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."

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.

Seamless enrollee experiences, operational efficiencies related to all stakeholders and improved enrollee outcomes are successful results of the fundamental processing of eligibility and enrollment files. Our approach is to make certain enrollees are added, updated and terminated in our eligibility systems accurately and timely so they can access providers, use all available services, be reviewed for preventive care and care coordination opportunities, and participate in quality management programs. Eligibility data are also important to support timely and accurate claims processing.

Our dedicated enrollment team applies rigorous procedures and uses adaptable, dependable systems to confirm that MCO program enrollees receive prompt access to services. The team works closely with the Commonwealth resources on handling enrollment transactions to maintain timely and accurate eligibility files. We apply comprehensive enrollment processes to confirm accurate enrollee data loads and complete system updates timely. They also support identification of complex care opportunities and quality management programs in compliance with all requirements in Attachment C – Draft Medicaid Managed Care Contract, Section 26.0 Enrollee Eligibility, Enrollment and Disenrollment.

Systems and Processes Accepting New Enrollee Assignments

Eligibility Determination and New Enrollee Assignments

Our enrollment team, combined with our Electronic Eligibility Management System (EEMS), will work with DMS as the "source of truth" for eligibility determination. We are committed to providing all segments of our enrollee populations with the resources and information they need to understand the programs and take charge of their health. Knowing the importance of enrollee-reported status changes (as these may affect eligibility and coverage), we will provide DMS with any information that may indicate a change in enrollee eligibility and will abide by the DMS determination. Additionally, we agree to abide by DMS' due consideration of new enrollee assignments in light of equitable distribution among MCOs and continuity of care.

We have significant experience with large-volume enrollee transitions and with month-to-month enrollee transitions. Recently, we implemented a new state contract with almost 132,000 members that went seamlessly, with weekly audit files having roughly 167,800 transactions on average. We reach out to the relinquishing health plan and, as appropriate, the member's care manager for our new member's medical authorization records, care plan, claims and service authorizations to identify the member's needs and to make sure current services are continued and transitioned without interruption. We also gather information about a member's hospital discharges and related lab work and medications. We take added measures to make sure we meet members' needs during and after the transition period so there is no disruption in care. In the first 30 days, we will contact the enrollee to complete an HRA and assign or confirm their PCP, which enables us to understand their needs better. Whenever possible, we take steps to maintain a relationship between the enrollee and their PCP, including securing a new contract with that PCP, as applicable and if possible.

Enrollment Provisions and Procedures

We will provide a continuous open enrollment period throughout the terms of the contract for newly eligible enrollees. We do not discriminate against individuals based upon race, color, national origin, age, sex, sexual orientation, gender identity, disability, ethnicity, language needs or health status. We follow written policies and procedures for Kentucky MCOs for enrolling all eligible populations and accepting the enrollment of all individuals appearing on monthly enrollment reports. Every enrollee will receive a mailing of their Kentucky MCO ID card, Welcome Packet, *Member Handbook* (containing information on the Population Health Management program and the list of covered services) and separately once the program is approved, a Kentucky HEALTH premium invoice, within five business days after receipt of notification from DMS.

Enrollee Eligibility File, Enrollment and Retroactivity

We will expect a monthly DMS HIPAA 834 transaction file and a reconciliation of enrollment information as determined by DMS. We will process electronic data transmissions ***daily*** to indicate new, terminated and changed enrollees and a ***monthly*** listing of all enrollees. We rely on our Electronic Communication Gateway (ECG) for data file exchanges. Our ECG service for business-to-business information exchanges provides a security-compliant electronic transport mechanism for internal entities and external business customers to exchange data files, such as 834 (enrollment/eligibility) and 837 (encounters) via scheduled integration with job automation and control services, including transmission validation. The ECG provides:

- Secured transport and nonrepudiation of file transfers between UnitedHealthcare and external parties
- Secured file exchange between internal UnitedHealthcare servers using client-based file transfer application
- Activity/audit reporting and UnitedHealthcare information technology security compliance

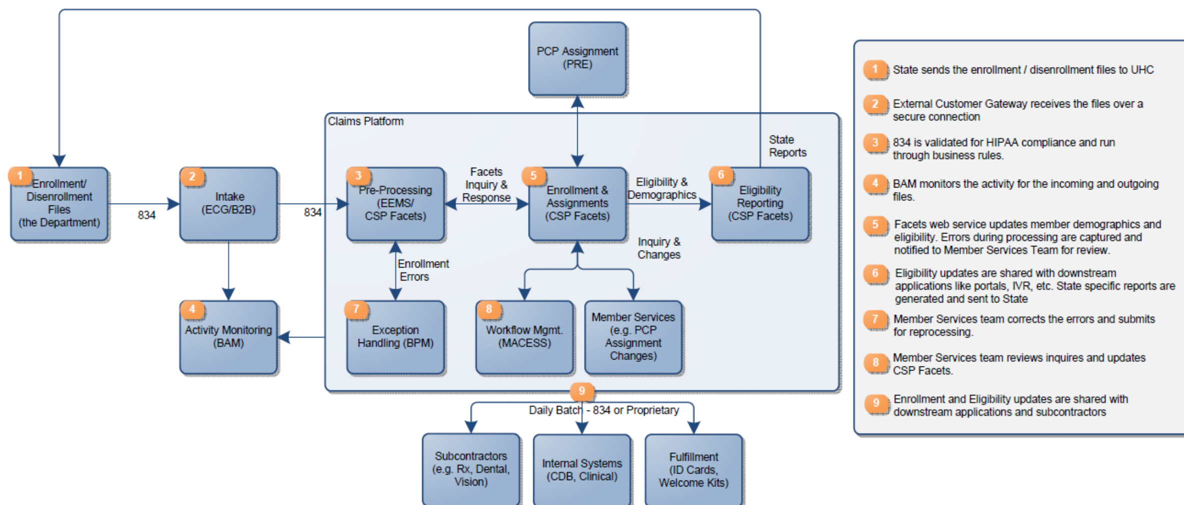

Figure 10. Enrollment Flow. Our efficient and thorough enrollment process supports enrollee access to providers and services from the first date of eligibility.

The ECG uses Secure File Transfer Protocol (SFTP), Hypertext Transfer Protocol Secure (HTTPS) and plain File Transfer Protocol (FTP) with encrypted files transport methods. We coordinate with external partners to validate data exchanges are and complete and valid. Firewalls and physical separation of processing systems further secure access to prevent unwanted entry.

We implement critical interfaces to appropriately and securely exchange enrollment and eligibility information, including:

- Accept Kentucky eligibility files in HIPAA-compliant formats
- Provide membership information to our internal systems, such as our clinical management system
- Provide data to our SMART data warehouse for reporting and performing data analytics
- Securely submit new enrollee data to the UnitedHealthcare ID card and enrollee welcome packet fulfillment center
- Confirm membership information is available to our enrollee portal following receipt of the 834 enrollment file
- Confirm membership information is available on the provider portal, so providers can verify eligibility information
- Provide membership information to applicable partners following receipt of the 834 enrollment file

We load new enrollment information within 24 hours after receiving the enrollment file. Timely information loads enable our partners and internal systems to promptly access information for enrollee ID card and welcome kit fulfillment, enrollee and provider website-data updates, claims processing and more.

Enrollment Platform

We use our state-of-the-art enrollment and claims platform, Facets Community Strategic Platform (CSP), to process enrollment automatically. It also enables off-cycle enrollment and error correction. We process the enrollment data to add, delete or modify membership records with accurate begin and end dates. Our system maintains a history of changes, adjustments and audit trails for current and retroactive data. It also uses logging, journaling and audit tables to maintain a record of all changes to transactions and data within each application. Our platforms actively store seven years of historical information including membership, eligibility and claims data.

The CSP stores eligibility information including state program code, region and enrollees' health care benefit package. We understand it is critical to maintain up-to-date coverage information to determine benefits eligibility and opportunities for coordination of benefits. The CSP's coordination of benefits extension allows us to store enrollees' additional insurance information, which we integrate into the claims processing application to provide proper claims adjudication.

Our enrollment team includes staff trained to resolve enrollee eligibility, disenrollment and demographic data discrepancies as communicated on the 834 files. The team includes dedicated supervisors, subject matter experts and eligibility representatives. Each team member fills a specific role to review and correctly update in our system within contractual time frames.

The CSP provides automatic error alerting that triggers processes and procedures for manual correction conducted by our eligibility team. Additionally, the eligibility team uses an internal error report of discrepancies identified when processing

Demographic Information

The CSP Facets stores our enrollees' demographic information (e.g., age, gender, geography, cultural, and linguistic needs), allowing us to develop interventions that accurately reflect and consider our enrollee composition, to include updating and refining program materials, provider networks and community resources.

the eligibility file received from the Commonwealth. The team uses the internal report to make manual corrections, as needed, for each 834 file. The report details the nature of the discrepancy, steps taken to resolve it, and the before-and-after data element in question.

Special Populations

Newborn Infants

We comply with the requirements specified in Attachment C – Draft Medicaid Managed Care Contract, Section 26.9 Newborn Infants and follow written policies and procedures (P&Ps) to provide all medically necessary services under the benefit package to newborns of program enrollees beginning at birth. Our systems enable us to learn about a newborn's birth before the mother completes the appropriate Commonwealth documentation to register her baby:

- Newborns are received on the 834 file, email or MACESS request
- Newborn eligibility is verified through the Commonwealth Eligibility Verification System (EVS)
- If the newborn is not showing eligible in the EVS, the mother must contact the Commonwealth to inquire about eligibility
- If the newborn is found, they are enrolled into CSP and RxClaim with the information from the mother's record if necessary

Therefore, our P&Ps enable coverage of the newborn through the mother, until the baby's separate Medicaid identification assignment allows system entry through the 834 file.

System data and other information help to prepare us for newborn coverage, and to make sure that expectant mothers receive needed care and education. We use several methods to identify expectant mothers, including the enrollment-file pregnancy indicator, claims analysis, new member welcome calls and initial health screenings. Mothers-to-be experiencing high-risk pregnancies receive referrals to our *Healthy First Steps* program. Our *Member Handbook* requests that members contact our member services staff when they become pregnant or give birth.

Systems and Processes for Disenrollment

Continuity of Care Disenrollment

We realize that continuity of care is as important for enrollees who leave our health plan as it is for our new enrollees. We are committed to seamless transitions and follow formal written P&Ps, in compliance with Attachment C – Draft Medicaid Managed Care Contract, Section 26.16 Continuity of Care upon Disenrollment, to confirm coordination, assuring a transfer of services with a good outcome and no disruption to the enrollee's care. Using the Kentucky MCO program *Transition/Coordination of Care Plan*, we will collaborate with the receiving health plan, pharmacy benefits manager, PCP, specialists, behavioral health and other providers to develop and implement the plans of care for enrollees during the transition, and deliver all services contained in the plans. We coordinate care transition and manage, coordinate and monitor transitions of care for enrollees regardless of the reason for the transition.

We communicate all service pre-authorizations to confirm appropriate handling of claims. If the enrollee transitioning from our health plan is a high-risk enrollee referred for care management, the assigned care manager works with the care team to communicate all provider appointments, supplies and services to the receiving health plan. In addition, the care manager may schedule a conference call with the care team to confirm preparations for the transfer and verify continuity of care.

We follow written P&Ps related to discharge planning, to make sure enrollees receive placement in the appropriate level of care from the hospital. These policies confirm the following:

- Enrollees requiring placement to an alternate setting receive placement in the appropriate level of care from the acute care hospital.
- The facility meets Commonwealth licensure requirements.
- Enrollees already residing in alternate placement return to the appropriate level of care.

This excludes enrollees who require skilled nursing facility placement upon discharge and those who are in the ED and not admitted to the hospital.

We provide the receiving health plan with enrollee information that minimally includes:

- Enrollee name, address, telephone number and Medicaid number
- The name of the assigned PCP
- Program enrollment date and disenrollment date
- Diagnoses
- Current home and community-based services in place (if applicable)
- Care manager's name and telephone number (if applicable)
- Any pending grievances, appeals and enrollee or provider service issues

We also provide the following information to inform the receiving health plan if the enrollee is:

- Hospitalized
- Pregnant
- Receiving dialysis
- Chronically ill

To maintain compliance with all confidentiality requirements, we obtain the enrollee's signature on the appropriate forms before releasing any information.

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.

We do not expect any limitations or issues, and we will comply with DMS requirements.

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