C.	**Technical Approach**
16.	**Enrollee Eligibility, Enrollment and Disenrollment** (*Section 26 Enrollee Eligibility, Enrollment and Disenrollment)*
a.	Describe the approach to meeting the Department's expectation and requirements outlined in RFP Attachment C **"Draft Medicaid Managed Care Contract and Appendices."**

Humana's enrollment and eligibility policies and procedures fully comply with Section 26 of the Draft Medicaid Contract.

ELIGIBILITY

Humana recognizes that the Department for Medicaid Services (DMS) has the exclusive right to determine eligibility. Our fully automated enrollment processes accept only what we receive from DMS through Health Insurance Portability and Accountability Act (HIPAA) 834 files. **In 2019, Humana processed eligibility files with 100% accuracy**. Additionally, we work with DMS to reconcile Enrollees identified as ineligible for the program. Similarly, Humana has developed our systems to be compliant with similar processes in our other Medicaid states where we also processed eligibility files with 100% accuracy.

Eligibility Reconciliation Audits

Humana conducts weekly audits of the 200 Report to ensure that information received from DMS is consistent with data in Humana's internal systems. A discrepancy report is created if 1) an Enrollee is active on the audit file but not active on Humana's platform or 2) an Enrollee is not included on the audit file but active on Humana's platform. Discrepancies are subsequently updated to match Humana's systems with data received from DMS. Our eligibility platforms are consistently accurate; in our most recent audit report (fourth quarter of 2019), **Humana's files matched those received from DMS 97% of the time**.

ENROLLMENT

We validate eligibility files (834 HIPAA 5010 transactions) from the DMS enrollment broker for HIPAA compliance using Edifecs and then load these files to the enrollment platform, Customer Interface (CI), via a mapping process. CI is the mainframe-based platform system that:

- Stores plan and Enrollee-level data for Humana's Medicaid membership, including Medicaid ID, Humana ID, demographics, contact, and coverage information
- Serves as the source system of data for downstream systems, including medical claims adjudication; pharmacy benefit management (PBM); eligibility feeds to behavioral health (BH), dental, vision, and Electronic Visit Verification (EVV) delegated partners; enterprise data warehouses (EDW); capitation payments to providers; fulfillment subcontractors for Enrollee ID cards/Welcome Kits; and applications, portals, and data storage that enable data availability for Enrollee Services and Clinical Guidance specialists

Humana's fully automated enrollment process can add or modify membership information (including coverage effective and end dates) based on incoming enrollment data from DMS. The unique Enrollee ID (displayed on the ID card and on the Enrollee mailings and handbooks) will follow the Enrollee throughout Humana systems and processes (including feeds to our subcontractors, providers, and partners). This allows users to identify a distinct Enrollee across populations and systems and maintain and cross-reference all Enrollee-related information with the most current Medicaid provider number.

Humana's Enrollment Team retrieves eligibility files that subsequently go through mapping in our automated enrollment system that makes edits (as necessary) before finally transferring the file to our CI platform. The processing of data occurs through both batch and real time processes. Thus, an eligibility update, such as a change in Enrollee eligibility type, is automated and occurs multiple times each day. When an Enrollee's enrollment does not appear in the Humana system, but the Enrollee is enrolled with Humana per the 834, our **Express Enrollment Team completes an outbound call within 24 hours** to reconcile the information and update our systems.

CI is designed to smoothly facilitate retroactive eligibility, ensuring the information activates our claims processing technology, Claims Adjudications System (CAS), to ensure that payments for services rendered to a person with retroactive eligibility are flagged for payment, if appropriate. Claims that occur during dates of Enrollee retroactivity are fed to us through our integrated clinical platform, Clinical Guidance eXchange (CGX), daily. **In 2019, Humana processed more than three million claims through our automatic adjudication process for 210,370 Enrollees who were assigned with retroactive eligibility**. Our provider contracts prohibit our network providers from billing Enrollees for services and our Provider Services associates educate providers about these requirements. We also inform Enrollees through our Enrollee Handbook and website that they are not responsible for any bills they receive and instruct them to send them to us. In the event we receive a bill that a provider improperly sent to an Enrollee, the provider's assigned Provider Relations (PR) representative contacts the provider and educates them and their staff regarding the bill and Humana's requirements. This training occurs in the format chosen by the provider (e.g., in person, online, by phone).

We follow similar processes in our Florida Medicaid plan and have successfully set up our systems to pay these claims within 30 days of receipt. CI also tracks Enrollee eligibility end dates. Due to the nightly flow of data from CI to the EDW, Member Services and Clinical Guidance specialists can view Enrollee end dates in real time. Our Enrollee Outreach and Education team proactively initiates outreach to ensure Enrollees take appropriate action to maintain eligibility and continuity of care. Additionally, Humana compares the Enrollee's information from the 834 file to the payment received by coverage month (from the 820 file) to ensure that the payment received matches the expected payment amount (calculated on the variables on the 834 and the payment rates from the published rate book). Through this process, our Capitation Reconciliation team reconciles any missing or incorrectly attributed Enrollees and notifies our Enrollment team to correct the information.

In accordance with Section 26.3 of the Draft Medicaid Contract, Humana will provide for a continuous open enrollment period throughout the Contract term and will not discriminate against potential Enrollees or enact any enrollment and eligibility requirements on the basis of health status, need for health services, race, color, religion, sex, sexual orientation, gender identity, disability, or national origin. All Humana associates, both Enrollee- and non-Enrollee facing, receive extensive training upon onboarding and annually thereafter on Humana's non-discrimination policies and procedures.

Enrollment Systems with Capacity to Scale

Humana's robust systems, including enrollment, claims, clinical, and fulfillment, are capable of vast enrollment growth without issues related to either storage or processing capacity. **Humana's Medicare and Medicaid membership has grown over one million members since the start of 2018. Our receiving systems experienced no capacity-related issues during this time**. All of Humana's systems and processes are organically scalable to anticipated enrollment growth upon award of the Draft Medicaid Contract.

During implementation of our Florida Medicaid Managed Medical Assistance (MMA) program Contract, enrollment quickly grew 700% from 50,000 to now more than 400,000 Enrollees. This large influx of new Enrollees created challenges to rapidly scale operations and meet enrollment requirements. To accommodate this high level of new enrollment, we brought in expert managers and representatives from our Member Services Call Center to handle calls through implementation and backfilled their previous roles in long-running centers with new associates. Moreover, given the scale of Humana's enrollment across all lines of business, we leveraged vast company-wide resources to maintain Enrollee satisfaction. To meet the requirement of

conducting all welcome calls within the required 60-day timeframe, Humana used both temporary and permanent associates. We also created an enhanced autodialing service to effectively serve our enrollment volume. Moreover, **we exceeded requirements and reached out to Enrollees six times as compared to the required three times**. Ultimately, Humana conducted all welcome calls within the required timeframe.

Experience Loading Dual Eligible Enrollees to Ensure Access to Appropriate Benefits

Humana has extensive experience coordinating care for dual eligibles through our plans in Florida, Illinois, and Virginia. Dual eligible Enrollees enter our CI system with an indicator on the 834 file that automatically transfers the file into a mapping system that appropriates proper benefits. The file is subsequently sent to an editing system to ensure accuracy of the information on the file, including address, Primary Care Provider (PCP), and Medicare indicator. The file is then sent downstream to notify our crossover claims and pharmacy departments to pay Medicare first. Humana actively ensures proper care for our dual eligible population by coordinating services through our Management Information Systems (MIS) and frequent Medicare provider communications to reduce over-utilization and duplication of services and costs.

Processing Newborn Enrollment without Access to Care Concerns

Humana's newborn enrollment processes comply with Section 26.9 of the Draft Medicaid Contract and ensure that newborns are proactively enrolled and can immediately access care. Upon receipt of a HIPAA 834 file indicating an Enrollee is a newborn, **Humana's systems automatically express-enroll the file to auto-assign newborns within 24 hours of receipt**. Our enrollment team also takes the following steps to proactively identify newborns and enroll them providing ease of access to care.

Pregnancy Identification Process: If a Humana Medicaid Enrollee gives birth to a baby while enrolled in a Humana Medicaid plan, Humana deems the baby a Humana Enrollee from the date of birth regardless of the date we receive the 834. This alleviates the burden of enrolling the newborn for the new mother, enabling the newborn to seamlessly access services immediately. To proactively identify pregnant Enrollees, our associates review various data sources daily and report any Humana Medicaid pregnancies to the Department in order to obtain an Unborn Medicaid PIN, which we use as an inactivated Medicaid ID.

Delivery Identification Process: To identify deliveries, we review multiple data sources daily (including hospital censuses) and coordinate internally with our clinical, Member Services, and claims teams. Once our systems identify a delivery, our associates check for an active Medicaid ID on the State enrollment portal, the 834, and DMS reports. If there is not an activated Medicaid ID for the Enrollee, we work quickly to collect the specific demographic information needed to activate the Medicaid ID, specifically the name, date of birth, and gender. We subsequently submit activations through the State portal daily.

Proactive Loading of the Enrollment Notification: Our streamlined enrollment processes screen incoming enrollment files from DMS and the Kentucky Certificate of Live Birth, hearing, immunization, and lab data (CHILD) Record system to review for cases when the newborn's Medicaid ID has been activated but not received from the 834. If we find a discrepancy, our Enrollment team reconciles the proactive enrollments with 834 data and sends a discrepancy report for further research.

Coordination with Humana's Call Center: When a pregnant or new mother contacts a Member Services Representative (MSR) in our call center, our associates verify their enrollment with Humana and collect key data elements about the newborn, including name, date of birth, and gender. Our MSRs notify the mother that Humana will cover the newborn and immediately notify our Enrollment team to process the newborn enrollment. The Enrollment team subsequently reconciles these proactive enrollments against 834 data and files discrepancy reports as needed for further research.

New Enrollee Outreach

Humana will mail a Welcome Kit, containing all required materials outlined in Section 26.4 of the Draft Medicaid Contract, to all new Enrollees within five business days of receiving DMS' enrollment file.

Welcome Kit: Our Welcome Kit includes the Enrollee Handbook [with a description of our Covered Services and value-added services (VAS)]; a welcome letter that includes the Enrollee's PCP, ID, and contact information; and the initial Health Risk Assessment (HRA) with a postage-paid return envelope. We also, in writing, notify Enrollees of their Care Manager's (CM) name; contact information; the number, type, and frequency of contacts with their CM; and the care management team number, along with the other requirements defined in Section 26.4 of the Draft Medicaid Contract. We also send Enrollee ID cards via first-class mail, ensuring a higher percentage of our Enrollees receive their ID card. This enables us to track those who do not receive the ID card and subsequently trigger additional research for any incorrect addresses; these efforts ensure our Enrollees are able to obtain services upon their effective enrollment date. We mail all of our welcome materials in clearly marked envelopes with a notification of the importance of the contents. Enrollees can also view or print a copy of their Enrollee ID card through our Enrollee Portal at any time.

Welcome Call: We greet new Enrollees with a welcome call during which we provide information about when they will receive their welcome kit and Enrollee ID card. We also attempt to complete an HRA at this time. If an enrollee indicates wanting to learn more or an interest in selecting a PCP, they will be connected to Humana's Member Service line, where they can be connected to a live agent for further assistance. Our MSRs will provide more detailed information about how the plan works, confirm receipt of the Welcome Kit, and attempt to capture enrollee health data and preferred contact information. If an HRA wasn't captured previously, our MSRs will also attempt to complete the HRA over the phone. If the Enrollee expresses an unmet healthcare need during the Welcome Call, we will connect them to our care management team for further assistance.

Ensuring Continuity of Care upon Enrollment

It is critical that our policy and process coordinates services in a way that ensures there is no disruption or interruption of service delivery. Humana carries out its continuity of care plan via the following steps:

1. Identification: Humana will identify new Enrollees currently receiving care from an out-of-network (OON) provider through several channels. These include enrollment files; information from the transitioning health plan, PCPs, and specialists; the initial HRA; Enrollee comments made during the welcome call and assessments; and claims (including those submitted to Humana and any available historical claims).

2. Payment of OON providers during the continuity of care period: We will verify current provider information through the welcome call, initial HRA, and a review of previous care plans, existing prior authorizations (PA), and any other data supplied by DMS. For those new Enrollees receiving care from an OON provider, we will create a continuity of care authorization for the relevant providers to prevent disruptions in care and ensure timely claims processing throughout the continuity of care period. **We pay OON providers for up to 90 days after the date of the Enrollee's enrollment**, or until the Enrollee's records, clinical information, care plans, authorizations, and care can be transferred to an in-network provider (whichever period is shorter).

   We will continue to pay OON providers on a case-by-case basis when medically necessary. Additionally, we will pay OON providers for second opinions rendered for any medically necessary covered service if an in-network provider is not available.

   For those Enrollees with outstanding orders for durable medical equipment (DME) or supplies that predate enrollment, we will coordinate with the appropriate provider or subcontractor to ensure prompt and timely delivery.

3. Ensuring continuation of authorized services and management of chronic conditions: When a new Enrollee joins Humana, we will review all open authorization files received from DMS and create authorizations to honor the approval of the services. Until all assessments and authorizations are complete, we will adhere to

all Draft Medicaid Contract requirements pertaining to continuity of care through the procedures outlined below:

- When a new Enrollee joins Humana with an existing PA, we will ensure continued authorization of those services for the same amount, duration, or scope until (a) 90 days after the Effective Date of Coverage, (b) the end of the current authorization period, or (c) our CMs have evaluated and assessed the Enrollee, and a new authorization has been issued or denied (whichever period is shortest).
- If the Enrollee is receiving a service for which a PA was not required by their previous fee-for-service (FFS) plan or MCO but is required by Humana, we will ensure that the Enrollee receives a continued authorization for that service until (a) our CMs have evaluated and assessed the Enrollee and issued or denied a new authorization or (b) for 90 days (whichever period is shortest).
- If an Enrollee is past the 24th week of pregnancy at the time of enrollment and wishes to remain with her current OON provider, we will reimburse the Enrollee's OON provider through completion of the pregnancy, immediate postpartum care, and the follow-up check-up within the first six weeks of pregnancy completion.
- If an Enrollee (at the time of enrollment) has been diagnosed with and is receiving treatment for a terminal illness, we will continue to reimburse the Enrollee's OON provider for up to nine months.
- If our Medical Director determines it is medically necessary for an Enrollee to continue receiving care from an OON provider after the continuity of care period has lapsed, we will initiate contracting procedures or will pursue a single case agreement (SCA) with the provider.

For those Enrollees who receive care management services from another MCO, we will request information about the Enrollee's existing Care Management services from that MCO and (wherever possible) will work to assess the Enrollee for our own Population Health Management Programs, with the aim of continuing the services received previously.

Re-Enrollment

Humana ensures continuity of care and a seamless transition for Enrollees who re-enroll with our plan. Humana assigns the Enrollee's previous PCP when the provider is still in-network. We keep claims history in our system for two years before it is archived (remains accessible upon archival). We coordinate with the Department and the Enrollee's prior MCO to receive additional claims and utilization data, including PAs. This information is automatically integrated into the Enrollee's file within Humana's systems. Upon re-enrollment, the Enrollee receives a new Welcome Kit as well as telephonic outreach to fully understand any updated health needs or medications. We log this new information into CGX to ensure continuity of care and correct authorizations.

DISENROLLMENT

Enrollee Request for Disenrollment

Upon receipt of an Enrollee's disenrollment request submitted to Humana, we will transmit the Enrollee's request to the Contract Compliance Officer of the Department in compliance with Section 26.13 of the Draft Medicaid Contract. When a Humana MSR receives a disenrollment request, the associate first checks the Enrollee's file to validate if the Enrollee has already contacted the State Medicaid broker to request disenrollment, if the plan is already terminated, if the Enrollee has lost eligibility, or if the Enrollee has a new health plan. In these cases, the Humana associate refers the Enrollee to the State Medicaid broker, providing the contact information and hours of operation in order for the Enrollee to receive more up-to-date information. In any other case, the MSR explains the disenrollment process, recognizes their right to dis-enroll, and tries to discuss what this may mean for the Enrollee. During this conversation, our associates attempt to conduct a root cause analysis to identify the reason for disenrollment. If the Enrollee is requesting to dis-enroll due to a care management issue, the MSR transfers the call to the Care Management team to identify the root cause of the issue and works to resolve the complaint. When an Enrollee requests to dis-enroll due to a complaint related to Covered Services, the associate works to fully understand the Enrollee's complaint and educates the Enrollee

that Covered Services are consistent across all of the Commonwealth's Medicaid MCOs. If the Enrollee is seeking to access a particular service, our MSRs actively seek ways to connect the Enrollee to proper care, reviewing Covered Services and VAS options with the Enrollee. In the event an Enrollee requests disenrollment due to a desire to see an OON provider, **Humana associates will actively work to get that provider in-network or will conduct special contracting such as SCAs**.

Humana Request for Disenrollment

Humana did not submit any requests for disenrollment to DMS in 2018.

Humana does not dis-enroll our Enrollees; we submit a request to the Commonwealth for disenrollment consideration if we determine:

- The Enrollee is deceased. Humana notifies DMS or the Social Security Administration (SSA) in the appropriate county within five business days of receiving notice of an Enrollee death. We subsequently monitor our capitation payments to ensure DMS has received and processed the notification.
- The Enrollee is incarcerated.
- The Enrollee has been out of the Commonwealth for greater than 90 days and is not expected to return within six months.
- The Enrollee has been threatening or attempted to harm their CM following multiple intervention attempts.
- The Enrollee is designated unable to contact (UTC) following our rigorous process to reach the Enrollee. We describe our UTC process further below.

Humana submits disenrollment requests to DMS in writing, explicitly specifying the basis for the request. When applicable, the submitted documentation will also include reasonable steps taken to educate the Enrollee regarding proper behavior and that the Enrollee refused to comply.

We notify Enrollees whose requests for disenrollment are denied of their right to a State Fair Hearing.

Humana's Unable to Contact Process

Our experience in serving Medicaid populations has underscored the challenges in reaching certain cohorts within our membership. We have discovered value in screening our population even after contractual timelines may have passed. Therefore, our efforts to complete the HRA for an Enrollee will not end after the initial completion period has passed. After 30 days with no successful contacts, we will designate the Enrollee as UTC. Even after the Enrollee is designated UTC, we continue to attempt HRA completion through subsequent Enrollee interactions. We indicate those Enrollees with an uncompleted HRA in our system, alerting those associates who may interact with the Enrollee and prompting action to complete the HRA.

Our UTC approach leverages data mining techniques and our Kentucky relationships to successfully locate and engage difficult-to-reach Enrollees. These methods include locating updated contact information through the following data sources:

- Claims data, including pharmacy data
- Information collected during discharge planning
- Clinical data feeds from participating providers and hospitals, including BH data
- Online search engines (e.g., LexisNexis) to access government records, including death certificates and correctional facility admissions
- Reports of updated contact information from our strategic partners that provide our Medical advice line, BH Crisis Line, prenatal and postpartum, dental, and vision services
- Contacting assigned PCPs, BH providers, pharmacies, and homeless shelters to determine if they have obtained updated or alternative contact information

Through our advanced data analytics systems and predictive models, we utilize that data that we do have available to us – including data from enrollment files and any received claims – to identify Enrollees with Special Healthcare Needs and Enrollees stratified to Intensive or Complex Care Management among our unable to

contact population. Our CHWs will perform additional outreach for these Enrollees, including working with providers and community organizations, and employing other feet-on-the-street approaches to target difficult-to-find and UTC Enrollees. **Humana hires CHWs from the communities we serve to increase our ability to successfully connect with these Enrollees**. CHWs are trained to administer the HRA and identify Enrollee risks and SDOH needs.

Ensuring Continuity of Care upon Disenrollment

Humana ensures continuity for all Enrollees who are dis-enrolled. This includes assisting in the selection of a new PCP, cooperating with the new PCP in transitioning the Enrollee's care, and making medical records available to the new PCP in compliance with applicable state and federal laws and regulations. Humana also authorizes and approves all services for 90 days past the disenrollment date to ensure a smooth transition for the Enrollee. With the exception of nursing facility care, if an Enrollee is in inpatient care at the date of disenrollment, we cover the costs of services until discharge, even if the discharge is past the designated recovery date.

Humana routinely shares Enrollee information with other MCOs when an Enrollee dis-enrolls to facilitate continuity of care. We receive daily files from DMS containing lists of Enrollees who are dis-enrolling and send them to an internal Market analyst. The Market analyst determines the status of the Enrollee and then triggers a process to pull relevant information (care plans, HRAs, PAs, provider name, and number) to append to the Enrollee transfer file. The accumulated information is sent to the subsequent MCO via secure email. If the Enrollee is transferring to Medicaid FFS, PAs will be sent to DMS via secure email. This **automated process ensures that we transfer information on Enrollees dis-enrolling from Humana within five business days** of receipt of a request from the new MCO. Upon Enrollee transfer to a new MCO, Humana will comply with the Transition/Coordination of Care Plans included in Appendix I.

b.	Detail any limitations and/or issues with meeting the Department's expectations or requirements and the Vendor's proposed approach to address such limitations and/or issues.

Humana has the operational framework in place to manage enrollment processes that meet and exceed the Department's expectations and requirements; Humana does not foresee any limitations or issues with meeting the Department's expectations and requirements.

We have implemented Medicaid enrolment systems in Florida, Illinois, Virginia, and Kentucky, encompassing more than 600,000 enrollees. Our implementation process begins with a thorough understanding of each state's requirements, which we match against our current systems and industry best practice. Where new or enhanced processes or systems are required, we deploy our state-of-the-art Project Management and Systems Development Life Cycle (SDLC) methodologies to design, develop, test, and implement approaches that meet requirements. New data feeds are subject to all of the applicable SDLC disciplines, including comprehensive unit, system, and integrated testing using the test environments established specifically for that purpose. We interact with the state Medicaid program during the development and implementation stages to ensure that we are meeting expectations.

To implement enrollment systems in Kentucky, we participated in testing of our enrollment system as part of the Readiness Review. The review team gave us full marks for the following tasks that are specifically relevant to enrollment, re-enrollment and disenrollment:

- Support accurate and timely enrollment, disenrollment and re-enrollment of Medicaid Enrollees and assignment of a PCP;
- Provide periodic reconciliation of state Enrollee records with PCP enrollment records;
- Automatically re-enroll an Enrollee who is disenrolled solely because he/she lost Medicaid eligibility for two months or less; and,

- Supports generation of Enrollee identification cards and other member materials.

The reviewer concluded: "Humana is well organized and prepared to handle Kentucky business." The transition from CareSource to Humana, which occurred on January 1, 2020, has gone very well. Any issues that have been identified have been minor and have been addressed promptly.

Our team is continuously monitoring our performance and implements a risk management strategy to anticipate and curtail any problems. The results of these efforts are documented and maintained in Humana's Governance Risk and Compliance (GRC) enterprise tool. Humana leverages an automated GRC tool, developed by Archer Technologies, identified internally as Enterprise Solution Point (ESP). ESP contains a variety of modules or functions that facilitate the Enterprise Risk Management function. Although there are dozens of modules and functions within ESP, the primary modules leveraged for risk management include (but not limited to): risk register, program/engagement, issues and opportunities, and process/procedure.

Humana maintains a central document repository for Directive Controls (i.e., Policies and Standards) called Policy Source. Policies provide directive guidance on risk management across all organizational domains (i.e., Financial, Operational, Compliance, and Strategic) in all lines of business, that are then leveraged by the ERM functions as an authoritative source against which to perform risk assessments and reviews.

The Enterprise Change Management team is responsible for evaluating risk and preparedness for all technology changes across Humana and our subcontractors. This team facilitates Change Approval Board meetings multiple times per week to ensure that high- and medium-risk infrastructure and security changes, as well as changes affecting critical systems, are operationally ready for deployment. Humana incorporates audit trails throughout our applications, and maintains a history of change and audit trails for current and retroactive data.