Attachment 9 Information Systems

Plan Vital
7-1-2024

ADMINISTRACION DE
SEGUROS DE SALUD

23-00044 H

Contrato Número

1. **GHP MANUAL**
2. **ADDENDUMS**

ADMINISTRACION DE
SEGUROS DE SALUD

23 - 00044 (1)

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GHP MANUAL

ADMINISTRACION DE
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I. INTRODUCTION

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

The Puerto Rico Department of Health, hereinafter known "PRDoH" was created under Act Number 81 of March 14, 1912, as amended, and raised to Constitutional ranking on July 25, 1952. The PRDoH is responsible for the management and execution of the Puerto Rico Medicaid Program ("PRMP"), which was implemented on January 1, 1966, under the Social Security Act, by adding Title XIX sections 1901 through 1910. The PRMP is the program through which the Federal Government aids the Government of Puerto Rico to pay the medical expenses of certain low-income groups. PRDoH has a cooperative agreement with ASES which implements and administers the island-wide health insurance system, although the PRMP is responsible for making eligibility determinations and offers a Carrier selection after a favorable result of said determination under GHP for Medicaid, CHIP, and Commonwealth coverage.

This document constitutes a reference manual, which establishes the requirements for the development of the systems, between the Information Systems Office of PRHIA and GHP Carriers, in accordance with the Government Health Plan ("GHP") contract (Contract). This includes processes of eligibility, enrollment, premium payment, Maternity Payment, Correctional Hospital Services, STAC Payment, and FMAP change (change in the FPL)- The Federal Medical Assistance Percentage, Member Rate Cell/Risk Score, supplementary payments (SMA, Hepatitis C, COVID 19, SYNTHROID, among others) and Objection to Payment. The history of the services provided by the beneficiary is identified and the Carrier becomes involved when he changes Carrier. 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 GHP as between PRHIA and the GHP Carriers shall be resolved in favor of CMS guidance and such contracts, as amended

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II. DEFINITIONS

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

Administración de Seguros de Salud de Puerto Rico (**"ASES"):** The Puerto Rico Health Insurance Administration (also known by its Spanish acronym "ASES" and by its English acronym "PRHIA"), is the entity within the Government of Puerto Rico responsible for oversight and administration of the Government Health Plan (GHP) or its Agent.

Auto-Assignment: The assignment of an Enrollee to a PMG and a PCP by ASES, Carriers, or Puerto Rico Medicaid Program ("PRMP").

Auto-Enrollment Process: The Enrollment of a Potential Enrollee in a GHP without any action by the Potential Enrollee, as provided in Article 5 of this Contract.

Business Day: Traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday, Puerto Rico's holidays, as defined in the Law for Compliance with the Fiscal Plan, Act No. 26 of April 29, 2017, or any other law enacted during the duration of this Contract regarding this subject, are excluded.

Calendar Days: All seven (7) days of the week.

Eligibility End Date: This is the date on which a member loses his or her eligibility for the GHP. The Puerto Rico Medicaid Program ("PRMP") is the only entity with the authority to cancel an enrollee's eligibility.

Carrier to ASES Data Submissions: Document that provides health insurance carriers information to submit their health care claims, network, provider, IPA, and capitation data to ASES. **Reference Addendum 5.**

Carrier Change: Process where the file of the beneficiaries who changed their MCO is sent to the actuary, to collect the history of the use of claims and meeting of the beneficiary for the Vital Plan and Medicare Platino. **Reference Addendum 7 Transition of Care (TOC)**

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

Eligibility date: It is the start date of an eligibility period. It is assigned by the Puerto Rico Medicaid Program ("PRMP") according to the evaluation performed and the eligibility program determined (CHIP, Medicaid, Commonwealth). As provided in Section 5.1.3 of this Contract, a decision of the PRMP where a person is eligible to receive services under the GHP, in a Medicaid, CHIP, or Commonwealth coverage classification. Some public employees and retirees can enroll in GHP without first receiving a Certification.

Children's Health Insurance Program ("CHIP"): The Children's Health Insurance Program was

established pursuant to Title XXI of the Social Security Act.

CHIP Eligible: A child is eligible to enroll in the GHP because he or she is eligible for CHIP.

COORDINATION OF BENEFITS ("COB"): –Some people who are beneficiaries of the Government Health Plan of Puerto Rico, which thrives on federal funds under certain circumstances may be eligible to receive benefits for a private plan or other health insurance funded by the Government of Puerto Rico. In accordance with applicable laws and federal guidelines, Medicaid is the payer of last resort, and the rest of the remedies must be exhausted before resorting to the services under the Medicaid funds provided. – **Reference Addendum 8**

Coverage Code: Code assigned by the Puerto Rico Medicaid Program ("PRMP") to eligible beneficiaries, according to Federal, CHIP, and Commonwealth indigence criteria. Under GHP, the coverage code will coincide with the Plan Version.

Covered Services: Those medically necessary health care services (listed in Article 7 of Contract) provided to Enrollees by Providers, the payment or indemnification of which is covered under this Contract.

Daily Basis: Each Business Day.

Deemed Newborns: Children born to a mother with Medicaid or CHIP eligibility on the date of delivery and who are eligible from the date of birth. They will be granted an eligibility period of thirteen (13) months.

Domestic Violence Population: Certain survivors of domestic violence referred by the Office of the Women's Advocate.

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

EDI: Electronic Data Interchange (EDI) Process

Effective date of the change of Carrier: It is the start date of the enrollment of an affiliate in a selected Carrier. For changes made in the first twenty days of the month, registration with the Carrier will become effective on the first day of the following month according to the selection of the Carrier. For Carriers, changes made after the first twenty days of the month, Carriers' registration will take effect on the first day of the following month (20-day rule).

Enrollment counselor: Call Center for beneficiary service change of insurer or PCP/PMG

Enrollment Effective Date (Carrier Effective Date): The date the eligible member is enrolled with the contracted Carrier. This date considers the effective date of eligibility or the effective date of the change in Carrier.

Enrollment End Date (Carrier End Date): The effective end date of the member's coverage period at the assigned insurance carrier.

Enrollment Start Date: This is the member's start date for the current period of continuous enrollment with the current insurance carrier.

Enrollee Seed Sets: These are GHP groups eligible by the date of execution of the automatic allocation algorithm, which are classified according to the expiration date of their eligibility and the cancellation date issued by the Puerto Rico Medicaid Program ("PRMP") (Cancellation date Medicaid). These groups are assigned to contracted Carriers and define the delivery packages sent to Carriers, during the self-allocation maintenance period.

Eligibility: Eligibility is determined by the Puerto Rico Medicaid Program ("PRMP") of the Puerto Rico Department of Health ("PRDOH").

Eligible Person - A person eligible to enroll in the GHP, as provided in Section 1.3.1 of this Contract, by being eligible for Medicaid, CHIP, or Commonwealth coverage.

Enrollee: A person who is enrolled in a Carrier's GHP, as provided in this Contract, and who, by relevant Federal and Puerto Rico laws and regulations, is an Eligible Person listed in Section 1.3.1 of the Contract.

Enrollment: The process by which an Eligible Person becomes an Enrollee of the Carrier's Plan.

Federal Category: Classification established by the Puerto Rico Medicaid Program ("PRMP") for an Enrollee, according to established criteria of indigence levels. This category includes the population that benefits from the Medicaid and CHIP programs.

FMAP change – This is a change in the Federal Poverty Level "FPL"), which is computed from a formula that considers the average per capita income for each State relative to the national average. It is used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

Foster Care Population: Children who are in the custody of the Administration for Families and Children (also known by its Spanish acronym "ADFAN)" of the Puerto Rico Department of Family and enrolled in the GHP.

Government Health Insurance Plan ("GHP"): Formerly called "Plan Vital", is the health insurance plan offered by the Government of Puerto Rico and administered by ASES. It serves a mixed population which is eligible for Medicaid, CHIP, and Commonwealth, and emphasizes the integrated delivery of physical and behavioral health services.

GHP Welcome Package: The first welcome package that a Carrier sends to Enrollees upon enrollment.

Health Insurer Code: This is the code assigned to the Insurance Company.

Health Insurance Claim Number ("HICN"): Previously it was a Medicare enrollee's identification number and appeared on the enrollee's insurance card. A new Medicare Enrollee Identifier ("MBI") replaced the SSN-based Health Insurance Claim Number ("HICN") on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

HIPAA Transaction 834 - The ANSI 834 EDI Enrollment Implementation Format is a standard file format for the electronic interchange of health plan enrollment data. The Health Insurance Portability and Accountability Act ("HIPAA") requires that all health plans or health insurance companies accept a standard enrollment format: ANSI 834A Version 5010. An 834 file contains an order of data, such as a subscriber's name, hire date, etc. in a data segment. The 834 is used to transfer enrollment information from the insurance coverage sponsor, benefits, or policy to a payer. This implementation guide intends to meet the specific needs of the healthcare industry for the initial enrollment and subsequent maintenance of individuals who are enrolled in insurance products. This implementation guide specifically addresses the enrollment and maintenance of healthcare products only. One or more separate flexible spending and retirement guidelines may be developed.

HIPAA Transaction 820 - The ANSI 820 is an X12 transaction set that contains the format and establishes the data contents of the Payment Order/Remittance Advice Transaction Set (820) for use within the context of an Electronic Data Interchange (EDI) environment. HIPAA 820 is sometimes referred to as the Health Plan Premium Payment Transaction. This HIPAA transaction is used to initiate the transfer of payment for health insurance premiums and to provide health plans with information about the transfer of funds, remittance details for individuals for whom premiums are being paid, and payment processing information (e.g., for payroll deductions).

HIPAA Transaction 835 – The ANSI 835 is an X12 transaction set that contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) for use within the context of the Electronic Data Interchange (EDI) environment. The HIPAA 835 transaction set is sometimes referred to as the Health Care Claim Payment and Remittance Advice. This HIPAA transaction can be used for the electronic transmission of healthcare payment and benefit information. The EDI 835 is used primarily by healthcare insurance plans to make payments to healthcare providers, to provide Explanations of Benefits (EOBs), or both.

ID Card Issue Date: This is the member ID card issue date.

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.

Incarcerated population: Individuals who are in the legal custody of the Puerto Rico Department of Corrections and Rehabilitation involuntarily held in a correctional facility and enrolled in the Puerto Rico Medicaid Program ("PRMP").

Initial Auto-Enrollment Enrollee: An eligible person enrolled prior to November 1, 2018, with a GHP Carrier is automatically enrolled with a Carrier by ASES with an effective date of November 1, 2018.

Carriers: The Managed Care Organization that is a Party of this Contract, licensed as a Carrier by the Puerto Rico Commissioner of Insurance ("PRICO"), which contracts hereunder with ASES under the GHP for the provision of Covered Services and Benefits to Enrollees based on PMPM Payments

Managed Care Organization ("MCO"): An entity that is organized to provide health care, is licensed as a Carrier by the Puerto Rico Insurance Commissioner ("PRICO"), and which contracts with ASES

for the provision of Covered Services and Benefits Island-wide based on PMPM Payments, under the GHP.

Maternity Payment - This is designed to support Managed Care Organizations ("MCOs") in reporting maternity deliveries for reimbursement as the payment is made outside of the monthly capitation payment process. – **Reference Attachment 29 of the Contract.**

Notice of Action Taken: Form issued by the Puerto Rico Medicaid Program ("PRMP"), entitled "Notice of Action Taken or Application and/or Recertification" containing the Certification decision which indicates whether a person was determined eligible or ineligible for Medicaid Coverage, CHIP, or Commonwealth.

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

Medicaid Eligible: An individual eligible to receive services under Medicaid, who is eligible, on this basis, to enroll in the GHP.

Medicaid ID: Identifier number assigned to the medical-physician provider after registration in the PEP system of the Puerto Rico Medicaid Program "PRMP".

Medically Necessary Services: Those services that meet the definition found in Section 7.2 of Contract.

Member Rate Cell: Process where the beneficiary's data is evaluated to assign them the corresponding Rate Cell monthly.

National Provider Identifier ("NPI"): The 10-digit unique-identifier numbering system for Providers created by the Centers for Medicare & Medicaid Services ("CMS"), through the National Plan and Provider Enumeration System.

New Enrollee: An Eligible Person who became a Potential Enrollee after November 1, 2018.

Non-Risk-Payment Arrangement: Methodology that has been utilized to meet the needs of the population without undermining the payment and cost of the actuarially quoted premiums.

Open Enrollment: A period of ninety (90) Calendar Days in which Enrollees have one (1) opportunity to select a different Carrier, without cause, as set forth in Section 5.2.5 of the Contract.

OTP or Objection of Payment: This is the process for Carriers to notify ASES of objections to erroneous payments and missed payments.

PCP Effective Date: The date on which a PCP1 or PCP2 enrollment becomes effective.

Plan Type: Code 01 to identify members with GHP.

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Plan Version: Product identification number that corresponds with the Plan Type. For GHP, the Plan Version will be the same as the code assigned to the beneficiaries by the Puerto Rico Medicaid Program ("PRMP").

PMPM Premium ("Per Member Per Month (PMPM)" Payment): The fixed monthly amount that the Contracted Carrier 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 Program ("PRMP") as eligible to enroll in the GHP (either Medicaid, CHIP, or Commonwealth category coverage), but who has not yet enrolled with a contracted Carrier.

Poverty Level: As required by Section 673(2) of the Omnibus Budget Reconciliation Act ("OBRA") of 1981 (42 U.S.C. 9902(2)), the Department of Health and Human Services ("HHS") updates the poverty guidelines at least annually and by law these updates are applied to eligibility criteria for programs such as Medicaid and the Children's Health Insurance Program ("CHIP"). These annual updates increase the Census Bureau's current official poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers ("CPI–U").

Primary Care Physician ("PCP"): A licensed medical doctor ("MD") who is a Provider and who, within the scope of practice and under Puerto Rico Certification and licensure requirements, is responsible for providing all required Primary 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 GHP 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 GHP Enrollees under the terms of this Contract.

PRMMIS: Puerto Rico Medicaid Management Information System. Is an integrated group of computer system functions and operational procedures developed per CMS requirements and guidelines to provide operational and reporting excellence for the Medicaid Program.

Prorated Payment: A late payment that covers a fraction of the month prior to the month in which the premium payment is made. Prorated payments only apply to Carriers specifically during the first month of eligibility for the Commonwealth-covered population and newborns. The concept of prorated payments also applies to adjusted payments considering the different reasons that trigger cancellations.

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.

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Puerto Rico Medicaid Program ("PRMP"): A program of the Puerto Rico Department of Health ("PRDOH") that makes eligibility determinations and offers a Carrier selection after a favorable result of said determination under GHP for Medicaid, CHIP and Commonwealth coverage.

Rate cell: Category that determines the monthly premium.

Recertification: A determination by the Puerto Rico Medicaid Program ("PRMP") that a person previously enrolled in the GHP subsequently received a Negative Redetermination Decision, is again eligible for services under the GHP.

Redetermination: The periodic Redetermination of eligibility of an individual for Medicaid, CHIP, and Commonwealth coverage, conducted by the PRMP.

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

Spinal Muscular Atrophy (**"SMA") -** The Spinal Muscular Atrophy population presents enormous challenges in terms of the high costs involved for a population that has so far represented less than 20 patients.

State Population (or "Commonwealth Population"): A group eligible to participate in the GHP as Other Eligible Persons, with no Federal participation supporting the cost of their coverage, which is comprised of low-income persons and other groups listed in Section 1.3.1.2.1 of the contract.

Transition of Care: Historical utilization data of the beneficiary when changing Carrier.

III. MEDICAID ELIGIBILITY PROCESSES

A. Eligibility Determination

The PRMP, which administers the Puerto Rico Medicaid Assistance Program, is the state plan agency with the authority to determine if a person is eligible to receive services covered under the GHP. Members can be determined eligible to participate in the GHP as a recipient of Medicaid funded with Federal (Federal), CHIP, or Commonwealth funds. For the Medicaid and CHIP populations, the eligibility criteria are established in the State Plan and in cooperation with CMS. For state beneficiaries, eligibility requirements are set by the Medicaid Program, except for public employees and pensioners included in Other Eligible Populations, which are determined by independent ASES policies.

B. Notice of Decision

Pursuant to Section 5.1.2 of the Contract, the PRMP's determination that a person is eligible for the GHP is contained in the Form Notice of Decision, titled "Notification of Action Taken on Application and/or Recertification." A person who has received a Notice of Decision is referred to as a "Potential Enrollee."

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The Potential Enrollee may access Covered Services using the Notice of Decision as a temporary Enrollee ID Card from the first day of the eligibility period specified on the Notice of Decision even if the person has not received an Enrollee ID Card. Only Medicaid, CHIP, and Commonwealth Enrollees receive a Notice of Decision and may access Covered Services with the Notice of Decision as a temporary Enrollee ID Card. A Form Notice of Decision will be provided for each Household Potential Enrollee included in the Application and the authorized contact member.

The Notice of Decision report is valid for the eligibility period identified on the Form Notice of Decision and may be used for a period of thirty (30) calendar days from the date of Certification to demonstrate eligibility. See **Addendum 1- Notice of Decision Form.**

C. Eligibility date

Federal Program Enrollee (Medicaid or CHIP)

The Eligibility Date for purposes of a Medicaid or CHIP Potential Enrollee is the first (1st) day of the month in which the PRMP determines eligibility. This should be the same date indicated as the eligibility period on the document Notice of Decision.

The eligibility period specified in the Decision Notification Report may be retroactive, up to three (3) months before the first (1st) day of the month, in which the Potential Affiliate submits his / her application for eligibility to the PRMP with Federal Medicaid and CHIP coverage where services can be covered retroactively. Retroactivity, the effective date of eligibility, is granted when the prospective member indicates that they incurred medical expenses prior to the current eligibility period, including any services covered by Federal Medicaid or CHIP coverage, that relate to drugs or services, where pharmacy expenses are generated and have not been paid. The effective date of eligibility will be within the three (3) months prior to the month in which the prospective member applies. If the prospective member is eligible for Federal Medicaid or CHIP coverage in the month the service was eligible, the prospective member will receive retroactive eligibility. Retroactive benefit does not apply to Commonwealth-covered beneficiaries. Retroactive eligibility is evaluated for all potential members with Federal Medicaid and CHIP coverage who notify the PRMP about their medical expenses and/or utilization of services during the allowed period of three (3) months.

When an Enrollee re-certification is filed, PRMP once his/her eligibility period has expired, the eligibility for the GHP is lost. This will happen even in cases in which the Enrollee's eligibility was lost for at least one (1) day. The Eligibility Date for a new eligibility period for these cases will be the first (1st) day of the month of the new application for certification.

A person can apply for Federal Medicaid / CHIP coverage on behalf of a person who has died, during the same month they applied or up to three (3) months retroactively if the person was eligible in those months. The eligibility period will be from PRMP determination to the date of death. This provision does not apply to Commonwealth-covered beneficiaries.

All pregnant women with federal, Commonwealth, and CHIP coverage may have an eligibility period greater than twelve (12) months by adding the required sixty (60) days of postpartum coverage. The expiration date will be the last day of the month, at the end of these sixty (60) days.

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Commonwealth Enrollees (Commonwealth Category Beneficiaries)

The Commonwealth effective date of eligibility is the eligibility period specified on the decision of notification report, and potential members are eligible to enroll as of that date. Note that a potential member may be classified as a Commonwealth-covered member for their current eligibility period but may be classified as a federally covered member for any of the retroactive eligibility periods.

Recertification for members of Commonwealth coverage, in which the member is re-eligible, the eligibility date is the first (1st) day of the month after the expiration of current eligibility. The certification date for beneficiaries of coverage in the Commonwealth will be when the certification is completed. If a Commonwealth coverage member's eligibility period expires prior to the recertification, the Commonwealth coverage member's eligibility will be processed as a new case and the eligibility effective date will be the new eligibility effective date provided on the document Notice of Decision. The member of Commonwealth coverage can request a Carrier at the PRMP for the new period of eligibility at the time of certification.

All pregnant women on Federal, CHIP, and Commonwealth coverage may have an eligibility period greater than twelve (12) months by adding the required sixty (60) days of postpartum coverage. The expiration date will be the last day of the month at the end of these sixty (60) days.

D. Enrollee Recertification

After a period of eligibility is granted to a member, two (2) or three (3) months prior to the expiration date of eligibility, the member will undergo a recertification process, for a new period of eligibility, which will be carried out by the PRMP. This will allow for the renewal of the covered services during the next twelve (12-month period. The effective date of recertification refers to the date that the PRMP reevaluates the eligibility of an enrollee. This date is provided for the decision notification report. The Eligibility Expiration Date refers to the expiration date of the eligibility period granted to the member by the PRMP. A federal and Commonwealth-covered member who is recertified will have their current eligibility period noted and will have a future Eligibility Effective Date in the Decision Notice for their next eligibility period beginning the day after the period expires. current eligibility.

E. Eligibility End Date

The cancellation or termination of an eligibility period is notified in the data transferred in the journal files in the standard 834 format. The specifications of these data and processes are determined in the current 834 Companion Guide.

Daily, all insurers contracted by ASES will receive from the PRMP an 834 transaction with the eligibility, change of circumstances, and enrollment status of the beneficiaries.

After a certification or recertification of a member, an Expiration Date is established. If the eligibility of a member is extended for any of the reasons explained later in this document, the expected termination of such extension will be expressed through the Medicaid Cancellation Date. Also, if the eligibility period of a member, extended or not, is terminated before the Expiration Date (for example, by the death of an enrollee, members identified in the PARIS file, or by voluntary resignation) or a previously stated Medicaid Cancellation Date (for example, by a pregnancy that ended prematurely),

the date for the real cancellation of the eligibility period of a member will be stated in the Medicaid Cancellation Date.

F. Eligibility Extensions

When the PRMP grants an extension of eligibility, the date the extension expires is included in the eligibility data in 834 formats.

If an enrollee qualifies for more than one (1) type of extension, the extensions will be combined applying the extension with the longest eligibility period extension stated through the Medicaid Cancellation Date and the extension that grants the most benefits stated through the Extension Flag containing the appropriate Extension Code. For example, if an enrollee is granted the extension due to pregnancy and the extension due to a natural disaster, the extensions will be combined and his or her eligibility will be extended because of the natural disaster extension and will have the coverage benefits of the pregnancy extension.

IV. ENROLLMENT IN GHP CARRIERS

A. General Enrollment Requirements

The Carrier must guarantee the maintenance, functionality, and reliability of all systems necessary for Enrollment and Disenrollment, pursuant to the Contract and this Manual.

B. Effective Date of Enrollment

The effective date of enrollment (assignment date) will be assigned in the 834 daily data. For new and recertification cases, the effective date must be equal to the date stipulated in the Notice of Decision document set forth in Section 5.2.6 of the Contract or based on carrier and other changes such as PCP and/or PMG changes. In addition to this section of the contract, please refer to the 834 Companion Guide.

The effective date of enrollment for a newborn whose mother is eligible for Federal Medicaid or CHIP coverage begins from the date of birth. The Effective Date of Enrollment for a newborn whose mother is an Affiliate of the Commonwealth coverage is the Effective Date of Eligibility established by the PRMP. A newborn will be automatically enrolled in accordance with the procedures established in Section 5.2.7 of the Contract.

Changes in Enrollment requested by the Enrollee received during the first twenty (20) Calendar Days of the month will be effective the first Calendar Day of the following month (e.g., requests received January 10 will be effective February 1).

Changes in Enrollment received after the first twenty (20) Calendar Days of the month will be effective the first Calendar Day of the second month following the request to change Enrollment (e.g., requests received January 25 will be effective March 1).

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C. Term of Enrollment

The Term of Enrollment with the Carrier shall be a period of twelve (12) consecutive months for all GHP Enrollees unless a different Carrier is selected during the applicable Open Enrollment Period described in Section 5.2.5 of the Contract, and except in cases in which the PRMP has designated an eligibility period shorter than twelve (12) months for an Enrollee who is a Federal Medicaid or CHIP Eligible or a member of the coverage Commonwealth, in which case that same period shall also be considered the Enrollee's Term of Enrollment. There may also be changes of insurer through the enrollment counselor for just cause.

Such a shortened eligibility period may apply, at the discretion of the PRMP, when an Enrollee is pregnant, is homeless, or anticipates a change in status (such as receipt of unemployment benefits or in family composition). Section 5.3.3 of the Contract controls the Effective Date of Disenrollment.

Pregnant Enrollees with a Term of Enrollment that expires during pregnancy or within sixty (60) Calendar Days of the post-partum period have an extended Term of Enrollment that expires on the last day of the month after sixty (60) Calendar days counted from the beginning of the post-partum period.

Except as otherwise provided in Section 5.2 of the Contract, and notwithstanding the Term of Enrollment provided in Section 5.2.3 of the Contract, Enrollees remain enrolled with the same Carrier until the occurrence of an event listed in Section 5.3 of the Contract (Disenrollment).

D. Carrier Notification Procedures Related to Redetermination

The Carrier must inform Enrollees who are Federal Medicaid and CHIP Eligible and coverage Commonwealth of an impending Redetermination through written notices. Such notices shall be provided ninety (90) Calendar Days, sixty (60) Calendar Days, and thirty (30) Calendar Days before the scheduled date of the Redetermination pursuant to Section 5.2.8 of the Contract.

E. Enrollment Procedures

For all Enrollees, the Carrier must comply with the Auto-Enrollment process and issue to the Enrollee a notice informing the Enrollee of the PMG and PCP they are assigned to and their rights to change the PMG or PCP without cause during the applicable Open Enrollment Period, on 834 formats.

The new enrollees for a Carrier could change his/her Auto-Assigned or Selected PMG and PCP without cause through the Carrier. The Carrier can offer counseling and assistance to the Enrollee in selecting a different PCP and PMG. The no new enrollees could change the PCP and/or PMG but with just cause. For both, the Carrier has the responsibility to notify PCP/PMG of changes to PRMP by the 834 transactions.

Enrollees under the Foster Care Population, Domestic Violence Population, and incarcerated in Correction Department facilities classifications are not assigned to a PCP or PMG.

For new enrollees, the Carrier must issue the Enrollee ID Card and a notice of Enrollment, as well as an Enrollee Handbook and Provider Directory either in paper or electronic form, within five (5)

Business Days of Enrollment pursuant to Section 5.2.6.2 of the Contract. The notice of enrollment must clearly state the Effective Date of Enrollment. The notice of Enrollment will explain that the Enrollee is entitled to receive Covered Services through the Carrier.

All Enrollees must be notified at least annually of their disenrollment rights as set forth in Section 5.3 of the Contract and 42 CFR 438.56.

The Carrier must comply with 5.2.7 of the Contract regarding Procedures for Auto-Enrollment of Newborns.

F. Enrollee Selection of Carrier

Open Enrollment Period for New Enrollees

New Enrollees to the GHP will have the opportunity to select a Carrier during the Medicaid eligibility process with the PRMP. If the New Enrollee does not select a Carrier, the PRMP will select a Carrier on behalf of the New Enrollee using an algorithm based on a Round-Robin order arrangement. New Enrollees shall be permitted to select a different Carrier once without cause, regardless of how the initial selection of the Carrier was made, during their Open Enrollment Period, which shall begin on the New Enrollee's Eligibility Certification Date and will extend for a period of ninety (90) days.

Annual Open Enrollment Periods

Each year, GHP offers its members an annual open enrollment period. The annual open enrollment period is determined by ASES and is announced in advance to allow beneficiaries to make the choice that is best for them. All enrollees will have the opportunity to select an insurance carrier without cause during the annual open enrollment period. If the enrollee does not make any insurance changes during the annual open enrollment period, he/she will remain enrolled with his/her current insurance carrier.

During each Annual Open Enrollment Period, all enrollees will have one (1) opportunity to change Carriers for no reason during their Annual Open Enrollment Period. If a New Affiliate's Open Enrollment Period in accordance with Section 5.2.5.2 of the Agreement coincides with the Annual Open Enrollment Period, the Open Enrollment Period in Section 5.2.5.2 will prevail.

Virtual Population

When an enrollee ceases to be part of the domestic violence or foster care population but remains an eligible individual, the enrollee can select a new Carrier during an open enrollment period.

Dual Population

When an enrollee loses some or all portions of Medicare and remains eligible, he or she is entitled to select a Carrier Vital with eligibility on the day he or she becomes ineligible for Platino coverage. This process is handled by ASES Customer Service technicians.

If a beneficiary with Medicare AB parts is enrolled in a Platinum Plan and wishes to move to a Vital Plan, he/she may do so through the ASES Customer Service technicians.

V. ENROLLMENT COUNSELOR OPERATIONS

ASES has procured Enrollment Counselor functions, by toll-free number and online, to help Enrollees understand the GHP and make informed choices for Carrier enrollment. It is the Enrollee's option to receive the services of the Enrollment Counselor. If any Enrollee actively selects a Carrier during the applicable Open Enrollment Period (or at the point of eligibility application for New Enrollees), the Enrollment Counselor will record the selected Carrier and such information, to formalize the enrollment process.

On an ongoing basis, Enrollees will have access to a Counselor to select a Carrier, PMG, and PCP. New Enrollees and re-certified Enrollees will be able to select a Carrier considering the availability of an enrollment spot within the capacity of each Carrier and available PCPs. The Effective Date of Enrollment of the Carrier, PCP, and PMG will coincide with the Effective Date of Eligibility pursuant to Section 5.2.2 of the Contract and as determined at the PRMP. New and re-certified Enrollees are entitled to assistance from the Enrollment Counselor during the Open Enrollment Period applicable to each population regarding the selection of a Carrier, PCP, and PMG.

VI. DATA EXCHANGE BETWEEN PRMP AND CARRIERS

The following sections provide an overview of data exchange information between PRMP, ASES, and Carriers. For specific data layout information, refer to Attachment 9 with the referenced layout files.

A. Data Exchange Between Medicaid, ASES, and the Carriers

1. Medicaid and ASES Data Exchange (834 file)

Under GHP, at the end of the certification process at Medicaid, a New Enrollee will have the opportunity to select a Carrier, and the PRMP will relay the resulting selection to the Carrier and ASES. This information will include any eligibility information resulting from the process and the Carrier selection or auto-enrollment.

Following receipt of the Carrier's file, the Carrier is required to send ID cards along with a GHP Welcome Package, to the new enrollees by postal mail in five (5) business days pursuant to Section 5.2.6.2 of the Contract.

The Enrollee, in turn, has ninety (90) days to request a change of MCO, PCP, or PMG. Then, the Carrier produces the electronic registration record and sends it to PRMP in a file (834). If the member's Coverage Code, PCP, or PMG changes, the Carrier must send an enrollment record to PRMP that reflects the change as confirmation of the issuance of a new plan identification card and its shipment to the member.

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Generally, Carriers have one (1) business day to remit enrollment records. They must notify information about the new Enrollees and send information about any changes made to a record previously enrolled. Such notification must be sent on the next business day.

When an enrollee changes Carriers, data is sent to the current Carrier including the carrier termination date. In this case, the previous Carrier must perform a disenrollment of the enrollee in its database. The new Carrier will receive the new enrollee effective date.

After receiving eligibility through the 834 data, insurers have one (1) business day for all new enrollment underwriting confirmation transactions. Any confirmation transaction that does not pass validation must be corrected and returned no later than two (2) business days. Refer to Section 5.3.8 of the Agreement. Likewise, changes in the Member's PMG and/or PCP will be effective as set forth in Section 5.4 of the Contract.

Records that are accepted without errors during the editing process are updated in the databases and the beneficiaries are duly enrolled and confirmed.

PRMP will validate data sent from the Carrier. The records for the rejected enrollments are returned to the Carrier with the applicable reject codes in a CSV file daily. The Carrier must correct any errors in the enrollment record and send the information back within two (2) business days. ASES will only pay the premiums related to those beneficiaries who are enrolled and confirmed. Therefore, the execution of the payment of the corresponding premium for these rejected records will be delayed until the enrollment records are sent back with the correction of the indicated errors. The Carrier must send the corrected enrollment records within the timeframe specified no later than two (2) business days past the date on which notifies the Carrier of the rejected subscriptions, after which the Carrier could start losing premium payments, as stated in Section 5.3.10 of the Contract.

During the premium payment process, confirmation received during the month prior to the execution of the process is considered. The Carrier must make sure to complete the reconciliation of beneficiaries every month.

This process is established in the Companion Guide for the requirement of format 834 – PRMMIS – Addendum 2

B. GHP Enrollment

For an enrollment record to be accepted during the editing and validation processes, it is important to consider the following considerations regarding concepts related to the enrollment processes:

Effective Date of Enrollment

a. The Carrier Effective Date

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Please consult Section IV of this Manual and Section 5.2.2 of the Contract for a discussion of Effective Dates of Enrollment.

b. The PCP1 and PMG information

In the case of new Enrollees, the PCP1 and PMG Effective Dates will match the Eligibility Effective Date. If a change for any of the PCPs or the PMG is performed through the Carrier, the Carrier will follow the specifications described under Section 5.4 of the contract where the management of those changes is defined.

c. Plan Version/Coverage Code Effective Date

The coverage code will only change during the recertification process performed and in the change of circumstances registered by PRMP. When a recertification is performed, the Effective Date of Eligibility changes to that of the next period, hence the Plan Version Effective Date will match the Eligibility Effective Date. These changes require insurers to send a new health plan ID card to members since changing the coverage code changes the co-payments.

The coverage code will only change during the recertification process performed and in the change of circumstances registered by PRMP. When a recertification is performed, the Effective Date of Eligibility changes to that of the next period, hence the Plan Version Effective Date will match the Eligibility Effective Date. These changes require insurers to send a new health plan ID card to members, since changing the coverage code changes the co-payments.

VIII. GHP DISENROLLMENT (CANCELLATION/TERMINATION OF ELIGIBILITY)

A. Disenrollment from the GHP

The process of disenrollment from the GHP occurs when the PRMP determines that an enrollee is no longer eligible for GHP.

A GHP disenrollment occurs when the PRMP determines that (1) an enrollee has lost eligibility to receive medical services coverage under the GHP; (2) the eligibility period granted by the PRMP has expired, (3) death of the member, (4) voluntary disaffiliation, (5) moving out of the Island and (6) matching with the PARIS file.

Medicaid will notify the cancellation of eligibility for the appropriate reason. **See the 834 Companion Guide.**

B. GHP Disenrollment Effective Date

The effective date of cancellations will be determined by the PRMP and expressed in the 834 files data. **See the 834 Companion Guide for more details.**

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IX. CARRIER DISENROLLMENT

A. Disenrollment Initiated by the Enrollee

All Enrollees must be notified at least annually of their disenrollment rights as set forth in Section 5.3 of the Contract and 42 CFR 438.56. Such notification must clearly explain the process for exercising this disenrollment right, as well as the coverage alternatives available to the Enrollee based on their specific circumstance.

An Enrollee wishing to make a change of carrier should contact the Enrollment Counselor. The Enrollment Counselor sends the change notification. This change of carrier outside of the Open Enrollment Period must be justified.

An Enrollee may request Disenrollment from the Carrier's Plan without cause once during the applicable Open Enrollment Period in accordance with Section 5.2.5.

Transition of Care Process ("TOC")

In these cases, in which the Enrollee changes Carriers, the Carrier that loses the Enrollee will be required to complete the Transition of Care ("TOC") information. It must be completed monthly, before the end of the month. The layouts and SOP of this process that included in Addendum 7.

In addition, send to the new Carrier the historical claims/encounters of enrollees. The layout of historical claims is in Addendum 7.

An Enrollee may request Disenrollment from the Carrier's Plan for cause at any time, pursuant to Section 5.3.5.4 of the Contract.

B. Effective Date of Temporary Payment Suspension

For the premium payment process to make the corresponding payment, confirmation of the beneficiaries' affiliation is indispensable. If the beneficiary does not have a confirmed affiliation, the payment will not be made. This temporary suspension takes place in those cases in which the PRMP has sent a change of coverage code for an enrollee and the Carrier has not submitted an enrollment with the new version of the plan related to the change of coverage, but the enrollee continues to be eligible and enrolled with the Carrier.

However in cases of Temporary Payment Suspension, the eligibility period will continue for the beneficiaries on behalf of whom the PRMP has sent a change of coverage code for an enrollee and the Contractor has not submitted an enrollment with the new plan version related to the change of coverage, the premium payment cannot be processed until a new enrollee enrollment is sent by the Contractor with the information of the new plan version related to the change of coverage. Once the new plan version is received, premium payments will resume, subject to section 5.3.10 of the Contract.

This process is established in the Companion Guide for the requirement of format 834 – PRMMIS – Addendum 2

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X. PREMIUM PAYMENTS

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

In each frequency scheduled, the system performs an automatic execution of payment in which the payment that corresponds to each one of the Carriers is calculated using the Member Assigned Rate Cell ID as described in Addendum 4 below according to the beneficiaries that are enrolled.

The premium paid for each enrollee will depend on his or her rate cell classification. ASES actuaries are responsible for providing the definition and the methodology for the application of the rate cells.

As a result of actuarial studies, each rate cell has a premium assigned to it.

The payment of the premium shall be made based on the data up to the end of the previous month. This means that active members (not expired) and confirmed members will be taken into consideration. The premium to be paid is based on the Rate Cell assigned by PRMP and included in the 834 files. ASES will not pay premiums for beneficiaries whose membership has not been confirmed or for expired members.

Rate Cell Table Reference: Addendum 3, 820 Companion Guide

The payment system calculates several payment categories as listed below:

A. Types of Payments

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 run on the first day of the month.

Prorated Payments

Prorated payments arise from eligibility effective dates other than the 1st of the month or non-month-end cancellations such as death cancellations.

However, prorated payments are generated for all the beneficiaries that the PRMP cancels during the month for different reasons. In these cases, as the payment would have been made already in advance, an adjustment would be made according to the cancellation date provided by the PRMP. Also, newborns that are not classified as deemed newborns and that are evaluated as any other federal coverage will have prorated payments for the first month from the date of birth.

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Retroactive Payments

These payments are calculated when the Effective Date of Enrollment falls on a period prior to the month for which the premium payment process 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 or carrier effective date. 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 PRMP's cancellation of a previous enrollment.

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, because of a retroactive payment calculation, a payment made in relation to the same enrollee is identified within the same period that has been affected under a Carrier change or Plan Version change. The adjustments are calculated for those cases where an enrollee changes Carrier, and the Carrier executed a late enrollment after ASES had disbursed payment to the first Carrier in a previous payment transaction. In these cases, an adjustment of the premium paid to the first Carrier is made.

Other adjustments are generated by retroactive cancellations leading to the recovery of payments already made.

Special Adjustments

Generally, special adjustments are carried out because of internal audit processes that reveal that a wrongly adjudicated payment (like for example, deceased beneficiaries, duplicate payments, rate change, reconciliations, rate cells change or risk score change) must be reverted or that, on the contrary, an omitted payment must be adjudicated. For this type of adjustment, the Contractor will receive the transaction details on the 820 or 835 files. The 820 and the 835 files identify the type of adjustment, the adjusted months, and the amount adjusted.

The process for death premium payment adjustments is as follows:

When PRMMIS receives the date of death from M3G, this data is captured in the eligibility and enrollment tables in the MMIS. As a result of these member level updates, any capitations that were paid for dates after the DOD will automatically be recouped/adjusted during the monthly capitation adjustment process in PRMMIS.

This may result in a prorated adjustment, except for beneficiaries enrolled in a Medicare Platino insurer.

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Adjustment type Table

Adjustment Code	Adjustment Description
1	Duplicate Payment
2	Deceased
5	Rate Adjustment
9	Newborn
4	COB
7	Fix Rate
14	Reconciliation Vital
8	Full Month Adjustment
10	Ineligible
11	Reconciliation Mi Salud
12	Rate Cell
13	Maternity Kick Payment
6	Reverse Adjustments
16	Incarcerated Payments
15	Overpayments to Provider

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B. ASES Reasons for not Executing a Premium Payment

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

(1) If the enrollee is not confirmed, enroll.

(2) If the enrollment had been rejected and a new enrollment was not submitted by the Carrier with the relevant corrections.

(3) If PRMP eligibility and enrollment data demonstrate that the enrollee had a disenrollment eligibility cancellation, eligibility expiration, or changed the Carrier.

(4) If for late eligibility enrollment.

C. EDI 820 and 835 Payment Files

The EDI 820 and 835 file are prepared for each run of the capitation and supplemental payment processes to enable insurers to reconcile payments made to them. These files both include the details of the types of payment corresponding to each of the beneficiaries assigned to the Carriers contracted and the supplemental payments calculated. It is important to note that the transactions in the 820 files include 98% of the payment, leaving out the 2% withholding.

See Addendum 3, 820 Companion Guide.pdf and Addendum 16 835 Companion Guide.pdf.

Note: Maternity and Incarcerated kick Payments are included in the 820 files.

XI. TRANSITION OF CARE

As part of the Vital Plan, beneficiaries have the right to change carriers for just cause or during the "Open Enrollment" and "90 days Open Enrollment" period and changes for just cause.

For beneficiaries to receive quality services, it is necessary to ensure continuity of services when changing insurance companies. For this purpose, the Transition of Care ("TOC") process was defined, which entails the movement of relevant health data of each beneficiary who makes the change from the outgoing insurer to the incoming insurer.

Description of the different files that insurers have to generate:

1. **Transition of Care Files**

The outgoing insurer must provide the data required by ASES so that the incoming insurer can continue the service required by the beneficiaries. Nine types of files were designed:

a. **Pharmacy (PX):** Pharmacy data where the health conditions that each beneficiary has are indicated so that the medication dispensing service is not stopped.

b. **Mental Health (SMI):** Data related to mental health conditions.

c. **Pre-authorizations (PA):** Data on approved pre-authorizations

d. **Denied pre-authorizations (PD):** Data of the denied pre-authorizations.

e. **OBGYN (OB):** Data related to pregnant women or any gynecological condition that requires follow-up.

f. **Special Coverage (SC):** Data related to special coverage.

g. **Life Support (LS):** Data on members who use life-support equipment.

h. **Hospitalizations (HP):** Hospitalizations at time of change

i. **Case Management (CM):** Any other condition that requires continuity of services and is not included in any of the files listed above.

See Addendum 7 TOC.

2. **MCO's Responsibilities in TOC Process**

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Insurers will have the responsibility to make maximum use of all such data for the benefit of our population under the PRMP. In addition, insurers are responsible for notifying ASES of erroneous data they receive from another insurer to the ASES Clinical Affairs department.

XII. CARRIER SUB-CAPITATION PAYMENTS

This document is the definition of the Monthly Carrier PMPM Sub-Capitation Payments Interface file layout that will be transmitted from each MCO to the PRMMIS. This file will contain the Carrier PMPM Capitation Payment records that are required to be added to PRMMIS as Carrier Sub-Capitation Payments. See Addendum 14.

XIII. NPL files to Enrollment Counselor

When a beneficiary is going to make an insurance change with the Enrollment Counselor, he/she has the right to select the desired PCP and/or PMG. In order for this process to be effective, the Enrollment Counselor needs to maintain up to date PCP and PMG contracting information for each insurer.

Using the format described in Addendum 15, the MCOs must prepare the file known as NPL on a weekly basis (on Fridays) and transfer it to the ASES FTP in the corresponding folder.

ADDENDUM

1. Addendum 1 Notice of Decision
2. Addendum 2 Eligibility and Enrollment Record File - PRMMIS_834_Companion_Guide
3. Addendum 3 PRMMIS 820 Companion Guide
4. Addendum 4 PRMMIS MCO Objection of Payments (OTP)
5. Addendum 5 CARRIER to ASES Claims and Provides Interface
6. Addendum 6 Coordination of Benefits (COB)
7. Addendum 7 Transition of Care (TOC)
8. Addendum 8 EFT Folder Organization Insurance Carrier
9. Addendum 9 For References: ASES Non-Risk Payment Arrangement (SMA, Hepatitis C and Synthroid)
10. Addendum 10 Incarcerated

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11. Addendum 11 Electronic Data Interchange (EDI) Process
12. Addendum 12 For reference: ASES COVID19 Vaccine and Remdesivir
13. Addendum 13 PRMMIS_PHASE_I_837_Companion_Guide
14. Addendum 14 PRMMIS CARRIER SUB-CAPITATION PAYMENTS
15. Addendum 15 ASES Enrollment Counselor NPL
16. Addendum 16 PRMMIS 835 Companion Guide

XV. APPROVALS

Revision Sheet

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