Government Business Division
Policies and Procedures

Section (Primary Department) **Medicaid Enrollment & Billing**	**SUBJECT (Document Title)** **Membership Load - Facets**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
October 01, 2000	March 10, 2022	~~August 18,~~ ~~2022~~October 27, 2022	~~August 18,~~ ~~2022~~October 27, 2022

Department Approval/Signature:

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☒ Arkansas	☒ Iowa	☒ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☒ Kentucky	☒ New Jersey	☒ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Louisiana	☐ New York – Empire	☒ Virginia
	☐ District of Columbia	☒ Maryland	☐ New York (WNY)	☐ Washington
	☒ Florida	☒ Minnesota	☐ North Carolina	☒ Wisconsin
	☒ Georgia	☐ Missouri	☐ South Carolina	☐ West Virginia
	☐ Indiana	☒ Nebraska		

PURPOSE:

To ensure that eligible members are loaded in the core claims processing system in a timely and accurate manner. The Medicaid Enrollment and Billing Department will load, process, and reconcile enrollment/eligibility information received from each state in accordance with contract requirements documented in the Enrollment Update Report.

DEFINITIONS:

None

PROCEDURE:

1) The Medicaid Enrollment and Billing Department will accept all eligible individuals, in the order in which they apply and without restriction. In addition, they will process enrollment/eligibility data received from the states in accordance with all contractual requirements.

2) The Medicaid Enrollment and Billing Department shall accept all recipients without restriction and shall not discriminate on the basis of religion, gender, race, color, sexual orientation, age, national origin, ancestry, marital status, health status or physical or mental disability, and shall not use any policy or practice that has the effect of discriminating on the basis of religion, gender, race, color or national origin, or on the basis of health, health status, pre-existing condition or need for health care services.

3) All markets are subject to the internal standard processing time of two (2) business days for daily files and three (3) business days for monthly files unless the state contract indicates a more stringent time frame. For those markets, the Company adheres to the state contracted timeline.

State	Requirement
AR	The PASSE must update its eligibility/enrollment databases within twenty-four (24) hours after receipt of the 834.
FL	Within 24 hours of receipt of the enrollment/eligibility file
GA – GF& GF 360º Program	Internal standard used. *Note: In the event that a Georgia Families or Georgia Families 360° member's enrollment status changes from an eligible to ineligible category, the 834 file is automatically updated by the DCH and submitted to AGP. Details regarding the disenrollment process can be found in the "Disenrollment-GA" policy.*
IA	Within 48 hours of receipt of the enrollment / eligibility file
KY	Prior to the start of the following business day for daily files and internal standard for monthly file
LA	Update eligibility and enrollment databases within twenty-four (24) hours of receipt of files
MD	Within two (2) days from receipt of the file.
NJ	Within forty-eight (48) hours from receipt of the file.
NV	Internal standard used.
TX	Medicaid: Internal standard used. CHIP: Within twenty-four (24) hours from receipt of the file.
VA	Internal standard used.

4) The load process provides reports that identify errors encountered, counts the transactions processed and provides a complete audit trail of the update process.

5) The Health Plan shall accept new members throughout the contract period up to the authorized maximum enrollment levels approved if such levels exist in each market.

6) The Medicaid Enrollment and Billing Department will additionally load membership through a manual process initiated by a communication log request from National Customer Care (NCC).
   a) Communications logs are reviewed on a daily basis and appropriate action is taken to rectify problems noted on the logs or load members into the claims processing system.
   b) Membership and roster files are processed when received so that membership within the claims processing system is current and accurate. The Enrollment Update Report identifies the receipt schedule for each of the files in the different markets.

c) Membership on the State file is then reconciled with membership information in the claims processing system. The variances are either corrected in the claims processing system or further researched with the state enrollment contact.
d) After completion of the reconciliation, Membership ID cards, new member packets and panel listings are generated as required for membership. Please refer to the Member ID Card - Facets Procedure and Provider Panel Listing Procedure.
   i) Reports are generated and distributed as required by State contracts.

7) Enrollment status of all enrollees for all markets shall continue uninterrupted when the state contract is renewed.

REFERENCES:

- AHCA Contract No. FP068
- FHKC Medical Services and Coverage Contract 2020-23
- GA Contract Number 2016004
- ~~LA – Contract Section 2.19.10 and 2.19.10.1.1[YCJ1] and 2.3.15~~
- LA – Contract Section 2.19.10 and 2.19.10.1.1[YCJ2] and 2.3.15 (New Executed Contract 08/23/2022)

RESPONSIBLE DEPARTMENTS:

Primary Department:
Medicaid Enrollment & Billing

EXCEPTIONS:

Florida - Statewide Medicaid Managed Care Express Enrollment process allows for daily enrollment files with members' eligibility with the Plan, beginning the day the State determined Medicaid eligibility.

Florida provides segment updates for its Medikids program and disenrollment updates that are faxed and manually loaded into Facets.

The Florida Statewide Medicaid Managed Care Long-Term Care program provides enrollment and disenrollment information via fax that is manually loaded into Facets.

Florida Healthy Kids program submits, via fax, enrollment, disenrollment and demographic member updates that are manually loaded into Facets.

Under the MMA contract there is a 60 day auth waiver for all new members, regardless of when they enroll with us. A user warning message will be applied to identify these members during the time period that they are affected by the 60 day auth waiver. This applies to new members and members who have 180 days or more break in coverage. This applies only to MMA & Comprehensive members, not Medicaid, LTSS or Healthy Kids (CHIP).
A new member is defined as never having prior eligibility coverage with Amerigroup/Simply Health Care/Better Health/Clear Health Alliance OR the member is considered new if they had prior eligibility coverage with Simply Healthcare /Clear Health Alliance with a break in coverage 180 days or greater.

Georgia - Planning for Healthy Babies (P4HB) participants -DCH or its Agent will Auto-Assign the individual to a CMO plan using the algorithm described in Section 2.3.3 for Members.

Women already enrolled in Georgia Families (GF) due to pregnancy will have an expedited enrollment into the Demonstration (Planning for Healthy Babies) upon termination of their pregnancy benefits. Members determined to be eligible for the Demonstration (Planning for Healthy Babies) must be afforded the opportunity to choose a new CMO, if desired, for the delivery of Demonstration (Planning for Healthy Babies) related Services. All P4HB participants will have Ninety (90) days from the date of eligibility notification to choose a CMO.

The Contactor will notify its current pregnant Members at least thirty (30) Calendar Days prior to the expected date of delivery and prior to the date upon which the Member will end RSM, that they may be eligible to enroll in the Demonstration (Planning for Healthy Babies) and may choose to switch to a different CMO plan for receipt of Demonstration (Planning for Healthy Babies) services. Members who do not make a choice will be deemed to have chosen to remain in their current CMO plan for receipt of the Demonstration (Planning for Healthy Babies) services they are eligible to receive.

The Contractor shall accept all eligible individuals for Enrollment as identified by DCH or its Agent without restrictions. The Contractor shall accept new enrollment from individuals in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the contract. The Contractor shall not discriminate against individuals on any basis, including but not limited to religion, gender, race, color, national origin, sex, sexual orientation, gender identity, or disability, or on the basis of health, health status, pre-existing Condition, or need for Health Care services.

Iowa - The Health Plan accepts individuals eligible for enrollment in the order in which they apply without restriction. The Health Plan will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll. Additionally, the Health Plan will not discriminate against individuals eligible to enroll on the basis of:

1) Race

2) Color

3) Ethnicity

4) Religion,

5) Sex;

6) Mental or physical disabilities;

7) Sexual orientation;

8) Genetic information;

9) Health status;

10) Age; or

11) Gender, or

12) National origin.

The health Plan will not use any policy or practice that has the effect of discriminating in such manner.

Maryland - Does not perform reconciliation with the claims processing system, rather a monthly reconciliation with the state for a two (2) year-rolling period.

Nevada - Identified discrepancies between information in the daily and monthly 834 files with respect to membership will be researched by the Medicaid Enrollment and Billing Department in the Nevada EVS eligibility system prior to questions being posed to the Nevada Division of Health Care Financing and Policy (DHCFP). Membership information will be manually uploaded based on feedback received from DHCFP through member and provider complaints and other DHCFP correspondence.

Texas - Retro-enrolled members will be sent on a daily file to the MCO and the MCO must upload the daily Enrollment File into its system within 24 hours of receipt.

REVISION HISTORY:

Section (Primary Department)	**SUBJECT (Document Title)**
Medicaid Enrollment & Billing	**Membership Load - Facets**

Review Date	Changes
04/28/2014	• Moved to Generic Template
05/27/2014	• Update file processing SLA
06/24/2015	• Minor update to GA language • Removed NM as applicable mkt
12/03/2015	• Off-cycle edit to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016. • Added Iowa to requirements grid • Added Iowa exception language
01/29/2016	• Off Cycle edits made by GA per the HSAG Audit
07/21/2016	• For annual review • Florida exception updated • Exceptions placed in alphabetical order
07/20/2017	• For annual review • Minor update to procedure section • IA added to exceptions section
07/16/2018	• Annual review • Additional language added to FL exceptions section
10/18/2018	• Off-cycle edit to add MN as an applicable market
01/14/2019	• Off-cycle edit to add AR as an applicable market & add AR contract requirements
11/14/2019	• Annual Review • Removed KS as applicable market • Removed KS under procedure table
01/14/2021	• Annual Review • Revised FL exceptions language • Update to GA requirement
03/10/2022	• Annual Review • Added NE as an applicable market • Revised Procedure, References, and Exceptions sections • Update TX SLA • Revised FL exceptions language
08/18/2022	• Off Cycle Review-Amended Contract GA • Updated GA References • GA Exceptions Updated
10/27/2022	• Off-Cycle Review for LA Rebid 2023 Readiness • Updated LA reference