Provider Newsletter

Inaugural Edition – July 2024

delaware first health

Delaware First Health

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

Welcome to the inaugural Delaware First Health Provider Newsletter, where we share updates, reminders, opportunities, and more with our provider network! As your partner in health, we want to support YOU in delivering the highest quality patient care. Together, we will continue transforming the health of our community, one person at a time!

Approximately 18 months ago, we entered the Delaware Medicaid market focused on positively impacting our members' lives. Our teams across various departments work tirelessly to serve our members and providers, and we are seeing the results. You are a big part of our success, and we appreciate all that you do. We are committed to being a supportive partner that eases the burden of working together while providing invaluable tools and resources to help you improve the health and wellness of our members.

With this year's addition of our affiliate Ambetter (Health Insurance Marketplace) and Wellcare (MA/DSNP) plans we are proud to serve more Delawareans. Thank you so much for participating in our network(s) and for ALL you do for our members and community!

~Delaware First Health Team

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What's New

Provider Advisory Council

Delaware First Health invites providers who want to partner together to find innovative ways to improve and strengthen the health care delivery system to join our Provider Advisory Council. Please send an email to de_providerengagement@delawarefirsthealth.com if you are interested.

PCP Change Form

We are pleased to present our new PCP Change Form, which allows providers to assist members with changing their assigned PCP by completing and returning the form signed by the member. The form is quick, easy to complete, and available to download from the Manuals, Forms and Resources page of our website. This new form is one initiative we are working on to assist the alignment of PCP assignment with attribution. More to come on this.

Self-Report Practitioner Race and Ethnicity

Delaware First Health is committed to maintaining a provider network that can meet the cultural and linguistic needs of our members. Because some members feel more comfortable with practitioners who share their language or background, we believe it is important to collect this data and provide members with choice.

Please add or update your race/ethnicity and language spoken by the practitioners and/or your office so we can better serve our members. The data will be included in our online directory and shared with our member facing teams so they may assist members with finding a provider that meets their needs. If you have multiple practitioners within your group, you can submit your information via our Provider Intake Roster Template, which is located on the Manuals, Forms and Resources page of our website.

Submit Provider Demographic Updates Online

Delaware First Health needs your help to ensure we have your most up to date provider information. This information is important so that our members can find you in our online Find A Provider (FAP) provider directory and to ensure data does not cause claims payment issues. Please visit our Provider Data Updates page for information on how to make these updates and keep your information with us current.

Provider Feedback

Your feedback matters! We have a couple of ways for you to share your thoughts with us:

- *Provider Feedback Form.* Share your experience with us by completing a brief online Provider Feedback Form. We want to hear what we are doing well and what we can do better.
- *Provider Experience Study.* A group of providers will be invited each month to participate in a brief survey to provide feedback on your experience with us. The email will come from noreply@survey.centene.com. If you receive the email, please complete the survey.
- *Annual Provider Satisfaction Survey.* Later this year, providers will be selected to participate in our first annual Provider Satisfaction Survey. Please lookout for a letter or email about the survey from our vendor partner Press Ganey.

21st Century Cures Act

Reminder to Register/Enroll with Delaware Medical Assistance Program (DMAP)

In accordance with the 21st Century Cures Act, all billing, rendering, attending, ordering, referring and prescriber providers of services/items to Medicaid beneficiaries must register/enroll with the DMAP. Claims will deny if the providers are not registered/enrolled with DMAP. Enroll with DMAP today.

Delaware First Health is Here to Support You

Tips:

- ✓ Review how you are submitting claims to Delaware First Health and confirm you are registered with DMAP.
- ✓ If the information you are billing does not match the information with DMAP, update your information/register with DMAP AND Delaware First Health.
- ✓ When submitting claims to Delaware First Health, include the taxonomy code on your claim.
- ✓ Review your personalized Delaware First Health DMAP report in the secure provider portal which shows the registration status of the information submitted on claims.
- ✓ Contact DMAP Provider Services (Gainwell Technologies) for any questions on your registration.

1-800-999-3371, option 0 then option 4

delawarepret@gainwelltechnologies.com

Join Us In-Person or Virtually with Gainwell Technologies

We welcome you to our next set of technical assistance sessions to help address any questions or concerns on provider registration under the 21st Century Cures Act. Please join us in-person on **July 18, 2024, from 9am to 2:30pm at Blue Hen Corporate Center, Board Room in Dover, DE.** Alternatively, providers and supporting staff may participate virtually.

You will need to register for a 30-minute session by scanning the QR code. We will also send out an invitation issued by fax, email and include the information on the Provider Training section on our website. We hope to see you there.

Tips: Claims Rejections

As a reminder any claim that is "rejected" is not in Delaware First Health's system. Providers are strongly encouraged to check their clearinghouse rejection reports on a regular basis to check if any claims have been rejected. Below are some of the top reasons claims are rejected, what it means, and what action a provider should take.

Top Reject Reason	What it Means	Tips for Providers
Member Not Valid at DOS	The member's coverage was not active for the date of service submitted.	Check the member's eligibility and/or verify with the member that the ID# used for the submission is correct for the date of service. If a correction is needed, submit a new claim. If the data is accurate, contact DFH's Provider Service for assistance.
Invalid Member/Invalid Member DOB	Either the patient information or the payer where the claim was sent is incorrect or out of date.	Check the patient's ID card. Confirm that the patient/subscriber information including patient name, date of birth, member ID, etc. are all correct. Confirm that the payer's name and ID are also correct.
Original Claim Number Required	We are not receiving the original reference number on this corrected/adjusted/voided claim. Whenever you send this type of claim, the payer requires the original reference number of the claim you are trying to replace. This can be found on the remittance advice (also called ICN/Original Claim number).	Check to make sure this original reference number is sent on your claims. If yes, please simply re-send as it did not come across at the time the original claim was submitted. If not, this would need to be added.
HCPCS Procedure Code is invalid in Professional Service.	Providers billing terminated or invalid procedure codes on a CMS1500 (i.e., 0490, J2930, G0450 (Termed on 11/8/2011), 7894, and 97111 (Invalid Codes).	Validate that the billed HCPCS codes is still active or valid for the date of service.

Tips: Claims Denials

Providers are encouraged to review the Explanation of Payment (EOP) on a regular basis to check if any action should be taken. Below are some of the common reasons for claims denials and tips that may help prevent the denial Please refer to our website for additional information on how to submit a claims reconsideration and provider complaint following claims denials.

Code	What it Means	Tips for Providers
EX18	Deny: Duplicate Claim Service EX18 denials occurs when a claim is received that is the same service, same patient, same date of service and same provider as another claim processed or pending processing.	• Avoid sending multiple new claims to prevent unnecessary duplicate rejections and administrative rework. • Use the appropriate modifier to designate whether services are unilateral (i.e., RT or LT) or bilateral (i.e., 50). • Appropriately apply modifiers to indicate multiple services as separate payments (see example below). • Check claim status in the portal. If claim processing exceeds 30 days, call provider customer service to have claim expedited. • If there is a dispute on how the claim was processed, submit a claim reconsideration to have a secondary review of the claim performed.
EX29	Deny: The time limit for filing a claim has expired	• Comply with the 120-day submission of an original clean claim and 90 days for submission of corrected claim. • A corrected claim must indicate XX7 in box 4 of UB04 claim form and 7 in resubmission type in the left side of box 22 on the CMS 1500 claim form. • Avoid sending multiple new claims to prevent unnecessary additional denials for the same reason. Utilize the claim reconsideration process within 90 days of receipt of the EOP.

EXL6	Deny: Bill Primary Insurer 1st, Resubmit with EOB	• Effective **10/09/2023**, reconsideration request with OIC proof (screen shot of eligibility screen of non-active coverage from the other insurer and/or denial letter from the other insurer) will be accepted and acted upon in the following manner:
		  o Proof will be used to remove other insurance record.
		  o Impacted claim(s) will be reprocessed to remove other insurance denial to allow for payment.

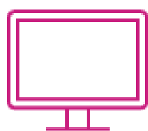
Primary Care Providers (PCP) Reminders

Review Member Panel List and Engage All Members Preventive Care

Delaware First Health thanks ALL our PCP partners who coordinate and provide essential primary care services to our members. As a reminder, all PCPs are assigned members based on member choice as well as an auto-assignment process. **PCPs and their staff should regularly check their member panel list via our secure provider portal, and outreach to all members assigned to their panel to ensure they are receiving the necessary preventive care.** Our new PCP Change form is one mechanism for updating PCP assignment to align with PCP attribution, where members are receiving care.

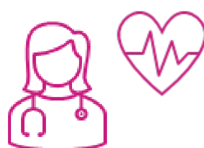
PCPs who are not enrolled in a value-based arrangement are eligible to earn bonus payments for engaging members and closing care gaps through our Pay for Performance (P4P) Program.

Engaging Delaware First Health Members



Review Member Panel List and clinical information available on our secure portal

Engage member for preventive and screening services



Render quality care

Submit claims and earn incentives based on performance

Tips when outreaching to members:

- Tell our members about our value-added (extra benefits/services), which includes our My Health Pays Rewards program. With My Health Pays, a member can earn dollars on a My Health Pays Visa Prepaid Card each time a member completes a qualifying health activity.
- Members who need **non-emergency medical transportation** to and from a covered medical service can request transportation at least three days in advance by calling the State's vendor, Modivcare at 1-866-412-3778.
- Contact our **Care Management** team at 1-877-236-1341 if you have any issues contacting our members.

Pay for Performance

Delaware First Health is proud to invite you to participate in our pay-for-performance (P4P) program. The program is designed to enhance quality of care through a focus on preventative and screening services while promoting engagement with our members. Based on program performance, you are eligible to earn additional compensation beyond what you are paid through your Participating Provider Agreement. The P4P program is “upside only” and involves no risk to you. Furthermore, contract document is not required to participate in this program.

The P4P program provides financial incentives for engaging with our members and closing care gaps based on NCQA and HEDIS quality performance standards. Each care gap has its own incentive amount, and payment is rendered for each compliant member event once the target has been achieved for that specific measure.

Incentives are paid based on member primary care assignment. In other words, a closed care gap results in an incentive to the tax identification numbers (TINs) for the primary care provider of record for that member. Incentives are paid three times per year and providers will receive credit for all care gaps closed during the calendar year. See the full list of incentives below:

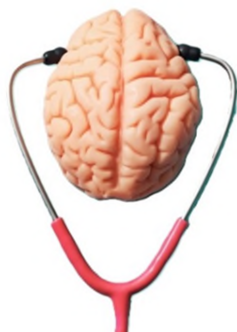
2024 Measures List	Target	Target Pays 100% Of Incentive
Hemoglobin A1c Control for Patients with Diabetes	50%	$35
Timeliness of Prenatal Care	66.67%	$50
Cervical Cancer Screening	50%	$25
Breast Cancer Screening	50%	$25
Colorectal Cancer Screening	50%	$25
Controlling High Blood Pressure	33%	$25
Childhood Immunization Status (Combo 10)	50%	$30
Adults’ Access to Preventive/Ambulatory Health Services	50%	$50
Immunizations for Adolescents (Combo 2)	50%	$30
Child and Adolescent Well Care Visits Well Child Visits (Total)	50%	$30
Asthma Medication Ratio (Total)	33%	$25

Each measure is assigned an incentive dollar amount and target percentage. Increasing amounts are paid on each compliant event once the target has been met for that specific measure. Target pays 100% of the incentive dollar amount.

How the Math Works (Number Compliant):
* Incentive Amount for Target Earned= Bonus Earned
* No Bonus is earned if Target is not achieved

Have questions about DFH’s P4P program? Contact your Provider Engagement Administrator or Quality Practice Advisor for more information.

Behavioral Health VBC Program



Delaware First Health is rolling out a Value-Based Contracting (VBC) program for behavioral health providers. VBC is a shift in the behavioral health care delivery model in which providers are rewarded based on the quality of care provided. The goal of VBC is to reduce costs while improving quality and patient outcomes.

To improve the total health of patients, we need to measure behavioral health care as robustly as we do physical health. Delaware First Health has partnered with Quartet to provide the technology and services needed for practices to measure health outcomes, and to also support provider success with this new payment model.

Your practice can participate in this pay-for-performance model, where you will earn bonuses for taking the appropriate action at key events during the patient care journey. These quarterly bonuses will be earned in addition to your current reimbursement structure with Delaware First Health.

This simple payment model focuses on three categories that are critical to high-quality care:

- **Engagement - Plan and Start Care**
  - Incentives for high-needs member sufficiently engaged in care
- **Measure - Monitor Patient Outcomes**
  - Incentives for utilizing clinical assessments, and for member improvement on the assessments over time
- **Support - Safety and Wellbeing**
  - Incentives for outpatient tenure (periods of time where patients are free of hospital stays, ER visits, or inpatient rehabilitation), or
  - Incentives for timely follow up after treatment in facilities occurs

Quartet will provide regular insights into your performance across these three categories in the VBC model. By participating in this program, you will receive:

- Monthly performance reports & data exchange support from Quartet
- Evidence-based workflow guidance from Quartet
- Quarterly bonuses, if achieved, from Delaware First Health

This is an exciting opportunity to be rewarded for providing high-quality care that focuses on patient outcomes through a transparent payment model. If you are interested in participating, or would like more details about the VBC program, please contact Dr. Ricardo Budjak at Ricardo.Budjak@DelawareFirstHealth.com and Lindsay Short lindsay.short@delawarefirsthealth.com.

2024 Continuity of Care Program

We are committed to supporting your efforts to provide the highest quality care to our members. As a result, we are excited to announce that our Continuity of Care (CoC) program launched effective February 2024. This initiative incorporates Appointment Agendas, HEDIS® measures, and pharmacy metrics into one comprehensive view.

Appointment Agenda

The CoC program is designed to support your outreach to members for annual visits and condition management, which will help us better identify members who are eligible for case management. The program achieves this goal by increasing visibility into members' existing medical conditions for better quality of care for chronic condition management and prevention. Providers earn bonus payments for proactively coordinating preventive medicine and for thoroughly addressing patients' current conditions to improve health and clinical quality of care. Our members benefit from this program by receiving more regular and proactive assessments for their chronic conditions. The CoC program is in addition to our health plan's other provider bonus programs and does not replace them. Providers also have the ability to earn bonuses via Quality programs. Please refer to your Provider Engagement Administrator for more information.

Providers are eligible for a bonus for each completed Appointment Agenda (Health Condition History only) with verified and documented diagnoses on qualified claims. Bonuses increase when Appointment Agendas are submitted electronically (i.e., completing checkboxes via the secure provider portal, RxEffect, etc.)

THRESHOLD PERCENTAGE OF APPOINTMENT AGENDAS COMPLETED	BONUS PAID PER PAPER APPOINTMENT AGENDA SUBMISSION	BONUS PAID PER ELECTRONIC APPOINTMENT AGENDA SUBMISSION
<50%	$50	$100
≥50% to <80%	$100	$200
≥80%	$150	$300

Thresholds are calculated at the Company, Line of Business, and Provider level.

Reducing the Stigma Surrounding Mental Illness

The Stigma surrounding mental illness originates from fear or a lack of understanding.

Inaccurate or misleading information contributes to both. Many in society still have a negative perception of mental illness. The stigma surrounding mental health not only affects those with a mental health illness, but also those who support and care for them.

This stigma can result in a worsening of symptoms and result in:

- A reluctance to seek treatment
- Loss of hope
- Less self-esteem
- Worsen or increase psychiatric symptoms
- Trouble with relationships
- Non-compliance with treatment
- Difficulty at work

These effects can lead to:

- Self-isolation
- Lack of family or friends understanding
- Fewer opportunities for employment, school or social activities
- Difficulty obtaining housing
- A belief that they cannot succeed or improve their current situation

How can you help your patients begin the dialog about the stigma associated with mental illness?

Use some of these following communication techniques may help patients to begin discussing their mental illness and bridge the barrier related to its stigma:

- ✓ Practice active listening, focus on what the patient is saying, and use good eye contact
- ✓ Speak with them person-to-person to help encourage participation in their care
- ✓ Avoid using highly technical medical terms or language
- ✓ Communicate at the patient's level of understanding
- ✓ Continue to build a relationship of trust
- ✓ Be nonjudgmental
- ✓ Validate the patient's feelings
- ✓ Ask about their cultural and spiritual beliefs, as they can greatly impact perception of mental illness
- ✓ Be sensitive to the way the patient presents themselves, which may be signs of undisclosed mental illness. These signs may indicate the presence of a mental illness that the patient may be reluctant to discuss:
  - Unexplained chronic pain or fatigue
  - Recent changes in eating or sleeping patterns
  - Difficulties at work or school
  - Past or current use of drugs or alcohol

Sources

American Psychiatric Association. (2024). Stigma, prejudice and discrimination against people with mental illness. Stigma and Discrimination (psychiatry.org)

Wu, B. (2016). What you should know: Talking to your patients about their mental health. https://www.studentdoctor.net/2016/03/15/know-talking-

Care Management

Multiple member-Facing Teams to Address all Needs

- ✓ **Case Management-** Assists members receiving LTSS benefits.
- ✓ **Care Coordination-** Assists members with chronic medical, behavioral, or health-related social needs, and discharge planning.
- ✓ **Service Coordination-** Available to all members to help with appointment linkage and health-related social needs.
- ✓ **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Outreach-** Informs members under the age of 21 of care gaps and available services.

Contact the Care Management team for assistance.
Monday-Friday 8am to 5 pm 1-877-236-1341.

Care Management July Spotlight: EPSDT Team

Delaware First Health is committed to ensuring all our pediatric members are receiving the medically necessary services covered by the EPSDT program.

Our team of dedicated EPSDT program coordinators conduct outreach to members who have been identified with care gaps such as missed well child visit(s), screenings, etc.

The EPSDT team may contact your office to request updated demographic information to assist with addressing these care gaps. Thank you in advance for helping us help our members. For any questions, please email EPSDT@delawarefirsthealth.com or contact EPSDT Coordinator Nicole Alexander at (302) 861-4137.

General Reminders

No Balance Billing

As a reminder, federal law prohibits providers from balance billing Medicaid recipients. Payment by Delaware First Health or non-payment for services is payment in full for services plus the amount of applicable cost sharing. Providers are not permitted to solicit or bill, charge, or collect a deposit from the member beyond member liability (applicable deductible, coinsurance or copayment). Please remind your staff accordingly

National Imaging Associates, Inc. (NIA) is now Evolent Specialty Services, Inc. (Evolent)

Effective January 1, 2024, NIA became Evolent. Materials are being updated to reflect this rebranding. As a reminder Evolent manages non-emergent outpatient imaging/radiology services, certain cardiac studies, and intervention pain management procedures. Please visit Evolent's website for more information.

Delaware First Health invites all Providers to Participate in our affiliated Ambetter (Health Insurance Marketplace) and Wellcare (Medicare Advantage and DSNP) Plans

Effective 1/1/24, Delaware First Health introduced two affiliated products designed to meet healthcare needs in Delaware. Ambetter Health of Delaware (Health Insurance Marketplace), offers affordable, comprehensive solutions for lower-income individuals and families who may not qualify for Medicaid or have access to employer coverage. Our WellCare (Medicare/DSNP) plans allow us to serve seniors and also better coordinate care for our DSNP members.

If you are not already participating in all three networks, we encourage you to submit a request to add the new product by completing the online Contract Request Form. Select *Amendment to Existing Contract* and indicate which product(s) you seek to add to your contract.

For more information about our plans:

MEDICAID
delawarefirsthealth.com
1-877-236-1341

HEALTH INSURANCE MARKETPLACE
ambetterhealthofdelaware.com
1-833-919-3214

MEDICARE
wellcarede.com
NON-DUALS/C-SNP PLANS:
1-800-977-7522
DUALS/D-SNP PLANS:
1-844-796-6811

General reminders cont.

Checking Member Eligibility

As a reminder, providers are responsible for verifying member eligibility every time a member is seen in the office. Providers can verify eligibility in the following ways:

- Log on to our secure provider portal at www.DelawareFirstHealth.com. You can search by date of service and either the following: member name and date of birth, or member Medicaid ID and date of birth.
- Call our automated member eligibility IVR system at our toll-free Provider Services number at 1-877-236-1341.
- Call our toll-free number at 1-877-236-1341 to speak to a live agent.

Provider Changes – Existing and New Providers

As a reminder, all providers must notify Delaware First Health of changes to provider data at least 30 days prior to the effective date of changes, when possible. Additionally, providers are required to notify us of the addition of new providers at least 60 days of such addition. Visit our Provider Data Updates website for additional information.

Quality Practice Advisor Program

Delaware First Health's Quality Improvement (QI) team partners with our network providers to improve the wellness and education of members. Our goals include the following:

- Advise and educate providers on HEDIS measures and CAHPS scores to improve performance and assist with gap closure.
- Partner with providers/provider staff to identify and explore new strategies to encourage and improve member clinical participation in wellness and education.

To begin receiving data on your practice performance, please contact our Quality Practice Advisor, Alysha McLaurin, at Alysha.McLaurin@DelawareFirstHealth.com or 302-382-2077. We look forward to working together to achieve our commitment to improving the health of the community one individual at a time.

Appointment Standards

The Delaware Medicaid program requires providers to meet appointment standards as set forth in the State's Quality Strategy (QS). Please refer to our Provider Manual for additional information. Also, please remind all staff to comply with audits conducted by or on behalf of our plan relating to appointment standards as our goal is to ensure our members can access the care they need when they need it.

Nursing Facility Notifications

Nursing facility staff are reminded to notify Delaware First Health case management of nursing facility conferences and any changes in a member's condition. Please send an email to DFHLTSS@delawarefirsthealth.com at least two weeks in advance of any nursing facility conference. You can also provide our case managers with timely updates by completing the Nursing Facility Report (formerly known as Member Census).

Self-Service

Online Resources:

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

- Prior Authorization List
- Applicable Forms
- Clinical Guidelines & Drug Formulary
- Provider News and Bulletins
- Billing Manual
- Information of Disability Access
- Contract Request Forms
- Provider Engagement Administrator Contacts
- Provider Manual
- Provider Education & Training Schedules

Please contact your Provider Engagement Administrator 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, submit and check the status of claims, request authorizations and send messages to communicate with Delaware First Health staff.

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

Once registered, providers and designated office staff may use the Provider Web Portal to easily obtain and share information such as:

- Check member eligibility
- View member health records
- View PCP panel (patient list)
- View and submit claims and adjustments
- View member gaps in care
- Contact us securely and confidentially
- View and print explanation of payment (EOP)
- Add/remove TINs from user account
- Verify proper coding guidelines
- View payment history
- View and submit prior authorizations
- Check prior authorization requirements
- Add/remove account users
- View PCP Quality Incentive Report
- Determine payment/check clear dates

Member Incentives

My Health Pays® Rewards

Delaware First Health rewards our members for focusing on their health! Our members can earn My Health Pays rewards by completing healthy activities like a yearly wellness exam, annual screenings, tests and much more. The reward dollars are added to a rewards card after we process the claim for each activity completed. Members can learn more at DelawareFirsthealth.com or call 1-877-236-1341 (TTY:711)

HELP OUR MEMBERS START EARNING TODAY!

$10 Member Portal Registration
Visit DelawareFirstHealth.com and click "Login".

$15 PCP Confirmation within 30 Days of Enrollment.

$20 Health Risk Assessment
One time reward.

$20 Child Well Visit
Ages 2-18. Once per year.

$15 Adult Well Visit
Ages 18 and up. Once per year.

$15 Flu Vaccination
Ages 6 months and up. Once per year.

$15 Breast Cancer Screening
Ages 40-74. One time reward.

$15 Cervical Cancer Screening
Ages 21-64. One time reward.

$15 Colorectal Cancer Screening
Ages 50-75. One time reward.

$20 Notification of Pregnancy
Once per pregnancy.

$50 Prenatal Visit within First Trimester
Once per pregnancy.

$20 Prenatal Visits
Reward requires three prenatal visits. Earn rewards after third and sixth visits.

$40 Postpartum Visit
One per pregnancy. Must be completed 7-84 days after delivery.

$100 Infant Well Visits
Ages 0-15 months. One time reward. Requires six visits or claims to receive reward.

$25 Child Lead Screenings
9-18 months and 19-27 months.

$20 Adult Annual Dental Visit
Ages 21 and up. Once per year.

$20 Diabetes HbA1c Test
Ages 18-75. Once per year.

$20 First Tobacco Cessation Medication
Fill Once per year.

$20 Behavioral Health Hospitalization Follow-up Visit
Once per year and within 30 days of hospitalization.

$20 Substance Use Disorder Residential Stay Follow-up Visit
Once per calendar year and within 30 days of discharge

Value-Added Benefits

Our Value-Added Benefits set us apart!

In addition to the State-provided Diamond State Health Plan (DSHP) and (DSHP Plus) benefits, Delaware First Health members also receive extra value-added services such as the benefits mentioned below. Please visit our website for a *comprehensive listing* of those additional services.

Help Paying for Over-the-Counter Pharmacy Products

Housing Transition Allowance
Funding available for adults experiencing homelessness, transitioning from facility care, or foster care to independent living.

My Health Pays® Rewards Program*
Earn dollar rewards on your My Health Pays® Visa Prepaid Card for making healthy choices.

Start Smart for Your Baby®
Free resources and support to help pregnant members and new parents.

Weight Watchers® Memberships
Up to $250/year to help you maintain a healthy weight.

At-Home Asthma Resources

Provider Training and Education

Our provider education team is dedicated to improving our partnership by providing initial and ongoing education through orientations, office visits, training, and updates. We have upcoming educational and training opportunities that are designed to improve our collaborative relationship and foster best practices to better serve our members. We encourage all our providers to visit our website for the current provider training schedule and to register for the training. Below is upcoming educational and training opportunities for Q3 2024.

21st Century Cures Act Technical Assistance (In Person) (Registration TBD)	
Dates and Times	**Location**
Thursday, July 18, 2024, 9:00 AM – 2:00 PM	665 Bay Road Unit B, Dover, DE 19901
TBD (August 2024) 9:00 AM- 2:00 PM	Sussex County - TBD

New Provider Orientation (Virtual)
Dates and Times
Wednesday, July 17, 2024, 10:00 am - 11:00 am
Thursday, August 8, 2024, 2:00 pm - 3:00 pm
Tuesday, September 17, 2024, 11:00 am-12:00 pm

Provider Portal Training (Virtual)
Date and Time
Wednesday July 24, 2024, 2:00 pm-3:30 pm

Behavioral Health Clinical Provider Training (Live Video)	
Topic	**Dates and Times**
Behavioral Health Screening Tools for Providers	Friday, July 12, 2024, 11:00 am – 2:00 pm
	Tuesday, August 6, 2024, 1:00pm-4:00 pm
Screening, Brief Intervention, and Referral to Treatment	Thursday, July 25, 2024, 1:30 pm – 4:00 pm
	Thursday, August 15, 2024, 11:00 am-1:30 pm
	Wednesday, September 18, 2024, 11:00 am-1:30 pm

Cultural Humility: Building Upon the Foundation of Cultural Competency (Live Video)	
Dates and Times	
Wednesday, July 3, 2024, 2:00pm – 4:30 pm	Wednesday, August 21, 2024, 4:00 pm-6:30 pm
Friday, July 19, 2024, 11:00 am-1:30 pm	Thursday, September 3, 2024, 12:00 pm – 2:30 pm
Thursday, August 1, 2024, 11:00 am – 1:30 pm	Thursday, September 19, 2024, 3:00 pm – 5:30 pm

Please Contact Us!

Key Contacts

We're Always a Phone Call or Click Away

Service Name	Phone Number	Hours of Operation
Provider Services	1-877-236-1341, option 3	Monday - Friday 8:00am – 5:00pm EST
Pharmacy Services	1-833-236-1887	24hrs/ 7 days a week
Member Services	1-877-236-1341, option 2	Monday - Friday 8:00am – 7:00pm EST
Utilization Management	1-877-236-1341, option 3	Monday - Friday 8:00am – 5:00pm EST
24-Hour Nurse Advice Line /Behavioral Health Crisis Line	1-877-236-1341, press * to connect to the Nurse Advice/Crisis Line	24hrs/ 7 days a week

Stay Connected

Visit our provider webpage to review various provider resources, Provider News, and obtain contact information for your assigned Provider Engagement Administrator.

Our Support Doesn't StopThere

Our provider website contains essential information, including member surveys, health equity resources, language services and resources, provider credentialing rights, the utilization management process, how to access care management services and other sources of support for you. Read more now: **https://www.delawarefirsthealth.com/providers/quality-improvement/quality-care.html**.

If you have additional questions or need specific support, call Provider Services at **1.877.236.1341.**