C.16. 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."

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.

Passport Highlights: Enrollee Eligibility, Enrollment and Disenrollment

How We're Different	Why It Matters	Proof
Special eligibility support team designated to process urgent eligibility requests quickly	• Eligible members never go without service	• Fewer member grievances related to eligibility issues • Member services team has access to the Commonwealth's portal to confirm eligibility on an ad hoc basis for urgent cases
Rigorous data quality management for eligibility file loads	• Ensures accurate and timely eligibility processing	• For 2019, 100% of eligibility/enrollment transactions from the 834 file processed accurately
We own our highly stable platform, which allows us to be nimble	• Ease of customizing to adapt to support new benefit structures and technical requirements	• Identifi℠ Health Plan Application (HPA) uptime of approximately 99.99% during business hours over the last six months • We completed substantial system modifications to meet KY HEALTH enrollment requirements in advance of initial rollout time frames

Introduction

Eligibility, enrollment and disenrollment are critical to achieving our mission. We understand the importance of providing an excellent member experience as individuals transition in and out of the plan while maintaining continuity of care and meeting Department requirements. For 22 years, Passport has supported the Department's requirements for eligibility, enrollment and disenrollment and will continue to support all contractual Department for Medicaid Services (DMS) requirements.

C.16.a. Describe the approach to meeting the Department's expectation and requirements outlined in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

Passport's Approach to Member Eligibility

We prioritize providing an excellent member experience as individuals join or transition out of the plan and will continue to meet the Department's expectations and requirements outlined in the draft contract. Passport will accept all members without restriction and maintain appropriate levels of staffing and service delivery to ensure an excellent member experience. Our eligibility processes and infrastructure serve as the foundation and core drivers of these critical functions and are especially significant with their immediate critical implications, such as member access to care, claims processing, provider panels and capitation and subcontractor services and operations. Our eligibility operations are highly controlled for accuracy and timeliness, with established processes to identify, investigate and address eligibility issues quickly. Dedicated leadership and technical teams are actively driving and overseeing these operations and positioned to lead any troubleshooting or modifications that may arise. In addition, Passport has in place the technical and procedural infrastructure to support member enrollment activities, as well as changes and disenrollments that occur over time.

Eligibility File Load Overview

When enrollment data regarding member eligibility is received from DMS through the 834 file, it is ingested into the system via a series of controlled steps with monitoring oversight to ensure accuracy.

File Load Monitoring

The file load process has end-to-end monitoring in place. Automated monitoring jobs track expected receipt of 834s from the Commonwealth and send triggered notifications to data operations if not found for investigation and confirmation. See **Exhibit C.16-1** for an example of our alerts received during the file-load monitoring process.

Exhibit C.16-1: Passport's File-Load Monitoring Sample Alerts

Details of Missed Execution Jobs

JOB_ID	JOB_DESC	FREQUENCY	START_TIME	END_TIME	SERVER_NAME	MISSEDEXECUTION_DATE	MISSEDEXECUTION_TIME
PH834DAILY	Eligibility Load and Processing	Every Day	0	23	ALDPRDDBPHKY\ALDERA_SANDBOX	2019-04-16	00:15:00
PH834DAILY	Eligibility Load and Processing	Every Day	0	23	ALDPRDDBPHKY\ALDERA_SANDBOX	2019-04-16	00:30:00
PH834DAILY	Eligibility Load and Processing	Every Day	0	23	ALDPRDDBPHKY\ALDERA_SANDBOX	2019-04-16	00:45:00
PH834DAILY	Eligibility Load and Processing	Every Day	0	23	ALDPRDDBPHKY\ALDERA_SANDBOX	2019-04-16	01:00:00
CCHHS837	837 Daily	Every Day	0	1	ALDPRDDBPHKY\ALDERA_SANDBOX	2019-04-16	00:15:00

Eligibility File Validation and Quality Assurance

Upon receipt of the 834, eligibility file loading immediately begins and includes a multistage quality assurance (QA) process with checkpoints throughout to ensure accuracy. During these standardized quality checkpoints, we will not proceed in our loading stages until we have received technical and business validations and approvals.

The technical team quality checks the record counts overall and by line of business, counts of expected additions and terminations; verifies the number of members on the 834 file against what is to be loaded; and provides validation and analysis of each file. For monthly, quarterly and reconciliation loads, or any loads connected to times of significant program change, we apply added layers of deep audit, quantification and QA checks. The eligibility team reviews the results from a preliminary loading process to monitor and validate loading results, as well as address member record-level issues. If a member record is flagged for rejection or warning, the eligibility team reviews and determines the appropriate steps to take to repair the account if possible, with corrections that can be made using Kentucky Health Net for verification. Discrepancies at the member level that cannot be corrected are communicated back to the DMS via the 200 Report. The 200 Report is also used to inform DMS of a member's date of death or if it has been discovered that a member may live out of state. The 200 Report is sent to DMS monthly by the tenth (10th) of the month.

Passport will notify DMS of any known enrolled members who were not included on the Health Insurance Portability and Accountability Act (HIPAA) 834 transaction file. Further, if we become aware of any changes in demographic information, we will advise the member to report the information to the appropriate source. In the event that the demographic information change does not appear on the 834 within sixty (60) days, Passport will report the conflicting information to DMS.

See **Attachment C.16-1_Eligibility Data Load Process Flow** for Passport's eligibility data load process flow and **Attachment C.16-2_834 Reject Reconciliation** for our full 834 reject reconciliation process.

After a thorough preliminary review and completion of these technical and business quality checks, the second phase of finalization occurs to commit the file into Identifi HPA and officially load the updated member eligibility.

Continuous Process Improvement Advances Passport's Data Loading Speed and Reliability

We prioritize a sound, high-performing technical foundation for consuming 834 files. Over the past two (2) years, we have made significant investments in infrastructure to support rapid 834 file ingestion for daily, monthly, quarterly and reconciliation files well within DMS time-bound load requirements. In 2019, our average file load time for a daily 834 was approximately ten (10) hours, within DMS's requirements for rapid loading. These investments and upgrades include the following:

- Developed and implemented a new 834 eligibility and enrollment parser to drastically reduce load time
- Upgraded data centers with new networking (firewalls, routers, etc.), providing greater platform stability and faster data access
- Migrated to a new server farm, enabling access to faster computing, more and faster storage and higher maximum memory configurations, as well as benefiting from greater distribution of shared services onto broader virtualized servers

- Implemented multiple database configuration and maintenance changes
- Migrated to new Storage Area Network (SAN), enabling access for larger data storage and faster inbound/outbound (I/O) speeds
- Built a new application quality assurance team (twenty [20] resources) focused on full automated regression testing against configuration
- Invested in architecture improvements of the code that drives plan assignment, which significantly reduced the processing time for loading the large 834 files
- Implemented replicated server for eligibility loading and extracts for improved performance of eligibility loading and extract generation
- Built a network operating center which provides around-the-clock IT operational monitoring and support
- Enhanced preproduction environments to support more comprehensive testing prior to code deployments by running additional scenarios and load tests
- Simplified data structures for faster loading and added reliability

Member Plan Assignment

The 834 file load process involves ingesting the raw data via an eligibility pipeline process to determine record-level program participation by using indicators from the 834 information to map the members to the correct “plan” in our core system (where the “plan” correlates directly to the benefits the program allows). Distinct plan types also support the benefit and coordination requirements of varying eligible member categories, and distinct member groups are placed into categories such as Kentucky Children's Health Insurance Program (KCHIP), newborn, family and children and dual eligible members. Additional identifiers are loaded in our front-end database for reconciliation and reporting. The maintenance code given on the 834 will determine if the member information on file will be an addition, termination or change to the member record. A history of all changes to a member’s eligibility record is maintained on the system for reference.

Retroactive Eligibility Processes

Retroactive eligibility indicators are also shared on the 834, and our existing plan structures support retroactive eligibility loads, assigning distinct retrospective eligibility segments aligned with appropriate claims processing behaviors. In addition, for members determined to have retroactive eligibility, authorization requirements are lifted for the period a member was retroactively eligible to prevent challenges to claims payments for providers during this period. For terminations and/or retro-terminations, specific processes assess prior claims payments for recoupment of funds when retro-termination activity occurs. Passport follows the same process to reconcile claims payments for eligibility claims that are pending for retroactive enrollment.

Reenrollments

Upon consumption of an 834 file, our system logic has a member-match component to review if the member is active or has previously been in our system. When matches are found, the logic will reinstate

members with their original IDs and primary care providers (PCPs) if they reenroll within a twelve (12)-month time period to support continuity of care. Our process adheres to all requirements of draft contract Section 26.12. See **Attachment C.16-3_Reinstatement Process Flow** for Passport's reinstatement process flow.

Distribution of Eligibility Information to Subcontractors

Our core eligibility system is also used to disseminate Passport's member eligibility to subcontractors providing services, such as CVS (pharmacy), Avesis (dental and vision) and Beacon (behavioral health). Eligibility is automatically extracted on a daily basis and sent to each subcontractor. The creation and successful distribution of these extracts are monitored through our data operations team and subcontractor operations teams to ensure regular and timely delivery. Subcontractors then load these extracts into their systems on a daily basis for the most updated view of member eligibility. Passport also works with subcontractors on a monthly and quarterly reconciliation schedule and is available to consult and partner with subcontractors to ensure the proper consumption methodology of the data. This collaboration is especially evident when new data elements are expected on the 834, and we jointly coordinate on readiness and testing of any file changes.

Enrollment in Passport Triggers ID Card and New Member Welcome Kit Generation

Passport will receive eligibility files from DMS. We will continue to provide for a continuous open enrollment period throughout the term of the contract for newly eligible members and recognize their right to change plans during the first ninety (90) days after initial enrollment and annually thereafter. Passport does not and will not discriminate against potential members nor use any policy or practice that has the effect of discriminating on the basis of an individual's health status, need for health services, race, color, religion, sex, sexual orientation, gender identity, disability or national origin. Passport understands that the individuals listed in Section 26.8, Persons Eligible for Enrollment and Retroactivity, of the draft contract shall be eligible for enrollment and agree to the associated terms for eligibility and retroactive coverage. We similarly understand that the individuals listed in Section 26.11 of the draft contract shall be ineligible for enrollment.

Passport understands enrollment packets will be developed by DMS for potential members. We understand that we will have an opportunity to review and comment on the information to be included in the enrollment packet and may be asked to provide material for it.

Upon receipt of new memberships, automated processes identify these individuals and initiate distribution of ID cards and new member welcome kits within the five (5)-day requirement. These time-sensitive documents contain critical information and begin plan engagement. We understand and acknowledge the enrollment period time frames, including those related to newborns and presumptive eligible individuals. We also understand that we will be responsible for the provision and costs of all covered services starting on

or after the beginning date of enrollment and the associated requirements related to the continuation of medically necessary covered services.

An extract is generated from the core eligibility system based on triggers of new members needing these materials. Automated monitoring built by our data operations team ensures that the extract is created as expected daily. Our eligibility team adds a second layer of monitoring of this extract process and validates extract content, performing QA checks to confirm that the number of ID cards to be distributed matches expectations from the core eligibility system. After validation, the ID card extract provided to Clarity, the ID card vendor. Quality checks are also done in the Clarity system prior to cards being mailed. When multiple members of the same family enroll at once, ID cards are sent grouped by family rather than in individual envelopes to avoid any delivery time differences that may cause member confusion.

The ID cards and New Member Welcome Kit communications include all required components with approachable, welcoming language. When members enroll in Passport, they are sent a New Member Welcome Kit within five (5) business days through a method that will take no longer than three (3) days to reach the member. This New Member Welcome Kit contains a confirmation letter, a provider listing and a copy of the Passport Member Handbook. An electronic copy of the Member Handbook is available on the Passport website. The contents of the Member Handbook are carefully organized to highlight important calls to action, emphasizing how to access care through clear and concise directions on the following matters:

- How a member selects or changes his/her PCP
- The role of the PCP. How to make appointments
- Specialist providers and hospital care
- Mental health services and substance abuse treatment resources
- What to do if the member has an emergency need for medical or mental health services
- How to access care when traveling away from home

The New Member Welcome Kit also contains important information, including the effective date of enrollment, PCP group and contact information, how to obtain referrals, role of Passport, benefits of preventive health care, overview of the Population Health Management (PHM) program and list of covered services.

Member Services Supports New Members to Address Eligibility Issues

Our Member Services team is poised to support and guide new members as well as address inquiries or challenges from all membership, working in close partnership with the eligibility team. Detailed training and talking points leveraged by the Member Services team help support effective responses and clear member instruction when needed—for example, on how to send demographic or address changes to the Commonwealth or Social Security Administration. The Member Services team has access to our core eligibility system, Identifi HPA, and can reference a member's enrollment status and history quickly at a detailed level, including PCP assignment and plan history. In combination with access to KY Health Net, the Member Services team is able to provide real-time eligibility support. See **Exhibit C.16-2** for Passport's process for responding to urgent eligibility issues and **Exhibit C.16-3** for Passport's process for responding to

non-urgent eligibility issues. Both workflows provide step-by-step guidance to call center representatives to address eligibility issues when a member calls and work to find the "source of truth" to validate a member's eligibility to ensure that he/she receives the right care at the right time in the right place.

Exhibit C.16-2: Passport's Process for Responding to Urgent Eligibility Issues

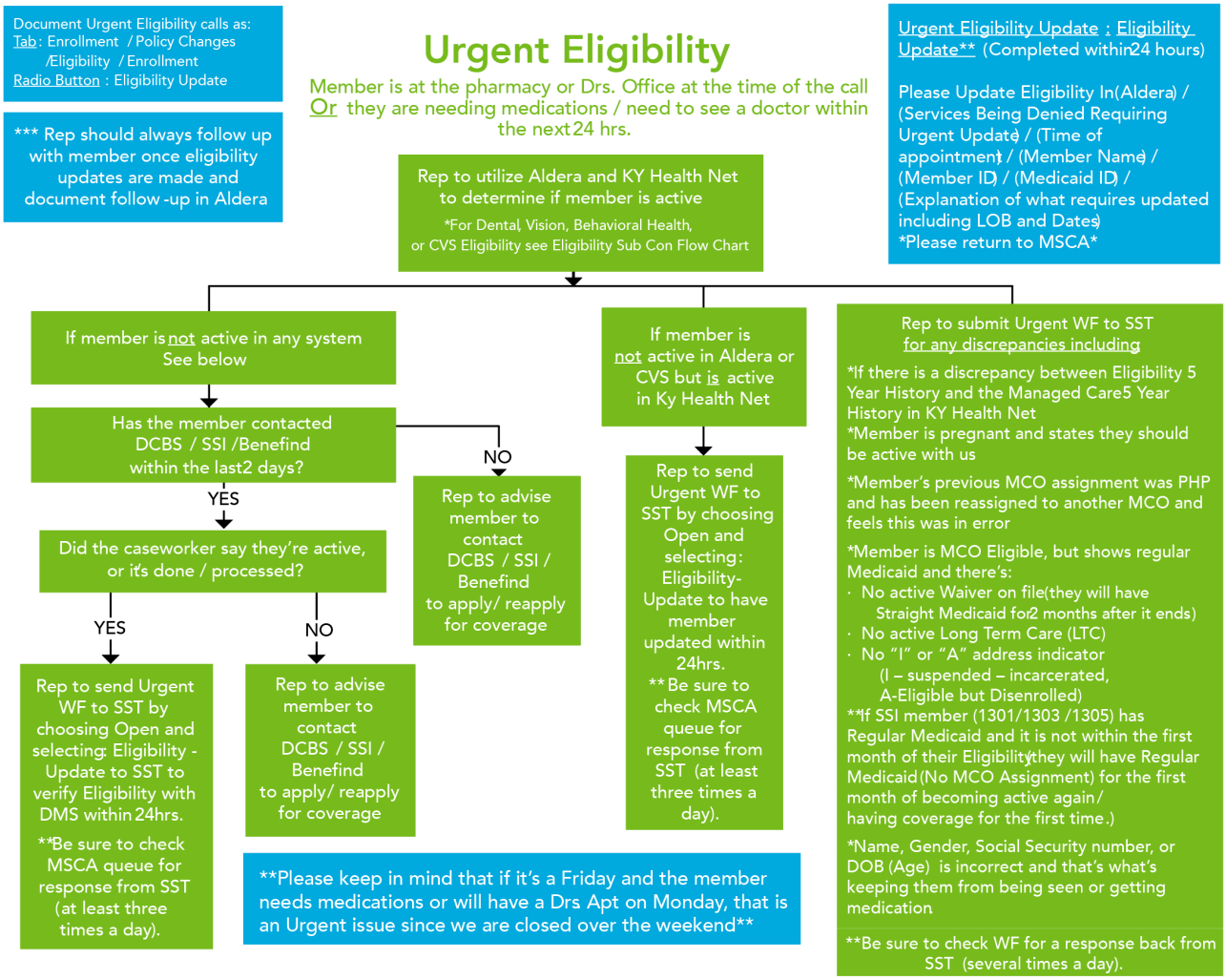
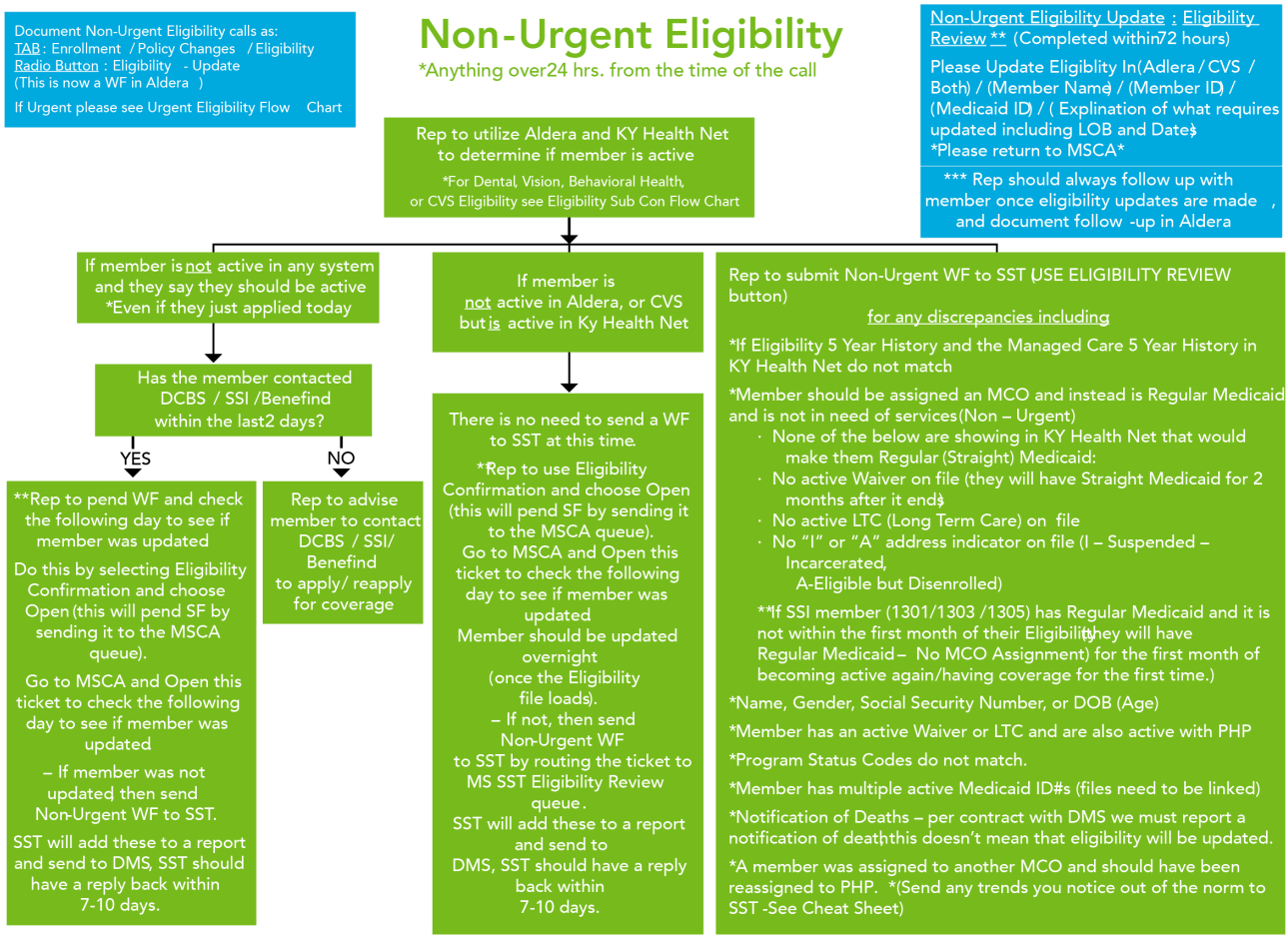


Exhibit C.16-3: Passport's Process for Responding to Non-Urgent Eligibility Issues



Passport's Approach to Disenrollment

Disenrollment-for-cause procedures are coordinated between the compliance team and Member Services and governed by steps to ensure adherence to investigation, documentation and communication requirements with DMS for timely review of the member or plan-initiated request. Our processes adhere to the requirements of draft contract Sections 26.13–26.18 inclusively.

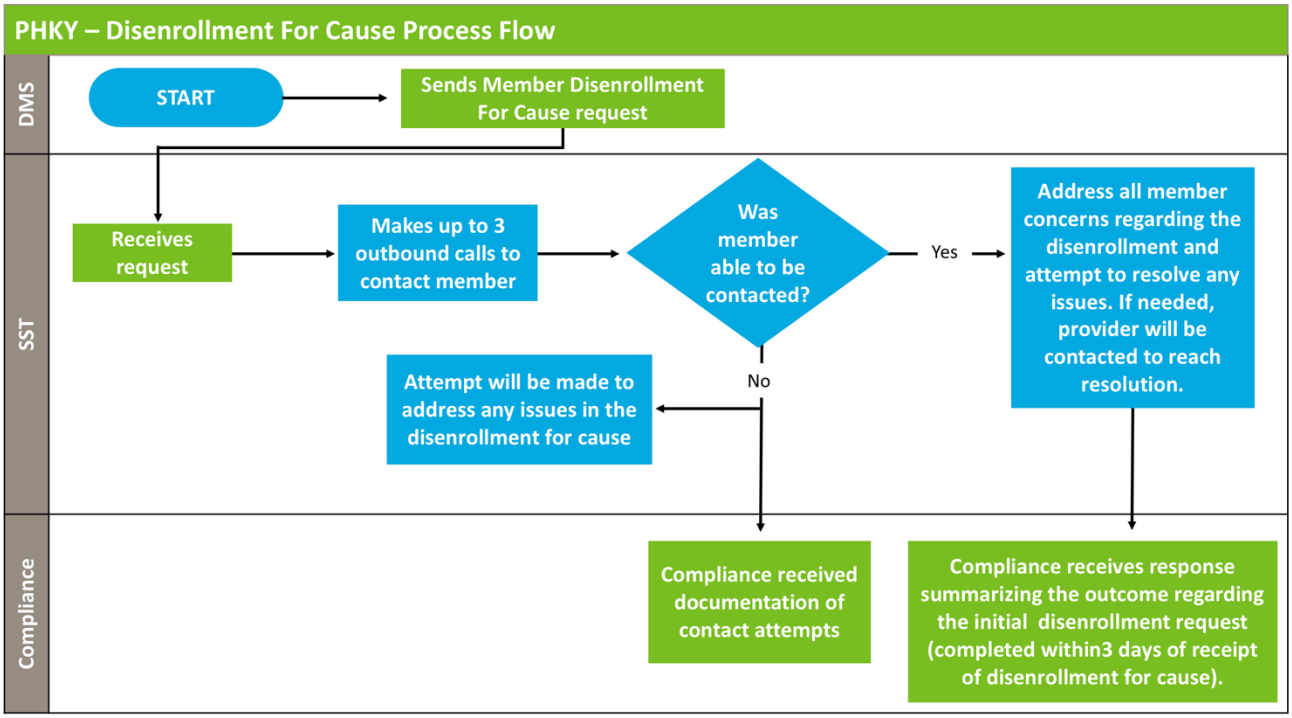
Disenrollment for Cause

This process addresses members who want to change their current managed care organization (MCO) and are not within their ninety (90)-day timeline to make a change or in an open enrollment period. Members contact DMS to start this process or send a request to the plan.

Once DMS receives a disenrollment-for-cause letter, it will forward it to our compliance department with an expected date of resolution (generally within three (3) days of receipt), and compliance will forward the letter to our member support services team (SST) for review. It is the SST's responsibility to complete a full

investigation and document the results in Identifi HPA. SST will reach out to the member and verify the dissatisfaction. SST will attempt to rectify the issue by taking all measures possible. If the issue is access related, before offering additional provider information to the member, SST must confirm that the provider is accepting new Passport members. Once completed, SST will route back to the compliance department, which will forward the results to DMS. See **Exhibit C.16-4** for Passport's disenrollment-for-cause process flow.

Exhibit C.16-4: Passport's Disenrollment-for-Cause Process Flow



Continuity of Care Upon Disenrollment

Passport takes all reasonable and appropriate actions necessary to ensure the continuity of a member's care upon disenrollment. The actions Passport takes include assisting in the selection of a new PCP, cooperating with the new PCP in transitioning the member's care and making the member's medical records available to the new PCP in accordance with applicable state and federal law. Passport follows the transition/coordination of care plan contained in Appendix I "Transition/Coordination of Care Plan" whenever a member is transferred to another MCO.

For inpatient services, if the member is eligible at the time of the inpatient admission and becomes ineligible during the stay, Passport continues the member's benefits until the member is discharged. For outpatient services, Passport ends the authorization at the end of eligibility.

Passport ensures the coordination of the following services for members:

- Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays—this will include discharge planning with the provider(s), referrals to case management and clinical rounds through the authorization process
- Services members receive from any other MCO or fee-for-service (FFS). The Utilization Management (UM) department will ensure continuity of care to avoid the disruption of treatment previously approved through another MCO or FFS plan
- Services the members receive from community and social support providers

Passport's Eligibility Team

The processes, systems and activities described are governed by a dedicated eligibility team responsible for monitoring, quality assurance and management. Our eligibility team works collaboratively to implement and oversee business processes, deliver and maintain enrollment data, maintain an enrollment database, assist with audits and validate and ensure member coverage. See **Exhibit C.16-5** for a description of the roles and responsibilities of Passport's eligibility team.

Exhibit C.16-5: Passport Eligibility Team Roles and Responsibilities

Role	Responsibilities
Director	Implements, manages and refines business processes required to deliver expected business results. Regularly tracks group/departmental costs, ensuring that they are managed within budget. Employs cost-containment measures while retaining quality and efficient operations and a productive, healthy work environment. Defines roles and accountabilities for staff within the group and in the context of the broader process/operation in support of cross-functional efforts.
Associate Director	Ensures the timely and accurate delivery and maintenance of new and existing enrollment data, including system setup, cross-departmental communication and exception reporting. Ensures that the team has appropriate resources and highlights areas of need to the director for resolution. Monitors the work environment and business operations. Addresses concerns that may affect the morale and/or operational effectiveness of the group.
Manager	Manages supervisors, monitors team performance and monitors operational deliverables for the team. Identifies and implements process improvement opportunities that lead to improved efficiency, accuracy and/or productivity. Provides guidance for the team and supervisors regarding escalations and helps to proactively resolve issues before they occur.
Enrollment Specialist	Maintains an internal member enrollment database. Assists with audit preparation as needed to meet regulatory requirements. Formally investigates, documents and responds to enrollment inquiries daily. Interacts with supervisors, peers, other departments, members, brokers/agents, employer groups and third-party administrators and assists with enrollment submissions, education, issues, updates and projects.

Role	Responsibilities
Coordination of Benefit (COB) Specialist	Responsible for the operational processing of COB functions, including paper COBs, customer service COB verifications, COB-termed workflow, claims department emails, UM COB notifications, cost-avoidance reports, cost of recoveries reports and Commonwealth Third Party Recovery (TPR) reports. Facilitates outbound phone calls to various carriers to validate or verify coverage.
Business Analyst	Defines business requirements and acceptance criteria/test cases related to the Commonwealth's Medicaid Program and Centers for Medicare & Medicaid Services (CMS) programs. Uses a variety of software and platforms for statistical analysis and research concerning data. Performs business analysis of identified process and software gaps or inefficiencies and develops plans to fill those gaps for internal business processes and external clients.

C.16.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.

Passport has supported DMS eligibility and enrollment expectations and requirements for more than twenty (20) years. Our system is flexible and nimble to accommodate changes to the Kentucky Medicaid program in a timely manner. Dedicated leadership and technical teams are actively driving eligibility, enrollment and disenrollment operations, and they are positioned to lead any troubleshooting or modifications that may arise. As demonstrated in the past, if issues are encountered, we have worked closely with DMS to resolve them in a timely manner and with collaboration and transparency, and we have implemented work-arounds in certain cases to meet the needs of DMS. In all cases, collaboration with DMS has been essential to a rapid and successful resolution of each challenge. Some of these past challenges that could persist include the following:

- Unexpected data on 834 files, such as seen with the presence of ineligible incarcerated members. Passport will leverage its fallout and regular daily auditing to identify any unexpected scenarios, as well as review collaboratively with DMS
- Accelerated development timelines for program changes. Looking ahead, we anticipate that the contract-specified, thirty (30)-day turnaround time cited in the draft contract could pose difficulties depending on the complexity of the change and clarity of upfront requirements. We look forward to collaborating further on requirements and timing for any future changes to allow for sufficient development and comprehensive testing for quality and to avoid any disruptions

Conclusion

Passport is confident in its ability to continue to meet the Department's expectations and requirements regarding member eligibility, enrollment and disenrollment. We have especially committed to deep platform and data structure optimizations over the last two (2) years, significantly strengthening the foundation, speed and reliability of eligibility data consumption. Multiple control and audit points look at eligibility data

as a whole to proactively monitor for any outliers or unexpected results that are directly fed to the enrollment team for correction. Our multidisciplinary team of eligibility, engineering and platform leadership is prepared to support eligibility program needs in both its current state and through evolutions. Through those efforts, a history of demonstrated responsiveness, flexibility and collaboration exists. Our Kentucky Health readiness efforts and results spotlight Passport's dedication to working as a partner with the Department to adapt to significant technical and program transformations and bring the focus and technical expertise required to apply intended changes. Furthermore, Passport understands the criticality of these business processes to achieve our mission "to help improve the health and quality of life for our members."

Passport has been honored to serve the Kentucky Medicaid and foster care populations for 22 years and will continue to comply with all provisions of the Medicaid Managed Care Contract and Appendices (including Kentucky SKY) as we continue to serve them in the future.