delaware first health

2023 Provider Manual

DelawareFirstHealth.com

State Approved: 1/1/2023

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) to serve Medicaid members enrolled in Diamond State Health Plan and Diamond State Health Plan-Plus (DSHP-Plus).

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

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 providers will need. 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		1-833-966-0532
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
Concurrent Review/Clinical Information		1-833-967-0495
Admissions		1-833-967-0497
Face sheets		1-833-974-1203
Assessments		1-833-967-0503
Care Management		1-833-966-0517
24/7 Nurse Advice Line		N/A
Behavioral Health Crisis Services		N/A
Interpreter Services		N/A
Non-Emergency Medical Transportation (NEMT)		1-833-974-1204

HEALTH PLAN INFORMATION		
Pharmacy Services	1-833-236-1887	Retail Prior Authorizations: 1-844-233-6130
		Medical Pharmacy Prior Authorizations: 1-833-938-0826
Envolve Vision	1-833-236-1886	1-800-980-4002 envolvevision.com
Envolve Dental		1-844-815-4448 envolvedental.com
Advanced Imaging (MRI, CT, PET) (NIA)	1-800-424-1655	www.RadMD.com
Cardiac Imaging (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:

- Diamond State Health Plan
- Diamond State Health Plan-Plus (DSHP-Plus)

VERIFYING ELIGIBILITY

Delaware First Health providers should verify 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.

2. **Call our automated member eligibility IVR system.** Call our toll-free Provider Services number 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 member Medicaid ID and the month of service to check eligibility.

3. **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 their services or were 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 the date of service.

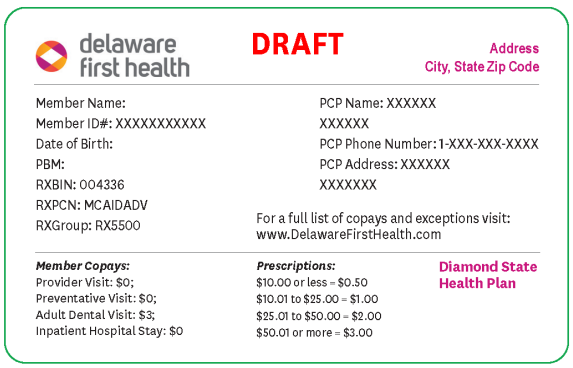
Member Identification Card

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

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Address
City, State Zip Code

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

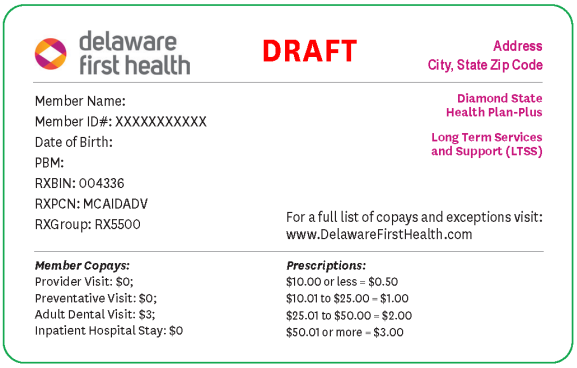
PCP Name: XXXXXX
XXXXXX
PCP Phone Number: 1-XXX-XXX-XXXX
PCP Address: XXXXXX
XXXXXXX

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

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

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

Diamond State Health Plan


delaware first health

DRAFT

Address
City, State Zip Code

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

Diamond State Health Plan-Plus

Long Term Services and Support (LTSS)

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

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

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


IMPORTANT CONTACT INFORMATION

www.DelawareFirstHealth.com

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

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

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

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


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Diamond State Health Plan-Plus

Long Term Services and Support (LTSS)

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

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

DRAFT

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

ONLINE RESOURCES

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

- Prior Authorization List
- Applicable Forms
- Delaware First Health Plan News
- Clinical Guidelines
- Provider Bulletins
- Billing Manual
- Information on Disability Access
- Contract Request Forms
- Provider Relations Specialist Contact Information
- Provider Training Manual
- Provider Education Training Schedule

Please contact your Provider Relations representative 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 Relations Representative.

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
- Verify proper coding guidelines
- 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
- Add/remove TINs from a user account
- View PCP Quality Incentive Report
- View and print Explanation of Payment (EOP)

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 RELATIONS AND SERVICES

Provider Relations

Delaware First Health's Provider Relations 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 Administrator. The Provider Engagement Administator will contact the provider to schedule an orientation.

Reasons to Contact a Provider Engagement Administrator

- 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 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 Delaware First Health 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 until 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 a specialist or subspecialties for a Delaware First Health member, please contact our Medical Management team at 1-877-236-1341 and we will identify a provider to make the necessary referral.

Tertiary Care

Delaware First Health offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical subspecialists 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 adequate 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 a network provider is contracted and will ensure coordination with respect to Prior Authorization and payment issues in these circumstances.

Voluntarily Leaving the Network

Providers must give Delaware First Health notice of voluntary termination following the notification time-period in the participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier to:

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

In addition, Providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to Delaware First Health or the member.

Delaware First Health will notify affected members in writing of a provider's termination, within fifteen (15) calendar days of the receipt of the termination notice from the provider, provided that such notice from the provider was 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, improve 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 with 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 Relations representative.

Referrals

Delaware First Health prefers the PCP to coordinate 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. Obtaining referrals from the PCP is not required by Delaware First Health as a condition of payment for services.

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 to 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 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	**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	Routine outpatient services within seven calendar days of request with a non-prescribing clinician for an initial assessment. Non-emergency outpatient services within 3 weeks of request for prescribing clinician services.
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 crisis, including a mobile team response based on the acuity of the member and not to exceed one (1) hour from the request.
Outpatient Services	**Timeframes**
Follow-up outpatient services	Within two (2) business days for:

	• Members being discharged from an inpatient or residential setting to a community placement; and; • Members seen in an emergency room, or by a behavioral health crisis provider for a behavioral health 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 a 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:

- Answer the member's 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 in order 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 supports the appropriate and effective use of Telehealth. Telehealth services are virtual health care visits with the use of information and communication technologies consisting of telephones, Remote Patient Monitoring devices or other electronic means to provide or support health care delivery. It occurs when the patient is at an Originating Site and the health care provider is a Distant Site.

Delaware First treats telehealth services with in-network providers in the same way as face-to-face visits with in-network providers. Telehealth visits with an in-network provider are subject to the same co-payments, co-insurance, and deductible amounts as an in-person visit with an in-network provider.

Please note: An Originating Site fee is not available if the Member site is the Member's home.

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

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 of our activities, and that meeting the unique needs of our diverse membership in a culturally competent manner promotes the best outcomes in the delivery of healthcare to our members regardless of race, ethnicity, or language.

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.

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 at www.thinkculturalhealth.hhs.gov 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.

- 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 facilitate 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 online at Reporter Portal (force.com). More information is available 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 at DelawareFirstHealth.com. Delaware First Health shall ensure suspected cases of abuse, neglect and/or exploitation are reported to DSAMH Risk Management. Critical incidents include but are not limited to the following incidents:

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

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.

988 SUICIDE & CRISIS LIFELINE

In 2020, Congress designated the new 988 dialing code to operate through the existing National Suicide Prevention Lifeline. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the lead federal agency, in partnership with the Federal Communications Commission and the Department of Veterans Affairs, working to make the promise of 988 a reality for America. Moving to a 3-digit dialing code is a once-in-a-lifetime opportunity to strengthen and expand the existing National Suicide Prevention Lifeline (the Lifeline). Of course, 988 is more than just an easy-to-remember number it is a direct connection to compassionate, accessible care and support for anyone experiencing mental health related distress – whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. Preparing for full 988 In pursuit of this bold yet achievable vision, SAMHSA is first focused on strengthening and expanding the existing Lifeline network, providing life-saving service to all who call, text or chat via 988. Longer term, SAMHSA recognizes that linking those in crisis to community-based providers—who can deliver a full range of crisis care services— implementation requires a bold vision for a crisis care system that provides direct, life-saving services to all in need. SAMHSA sees 988 as a first step towards a transformed crisis care system in much the same way as emergency medical services have expanded in the US.

Frequently Asked Questions

What is the Lifeline and will 988 replace it?

The Lifeline is a national network of over 200 local, independent, and state-funded crisis centers equipped to help people in emotional distress or experiencing a suicidal crisis. Moving to 988 will not replace the Lifeline, rather it will be an easier way to access a strengthened and expanded network of crisis call centers. Beginning July 16, 2022, people can access the Lifeline via 988 or by the 10-digit number (which will not go away).

When will 988 go live nationally?

The 988 dialing codes will be available nationwide for call (multiple languages), text or chat (English only) on July 16, 2022. Until then, those experiencing a mental health or suicide-related crisis, or those helping a loved one through crisis, should continue to reach the Lifeline at its current number, 1-800-273-8255.

How is 988 different from 911?

988 was established to improve access to crisis services in a way that meets our country's growing suicide and mental health related crisis care needs. 988 will provide easier access to the Lifeline network and related crisis resources, which are distinct from 911 (where the focus is on dispatching Emergency Medical Services, fire and police as needed).

How is 988 being funded?

Congress has provided the Department of Health and Human Services workforce funding through the American Rescue Plan, some of which will support the 988 workforce. At the state level, in addition to existing public/private sector funding streams, the National Suicide Hotline Designation Act of 2020 allows states to enact new state telecommunication fees to help support 988 operations.

Is 988 available for substance use crisis?

The Lifeline accepts calls from anyone who needs support for a suicidal, mental health and/or substance use crisis.

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:

	Delaware First Health ***DSHP Benefit Package***	**Delaware First Health** ***DSHP Plus LTSS Benefit Package***
Preventative Services		
Affordable Care Act (ACA) Preventive Services	Covered	Covered
Routine Check-Ups	Covered	Covered
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Covered for Children under age 21	Covered for Children under age 21
Immunizations	Covered	Covered
Primary Care Provider	Covered	Covered

Office Visit	Covered	Covered
Professional Office Services		
Allergy Testing	Covered	Covered
Certified Nurse Midwife Services	Covered	Covered
Chiropractor	Covered	Covered
Contraceptive Devices	Covered	Covered
Family Planning and Family Planning Related Services	Covered *Infertility Treatment Not Covered*	Covered *Infertility Treatment Not Covered*
Gynecological Exam	Covered	Covered
Laboratory Tests	Covered	Covered
Podiatry	Covered	Covered
Routine Eye Exam *1 PER YEAR*	Covered: Ages 0-20 Not Covered: Ages 21 & over	Covered: Ages 0-20 Not Covered: Ages 21 & over
Routine Hearing Exam	Covered under EPSDT for children 21 years of age and under	Covered under EPSDT for children 21 years of age and under
Specialist Office Visit	Covered	Covered

	Delaware First Health ***DSHP Benefit Package***	**Delaware First Health** ***DSHP Plus LTSS Benefit Package***
Inpatient Hospital Services		
Room and Board	Covered	Covered
Inpatient Physician services	Covered	Covered
Inpatient Supplies	Covered	Covered
Inpatient Surgery	Covered	Covered
Bariatric Surgery for Morbid Obesity	Covered *Prior Authorization Required*	Covered *Prior Authorization Required*
Breast Reconstruction, Following Breast Cancer and Mastectomy	Not Covered	Not Covered
Organ/Bone Marrow Transplants	Covered	Covered
Outpatient Hospital Services		
Abortions	Covered if Medically Necessary	Covered if Medically Necessary
Ambulatory Surgical Center	Covered	Covered
Dialysis	Covered	Covered
Outpatient Diagnostic Lab, Radiology	Covered	Covered
Emergency Care		
Ambulance	Covered: Emergency Services Only	Covered: Emergency Services Only
Free Standing Emergency Room	Covered	Covered
Hospital Emergency Room	Covered	Covered
Non-Emergency Medical Transportation (NEMT)	Not Covered – Covered by the State	Not Covered – Covered by the State

Behavioral Health Services		
Inpatient Behavioral Health Services	Covered for members aged 18 and older *Inpatient BHs members under age 18 are provided by the DSCYF*	Covered for members aged 18 and older *Inpatient BHs members under age 18 are provided by the DSCYF*
Medication-Assisted Treatment (including outpatient addiction services and residential addiction services)	Covered	Covered
Substance Use Disorder Treatment Services	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)

	Delaware First Health ***DSHP Benefit Package***	**Delaware First Health** ***DSHP Plus LTSS Benefit Package***
Office Visit	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)
Outpatient Mental Health and Substance Abuse	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)
Behavioral Services to treat Autism Spectrum Disorder (ASD) pursuant to EPSDT	For members under age 21 30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by the State)	For members under age 21 30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by the State)
Crisis Response and Subacute Mental Health Services	Covered	Covered
Outpatient Therapy Services		
Cardiac Rehabilitation	Covered	Covered
Occupational Therapy	Covered	Covered
Oxygen Therapy	Covered	Covered
Physical Therapy	Covered	Covered
Pulmonary Therapy	Covered	Covered
Respiratory Therapy	Covered	Covered
Speech Therapy	Covered	Covered
Radiology Services		
Mammography	Covered	Covered
Routine Radiology Screening and Diagnostic Services	Covered	Covered
Sleep Study Testing	Covered	Covered
Laboratory Services		
Colorectal Cancer Screening	Covered	Covered

Pap Smears	Covered	Covered
Pathology Tests	Covered	Covered
Routine Laboratory Screening and Diagnostic Services	Covered	Covered
Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) Testing	Covered	Covered
Durable Medical Equipment (DME)		
Medical Equipment and Supplies	Covered	Covered
Diabetes Equipment and Supplies	Covered	Covered

	Delaware First Health ***DSHP Benefit Package***	**Delaware First Health** ***DSHP Plus LTSS Benefit Package***
Hearing Aids	Ages 0-20: Covered Ages 21 & Older: Not Covered	Ages 0-20: Covered Ages 21 & Older: Not Covered
Orthotics	Covered	Covered
Long Term Services Supports (LTSS) – Community Based		
Care Management HCBS Waiver and HCBS Habitation populations only	Not Covered	Covered
Section 1915(C) Home- and Community-Based Services (HCBS)	Not Covered	Covered
Section 1915(I) Habilitation Services	Not Covered	Covered

Long Term Services Supports (LTSS) – Institutional		
ICF/ID (Intermediate Care Facility for individuals with Intellectual Disabilities)	Not Covered	Not Covered
Nursing Facility (NF)	Covered not to exceed 30 days	Covered
Nursing Facility for the Mentally Ill (NF/MI)	Covered not to exceed 30 days	Covered
Skilled Nursing Facility (SNF)	Not Covered	Covered
Skilled Nursing Facility Out of State (Skilled preapproval)	Not Covered	Not Covered
Community-based Neurobehavioral Rehabilitation Services	Not Covered	Covered
Hospice		
Hospice	Covered	Covered
Health Homes		
Private duty nursing/Personal cares per EPSDT authority	Covered	Covered
Vision Services		
Exams Annually	Covered for Ages Under 21	Covered for Ages Under 21

Eyewear	Covered for Ages Under 21	Covered for Ages Under 21
Repairs	Covered for Ages Under 21	Covered for Ages Under 21
Dental		
Dental	Covers preventive and corrective dental care with $1,000 limit, excluding removal of bony impacted wisdom teeth. Additional $1,500 may be approved for emergency care.	Covers preventive and corrective dental care with $1,000 limit, excluding removal of bony impacted wisdom teeth. Additional $1,500 may be approved for emergency care.

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.

Once the member's emergency medical condition is stabilized, Delaware First Health requires notification for hospital admission or Prior Authorization for follow-up care, as noted elsewhere in this manual.

VALUE-ADDED SERVICES

Delaware First Health members are eligible to receive Value-added Services (VAS) in addition to their covered benefits. These are called Value-added Services (VAS). Members can contact Member Services at 1-877-236-1341 (TTY: 711) for questions or to learn more about these services.

Cell Phone Programs

SafeLink

Delaware First Health is proud to work with SafeLink Wireless to offer our members this special, federal program. Members would have access to all the benefits of a SafeLink phone including unlimited inbound text messages and calls to Delaware First Health Member Services. There is no added cost for these extras. Some limitations may apply.

How to Enroll:

- If the member already has a SafeLink phone, have them call 1-877-631-2550 to begin receiving the additional SafeLink benefits.
- Visit SafeLink's website to apply online.
- Call SafeLink at 1-877-631-2550 to apply over the phone.

In any given month, Delaware First Health will reimburse qualified members needing additional data beyond the SafeLink allowance up to 1GB per month while actively engaged in care management.

Connections Plus®

Delaware First Health offers smartphone distribution programs, such as Connections Plus®, which provides pre-programmed cell phones to certain high-risk members, or their parents/ guardians enrolled in Care Management who lack reliable phone access. This provides 24-hour instant access, allowing them to make calls to and receive calls from their providers, care managers, pharmacies, important family contacts, our 24/7 nurse advice line, and 911. Additionally, members can use their phone's alarm feature to remind them to take medications, a functionality beyond that which is available through a standard mobile phone. Requires prior authorization.

YMCA Diabetes Prevention Program (DPP)

The YMCA DPP is a one-year program to help adults lower their risk of diabetes by learning about physical activity and nutrition leading to weight loss and risk reduction. A trained Lifestyle Coach will teach a small group of members how healthy eating, exercise, and behavior changes can help lower their risk for diabetes and improve their overall health.

Members who currently have diabetes would not be eligible since this program is preventative. Requires prior authorization.

Healthy Weight Program

Delaware First Health offers a comprehensive weight management program to help members increase physical activity and healthy eating. Our Care Team staff will engage with members in our weight management program to provide education and health coaching for the adoption of healthy lifestyles. As a VAS for members in our weight management program, we will offer vouchers to these activities to help members achieve their healthy lifestyle goals:

- Community-based organization (CBO sponsored physical activities such as Boys & Girls Clubs, YMCA, sports teams, or summer camps for children
- Senior center (for ages 60+) physical activity classes or monthly memberships to community facilities such as the YMCA
- Weight Watchers virtual or in-person programs

Medical Respite

Delaware First Health will provide 48 hours of additional respite care hours to families and caregivers for medically complex children in need of additional support and temporary relief. Delaware First Health will provide an additional 48 hours of medical respite care annually for non-paid caregivers who provide support for medically complex children in DSHP Plus and DSHP Plus LTSS. Delaware First Health will offer this benefit to DSHP Plus and DHSP Plus LTSS members under age 21 and their families or caregivers. Members must be in Care Coordination or Case Management and have exhausted the respite care covered benefit.

Asthma Healthy Home

Delaware First Health offers members with asthma services that combine in-home education, a healthy home environment assessment, and financial assistance of up to $250 a year to support asthma-related needs.

Housing Transition Supplement

Delaware First Health offers housing transition to members transitioning from a nursing facility or community setting, homelessness to supportive or independent housing, or foster care to independent living to help members establish stable housing that meets their needs. Eligible members must have an assigned Care Coordinator or Case Manager.

Pregnancy and Newborn Services

Start Smart for Your Baby (Start Smart) is our special program for women who are pregnant or for those moms who just had a baby. We want to help members take care of themselves and their baby every step of the way. If the member is pregnant, please let us know by completing a Notification of Pregnancy form found on delawarefirsthealth.com. After completing this form, the member will be enrolled in Start Smart and receive information in the mail.

Vision Benefit

Delaware First Health offers vision services for adults and children in foster care. Every other year, adults are eligible for a comprehensive eye exam with refraction and an eyewear allowance of up to $160 for frames, lenses, lens upgrades, or contact lenses. Children in foster care are eligible for replacement eyewear as often as needed.

GED Testing

Delaware First Health provides vouchers to eligible members ages 16+ to be used toward the cost of GED testing.

Tutoring Services

Delaware First Health offers up to $200 per year in tutoring vouchers for members currently enrolled in K- 12 schools who are at risk of failing one or more core subject areas. Tutoring vouchers for K-12 students will be offered annually to members through Care Management.

On-Demand Diabetes Program

Delaware First Health offers our innovative, home-based on-demand Diabetes Program to increase the number of members with diabetes able to control their diabetes using real-time blood sugar monitoring through connected glucometers, capturing blood sugar readings, and providing triage, coaching, and support.

Members enrolled in the on-demand Diabetes program will receive a supply kit delivered to their home with an introduction to the program, a glucometer, a how-to instruction guide, and a supply of testing strips. A secure cloud environment then records blood glucose measurements and records the test strips as used. A new supply of test strips will be automatically mailed to the member at least seven days before their supply runs out.

Delaware First Health Care Team staff will monitor a member's records remotely and outreach to the member if blood glucose readings are missed or high levels are recorded. Care Team staff will help schedule appointments with the member's PCP if needed. PCPs will view monitoring data in the member record through Delaware First Health's provider portal. Delaware First Health will work with members to access SafeLink phones or our ConnectionsPlus® program if they need reliable cell phone service to participate in on-demand Diabetes monitoring.

Rewards Program

Members can earn dollar rewards on their My Health Pays® Visa® Prepaid Card for making healthy choices. Rewards can be spent at Walmart® on personal care items, diapers, and healthy food. Members can also spend them on necessities such as rent, utilities and childcare.[i]

Nutritional Counseling

Delaware First Health offers eligible members up to six hours per year of nutrition counseling provided by a registered dietitian to reduce symptoms of disease and improve overall health.

Post-Discharge Home Meal Delivery

Delaware First Health offers post-discharge meal delivery benefits to members at high risk for readmissions to improve nutrition and overall health. Eligible members can receive three meals a day for seven days after being discharged from the hospital or other inpatient facility, with a maximum of 28 meals per year.

Practice Dental Visits

Delaware First Health offers practice dental visits to eligible adult members. Eligible adult members are provided a practice dental visit when they establish with a new dentist to meet with the dental team, voice preferences and concerns, and understand what happens in a dental appointment in advance of any exams or treatments.

Social Threads

Delaware First Health offers vouchers up to $250 per year to local senior centers for membership and classes for social, recreational, and educational activities to help members create social connections with peers. Virtual social isolation support can be provided by our partner, Pyx Health.

Digital Behavioral Health Application

Members have access to myStrength®. Targeted mobile support application provides 24/7 emotional support for members online or via their mobile app. Services include personalized support and recommended content and activities based on member need

Chronic Pain Management Alternatives

Delaware First Health offers multiple, evidence-based, member-centric alternatives to opiate therapies for chronic pain management. There are two treatment options to alleviate pain, improve whole-person health, and restore activity levels.

One of those treatment options includes Acupuncture. Eligible members can receive 15-minute increments of personal contact, one or more needles, with and without electrical stimulation.

Whole Health Transportation

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

Type	Description
Delaware Healthy Children Program	We offer roundtrip rides to Delaware Health Children Program members for Early and Periodic Screening, Diagnostic, and Treatment-related visits according to the American Academy of Pediatrics Bright Futures™ periodicity schedule, including dental visits and recommended screenings and assessments not performed by the member's PCP. We also allow parents and siblings to accompany the DHCP member to remove barriers related to childcare for siblings.

Type	Description
HRSN	We offer up to four roundtrip rides per month to address issues beyond medical needs. Examples of this includes full-service grocery stores, WIC appointments, food pantries, farmer's markets, housing needs, prenatal support programs, GED and educational programs, childcare, and job interviews.
Hospital Discharge Support	We offer up to two roundtrip rides per inpatient stay for a member's family or caregiver to visit the hospital or other inpatient facility for hospital discharge planning. We also provide on-demand rides from Lyft for members discharging from the hospital to reduce long wait times for rides are also provided.
On-demand and Door-to-Door Rides	Working with Lyft, we offer on-demand rides and door-to-door support for DSHP and DSHP Plus members in Care Coordination to encourage connections with PCPs and to meet urgent care needs. For door-to-door support, drivers will park the car and walk to the member's front door/facility to provide light physical assistance to and in the car. At drop-off, the driver will offer this same level of service in helping the member back to the front door/facility. Medical and non-medical rides will be eligible. All rides will be roundtrip.
Pharmacy Delivery in Place of Ride	Modivcare and Lyft are authorized to provide home delivery of prescriptions from local pharmacies when a member does not live near a pharmacy with a delivery service.
Rides to VASs	We offer roundtrip rides for value added services as described above. If a VAS requires prior authorization, transportation will be approved simultaneously.
Social Outings for Children in Foster Care	We offer up to four roundtrip rides per month for children in foster care to attend social outings or other activities (for example, school sports).
SUD Recovery Supports	We offer up to four roundtrip rides per month for 60 days post-discharge (from an inpatient or residential facility) for members to attend community-based recovery supports, such as Narcotics Anonymous or Alcoholics Anonymous.

STATE COVERED SERVICES

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

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

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

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 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:
10. observed difficulties in responsiveness, age-appropriated interaction, or communication
11. a report by parent or caregiver
12. diagnosis of an ASD in a sibling
13. Vision screening and services, including at a minimum, diagnosis, and treatment for defects in vision, including eyeglasses
14. 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
15. Hearing screening and services, including at a minimum, diagnosis, and treatment for defects in hearing, including hearing aids; and

16. Health education and anticipatory guidance

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

“EPSDT Guarantee”

DFH 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 or her licensure, who is responsible for supervising, prescribing, and providing primary care service; locating, coordinating, and monitoring 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, supports continuity of care, and patient safety. This leads to elimination of redundant services, cost effective care, and better health outcomes.

Delaware First Health offers a robust network of PCPs to ensure every member has access to a Medical Home within 30 miles or 45 minutes within the member's primary address. LTSS members will have access to a Medical Home within 30 miles or 45 minutes between the appropriate facility placement.

Delaware First Health requires PCPs and specialists to conduct affirmative outreach whenever a member misses an appointment and to document this in the medical record. An effort will be considered reasonable if it includes three (3) attempts to contact the member. Attempts may include but are not limited to written attempts, telephone calls, and home visits. At least one (1) such attempt must be a follow-up telephone call.

Provider Types That May Serve as PCPs

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

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

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.

PCPs interested in exceeding the member limit should contact their Provider Relations Representative to discuss providing satisfactory evidence of added capacity by use of physician extenders and/or extended office hours to accommodate additional members.

If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact Delaware First Health Provider Services toll-free at 1-877-236-1341. A PCP 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 under Delaware First Health agreements. In no event shall any established patient who becomes a Delaware First Health member be considered 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 them to select a PCP. For those members who have not selected a PCP during enrollment or within thirty (30) calendar days of enrollment, Delaware First Health will use a PCP auto-assignment algorithm to assign an initial PCP. Members reserve the right to change their PCP at any time. PCP's can be updated by calling our Member Services toll free at 1-877-236-1341.

The 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 family Members' PCPs, if known.
4. Special healthcare needs, including pregnancy, if known.
5. Special language and cultural considerations, if known.

PCP Responsibilities

Delaware First Health will monitor PCP actions for compliance with the following responsibilities. PCP responsibilities include, but are not limited to, the following:

- Providing 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 provide 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 using (free of charge to the member):
    - Sign language interpreters for those who are deaf or hard of hearing.
    - Oral interpreters for those individuals with LEP (Limited English Proficiency).
- Making referrals for specialty care and other medically necessary services.
- Maintaining a current medical record for the member, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services.
- Arranging 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, regulatory, or other 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 prevention services for the Member's age group.
- 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 to 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 specialists is a participating provider within the Delaware First Health network and that the PCP is aware of the additional service request. The specialists 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 if needed 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 HEDIS and other contractual, regulatory, or other programs.

Delaware First Health requires PCPs and specialists to conduct affirmative outreach whenever a member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the member. Such attempts may include but are not limited to written attempts, telephone calls and 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 selected outpatient services as listed on the current 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.

Integrated Care

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 out-reach; face-to-face meetings; and written educational materials). In some circumstances, face-to-face education is preferred because it more effectively engages members, allows staff to provide information that can address member questions in real time and better meets member 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.

Medically Necessary

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.

For members enrolled in DSHP Plus LTSS, provide the opportunity for members to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

Medically necessary services:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability.
- Will, or is 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 must be made by qualified and trained healthcare providers.

Care Management Program

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

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
- Discharge planning

High Risk Pregnancy Program

Delaware First Health provides our *Start Smart for Your Baby*® Program (Start Smart), which incorporates care management and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age.

The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing care management to high and moderate risk members through the postpartum period. A nurse care manager with obstetrical experience will serve as lead Care Manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead Care Manager (CM) for newborns being discharged from the NICU unit and will follow them through the first year of life as needed based on their specific condition or diagnosis.

The Maternity Team has provider oversight advising the team on overcoming obstacles, helping identify high risk members, and recommending interventions. These providers will provide input to Delaware First Health Medical

Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

Delaware First Health offers a premature delivery prevention program by supporting the use of 17-P. When a provider determines that a member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the Delaware First Health CM who will check for eligibility.

The CM will arrange for 17-P to be administered via a home health agency in the member's home, or in the practitioner's office as part of the member's medical benefit. The nurse manager will contact the member and do an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing provider during the entire treatment period. The Maternity Team works in collaboration with local PCP's, Federally Qualified Health Center(FQHCs), Health Homes and local Health Departments to support this program with the goal of improved maternity/neonate care in Delaware.

Contact the Delaware First Health Care Management department for enrollment in the obstetrical program.

MemberConnections® - Community Health Services Program

Delaware First Health outreach program is designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable.

The program components are integrated as a part of our Care Management program in order to link Delaware First Health and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of Delaware First Health within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to Community Health Services through numerous sources. Members who call the Delaware First Health Member Service department may be referred for more personalized discussion on the topic they are inquiring about. CMs may identify members who would benefit from one of the many Community Health Services components and complete a referral request. Providers may request Community Health Services referrals directly to the Community Health Services Representative or their assigned CM. Community groups may request that a Community Health Services Representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Care Coordination – Coaching

Community Health Services Representatives are available to work with members to targeted health education, advocate, coach as well as foster the development of independent health skills, support them in addressing any social service and concrete barriers that the member faces when working to achieve whole health and wellness. The Community Health Services Representative collaborates closely with the provider, nurse care manager, team nurse manager, and other members of the interdisciplinary care team. The Community Health Services Representative works with the member in the community settings like their home, community centers, and more to provide culturally fit

health education and assistance and are available whenever a need or request from a CM, member, provider, or where a member is recommended for a specific coaching program is identified based on health status.

Navigation & Other Assistance

General assistance and navigation support may be provided to members and requested by CM, member, or provider as needed. Topics covered during these in-person visits include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive healthcare, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, reliable phone access through our Connections Plus®. Connections Plus is a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan CM, PCP, specialty provider, 24/7 nurse advice hotline, 911, or other members of their healthcare team. Community Health Services Representatives may also ensure the member knows how to contact the health plan for assistance. Social needs may also be addressed during these visits as well to ensure holistic care and removal of barriers to accessing the healthcare system. Community Health Services Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered, and any additional questions answered.

Building Community Capacity

Community Health Services Representatives are available to present to group setting during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Medicaid coordinated care is all about, overview of services offered by Delaware First Health, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and Delaware First Health and health education. Targeted community events include our Adopt-a-School program where a representative will actively promote healthy lifestyle activities related to disease prevention and health promotion by going into the schools of the communities served. Community Baby showers to promote health education and awareness for healthy pregnancies and healthy babies. Health Fairs to enable easy access to providers, other healthcare services and more.

To contact the Community Health Services 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 to lead 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 member 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 member to complete activities necessary to maintain LTSS eligibility. The LTSS CM will keep the member 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. To contact a LTSS CM, 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 Authorizations

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.

Services That Require Prior Authorization

Please note: This list is not all inclusive. Please visit DelawareFirstHealth.com and use the Prior - Auth Check tool to determine if a service requires Prior Authorization and to easily submit a request for Prior Authorization or referral.

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)

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.

Home and Community-Based Waiver 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
- Behavioral Therapies
- Case Management Services
- Case Management (for those that are receiving both 1915(i) and 1915(c) waiver services)
- Chore Services
- Cognitive Services

- Counseling
- Day Habilitation
- Environmental Modifications and Adaptive Devices
- Family and Community Support
- Family Counseling & Training
- Home Based Habilitation
- Home Delivered Meals
- Home Health Aide
- Homemaker
- In-home Family Therapy
- Interim Medical Monitoring & Treatment (IMMT)
- Medication Assistance
- Mental Health Outreach
- Minor Home Modifications
- Nursing
- Nutritional Supports
- Personal Emergency Response System (PERS)
- Prevocational Services and Habilitation
- Respite: Individualized, group, specialized
- Self- Directed Attendant Care (SDAC)
- Specialized Medical Equipment
- Supported Employment (SE)
- Transportation
- 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)
- Mental Health Institution (MHI)
- Observation Services (outpatient)
- Skilled Nursing Facility
- Intermediate Care Facility (ICF/ID) (Concurrent review Authorization required for state approved stays)
- Nursing Home – permanent full-time resident (Concurrent review Authorization required for state approved stays)

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

Therapy Services (PT, OT, ST)

- Physical Therapy (excluding initial evaluation)
- Occupational Therapy (excluding initial evaluation)
- Speech Therapy (excluding initial evaluation)

Requesting a Prior Authorization

- The preferred method for submitting Prior Authorizations is through our Secure Provider Web Portal at DelawareFirstHealth.com. 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 Prior Authorization requests are as follows:

    - 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.

    - Fax Prior Authorization requests on the Prior Authorization fax forms posted at DelawareFirstHealth.com. Faxes will not be monitored after hours and will be responded to on the next business day.

Timeframes for Prior Authorization Requests and Notifications

Prior Authorization must be obtained prior to the delivery of certain elective and scheduled services. The following timeframes are required for Prior Authorization and notification.

Any Prior Authorization request that is faxed or sent via the Secure Provider Web Portal after normal business hours Monday – Friday 8:00am – 5:00pm EST, excluding holidays) will be processed the next business day.

Failure to obtain Prior Authorization may result in claim denials.

Timeframes for Authorization Decisions

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

Type	Timeframe
Expedited Pre-service/Urgent[1]	72 hours
Standard Pre-service/Non-Urgent[2]	Within 7 calendar days
Concurrent review	24 hours

For cases in which a provider indicates (in making the request on the member's behalf or supporting the member's request), Delaware First Health determines (upon a request from the member), that the standard service authorization decision timeframe could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function, Delaware First Health must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.

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.

Clinical Information

Delaware First Health clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Delaware First Health is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the Member.

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

[1] Delaware First Health may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if Delaware First Health justifies (to the State upon request) a need for additional information and how the extension is in the member's interest.

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

- 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 affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Delaware First Health does not reward providers or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct Utilization Management (UM) activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Delaware First Health Medical Director, is responsible for making UM decisions in accordance with the member's plan of covered benefits and established PC criteria. Failure to obtain Prior Authorization for services that require plan approval may result in payment denials.

Review Criteria

Delaware First Health has adopted utilization review criteria developed by McKesson InterQual®, the American Society of Addiction Medicine (ASAM), and the State of Delaware DHSSS, as indicated, to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from Physicians. All criteria are utilized as screening guides and are not intended to be a substitute for provider judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will

make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

LTSS including all HCBS services will be authorized in the context of member specific needs identified through a person-centered assessment and any member encounters in order to determine the appropriate type, scope, and volume of services to be authorized for each member. The needs of members are unique, and in instance of complex healthcare needs that require additional input a member's community base care manager will collaborate with the Delaware First Health chief medical officer as well as identified members of the care team to determine the services necessary to best support a member's needs to ensure successful, member driven, outcomes.

Peer-to-Peer Review

Providers may obtain the criteria used to make a specific adverse determination or request a peer review with the Medical Director by contacting Medical Management toll-free at 1-833-236-3360.

Appealing an Adverse Benefit Determination

Members, their authorized legal representatives, or a provider, with the member's written consent, may request an appeal related to an adverse benefit determination. Instructions for how to file an appeal are provided in the Grievances and Appeal Processes section of this Manual.

Second Opinion

Members or a healthcare professional, with the member's consent, may request and receive a second opinion from a qualified professional within the Delaware First Health network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network and in-network providers require Prior Authorization by Delaware First Health when performing second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

New Technology

Delaware First Health evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the Delaware First Health population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact Medical Management toll-free at 1-877-236-1341.

Notification of Pregnancy

Members that become pregnant while covered by Delaware First Health may remain a Delaware First Health member during their pregnancy. The managing Physician should notify the Delaware First Health prenatal team by completing the Notification of Pregnancy (NOP) form available at DelawareFirstHealth.com within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. See the Care Management section for information related to our *Start Smart for Your Baby*® program and our 17-P program for women with a history of early delivery.

Concurrent Review and Discharge Planning

Concurrent Review Nurses conduct concurrent review for inpatient admissions through onsite or telephonic methods with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending Physician. The Concurrent Review Nurse will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within one (1) business day of receipt of clinical information. For a length of stay extension request, clinical information must be submitted by 3:00 p.m. CST on the day review is due. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review, however; the hospital must notify Delaware First Health within one (1) business day of delivery with complete information regarding the delivery status and condition of the newborn.

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.

Speech Therapy and Rehabilitation Services

Delaware First Health offers our members access to all covered, medically necessary outpatient physical, occupational and speech therapy services.

Prior Authorization is required for outpatient occupational, physical or speech therapy services and should be submitted to Delaware First Health as described in Procedures for Requesting a Prior Authorization section of this Manual.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, Delaware First Health is using National Imaging Associates (NIA) to provide prior authorization services and utilization of advanced diagnostic imaging. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA
- PET Scans

Key Provisions

- Emergency Room, observation and inpatient imaging procedures do not require Prior Authorization.
- It is the responsibility of the ordering provider to obtain Prior Authorization.
- Providers rendering the above services should verify that the necessary Prior Authorization has been obtained. Failure to do so may result in claim non-payment.

To reach NIA and obtain authorization, please call our toll-free number at 1-800-424-1655 and follow the prompt for radiology authorizations. NIA also provides an interactive website which may be used to obtain online authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Delaware First Health, in collaboration with NIA Magellan, will launch a cardiac imaging program to promote healthcare quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, NIA Magellan addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

NIA Magellan has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. NIA Magellan also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient.
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed.
- Quality assessment of imaging providers to ensure the highest technical and professional standards.

How the Program Works

In addition to the other procedures that currently require prior authorization for members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through NIA Magellan:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach NIA and obtain authorization, please call our toll-free number at 1-800-424-1655 and follow the prompt for radiology and cardiac authorizations. NIA also provides an interactive website, which may be used to obtain online authorizations. Please visit RadMD.com for more information.

CLINICAL PRACTICE GUIDELINES

Delaware First Health clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, Delaware First Health adopts guidelines that are published by nationally recognized organizations or government institutions, as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field.

Delaware First Health providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Management Program. The following 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

For links to the most current version of the guidelines adopted by Delaware First Health, visit our website at DelawareFirstHealth.com. A paper copy of the practice guidelines can be requested by calling Provider Services toll-free at 1-877-236-1341.

PHARMACY

Delaware First Health provides pharmacy benefits through its Pharmacy Benefit Manager, CVS Caremark.

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 (PA). Please visit the Delaware First Health website at DelawareFirstHealth.com for a link to 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 Authorization

The State of Delaware PDL includes a broad spectrum of brand name and generic drugs. Prescribers are encouraged to prescribe from the State of Delaware PDL for their patients who are members of Delaware First Health. Some drugs will require Prior Authorization (PA) to be approved for payment by Delaware First Health.

These include:

- Non-preferred medications

- Some State of Delaware preferred drugs (designated PA on the Preferred Drug List)

In addition, all non-preferred drugs not listed on either the PDL or PA list will require Prior Authorization.

Drug Prior Authorization requests can be submitted to Pharmacy Services through CoverMyMeds, phone, or fax. To ensure timeliness of our members' pharmacy needs, Delaware First Health has a strict twenty-four (24) hour turnaround time requirement to process these 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 HIPPA compliant.

Go to: covermymeds.com to log in, or if a new user, sign up.

To create an account, click New Request and enter:

- BIN: 004336
- PCN MCAIDADV
- RxGroup: RX5500
- Complete the request
- Once reviewed, determination will appear in your CoverMyMeds account.

For CoverMyMeds support:

- Call toll-free: 1-866-452-5017
- Monday – Friday: 8:00 AM – 11:00 PM EST
- Saturday: 8:00 AM - 6:00 PM EST

Phone

- Prescribers may call the Pharmacy Services to initiate a Prior Authorization by calling the toll-free number 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.
- **Retail** Prior Authorization requests, Fax 1 (844) 233-6130.
- **Medical Pharmacy** Prior Authorization requests, Fax 1 (833) 938-0826.
- Once approved, Pharmacy Services notifies the prescriber by fax. When medical necessity criteria are not met based on the clinical information submitted, the prescriber will be notified of the reason via fax. The notification will include PDL alternatives if applicable.

All reviews are performed using the PA criteria established by the State of Delaware. Once approved, Pharmacy Services notifies the Prescriber by fax. If the clinical information provided does not meet the medical necessity and or Prior Authorization guidelines for the requested medication, Delaware First Health will notify the member and the Prescriber of medication alternatives in addition to provide information for the appeal process.

Pharmacy Claim Submission

For member, CVS 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 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

Compounded prescriptions must be submitted online, and each ingredient must have an active and valid NDC. Compounded medications may be subject to Prior Authorization based on ingredients submitted. Compounds that have a commercially available product are not reimbursable.

Pharmacy Copayments

Some Delaware First Health members will have a copay for prescription medications:

- $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

Copayments are based on the cost of the medication.

The most a member will pay for prescription copays in a rolling 30 days is $15. Once the member reaches the $15 of accumulated prescription copays in a rolling 30 days, copays are waived for the remainder of the calendar month the member reaches the $15 maximum. The copays and the $15 copay maximum 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 (90 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

72-Hour Emergency Supply of Medications

Federal law allows dispensing of a 72-hour supply of medication in an emergency situation. Delaware First Health will allow a 72-hour supply of medication to a patient awaiting a PA determination, unless PA criteria does not allow. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication (unless PA criteria does not allow), whether or not the PA request is ultimately approved or denied. The pharmacy will contact the CVS Pharmacy Help Desk at toll-free 1-833-236-1887 for a prescription override to submit the 72-hour medication. The pharmacy help desk call center is available 24 hours a day, 7 days a week.

Newly Approved Products

New FDA approved drugs, and on the CMS Labeler list, will be evaluated by the P&T Committee at the next scheduled meeting. They will require a PA prior to P&T Committee review. If Delaware First Health does not grant Prior Authorization, the member and provider will be notified and provided information regarding the appeal process.

Step Therapy

Some medications listed on the State of Delaware PDL may require specific medications to be used before the member can receive the medication. If Delaware First Health has a record that the required medication met the Step Therapy criteria, the medications are automatically covered. If Delaware First Health does not have a record that the required medication was tried, the member or prescriber may be required to provide additional information. If Delaware First Health does not grant Prior Authorization, the member and prescriber will be notified and provided information regarding the appeal process.

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 drugs may be dispensed up to a maximum 35-day supply. Some contraceptives and maintenance drugs can be

filled up to a 100-day supply. Dispensing outside the Quantity Limit (QL) or Age Limits (AL) requires Prior Authorization. Delaware First Health may limit how much of a medication a member can get at one time. If the prescriber feels a member has a medical reason for getting a larger amount, he or she can ask for Prior Authorization. If Delaware First Health does not grant a PA approval, we will notify the member and prescriber and provide information regarding the appeal process. Some medications on the state of Delaware PDL may have age limits. These are set for certain drugs based on FDA approved labeling and for safety concerns as well as current medically accepted quality standards of care as supported by clinical literature. There is always consideration for an exception during the PA review for medically necessary treatments.

Over The Counter Medications (OTC)

The pharmacy program covers approved OTC medications listed in the state of Delaware PDL. Some OTC medications may require prior authorizations. All OTC medications must be written on a valid prescription by a licensed Physician in order to be reimbursed. Refer to the state of Delaware PDL for a list of covered OTC products using the link provided on the Delaware First Health website, DelawareFirstHealth.com.

Over-the-Counter Enhanced Benefit

Members are eligible for additional over-the-counter items up to a calendar, quarterly maximum benefit of $30 per Household. See the pharmacy section on the Delaware First Health website, DelawareFirstHealth.com for items available and how to order.

Pharmacy and Prescriber Lock-In

Centene Pharmacy Services wants to help members enjoy a healthy lifestyle. Many plans have implemented a prescription lock-in program or pharmacy home program that require members to fill certain medications at a specific pharmacy and order by only one designated prescriber. Examples include opioids and other narcotic medications. The program helps in making sure a member is taking only the medicine prescribed. Our members that are enrolled in this program may also have the option to work with Case Managers to assist with their medication needs while using their benefits appropriately.

Members who misuse an emergency room, a pharmacy, or a provider's services for the purpose of obtaining opioids or other narcotics, or that commit fraud by engaging in doctor or pharmacy shopping, are often enrolled.

Centene Pharmacy Services supports active programs that help curb medication abuse and dependence. If a member meets the eligibility criteria, they will receive notification advising why they are being enrolled in the program as well as a detailed explanation of the program. The notification letter will also offer insights about the duration of enrollment and provide contact information for assistance.

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 CVS Health.

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. Screening is required at initial enrollment, reenrollment, revalidation, and when adding or changing service locations.

Effective March 1, 2022, providers who wish to participate 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 the 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 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 at a minimum of every three 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.

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, 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 Delaware Medicaid Enterprise 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 Delaware Medicaid Enterprise and submit:

- Completed, signed, and dated Delaware First Health Facility Application with attachments requested 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)
- 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 HCBS Providers when applying for participation or recredentialing with Delaware First Health must be enrolled through the Delaware Medicaid Enterprise 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
- Self-Directed 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 has received an application, it verifies the following information, 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 participation 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 termination and direction of the credentialing procedures, including provider participation, denial, and termination. Delaware First Health will ensure that credentialing of all providers applying for network provider status shall be completely processed within 45 calendar days. The start time begins when all necessary credentialing materials, including all necessary documents and attachments have been received. Completely process means that Delaware First Health shall review, approve, and load approved applicants in its claims processing system or deny the application and notify the provider that the provide is not used for services under this contract. 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 adequacy of waiting and examining 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.

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 any changes in the provider's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the provider is under contract to provide. This process includes all providers, PCPs, specialists, and ancillary providers/facilities previously credentialed to practice within the Delaware First Health network.

In between credentialing cycles, Delaware First Health conducts ongoing monitoring activities on all network providers. This includes an inquiry to the appropriate state licensing agency to identify newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry helps make certain that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Delaware First Health reviews monthly reports including OIG, SAM, and Medicare Opt-Out to identify 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.

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 that submitted by the provider, the provider has the right to correct any erroneous information submitted by another party. 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

Upon receipt of this information, the provider has thirty (30) days to provide a written explanation detailing the error or the difference in information. The Delaware First Health Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

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 Network Specialist 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 in writing within thirty (30) days of 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 reconsideration request at its next regularly scheduled meeting, but in no case later than sixty (60) calendar days from the receipt of the additional documentation. Delaware First Health will send a written response to the provider's reconsideration request within two weeks of the final decision.

The applicant will be sent a written response to his/her request within two weeks of the final decision. A written request for appeal should be sent to:

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

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

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 regarding the nature of 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 for 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 with any questions, comments, or problems.
- Collaborate with other healthcare professionals who are involved in the care of members.
- Not 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 on the basis of 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 an enrollee or helping an enrollee to file a grievance; for protesting a plan decision, policy or practice the healthcare provider believes interferes with its 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 on the basis of 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 on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.

- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.

- 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.

- Allow members to request restriction 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 be able to request that they 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, as long as the member understands 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.
- Not deny services to a member due to inability to pay the copayment if the household income is at or below 100% FPL.
- Reimburse copayments to members who have been incorrectly overcharged.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Obtain and report to Delaware First Health information regarding other insurance coverage.
- Notify Delaware First Health in writing if the provider is leaving or closing a practice.
- Update their enrollment information/status with the Delaware Medicaid program if there is any change in their location, licensure or certification, or status via the Delaware Medicaid's Provider Web Portal.
- Contact Delaware First Health to verify member eligibility or coverage for services, if appropriate.
- 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 languages, including the ability to communicate with sign language.
- Office hours of operation offered to Medicaid members will be no less than those offered to commercial members.
- Not be excluded, penalized, or terminated from participating with Delaware First Health for having developed or accumulated a substantial number of patients in the Delaware First Health with high-cost medical conditions.
- 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 on the basis of 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 the purpose of 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) reach out 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 inpatient-stay within the last twenty-four (24) hours since notification.
    - Have a gap-in-care overdue by thirty (30) days.
- Develop report 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 programs rely on complete and accurate diagnosis coding and reporting according to the ICD-10-CM coding guidelines.
- 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).
- Report all suspected physical and/or sexual abuse and 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 staffs 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 other than an adverse benefit determination provided to Delaware First Health by a member and their authorized representative. Examples of these type of complaints include, but are not limited to:

- 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 wants to resolve member concerns. We will not hold it against the member if they file a grievance. We will not treat members differently.

How to File a Grievance

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

- Call Member Services toll-free at 1-877-236-1341 (TDD/TTY: 711).
- Send a fax to 1-844-273-2671
- Send by mail at:

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

Be sure to include:

- 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

Delaware First Health will send a letter within five (5) business days to acknowledge receipt of the grievance. If another person files a grievance for a member, Delaware First Health must have written permission from the member for that person to act on the member's behalf unless that person is the member's legal authorized representative. No one can act on a member's behalf without written permission.

If filing a grievance on behalf of a member, you will need to provide an Authorized Representative Designation Form, signed by the member, to Delaware First Health. To obtain this form, contact Member Services or find it on the Delaware First Health website at DelawareFirstHealth.com. You or the member can return it by mail or fax. Members can also call Member Services for assistance with this.

A member may have additional information supporting their grievance. If so, please send it along with the grievance so we can add it to our information. Members may ask to receive copies free of charge of any documentation Delaware First Health uses to make the decision about the member's grievance.

Delaware First Health will work to resolve the grievance as expeditiously as the member's condition warrants and will send a resolution notice within 30 calendar days of the receipt of the grievance.

Appeals

An appeal is a request for Delaware First Health to review an adverse benefit determination made by Delaware First Health. Members may appeal a service that has been denied, limited, reduced, or terminated.

Appeals may be filed by a member (parent or guardian of a minor Member) or authorized representative with the written consent of the member to act on their behalf. Appeals may be filed verbally or in writing.

When Delaware First Health issues a "Notice of Adverse Benefit Determination" to the member, the member may file an appeal within sixty (60) calendar days from the date on the Notice.

Members can request copies of any documentation Delaware First Health used to make the decision about their care or appeal. Members can also request a copy of their member records. These copies will be free of charge. We will not hold it against a member or provider supporting an appeal if he/she files an appeal. We will not treat members differently in any way.

How to File an Appeal

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

- Call Member Services toll-free at 1-877-236-1341 (TDD/TTY: 711).
- Send it electronically by fax to 1-833-525-0054
- In person or by mail at:

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

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

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.

Delaware First Health will send an appeal resolution letter within thirty (30) calendar days of receipt of an appeal request. Delaware First Health wants to resolve appeal concerns quickly and will resolve member appeals within 30 calendar days of filing with us. If we cannot resolve the member's appeal in 30 calendar days, we may extend the timeframe by up to fourteen (14) calendar days to gather more information to assist in our decision. If Delaware First Health needs more than 30 calendar days to resolve the appeal, with approval of the State, Delaware First Health will notify the member of the extension verbally and inform the member that a written explanation of the reason for the delay will follow within two (2) calendar days.

Members may also request an extension. To request an extension, call Member Services toll-free at 1-877-236-1341 (TDD/TTY: 711). The Authorized Representative Designation Form must be sent in with the appeal and must be received within 60 days from the date of the Adverse Benefit determination notice.

If a member needs help filing an appeal, please call Member Services at 1-877-236-1341 (TDD/TTY: 711). We have representatives to help members Monday through Friday, 8:00am-5:00pm CST (excluding State holidays).

Continuation of Benefits During the Appeal Process

Members may request services continue while Delaware First Health reviews their appeal and during the State Fair Hearing process, if it is not resolved at the first appeal level. Members must request to continue services within 10 days of the date on the Adverse Benefit Determination notice.

IMPORTANT: If the final resolution of the appeal or State Fair Hearing is adverse to the member, that is, upholds Delaware First Health adverse benefit determination, Delaware First Health may recover the cost of services furnished to the member while the appeal and State Fair Hearing was pending to the extent that they were provided during the appeal and State Fair Fearing process.

Expedited Appeal Decisions

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.

Expedited appeals will be reviewed as expeditiously as the member's condition warrants and no later than within 72 hours of our receiving the request. To request an expedited appeal, please call Delaware First Health at 1-877-236-1341 (TDD/TTY: 711). Delaware First Health will make reasonable efforts to verbally notify the requestor and the member of the expedited appeal decision.

If Delaware First Health denies the request to expedite a reconsideration, Delaware First Health will provide the Member with verbal notification within 24 hours. Within two (2) calendar days of the verbal notification, Delaware First Health will mail a letter to the Member explaining:

- That Delaware First Health will automatically process the request using the 30-calendar-day time frame for standard reconsiderations;
- The Member's right to file an expedited grievance if he or she disagrees with the decision not to expedite the reconsideration, and providing instructions about the expedited grievance process and its time frames; and
- The Member's right to resubmit a request for an expedited reconsideration, and that if the Member gets any Provider's support indicating that applying the standard time frame for making a determination could seriously jeopardize the Member's life, health, or ability to regain maximum function, the request will be expedited automatically.

State Fair Hearings

If a member is not satisfied with a Delaware First Health appeal decision, they have the right to request a State Fair Hearing. Members must exhaust Delaware First Health internal appeal process before they may file a request for a State Fair Hearing. In the event Delaware First Health fails to complete the appeals review within the 30-calendar day timeframe, the member is deemed to have exhausted the appeals process and may request a State Fair Hearing. Members have ninety (90) calendar days from the date on the appeal decision notice to request a State Fair Hearing. Members may request their services to continue during the State Fair Hearing process.

The member or their authorized representative can ask the Delaware Department of Health and Social Services for a State Fair Hearing. Requests for a State Fair Hearing can be submitted in person, online, by telephone or in writing. To file online visit: https://www.dhss.delaware.gov/dhss/dmma/fairhearings.html to file 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 by telephone, please contact the 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 anytime 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

Informal Request for Claim Reconsideration (Non-Clinical)

For claims that do not require any correction or change to the original billed claim, a provider may file a request for reconsideration of a claims payment unrelated to a medical necessity determination, including but not limited to a claims payment received being less than the payment expected. A request for reconsideration precedes a claims appeal. To submit a request, a provider must:

- Make a request via Provider Services at 1-877-236-1341, the provider portal, or in writing at the address below:

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

- The request must be received within 90 days of the date of the EOP or denial, or as defined in a provider's contract with Delaware First Health.

A representative will evaluate the payment and, if appropriate, will:

- Request reprocessing of the claim, or
- Indicate that the provider needs to resubmit the claim as a "corrected claim"

Claim Correction or Adjustment

A provider may submit a corrected claim to correct a billing error in the initial claim submission. Corrected claims must be received within 90 days of the date of the EOP or as defined in the provider's contract with Delaware First Health. A claim correction or adjustment is **not** considered an appeal.

- CMS-1500 should be submitted with the appropriate resubmission code (value of 7) in field 22 of the paper claim with the original claim number of the corrected claim. For the EDI 837P, the data should be sent in the 2300 Loop, segment CLM0S (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.
- UB-04 should be submitted with the appropriate resubmission code in the 3rd digit of the bill type (for corrected claim this will be 7) and the original claim number in field 64 of the paper claim. For the EDI 8371, the data should be sent in the 2300 Loop, segment CLM0S (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

Omission of these data elements may cause inappropriate denials, delays in processing and payment or may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline.

Corrected or adjusted claims submission can be submitted via our provider portal. To access this function, provider representatives must become a registered user at: delawarefirsthealth.com

Corrected or adjusted paper claims can be mailed to:

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

For Behavioral Health corrected or adjusted paper claims mail to:

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

Claim Overpayment

A provider may receive more payment for a claim than is expected. Providers are required to report and return any overpayments received within 60 days of the discovery of the overpayment, and must notify Delaware First Health in writing of the reason for the overpayment. Delaware First Health will recoup the amount of the overpayment as outlined below. If the claim involves COB, a copy of other insurance EOP must be sent to the Delaware First Health Claims Department to recoup along with the description of processing codes.

Return uncashed Delaware First Health checks to:

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

If you prefer to refund the overpayment by check (on your check stock), include a copy of the EOP and send to:

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

For behavioral health claims, send to:

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

Code Review Denial

Delaware First Health utilizes a claims adjudication software package, for automated claims coding verification and to ensure that Delaware First Health is processing claims in compliance with general industry standards.

A provider may request re-evaluation of claims denied by code auditing software. The most common codes are listed below but are 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:

- Submit a request in writing, within 90 days of the EOP or as defined in your Delaware First Health contract.
- Include a copy of the EOP that indicates how and when the claim was processed.
- Include the patient's medical record, chart notes and/or other pertinent information to support the request for reconsideration.

Mail to:

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

Non-Clinical Claim Appeal

If a provider does not agree with a non-clinical reconsideration decision, a provider may file a formal claims appeal. Prior to submitting the claims appeal, a provider must have submited a timely claim reconsideration request.

To request a non-clinical claims appeal the provider must:

- Complete the Claim Appeal Form that can be found on the Delaware First Health website and submit the form in writing to the address below. The claim appeal and supporting documentation must be received within 120 days of the date of service or no later than 60 calendar days after the reconsideration decision, whichever is latest.
- Clearly mark the request as an “Appeal”.
- Note the reason the claim or issue merits reconsideration. Please be specific.

- Include a copy of the claim in question and a copy of the EOP that indicates how and when the claim was processed.
- Include all medical records, chart notes and other pertinent information to support the request for the appeal.

Formal claims appeals must be mailed to the address below.

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

Note: Any formal appeals sent to addresses other than what is listed above will not be accepted and will be returned to the sender. Further, the use of USB flash drives, CDs, etc. are restricted from company authorized devices, and will not be accepted for review of medical records and will also be returned to the sender.

A final determination of the review will be communicated within 45 days of receipt of the appeal.

Medical Necessity Appeals (Post-Service Appeal)

When an emergent service has been denied based on medical necessity and the member still received care, a provider may file a clinical appeal.

To file a clinical appeal, a provider must follow these guidelines:

- Submit a request in writing, which must be 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 latest.
- Clearly mark the request as an “Appeal”.
- Explain the reason the claim or issue merits reconsideration. Please be specific.
- Include a copy of the claim in question and a copy of the EOP that indicates how and when the claim was processed.
- Include all medical records, chart notes and other pertinent information to support the request for the appeal.

Note: Any formal appeals sent to addresses other than what is listed below will not be accepted and will be returned to the sender. Further, the use of USB flash drives, CDs, etc. are restricted from company authorized devices, and will not be accepted for review of medical records and will also be returned to the sender.

Mail medical necessity 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 and decided by a different Delaware First Health medical director than the medical director who made the original adverse decision.

Second Level Medical Necessity Appeals (Post-Service Appeal)

If a provider is not in agreement with Delaware First Health's decision on the initial medical necessity appeal and has additional information to support the appeal that has not been previously submitted, a provider may request a second level clinical provider appeal. To request a second level medical necessity appeal, the provider must:

- Submit the request for a second level appeal in writing within 60 calendar days of the date of the first level provider appeal decision letter.
- Clearly mark the request as a "Second Level Clinical Appeal".
- Note the reason why the provider does not agree with the first level appeal decision. Please be specific.
- Include a copy of the claim in question and a copy of the EOP that indicates how and when the claim was processed.
- Include all medical records, chart notes and other pertinent information to support the request for the appeal.

The second level medical necessity appeal is reviewed and decided by a different Delaware First Health medical director than the medical director who made the original adverse decision and the first appeal.

PROVIDER COMPLAINTS

Complaint Process

Delaware First Health maintains written policies and procedures for the filing of provider complaints. A provider has the right to file a complaint with us. Provider complaints written expressions of dissatisfaction.

Providers may file a complaint regarding Delaware First Health policies, procedures, or any aspect of Delaware First Health administrative functions including but not limited to claims, payments, and service authorizations. Delaware First Health wants to resolve provider concerns. We will not hold it against the provider if he/she files a complaint. We will not treat providers differently.

Providers may file a complaint in writing that is non-claims related within forty-five (45) calendar days of the date of the dissatisfaction. Complaints related to claims, may file a written complaint within twelve (12) months from the date of service or sixty (60) calendar days after the payment or denial of a timely claim submission.

Provider complaints will be acknowledged within three (3) days of receipt. Provider complaints will be resolved within ninety (90) calendar days. If the provider's complaint is not resolved within thirty (30) calendar days, documentation why and a written notice of the status to the provider will be provided every thirty (30) calendar days thereafter until the complaint is resolved.

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

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

- File a complaint by logging into their provider portal on www.delawarefirsthealth.com
- File a complaint by mail:

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 the 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 in order 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 is 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 the 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 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

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;
- 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:

https://dhss.delaware.gov/dhss/

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 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 claim 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 consists 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 medical record reviews for the purposes including, but not limited to, utilization review, quality management, medical claim review, and member grievance/appeal investigation. Providers must meet 80% of the requirements for medical record keeping; elements scoring below 80% are considered deficient and in need of improvement. Delaware First Health will work with any provider who scores less than 80% to develop an action plan for improvement. MRR results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re-credentialing.

Required Information

Medical records mean 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 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 chart pages.
- Personal/biographical 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.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and 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 are 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 member's presenting appeal 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 plan is appropriate for diagnosis.
- Documented 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 studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the PCP 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 have 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 placed at inappropriate risk by a diagnostic or therapeutic problem.

- Confidentiality of member information and records protected.
- Evidence that an Advance Directive has been offered to 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.

Nursing Facility records will 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 informed of any patient pay 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 or the Department.

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a member's authorized representative. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on 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 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 remember where they obtained medical care, or they are unable to provide addresses of the previous providers, this should also 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 conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted from February through May each year. At that time, if any of your patients' medical records are selected for review, you will receive a call and/or letter from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated.

REVISIONS

Revised by	Revision Date	Page No.	Comment
Provider Communications	10/25/2022	71, 88	Added: Mandatory
Provider Communications	12/27/2022	60	Updated: Peer to peer review phone number
PHCO	12/27/2022	45	Revised: Integrated Health Services section content
Claims Operations and Network	12/27/2022	87	Added: Provider Inquiry, Reconsiderations, Adjustments and Appeals section

[i] My Health Pays™ rewards cannot be used for pharmacy copays.

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