. Special language and cultural considerations, if known.

If your member presents for services and you are not the PCP of record, please have your office assist the member in completing a Primary Care Provider (PCP) Change Request Form and submitting it to Delaware First Health. Once processed, our system will be updated, and you will be the PCP of record.

PCP Responsibilities

PCPs are responsible for the comprehensive coordination of care for their assigned and attributed Medicaid members. This includes conducting outreach, engaging members in their care, and ensuring 24/7 access and oversight of all aspects of the member's health care journey. Delaware First Health will monitor PCP actions, behaviors and performance for compliance with the following responsibilities which include but are not limited to:

- Delivering primary and preventive care and acting as the Member's advocate.
- Providing, recommending and arranging for care.
- Complying with all federal and state disability access laws and regulations and offer physical and programmatic access to members with disabilities.
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the DHSS data specifications.
- Maintaining continuity of each member's healthcare.
- When needed, effectively communicating with the member by offering, at no charge:,
    - Sign language interpreters for those who are deaf or hearing impaired.
    - Oral interpreters for those individuals with LEP (Limited English Proficiency).
- Coordinating referrals for specialty care and other medically necessary services.
- Maintaining a current and complete medical record for each member, including documentation of all services provided by the PCP, as well as any specialty or referred services.
- Arranging, as appropriate, for Behavioral Health Services.
- Allowing Delaware First Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as Healthcare Effectiveness Data and Information Set (HEDIS) and other contractual or regulatory programs.
- Ensuring coordination and continuity of care with providers, including all Behavioral Health and Long-Term Care providers, according to Delaware First Health policy; and
- Ensuring that the member receives appropriate preventative services for the Member's age group, and actively coordinating health care services needed by members, including scheduling annual visits.
- Referring a member for Behavioral Services based on the following indicators:

- Suicidal/homicidal ideation or behavior;
- At-risk of hospitalization due to a Behavioral Health condition;
- Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;
- Trauma victims;
- Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;
- Request by member or authorized representative for Behavioral Health services;
- Clinical status that suggests the need for Behavioral Health services;
- Identified psychosocial stressors and precipitants;
- Treatment compliance complicated by behavioral characteristics;
- Behavioral and psychiatric factors influencing medical condition;
- Victims or perpetrators of abuse and/or neglect and members suspected of being subject to abuse and/or neglect;
- Non-medical management of substance abuse;
- Follow-up to medical detoxification;
- An initial PCP contact or routine physical examination indicates a substance abuse problem;
- A prenatal visit indicates substance abuse problems;
- Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;
- A pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other Behavioral Health conditions; and/or
- The persistence of serious functional impairment.

Specialist Responsibilities

Delaware First Health encourages specialists to communicate with the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the members' care and ensure the referred specialist is a participating provider within the Delaware First Health network and that the PCP is aware of the additional service request. The specialist may order diagnostic tests without PCP involvement.

Female members will have direct access to an in-network OB/GYN, or other women's health specialist for routine OB/GYN services regardless of whether their PCP (general practitioner, family practitioner or internist) provides such women's health services, including routine gynecological exams.

Emergency admissions will require notification to Delaware First Health Medical Management department within the standards set forth in the Utilization Management section of this manual. All non-emergency inpatient admissions require Prior Authorization from Delaware First Health.

The Specialist must:

- Maintain contact with the PCP.

- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to Members with disabilities.
- Obtain Prior Authorization from Delaware First Health Medical Management department, as required, before providing services.
- Coordinate the member's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five (5) business days.
- Be available or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of medical information.
- Allow Delaware First Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as Healthcare Effectiveness Data & Information Set (HEDIS) and other contractual, regulatory, or other programs.

Delaware First Health requires PCPs and specialists to conduct reasonable outreach to a member who misses a scheduled appointment and to document the outreach actions in the medical record. A reasonable outreach effort includes three (3) attempts to contact the member. Such attempts may include but are not limited to written attempts, telephone calls and/or home visits. At least one (1) such attempt must be a follow-up telephone call.

Hospital Responsibilities

Delaware First Health utilizes a network of hospitals to provide services to Delaware First Health members. Hospital Services Providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the participating provider agreement.

Hospitals must:

- Notify the PCP immediately or at most no later than the close of the next business day after the member's Emergency Room (ER) visit.
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Obtain authorizations for all inpatient and select outpatient services as listed on the Delaware First Health Prior Authorization list, except for emergency stabilization services.
- Notify Delaware First Health Medical Management department by sending an electronic file of the ER admission within 24 hours or the next business day. The electronic file should include the member's name, Medicaid ID, presenting symptoms/diagnosis, Date of Service (DOS), and member's phone number.
- Notify Delaware First Health Medical Management department of all admission within one business day.
- Notify Delaware First Health Medical Management department of all newborn deliveries within two (2) business days of the delivery.
- Allow Delaware First Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.

INTEGRATED HEALTH SERVICES

Overview

The Delaware First Health Population Health and Clinical Operations (PHCO) department's 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 answer questions about Prior Authorization.

Population Health and Clinical Operations includes the areas of utilization management, care coordination, service coordination, and case management. PHCO services are overseen by the Delaware First Health Chief Medical Director. The Vice President of Population Health and Clinical Operations (VPPHCO) has responsibility for direct supervision and operation of the department. To reach the Chief Medical Director or VPPHCO, please contact Provider Services toll-free at 1-877-236-1341.

Care Management

Delaware First Health uses a multi-disciplinary Integrated Care Team to 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. Integrated care is an integral part of the range of services we provide to all members. Through this, we continually strive to achieve optimal health status through member engagement and behavioral change motivation using a comprehensive approach that includes:

- Strong support for the integration of both physical and behavioral health services.
- Assisting members in achieving optimum health, functional capability, and quality of life.
- Empowering members through assistance with referrals and access to available benefits and resources.
- Working collaboratively with members, family and significant others, providers, and community organizations to assist members using a holistic approach to care.
- Maximizing benefits and resources through oversight and cost-effective utilization management.
- Rapid and thorough identification and assessment; especially members with special healthcare needs.
- A team approach that includes staff with expertise and skills that span departments and services.
- Information technologies that support care coordination within plan staff and among a member's providers and caregivers.
- Multifaceted approach to engage members in self-care and improve outcomes.
- Continuous quality improvement processes that assess the effectiveness of integrated care and identify areas for enhancement to fully meet member priorities.
- Assessment of member's risk factors and needs.
- Contact with high-risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members understand treatment recommendations.

- Active coordination of care for members with coexisting behavioral and physical health conditions; residential; social and other support services where needed.
- Development of an integrated plan of care.
- Referrals and assistance to community resources and/or behavioral health providers.

The model emphasizes direct member contact (i.e., telephonic outreach; face-to-face meetings; and written educational materials). In some circumstances, face-to-face contact is preferred because it more effectively engages members, allows staff to provide information that can address member questions in real time and better meets members' needs. Participating members also receive preventive care and screening reminders, invitations to community events, and can call any time regarding healthcare and psychosocial questions or needs.

Care Coordination

Care Coordination is available to all Delaware First health members via direct provider referral.

Care coordination is appropriate for members with higher level needs related to physical health conditions, behavioral health conditions, and/or issues related to social determinants of health such as housing instability, food insecurity, and transportation.

If you have a member with complex health care needs, have a difficult time navigating the health care system, or need assistance finding community resources, the Care Coordination Department can help.

Care Coordinators are nurses and social workers that can assist members with many healthcare and health-related needs. Care Coordinators can speak to members over the phone or meet with them in person to help them get the medical, behavioral health, and substance use care they need. They will develop a care plan with the members and work with their care team to help them achieve goals that are important to them.

The Care Coordination team can be contacted by calling 1-877-236-1341 toll-free. The Care Coordination team is available Monday through Friday, 8 a.m.– 5 p.m.

Care Coordinators help members with the following:

- Learn about their condition and medicines.
- Obtain durable medical equipment.
- Find programs in the community, such as nutrition and weight loss programs.
- Access community resources such as food banks or other programs that help meet their needs.
- Help members achieve their healthcare related goals.
- Help after a hospitalization by:
    - Calling members after discharge to make sure they have everything they need.
    - Help members review their discharge instructions.
    - Remind members to ask about any medications that they may need to take.
    - Remind members to make an appointment to follow up with their provider.

Service Coordination

Service Coordination is available to all Delaware First Health members to assist with:

- Appointment assistance and linkage
- Access to wellness and community resources
- Information/education about benefits
- Education and assistance related to preventive care

The Service Coordination team can be contacted by calling 1-877-236-1341 toll-free. The Service Coordination team is available Monday through Friday, 8 a.m.– 5 p.m.

Pregnancy and Maternity

Obstetrical (OB) care is covered for all Delaware First Health members. Members can receive prenatal and postpartum care, as well as care during labor and delivery. Members that become pregnant while covered by Delaware First Health may remain a Delaware First Health member during their pregnancy. Providers can complete a notification of pregnancy (NOP) through the provider portal or by faxing the form available on our website.

Prior authorization is not required for medically necessary ultrasounds which include one first trimester ultrasound, one second or third trimester ultrasound, and up to two detailed anatomic ultrasounds.

Prior authorization is not required for hospital stays of less than 48 hours for vaginal delivery or 96 hours for cesarean delivery. However, providers must complete the Obstetrical Outcome Form within 2 days after delivery.

Doula services are a covered benefit for Delaware First Health members. Doula services include up to three prenatal visits, attendance at birth, and three postpartum visits. Five additional postpartum visits are available at the recommendation of a provider. Please complete the Additional Postpartum Doula Visit Recommendation Form, on our Doula Services webpage and under the Manuals, Forms and Resources webpage. Prior authorization is not required for doula services. For doula providers, please visit Doula Services webpage to find out more information about the benefit.

Service	Scope of Service	Prior Authorization Required
First trimester ultrasound	One per pregnancy	None
Second or third trimester ultrasound	One per pregnancy	None
Detailed anatomic ultrasound	Two per pregnancy	None
Labor & delivery	Vaginal delivery stay <72 hours Cesarean delivery stay <96 hours	No – obstetrical outcome form required
Doula Services	3 prenatal visits Attendance at birth 3 postpartum visits (5 additional with provider recommendation)	None

Delaware First Health members may be eligible to receive meals, diapers, and wipes after they deliver through the Postpartum Nutrition Program. Members interested in the program can reach out to Member Services at 1-877-236-1341 for more information. Other benefits available to pregnant members include evidence-based home visiting services, breast pumps, and lactation services.

Members can receive up to $150 in rewards for completing healthy activities during their pregnancy and after delivery. This includes timely (prenatal visit in first trimester or within 42 days of enrollment) and ongoing prenatal care and attending their postpartum visit.

All pregnant and postpartum members are eligible for maternal care coordination services through our Start Smart for Your Baby (SSFB) program. Start Smart provides education and support throughout pregnancy and postpartum, and provides support in dealing with medical, socioeconomic, and environmental issues that may contribute to adverse outcomes. Identifying pregnant members as early as possible, providing them with adequate prenatal care and guidance, and addressing complications as effectively as possible can help to improve outcomes for both mother and baby.

Building Community Capacity

Community Relations Representatives are available to make presentations during events initiated by state entities, community-based organizations, providers, or in any other approved setting. Presentations may include information about Medicaid services generally, and the additional services and benefits offered specifically by Delaware First Health, coordinated care / care management, how to use the health plan and access services, the importance of obtaining primary preventive care, general health education, and other valuable information related to obtaining services from providers and Delaware First Health. Often Community Relations Representatives will engage in targeted community events designed to increase health literacy, promote healthy lifestyle activities, or address care gaps in needed areas. We also host community baby showers to promote health education and awareness for healthy pregnancies and healthy babies.

To contact the Community Relations Team, call our toll-free number at 1-877-236-1341.

24-Hour Nurse Advice Line

Our members have many questions about their health, their PCP, and access to emergency care. Therefore, we offer a nurse advice line to help members proactively manage their health needs and decide on the most appropriate care and encourage members to talk with their provider about preventive care. We provide this service to support your practice and offer our members access to a registered nurse at any time — day or night. The toll-free telephone number is 1-877-236-1341.

The nurse advice line is always open and always available for members. Registered Nurses (RNs) provide basic health education and nurse triage, and they answer questions about urgent or emergency access. Nursing staff members often answer basic health questions but are also available to triage more complex health issues using nationally recognized protocols. Nurses will refer members with chronic problems, like asthma or diabetes, to our Care Management or Member Service departments for follow-up assistance, education, and encouragement to improve their health. Members can call the nurse advice line to request information about providers and services

available in the community after hours, when the Delaware First Health Member Service department is closed. The staff is proficient in both English and Spanish and can provide additional translation services if necessary.

DSHP PLUS LONG TERM SERVICES AND SUPPORTS (LTSS)

The provider is responsible for supervising, coordinating, and providing all authorized care to each assigned member. In addition, the provider is responsible for ensuring the receipt of an authorization for all services from the member's LTSS Case Manager (LTSS CM), maintaining continuity of each member's care and maintaining the member's medical record, which includes documentation of all services provided by the provider as well as the Member or responsible party's signature for receipt of covered services.

Role of the LTSS Case Manager (LTSS CM)

The LTSS CM's primary function is to support members and facilitate their access to LTSS and other services. The LTSS CM is responsible for leading the Person-Centered Service Plan (PCSP) process and oversee the implementation of the member's PCSP. The LTSS CM will identify, coordinate, and assist the member in gaining access to all needed services including covered and non-covered services, medical, social, housing, educational, and other necessary services and supports. The LTSS CM is responsible for locating and coordinating providers, specialists, or other entities essential for service delivery. This includes seamless coordination between physical, behavioral, and support services. LTSS CMs work with the members to coordinate evaluations and reassessments, establish level of care, identify strengths and the member's goals, and development and implementation of the PCSP. The LTSS CM will work with the members to complete activities necessary to maintain LTSS eligibility. The LTSS CM will keep the members informed during the process of facilitating, locating, and monitoring services and support. Service alternatives and other options will be taken into consideration, such as Self-Directed Attendant Care, and other LTSS services. If you feel your patient would benefit from LTSS benefits, let us know how we can help. Please call Delaware First Health at 1-877-236-1341.

Provider's Role in Service Planning and Care Coordination

The provider is responsible supervising, coordinating, and providing authorized services. The provider will work with LTSS CMs to address necessary services and supports and participate in the PCSP to ensure members' needs are addressed. The provider will comply with the reporting requirements of the member Complaint, Grievance, and DHSS Fair Hearing Processes.

Service Request Process for LTSS

LTSS services require approval and Prior Authorization by Delaware First Health. Service request authorizations are sent to providers by the Delaware First Health LTSS CM once the member's comprehensive needs assessment is complete and the member's PCSP is developed, and agreed upon with the member, their identified caregivers/supports, and their IDT.

PCSPs are reviewed with members during regularly scheduled face–to-face visits and at the time of assessment and re-assessments. If a member experiences a significant change in condition, if there is a change in level of support, or if the member requests a change in service(s) or change in placement, there may be a need to amend the PCSP to ensure the member's needs are met.

In addition, all services are subject to benefit coverage, limitations, and exclusions, as described in applicable State rules and regulations. Delaware First Health providers are contractually prohibited from holding any Delaware First Health member financially liable for any service administratively denied by Delaware First Health. Continuity of care coverage begins on the member's effective date of enrollment for any existing services and remains in effect until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented.

LTSS Provider Responsibilities

LTSS Providers are required to adhere to the following responsibilities:

- Provide Delaware First Health members with a professionally recognized level of care and efficiency consistent with community standards, the health plan's clinical and non-clinical guidelines, and within the practice of your professional license.
- Abide by the terms of the Participating Provider Agreement.
- Comply with all plan policies, procedures, rules, and regulations, including those found in this manual.
- Maintain confidential medical records consistent with Delaware First Health's medical records standards, medical record keeping guidelines, and applicable HIPAA regulations.
- Maintain a facility that promotes enrollee safety and equity.
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Participate in Delaware First Health's quality improvement program initiatives.
- Participate in provider orientations and continuing education.
- Abide by the ethical principles of your profession.
- Notify the plan if you are undergoing an investigation or agree to written orders by the state licensing agency.
- Notify the plan if there is a change of status with member eligibility.
- Ensure you have staff coverage to maintain service delivery to members.
- Allow Delaware First Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.
- Continue to provide services to members whose services are being transitioned to another provider. Providers should continue provision of HCBS, in accordance with the member's plan of care, until the member has been transitioned to a new provider, which may exceed thirty (30) days from the date of the notice.

UTILIZATION MANAGEMENT

The 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. 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.

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 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 Requirements

Failure to obtain the required Prior Authorization for a service may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions, as described in applicable plan coverage guidelines. All out-of-network services require Prior Authorization except for family planning, emergency room, post-stabilization services and tabletop x-rays. Delaware First Health providers are contractually prohibited from holding any Delaware First Health member financially liable for any service administratively denied by Delaware First Health for payment due to the provider's failure to obtain timely Prior Authorization.

Secondary Payor

When DFH is the secondary payer (i.e., the member has another primary insurance), prior authorization is not required if the service is covered by the primary insurance.

However, prior authorization is required if:

- The service is not covered by the primary insurance, or
- The benefit has been exhausted under the primary insurance.

In such cases of non-coverage from the primary payor as previously stated:

- A signed Advanced Beneficiary Notice (ABN) or Evidence of Coverage (EOC) must be submitted with the initial authorization request.
- An Explanation of Benefits (EOB) and/or ABN must be included with the claim submission.

Services That Require Prior Authorization

Please note, the list below is not all inclusive. Please visit our website and use the Medicaid Pre-Auth Tool to determine if a service requires Prior Authorization and to easily submit a request for Prior Authorization or referral. Prior Authorization forms may be found on our Manuals, Forms and Resources webpage.

Medical Necessity

Medical Necessity is defined as the essential need for health care or services that, when delivered by or through authorized and qualified providers, will:

- Be directly related to the prevention, diagnosis and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability (the physical or mental functional deficits that characterize the member's condition), and be provided to the member only;
- Be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities, and environment) of the member and the member's family;
- Be primarily directed to the diagnosed medical condition or the effects of the condition of the member, in all settings for normal Activities of Daily Living (ADLs); Be timely, considering the nature and current state of the member's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;
- Be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of funds;
- Be the most appropriate care or service that can be safely and effectively provided to the member, and will not duplicate other services provided to the member;
- Be sufficient in amount, scope, and duration to reasonably achieve its purpose;
- Be recognized as either the treatment of choice (i.e., prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of other care and services that are commonly provided; and
- Be rendered in response to a life-threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay.

Providers serving members enrolled in DSHP Plus LTSS must support access to community-based living, promote the achievement of person-centered goals, and facilitate opportunities for members to live and work in settings of their choice.

Medically necessary services:

- Will, or are reasonably expected to, prevent the onset of an illness, condition, injury, or disability.
- Will, or are reasonably expected to, reduce, or ameliorate the physical, mental, or developmental effects of an illness, condition, or disability.
- Will assist the member in achieving or maintaining maximum functional capacity in performing daily activities, considering both the functional capacity or the member and those functional capacities are appropriate for members of the same age.

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 are made by qualified and trained healthcare providers.

Please visit our website and use the Medicaid Pre-Auth Tool to determine if a service requires Prior Authorization and to easily submit a request for Prior Authorization or referral. Prior Authorization forms may be found on our Manuals, Forms and Resources webpage.

Examples of services that typically require prior authorization include:

Ancillary Services

- Cochlear Implant
- Durable Medical Equipment (DME)-includes medical supplies, enteral and parenteral pumps, wound vacs, bone growth stimulator, customized equipment (based on DME, orthotics, and prosthetics listing)
- Fixed Wing non-emergency air transport
- Hearing Aid Devices
- Home healthcare (incl. infusions, home health aide, private duty)
- Hospice services - other than inpatient facility
- Hyperbaric oxygen treatment (outpatient)
- Implantable devices (infusion pumps, intraocular implant/shunt, neuromuscular stimulator, spinal stimulator for pain management, testicular/penile prosthesis, vagus nerve stimulator)
- Orthotics & Prosthetics (based on DME, orthotics, and prosthetics listing)
- Speech, Occupational, and Physical therapies

Behavioral Health

- Autism Spectrum Disorders and Habilitative Services - diagnosis and treatment
- Behavioral Health - inpatient and substance abuse admissions, Partial Hospitalization Program (PHP), outpatient services, crisis intervention services, and medication assisted treatment (MAT) including outpatient addiction services.

- Prior authorization is not required for medically necessary inpatient treatment of drug and alcohol dependencies. However, notification is required within 48 hours of admission. Prior authorization is required after:
    - 14 days for inpatient SUD admission
    - 30 days for SUD intensive outpatient program treatment
    - 5 days for inpatient withdrawal management

Home and Community-Based Services

Please also see the Service Request Process for LTSS in the Long-Term Services and Supports section of this manual.

- Adult Day Services
- Assistive Devices
- Assisted Care Living
- Attendant Care Services
- Chore Services
- Cognitive Services
- Day Habilitation
- Environmental Modifications and Adaptive Devices
- Home Delivered Meals
- Minor Home Modifications
- Nutritional Supports
- Personal Emergency Response System (PERS)
- Respite: Individualized, group, specialized
- Self- Directed Attendant Care (SDAC)
- Specialized Medical Equipment
- Transition Services

Facility Services

- Elective/planned hospitalizations (notification at least 5 business days prior to the scheduled date of admit)
- Emergency Admissions and/or Observation Stay (notification within 1 business day of admission)
- Inpatient Rehabilitation
- Observation Services (outpatient)
- Skilled Nursing Facility

Pharmaceuticals

- Specialty Pharmaceuticals as per prior authorization list
- Selected Injectable therapy/biopharmaceuticals (e.g., Synagis®, Growth Hormone) as per prior authorization list

- Enteral/Parenteral Formulas (Pumps and supplies - see DME)

Practitioner Services

- Chiropractic
- Infertility Treatment
- Transplants (surgery itself)

Radiology & Laboratory Services

- Genetic/Molecular Diagnostic Testing
- MR-guided focused ultrasound (MRgFUS) to treat uterine fibroid
- Quantitative Drug Screening

Surgery & Procedures

- Ablative techniques for treating Barrett's Esophagus and for treating primary and metastatic liver malignancies
- Bariatric surgery
- Capsule endoscopy
- General Anesthesia- with a dental diagnosis
- Hyperhidrosis treatment
- Joint replacement - outpatient and inpatient joint replacement procedures in addition to total hip and knee
- Lung volume reduction surgery
- Maze procedure (for treatment of atrial fibrillation)
- Muscle flap procedure
- Orthognathic surgery (treatment of maxillofacial (jaw) functional impairment)
- Pain Management Services
- Potentially Cosmetic or plastic surgery e.g.: Blepharoplasty, Blepharoptosis repair, Brow Lift, Breast surgery or reconstruction other than post mastectomy, cranial/facial/jaw procedures, nasal/sinus surgery, panniculectomy and lipectomy/diastasis recti repair, Vein procedures
- Potentially Experimental Treatment/Clinical Trials
- Sleep apnea procedures and surgeries
- Sleep studies
- Spinal surgery
- Surgeries/procedures performed in Outpatient facilities or ambulatory Surgery Centers e.g.: arthroscopy, gender reassignment, joint replacement, obstructive sleep apnea surgery, potentially cosmetic or plastic surgery, TMJ, transcatheter uterine artery embolization, vein procedures and others to be listed
- Tonsillectomies in children
- Uvulopalatopharyngoplasty (UPPP)
- Ventriculectomy, cardiomyoplasty
- Wearable cardioverter-defibrillators

Requesting Prior Authorization

The preferred method for submitting Prior Authorizations is through our Secure Provider Web Portal. The Provider must be a registered user on the Secure Provider Web Portal. If the Provider is not a registered user and needs assistance or training on submitting Prior Authorizations there, the Provider should contact their assigned Provider Relations Representative.

Other methods for submitting Medical Prior Authorization requests are as follows:

By Phone: Call the Medical Management Department toll-free at 1-877-236-1341. Medical Management's normal business hours are Monday – Friday 8:00am – 5:00pm EST. Voicemails left after hours for services other than Inpatient hospitalization will be responded to on the next business day.

Availity Essentials: Access our newest secure web portal, Availity Essentials where you can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources. Please visit the Manuals, Forms, and Resources webpage to locate the most appropriate prior authorization forms.

Medical Management Fax Numbers	
Face Sheets	833-974-1203
Concurrent Review Fax	833-967-0495
Prior Authorization	833-967-0502
Behavioral Health Inpatient	833-967-0499
Behavioral Health Outpatient	833-967-0498

Complex Imaging and Interventional Pain Management

Complex imaging, such as MRA, MRI, PET, and CT scans must be submitted through the Evolent website (formerly National Imaging Associates, Inc. or NIA). To reach Evolent and obtain authorization, please call 1-800-424-1655 and follow the prompts for radiology authorizations. Evolent also offers an interactive website that can be used to request authorizations online. Please visit www.RadMD.com for more information or call our Provider Services department at 1-877-236-1341.

Cardiac imaging including Myocardial Perfusion Imaging (MPI), MUGA Scan, Echocardiography, and Stress Echocardiography must be submitted through Evolent. Interventional Pain Management service requests must also be obtained through Evolent.

Timeframes for Prior Authorization Requests and Notifications

Prior Authorization must be obtained prior to the delivery of certain elective and scheduled services. Submissions are not monitored outside of normal business hours (Monday – Friday 8:00am – 5:00pm EST, excluding holidays) and will be acknowledged the next business day. Failure to obtain prior authorization may result in claim denials.

Delaware First Health medical authorization decisions are made as expeditiously as the member's health condition requires but shall not exceed the timeframes as follows:

Type	Timeframe
Expedited Pre-service/Urgent[1]	72 hours
Standard Pre-service/Non-Urgent[2]	Within 7 calendar days
Concurrent review	72 hours

If a provider indicates—either by submitting a request on the member's behalf or by supporting the member's request—that waiting for a standard service authorization decision could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, and Delaware First Health confirms this upon review of the member's request, then Delaware First Health must make an expedited authorization decision. The decision and notification must be provided as quickly as the member's health condition requires, and no later than 72 hours after receiving the service request.

Adverse Benefit Determination

An adverse benefit determination is the denial or limited authorization of a requested service, including determinations based on the type or level of service, include requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. Untimely service authorizations constitute a denial and are thus Adverse Benefit Determinations. This includes situations in which Delaware First Health gives notice of its intent to extend the timeframe on the date that the original timeframe expires. Both the requesting provider and member will be notified of any decision made by Delaware First Health to deny a service authorization completely or to authorize in any amount, duration, or scope that is less than requested.

Providers may file appeals in writing. An appeal must be filed within 60 days from the date of the Notice of Adverse Benefit Determination letter. Providers can send or attach any additional information that will help with the appeal review to:

Delaware First Health
ATTN: Medical Appeals
PO Box 10353
Van Nuys, CA 90410-0353

Additional information on this process may be found in the Appeals and Grievances section of this manual.

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[1] Delaware First Health may extend the initial 72-hour timeframe up to 14 calendar days if requested by the member, or if Delaware First Health can demonstrate to the State--upon request--that more information is needed and the extension serves the member's best interest.

[2] For standard service authorization decisions, Delaware First Health shall provide notice as quickly as the member's health condition requires and, no later than 7 calendar days after receiving the service request, if: (1) the member, or the provider, requests extension; or (2) Delaware First Health demonstrates to the State-upon request--that additional information and the extension is in the member's interest.

Clinical Information

Delaware First Health clinical staff request only the minimum necessary clinical information required to support sound clinical decision-making. All information is collected in compliance with applicable federal and state regulations governing the confidentiality of medical information.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Delaware First Health is permitted to request and receive protected health information (PHI) for purposes of treatment, payment, and healthcare operations without requiring separate authorization from the member. These activities include coordinating care, processing claims, conducting quality assessments, and other essential administrative functions that support the delivery and management of healthcare services.

Information necessary for Authorization of covered services may include but is not limited to:

- Member's name, member ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate including the date of birth and gender of infant must be provided to Delaware First Health within one (1) business days or before discharge
- If additional clinical information is required, a Delaware First Health representative will notify the requestor of the specific information needed to complete the Authorization process.

Clinical Decisions

Delaware First Health ensures that all utilization management (UM) decisions are based solely on the appropriateness of care and services, as well as the existence of coverage. The organization does not incentivize providers or staff to deny services or care.

Delegated providers must also ensure that compensation structures for individuals or entities conducting UM activities do not encourage the denial, limitation, or discontinuation of medically necessary services. Clinical decisions regarding a member's care and treatment are the responsibility of the treating provider, in collaboration with the member.

Please note, failure to obtain prior authorization for services that require plan approval may result in denial of payment.

Review Criteria

Delaware First Health utilizes evidence-based utilization review criteria developed by McKesson InterQual®, the American Society of Addiction Medicine (ASAM), and the Delaware Department of Health and Social Services (DHSS), as applicable, to assess the medical necessity of healthcare services.

InterQual® criteria are developed by a national panel of specialists from both community-based and academic practices. These criteria address medical and surgical admissions, outpatient procedures, specialist referrals, and ancillary services. All medical criteria are established, reviewed, and updated periodically with appropriate physician involvement.

These criteria serve as clinical screening tools and are not intended to replace provider judgment. Final decisions regarding potential adverse determinations are made by the Medical Director or another qualified healthcare professional with appropriate clinical expertise in the member's condition. These decisions are based on accepted medical standards and take into account the unique circumstances of each case, which may warrant deviation from standard screening criteria.

Long-Term Services and Supports (LTSS), including all Home and Community-Based Services (HCBS), are authorized based on each member's specific needs. These needs are identified through a person-centered assessment and any relevant member encounters. This process helps determine the appropriate type, scope, and volume of services to be authorized for each individual.

Because each member's needs are unique, cases involving complex healthcare requirements may require additional input. In such instances, the member's community-based care manager will collaborate with the Delaware First Health Chief Medical Officer (CMO) and other identified members of the care team. Together, they will determine the services necessary to best support the member and ensure successful, member-driven outcomes.

Peer-to-Peer Review

Providers may request the specific criteria used in making an adverse benefit determination or initiate a peer-to-peer review with the Medical Director by contacting Delaware First Health Medical Management toll-free at 1-833-236-3360. Once a physician is informed of their right to request a peer-to-peer review, they have three (3) business days to initiate the review process.

Appealing an Adverse Benefit Determination

Members, their authorized legal representatives, or providers (with the member's written consent) may request an appeal related to an adverse benefit determination. Detailed instructions on how to file an appeal on behalf of the member are provided in the Grievances and Appeals Processes section of this Manual.

Second Opinion

Members may request a second medical opinion from a qualified provider within the Delaware First Health network. A healthcare professional may also make this request on the member's behalf, with the member's consent. If an appropriate in-network provider is not available to provide the second opinion, the member may obtain the second opinion from an out-of-network provider at no cost to the member.

Prior authorization is required from Delaware First Health for both in-network and out-of-network providers when performing second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon is determined by the nature of the procedure and the assistant surgeon's presence during the surgery. Hospital medical staff by-laws requiring an assistant surgeon for certain procedures do not, by themselves, justify reimbursement, as they may not meet the criteria for medical necessity.

Additionally, reimbursement is not guaranteed solely based on a patient's or family's request for an assistant surgeon unless medical necessity is clearly indicated.

New Technology

Delaware First Health reviews the inclusion of new technologies and new applications of existing technologies to determine coverage. This evaluation may include medical procedures, drugs, and devices. Relevant topics for review may be identified by the Medical Director and/or Medical Management staff based on the needs of the Delaware First Health member population. All requests for coverage are reviewed by the Clinical Policy Committee (CPC), which makes determinations regarding any necessary benefit changes.

To request a benefit determination for new technology or to initiate an individual case review, please contact Medical Management toll-free at 1-877-236-1341.

Concurrent Review and Discharge Planning

Concurrent Review Nurses conduct inpatient reviews either onsite or by phone, working with the hospital's Utilization and Discharge Planning departments, and when necessary, the member's attending physician. These reviews assess the member's current condition, treatment plan, and results of diagnostic tests or procedures to determine ongoing medical necessity and the appropriate level of care.

Decisions related to concurrent review are made within one (1) business day of receiving the required clinical information.

For length-of-stay extension requests, clinical documentation must be submitted by 3:00 p.m. CST on the day the review is due. Written or electronic notifications will include the number of approved service days and the date of the next review.

Routine, uncomplicated vaginal or cesarean deliveries do not require concurrent review. However, hospitals must notify Delaware First Health within two (2) business days of discharge, providing complete information about the delivery and the newborn's condition.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which Prior Authorization and/or timely notification to Delaware First Health was not obtained due to extenuating circumstances (i.e., member was unconscious at presentation, member did not have their Medicaid ID card, or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of request, not to exceed 90 calendar days from the date of service. Presumptive eligibility rules apply as follows:

- Outpatient Services (Ongoing)
  For outpatient services when services are already being received, services received prior to the date of notification may be retrospectively reviewed for medical necessity for up to five (5) calendar days if there are extenuating circumstances, dates prior to five (5) calendar days are administratively denied.
- Outpatient Services (Completed)
  Medical necessity reviews are conducted for outpatient post-discharge services (i.e., durable medical equipment) if notification is received within five (5) calendar days of the service date.

CLINICAL PRACTICE GUIDELINES

Delaware First Health's clinical and quality programs are guided by evidence-based preventive and clinical practice guidelines. Whenever possible, these guidelines are adopted from nationally recognized organizations, government institutions, statewide collaboratives, or consensus recommendations from healthcare professionals in the relevant field. Delaware First Health providers are expected to follow these guidelines. Adherence is evaluated at least annually as part of the organization's Quality Management Program.

Below is a sample of the clinical practice guidelines adopted by Delaware First Health:

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Healthcare
- 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

To view the most current clinical practice guidelines adopted by Delaware First Health, please visit our website at DelawareFirstHealth.com on the Clinical Practice Guidelines webpage. If you prefer a paper copy of the guidelines, you may request one by calling Provider Services toll-free at 1-877-236-1341.

PHARMACY

Delaware First Health administers pharmacy benefits through its Pharmacy Benefit Manager, Express Scripts. Coverage decisions are guided by the State of Delaware Preferred Drug List (PDL), which outlines medications covered under the pharmacy benefit and identifies those requiring Prior Authorization (PA).

Delaware First Health submits all proposed changes to pharmacy policies and procedures to the State for annual review and approval. Additionally, all pharmacy prior authorization and step therapy policies, along with their associated criteria, are submitted to the State for monthly review and prior approval. Any proposed changes to the pharmacy program must be submitted to the State and receive approval prior to implementation. Please visit the Delaware First Health Pharmacy webpage to view the state's current PDL and PA criteria.

Some members may have copayment or cost share when utilizing their prescription benefits. Please refer to the Delaware First Health Member ID card for information or call Delaware First Health at 1-877-236-1341.

Pharmacy Prior Authorizations

The State of Delaware PDL includes a wide range of brand-name and generic medications. Prescribers are encouraged to select medications from the PDL when treating Delaware First Health members. Delaware First Health does not permit therapeutic substitution of a prescribed drug or device by a pharmacist without explicit authorization from the licensed prescriber.

Some medications require Prior Authorization (PA) to be eligible for coverage. These include:

- Non-preferred medications
- Certain preferred medications listed on the PDL as requiring PA

Additionally, all non-preferred drugs not listed on either the PDL or PA list will require prior authorization. Requests can be submitted to Pharmacy Services via:

- CoverMyMeds
- Phone
- Fax

To ensure timely access to medications, Delaware First Health enforces a strict 24-hour turnaround time for processing PA requests.

CoverMyMeds (CMM)

Use of CoverMyMeds for Prior Authorization requests is strongly recommended, when possible, because it:

- Enables pharmacy-initiated requests to be completed electronically.
- Eliminates telephone calls, and faxes, saving time on determinations.
- Allows for renewal of previously submitted PA requests.
- Is secure and HIPAA compliant.

Submitting a Prior Authorization Request via CoverMyMeds

1. Visit covermymeds.com.
2. Log in to your account. If you're a new user, click Sign Up to create an account.
3. Once logged in, click New Request.
4. Enter the required patient and medication information including the following billing details.
   - BIN: 003858
   - PCN DSHP
   - RxGroup: 2ECA
5. Complete the request
6. Once reviewed, determination will appear in your CoverMyMeds account.

For support, please reach out to the CoverMyMeds call center toll-free at 1-866-452-5017. Their hours of operation are Monday – Friday: 8:00 AM – 11:00 PM EST and Saturday: 8:00 AM – 6:00 PM EST

Phone

- Prescribers may contact Pharmacy Services by phone to initiate a Prior Authorization at 1-833-236-1887.
- The Pharmacy Services Prior Authorization (PA) Help Desk is available 24 hours each day and staffed with PA Triage Specialists
  - Monday – Friday: 6:00 AM – 12:00 AM EST
  - Saturday –Sunday: 8:00 AM – 8:00 PM EST
- During regular business hours, licensed Clinical Pharmacists and Pharmacy Technicians are available to answer questions and assist providers.
- A nurse advice line is available to assist providers outside regular business hours.

Fax

- Prescribers may complete the Delaware First Health/Pharmacy Services Medication Prior Authorization Request form, found on the Delaware First Health website at DelawareFirstHealth.com on the Pharmacy webpage under Pharmacy Forms.
- Retail Prior Authorization requests, Fax 1 (844) 233-6130.
- Medical Pharmacy Prior Authorization requests, Fax 1 (833) 938-0826.

All prior authorization reviews are conducted using criteria established by the State of Delaware. Prescribers will be notified of the final determination via fax. If the submitted clinical information does not meet medical necessity criteria or authorization guidelines, the denial notification will include:

- The reason for the denial
- Preferred Drug List (PDL) alternatives, if applicable
- Instructions and information regarding the appeal process

Pharmacy Claim Submission

For members, Paper Claim submissions, send correspondence to:

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

Preferred Drug List (PDL)

Delaware First Health adheres to the State of Delaware Preferred Drug List (PDL) to determine medications that are covered under the Delaware First Health Pharmacy Benefit, as well as which medications may require Prior Authorization. Please visit the Delaware First Health website at DelawareFirstHealth.com on the Pharmacy webpage for a link to the state's current PDL and criteria.

The Preferred Drug List does not:

- Require or prohibit the prescribing or dispensing of any medication.
- Substitute for the independent professional judgment of the provider or pharmacist.
- Relieve the provider or pharmacist of any obligation to the member or others

The State of Delaware PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Medications requiring PA are listed with a notation throughout the PDL.

Compounds

For compounded medications, the prescription must be submitted to a local retail pharmacy. The pharmacy must process the claim through its point-of-sale (POS) system, flagging it as a compound and including all required details such as the ingredients, compounding method, and the medical justification for the formulation. Each ingredient must have an active and valid National Drug Code (NDC). In some cases, prior authorization must be obtained depending on the ingredients. If an ingredient is not covered, the pharmacy may suggest an alternative. The pharmacy and prescriber should work with the member to adjust or authorize the request as appropriate. Compounds that replicate a commercially available product are not eligible for reimbursement.

Pharmacy Copayments

Some Delaware First Health members will have a copay for prescription medications, based on the cost of the medication:

- $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

The most a member will pay for prescription copays in 30 calendar days is $15. Once the member reaches the $15 of accumulated prescription copays within this timeframe, copays are waived for the remainder of the month. The copays and the $15 copay threshold will start over on the next calendar month.

Members who are exempt for copays:

1. Children under the age of 21
2. Pregnant women, including the post-partum period (365 days)
3. Chronic Renal Disease Program (CRDP) members
4. Long-term care nursing facility group or the acute care hospital group
5. Family planning services and supplies
6. Hospice services
7. Naloxone opioid overdose rescue medications
8. Medication-Assisted Treatment (MAT) used for Opioid Use Disorder
9. Smoking cessation products
10. All immunizations that are recommended by the Advisory Committee on Immunization Practices (ACIP) are recommended

72-Hour Emergency Supply of Medications

Federal law permits the dispensing of a 72-hour supply of medication in emergency situations. Delaware First Health allows a 72-hour supply to be provided to members who are awaiting a prior authorization (PA) determination—unless the PA criteria specifically prohibit it. This policy is intended to prevent interruptions in ongoing therapy or delays in starting necessary treatment.

All participating pharmacies are authorized to dispense a 72-hour supply and will be reimbursed for both the ingredient cost and the dispensing fee, regardless of whether the PA request is ultimately approved or denied (unless PA criteria prohibit dispensing).

To process a 72-hour emergency supply, pharmacies must contact the Pharmacy Help Desk at 1-833-236-1887 for a prescription override. The help desk is available 24 hours a day, 7 days a week.

Newly Approved Products

New drugs that are approved by the FDA and listed on the CMS Labeler list will be evaluated by the Pharmacy and Therapeutics (P&T) Committee at its next scheduled meeting. Until reviewed by the P&T Committee, these medications will require Prior Authorization (PA) for coverage. If Delaware First Health does not approve the PA request, both the member and the prescriber will receive notification. This notification will include:

- The reason for the denial
- Information about the appeal process

Step Therapy

Some medications on the State of Delaware PDL require trial of specific drugs before coverage is approved. If Delaware First Health has a record of the required medication being used, coverage is automatic. If not, the member or prescriber may need to submit additional information.

If Prior Authorization is denied, both the member and prescriber will be notified with the reason and appeal instructions.

Benefit Exclusions

The following drug categories are not part of the Delaware First Health benefit and are not covered:

- Drugs or devices marketed by a manufacturer who does not participate in the Federal Medicaid Drug Rebate Program.
- Drug Efficacy Study Implementation (DESI) drugs
- Fertility drugs
- Investigational/experimental drugs
- Drugs not approved by the FDA
- Compound prescriptions that do not contain at least one Formulary/FDA-approved covered ingredient
- Drugs used for treatment of sexual or erectile dysfunction
- Drugs to promote weight gain not due to AID wasting or cachexia
- Drugs not medically necessary
- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence

DESI drugs products and known related drug products are defined as less than effective by the FDA because there is a lack of substantial evidence of effectiveness for all labeling indications and because a compelling justification for their medical need has not been established.

Dispensing Limits, Quantity Limits and Age Limits

- Retail Dispensing Limits: Most medications are limited to a 34-day supply. However, some contraceptives and maintenance drugs may be dispensed in up to a 100-day supply.
- Quantity and Age Limits: Certain medications have Quantity Limits (QL) or Age Limits (AL). Dispensing beyond these limits requires Prior Authorization (PA).
- Age Restrictions: Some drugs listed on the State of Delaware Preferred Drug List (PDL) have age limits

based on FDA-approved labeling, safety concerns, and clinical standards of care.
- Exceptions: During the PA review, exceptions may be considered for medically necessary treatments.

Delaware First Health may restrict the amount of medication dispensed at one time. If a prescriber believes a larger quantity is medically necessary, they may request a PA. If the PA is not approved, both the member and prescriber will be notified and provided with appeal process information.

Over The Counter Medications (OTC)

Delaware First Health's pharmacy program covers approved over-the-counter (OTC) medications listed on the State of Delaware Preferred Drug List (PDL). Some OTC medications may require prior authorization before they can be dispensed. In order to be reimbursed, all OTC medications must be prescribed by a licensed physician and written on a valid prescription. For a complete list of covered OTC products, members and providers should refer to the State of Delaware PDL. The PDL and criteria may be accessed through the link provided on the Delaware First Health website at DelawareFirstHealth.com on the Pharmacy webpage for a link to the state's current PDL and criteria.

Over-the-Counter Enhanced Benefit

Members are eligible to receive additional over-the-counter (OTC) items through a quarterly household benefit of up to $120 annually. To view the list of eligible items and how they may be ordered, please visit the Value Added Benefits webpage at DelawareFirstHealth.com.

Pharmacy and Prescriber Lock-In

Delaware First Health administers a Pharmacy Lock-In Program, approved by the State of Delaware, to help manage medication utilization and promote safe prescribing practices. This program restricts certain members to using a single designated participating pharmacy and/or a single prescriber for filling their prescriptions.

Purpose and Eligibility

The program is designed to support members who may benefit from more closely managed medication access. This includes, but is not limited to:

- Members with complex drug regimens who see multiple providers.
- Members suspected of misusing benefits, such as seeking duplicate or inappropriate prescriptions—especially for controlled substances.

Members may be identified for the program through data analysis, provider referrals, or State referrals.

Enrollment and Member Notification

Before a member is placed in the lock-in program, Delaware First Health will:

- Notify the member of the intent to enroll them in the program.
- Provide access to the Grievance process, which allows the member to request a review of their lock-in status at the time of enrollment and annually thereafter.

Program Coordination and Exceptions

A member may be enrolled in both the Pharmacy Lock-In Program and the Primary Care Provider (PCP) Lock-In Program simultaneously (see PCP Lock-In section for additional details).

If the designated pharmacy is unable to provide a member's prescribed medically necessary drugs or devices, Delaware First Health will allow the member to obtain those items from another participating pharmacy provider.

Delaware Prescription Monitoring Program

The State of Delaware requires participating providers to comply with the requirements of the Delaware Prescription Monitoring Program (PMP), to query the PMP to view information about client usage before prescribing Schedule II or III controlled substances, and to document the results of the query in the member's record.

For more information on the State required Prescription Monitoring Program, visit dpr.delaware.gov/boards/pmp.

340B Discount Drug Program

To participate in the Delaware Diamond State Health Plan and Diamond State Health Plan Plus Medicaid programs, providers must be enrolled with the State and contracted with Delaware First Health, and Pharmacies also need to be contracted with Express Scripts.

340B pharmacy claims must include the following Submission Clarification Code (SCC) which identifies the Pharmacy claim as a 340B claim and subsequently allows Delaware First Health to report 340B claims to the State:

- NCPDP Field: 420-DK, 340B Identifier, enter "20"

Pharmacy reimbursements will reflect the lower cost of drugs purchased through this program.

MANDATORY PROVIDER DMAP ENROLLMENT

The Delaware Medical Assistance Program (DMAP) has developed processes to screen current and prospective Managed Care Organization (MCO) providers according to the Centers for Medicare & Medicaid Services (CMS) guidelines in compliance with 42 CFR § 438.602 and 42 CFR Part 455, subparts B and E and the 21st Century Cures Act. Screening is conducted according to provider risk levels and includes additional disclosure requirements. Provider screening is required at initial enrollment, reenrollment, revalidation, and when adding or changing service locations.

Effective March 1, 2022, all providers who wish to contract with a Delaware MCO are required to enroll with DMAP prior to contracting and credentialing with the MCO. Any current provider already contracted with a Delaware MCO must follow instructions for enrollment as set forth in their DMAP letter. Please note, failure to enroll with DMAP will make a provider ineligible to contract with Delaware First Health and receive payment.

Providers can refer to the DMAP Portal for additional information regarding the mandatory enrollment process.

CREDENTIALING AND RE-CREDENTIALING

Overview

The purpose of the credentialing and re-credentialing process is to help make certain that Delaware First Health maintains a high-quality healthcare delivery system. The credentialing and re-credentialing process helps achieve this by validating the professional competency and conduct of our providers. This includes verifying licensure, board certification, education, and identification of adverse actions, including malpractice or negligence claims and/or criminal charges, through the applicable state and federal agencies and the National Practitioner Data Base. Criminal background check is conducted through use of Background Check Center (BCC) from DHSS.delaware.gov. Network providers must meet the criteria established by Delaware First Health, as well as government regulations and standards of accrediting bodies.

Delaware First Health requires re-credentialing of providers other than HCBS providers every three (3) years because it is essential to maintain current provider professional information. This information is also critical for Delaware First Health's members, who depend on the accuracy of the information in its provider directory. Delaware First Health recredentials or verifies participation criteria for HCBS providers annually.

Note: In order to maintain a current provider profile, providers are required to notify Delaware First Health of any relevant changes to their credentialing information in a timely manner.

Which Providers Must Be Credentialed?

The following providers are required to be credentialed:

Medical Practitioners

- Medical doctors
- Chiropractors
- Osteopathic doctors
- Podiatrists
- Nurse Practitioners
- Physician Assistants
- Other medical practitioners

Behavioral Health Practitioners

- Psychiatrists and other Physicians
- Addiction Medicine Specialists
- Doctoral or Master's-Level Psychologists
- Master's-Level Clinical Social Workers
- Master's-Level Clinical Nurse Specialists or Psychiatric Nurse Practitioners

- Other behavioral healthcare specialists

Facility and Other Providers

- Hospitals, Home Health agencies, skilled nursing facilities, FQHCs, Rural Health Clinics (RHCs), laboratory testing/diagnostic facilities, urgent care centers, rehabilitation centers and free- standing surgical centers;
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or in an ambulatory setting; and
- Other atypical LTSS providers including HCBS and Long-Term Care (LTC) institutional-based services providers.

Information Provided at Credentialing

All new providers and those adding providers to their current practice must be enrolled through the DMAP and submit at a minimum the following information when applying for participation with Delaware First Health:

- Completed, signed, and dated Delaware State Universal Practitioner Credentialing Application that is no older than 365 days, or
- Practitioners can authorize Delaware First Health to access their information on file with the Council for Affordable Quality Healthcare (CAQH) at: www.CAQH.org
- Current malpractice insurance coverage detailed on the credentialing application or a copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with applicable Delaware regulations regarding malpractice coverage or alternate coverage
- Copy of current Drug Enforcement Administration (DEA) registration Certificate, if applicable
- Copy of current Delaware Controlled Substance registration certificate, if applicable
- Completed and signed W-9 form
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history (not required if work history is completed on the application)
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable

All providers (Hospital, Facility, or Group, Clinic or Ancillary Provider) when applying for participation or recredentialing with Delaware First Health must be enrolled through the DMAP and submit:

- Completed, signed, and dated Delaware First Health Facility Application with attachments required that is no older than 365 calendar days.
- Copy of State Operational License
- Copy of Accreditation Certificates (by a nationally recognized accrediting body, e.g., TJC/JCAHO), if applicable

- If not accredited, a copy of provider's most recent state or CMS survey, including response to any corrective actions, and response from surveyor recognizing corrective action taken by provider
- Completed and signed W-9 form
- Other applicable State/Federal/Licensures (e.g., CLIA, DEA, Pharmacy, or Department of Health)
- Complete and current roster (in an approved Delaware First Health format) or CAQH data form for each practitioner employed by the provider
- Current malpractice insurance coverage detailed on the credentialing application or a copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with applicable Delaware regulations regarding malpractice coverage or alternate coverage
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)

All Home & Community Based Service (HCBS) Providers when applying for participation or recredentialing with Delaware First Health must be enrolled through the DMAP and submit:

- Completed, signed, and dated Delaware First Health HCBS Waiver Provider Application
    - For Consumer Directed Attendant Care (CDAC) Agency only: Completed Delaware First Health Provider Attestation Statement
- Copy of Certificate and/or Licensures, as applicable
- Other applicable State/Federal/Licensures (e.g., CLIA, DEA, Pharmacy, or Department of Health)
- Current malpractice insurance coverage detailed on the credentialing application or a copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with applicable Delaware regulations regarding malpractice coverage or alternate coverage only when required pursuant to state HCBS Waiver Provider requirements or applicable Provider licensing requirements
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage) that meets the minimum required amount set by the state of Delaware as applicable to the services each HCBS waiver provider is contracting to provider
- Independent HCBS Employees must be at least 18 years of age, have the skills necessary to perform the required services, possess a valid Social Security number and must be willing to submit to a criminal background check.

Credentialing Process

Once Delaware First Health receives an application, the following information is verified, at a minimum, submitted as part of the Credentialing process (please note that this information is also re-verified as part of the re-credentialing process):

- Current enrollment in the Delaware Medicaid Program
- A current Delaware license through the appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions

- Hospital privileges in good standing or alternate admitting arrangements
- Five-year work history
- Social Security Death Master File
- Federal and state sanctions and exclusions including the following sources:
    a. Office of Inspector General (OIG)
    b. The System for Award Management (SAM)
    c. Medicare Opt-Out Listing
    d. Delaware List of Excluded Individuals/Entities
    e. DHSS Background Check Center – Quick Background Check

Once the application is complete, the Delaware First Health's Credentialing Committee renders a final decision on acceptance following its next regularly scheduled meeting.

Credentialing Committee

The Credentialing Committee is responsible for establishing and adopting as necessary, criteria for provider participation. It is also responsible for terminating and directing the credentialing procedures, including provider participation, approval, denial, and termination. Delaware First Health will ensure that credentialing of all providers applying for network participation status shall be completely processed within 45 calendar days following the receipt of a complete credentialing/recredentialing file. The start time begins when all necessary credentialing materials, including all necessary documents and attachments have been received and verified. Completely process means that Delaware First Health shall review, approve, and add approved applicants to its claims processing system; or deny the application and notify the provider of the denial decision and advise that the provider not be used for care of Delaware First Health members.. Providers must be credentialed prior to accepting or treating members unless Prior Authorization has been obtained. PCPs cannot accept member assignments until they are fully credentialed.

Site visits are performed at provider offices within thirty (30) days of identification of one (1) or more member complaints related to physical accessibility, physical appearance, and/or adequacy of waiting and examination room space (the Plan has up to sixty (60) days to complete the site visit if necessary). If the provider's site visit score is less than eighty (80%) percent, the provider may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices, and safety procedures.

Credentialing Committee meetings are held monthly, no less than ten (10) times/year and more often as deemed necessary.

Note: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Re-Credentialing

To comply with accreditation standards, Delaware First Health re-credentials providers at least every 36 months from the date of the initial credentialing decision (HCBS providers are recredentialed or participation criteria verified annually). The purpose of this process is to identify and update any changes in the provider's licensure, sanctions, certification, competence, or health status that may affect his/her ability to perform services in accordance with the Participating Provider Agreement (PPA). This process includes all providers, PCPs, specialists, ancillary services /facilities previously credentialed to practice within the Delaware First Health network.

In between credentialing cycles, Delaware First Health conducts ongoing monitoring activities of all participating network providers. This includes monthly inquiries to the appropriate state licensing agency to identify newly disciplined providers and providers with a negative change to current licensure status. These inquiries confirm providers are maintaining a current, active, unrestricted license to practice at all times. Additionally, Delaware First Health reviews monthly reports including Social Security Administration's Death Master File (DMF), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals & Entities (LEIE), the System for Award Management (SAM), the OIG, and Medicare Opt-Out to monitor network providers who have been newly sanctioned or excluded from participation in federal and state programs.

Loss of Network Participation

A provider's agreement may be terminated at any time if Delaware First Health Credentialing Committee determines that the provider no longer meets the credentialing requirements.

Upon notification from the from the Regulatory agencies/State licensing board that a provider with whom Delaware First Health has entered into an agreement is suspended or terminated from participation in the Medicaid or Medicare Programs, Delaware First Health will immediately act to terminate the provider from participation. Terminations for loss of licensure and criminal convictions will coincide with the effective date of the action.

Right to Review and Correct Information

All providers participating within the Delaware First Health network have the right to review information obtained by the health plan that is used to evaluate providers' credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review peer review-protected information such as references, personal recommendations, or other information. To request release of such information, a provider must submit a written request to Delaware First Health's Credentialing Department at:

Delaware First Health
Credentialing Manager
7700 Forsyth Boulevard
St. Louis, MO 63105

Should a provider identify any erroneous information used in the credentialing/re-credentialing process, or should any information gathered as part of the primary source verification process differ from what the provider submitted, the provider has the right to correct any erroneous information reported by another agency.

Upon receipt of this information, he/she has thirty (30) days to submit a written explanation detailing the error or the difference in information. The Delaware First Health Credentialing Committee will then add this disputed documentation to the credentialing/re-credentialing file.

Right to Be Informed of Application Status

All providers who have submitted an application to join Delaware First Health have the right to be informed of the status of their application upon request. To obtain status, contact your Provider Engagement Account Manager (PEAM) toll-free at 1-877-236-1341.

Right to Appeal Adverse Credentialing Determinations

Delaware First Health may decline an existing provider applicant's continued participation for reasons such as quality of care or liability claims issues. In such cases, the provider has the right to request reconsideration of denial decisions by submitting written notice thirty (30) days of receipt of the formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the Delaware First Health network. The Credentialing Committee will review the documentation submitted at its next regularly scheduled meeting, but in no case later than sixty (60) calendar days from the receipt of the submitted information. Delaware First Health will send a written notice of the Credentialing Committee's decision to the provider's request within two weeks of the following final decision. A written request for reconsideration should be sent to:

Delaware First Health
Credentialing Manager
7700 Forsyth Blvd.
St. Louis, MO 63105

Further, and in accordance with Delaware Code sections 17A.4 through 17A.8, a provider has the right to appeal Delaware First Health's decision and request a state fair hearing.

MEMBER AND PROVIDER RIGHTS AND RESPONSIBILITIES

Member Rights

Delaware First Health expects providers to respect and honor members' rights, including the right to:

- Receive information about Delaware First Health, its services, its providers.
- Be treated with respect and with due consideration for his or her dignity and privacy, including but not limited to the right to fully participate in the community and to work, live and learn to the fullest extent possible.
- Receive information on available treatment options and alternatives that are presented in a manner that the

member is able to understand.

- Participate in decisions about their healthcare. This includes the right to refuse treatment.
- A right to get care right away for an Emergency Medical Condition.
- A right to decide about their healthcare and to give permission before the start of diagnosis, treatment, or surgery.
- Request and receive a copy of his or her medical records, and to request that they be amended or corrected.
- A right to have the personal information in medical records kept private.
- A right to report any complaint or grievance about a provider or their medical care.
- A right to file an appeal of an action that reduces or denies services based on medical criteria.
- A right to express a concern or appeal to the Ombudsman's office.
- A right to receive interpretation services.
- A right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- A right to not be discriminated against due to race, color, national origin or health status or the need for healthcare services.
- A right to request a second opinion.
- A right to be notified at the time of enrollment and annually of disenrollment rights.
- A right to make an Advance Directive and to file a complaint with the Delaware DHSS if they feel it is not followed.
- A right to choose a provider who gives care whenever possible and appropriate.
- A right to receive accessible healthcare services equivalent in amount, duration, and scope to those provided under Medicaid FFS and sufficient in amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished
- A right to receive appropriate services not denied or reduced solely because of diagnosis, type of illness or medical condition.
- Freedom to exercise the rights described herein without any adverse effect on the treatment by the Delaware Department of Health and Social Services, Delaware First Health, its providers, or contractors.
- A right to receive all written member information from Delaware First Health:
    - At no cost to the member.
    - In the prevalent non-English languages of members in the service area.
    - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- A right to receive oral interpretation services free of charge for all non-English languages, not just those identified as "prevalent" and how to access them.
- A right to get help from both Delaware Department of Health and Social Services and its Enrollment Broker in understanding the requirements and benefits of Delaware First Health.

Member Responsibilities

Members have certain responsibilities to:

- Inform Delaware Department of Health and Social Services of changes in family size.
- Inform Delaware Department of Health and Social Services if the member moves out of the Region, out-of-state or have other address changes.
- Inform Delaware First Health if the member obtains or has health coverage under another policy, other third party, or if there are changes to that coverage.
- Allow Delaware First Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.
- Take actions toward improving their own health, their responsibilities and any other information deemed essential by Delaware First Health.
- Keep appointments and follow-up appointments.
- Access preventive care services.
- Receive Information on any of cost-sharing responsibilities.
- Learn about Delaware First Health coverage provisions, rules, and restrictions.
- Choose a PCP.
- Treat providers and staff with dignity and respect.
- Inform Delaware First Health of the loss or theft of a member ID card.
- Present member ID card(s) when using healthcare services.
- Call or contact Delaware First Health to obtain information and have questions clarified.
- Provide providers with accurate and complete medical information.
- Follow prescribed treatment of care recommended by a provider or let them know the reason(s) treatment cannot be followed, as soon as possible.
- Ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives and make care decisions after weighing all factors.
- Understand health problems and participate in developing mutually agreed upon treatment goals with their provider to the highest degree possible.
- Make their PCP aware of all other providers who are treating them. This is to ensure communication and coordination in care. This also includes Behavioral Health Providers.
- Follow the grievance process established by Delaware First Health (and as outlined in the Member Handbook) if there is a disagreement with a provider.

Provider Rights

Delaware First Health providers have the right to:

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments.
    - Provide information about treatment options.
    - Provide information about the availability of alternative treatment options, therapies, consultations,

and/or tests, including those that may be self-administered.
    - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment, as well as the benefits of such treatment options.
- Be treated by their patients and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical histories for members' care.
- Have their patients act in a way that supports the care given to other patients and does not interfere with their operations.
- Expect other network providers to act as partners in members' treatment plans.
- File a dispute with Delaware First Health regarding payment issues and/or utilization management, or a general complaint with Delaware First Health and/or a member.
- File a grievance or an appeal with Delaware First Health on behalf of a member, with the member's written consent.
- Have access to information about Delaware First Health Quality Management/Quality Improvement (QM/QI) programs, including program goals, processes, and outcomes that relate to member care and services.
- Contact Delaware First Health Provider Services at 1-877-236-1341 with any questions, comments, or problems.
- Collaborate with other healthcare professionals who are involved in the care of members.
- Not to be discriminated against by Delaware First Health based solely on any characteristic protected under state or federal non-discriminate laws. Delaware First Health does not, and has never had a policy of terminating a Provider who:
    - Advocated on behalf of a member
    - Filed a complaint against us
    - Appealed a decision of ours
- Not be discriminated against by Delaware First Health in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. This does not require Delaware First Health to contract with providers beyond the number necessary to meet the needs of members, preclude Delaware First Health from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude Delaware First Health from establishing measures that are designed to maintain quality of services and control costs, or consistency with responsibilities to members.
- Not be discriminated against for serving high-risk populations or specializing in the treatment of costly conditions; for filing a grievance on behalf of and with the written consent of a member or helping a member to file a grievance; for protesting a plan decision, policy or practice the healthcare provider believes interferes with his/her ability to provide medically necessary and appropriate healthcare.
- Not be discriminated against based on any of the following: race/ethnicity, color, national origin, gender, age, lifestyle, disability, religion, sexual orientation, specialty/licensure type, geographic location, patient type in which the practitioner specializes, financial status, or based on the providers association with any member of the aforementioned protected classes.

Provider Responsibilities

Delaware First Health providers have the responsibility to:

- Treat members with fairness, dignity, and respect.
- Not discriminate against members based on 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.
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA guidelines.
- Allow members to request restrictions on the use and disclosure of their personal health information.
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records, and the ability to request the record be amended or corrected as specified in 45 CFR §164.524 and §164.526.
- 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.
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- Allow a member who refuses or requests to stop treatment the right to do so, if they understand that by refusing or stopping treatment, the condition may worsen or be fatal.
- 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.
- Participate in Delaware First Health data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- Review clinical practice guidelines distributed by Delaware First Health.
- Comply with Delaware First Health Medical Management program as outlined in this handbook.
- Disclose overpayments or improper payments to Delaware First Health.
- Timely and proactively manage accounts receivable, including prompt review of payments and EOP to identify discrepancies and, if applicable, take prompt action within the timelines outlined in this Provider Manual to dispute, request reconsideration, and/or appeal within timelines outlined in this Provider Manual.
- Not deny services to a member due to inability to pay the copayment if the household income is at or below 100% Federal Poverty Level (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 information regarding member's other insurance coverage to Delaware First Health.
- Notify Delaware First Health in writing and in accordance with the Participating Provider Agreement (PPA) of changes to provider data at least 30 days prior to the effective date, when possible. Additionally, all providers shall provide at least 60 days' written notice of the addition of providers and any changes (e.g., if the provider is leaving or closing a practice).
- Update provider data, 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.
- Contact Delaware First Health to verify member eligibility and/or coverage prior to rendering services.,
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems they may have and to develop mutually agreed upon treatment goals, to the extent possible.
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and language services, 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.
- Coordinate and cooperate with other service providers who serve Medicaid members, such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships, and school-based programs as appropriate.
- Object to providing relevant or medically necessary services based on the provider's moral or religious beliefs or other similar grounds.
- Disclose to Delaware First Health, on an annual basis, any Physician Incentive Plan (PIP) or risk arrangements the Provider or Provider Group may have with providers either within its group practice or other providers not associated with the group practice even if there is no substantial financial risk between Delaware First Health and the provider or provider group.
- Provide services in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the Participating Provider Agreement.
- Allow Delaware First Health direct access (not via vendor) to medical records for data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.
- Review and follow clinical practice guidelines distributed by Delaware First Health.
    - Document Medical chart with up to three (3) outreach attempts via phone to Members who have not completed an office visit in the past twelve (12) months or more.
    - Have been discharged from an impatient stay within the last twenty-four (24) hours since notification.
    - Have a gap-in-care overdue by thirty (30) days.
- Develop a reporting system based on Delaware First Health specification to submit monthly clinical data feed from the Electronic Medical Record (EMR) system within one year of enrolling in the Delaware First Health Provider Network.
- Comply with Delaware Risk Adjustment program requirements by utilizing complete and accurate diagnosis coding and reporting according to the ICD-10-CM coding guidelines.
- Report all suspected physical and/or sexual abuse and/or neglect.
- Report Communicable Disease to Delaware First Health.

- Delaware First Health must work with DHSS State and District Office epidemiologists in partnership with the designated county or municipal health department staff to appropriately report reportable conditions.

MEMBER GRIEVANCE AND APPEALS PROCESSES

A member, a member's authorized representative, or a member's provider (with written consent from the member), may file an appeal or grievance either verbally or in writing.

Delaware First Health gives members reasonable assistance in completing all forms and taking other procedural steps of the appeal and grievance process, including, but not limited to, providing translation and interpreter services, communication in alternative languages, braille, and toll-free numbers with TTY/TDD and interpreter capability.

Grievances

Grievances are defined as any expression of dissatisfaction about any matter, excluding an adverse benefit determination, provided to Delaware First Health by a member or their authorized representative. Examples of grievances include, but are not limited to, complaints regarding the quality of care or service provided such as:

- Unclear and inaccurate information from staff
- Quality of care or services provided to a member
- Rudeness of a provider or employee
- Failure to respect a member's rights
- Harmful administrative processes or operations
- Disagrees with the decision to extend an appeal timeframe

Delaware First Health is committed to resolving member concerns respectfully and fairly. Filing a grievance will not result in retaliation or affect how a member is treated. All members will continue to receive the same quality of care and service, regardless of whether they file a grievance.

How to File a Grievance

A member may file a grievance at any time by doing one of the following:

- Phone: Reach out to Member Services toll-free at 1-877-236-1341 (TDD/TTY: 711).
- Fax: 1-844-273-2671
- Mail: Within the written correspondence, be sure to include the following:
    - Member first and last name
    - Member Medicaid ID number
    - Member address and telephone number
    - Member's complaint about why they are unhappy
    - What the member would like to happen to resolve the complaint

Please issue the complete submission to:

Delaware First Health
ATTN: Appeals & Grievances
PO Box 10353
Van Nuys, CA 91410-0353

Grievance Acknowledgement and Representation

Delaware First Health will send a written acknowledgment within five (5) business days of receiving a grievance.

If someone files a grievance on behalf of a member, they must have written permission from the member—unless they are the member's legally authorized representative. This permission is granted by submitting the Member Grievance Form, which is available on DelawareFirstHealth.com under Member Forms. Alternatively, you may get assistance by contacting Member Services by phone at 1-877-236-1341. The completed form can be returned by mail or fax. Member Services can also assist with this process.

Members may submit additional supporting information with their grievance. They may also request, at no cost, copies of any documents Delaware First Health used to make a decision. Grievances will be resolved as quickly as the member's condition requires, and a resolution notice will be sent within 30 calendar days of receipt.

Appeals

An appeal is a request for Delaware First Health to review a decision that denies, limits, reduces, or stops a member's benefits or services. Appeals can be filed by the member, a parent or guardian of a minor, or an authorized representative with written consent from the member.

Appeals may be submitted verbally or in writing within 60 calendar days from the date on the Notice of Adverse Benefit Determination.

Members may request free copies of any documents used in the decision-making process, including their medical records. Filing an appeal will not affect how the member or their provider is treated—Delaware First Health does not retaliate or discriminate based on appeal activity.

How to File an Appeal

Members may file a medical or behavioral health appeal by doing one of the following:

- By Phone: Call Member Services toll-free at 1-877-236-1341 (TDD/TTY: 711).
- By Mail: Please submit medical appeals by mail to:

Delaware First Health
ATTN: Medical Appeals
PO Box 10353
Van Nuys, CA 90410-0353

- In-person: Please visit the Delaware First Health local office and request the Appeals department at the below address:

Delaware First Health
750 Prides Crossing
Suite 200
Newark, DE 19713

For Behavioral Health Member Appeals, send by mail to:

Delaware First Health
ATTN: Member Appeals (Behavioral Health)
13620 Ranch Road 620
N, Bldg. 300C
Austin, TX 78717

Appeals Acknowledgement and Representation

When a member submits an appeal—whether by phone, in writing, or electronically—Delaware First Health will send an acknowledgment letter within five (5) business days of receiving the appeal.

We aim to resolve appeals promptly. An appeal resolution letter will be sent within thirty (30) calendar days of receiving the appeal request. If additional time is needed to gather information, we may extend the resolution timeframe by up to fourteen (14) calendar days. In such cases, and with approval from the State, we will notify the member verbally and follow up with a written explanation within two (2) calendar days.

Members may also request an extension. To do so, please contact Member Services toll-free at 1-877-236-1341 (TDD/TTY: 711).

If the appeal is being submitted by an authorized representative, the authorization may be granted by completing the Member Appeal Form. This must be completed and received within sixty (60) days of the date on the Adverse Benefit Determination notice.

After we receive a member's call, written, or electronic appeal, we will send a letter within five (5) business days of receipt of the appeal acknowledging the appeal has been received.

Continuation of Benefits During the Appeal Process

Members may request that services continue while Delaware First Health reviews their appeal. If the appeal is not resolved at the first level and escalates to a State Fair Hearing, services may also continue during that process. To request continued services, members must contact us within ten (10) calendar days from the date on the Adverse Benefit Determination notice.

NOTE: If the final decision from the appeal or State Fair Hearing is not in the member's favor—meaning Delaware First Health's original decision is upheld—we may recover the cost of any services provided during the appeal and hearing process.

Expedited Appeal Decisions

If a member's health or ability to function is at immediate risk, an expedited appeal may be requested. This request can be made verbally and does not require written documentation or member consent.

Delaware First Health will review expedited appeals as quickly as the member's condition requires, and no later than 72 hours after receiving the request. To request an expedited appeal, call 1-877-236-1341 (TDD/TTY: 711). We will make reasonable efforts to notify both the requestor and the member of the decision verbally.

If Delaware First Health denies the request for expedited review, we will notify the member verbally within 24 hours. A written notice will follow within two (2) calendar days, explaining:

- That the appeal will be processed under the standard 30-calendar-day timeframe;
- The member's right to file an expedited grievance if they disagree with the decision, including instructions and timelines;
- The member's right to resubmit the expedited appeal request. If a provider supports the request and indicates that using the standard timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function, the request will be expedited automatically.

If the member's health or function is at immediate risk, an expedited appeal may be requested. A request may be submitted verbally and does not require a written request or member consent.

State Fair Hearings

If a member is not satisfied with Delaware First Health's appeal decision, they have the right to request a State Fair Hearing. However, members must first complete Delaware First Health's internal appeal process before requesting a hearing. If Delaware First Health does not issue a decision within 30 calendar days, the appeal process is considered exhausted, and the member may proceed directly to request a State Fair Hearing. Members have ninety (90) calendar days from the date on the appeal decision notice to request a hearing. They may also request that their services continue during the State Fair Hearing process.

A State Fair Hearing can be requested by the member or their authorized representative through any of the following methods:

- Online: Delaware DHSS Fair Hearing webpage
- In person: Visit a local office of the Delaware Department of Health and Social Services
- By phone: Call the Division of Medicaid & Medical Assistance (DMMA)
- In writing: Submit requests to:

Division of Medicaid & Medical Assistance (DMMA)
Fair Hearing Officer
1901 North DuPont Highway
P.O. Box 906, Lewis Building
New Castle, DE 19720

If you need help filing a State Fair Hearing request or want to file it by telephone, please contact the Delaware Division of Medicaid & Medical Assistance (DMMA) at 1-302-255-9500 or 1-800-372-2022.

PROVIDER INQUIRIES, CLAIMS RECONSIDERATION, CLAIMS CORRECTION AND ADJUSTMENTS, AND APPEALS

A provider can inquire on the status of the claim at any time via the provider portal or calling Provider Services.

Verbal Inquiry

To check the status of a previously submitted claim, call the Delaware First Health Provider line at 1-877-236-1341. The provider call center can be reached from 8 a.m. to 5 p.m., Monday through Friday.

Be sure to have the following information on hand:

- Servicing provider's name
- Member ID number
- Member name
- Member date of birth
- Date of service
- Claim number, if applicable

Claims Reconsideration Requests (Non-Clinical)

For claims that do not require any corrections or changes to the originally billed information, providers may submit a request for reconsideration regarding the claim's payment. This applies to issues unrelated to medical necessity determinations, such as receiving a payment amount that is less than expected.

Note: A reconsideration request must be submitted before initiating a formal claim appeal.

To submit a request, providers may use one of the following methods:

- Phone: Contact Provider Services at 1-877-236-1341
- Online: Use the provider portal
- Mail: Send a written request to:

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

Deadline:
Requests must be received within 90 days of the date on the Explanation of Payment (EOP) or denial notice, unless otherwise specified in the provider's contract with Delaware First Health.

Once the request is received, a representative will review the payment. If appropriate, they will either:

- Request reprocessing of the claim, or
- Advise the provider to resubmit the claim as a corrected claim

Corrected Claim Submission Guidelines

A provider may submit a corrected claim to address billing errors in the original claim submission. Corrected claims are not considered appeals and must be received within 90 days of the date on the Explanation of Payment (EOP), unless otherwise specified in the provider's contract with Delaware First Health.

Submission Requirements

For CMS-1500 (Professional Claims):

- Use resubmission code "7" in Field 22 of the paper claim.
- Include the original claim number.
- For EDI 837P submissions:
    - Use Loop 2300, Segment CLM05 with a value of "7".
    - Include Loop 2300, Segment REFF8 with the original claim number.

For UB-04 (Institutional Claims):

- Use resubmission code "7" in the third digit of the bill type.
- Include the original claim number in Field 64 of the paper claim.
- For EDI 837I submissions:
    - Use Loop 2300, Segment CLM05 with a value of "7".
    - Include Loop 2300, Segment REFF8 with the original claim number.

Important: Missing or incorrect data elements may result in:

- Denial as a duplicate claim
- Processing delays
- Denial for exceeding the filing limit

Submission Methods

Online Submission:
Corrected or adjusted claims can be submitted via the provider portal.
To access this feature, providers must register by accessing the Secure Provider Portal Login page on the Delaware First Health website.

Paper Submission:
Send corrected or adjusted paper claims to:

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

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

Claims Overpayment Reporting

If a provider receives more payment than expected for a claim, they are required to:

- Report and return the overpayment within 60 days of discovering it.
- Notify Delaware First Health in writing, including the reason for the overpayment.

Delaware First Health will initiate recoupment of the overpaid amount as outlined in its policies.

Coordination of Benefits (COB) Claims

If the overpayment involves Coordination of Benefits (COB):

- Include a copy of the other insurance's Explanation of Payment (EOP).
- Provide a description of the processing codes.
- Send this documentation to the Delaware First Health Claims Department.

Returning Overpayments

If you are returning an uncashed Delaware First Health check, mail it to:

Delaware First Health
ATTN: Returned Checks
P.O. Box 8001
Farmington, MO 63640-3001

If you prefer to refund the overpayment using your own check stock, include a copy of the EOP and mail it to:

Delaware First Health
P.O. Box 8001
Farmington, MO 63640-3001

For Behavioral Health claims, send the refund and documentation to:

Delaware First Health
ATTN: Behavioral Health Claims
P.O. Box 8001
Farmington, MO 63640-3001

Claims Adjudication and Code Auditing Review Requests

Delaware First Health uses a claims adjudication software to automate coding verification and ensure claims are processed in accordance with general industry standards. If a claim is denied due to code auditing, providers may request a re-evaluation of the denial. While the most commonly audited codes are listed separately, this list is not all-inclusive.

EX Code List									
x1	x2	x3	x4	x5	x6	x7	x8	x9	xa
xB	xc	xD	xE	xf	xg	xh	xo	xp	xq
xr	xy	ya	yd	ye	yQ	ys	yu	57	58

Providers must follow the steps below to request a reconsideration of a claim through medical review:

Submission Requirements

- Submit the request in writing within 90 days of the Explanation of Payment (EOP) date, or as defined in your Delaware First Health provider contract.
- Include a copy of the EOP showing how and when the claim was processed.
- Provide supporting documentation, such as:
    - Patient's medical records
    - Chart notes
    - Any other relevant information that supports the reconsideration request

Mailing Address:

Please send all documentation to:

Delaware First Health
ATTN: Medical Review
P.O. Box 8001
Farmington, MO 63640-3001

Non-Clinical Claim Appeal Process

If a provider disagrees with a non-clinical reconsideration decision, they may submit a formal claims appeal. A timely claim reconsideration request must be submitted before initiating an appeal.

To submit a non-clinical claims appeal, the provider must:

- Complete the Claim Appeal Form, available on the Delaware First Health website.
- Submit the completed form and supporting documentation in writing to the address below.
- Ensure the appeal is received within 120 days of the date of service, or within 60 calendar days after the reconsideration decision—whichever is later.
- Clearly mark the request as an "Appeal."
- Provide a specific explanation of why the claim or issue merits reconsideration.
- Include a copy of the claim in question and the EOP showing how and when the claim was processed.

Formal claims appeals must be mailed to the address below or faxed to (833) 641-0208.

Delaware First Health
ATTN: Claims Appeals Department
P.O. Box 8001
Farmington, MO 63640-3001

Behavioral Health claims appeals must be mailed to:

ATTN: Behavioral Health Claims Appeals
P.O. Box 8001
Farmington, MO 63640-3001

- Appeals sent to any address other than the one listed for claims appeals will not be accepted and will be returned to the sender.
- Electronic media such as USB flash drives, CDs, or similar devices are not accepted. These items are restricted from use with Delaware First Health's authorized systems and will also be returned to the sender.

A final determination regarding the appeal will be communicated within 45 calendar days of Delaware First Health receiving the appeal.

Medical Necessity Appeals (Post-Service Appeal)

If an emergency service is denied based on medical necessity but the member received care, the provider may submit a clinical appeal.

Clinical Appeal for Emergency Services Due to Medical Necessity

To file a clinical appeal, the provider must:

- Submit the appeal in writing, ensuring it is received:
  - Within 120 days of the date of service, or
  - No later than 60 calendar days after the payment or denial of a timely claim submission—whichever is later
- Clearly label the request as an "Appeal"
- Provide a detailed explanation of why the claim or issue merits reconsideration
- Include:
  - A copy of the claim in question
  - A copy of the Explanation of Payment (EOP) showing how and when the claim was processed
  - All relevant medical records, chart notes, and other supporting documentation

Important Submission Requirements

- Appeals sent to any address other than the one listed below will not be accepted and will be returned to the sender.
- Electronic media such as USB flash drives, CDs, or similar devices are not accepted due to company security restrictions. These items will also be returned.

Mail medical necessity clinical appeals to:

Delaware First Health
ATTN: Appeals Department
P.O. Box 8001
Farmington, MO 63640-3001

Mail medical necessity appeals related to Behavioral Health claims to:

ATTN: Behavioral Health Appeals
P.O. Box 8001
Farmington, MO 63640-3001

Medical necessity appeals are reviewed by a Delaware First Health medical director who was not involved in the original adverse determination. This ensures an independent and impartial evaluation of the appeal.

Second Level Medical Necessity Appeals (Post-Service Appeal)

If a provider disagrees with Delaware First Health's decision on a first-level medical necessity appeal and has additional supporting information that was not previously submitted, they may request a second-level clinical appeal.

Submission Requirements

To request a second-level medical necessity appeal, the provider must:

- Submit the request in writing within 60 calendar days of the date on the first-level appeal decision letter.
- Clearly label the request as a "Second Level Clinical Appeal."
- Provide a specific explanation of why the provider disagrees with the first-level appeal decision.
- Include:
    - A copy of the claim in question
    - A copy of the Explanation of Payment (EOP) showing how and when the claim was processed
    - All relevant medical records, chart notes, and additional documentation supporting the appeal

Review Process

The second-level medical necessity appeal will be reviewed by a Delaware First Health medical director who was not involved in either the original adverse determination or the first-level appeal decision, ensuring an impartial and independent review.

PROVIDER COMPLAINTS

Complaint Process

Delaware First Health maintains written policies and procedures for filing provider complaints. Providers have the right to express dissatisfaction and submit a complaint without fear of retaliation or differential treatment.

What is a Complaint?

Providers may file complaints related to:

- Delaware First Health policies and procedures
- Administrative functions, including but not limited to:
- Claims
- Payments
- Service authorizations

Complaint Submission Guidelines

- Non-claims-related complaints must be submitted in writing within forty-five (45) calendar days from the date of the issue or dissatisfaction.
- Claims-related complaints must be submitted in writing within twelve (12) months from the date of service or within 60 calendar days after the payment or denial of a timely claim submission—whichever is later.

Complaint Handling Timeline

- Complaints will be acknowledged within three (3) business days of receipt.
- Complaints will be resolved within ninety (90) calendar days.
- If a complaint is not resolved within thirty (30) calendar days, Delaware First Health will provide a written status update every thirty (30) calendar days until the complaint is resolved.

How to File a Complaint

A provider can file a complaint in any way that works best for them.

Filing a Complaint Not Related to a Claim

To file a complaint unrelated to a claim, a provider can:

- Send a fax to 1-844-273-2671
- Log into the provider portal on www.delawarefirsthealth.com
- Mail correspondence to the following address:

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

How to File a Complaint Related to a Claim

Providers may file a complaint in the way that works best for them. Delaware First Health encourages providers to share concerns and is committed to resolving them without retaliation or differential treatment.

Filing a Non-Claims Related Complaint
To submit a complaint not related to a claim, providers may:

- Fax to: 1-844-273-2671
- Log into the secure provider portal at www.delawarefirsthealth.com
- Mail written correspondence to:

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

Filing a Claims Related Complaint
To submit a complaint not related to a claim, providers may:

- Log into the secure provider portal at www.delawarefirsthealth.com
- Mail written correspondence to:

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

FRAUD, WASTE, AND ABUSE

Delaware First Health takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with state and federal laws.

Fraud means the intentional deception or misrepresentation an individual or entity makes knowing that that misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. This includes "reckless disregard" of the facts with the intent to receive an unauthorized payment. This party may also conceal facts to receive reimbursement for which they are not entitled.

Waste means the incorrect submission of claims due to factors such as uneducated office staff, coding illiteracy, staff turnover, or keying errors. Wasteful billing can typically be resolved after the provider or subcontractor and office staff are educated on proper billing requirements and/or claim submission.

Abuse: means practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the health plan. It includes billing for services that are not covered or medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes enrollee and provider practices that result in unnecessary cost to the health plan. In the case of abuse, there is no conspiracy or malicious intent to deceive.

Delaware First Health successfully operates a Special Investigations Unit (SIU), with dedicated staff that reside in Delaware. This unit routinely inspects claims submitted to assure that Delaware First Health is paying appropriately for covered services. Delaware First Health performs front and back-end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claim's payment process. To better understand this system, please review the Billing Manual located on our website. Delaware First Health also performs retrospective audits, which in some cases these activities may result in taking actions against providers who, individually or as a practice, commit fraud, waste, and/or abuse. These actions include but are not limited to:

- Remedial education and/or training to prevent billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Referral to the Delaware Program Integrity Unit
- Referral to the Medicaid Fraud Control Unit
- Onsite Investigations
- Corrective Action Plan
- Any other remedies available to rectify

Delaware First Health instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

Delaware First Health requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons, or entities providing care or services to all Delaware First Health members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, healthcare fraud, obstruction of a state and/or federal healthcare fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, Physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or members' medication fraud.

Training is available via our company website at DelawareFirstHealth.com. that providers can download in PDF format. We also include FWA training in our Provider Orientation packets.

To report any fraud, waste and abuse concerns please call the Fraud and Abuse Line at 1-866-685-8664.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Delaware First Health auditors request medical records for a defined review period. Providers have thirty (30) to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Delaware First Health will recover all amounts paid for the services in question.

Delaware First Health auditors review cases for common FWA practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

Delaware First Health auditors consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Delaware First Health will seek recovery of all overpayments. Depending on the number of services provided during the review period, Delaware First Health may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998). To ensure accurate application of the extrapolated methodology, Delaware First Health uses RAT-STATS 2007 Version 2, the OIG's statistical software tool, to select random samples, assist in evaluating audit results, and calculate projected overpayments. Providers who contest the overpayment methodology or wish to calculate an exact overpayment figure may do so by downloading RAT STATS and completing the extrapolation overpayment. Audit findings are reported to the Delaware OIG and the Office of the Attorney General Medicaid Fraud Control Section.

In accordance with 42 CFR 438.608, Delaware First Health will require and have mechanisms in place for participating providers to report overpayments, return the overpayment within sixty (60) calendar days of identifying the overpayment, and notify the Contractor in writing of the reason for the overpayment. Delaware First Health will

notify the State of any proposed recoveries for provider overpayment within five (5) business days of identification and report to the State all recoveries of overpayments at a minimum annually and as otherwise directed by the State.

Prior to recovering an overpayment from a provider, Delaware First Health will give the provider a notice of intent to recover due to an overpayment. Providers will have thirty (30) calendar days from receipt of the notice to submit a written response disputing the overpayment or requesting an extended payment arrangement or settlement. If a written response is not received, Delaware First Health may execute the recovery as specified in the notice.

Upon receipt of a written response disputing the overpayment, Delaware First Health will, within thirty (30) calendar days from the date the written response is received, consider the response, including any relevant additional information submitted by the provider, and determine whether the evidence justifies recovery. Delaware First Health will provide a written notice of determination that includes the justification for the determination. Additionally, Delaware First Health will determine whether to allow an extended payment arrangement or enter into settlement discussions. Delaware First Health will provide a written notice of determination and, as applicable, the proposed extended payment arrangement or settlement terms. Delaware First Health will also submit the proposed extended payment arrangement or settlement terms to DMMA for prior approval.

A provider can call Provider Services at 1-877-236-1341 (TDD/TTY: 711) for questions and inquiries about recovery of overpayments. Documentation and payments for overpayments can be sent by mail at:

Delaware First Health
ATTN: Overpayments
PO Box 10353
Van Nuys, CA 90410-0353

Please also see the Claims Overpayment Reporting section of this manual.

Suspected Inappropriate Billing

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Delaware First Health takes all reports of potential fraud, waste, and/or abuse very seriously and investigates all reported issues.

NOTE: Due to the evolving nature of fraudulent, wasteful, and abusive billing, Delaware First Health may enhance the FWA program at any time. These enhancements may include but are not limited to creating, customizing, or modifying claim edits, and upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of aberrant billing patterns.

Prohibited Marketing Activities

The following marketing activities are prohibited:

- Marketing to members, potential members, or the general public with the intention of inducing members to join a particular MCO or to switch membership from one MCO to another except during the annual open enrollment period;

- Asserting or implying that the member must enroll in Delaware First Health in order to obtain Medicaid benefits or in order not to lose Medicaid benefits;
- Discouraging or encouraging MCO selection based on health status or risk;
- Suggesting that Delaware First Health is endorsed by CMS, the Federal Government, the State, or a similar entity;
- Directly or indirectly engaging in door-to-door, telephone, email, texting, or other Cold Call Marketing activities;
- Seeking to influence enrollment in conjunction with the sale or offering of any private insurance (private insurance does not include a qualified health plan, as defined in 45 CFR 155.20); and
- Offering gifts, rewards, or material or financial gains as incentives to enroll.

The State reserves the right to prohibit additional Marketing activities at its discretion.

Fraud, Waste and Abuse Reporting

Providers may voluntarily disclose any suspected fraud, waste or abuse using the tool on the DHSS website.

QUALITY MANAGEMENT

Delaware First Health culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Management/Quality Improvement (QM/QI) program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members, including those with special needs.

This system provides a continuous cycle for assessing and analyzing the quality of care and service among plan initiatives including primary, secondary, and tertiary care, preventive health, acute and/or chronic care, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. The system allows for systemic analysis and re-measurement of barriers to care, the quality of care, and utilization of services over time.

Delaware First Health recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, we will provide for the delivery of quality care with the primary goal of improving the health status of members.

Where the member's condition is not likely to improve, Delaware First Health will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions.

Whenever possible, the Delaware First Health QM/QI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of members.

Program Structure

The Delaware First Health Board of Directors (BoD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BoD oversees the QM/QI Program and has established various committees and ad-hoc committees to monitor and support the QM/QI Program.

The Quality Improvement Committee (QIC) is a senior management committee with Delaware First Health network physician representation that is directly accountable to the BoD. The purpose of this committee is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers, and staff regarding the quality and medical management programs.

The following committees report directly to the Quality Management Committee (QIC):

- Utilization Management/Medical Management Committee (MMC)
- Pharmacy & Therapeutics Committee (P&T)
- Credentialing Committee (CC)
- Performance Improvement Team
- Joint Operations Committee
- Health Equity & Diversity Council
- Patient Safety/Quality of Care Work Group
- National Continuity & Coordination of Care Workgroup
- Clinical Policy Committee
- BOD Regulatory Compliance Committee DSCYF/DDDS Dispute Resolution Committee (Ad Hoc Committee) Peer Review Committee (Ad Hoc Committee)

In addition to the committees reporting to the QIC, Delaware First Health has sub-committees and workgroups that report to the above committees including, but not limited to:

- Appeal Committee
- Provider Advisory Council
- Member Advisory Council
- Community Stakeholder Advisory Council
- LTSS Community Stakeholder Advisory Council
- Health Equity Zone Councils
- BH Advisory Workgroup
- LTSS Provider Advisory Workgroup
- Health Plan Compliance Committee
- Special Investigation Committee
- Vendor Oversight Committee

- Ad-hoc committees may also include regional level committees for Member Advisory and/or Community Advisory based on distribution of Membership.

Provider Involvement

Delaware First Health recognizes the integral role provider involvement plays in the success of its QM/QI program. Provider involvement in various levels of the process is highly encouraged through provider representation and participation on the Quality Committees. Delaware First Health encourages PCP, specialty, OB/GYN, pharmacy, LTSS and Behavioral Health representation on key quality committees including, but not limited to:

- Quality Management Committee
- Provider Advisory Council
- Health Equity Zone Councils
- BH Advisory Workgroup
- LTSS Provider Advisory Workgroup
- Utilization Management/Medical Management Committee (MMC)
- Pharmacy & Therapeutics Committee (P&T)
- Credentialing Committee (CC)
- Health Equity & Diversity Committee
- Peer Review Committee (Ad Hoc Committee)

Quality Management/Quality Improvement (QM/QI) Program Scope

The scope of the QM/QI program is comprehensive and addresses both the quality of clinical care and the quality of service provided to Delaware First Health members. Delaware First Health QM/QI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, ancillary services, and operations.

Goals

Delaware First Health primary QM/QI program goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

The Delaware First Health QM/QI program monitors the following:

- Acute and chronic care coordination
- Behavioral Healthcare
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and Provider cultural competency

- Identifying and improving Health Equity, reducing health inequities, and monitoring HRSN
- Marketing practices
- Member enrollment and disenrollment
- Member grievances and appeals
- Member experience
- Medical Management, including population health management
- Member Safety
- Primary Care Provider changes
- Pharmacy
- PCP after-hours telephone accessibility provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including over- and under-utilization

Patient Safety and Quality of Care

Patient Safety is a key focus of Delaware First Health QM/QI program. Monitoring and promoting member safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member.

Delaware First Health employees (including Medical Management, Member Services, Provider Services, Appeal Coordinators, etc.), panel providers, facilities or ancillary providers, members or member representatives, medical directors or the BoD may advise the Quality Management (QM) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues requires investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee (Ad Hoc Committee) as indicated.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

Delaware First Health QIC reviews and adopts an annual QM/QI program and Work Plan aligned with Delaware First Health vision and goals and appropriate industry standards. The QM Department implements quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving member health outcomes, quality of access to care and services.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies

are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each performance improvement initiative is also designed to allow Delaware First Health to monitor improvement over time. Quality Performance Measures have been identified based on the potential to improve healthcare for Delaware First Health members. The measures are HEDIS measures, integrated behavioral healthcare, along with identified state metrics. Performance is measured against established benchmarks and progress to performance goals.

Annually, Delaware First Health develops a QM/QI Work Plan for the upcoming year. The QM/QI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QIC activities, reporting, and studies from all areas of the organization (clinical and service). It also includes timelines for completion and reporting to the QIC and requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QM/QI Work Plan.

Delaware First Health communicates activities and outcomes of its QM/QI Program to both members and providers through avenues such as the member newsletter, provider newsletter, and the Delaware First Health web portal at DelawareFirstHealth.com.

At any time, Delaware First Health providers may request additional information on the Health Plan programs, including a description of the QM/QI Program and a report on Delaware First Health progress in meeting the QAPI program goals, by contacting the QI department.

Feedback on Provider Specific Performance

As part of the quality improvement process, performance data at an individual provider, practice or site level is reviewed and evaluated. This performance data may be used for quality improvement activities, including use by Delaware First Health quality committees. This review of Provider specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency, and in-office waiting time.
- Preventive care, including wellness exams, immunizations, prenatal care, lead screening, cervical cancer screening, breast cancer screening, and other age-appropriate screenings for detection of chronic diseases or conditions.
- Member appeal and grievance data.
- Utilization management data including ER visits/1000 and bed days/1000 reports.
- Critical Incident reporting, sentinel events and adverse outcomes.
- Compliance with clinical practice guidelines.
- Pharmacy data including use of generics or specific drugs.

As part of its motivational incentive strategies, Delaware First Health systematically profiles the quality of care delivered by high-volume PCPs to improve provider compliance with preventive health and clinical practice guidelines and clinical performance indicators. The profiling system is developed with network providers to ensure the process has value to providers, members and Delaware First Health, and may include a financial component.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Delaware Department of Health and Social Services.

As both Delaware and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. Delaware purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Provider specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for provider incentive programs, such as "Pay for Performance." These programs reward providers based on scoring of such quality indicators used in HEDIS.

How Are HEDIS Rates Calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claims and submitted to the health plan. Measures calculated using administrative data may include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid rates consist of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered that were not reported to the Health Plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate procedure and diagnosis codes can reduce the necessity of Medical Record Reviews (MRR); see Delaware First Health website and HEDIS brochure for more information on reducing HEDIS medical record reviews and improving your HEDIS scores. Measures typically requiring medical record review include: diabetic HbA1c, eye exam and nephropathy, controlling high blood pressure, cervical cancer screening, and prenatal care and postpartum care.

When Will the Medical Record Reviews (MRR) Occur for HEDIS?

MRR audits for HEDIS are usually conducted February through May each year. Delaware First Health QM representatives, or a national MRR vendor contracted to conduct the HEDIS MRR on Delaware First Health behalf may contact you if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, PHI that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Delaware First Health which allows them to collect PHI on our behalf.

What Can Be Done to Improve My HEDIS Scores?

Understand the specifications established for each HEDIS measure.

Submit claim/encounter data for each and every service rendered. All providers must bill or report by encounter submission for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.

Ensure chart documentation reflects all services provided.

Bill CPT II codes related to HEDIS measures such as, Body Mass Index (BMI) calculations, eye exam results and blood pressure readings.

If you have any questions, comments, or concerns related to the annual HEDIS project or the MRRs, please contact the Quality Improvement Department at toll-free 1-877-236-1341.

COORDINATION WITH PROVIDERS, SUBCONTRACTORS/DOWNSTREAMS ENTITIES AND STATE CONTRACTORS

Delaware First Health's organizational structure and approach to conducting administrative functions supports integrated accountability with physical, behavioral, social needs, and pharmacy staff aligned through our clinical, administrative, and operational structure. Our staff works collaboratively across all areas of the operation, including Related Entities, Subcontractors, and Downstream Entities, to:

- Improve health outcomes of our members;
- Advance health equity for our members;
- Deliver high quality, cost-effective health care services;
- Be a leader in innovation across the health care system; and
- Collaborate with our state partners to align programs and initiatives to Delaware's goals.

MEDICAL RECORDS REVIEW (MRR)

Delaware First Health providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Delaware First Health to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location.

Delaware First Health requires providers to maintain all records for members for at least ten (10) years. See the Member Rights section of this handbook for policies on member access to medical records. Delaware First Health may conduct periodic medical record reviews (MRR) for the purposes including, but not limited to, utilization review,

quality management, medical claim review, and/or member grievance/appeal investigation. Providers must meet 80% of the requirements for medical record keeping; elements. Scores below 80% are considered deficient and require improvement. Delaware First Health will assist providers who score less than 80% to develop an action plan for improvement. MRR results are filed in the Delaware First Health Quality Improvement Department and shared with the Credentialing Department consideration at the time of re-credentialing.

Required Information

A member's medical record is the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating PCP or other healthcare provider, that document all medical services received by the member; this includes inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the provider rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all notes and chart pages.
- Personal/demographic data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance needed.
- All entries must be legible and maintained in detail including date.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant and chronic illnesses and/or medical conditions are documented on the problem list along with all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If no known allergies, NKA or NKDA indication is documented.
- An appropriate history of immunizations is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Delaware First Health practice guidelines.
- Appropriate subjective and objective information pertinent to the members' presenting complaint is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.
- Working diagnosis is consistent with findings.
- Treatment plans are appropriate for diagnosis.
- Documentation of treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other diagnostic studies are ordered as appropriate.

- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed and dated by the PCP or ordering provider to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- Appropriate notations concerning use of tobacco, alcohol and substance use; for members seen three or more times substance abuse history should be queried.
- Documentation of failure to keep an appointment.
- Encounter forms or notes contain a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not at any risk related to diagnostic or therapeutic problems.
- Confidentiality of member information and protection of all records.
- Evidence that an Advance Directive has been recommended for adults 18 years of age and older.

Additionally, the LTSS Comprehensive Medical and Service Record should contain:

- Medication Record and Person-Centered Service Plan (PCSP/IPoC), where applicable.
- Provider Acknowledgement of PCSP.
-

Assisted Living & Skilled Nursing Facilities records shall l also include:

- Substantiation of Preadmission Screening and Resident Review (PASRR).
- Documentation of specialized services delivery.
- Evidence of education regarding Patient Rights and Responsibilities.
- Acknowledgement that the member was advised of any patient financial liability.
- Documentation of financial eligibility including audit of personal assets and authentication of known personal care accounts.
- Other processes identified by either Delaware First Health

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the member or the member's authorized representative. When the release of medical records is appropriate, the extent of the information released should be based upon medical necessity and/or limited to a need-to-know basis.

As a reminder, PHI that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The Medical Record Review (MRR) vendor will sign a HIPAA compliant Business Associate Agreement with Delaware First Health which allows them to collect PHI on our behalf.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Delaware First Health members. If the member or member's authorized representative is unable to give the previous provider's name, addresses, phone number, etc., this should be noted in the medical record.

Who Conducts Medical Record Reviews (MRR) for HEDIS?

Delaware First Health may contract with an independent national MRR vendor to assist with the HEDIS MRR audits on its behalf. HEDIS MRR audits are conducted annually (usually from Feb – May). If any Delaware First Health records are selected for review, the provider will receive telephonic or written notification from the MRR representative. Your prompt cooperation with the audit is greatly needed and appreciated.

REVISIONS

Summary of changes for Delaware First Health Provider Manual as of August 11, 2025.

Section	Description of Changes	Additional Comments
COVER	Replaced cover image and relevant dates	
KEY CONTACTS	Updated Centene Dental weblink & omitted fax number	New branding; fax could not be verified
	Updated Centene Vision Weblink & omitted fax number	New branding; fax could not be verified
	Added Admissions fax number	Added to table
	Combined Specialty & Retail Pharmacy section (same fax#) and added weblink	Added preferred weblink and updated fax numbers
VERIFYING ELIGIBILITY	Added Availity Essentials as a secure portal option	New portal eff 10/21/24
ONLINE RESOURCES	Added additional online resources	New resources added since last update
SECURE PROVIDER WEB PORTAL	Added Availity Essentials as a secure portal option	New portal eff 10/21/24
NETWORK DEVELOPMENT AND MAINTENANCE	Indicated members may see an OON provider at no cost, until a PAR provider is available	Clarity in responsibility; Also updated grammar and language for clarity
VOLUNTARILY LEAVNG THE NETWORK	Indicated providers must provide advanced notice of voluntary termination in accordance with PPA	Clarity in responsibility
PROVIDER GUIDELINES: REFERRALS	Specified referrals are not required for specialty care	Previous statement, referrals are not required.
APPOINTMENT AVAILABILITY AND ACCESS STANDARDS	Included OBGYN as PCP provider type	MSA specification
	BH Timeframe updated to specify parameters for prescribing and non-prescribing BH clinician	MSA Specification
	Removed BH Emergency Services timeframe	MSA Specification (not needed)
CULTURAL COMPETENCY	Added Interpreter Request Form instruction	New Form
	Added in Annual PCP Attestation Form and requirements	New Form
COVERED SERVICES AND LIMITATIONS	Standard DSHP Benefits Package table replaced with current 2025 table	2025 Benefits
	Diamond State Health Plan (DSHP) Plus LTSS Benefit Package table replaced with current 2025 table	2025 Benefits
VALUE-ADDED SERVICES	Updated Diabetes Prevention Program to include more detail	2025 VABs
	Updated Community-Based Wellness Program for children with specific program name, Boys & Girls Club	2025 VABs
	Home-Based Interventions for Asthma now specifies support as non-clinical and omitted mold removal, carpet cleaning and low VOC cleaning products	2025 VABs
	Practice Dental Visit now revised from all pediatric members and LTSS adult members, to all pediatric	2025 VABs

	members (age 20 and younger) and adults (21+) with an intellectual or developmental disability (IDD)	
PRIMARY CARE PROVIDER (PCP)	Updated Grammar and language	Improved for clarity
	Physician Assistant removed from Provider.Types.That. May.Serve.s.PCPs.sub-section	Not permitted per MSA
	Added "across all payors" and indicted attestation requirement along with attestation form in Member. Panel.Capacity.sub-section	New form
	Added in outreach and engagement requirements for all assigned members in PCP.Responsibilities.sub-section	
	Added Geriatricians as approved provider type to serve as PCP	
	Updated to elaborate on PCP responsibility for the comprehensive coordination of care for assigned and attributed Members, this includes outreaching and scheduling visits in PCP.responsibilities sub-section	
	Added language to encourage PCP offices to assist members with the completion of the PCP Change Request Form in PCP.Assignment.sub-section	
INTEGRATED HEALTH SERVCIES	OB Outcome Form linked in Pregnancy.and.Maternity. sub-section	
	Five additional postpartum doula visits are now available at the recommendation of the provider in Pregnancy.and.Maternity.sub-section	
	Additional benefits to pregnant members detailed including Postpartum Nutrition Program, breast pumps, lactation service and evidence-based home visiting services in Pregnancy.and.Maternity.sub-section	
	Updated description and grammar in Building. Community.Capacity.sub-section	Improved for clarity
UTILIZATION MANAGEMENT	Added Secondary Payor section in Prior.Authorizations. sub-section	
	Added in pre-auth tool in Medically.Necessary.sub-section	
	Added link to Manuals, Forms and Resources page in Requesting.Prior.Authorization.sub-section	
	Added additional detail about provider peer to peer right in Peer_to_Peer.sub-section	(3) days to initiate peer-to-peer review
	Added in eligibility timeframes for retrospective review in Retrospective.Review.sub-section	
PHARMACY	Added description of pharmacy policy and authorization review	DMMA reviews pharmacy policy, procedural and program changes prior to implementing
	Added Pharmacy page weblink	For all related forms and PDL

	Added restrictive statement in Pharmacy.Prior. Authorization.sub-section	DFH will not mandate the therapeutic substation of a prescription drug or device by a pharmacist without explicit authorization from the licensed prescriber.
CREDENTIALING AND RE-CREDENTIALING	Added “Urgent Care Centers” as facilities that must be credentialed in Which.Providers.Must.be.Credentialed?. Sub-section	
	Changed “participation” to “enrollment” in DE Medicaid Program in Credentialing.Process.sub-section	
	Added “approval” to credentialing committee notification responsibilities in Credentialing.Committee. sub-section	Now includes notification of approval, denial and termination
	Added “following receipt of a complete credentialing/recredentialing file” in Credentialing. Committee.sub-section	Application will be completely processed within 45 calendar days following receipt of file
	Added “verified” to credentialing committee notification responsibilities in Credentialing.Committee.sub-section	The start time (45 calendar days) begins when all necessary documents are received and verified
	Added “update changes” to purpose of recredentialing in Re-credentialing.sub-section	Purpose of process
	Included additional reports reviewed, Social Security Administration’s Death Master File (DMF), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals & Entities (LEIE), the System for Award Management (SAM), monthly in the re-credentialing process in Re-credentialing.sub-section	
	Added address and direction to request release of information in Right.to.Review.and.Correct.Information. sub-section Delaware First Health Credentialing Manager 7700 Forsyth Boulevard St. Louis, MO 63105	
	Added language on the frequency of recredentialing of HCBS providers (annually) in Overview.sub-section	
	Updated section in Right.to.Appeal.Adverse. Credentialing.Determinations.sub-section	Improved for clarity

MEMBER AND PROVIDER RIGHTS AND RESPONSIBILITIES	Added Provider Services phone number in Provider. Rights.sub-section	
	Updated section in Provider.responsibilities.sub-section	Improved for clarity
	Would like to omit "Not be excluded, penalized, or terminated from participating with Delaware First Health for having developed or accumulated a substantial number of patients in Delaware First Health with high-cost medical conditions" from Provider. responsibilities.sub-section	
	Would like to omit "Providers must allow for and process voluntary payroll deductions of fringe benefits or wage supplements for any employee who requests it, in accordance with the Wage Payments and Collection Law (43 P.S. §§ 260.2a and 260.3)." from Provider. responsibilities.sub-section	
	Added language that providers have the responsibility to proactively manage accounts receivable, including prompt review of payments and EOP to identify discrepancies and, if applicable, take prompt action within the timelines outlined in this Provider Manual to dispute, request reconsideration, and/or appeal within Provider.Responsibilities.section	
	Added language about updating provider data and changes to practice information within Provider. Responsibilities.section	
MEMBER GRIEVANCE AND APPEALS PROCESS	Updated Zip Code from 91410-0353 to 91410-03534 in How.to.File.a.Grievance.sub-section	
	Removed fax number in in How.to.File.an.Appeal.sub-section	Mail only
	Updated Zip Code from 91410-0353 to 91410-03534 in How.to.File.an.Appeal.sub-section	
PROVDER INQUIRIES, CLAIMS RECONSIDERATIONS, CLAIMS CORRECTION AND ADJUSTMENTS, AND APPEALS	Updated Ex Code List Table in Code.Review.Denial.sub-section	
PROVIDER COMPLAINTS	Updated section language/grammar in Complaint. Process.subsection.	Improved for clarity
	Specified acknowledgement within 3 business days of receipt in Complaint.Process.subsection.	
	Omitted "documentation" in written notice (status) response to provider	Written notice of complaint status will not include any other documentation or attachments

QUALITY MANAGEMENT	Added the following committees to program structure: • Health Equity & Diversity Council • Patient Safety/Quality of Care Work Group • National Continuity & Coordination of Care Workgroup • Clinical Policy Committee	
MEDICAL RECORDS REVIEW	Updated section language/grammar in entire section	Improved for clarity
	Specified Assisted Living & Skilled Nursing Facilities in Required.Information.sub-section	Previously listed as Nursing Facilities
ALL SECTIONS	Changed Provider Engagement Administrator (PEA) to Provider Engagement Account Manager (PEAM)	Internal title change

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