ENROLLMENT MANUAL

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I. INTRODUCTION

I. INTRODUCTION

The Puerto Rico Health Insurance Administration, hereinafter known as PRHIA or ASES, is a government corporation created in accordance with the Act No. 72 of September 7, 1993 as amended, also known as the "Puerto Rico Health Insurance Administration Act". PRHIA is created with the purpose of management, negotiation and contracting of health insurance plans that enable it to obtain, for its beneficiaries, particularly the medically needy, quality hospital and other medical services.

This document constitutes a reference manual, which establishes the requirements in the development of the systems, between the Information Systems Office of PRHIA and the contracted insurers, in the different products according to contract. This includes processes of eligibility, subscription, premium payment. Any conflicts between this document and the applicable statutes, regulations and guidance from the Centers for Medicare and Medicaid Services (CMS) or Contracts for the Provision of Physical and Behavioral Health Services Under the Government Health Plan Program as between PRHIA and the Managed Medicaid managed care organizations shall be resolved in favor of CMS guidance and such contracts, as amended.

Changes are incorporated as required by CMS for Modified Adjusted Gross Income (MAGI) effective July 1, 2017.

II. DEFINITIONS

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Adjusted Payment
Reversal of a payment that has been adjudicated during the payment process of a previous premium payment cycle.

ASES
Administración de Seguros de Salud de Puerto Rico (the Puerto Rico Health Insurance Administration (PRHIA), the entity in the Commonwealth responsible for oversight and administration of the Government Health Insurance Plan (GHIP) or its Agent.

Auto-Assignment
The assignment of an Enrollee to a PMG and a PCP by the carrier, normally at the same time that ASES or the carrier auto-enrolls the person in the GHIP.

Auto-Enrollment
The enrollment of a Potential Beneficiary in the GHIP by the carrier's database, in compliance with Article 5 of the Contract between ASES and the carriers, without any action by the Potential Beneficiary.

Beneficiary
A person who is eligible and receives services in the health plan, as established in Section 1.3.1 of the contract between ASES and contracted insurers.

Business Day
Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. Puerto Rico Holidays are excluded.

Calendar Days
The seven days of the week.

Capitation
A contractual agreement through which a carrier or provider agrees to provide specified health care services to members for a fixed payment per month.

Carrier
Provides Managed Care Services in an ASES region. It is responsible for contracting with PMG's, PCP's and other providers.

Centers for Medicare and Medicaid Services ("CMS")
The agency within the U.S. Department of Health and Human Services which is responsible for the Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

Certification
A decision by the Puerto Rico Medicaid Office, that a person is eligible for services under the GHIP because the person is Medicaid Eligible, CHIP Eligible, or a member of the Commonwealth Population.

Certification Date
Date when the Medicaid Office completes a beneficiary's evaluation of eligibility for healthcare services.

Children's Health Insurance Program ("CHIP")
The Children's Health Insurance Program established pursuant to Title XXI of the Social Security Act.

Copayment
A cost-sharing requirement that constitutes a fixed amount paid by the beneficiary to a provider for the provision of medical services covered by the health plan. Copayments are defined by ASES for each of the coverage codes.

Coverage Code
Code assigned by the Puerto Rico Medicaid Office to eligible beneficiaries, according to Federal, CHIP and State indigence criteria. Under GHIP, the coverage code will coincide with the Plan Version.

Daily Run Processes Date
It is the date of the day, when the eligibility process is received, received by the Medicaid Office and the subscriptions submitted by the contracted insurers. These processes are performed in the Office of Information Systems.

Deemed newborns
Are children born to a mother with Medicaid eligibility.

Disenrollment
The termination of an individual's enrollment in the GHIP or carrier's plan.

Dual Eligible Beneficiary
An Enrollee or potential enrollee eligible for both Medicaid and Medicare.

Effective Date of Disenrollment
The date on which an Enrollee ceases to be covered under the carrier's plan.

Effective Date of Eligibility
The date of eligibility of the beneficiary in the GHIP, described in the contract established with the corresponding insurer.

Enrollment Effective Date
The date when you subscribe to the eligible beneficiary in the contracted insurer's database.

PCP Effective Date
Date on which a PCP1 or PCP2 change becomes effective.

Recertification Effective Date
Date the Medicaid Office reevaluates the eligibility of the beneficiary.

Eligibility
Eligibility is determined by the Medicaid Office of the Puerto Rico Department of Health except for populations covered under code 400

Eligible Person
A person who meets the requirements and standards established by the Medicaid Office to be eligible for the GHIP. Eligibility for populations covered under code 400 are not determined by the Medicaid Office of the Puerto Rico Department of Health.

Enrollee
A person who is eligible and is enrolled in the GHIP.

Enrollment
The process by which an eligible person becomes an Enrollee.

Federal Category
Classification established by the Medicaid Office of the Puerto Rico Department of Health for a beneficiary, according to established criteria of indigence levels.

Government Health Insurance Plan (GHIP)
The Government Health Services Program (also known as "La Reforma" or "Mi Salud") offered by the Government of Puerto Rico, and administered by ASES, which serves mixed population of Medicaid Eligible, CHIP Eligible, and other Eligible Persons, and emphasizes integrated delivery of physical and behavioral health services.

Health Insurance Claim Number (HICN)
Is a Medicare beneficiary's identification number, appears in the beneficiary's insurance card. All Medicare beneficiary claims are processed according to this number

Identification Card (ID)
A card bearing an Enrollee's name, contract number, and co-payment amounts, and a customer service telephone number, which is used to identify the Enrollee in connection with the provision of services.

Managed Care Organization (MCO)
An entity that is organized for the purpose of providing health care and is licensed as an insurer by Puerto Rico Commissioner of Insurance ("PRICO"), which contracts with ASES for provision of Coverage Services and Benefits in designated Service Regions on the basis of PMPM Payments, under the GHIP.

MA-10
Form issued by the Puerto Rico Medicaid Office, entitled "Notice of Action Taken or Application and/or Recertification" containing the Certification decision (whether a person was determined eligible or ineligible for Medicaid, CHIP, or the Commonwealth Population).

MAGI
Modified Adjusted Gross Income is a method that is used to standardize the way in which income is calculated to determine Medicaid/CHIP eligibility. This new method introduces changes to the real

structure of addressing and complying with the specifications established by the Centers for Medicare & Medicaid Services (CMS).

Master Patient Index (MPI)
Master Patient Index. Unique number which identifies a Member in ASES and the Medicaid Office databases.

Medicaid Office
The medical assistance federal/state joint government program established by Title XIX of the Social Security Act.

Medicare
The Federal Program of medical assistance for persons over sixty-five (65) and certain disabled persons under Title XVIII of the Social Security Act.

Medicare Beneficiaries
People older than sixty-five (65) years of age or disabled or people who have end state renal disease (ESRD), who are eligible for Medicare Part A coverage which covers hospital services or Parts A and B. which cover hospital, ambulatory and medical care services.

Medicare Part A
The part of the Medicare program that covers inpatient hospital stays, skilled nursing facilities, home health and hospice care.

Medicare Part B
The part of the Medicare program that covers physician, laboratories, outpatient, and preventive services.

Medicare Part C
The part of the Medicare program that permits Medicare recipients to select coverage among various private insurance plans.

Medicare Part D
The Medicare prescription outpatient drug benefit.

Medicare Platino
A program administered by ASES for Dual Eligible Beneficiaries, in which MCOs or other carriers under contract with ASES function as Part C plans to provide services covered by Medicare, and also to provide a "wrap-around" Benefit of Covered Services and Benefits under the GHIP.

Newborn
For purposes of the agreement, is a child born during the eligibility period of his/her mother to the GHIP.

Participating Provider
All of the healthcare service providers contracted by the carriers to provide healthcare services to the beneficiaries represented by ASES.

Plan Type
Code 01 to identify members with GHIP and code 02 to identify member with Medicare Platino.

Plan Version
Product identification number that corresponds with the Plan Type. For GHIP, the Plan Version will be the same as the coverage code assigned to the beneficiaries by the Medicaid Office. For Platino Plans, ASES will assign a Plan Version code for each contracted product.

Platino Health Plans
Specific health plans offered by Medicare Advantage Organizations contracted by ASES that cover beneficiaries with dual eligibility (Medicaid and Medicare Part A and Part B). ASES pays a monthly premium to these insurance companies to cover the differential between Medicaid coverage and Medicare Advantage coverage.

Platino Plan Beneficiaries
Medicaid beneficiaries covered by Medicare Part A and Part B who are 65 years old or older or disabled. Commonwealth Beneficiaries funded solely through state funds are not eligible to be enrolled in a Platino Plan.

PMPM Premium ("Per Member Per Month" Payment)
The fixed monthly amount that the Contracted Insurer is paid by ASES for each Enrollee to ensure that benefits under this contract are provided. This payment is made regardless of whether the enrollee receives benefits during the period covered by the payment.

Potential Enrollee
A person who has been certified by the Puerto Rico Medicaid Office as eligible to enroll in the GHIP (whether on the basis of Medicaid Eligibility, CHIP eligibility or eligibility as a member of the Commonwealth Population, but who has not yet enrolled with the Contracted Insurer.

Primary Care Physician (PCP)
A licensed medical doctor (MD) who is a Provider and who, within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all required care to Enrollees. The PCP is responsible for determining services required by Enrollees, provides continuity of care, and provides Referrals for Enrollees when Medically Necessary. A PCP may be a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

Primary Medical Group (PMG)
A grouping of associated Primary Care Physicians and other Providers for the delivery of services to GHIP Enrollees using a coordinated care model. PMGs may be organized as Provider care organizations, or as another group of Providers who have contractually agreed to offer a coordinated care model to GHIP Enrollees under the terms of the Contract. This Type of provider is contracted by the Carrier on a PMPM basis.

Process Date
The date on which the beneficiary acquires the cover of services with the contracted insurer.

Prorated Payment
A back payment that covers a fraction of the month prior to the month in which the premium payment is made.

Provider
Any physician, hospital, facility, or other Health Care Provider who is licensed or otherwise authorized to provide physical or Behavioral Health Services in the jurisdiction in which they are furnished.

Puerto Rico Medicaid Office
The subdivision of the Health Department that conducts eligibility determinations under GHP for Medicaid, CHIP, and the Commonwealth Population.

Re-enrollment
Refers to the process of re-enrollment for a beneficiary of Federal GHIP populations (Medicaid or CHIP), state funded GHIP beneficiaries (Commonwealth), or Platino beneficiaries who have lost eligibility for a period of two (2) months.

Recertification
A determination by the Puerto Rico Medicaid Office that a person previously enrolled in the GHIP is again eligible for services under the GHIP.

Redetermination
The periodic redetermination of eligibility of an individual for Medicaid, CHIP or the Commonwealth Population, conducted by the Puerto Rico Medicaid Office.

Retroactive Payment
Refers to a payment that corresponds to a period prior to the month in which the premium payment is made.

Retroactivity
Identifying a premium payment that corresponds to a period prior to the current one.

Special PMG
The assignment of a PMG ("Primary Medical Group") to a beneficiary who does not belong with the PMG assigned to his family.

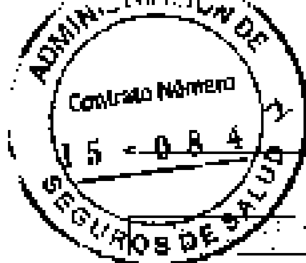
State/Commonwealth Population: A group eligible to participate in the GHIP as well as other eligible individuals, who do not receive federal coverage, made up by low income people and other groups listed in Section 1.3.1.2 of the contract between ASES and carriers.

Suspension of Healthcare Services
The culmination of the eligibility period allowed by the Medicaid Office.

SYSPREM

System that provides for the enrollment of a beneficiary in historical data. It allows the update and/or enrollment of data that corresponds to eligibility periods prior to the cancellation period of the eligibility of a beneficiary or before an enrollment to a different carrier comes into effect.

III. ELIGIBILITY



1. ELIGIBILITY CONCEPTS

1.1 Eligibility Determination

The Medicaid Office, which administers the Puerto Rico Medical Assistance Program, is the body with authority to determine whether a person is eligible to receive medical services under the GHIP, either in the federal category (Medicaid and CHIP) or in the Commonwealth Population. This includes certification of beneficiaries with Medicare Platino coverage.

The eligibility criteria for the beneficiaries are set by CMS requirements, including their level of indigence. In Medicare Platino, the age of the applicant (aged 65 or older) or the disability status as mentioned in Title XVIII of the Social Security Act is considered.

Medicaid, CHIP and state funded Commonwealth beneficiaries are annually certified for an eligibility period of twelve (12) months. The Medicare or Medicaid eligibility period may be less than twelve (12) months in situations where: the beneficiary notifies that his/her circumstances have changed and adversely affect his/her eligibility, persons with medical expenses fail to qualify under the "spend down" method, deceased or incarcerated persons, or others as determined by the Medicaid Office. Children identified as Deemed Newborn are certified until thirteen (13) months of age.

1.2 MA-10

The eligibility determination of the Puerto Rico Medicaid Office granted to an applicant for the GHIP or Medicare Platino is contained in Form MA-10, and is provided to the beneficiary on the day he/she is certified.

The beneficiary will continue to receive coverage for services based on the day they were certified by the Medicaid Office, as written on the Form MA-10, until the day they receive their health insurance card by regular mail. The MA-10 form may be used for a period of 30 days from the date of certification for the purpose of demonstrating eligibility and receiving services without an identification card issued by an MCO.

We will have two (2) MA-10 models in force. The current (rev. 10/2015): These are the MA-10 forms that were issued between July 1, 2016 and June 30, 2017, which will continue to be valid until the beneficiary is re-evaluated and recertified following the rules of MAGI. The new (Rev. 6/2017): These are the MA-10 forms that will be issued after July 1, 2017, after the applicant or beneficiary has been evaluated or recertified following the MAGI rules.

1.3 Eligibility Effective Date

The Effective Date for purposes of a Medicaid or CHIP Enrollee is the first of the month in which the Medicaid Office determines eligibility. This should be the same date indicated as the period of eligibility on the MA-10 form. For purposes of a state funded Commonwealth beneficiary, it is the Date of Certification.

When a re-certification is filed, and the person is again eligible for Medicaid/CHIP, the eligibility date is generally the 1st of the month after eligibility expires. However, if the Enrollee's eligibility was lost for less than two (2) months, enrollment should be effective as of the eligibility period specified on the MA-10, and the person should be automatically enrolled in its previous PCP/PMG.

A person may apply for Medicaid/CHIP on behalf of a person who has died in the same month in which they apply or up to three months retroactively in the event the person would have been eligible in those months. The eligibility period will be from the first (1st) day of the month of the application until the date of death. This provision does not apply to state funded Commonwealth beneficiaries.

All pregnant women under both federal Medicaid/CHIP and State-funded) may have a period of eligibility greater than twelve 12 months when adding the required 60 days of postpartum coverage. The expiration date will be the last day of the month at the end of these 60 days.

Retroactivity on the effective date is granted when the applicant indicates that he/she has medical expenses prior to the effective date, including any Medicaid-covered service that has not been paid for. The effective date will be within three (3) months before the month in which the Enrollee is applying. If the applicant is Medicaid or CHIP eligible in the month in which the service was eligible, the applicant will be granted retroactivity. This retroactive benefit does not apply to eligible state category.

In a recertification for state funded Commonwealth beneficiaries in which the person is eligible again, the effective date is the first day of the month after the current eligibility expires.

The date of certification for state category will be when the evaluation is completed.

No retroactive eligibility is contemplated in the state funded category for Commonwealth beneficiaries.

1.4 Certification Date and its Relation with the Effective Date

The date when the Medicaid Office issued an eligibility determination is known as the Certification Date. In the state funded category for Commonwealth beneficiaries, the Effective Date will always coincide with the Date of Certification and would mark the beginning of the eligibility period granted to the beneficiary. In the Medicaid/CHIP category, the Effective Date will be the first day of the month in which the beneficiary was certified by the Medicaid Office. In both cases, the Certification Date is provided on Form MA-10.

1.5 Eligibility Effective Date in the Case of a Newborn

The eligibility to be granted to the child is the same as the mother's at the time of birth. A newborn born to a mother who is a Medicaid Enrollee shall have an Eligibility Effective Date of the date of birth. In the event that the mother is retroactively eligible as a federal Medicaid beneficiary at the time of the newborn's birth, the newborn's eligibility shall also have an Eligibility Effective Date retroactive to the date of birth. All federally eligible newborns are auto-enrolled into the program and provided coverage from the date of birth. [1] If the mother was a state funded Commonwealth beneficiary, the Eligibility Effective Date of the newborn shall be the Certification Date.

2. MAGI ELIGIBILITY RECORDS CHANGES

2.1 Transfer of Eligibility Files from Medicaid

Once eligibility processes are completed by the Medicaid Office, the data of certified beneficiaries are received via FTP Server by ASES, where ASES, in turn, completes a daily process of updating the data received in their systems.

ASES - "ASSIST" systems and Office of Medicaid - "MEDITI" systems currently handle eligibility using the concept of FAMILY. For this purpose, they will be kept in the same concept, in that each FAMILY will consist of a single member and the suffix "01", a constant that will remain in each register of the member. The FAMILY code will become the last 11 digits of the MPI number

[1] See Sections 5.2.2.2 and 5.2.6.2 of the GHIP Contract

As of the date of change to MAGI, ASES will convert the data from January 2010 to the present. Data prior to 2010 will be archived. This will be the definition:

RECORD TYPE	CODE
A Family Record	(F)- Required
A Member Record	(M)-Required
A Household Record (A group of related members)	(O)-Required
One or several additional insurance records.	(I)- If applicable
One or several Spend-Down Records	(S)- If applicable

2.2 Medicaid Family Record Changes since July 1st, 2017

There will be fields that will not be used. These are labeled in the layout specification for the file that will remain as zeros or spaces. There will be a family register per group. See the changes below in the family log design.

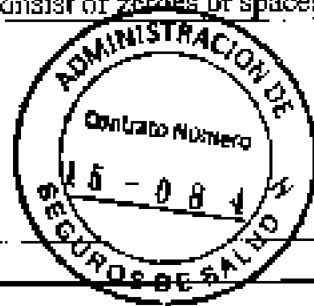
FIELD	DESCRIPTION
Record_type	It is labeled with the letter "F" in the *Record_type* column.
Family Code	The last 11 digits of the MPI Number will be included in the family code column.
Tran_id	New values ('1', '2', '3') were added to the *Tran_id* column to identify retroactive eligibility periods. This will be explained further below, in the MAGI Retroactive Eligibility Period Section.
Contact last name 1	Paternal surname of the contact person. **Required.**
Contact last name 2	Maternal surname of the contact person. **Required.**
Contact first name	First name of the contact person **Required.**
Residence-zip	Postal zone of the physical address. **Required.**
Residence-zip4	Additional digits for the postal zone
PCT-of-poverty-level	This field will not be used. It must be filled with zeroes.
Deductible-level-code	This field will not be used. It must be filled with zeroes.
ELA_errors	This field will not be used. It must be fill with zeroes.

Mancomunado	This field will not be used. It must be fill with zeroes.
Application Number [new field]	This number corresponds to a unique number, linked to the way people fill out in the Medicaid Office, when they request the GHIP or when a recertification occurs. This number changes each time the "Family" group is to be re-certified.

2.3 Medicaid Member Record Changes since July 1st, 2017

There is a member record per group. There are many fields in this record that will no longer be in use. These are labeled in the layout specification for the file and will remain as zeroes or spaces. See changes below to the member record layout.

FIELD	DESCRIPTION
Record Type	This record is identified with the letter "M" in this column.
Member suffix	The content of the *Member suffix* column will always be "01".
Tran_id	New values ('1', '2', '3') were added to the *Tran_id* column to identify retroactive eligibility periods. This will be explained further below.
Contact Member	*New field.* The MPI number of the contact member will be included in this field. If the contact person or guardian does not belong to the medically indigent population, Medicaid will assign him/her a number. This field is tied to the contact name in the family record.
Relationship	This field will not be used. Its content will consist of zeroes or spaces.
Place-of-Birth	This field will not be used. Its content will consist of zeroes or spaces.
Category	This field will not be used. Its content will consist of zeroes or spaces.
Category-2	This field will not be used. Its content will consist of zeroes or spaces.
Condition	This field will not be used. Its content will consist of zeroes or spaces.
Med-ins-code	This field will not be used. Its content will consist of zeroes or spaces.
Policy	This field will not be used. Its content will consist of zeroes or spaces.
Class	This field will not be used. Its content will consist of zeroes or spaces.
Class-2	This field will not be used. Its content will consist of zeroes or spaces.
Denial-cat	This field will not be used. Its content will consist of zeroes or spaces.
Denial-cat 2	This field will not be used. Its content will consist of zeroes or spaces.
Pilot-cat	This field will not be used. Its content will consist of zeroes or spaces.
Pilot-class	This field will not be used. Its content will consist of zeroes or spaces.
Pilot-denial	This field will not be used. Its content will consist of zeroes or spaces.
Cost-Sharing Flag	New Field. The accepted values are: N = No exception, C = Child, P = Pregnant, A = American Indian, I = Institutionalized.



	H = Hospice. For the moment, this piece of information will remain informational in nature.
Max-copay	New field. This is the maximum co-pay amount that a beneficiary can pay within a given period. For the moment, this piece of information will remain informational in nature.
Extension-Flag	New field. Its content will be: **N** = Not undergoing an appeals process **A** = Currently undergoing an appeals process **U** = Close of the appeal **P** = Extension due to pregnancy **X** = Extension due to other reasons The appeals process will be explained further below (See Section 8.1).
Spend Down Flag	New field. This field indicates whether or not "S" ("Spend-down") records are included. If it does not contain this type of record, this field will show the letter "N". If it does contain this type of record, it will show the letter "S".

2.4. Eligibility Records Concerning Household, new record since July 1st, 2017

A Household record will be included in each group of records. It contains all the MPI's related to the member at the time that his/her eligibility is evaluated. See changes below to the household record layout.

FIELD	DESCRIPTION
Record_type	It is labeled with the letter "O".
Tran_id	This field will have the same content as the Family and Member records.
Process_date	Will have the same date contained in the Family and Member records.
MPI_1 al MPI_18	These are the MPIs of each member related to the member in the *Member_id* field at the time during which the eligibility evaluation is being carried out at *Medicaid*'s Offices.

2.5 Additional Health Insurance Record (*Insurance Record*)

There can be more than one additional health insurance record in the group. See changes below to the additional health insurance record layout.

FIELD	DESCRIPTION
Record_type	It is labeled with the letter "I".
Tran_id	New values ('1', '2', '3') were added to the *Tran_id* column to identify retroactive eligibility periods. This will be explained further below in Medicaid or CHIP Retroactive Eligibility Record.

NOTE:
The file layouts are in the Appendix 9 for GHIP contract and Appendix K for Platino contract.

3. MEDICAID /CHIP'S RETROACTIVE ELIGIBILITY

The new MAGI changes have implications for the treatment of enrollments and payments related to periods of retroactive eligibility under the federal Medicaid and CHIP category. The new rules applicable to this topic are described below.

3.1 Medicaid/CHIP's Retroactive Eligibility Effective Date

Under Medicaid or CHIP, the Effective Date of the Eligibility for the enrollments that correspond to a retroactive period will be determined month by month. Each retroactive period or record shall correspond to one (1) calendar month. The Medicaid Office may grant up to four (4) eligibility periods for the same beneficiary which may be comprised of three (3) retroactive periods and one (1) record for the current period. Each record of retroactivity will mark the beginning and end of the eligibility in relation to the period to which it corresponds. That is, each of the retroactive periods of eligibility granted will determine the start and completion of the Eligibility Effective Date for that particular period.

3.2 Group of Records for Retroactive Periods - if applicable.

Each retroactive eligibility period involves a group of records. The beneficiary labeled as Federal (Medicaid, CHIP) could have one (1) to three (3) retroactive eligibility periods. Each retroactivity period runs from the first day of the month until the last. Each retroactivity period is evaluated separately. Therefore, there can be a change in coverage from one period to the next.

The evaluation of the retroactive eligibility period is independent from that of the current period. A member can have retroactive eligibility periods and not be currently eligible.

Retroactive eligibility periods will be confirmed and sent to insurance carriers in the daily eligibility file (.exp). Each period will have a group of records labeled with the '1', '2', '3' indicators in the *Tran id* column. The indicators are unrelated to the order of the periods; they are only used to unify the group of records.

ASES could receive, for a single member, up to three (3) retroactive eligibility enrollment records and one (1) current eligibility enrollment record in an enrollments file. A member may be eligible for one (1) to three (3) retroactive periods and not be eligible for the current term. In this case, sets of records for the retroactive periods may be received but none for the current eligibility period. Retroactive eligibility period will be from the first day of the month of retroactive eligibility until the last day of the month of retroactivity.

4. TERMINATION OF ELIGIBILITY AND RECERTIFICATION PROCESS

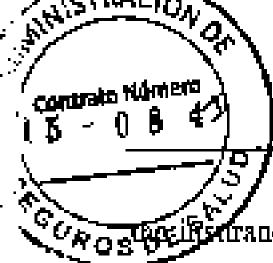
After a period of eligibility is granted to a beneficiary, a Recertification Process will be initiated whereby a new eligibility evaluation will be carried out, which will allow the renewal of the health services for the corresponding period. The Re-certification Effective Date refers to the date Medicaid re-evaluates a beneficiary's eligibility. This date is provided on the MA-10 form. The Eligibility Expiration Date refers to the expiration date of the eligibility period granted to the beneficiary by the Medicaid Office

A federal beneficiary of the GHIP (Medicaid or CHIP), or a beneficiary of the GHIP whose coverage is funded solely through state funds (Commonwealth) who, as a result of a Recertification Process, receives a negative eligibility determination for GHIP, will continue to be eligible to receive services under the GHIP until the date specified in the document titled Negative Redetermination Decision on MA-10 issued by the Puerto Rico Medicaid Office. The cancellation of health services transaction due to the expiration of the eligibility period will be notified by the Medicaid Office and will be reflected in the ASES databases on the last day of each month. Only the Medicaid Office may cancel and provide notice of the cancellation of a beneficiary's eligibility.

5. ELIGIBILITY PERIOD EXTENSION

5.1 Appeals Process for Re-Certification

When a beneficiary does not qualify during his/her re-certification process, he/she has the right to appeal his/her eligibility within a term of fifteen (15) days. If a previously eligible Medicaid or CHIP member appeals within fifteen (15) days of an adverse eligibility determination, content "A" or "X" will be sent to



the insurance carrier in the *Extension flag* field. The member may not be cancelled during the appeals process even if the expiration date passes. When the appeals process is completed, Medicaid will send an update of the member's status to ASES. If the appeal is presented after the first fifteen (15) days after the adverse eligibility determination, no extension will be issued. In this case, a cancellation will be received from Medicaid at the end of eligibility period or fifteen (15) days after the evaluation for disenrollment exceptions.

(1) If the appeal finds in favor of the beneficiary: the expiration date will be updated to the appropriate one. He/she will be identified as eligible and the termination of the appeals process will be labeled with a "U" and a new eligibility period. If there were to be a change in coverage, a new enrollment with the new coverage must be sent, just as is currently done.

(2) If the appeal finds against the beneficiary: the Medicaid Office will send a cancellation with the original expiration date. He/she will be identified as ineligible and the termination of the appeals process will be labeled with a "U". The insurance carrier will keep offering services to the beneficiary until it receives the cancellation in the eligibility file sent by ASES. ASES will continue paying premiums until the cancellation is received from Medicaid Office. Only Medicaid Office may cancel a beneficiary. The cancellation's effective date will reflect the date in which ASES receives said cancellation.

(3) If the appeal is resolved only after a cancellation, the insurance carrier will receive the eligibility information only if the appeal is in favor of the beneficiary and with updated dates with the new eligibility period.

5.2 Appealing a Certification (either new or not active at the time)

If a person who is not active in the Medicaid Program requests eligibility and he/she does not qualify, he/she has the right to appeal the result of the evaluation. This type of appeal is an internal Medicaid Office process. The Medicaid Office will not send to ASES records of these processes unless the appeal is decided in the person's favor. In the case of Medicaid or CHIP eligible beneficiaries, a group of records will arrive with an effective date that may be retroactive to the first day of the month corresponding to the certification date. If the beneficiary has used medical services, the insurance carrier will treat the enrollment as an emergency (*special enroll* - 'E'), since the retroactivity could go back more than three (3) months. In the event the person is certified as a state funded Commonwealth beneficiary, the date of eligibility after a favorable appeal shall be prospective from the date of the favorable determination.

5.3 Eligibility Extension Due to Pregnancy

If a pregnant woman is undergoing re-certification and she is determined to be ineligible, she cannot be terminated until sixty (60) days after the date on which she gives birth or loses the fetus. These cases will

be labeled with the letter "P" in the *Extension flag* field. The Medicaid Office will send ASES cancellation at the appropriate point.

Important Note:
Neither ASES nor insurance carriers may cancel a beneficiary until Medicaid Office sends a cancellation, even if the expiration date has already passed.

6. ELIGIBILITY PERIOD TERMINATION

In those cases where it is determined that a beneficiary of the GHIP is no longer eligible to continue receiving services after a Recertification Process has been performed by the Medicaid Office, the beneficiary will maintain his or her eligibility until the date specified in the document entitled Negative Redetermination on MA-10 issued by the Puerto Rico Medicaid Office.

On a daily basis, ASES receives a file with the eligibility status of the beneficiaries, including the cases in which the eligibility period has ended. In such cases, ASES will send to the carriers the contents of the files of those beneficiaries who have received a Negative Redetermination Decision within a period of twenty-four (24) hours from the time it receives the file from the Medicaid Office. [7]

[7] See Section 5.1.4 of the GHIP Contract.

IV. ENROLLMENT PROCESSES

7. DATA EXCHANGE

The eligibility files described in the previous sections are entered into the daily run cycle and are evaluated through an editing and verification program at the Information Systems Office at ASES. After receiving and processing the eligibility data of each beneficiary, ASES creates an electronic record that includes information which the carrier can use to enroll the beneficiary, such as information about the Plan Type [federally funded GHIP (Medicaid and CHIP), state funded GHIP (Commonwealth), or Platino]and Plan Version along with their respective effective dates and other related data elements. ASES sends accepted enrollments, new eligibility, updates and cancellations data to carriers in a file (.exp) that shows the activity generated in a daily manner.

Under the automatic assignment, carriers update their database, assign a Primary Medical Group (PMG) and a Primary Care Physician (PCP) based on the beneficiaries' physical address, and issue the plan identification cards for each beneficiary. These cards are sent to the beneficiaries by postal mail in an approximate period of five (5) days. The beneficiaries, in turn, have ninety (90) days to request a change of the PMG or the PCP, if they so desire. The carrier then produces the electronic enrollment record and submits it to ASES in a file (.sus) that accounts for the enrollments made.[3]

Generally, carriers have a twenty-four (24) hour period to remit membership records to ASES. They must notify ASES of the information about the new beneficiaries enrolled and send information about any changes performed on a record previously enrolled. Such notification must be sent on the next business day.

In the case that the carrier has to update the information previously sent to ASES in relation to a new enrollment, or when it is appropriate to add a new beneficiary that has been previously omitted, that update must occur the next business day after the information has been updated or that a new beneficiary has been added. In these cases, ASES reserves the right not to accept new additions or corrections to the enrollment data after sixty (60) calendar days after the Effective Date of the Enrollment indicated in the carrier's notification to ASES. Likewise, the beneficiary's PMG and/or PCP changes will take effect as stated in Section 13.5. [4]

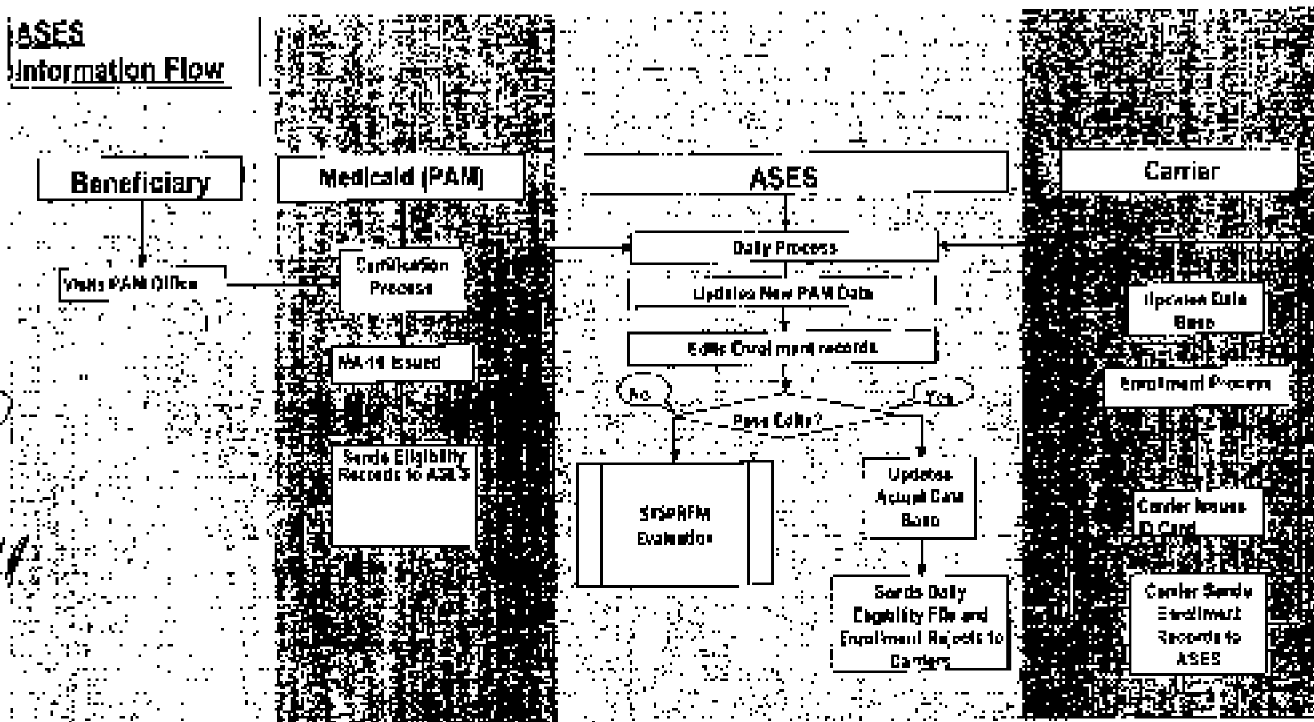
Records that are accepted without changes or modifications during the editing process are updated in the databases at ASES and the beneficiaries are duly enrolled. Enrolled Medicaid and CHIP beneficiaries, beneficiaries of the GHIP funded solely through state funds (Commonwealth), and Platino beneficiaries are those that are listed as eligible in the ASES databases. Any record that is accepted during the editing and verification processes will be stored in the current and historical data tables.

[3] See Section 5.2.5 of the GHIP Contract.
[4] See Section Sec. 5.4.1.3 of the GHIP Contract.

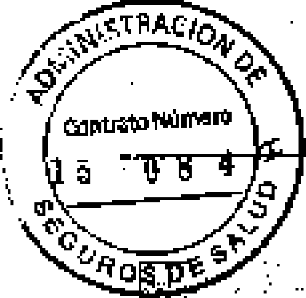
The records that are rejected are returned to the carrier with the applicable reject codes in a file (.rjc). The carrier must correct any errors in the enrollment record and send the information back to ASES in a file (.sus) within 24 hours. ASES will only pay the premiums related to those beneficiaries who are enrolled in the databases at ASES. Therefore, the execution of the payment of the corresponding premium for these rejected records will be stopped until they are sent back with the correction of the indicated errors.

The exchange of data regarding eligibility and enrollment processes between the Medicaid Office, ASES and the contracted carriers occurs on a daily basis. In Figure 1, which is provided below, the information exchange processes described in the previous subsections are presented.

Figure 1 ASES Information Flow



This process of information exchange is quite similar in both the CHIP and the Platino Medicare programs with the exception of the need to comply with the additional requirements applicable in the case of the latter. Before a beneficiary of a Platino Plan can be enrolled, the carrier must perform the procedures described later in this document.



8. VALIDATION PROCESS

Carriers are responsible for transmitting enrollment files of their beneficiaries to ASES on a daily basis. For proper processing of the enrollment transactions, carriers must keep the eligibility information of the beneficiaries who are referred to ASES daily updated in their respective databases. To that end, they should use the following conventions related to the file submission process.

9. ENROLLMENT FILES

Definition of the nomenclature of the data files to be exchanged between Medicaid, ASES and carriers

9.1 ENROLLMENT FILE [CCYYMMDD.sus]

a. CC = Carrier Code
b. YY = Year
c. MM = Month
d. DD = Day
e. .SUS = Identifies the file as an enrollment file. The enrollment file may contain records belonging to any of the regions contracted by the carrier.

Notes:
✓ Files received at 9:00 am are entered in the ASES daily cycle.
✓ If a file is received after 9:00 am, it will be entered in the next day's cycle.

9.2 ELIGIBILITY FILE [VYYMMDD.ref]

a. V = indicates that it is an eligibility file
b. YY = Year
c. MM = Month
d. DD = Day
e. .ref = Indicates that it is a file containing the records of the beneficiaries' eligibility.

9.3 DATA EXPORT FILE [RRCCYYMMDD.exp]

a. RR = region code
b. CC = carrier code
c. YY = Year
d. MM = Month
e. DD = Day
f. .exp = Indicates that it is a file containing all the eligibility and enrollment transactions processed during the daily run.

9.4 REJECTED ENROLLMENTS FILE [*.rje]

a. CC Carrier Code
b. YY = Year
c. MM = Month
d. DD Day
e. .rje= Indicates that it is a file containing the records of the beneficiaries who have been rejected.

Notes: ASES runs a separate edition and update cycle for each contracted region. Enrollments are filtered through various editing and verification programs and identified as valid or rejected. This process produces a file (.rje) that contains all the records that are rejected.

9.5 ELIGIBILITY QUERY FILE [CCYYMMDD.qry]

a. CC= Carrier Code
b. YY=Year
c. MM=Month
d. DD=Day
e. .qry =Indicates that is a file for eligibility verification.

Notes: A '.query' file is submitted by the carriers to verify a person's eligibility for the Medicare Platino Plan and the GHIP if necessary. Consequently, ASES generates a response in a '.res' (response) file with the requested information.

9.6 ELIGIBILITY QUERY RESPONSE FILE [CCYYMMDD.res]

a. CC=Carrier Code
b. YY Year
c. MM=Month
d. DD=Day
e. .res = Indicates that it is a query response file.

Notes: This file is sent by ASES in response to a query file.

10. GHIP BENEFICIARY ENROLLMENT

In order for an enrollment record to be accepted during the editing and validation processes, it is important to take into account the following considerations regarding concepts related to the enrollment processes:

10.1 Effective Date of Enrollment

The Effective Date of an Enrollment refers to the date that a carrier establishes as the beginning of the coverage period for a beneficiary. Generally, this date concurs with the beginning of the eligibility period as defined by the Medicaid Office for the Federal and State categories. For the federal population, this date will be the first of the month in which the beneficiary applied for health services coverage. For the

Commonwealth population, this date will be the same as the Certification Date. Also, this date refers to the date on which a change of PMG, PCP or Plan Version will be effective. The Effective Date of the Enrollment of these changes will fall as described in Section 13.5.

10.2 Date of Enrollment in the Case of Newborns

In newborns, the Effective Date of the Enrollment will be on the day of birth for babies of federal mom and Certification Date for state mom, unless in the newborn evaluation turns to be CHIP. In this case, the newborn could have retroactive periods if there were utilization.[5]

10.3 Date of Re-enrollment in Cases of Loss of Eligibility

In the cases of re-enrollment of federal beneficiaries (Medicaid and CHIP), state funded Commonwealth beneficiaries, or beneficiaries who have lost eligibility for a period not exceeding two (2) months, the beneficiary will be auto-assigned to the same PMG as previously assigned to. The Effective Date of the Enrollment will fall on the same eligibility period specified in the MA-10.[6]

10.4 PCP/PMG Change Enrollment Effective Date

If an enrollee changes PCP/PMG during the first five (5) days of the month, the change will be effective in the next subsequent month. If an enrollee changes PCP/PMG after the fifth (5th) day of the month, the change will be effective in the second subsequent month of the change. The enrollees can still receive services until the change is effective through the original PCP/PMG assigned by the contractor during the Auto-Enrollment process.[7]

10.5 Changes in Coverage Codes and Enrollment

If the coverage code of a GHIP beneficiary changes, the insurer must send a subscription with the new plan version (that is equal to the coverage code) with the effective date of the first day of the next month. For Platino beneficiaries, the insurer must send the plan version corresponding to the product that the beneficiary has. The effective date is also the first day of the next month.

10.6 Process Date

The Process Date has relevance both in cases of new enrollment of a beneficiary and in cases of changes of PMG, PCP or Plan Version in relation to a record of enrollment of a beneficiary. This is a date provided by the carrier that identifies the day on which a new enrollment or a change in the record of a beneficiary's enrollment was processed in its databases. For GHIP beneficiaries, the Process Date must be equal to or before the Effective Date, but after the three (3) months preceding the Effective Date.

In the case of a new enrollment under a Platino Plan, it refers to the date on which the beneficiary

[5] See Section 5.2.2.2 of the GHIP Contract.
[6] See Section 5.2.2.4 of the GHIP Contract.
[7] See Section 5.4.1.4 of the 2015 Contract Amendment.

contracted the coverage services with the corresponding carrier. In Platino plans, the Process Date must be prior to the Effective Date of the new enrollment or the change in question, but subsequent to the three (3) months prior to the Effective Date of the new enrollment or change.

11. MEDICARE PLATINO ENROLLMENT PROCESS

ASES is able to employ a variety of methods for the purpose of subscribing persons who are eligible to receive coverage under Medicare Platino plans. This includes enrollment assisted by Platino carriers, enrollment by ASES or a combination of both. The procedure used for the enrollment under the Platino Medicare Program is described in the Appendix F which accompanies the contract entered into between ASES and the Platino carriers[5]. Relevant considerations are highlighted throughout this manual.

11.1 Eligibility Query Preceding a Medicare Platino Enrollment

(1) **Query:** through a file (".query"), the carrier requests a verification of a beneficiary's eligibility for the Medicaid Office.

(2) **Response:** ASES processes this query file and sends a response to the request in a file (.res). This file includes information regarding the beneficiary's eligibility for the Medicaid Office, Medicaid Office specification for which the beneficiary is eligible (federal or local), and the data that identifies the beneficiary in the database, both at Medicaid Office and ASES.

(3) **Platino Product Enrollment:** If the beneficiary is eligible for Medicaid coverage and has Medicare Part A and Part B benefits (dual-eligible beneficiary), the carrier will complete an enrollment record that will include data corresponding to the health plan under which the beneficiary is to be enrolled.

(4) **Enrollment Update:** Subsequently, ASES will edit and update the data in the electronic enrollment record to identify the individual as a Platino Medicare beneficiary using CMS data file in monthly based. A daily eligibility file is then sent to the carrier that contains the data that shows the beneficiary's enrollment to Medicare Platino.

(5) **Rejected Enrollments:** The enrollment records sended by carriers, are evaluated. If the enrolment file contain errors will be returned to the carriers for corresponding corrections.

[5] See Section 6.1.1 of the Platino Contract

11.2 Transfer of Beneficiaries to Platino Products

Medicare Advantage beneficiaries who are granted Medicaid coverage may elect to transfer to the Medicare Platino products offered by their preferred carrier or may enroll to Medicare Platino products available to dual eligible individuals. In these cases, the carrier must process a new enrollment for the purpose of transferring the beneficiary of the Medicare Advantage product to Medicare Platino. To the extent possible, such enrollments will be effective on the first day of the month in which the beneficiary's Medicaid coverage is effective.[9]

11.3 Effective Date of Medicare Platino Enrollment

The Effective Date for a beneficiary's Enrollment under a Platino Medicare Plan will fall on the first day of the month in which the name of the beneficiary appears on the CMS Prepaid Premium Plans List and on the first day of the month in which it appears enrolled in the Platino Medicare plan of the carrier in question.[10]

11.4 Recovery of Eligibility and Prospective Enrollment

In those cases in which the enrollment of a Platino Medicare beneficiary is canceled due to the loss of eligibility as a Medicaid beneficiary, but recovers that eligibility within a period of two (2) consecutive months, the beneficiary may be enrolled automatically and prospectively under the Platino Medicare plan of the carrier in question.[11]

12. RETROACTIVE ENROLLMENT

The retroactive enrollment processes involve the processing of an enrollment in the ASES databases for a period prior to the current eligibility period. It is important to distinguish between the terms granted for the retroactive enrollment processes and the periods of retroactive eligibility granted by the Medicaid Office, as they represent retroactivity in different contexts

[9] See Section 6.8.1 of the Platino Contract.
[10] See Section 6.4 of the Platino Contract.
[11] See Section 6.6.1 of the GHIP Contract.

12.1 Retroactive Enrollment for Federal and State Category

Under the federal Medicaid and CHIP programs, and the state funded Commonwealth population, this date may be extended retroactively up to three (3) months prior to the date the enrollment is processed at ASES, provided that the period to be enrolled falls within the period of eligibility granted by Medicaid Office.

In the same subscription file, no more than one subscriber may be included for the same member unless it is a subscription for a current eligibility period and one to three subscriptions for retroactive eligibility periods.

The letters "E" or "C" will be included for retroactive eligibility period enrollments, just like in SYSPREM cases. Retroactive period enrollments will be labeled with the letter "T" in the *Special_enroll* field.

Each enrollment with retroactive eligibility period will be validated against the member's eligibility history. Therefore, the insurance carrier's effective date for each enrollment must correspond to the date of each retroactive period in ASES's member history.

12.2 Retroactive Enrollment for Platino Plans

For Platino plans, the enrollment may be extended retroactively from six (6) to eighteen (18) months prior to the date on which the beneficiary's enrollment is processed at ASES. That is, the Information Systems Office of ASES may accept an enrollment of a beneficiary of the Platino Plan for up to eighteen (18) retroactive months as long as the limits of the period to be enrolled fall within the period of eligibility granted by the Medicaid Office.

For a better understanding of the concept of retroactivity in eligibility and retroactivity in enrollment as discussed in the preceding sections, Table 1 is provided with the applicable periods granted.

Table 1: Retroactivity in Eligibility and Retroactivity in Enrollment

PLAN	RETROACTIVITY			
	Eligibility		Enrollment	
	Yes	No	Yes	No
Federal GHIP (Medicaid and CHIP)	✓ (Up to Three (3) months)		✓ (3) months	
State GHIP (State Population)		✓	✓ (3) months	
Platino (65 years old, disabled, dual)	✓ (3) months		✓ (6-18) months	

13. ENROLLMENT RECORD

The enrollment record that is used by carriers to notify ASES of the enrollment of a beneficiary contains a series of data that are used for the purpose of informing the details of the enrollment made and to verify their accuracy and certainty. A beneficiary can be enrolled in one of two (2) types of plans available:

Table 2: Plan Types

Code	Plan
01	State (Commonwealth Population) y Federal (Medicaid or CHIP).
02	Platino SNP (Special Needs Plan).

Under this diversity of plans, the carriers can offer different products that are identified by their Plan Version number. ASES assigns a Plan Version number for each contracted Platino product. In the cases that fall under any of the GHIP, the Plan Version must be equal to the coverage code assigned to the beneficiaries by the Medicaid Office.

Some of the plans contracted with ASES may require the assignment of Primary Medical Group (PMGs) and/or Primary Care Physicians (PCPs) to beneficiaries by the carriers. The enrollment record includes these fields as well as the Plan Type and Plan Version noted above. The enrollment record also reports the date a beneficiary has been processed by the carrier and the Effective Date of Enrollment.

14. ENROLLMENT RECORD FIELDS

The record of each beneficiary's enrollment contains the following information that must be provided by the carrier:

1 **RECORD_TYPE** In every case, and regardless of the transaction in question, this field requires the insertion of code "E" that identifies the entry as an enrollment record for both new enrollments of beneficiaries and changes on records of beneficiaries previously enrolled.

2. **TRAN_ID** - This field allows the ASES systems to identify the action to take on the record submitted. It can contain one of the values listed below:

a. **E** – New Enrollment. This value identifies that the record is a new enrollment for a beneficiary who has not been previously enrolled or that is currently inactive. It could also imply that this is a retroactive enrollment record for transactions not previously enrolled. For transactions previously enrolled, either by the same or one that is different from the previous enrollment, a "C" would be inserted.

b. **C** = Carrier Change. Used when the beneficiary has selected a different carrier than the one in which he/she is presently enrolled. It is also used for initial enrollment in Platino Plans when the beneficiaries were previously enrolled in a GHIP and they opt to change to Platino. It could also identify a retroactive enrollment record in cases that are carried out by a carrier different than that arising from the ASES database or by the same carrier if it has to make a change on a previous enrollment.

c. **P** Changes in the Plan Type. It is used when a member enrolled under a particular carrier changes from a product the carrier offers to one which is identified under a different Plan Type under the same carrier.

d. **V** – Plan Version Change. For GHIP carriers, it implies a change from a product the carrier offers to one which is identified under the same Plan Type. This transaction code is also used when a GHIP beneficiary's coverage code changes. In these cases, the carrier must reissue a health plan ID card displaying the new benefits, and submit a version change enrollment record to ASES where the Version number should be equal to the new coverage code. Failure to submit said information to ASES, will trigger an automatic disenroll of the beneficiary from the carrier that omits the timely submission. While in these circumstances the beneficiary continues being eligible to receive the medical services, the carrier will remain unable to claim a premium payment for said beneficiary until a submission of the required information is performed.

e. **1** = PMG (Primary Medical Group) Change. It is used to register, in ASES, a change in the beneficiaries' selected PMG under the same carrier, Plan Type and Version.

f. 1 – **PCP1 change.** It is used to register, in ASES, a change in the beneficiaries' selected PCP1 under the same carrier, Plan Type, Version and PMG.

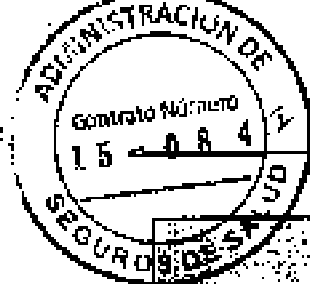
g. 2 – **PCP2 change.** It is used to register, in ASES, a change in the beneficiaries' selected PCP2 under the same carrier, Plan Type, Version and PMG.

h. 3 = **PCP1 and PCP2 change.** It is used to register, in ASES, a change in the beneficiaries' selected PCP1 and PCP2 under the same carrier, Plan Type, Version and PMG.

As we have seen, the content of the Tran_id field determines what type of transaction is going to be executed through the enrollment record sent to ASES. Some of the authorized transactions are broken down below. Table 3 below identifies the information that each change will require and states the fields that will be impacted by each one.

Table 3: Hierarchy Table

TRAN_ID	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	Y	Y	Y	Y	Y	O
[illegible]	Must be different from ASES DB	Y	Y	Y	Y	O
[illegible]	Must be the same as in ASES DB	Must be different from ASES DB	Y	Y	Y	O
[illegible]	Must be the same as in ASES DB	Must be the same as in ASES DB	Must be different from ASES DB	Y	Y	O
[illegible]	Must be the same as in ASES DB	Must be the same as in ASES DB	Must be the same as in ASES DB	Must be different from ASES DB	Y	O
[illegible]	Must be the same as in ASES DB	Must be the same as in ASES DB	Must be the same as in ASES DB	Must be the same as in ASES DB	Y	N
[illegible]	Must be the same as in ASES DB	Must be the same as in ASES DB	Must be the same as in ASES DB	Must be the same as in ASES DB	N	Y



3 - Change PCP1 & PCP2	Must be the same as in ASES DB	Must be the same as in ASES DB	Must be the same as in ASES DB	Must be the same as in ASES DB	Y	Y

Legend:
Y = Information required for the transaction type specified.
O – Optional information.
N – Information that should not be sent for the transaction type specified.

(A) New enrollment ("E"): The system will require all fields related to information about the Carrier, Plan Type, Plan Version, Primary Medical Group and PCP1 to be completed. The PCP2 information will remain as optional information for some cases.

(B) Change of Carrier ("C"): The system will require registering the name of the new carrier and inserting information regarding the Plan Type, Plan Version, Primary Medical Group, PCP1 and PCP2 (optional).

(C) Change of Plan Type ("P"): It will be necessary to insert the same code of the carrier that submits the change with the new information of the Type of Plan that corresponds to the beneficiary. Also, the information of Plan Version, Primary Medical Group and PCP (optional) must be included.

(D) Plan Version Change ("V"): The carrier code and Plan Type information provided must match the information in the ASES databases. Only information regarding the new assigned Plan Version will be provided. Information should also be provided in relation to the Primary Medical Group and PCP1 Center.

(E) Primary Medical Group Change ("I"): Information regarding the Carrier, Plan Type and Plan Version must match the information contained in the ASES databases. Only new information will be sent to ASES regarding the new Primary Medical Group (PMG) that corresponds to the beneficiary.

(F) Change of PCP1 ("1"): It will be necessary that the information of Carrier, Plan Type, Plan Version and Primary Medical Group provided coincide with the information contained in the ASES databases. It will be necessary to submit the new information regarding the change in PCP1 and it will not be necessary to provide information on the PCP2.

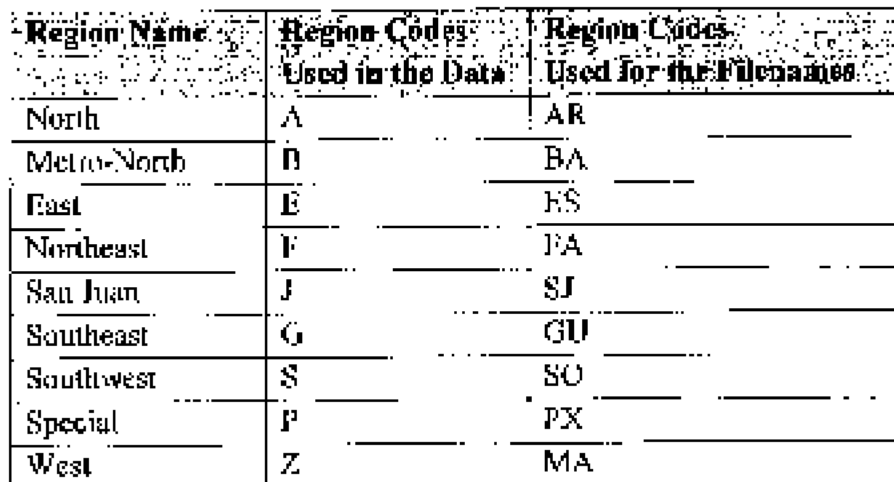
(G) Change of PCP2 ("2"): It will not be necessary to provide information about the PCP1. The only information allowed to differ with the one contained in the ASES records will be the one related to the PCP2.

(H) Change of PCP1 and PCP2 ("3"): It will be necessary to submit new information regarding the assigned PCP1 and PCP2. The information provided regarding the other fields should remain unchanged.

3. **PROCESS_DATE** – Process Date. Refers to the date on which the beneficiary contracted the coverage services with the corresponding carrier. It also refers to the date on which the carrier processed a change in PMG, Plan Version, Plan Type or PCP.

4. **REGION** Contains the region code assigned by ASES. This code must correspond to the region assigned to the beneficiary in the ASES database. ASES is responsible for assigning this code to Platino carriers. The Platino Plan carriers obtain this code directly from ASES after a request process initiated for these purposes. See Table 4 below for more information about the Region Codes.

Table 4: Region Codes



Region Name	Region Codes Used in the Data	Region Codes Used for the Filenames
North	A	AR
Metro-North	B	BA
East	E	ES
Northeast	F	FA
San Juan	J	SJ
Southeast	G	GU
Southwest	S	SO
Special	P	PX
West	Z	MA

5. **CARRIER** Two digit carrier code assigned by ASES to each of the carriers with the purpose of identification.

6. **MEMBER_PRIMARY_CENTER** – Up to four digits code assigned by carrier to identify their Primary Medical Groups (PMGs). Not required for some Plan Types/Versions

7. **ODSI_FAMILY_ID** - Eleven digit family identification code assigned by the Medicaid Office. This is the first part of the identifier for the beneficiaries in the ASES database. Platino carriers obtain this code from the ASES query response.

8. **MEMBER_SSN** - Social Security number of the member. It is required that this number matches with the one for the member in the ASES database.

9. **MEMBER_SUFFIX** – Two digit number which identifies a member within a family. This is the second part of the identifier for the beneficiaries in the ASES database.

10. EFFECTIVE_DATE – Date in which the carriers start providing coverage for the beneficiary under the enrolled Plan or the change for which the enrollment record was submitted becomes effective. For the Federal GHIP population, this date will be on the first of the month that the beneficiary applied for services coverage. For the GHIP population funded solely through state funds, this date will concur with the Certification Date. This date also refers to the date in which the PMG, PCP or Plan Version change becomes effective. For Tran_Id's other than "E" in GHIP enrollment the Effective Date must be 1st of the month following the enrollment.

11. PLAN_TYPE – Plan Type code that identifies the one under which the member is enrolled.

12. PLAN_VERSION – Plan version code that identifies the one under which the member is enrolled.

13. MPI- Master Patient Index. It is a unique number that identifies a member in the ASES and Medicaid Office's databases.

14. PCP1 – Fifteen digit number assigned by carriers. It is used to identify the PCP1 selected by the beneficiaries.

15. PCP1_EFFECTIVE_DATE – Date in which the PCP1 assignment became effective. If there is a change of PCP1, the initial PCP1 Effective Date will be kept until the Effective Date of the PCP1 Change has been reached.

16. PCP2 – Fifteen digit number assigned by carriers. It is used to identify the PCP2 selected by the beneficiaries.

17. PCP2_EFFECTIVE_DATE – Date in which the PCP2 assignment was effective. If there is a change of PCP2, the initial PCP2 Effective Date will be kept until the Effective Date of the PCP2 Change has been reached.

18. FAMILY_PRIMARY_CENTER – PMG assigned by the carrier to the beneficiary.

19. FAM_PRIMARY_CENTER_EFF_DATE – Date in which the assignment of the beneficiary's PMG became effective.

20. IPA_PCP_CHANGE_REASON – Not in use currently.

21. INDICADOR MEDICARE – Required for Platino enrollments only. (01=A&B, 03=A, 09=B).

22. NÚMERO HIC – Medicare Health Insurance Claim Number. It is required for Platino beneficiaries' enrollment.

23. IPA_ESPECIAL – A code "1" indicates that the member is assigned to a special IPA which is not the family IPA. Used for GHIP enrollment.

24. CONTRACT NUMBER – Contract number assigned by the carrier. It should be the number by which the member is identified in the carriers' ID card and internally in their database.

25. SPECIAL ENROLL – It is used to identify (1) the enrollment for newborns that are beneficiaries of the Federal CHIP Program; (2) to process the cases of utilization before the Certification Date (emergencies) for the federal population and (3) to identify the cases of retroactive periods under MAGI. The inclusion of an "N" in this field will allow the enrollment of the newborn from his/her birthdate. The inclusion of an "E" will allow the enrollment of emergency cases from the Eligibility Effective Date notified by the Medicaid Office and the insertion of a "T" will allow the enrollment on a retroactive period under MAGI.

26. Other data elements complimented by ASES – When a beneficiary's record is validated, the ASES system enters the following data in the enrollment record:

a. **Reject Identifier** - As a result of the validations, the record could be accepted or rejected. This field contains the codes that specify the result of said validation.

"A" = Accepted;
"M" - Accepted Retroactively;
"T" – Retroactive Eligibility Period Enrollment
"R" = Rejected;

Identifier = "A"
Identifies an accepted enrollment that will be applied on a current or future effective date. In this case, the update process moves the enrollment fields of the carrier, Plan Type, Plan Version, PMG and PCP to the fields intended for new enrollments in the beneficiary record. Until such time as the new Effective Date is reached, the beneficiary will remain under the current enrollment condition (same carrier, Plan, Version, PMG and PCP). During the end-of-month cycle, the new fields are moved to the current fields and the enrollment becomes effective.

Identifier = "M"
Indicates a retroactive enrollment. In these cases, Enrollment data (Carrier, Plan Type, Plan Version, PMG and PCP) are updated directly in the beneficiary's historical record.

Identifier = "T"
Under MAGI, it identifies a successfully processed retroactive enrollment.

Identifier "R"
In cases when an enrollment record is not successfully processed because an error has been identified, it indicates a record returned for correction.

b. **Record Key** - Internal number assigned by the ASES system.

c. **Error Codes one (1) to ten (10)** – It is possible to record up to ten error codes.

d. **Update Date** -- Date for which the validation is run. Corresponds to the date of the daily cycle the validation run was a part of.

e. **Update User** – ASES internal user code

15. REJECTION OF AN ENROLLMENT RECORD

An enrollment record related to any type of enrollment, modification or update transaction could be rejected if it does not pass the validation tests at the ASES systems. As mentioned above, rejected enrollments are sent daily to carriers in a file (.rje) that includes error codes for records that have not successfully passed the validation process. Carriers must correct identified errors and resubmit the corrected records to ASES with the next file submission, meaning the next business day. For the adequate correction of these errors please refer to the Error Codes Table provided in Section 22.

16. REJECTED ENROLLMENTS MANAGEMENT

The daily process of carriers in relation to rejected enrollments should include:

(1) **Receipt of** rejected enrollment records;
(2) **Evaluation** of rejection codes received;
(3) **Identification** of situations in which rejection is not clear for consultation with ASES;
(4) **Timely** correction of identified errors;
(5) **Transfer** of the corrected records to ASES in a 24 hour period.

17. ERROR CODES

This section addresses the error codes produced by the ASES validation process. In addition to the error codes known so far and as a result of the new changes involved in the implementation of MAGI, two (2) new error codes have been introduced and could appear as the result of the processes of validation and verification of the enrollment records.

18. NEW ERROR CODES UNDER MAGI

Code 023: If code "T", corresponding to a retroactive transaction, has been entered in the "Special Enroll" field, the field "Tran_ID" should be filled with code "E" or "C", accordingly.

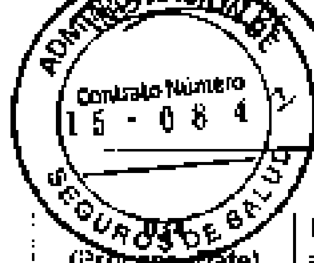
Code 109: In the 'Special Enroll' field it is necessary to insert a 'T' code when dealing with transactions for retroactive eligibility periods (1, 2 or 3). The notification of this error suggests that the "T" code was not found in the field 'Special Enroll' for an enrollment corresponding to retroactive eligibility periods on eligibility history files.

19. ERROR CODES TABLE

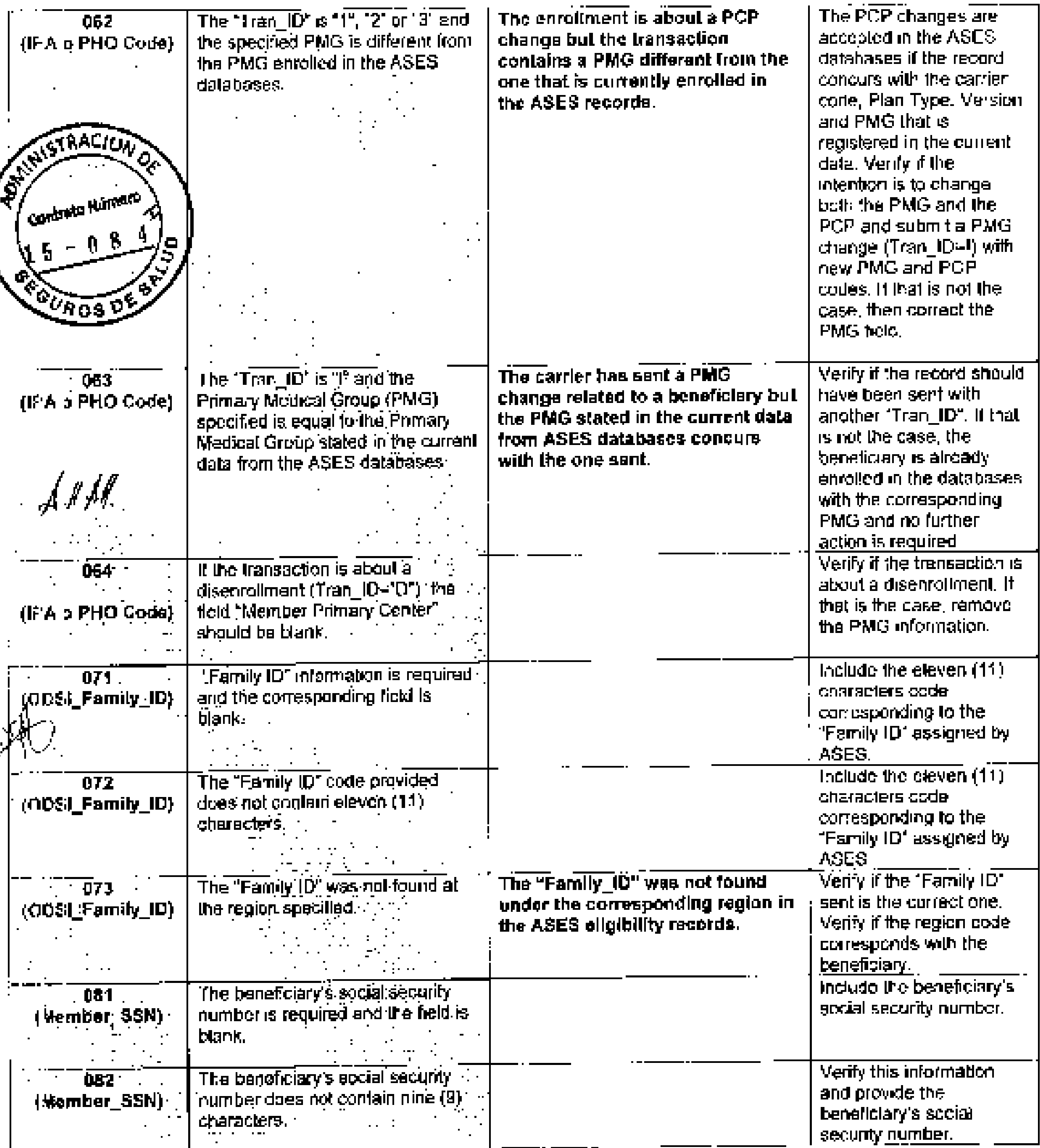
The following table contains the error codes produced by the validation program. Additional descriptions and possible corrective actions have been included to assist in the correction process.

Table 5: ErrorCodes

Error Code	Error Message	Additional Description	Possible Corrective Actions
011 (Record Type)	Invalid Record Type Code.	**This field is required to be filled with code "E" in every case.**	Fill with code "E".
021 (Tran_ID)	Tran_ID field is blank.	**This field is required to be filled with information about the type of transaction being processed.**	Fill this field with the corresponding code
022 (Tran_ID)	Invalid "Tran ID".	**An invalid transaction code has been identified.**	Fill this field with a valid transaction code.
023 MAGI	If the field "Special Enroll" has been filled with code "T" then the field "Tran_ID" should contain code "E" for new enrollments or code "C" if the transaction is about another change.	**For retroactive transactions ("T"), the field Tran_ID should be filled with code "E" or "C", accordingly.**	Verify and correct the information contained in the field.
031 (Process_Date)	Process date field is blank.		
032 (Process_Date)	Invalid process date.		
033 (Process_Date)	Except for the cases about newborns, for GHIP transactions, the process date should be lesser or equal to the effective date of the new enrollment or the change that is notified and greater or equal to three months before the effective date.	For GHIP (Plan Type = 01) the **process date should be lesser or equal to the effective date of the new enrollment or the change notified. The process date should fall within three (3) months before the effective date.**	Compare the process date with the effective date of the new subscription or the change about the record notified.



03[illegible] (Process_Date)	For GHIP transactions with Tran_Id = "E" and process date greater or equal to '11/16/2006', the effective date cannot be equal to '11/01/2006'	**Special code for the coverage code conversion of November 2006.**	Verify the effective date.
035 (Process_Date)	For Platino transactions, the process date should be within three (3) months before the effective date.	**For Platino (Plan Type = 02 or 03) the process date should be before the effective date. The process date of the new enrollment or change in the enrollment record should fall within three months before the effective date.**	Compare the process date to the effective date and correct.
041 (Region)	Region code field is blank.		Fill the field with the corresponding region code.
042 (Region)	Invalid region code.		Verify and fill the field with the corresponding region code.
051 (Carrier)	Carrier code field is blank.		Verify and fill the field with the corresponding carrier code.
052 (Carrier)	Invalid carrier code provided.		Verify and fill the field with the corresponding carrier code.
053 (Carrier)	The carrier has notified that a change of carrier has been performed but the carrier notifying the change is the same as the one registered in ASES's database.	**The enrollment has code "C" (carrier change) in the "Tran_ID" field and the carrier is the same as the one identified** in the **beneficiary's record** in **ASES.**	Verify if the record should have been sent with another "Tran_ID" (V or I, for example). If that's not the case, the beneficiary is already enrolled in the database with the submitting carrier and no further action is required.
054 (Carrier)	If the "Plan Type" = 01, the "Tran_ID" is "C" or "D" and the enrollment effective date ("Effective Date") is in the future, this date should on or before the first of the month three months in the future from the current date.	**The future disenrollment or carrier change transactions should have effective dates on or before the first of the month three months in the future from the current date.**	The effective date of the future disenrollment or carrier change transactions should fall on or before the first of the month three months in the future from the current date.
061 (IPA o PHO code)	It has been identified that the "Tran_ID" is "E", "C", "P", "V" or "I". These changes require that the Primary Medical Group (PMG) field contains PMG information.	**Specifying the Primary Medical Group is required when the enrollment for a GHIP carrier, or a Platino carrier for which the PMG is required, has a "Tran_ID" "E", "C", "P", "V" or "I".**	Provide the corresponding PMG code



062 (IFA o PHO Code)	The "Tran_ID" is "1", "2" or "3" and the specified PMG is different from the PMG enrolled in the ASES databases.	**The enrollment is about a PCP change but the transaction contains a PMG different from the one that is currently enrolled in the ASES records.**	The PCP changes are accepted in the ASES databases if the record concurs with the carrier code, Plan Type, Version and PMG that is registered in the current data. Verify if the intention is to change both the PMG and the PCP and submit a PMG change (Tran_ID=I) with new PMG and PCP codes. If that is not the case, then correct the PMG field.
063 (IFA o PHO Code)	The "Tran_ID" is "I" and the Primary Medical Group (PMG) specified is equal to the Primary Medical Group stated in the current data from the ASES databases.	**The carrier has sent a PMG change related to a beneficiary but the PMG stated in the current data from ASES databases concurs with the one sent.**	Verify if the record should have been sent with another "Tran_ID". If that is not the case, the beneficiary is already enrolled in the databases with the corresponding PMG and no further action is required
064 (IFA o PHO Code)	If the transaction is about a disenrollment (Tran_ID="D") the field "Member Primary Center" should be blank.		Verify if the transaction is about a disenrollment. If that is the case, remove the PMG information.
071 (ODSI_Family_ID)	"Family ID" information is required and the corresponding field is blank.		Include the eleven (11) characters code corresponding to the "Family ID" assigned by ASES.
072 (ODSI_Family_ID)	The "Family ID" code provided does not contain eleven (11) characters.		Include the eleven (11) characters code corresponding to the "Family ID" assigned by ASES
073 (ODSI_Family_ID)	The "Family ID" was not found at the region specified.	**The "Family_ID" was not found under the corresponding region in the ASES eligibility records.**	Verify if the "Family ID" sent is the correct one. Verify if the region code corresponds with the beneficiary.
081 (Member_SSN)	The beneficiary's social security number is required and the field is blank.		Include the beneficiary's social security number.
082 (Member_SSN)	The beneficiary's social security number does not contain nine (9) characters.		Verify this information and provide the beneficiary's social security number.

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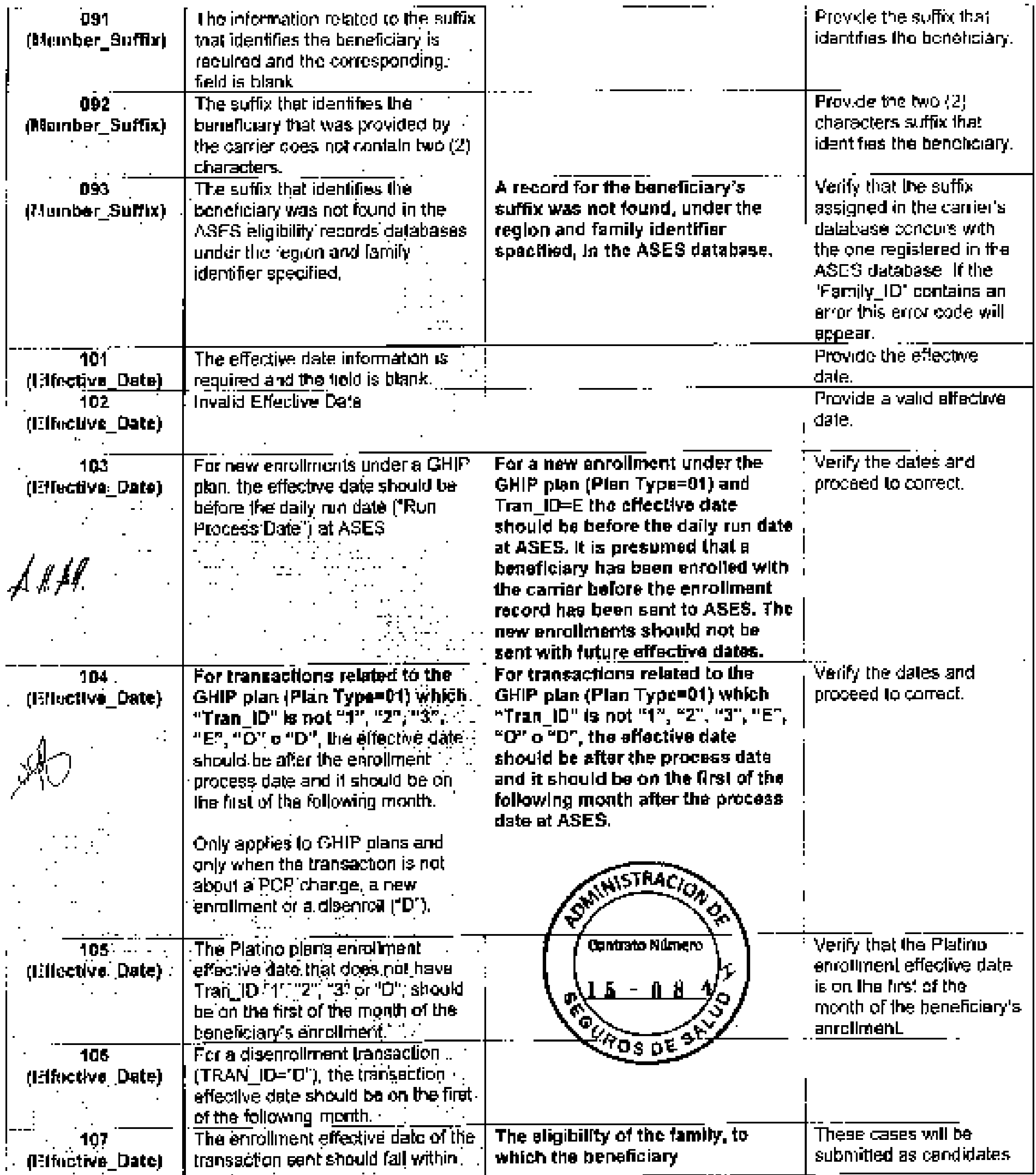

091 (Member_Suffix)	The information related to the suffix that identifies the beneficiary is required and the corresponding field is blank		Provide the suffix that identifies the beneficiary.
092 (Member_Suffix)	The suffix that identifies the beneficiary that was provided by the carrier does not contain two (2) characters.		Provide the two (2) characters suffix that identifies the beneficiary.
093 (Member_Suffix)	The suffix that identifies the beneficiary was not found in the ASES eligibility records databases under the region and family identifier specified.	**A record for the beneficiary's suffix was not found, under the region and family identifier specified, in the ASES database.**	Verify that the suffix assigned in the carrier's database concurs with the one registered in the ASES database. If the 'Family_ID' contains an error this error code will appear.
101 (Effective_Date)	The effective date information is required and the field is blank.		Provide the effective date.
102 (Effective_Date)	Invalid Effective Date		Provide a valid effective date.
103 (Effective_Date)	For new enrollments under a GHIP plan, the effective date should be before the daily run date ("Run Process Date") at ASES	**For a new enrollment under the GHIP plan (Plan Type=01) and** Tran_ID=E **the effective date should be before the daily run date at ASES. It is presumed that a beneficiary has been enrolled with the carrier before the enrollment record has been sent to ASES. The new enrollments should not be sent with future effective dates.**	Verify the dates and proceed to correct.
104 (Effective_Date)	**For transactions related to the GHIP plan (Plan Type=01) which "Tran_ID" is not "1", "2", "3",** "E", "O" o "D", the effective date should be after the enrollment process date and it should be on the first of the following month. Only applies to GHIP plans and only when the transaction is not about a PCP change, a new enrollment or a disenroll ("D").	**For transactions related to the GHIP plan (Plan Type=01) which "Tran_ID" is not "1", "2", "3", "E", "O" o "D", the effective date should be after the process date and it should be on the first of the following month after the process date at ASES.**	Verify the dates and proceed to correct.
105 (Effective_Date)	The Platino plans enrollment effective date that does not have Tran_ID "1", "2", "3" or "D", should be on the first of the month of the beneficiary's enrollment.		Verify that the Platino enrollment effective date is on the first of the month of the beneficiary's enrollment.
106 (Effective_Date)	For a disenrollment transaction (TRAN_ID="D"), the transaction effective date should be on the first of the following month.		
107 (Effective_Date)	The enrollment effective date of the transaction sent should fall within	**The eligibility of the family, to which the beneficiary**	These cases will be submitted as candidates

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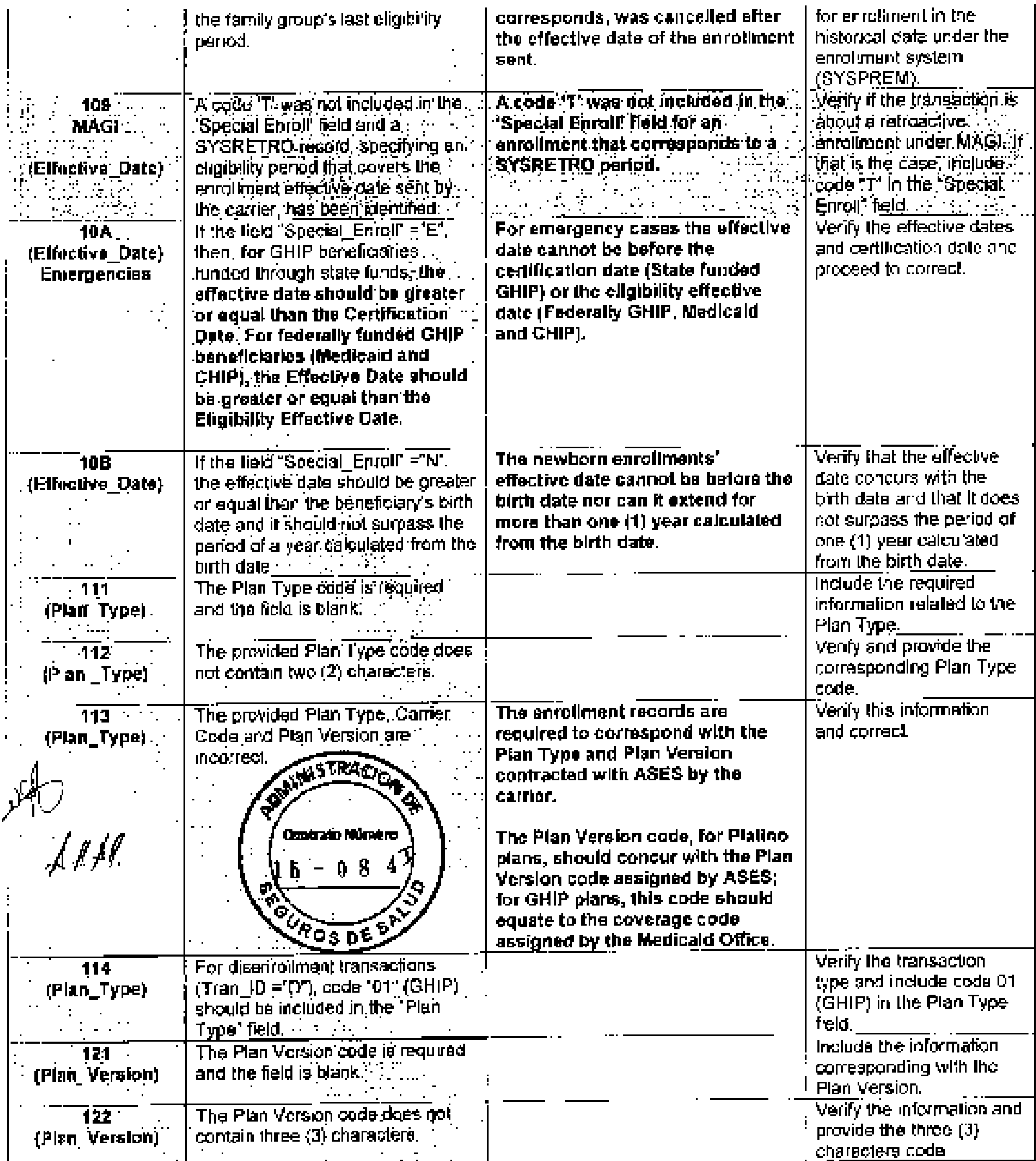
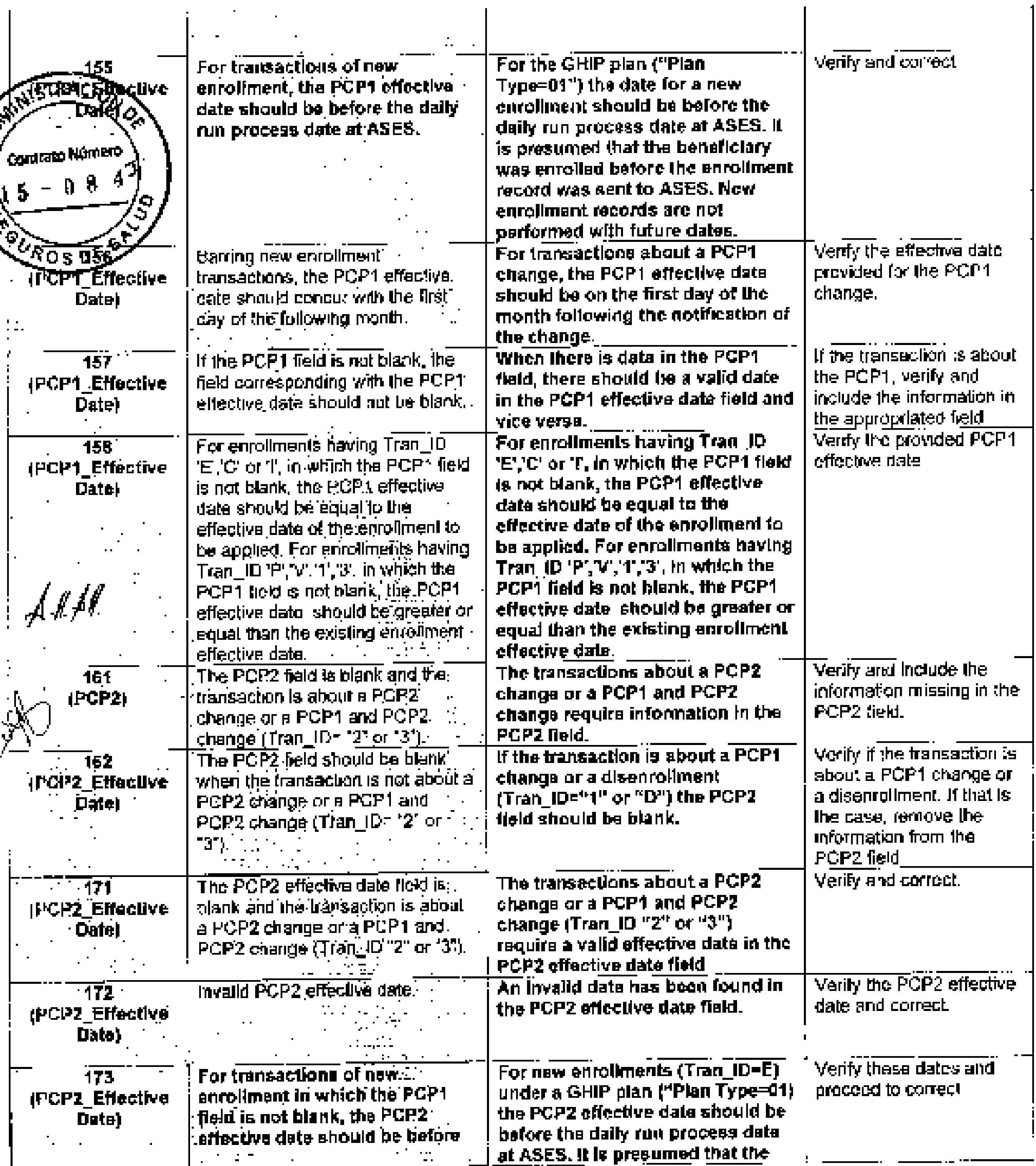


	the family group's last eligibility period.	**corresponds, was cancelled after the effective date of the enrollment sent.**	for enrollment in the historical date under the enrollment system (SYSPREM).
109 MAGI (Effective_Date)	A code 'T' was not included in the 'Special Enroll' field and a SYSRETRO record, specifying an eligibility period that covers the enrollment effective date sent by the carrier, has been identified.	**A code 'T' was not included in the 'Special Enroll' field for an enrollment that corresponds to a SYSRETRO period.**	Verify if the transaction is about a retroactive enrollment under MAGI. If that is the case, include code 'T' in the 'Special Enroll' field.
10A (Effective_Date) Emergencies	If the field "Special_Enroll" = "E", then, for GHIP beneficiaries funded through state funds, **the effective date should be greater or equal than the Certification Date. For federally funded GHIP beneficiaries (Medicaid and CHIP), the Effective Date should be greater or equal than the Eligibility Effective Date.**	**For emergency cases the effective date cannot be before the certification date (State funded GHIP) or the eligibility effective date (Federally GHIP, Medicaid and CHIP).**	Verify the effective dates and certification date and proceed to correct.
10B (Effective_Date)	If the field "Special_Enroll" = "N", the effective date should be greater or equal than the beneficiary's birth date and it should not surpass the period of a year calculated from the birth date.	**The newborn enrollments' effective date cannot be before the birth date nor can it extend for more than one (1) year calculated from the birth date.**	Verify that the effective date concurs with the birth date and that it does not surpass the period of one (1) year calculated from the birth date.
111 (Plan_Type)	The Plan Type code is required and the field is blank.		Include the required information related to the Plan Type.
112 (Plan_Type)	The provided Plan Type code does not contain two (2) characters.		Verify and provide the corresponding Plan Type code.
113 (Plan_Type)	The provided Plan Type, Carrier Code and Plan Version are incorrect.	**The enrollment records are required to correspond with the Plan Type and Plan Version contracted with ASES by the carrier.** **The Plan Version code, for Platino plans, should concur with the Plan Version code assigned by ASES; for GHIP plans, this code should equate to the coverage code assigned by the Medicaid Office.**	Verify this information and correct.
114 (Plan_Type)	For disenrollment transactions (Tran_ID = 'D'), code '01' (GHIP) should be included in the 'Plan Type' field.		Verify the transaction type and include code 01 (GHIP) in the Plan Type field.
121 (Plan_Version)	The Plan Version code is required and the field is blank.		Include the information corresponding with the Plan Version.
122 (Plan_Version)	The Plan Version code does not contain three (3) characters.		Verify the information and provide the three (3) characters code.

			corresponding to the Plan Version.
123 (Plan_Version)	The provided Plan Version code is invalid for the specified Effective Date.	**The Plan Version code should be one that is active at the Effective Date indicated.**	Verify the Plan Version code and/or Effective Date.
124 (Plan_Version)	Invalid Plan Version code. If the transaction is about a disenrollment (Tran_ID="D"), the plan version code should be 001.	**If the transaction is about a disenrollment (Tran_ID ="D"), then the Plan Version field should contain the code "001".**	Verify the transaction type and include the corresponding code.
131 (MPI)	The provided "MPI Number" does not contain thirteen (13) characters.		Verify the included code. Provide the thirteen (13) characters code of the corresponding MPI Number
132 (MPI)	The "MPI Number" does not concur with the ASES records for the region specified.		Verify that the correct MPI Number has been provided. Verify if the region code sent corresponds with the region to which the beneficiary corresponds.
141 (PCP1)	The PCP1 field is blank and the transaction is not type "2" or "D" (which require this field to be blank).	**The PCP1 field should not be blank if the PCP1 is required and the transaction is not type "2" or "D".**	Verify the transaction type and include the corresponding PCP1 code.
142 (PCP1)	The PCP1 should be blank when the Tran ID is "2" or "D".	**If the transaction is about a PCP2 change or a disenrollment, the PCP1 field should be blank.**	Verify the transaction type. If the transaction is about a PCP2 change, remove the information included in the PCP1 field.
151 (PCP1_Effective Date)	The PCP1 field is blank and the Tran_ID is neither "2" nor "D".	**The PCP1 field is blank or the provided date is invalid in a transaction for which the PCP1 information was required.**	Verify and correct.
152 (PCP1_Effective Date)	An invalid effective date was provided for the PCP1 Effective Date and this information was required	**The PCP1 effective date field is blank or the provided date is invalid.**	Verify the error and correct.
153 (PCP1_Effective Date)	**There is information in the PCP1 effective date field and the transaction is not about a PCP2 change or a disenrollment and the PCP1 is not required.**	**The PCP1 effective date should be blank when the enrollment does not imply a PCP2 change and the PCP1 is not required.**	Verify and correct.
154 (PCP1_Effective Date)	The field corresponding with the PCP1 effective date should be blank when the transaction is about a PCP2 change or a disenrollment.	**The PCP1 effective date should be blank when the transaction is about a PCP2 change or a disenrollment.**	Verify and correct.



155 (PCP1_Effective Date)	**For transactions of new enrollment, the PCP1 effective date should be before the daily run process date at ASES.**	For the GHIP plan ("Plan Type=01") the date for a new enrollment should be before the daily run process date at ASES. It is presumed that the beneficiary was enrolled before the enrollment record was sent to ASES. New enrollment records are not performed with future dates.	Verify and correct
156 (PCP1_Effective Date)	Barring new enrollment transactions, the PCP1 effective date should concur with the first day of the following month.	**For transactions about a PCP1 change, the PCP1 effective date should be on the first day of the month following the notification of the change.**	Verify the effective date provided for the PCP1 change.
157 (PCP1_Effective Date)	If the PCP1 field is not blank, the field corresponding with the PCP1 effective date should not be blank.	**When there is data in the PCP1 field, there should be a valid date in the PCP1 effective date field and vice versa.**	If the transaction is about the PCP1, verify and include the information in the appropriated field
158 (PCP1_Effective Date)	For enrollments having Tran_ID 'E','C' or 'I', in which the PCP1 field is not blank, the PCP1 effective date should be equal to the effective date of the enrollment to be applied. For enrollments having Tran_ID 'P','V','1','3', in which the PCP1 field is not blank, the PCP1 effective date should be greater or equal than the existing enrollment effective date.	**For enrollments having Tran_ID 'E','C' or 'I', in which the PCP1 field is not blank, the PCP1 effective date should be equal to the effective date of the enrollment to be applied. For enrollments having Tran_ID 'P','V','1','3', in which the PCP1 field is not blank, the PCP1 effective date should be greater or equal than the existing enrollment effective date.**	Verify the provided PCP1 effective date
161 (PCP2)	The PCP2 field is blank and the transaction is about a PCP2 change or a PCP1 and PCP2 change (Tran_ID= "2" or "3").	**The transactions about a PCP2 change or a PCP1 and PCP2 change require information in the PCP2 field.**	Verify and include the information missing in the PCP2 field.
162 (PCP2_Effective Date)	The PCP2 field should be blank when the transaction is not about a PCP2 change or a PCP1 and PCP2 change (Tran_ID= "2" or "3").	**If the transaction is about a PCP1 change or a disenrollment (Tran_ID="1" or "D") the PCP2 field should be blank.**	Verify if the transaction is about a PCP1 change or a disenrollment. If that is the case, remove the information from the PCP2 field
171 (PCP2_Effective Date)	The PCP2 effective date field is blank and the transaction is about a PCP2 change or a PCP1 and PCP2 change (Tran_ID "2" or "3").	**The transactions about a PCP2 change or a PCP1 and PCP2 change (Tran_ID "2" or "3") require a valid effective date in the PCP2 effective date field**	Verify and correct.
172 (PCP2_Effective Date)	Invalid PCP2 effective date.	**An invalid date has been found in the PCP2 effective date field.**	Verify the PCP2 effective date and correct.
173 (PCP2_Effective Date)	**For transactions of new enrollment in which the PCP1 field is not blank, the PCP2 effective date should be before**	**For new enrollments (Tran_ID=E) under a GHIP plan ("Plan Type=01") the PCP2 effective date should be before the daily run process date at ASES. It is presumed that the**	Verify these dates and proceed to correct

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	the daily run process date at ASES.	beneficiary was enrolled before the enrollment record was sent to ASES. The system will not be able to process new enrollments with future dates in this field.	
174 (PCP2_Effective Date)	Barring new enrollment transactions, the PCP2 effective date should concur with the first day of the month following the notification of the change.	For transactions about a PCP2 change, the PCP2 effective date should be on the first day of the month following the notification of the change.	Verify that the PCP2 effective date is on the first day of the month following the notification of the change.
175 (PCP2_Effective Date)	If the PCP2 field is not blank, the field corresponding with the PCP1 effective date should not be blank and vice versa	When there is data in the PCP2 field, there should be a valid date in the PCP2 effective date field and vice versa.	Verify the related fields and proceed to include the missing information
176 (PCP2_Effective Date)	If the transaction is about a disenrollment (Tran_ID="D"), then the PCP2 effective date field should be blank.		Verify the transaction type and remove any PCP2 information that is not required.
177 (PCP2_Effective Date)	It has been identified that the beneficiary is already enrolled with another carrier for a date equal or after the Effective Date of the enrollment sent. This error applies to cases of new enrollment and carrier change.	The beneficiary is already enrolled at ASES with another carrier for a date equal or after the effective date of the enrollment sent.	Verify that the effective date sent to ASES corresponds with the appropriated date.
178 (PCP2_Effective Date)	For enrollments having Tran_ID 'E','C' or 'I', in which the PCP2 field is not blank, the PCP2 effective date should be equal to the effective date of the enrollment to be applied. For enrollments having Tran_ID 'P','V','2','3', in which the PCP2 field is not blank, the PCP2 effective date should be greater or equal than the existing enrollment effective date.	For enrollments having Tran_ID 'E','C' or 'I', in which the PCP2 field is not blank, the PCP2 effective date should be equal to the effective date of the enrollment to be applied. For enrollments having Tran_ID 'P','V','2','3', in which the PCP2 field is not blank, the PCP2 effective date should be greater or equal than the existing enrollment effective date.	Verify the provided PCP2 effective date.
181 (Family_Primary_Center)	For GHIP plans, it is required to provide information about the Family Primary Medical Group.	For GHIP plans, the information about the Family Primary Medical Group is required.	Include the corresponding Primary Medical Group code for the corresponding Family.
182 (Family_Primary_Center)	The transaction did not require information about the Family Primary Medical Group and information was provided for said field.		Verify the transaction type and remove the information not required from the corresponding field.
183 (Family_Primary_Center)	If the transaction is about a disenrollment (Tran_ID="D"), the Primary Medical Group field should be blank.	The transaction is about a disenrollment "D" and there is information in the Primary Medical Group field.	Verify the transaction type and remove the information not required from the PMG field.

191 (Family_Primary_Center Effective Date)	The effective date for the Family Primary Medical Group is blank and the information in this field is required.		Include a valid effective date in the Family Primary Medical Group field
192 (Family_Primary_Center Effective Date)	The Family Primary Medical Group effective date included is not valid	**An invalid date was found in the Family Primary Medical Group effective date field.**	Verify the PMG effective date and provide the corresponding date.
193 (Family_Primary_Center Effective Date)	The information for the Family Primary Medical Group is not required and there should be no information in this field.	**The Information for the Family Primary Medical Group is not required and there is information in this field.**	If this information should not be sent, remove the information provided in this field
194 (Family_Primary_Center Effective Date)	If the transaction is about a disenrollment (Tran_ID="D") this field should be blank.		If the transaction is about a disenrollment, remove the information provided in this field.
200 200 (IPA PCP Change Reason)	If the transaction is about a disenrollment (Tran_ID="D"), then the PMG or PCP Change Reason field should be blank.	If the transaction is about a disenrollment, then the PMG or PCP Change Reason field should be blank.	If the transaction is about a disenrollment, remove the information provided in the PMG or PCP Change Reason field should be blank
211 Medicaid_IND	The Plan Version and Type are incorrect. The beneficiary does not receive medical services under Federal Medicaid.	**The Plan Version and Type codes provided by the carrier require that the beneficiary is eligible to receive services under Federal Medicaid and the ASES database states that the beneficiary is not eligible for that** coverage.	Verify and submit the corresponding information
221 (Relationship Edit)	Duplicate enrollment.	**Two or more enrollment records with the same Family_ID and suffix were identified in the same daily run process cycle at ASES.**	Verify this information.
222	The transaction is about a new enrollment and the beneficiary is already enrolled under the same carrier trying to enroll it through this transaction.	**The transaction is about a new enrollment and it has been identified that the beneficiary is already enrolled under the same carrier as the one sending the enrollment.**	Verify if the record should have been sent with another "Tran_ID" like, for example, "V" or "I". If that is not the case, the beneficiary is already enrolled and no further action is required
223	The transaction is about a new enrollment and the beneficiary is already enrolled with another carrier.	**The transaction is about a new enrollment (Tran_ID = "E") and beneficiary records of enrollment under another carrier have been found at the ASES database.**	Verify if the enrollment record should have been sent with a carrier change code included in the "Tran_ID"
224	The beneficiary was not eligible for the effective date indicated by the carrier.		Verify the effective date.
225 (Member_SSN)	The social security number provided was not found in the ASES databases current data.		Verify and correct the social security number.
226 (MPI)	The MPI Number sent was not found in the ASES databases current data.		Verify and correct the MPI Number.

227 (Plan Type change)	The transaction is about a Plan Type change and the carrier sending it is different from the carrier currently enrolled in the ASES databases.	**Only the carrier registered in the ASES database at the moment a Plan Type change is submitted may submit a Plan Type change in the enrollment record.**	Verify if the record should have been sent with another Tran_ID.
228 (Plan Version change)	The transaction is about a plan version change (Trans_ID= "V") and the carrier or plan type submitted do not concur with the data found in the ASES database.	**The plan type changes are accepted by the system if they are sent by the same carrier and under the same plan type registered in the current data at ASES.** **Only the carrier registered in the ASES database at the moment a Plan Version change is submitted may submit a Plan Version change in the enrollment record.**	Verify if the record should have been sent with another Tran_ID
229 (IPA change)	The transaction is about a PMG change (Trans_ID= "I") and the carrier, plan type or plan version submitted do not concur with the data found in the ASES database.	**The PMG changes are permitted if they are sent by the carrier, plan type and plan version registered in the current data at ASES.** **Only the carrier registered in the ASES database at the moment a PMG change is submitted may submit a PMG change in the enrollment record.**	Verify if the record should have been sent with another Tran_ID.
22A (PCP1, PCP2 o PCP1 y PCP2 Change)	The transaction is about a PCP1, PCP2 or PCP1 and PCP2 change ("Tran_ID" ="1", "2" o "3") and the carrier, Plan Type, Plan Version and PMG do not concur with the current data in the ASES databases.	**The PCP changes are permitted under the same carrier, Plan Type, Plan Version and PMG as stated by the beneficiary's current data at ASES. This error suggests that the beneficiary is currently enrolled under another carrier, Plan Type, Plan Version or PMG in the ASES database.**	Verify if the record should have been sent with another Tran_ID.
22B (PCP1 Effective Date; PCP2_Effective_Date)	If the transaction is about a PCP1 and PCP2 change (Tran ID=3), both the PCP1 and PCP2 affective dates should be future or retroactive dates.	**Both the PCP1 and PCP2 effective dates should be future or retroactive dates.**	Verify the dates for PCP1 and PCP2 and correct.
22D	Invalid date values for enrollments of future effect. This error applies to all the transactions that are not of type "D".	**The PCP, PMG, Plan Version and carrier changes cannot be sent with dates more than four (4) months into the future. This error applies to all the transactions that are not of type "D".**	
22E	If the plan type is GHIP ("Plan Type" =01), then the plan version should be equal to the "Coverage Code"	**For the GHIP enrollment record ("Plan Type" 01) the plan version code should concur with the coverage code registered in ASES database for the beneficiary being enrolled.**	Verify and correct.

22F	All GHIP beneficiaries from a same family group will be rejected if a record corresponding to any of them is marked with an error code	**When a GHIP beneficiary's enrollment record contains an error, every record from beneficiaries belonging to the same family group receives a 22F error code. This has the effect of maintaining all the beneficiary records under a same family record and avoids the partial processing of the family in a same daily run process cycle at ASES.**	Verify and correct every additional error identified other than the 22F codes for every GHIP beneficiary in the family
250 (HIC Number)	If the transaction is about a disenrollment (Tran_ID="D") the HIC Number field should be blank.	**There should be no information in the "HIC Number" field if the transaction is about a disenrollment ("D").**	If the transaction is about a disenrollment ("D"), remove the information provided in the HIC Number field.
260 (IPA_Special)	If the transaction is about a disenrollment (Tran_ID="D") the IPA_SPECIAL field should be blank.	**There should be no information in the IPA_SPECIAL field if the transaction is about a disenrollment ("D").**	If the transaction is about a disenrollment ("D"), remove the information provided in the IPA_SPECIAL field.
270 (Medicare Indicator)	If the transaction is about a disenrollment ("Tran_ID" = 'D') the 'Medicare Indicator' field should be blank.	**There should be no information in the Medicare Indicator field if the transaction is about a disenrollment ("D").**	If the transaction is about a disenrollment 'D', remove the information provided in the Medicare Indicator field.
280	The family should be eligible at the moment the record is being processed.	**Family not eligible at the moment the record is being processed.**	
281	The beneficiary should be eligible at the moment the record is being processed.	**Beneficiary not eligible at the moment the record is being processed.**	
998	Record number is blank.	**Transaction without Record Number. Does not constitute an error. No further action required.**	No action required.
999	The record number sent does not concur with a previous record number from a previous transfer	**The record number sent does not concur with a record number from a previous transfer. Does not constitute an error. No further action required.**	No action required.

20. DISENROLLMENT (Cancellation)

20.1 Disenrollment under GHIP and Medicare Platino

The process of a disenrollment occurs only when the Medicaid Office determines that a beneficiary is no longer eligible for GHIP or Medicare Platino or in those cases where a disenrollment from the plan is requested by the Carrier or the beneficiary and has been approved by ASES. [12]

Medicaid will notify the disenrollment to ASES, and ASES will notify the carrier of the disenrollment. Such notification shall be effected by means of a daily transfer of files to the carrier together with files containing information on new beneficiaries to be enrolled. This will be done within five (5) calendar days after a final determination on the disenrollment. [13]

Only the Medicaid Office may notify and cancel eligibility. However, both ASES and the carriers may continue to process disaffiliations that do not have the effect of cancelling the eligibility of a beneficiary to receive medical services.

20.2 Effective Date of Disenrollment:

This is the date, as defined in Section 5.3.3 of the contract signed between ASES and the carriers, in which the coverage of a beneficiary under a contracted carrier ends. The effective date of the cancellation is the date ASES notifies to carriers.

21. GHIP DISENROLLMENT (Cancellation)

21.1 Disenrollment Made by Medicaid Office

A GHIP disenrollment occurs when the Medicaid Office determines that (1) a beneficiary has lost eligibility to receive medical services coverage under the GHIP; (2) the eligibility period granted by the Medicaid Office has expired or (3) a request for re-enrollment has been received from a beneficiary or a new carrier as set forth in Sections 5.3.4 and 5.3.5 of the agreement signed between ASES and the carriers. In general, a disenrollment will be notified to the carriers by ASES Any disenrollment shall take effect as of its Effective Date specified in the notice issued by ASES to the carrier in that respect.

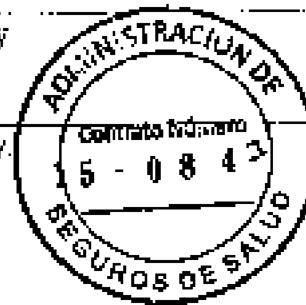
In cases where ASES notifies the carrier of the disenrollment on or before the last working day of the month in which the beneficiary's eligibility expires, said disenrollment shall be effective on the first day of the following month.

[12] See sections 5.3.4 y 5.3.5 of the GHIP contract between ASES and the carriers.
[13] See section 5.3.2 of the contract between ASES and the carriers.

When the disenrollment is made at the request of the carrier or the beneficiary, as provided in Sections 5.3.4 and 5.3.5 of the contract signed between ASES and carriers, the disenrollment shall take effect no later than the first day of the second month following the month in which the request was made.

Table 6: Examples of GHIP Effective Dates of Disenrollment

GHIP Disenrollment Reason	GHIP Disenrollment Effective Date
Notified by ASES (not notified on the last business day of the month).	Date Specified in the ASES Disenrollment Notification.
Notified by ASES (on the last business day of the month).	First day of the following month.
Requested by Beneficiary or Carrier.	No later than the first day of the second month in which the Carrier or Beneficiary has requested disenrollment.
Death of the Beneficiary	Federal and state funded Commonwealth beneficiaries are disenrolled from the first day after death.
Move of the Beneficiary.	Since the contract covers all regions on the island any move within the island has no impact. If the move causes a change of region, then the effective date is the date notified by Medicaid.
Beneficiary moved outside of Puerto Rico.	Federal and state funded Commonwealth beneficiaries will be disenrolled as of the first day of ineligibility as notified by the Medicaid Office.
Incarceration of the Beneficiary	Federal and state funded Commonwealth beneficiaries will be disenrolled as of the first day of ineligibility as notified by the Medicaid Office.
After completing the pregnancy and post-natal care eligibility extension	If at re-certification a woman becomes ineligible for GHIP and is pregnant, the eligibility is extended for 60 days after the baby is born or after a pregnancy loss



21.2 Effective Date of the Programmatic Disenrollment (Disaffiliation)

For programmatic purposes of the ASES Information Systems Office, this Disenrollment Effective Date also refers to the day on which a beneficiary ceases to be enrolled under a particular carrier in the ASES databases. This disenrollment takes place in those cases in which the Medicaid Office has sent a change of coverage code for a beneficiary and the carrier has not submitted an enrollment with the new plan version related to the change of coverage.

Although in cases of programmatic disenrollment the eligibility period will continue for the beneficiaries who are disenrolled, the premium payment cannot be processed until a new beneficiary enrollment is sent by the carrier with the information of the new plan version related to the change of coverage

22. MEDICARE PLATINO DISENROLLMENT

22.1 Disenrollment by Beneficiary Request

Platino Medicare beneficiaries may under certain circumstances require the termination of the enrollment agreement that covers their services. The Effective Date of these disenrollment will fall on the first day of the month following the disenrollment request. However, in spite of the above, the Effective Date of the Disenrollment shall in no case fall on a date after the first day of the following month after the one in which the beneficiary has made the disenrollment request.

22.2 Automatic Disenrollment

The carrier shall automatically process disenrollment in cases of death of a beneficiary, loss of eligibility, for the causes outlined in Schedule F of the Draft Agreement between ASES and Platino carriers, termination of the eligibility period Granted by Medicaid, or in case of disenrollment of the Medicare Platino product it offers. The Effective Date of the Disenrollment in these cases will fall on the last day of the month in which any of the events mentioned above takes place.

22.3 Retroactive Disenrollment

Retroactive disenrollment occurs exceptionally and only if a beneficiary has been enrollment and is ineligible to receive medical services, in circumstances in which he or she has been retroactively deprived of the Advantage product of the carrier in question and in Cases of incarceration or death of the beneficiary, etc. The Effective Date in these cases is discussed in Table 7 below.

Table 7: Medicare Platino Effective Dates of Disenrollment

Reason for Disenrollment	Effective Date of Disenrollment
Death of the Beneficiary	First day after death.
Incarceration of the Beneficiary	First day of ineligibility as notified by Medicaid.
Beneficiary enters or stated in a residential institution under circumstances which rendered the individual ineligible for enrollment in Medicare Advantage, including when an enrollee is admitted to the hospital that (1) is certified by Medicare as a long term care hospital and (2) has an average stay for all patients greater than ninety-five (95) days.	First day of ineligibility as notified by Medicaid

Beneficiary enrollment while being eligible	Effective Date of Enrollment in the Platino Plan Carriers.
Move of the Beneficiary.	Since the contract covers all regions on the island any move within the island has no impact.
Beneficiary moved outside of Puerto Rico.	First day of ineligibility as notified by Medicaid.
Expedite Disenrollment: - Urgent Medical Need	First day of the next month after determination except where medical need requires an earlier disenrollment.
Expedite Disenrollment: - Non-consensual enrollment	Retroactive to the first day of the month
Expedite Disenrollment: - Disenrollment from the carrier Medicare Platino	Concurrent with the Effective Date of Disenrollment from the carrier Medicare Advantage Product.

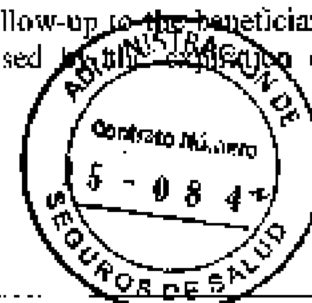
23. UPDATES TO NEW ENROLLMENTS AND ENROLLING OMITTED BENEFICIARIES

In cases in which the carrier must update the information previously sent to ASES on a new enrollment, or that it must add a new beneficiary previously omitted, that update must occur on the next Business Day after the information has been updated or a new beneficiary has been added. ASES reserves the discretion of not accepting new additions or corrections to the enrollment data sixty (60) calendar days after the Enrollment Effective Date indicated in the carrier's notification to ASES.

24. CARRIERS RESPONSIBILITIES IN THE ENROLLMENT PROCESSES

In summary, as part of the enrollment process, it will be the responsibility of the carriers to ensure compliance with the duties described in Table 8 below.

Table 8: Carriers Responsibilities about an Enrollment Transaction

Change or Modification	Action Required
1. Transfer of Daily Eligibility Files.	Daily Update of Eligibility Files in the carrier's databases.
2. New Enrollments.	GHIP carriers should start the enrollment process with the beneficiary and verify each of the enrollments made including the enrollment of newborns and emergency cases. They must also enroll beneficiaries who have an Effective Date prior to a cancellation period.
3. Carrier Change.	Identify the beneficiaries who have requested a change of carrier and take action on behalf of these. The carrier that lost the beneficiary must identify the loss of the beneficiary in the corresponding file.
4. Changes to the enrollment data. (Change of Plan Type, Plan Version, PMG and/or PCP).	Identify beneficiaries who have changed coverage code, Plan Type, Plan Version, PMG or PCP (1 or 2) and notify these changes. The carrier's system must be updated in accordance with these modifications as failure to do so may lead to the rejection of the enrollment record in future transactions.
5. Change in the demographic data of a beneficiary. This information is received from the Medicaid Office but does not cause a change in the enrollment.	The carrier must update the beneficiary's record with the new data in its database.
6. Rejected Records	Correct the rejected records.
7. Cancellation of Beneficiary: Only the Medicaid Office may cancel the eligibility of a beneficiary, having the effect that until such notice of Medicaid is received the beneficiary will remain active in the databases of both ASES and the carriers even when the period of eligibility granted has expired.	Identify the cases of beneficiaries canceled or denied coverage and take action on behalf of these. The carriers must perform follow-up to the beneficiaries in case the cancellation is caused by the expiration of the Certification Date. 
8. Programmatic Disenrollment: Change in the coverage code.	Carriers should identify when a record received has a different coverage code than is recorded in their databases.

	In these cases, carriers must assess whether the new coverage code requires the beneficiary to be enrolled in a different "Plan Version". If so, they must re-enroll these beneficiaries under the new "Plan Version" to correspond with the new coverage code. Subsequently, a change of "Plan Version" must be sent to ASES before the end of the current month. Beneficiaries who are not registered with a "Plan Version" that corresponds with the coverage code will be disenrolled in the run of the end-of-month cycle in the ASES databases. The carrier should enroll the beneficiaries that have been disenrolled.
9. Beneficiary Disenrollment.	End of Month: When a record of a beneficiary is received with the field corresponding to the carrier empty and it is identified that the beneficiary was previously enrolled in the ASES databases it should be understood that a process of disaffiliation of this beneficiary has been carried out in response to the fact that no information has been received in response to a change of coverage in ASES Carrier change: When a beneficiary's data is received with a different carrier code from the one that appears in the carrier's database, it means that the beneficiary has been enrolled with a different carrier (this usually applies to Platino plans). In this case, the previous carrier must disenroll the beneficiary in its database.

V. PREMIUM PAYMENT

25. PREMIUM PAYMENT

The premium payment system operates under the concept that premiums are calculated and paid only in relation to beneficiaries who are already enrolled before the first day of the month to which the payment corresponds. Beneficiaries enrolled after that date will be considered for the next payment of the corresponding premium.

On a monthly basis, the system performs an automatic execution of payment in which the payment that corresponds to each one of the carriers is calculated by region according to the beneficiaries that are enrolled under each one of the regions in the ASES databases.

Premium payments will be made on the first day of the month following the acceptance of the enrollment by ASES. ASES is not obligated to pay premiums on beneficiaries who are not duly enrolled according to ASES's databases nor for beneficiaries whose records contain transactions that have been rejected in the ASES databases and have not been corrected within the periods established by contract.

The payment system calculates several payment categories as listed below:

The reconciliation processes carried out with the insurers must be based on the payment file for a given month and must take into consideration the status of the subscriptions of the beneficiaries in ASES. Premium payments will be made on the first day of the month following the acceptance of the ASES subscription.
The payment system calculates several payment categories as listed below:

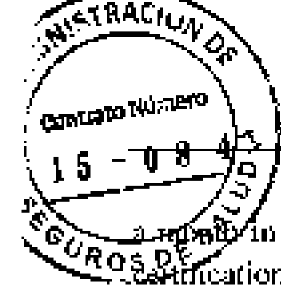
26. TYPES OF PAYMENT

26.1 Monthly payments

In this case the system produces a payment for those beneficiaries whose enrollment has already taken effect before the first day of the month for which the payment transaction is executed. The execution of premium payment is made on the first day of the month.

26.2 Prorated Payments

Prorated payments are specifically calculated for beneficiaries of the CHIP funded solely through state funds (Commonwealth) who have been enrolled at some point in a month prior to the month in which the premium payments are to be made. The payment in these cases will satisfy a portion of the month and not



a month in its entirety. Under the state-funded GHIP a daily prorated premium is calculated from the certification date of the enrollment that falls on that previous month. This type of payment is not made for federal beneficiaries of the GHIP (Medicaid or CHIP) or Platino Plan because under these plans, payments are made based on full monthly periods. The only scenario in which a prorated payment will occur for the federal population will be in cases of a region change.

However, in the event of a deceased or incarcerated beneficiary, loss of eligibility by exceptions or one that has moved from Puerto Rico's jurisdiction, all populations including Medicaid, CHIP, and state funded Commonwealth beneficiaries will be subject to the rule of proration regarding effective dates of eligibility and disenrollment.

26.3 Retroactive Payments

These payments are calculated when the Effective Date of the Enrollment falls on a period prior to the month for which the payment transaction is being executed. In other words, this type of payment is executed when payments are identified corresponding to months prior to the month in which a premium payment is made. The retroactive payments will be computed based on the Enrollment Effective Date. GHIP retroactive payments are always made for periods of up to three (3) months before the month of payment. The system will process the premiums for enrolled beneficiaries with an Effective Date prior to the payment date in the case of monthly premiums or prorated premiums that have not been previously paid within the time limits for retroactive payments. Retroactive payments may result in an adjusted payment if they are the result of a carrier's cancelation of a previous enrollment or a region change due to move.

Premiums are paid retroactively when a carrier has submitted a late enrollment in relation to newborn beneficiaries and to cases of utilization prior to the MA-10 Certification Date (emergencies) under the federal portion of the GHIP (Medicaid and CHIP). In the first case the payment can only extend retroactively for up to three (3) months. For the case of emergencies, this payment can only extend retroactively for up to twelve (12) months.

Deemed Newborns- newborns born to a Medicaid-eligible mother shall be provided coverage from the date of birth. The Medicaid identification number of the mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the state issues the child a separate identification number.

26.4 Prorated-retroactive payment

The prorated retroactive payment is calculated taking into consideration the cases in which the Enrollment Effective Date falls on the first month considered for a retroactive payment. This is a partial payment of the first month that starts a series of months of pending payments. Usually, this type of payment is used for GHIP State funded Commonwealth beneficiaries.

26.5 Adjustments

A payment adjustment is calculated when there is a need to reverse a payment that was awarded to a carrier during a previous premium payment process. It occurs when, as a result of a retroactive payment calculation, a payment made in relation to the same beneficiary is identified within the same period that has been effected under a different carrier, type of plan or Plan Version. The adjustments are calculated for those cases where a beneficiary changes carrier retroactively after ASES had disbursed payment to the first carrier in a previous payment transaction. In these cases an adjustment of premium paid to the first carrier is made.

26.6 Special Adjustments

Generally, the special adjustments are carried out as a result of internal audit processes that reveal that a wrongly adjudicated payment (like for example, deceased beneficiaries or duplicate payments, etc.) must be reverted or that, on the contrary, an omitted payment must be adjudicated.

26.7 Reasons why ASES will not execute a premium payment:

A premium payment will not be executed in favor of a carrier in the following circumstances:

(1) If the beneficiary is not enrolled in the ASES databases on the first day of the month for which the payment transaction is being executed;
(2) If the beneficiary is enrolled on a date after the date of payment;
(3) If the enrollment had been rejected by ASES and a new enrollment was not submitted by the carrier with the relevant corrections. (4) If from of the ASES eligibility data arises that the beneficiary had a cancellation or changed the carrier

26.8 EDI 820 Payment File

The reconciliation process carried out between ASES and the carriers in relation to the payment of premiums must take into account the content of the EDI 820 Files. This file is produced monthly by region, carrier and Plan Type. It includes details of the types of payment that correspond to each of the beneficiaries assigned to the carriers contracted for the month in question.

In this file, a distinction is not made about if the payment corresponds to an adjustment from a regular premium payment process or a special adjustment. Thus, in cases when special adjustments proceed, ASES will provide a separated file for the special adjustments to the carrier.

VI. SYSPREM ENROLLMENT IN HISTORICAL DATA

27. SYSPREM: ENROLLMENT IN HISTORICAL DATA

Generally, enrollments are applied to the current eligibility data contained in the ASES databases. That is transactions related to federal beneficiaries of the GHIP (Medicaid and CHIP), GHIP beneficiaries covered solely through state funds (Commonwealth) and Medicare Platino are only processed based on a beneficiary's current eligibility period. The eligibility period starts from the first notification of eligibility in ASES, as the first record received about a beneficiary or after a cancellation period in cases of beneficiaries who have been canceled and then re-certified, and extends until a cancellation that is related to say eligibility is made.

When a carrier does not send an enrollment on time or a record is not corrected in a timely manner, the beneficiary's enrollment data will remain unregistered in the ASES databases, which will prevent the processing of the corresponding premium payment. This is due to the fact that the payment system does not make premium payments for beneficiaries who are not enrolled at the moment in which it corresponds to process the premium payment. As an example, in these cases, if a beneficiary is canceled or is enrolled by a second carrier, the first carrier will be prevented, during the validation phase of the system, from enrolling the beneficiary in a period previous to the cancellation or the enrollment from the second carrier. The main function of SYSPREM will be to allow the registration of the beneficiary's enrollment in historical data in those cases that cannot be processed as current enrollments.

27.1 SYSPREM Functionality

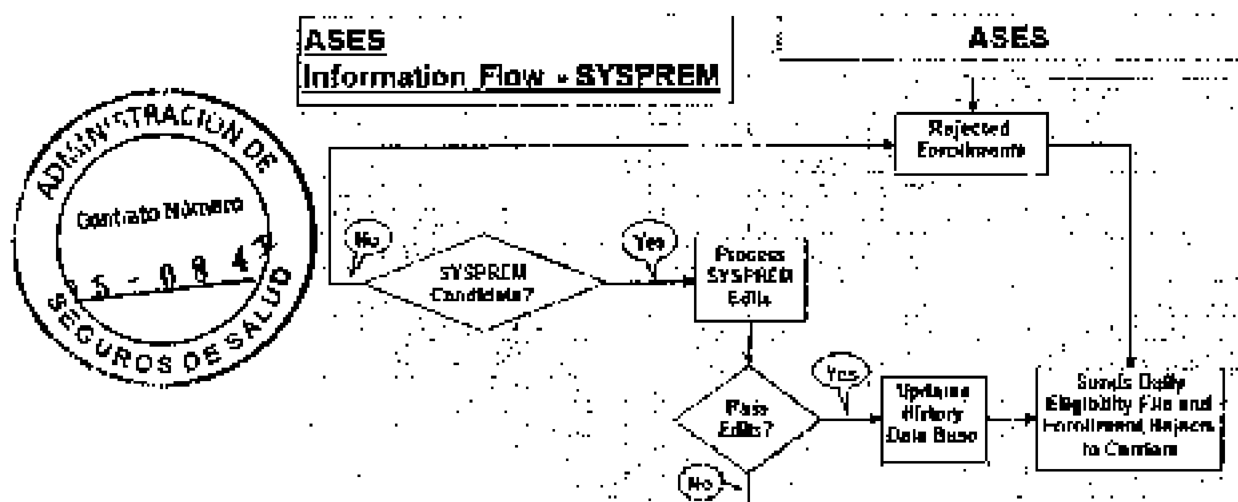
Among the main functions of this system is the identification of enrollment records that are candidates for processing in historical data because they are enrollments that do not correspond to a current period of eligibility.

27.2 Carriers Eligibility File

The carrier's daily eligibility file will include beneficiary information updated in historical data by the SYSPREM subsystem. In these transactions, the Tran_id field will contain an "H" to identify the historical data. Carriers must modify their systems so that the SYSPREM data is not included as current data when processing the eligibility file. Once a transaction is received, which must be processed through SYSPREM, a process of verification and validation of the information that is contained in the record is carried out. Once the validation tests have been passed, the record, in the database, containing the information corresponding to historical transactions is updated. Those records that do not successfully complete the verification processes will be sent in a file of rejected enrollments to the corresponding carrier for correction

The figure below shows the validation process performed for the purpose of processing a candidate record for SYSPREM.

Figure 2: Validation Process under SYSPREM



27.3 Premium Payment for SYSPREM

The run for the monthly premium payment will include all SYSPREM records that have been processed during the previous month. The payment for these transactions is calculated based on monthly periods from the Enrollment Effective Date of the SYSPREM to:

(1) The month in which the beneficiary was enrolled with a different carrier,
(2) The month in which the beneficiary is cancelled or
(3) Until the date of current billing

27.4 SYSPREM Error Codes

The following is a breakdown of the Error Codes that will trigger an evaluation under SYSPREM:

Table 9: Primary Error Codes for SYSPREM

Code	Primary Error Description
107	Effective Date prior to the current family eligibility period.
108	Effective date prior to the current beneficiary eligibility period.
280	The family must be eligible in the current eligibility data.
281	The beneficiary must be eligible in the current eligibility data.
177	Enrolled with another carrier on or after the effective date.

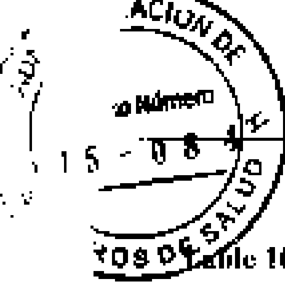


Table 10: Secondary Error Codes for SYSPREM

Code	Secondary Error Description
083	Social Security Number Not Found.
093	Suffix not found.
132	MPI Not Found.
222	Currently enrolled with the same carrier
223	Currently enrolled with another carrier
225	Incorrect Social Security Number
226	Incorrect MPI Number
22F	Error found in other beneficiaries of the family (GHIP).

The following is a breakdown of the Error Codes that could appear during an evaluation under SYSPREM.

Table 11: SYSPREM Error Codes

Code	New Error Codes Description
996	Sysprem record successfully inserted in history.
980	The Process Date of the enrollment record must be greater than the Process Date of the previous enrollment record for the beneficiary who appears previously enrolled for the month corresponding to the Effective Date of the enrollment.
981	The beneficiary must not have beneficiaries of his family with errors not acceptable by SYSPREM in the same enrollment file.
982	The enrollment record must not have an Effective Date prior to 01/01/2006.
983	Enrolled in history for the Effective Date of the enrollment record.
984	It is a New Enrollment, the Effective Date is not first of the month and the beneficiary is already subscribed in another carrier at the Effective Date specified.
985	It is a New Enrollment and the Effective Date should be at least as recent as the beneficiary's Certification Date at the specified Effective Date.
986	For SYSPREM processing, the Enrollment Effective Date should be before the Effective Date of the current enrolled record at the ASES databases.

In summary, SYSPREM will process and/or enroll transactions in history in those cases in which the enrollment cannot be applied to current data or to current periods of eligibility. Some beneficiaries will not appear as enrolled in history because they are not eligible for the Effective Date or because they are enrolled with a different carrier. Carriers need to evaluate the cases rejected by SYSPREM in order to identify errors in the assigned Effective Date and the correctness of the beneficiaries' data included in the enrollment record.