Table of Contents

State/Territory Name: Puerto Rico

State Plan Amendment (SPA) #: 23-0009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106
Medicaid and CHIP Operations Group

January 22, 2024

Dinorah Collazo
Medicaid Director
Department of Health
P.O. Box 70184
San Juan, PR 00936-8184

Re: Puerto Rico State Plan Amendment (SPA) 23-0009

Dear Director Collazo:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid Premium and Cost-Sharing State Plan Amendment (SPA) submitted to CMS on March 31, 2023, under transmittal 23-0009. This SPA proposes eliminating all cost-sharing except for copays associated with pharmacy and non-emergency use of the Emergency Room.

This letter informs you that Puerto Rico Medicaid SPA 23-0009 was approved on January 19, 2024, with an effective of January 1, 2023. We approved this SPA with a companion letter to address concerns about Puerto Rico's cost sharing tracking and reimbursement process, which are inconsistent with the requirements. Enclosed are a copy of the companion letter and the approved state plan pages to be incorporated into Puerto Rico's state plan.

If you have any questions, please contact Ivelisse Salce at 212-616-2411 or via email at Ivelisse.Salce@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

cc: Brandon Smith
Debra Harris

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

January 22, 2024

Dinorah Collazo
Medicaid Director
Department of Health
P.O. Box 70184
San Juan, PR 00936-8184

Dear Director Collazo:

This letter is being sent with the Centers for Medicare & Medicaid Services (CMS) approval of Puerto Rico's State Plan Amendment (SPA) #23-0009, which eliminates all cost sharing except for copays associated with pharmacy and non-emergency use of the Emergency Room. Consistent with the State Medicaid Director letter (SMD) #10-020 published on October 1, 2010 (relating to the SPA review process), we are sending this letter to address concerns that Puerto Rico's cost sharing tracking and reimbursement process is not consistent with federal requirements. This letter memorializes the agreement that the territory will implement a cost sharing tracking system and an appropriate reimbursement process for all beneficiaries subject to cost sharing under the state plan.

During our review of SPA #23-0009, we identified two cost sharing policies and procedures inconsistent with federal requirements.

First, sections 1916A(a)(2)(B), (b)(1)(B)(ii) and (b)(2)(A) of the Social Security Act (the Act), implemented at 42 CFR §447.56(f), set an aggregate cap on the total premiums and cost sharing charged to a given Medicaid beneficiary (or, in the case of a family with multiple beneficiaries, all beneficiaries in the household) of five percent of the beneficiary's family income. This five percent aggregate cap may be applied, at the territory option, on either a monthly or quarterly basis ("aggregate cap period"). Under 42 CFR §447.56(f)(2), if the state adopts premiums, cost sharing, or a combination of charges that could place beneficiaries at risk of reaching the aggregate family limit, the state plan must indicate a process to track each family's incurred charges through an effective mechanism that does not rely on beneficiary documentation. CMS will need additional information from Puerto Rico on how it is meeting these tracking requirements and complying with the aggregate cap.

Second, 42 CFR §§ 447.10(d) and 447.25 do not permit Medicaid agencies to issue direct payments to beneficiaries except in limited circumstances. Thus, a state may not issue direct reimbursement payments to individual beneficiaries unless they meet the limited exceptions described in 42 CFR 447.25.

As discussed with Puerto Rico agency staff on March 20, 2023, April 5, 2023, and July 12, 2023, the territory has not yet implemented a system to track beneficiaries' premiums and cost sharing payments prior to beneficiaries reaching their household aggregate cap. In addition, when agency staff become aware that a beneficiary has reached their aggregate cap, the agency currently directly reimburses the beneficiary who is found to have incurred cost sharing in excess of five percent of the beneficiary's family income. Puerto Rico informed CMS that it was aware of these issues and that it intends to comply with federal policy concerning cost sharing and premium tracking through a newly developed system which will enable the territory to automate the tracking of beneficiary's incurred premium and cost sharing towards their family aggregate and will stop assessing cost sharing to beneficiaries once the household aggregate limit has been reached, thereby obviating a need to reimburse beneficiaries.

Puerto Rico has confirmed that this tracking system will be implemented by March 31, 2024. Until the tracking system is implemented, Puerto Rico will ensure that beneficiaries can report to the territory's Medicaid agency when they have incurred cost sharing on eligible medical expenses over five percent of the beneficiary's family income as approved under the state plan. Tracking cost sharing and premiums and direct reimbursement of beneficiaries is not integral to the purpose of SPA #23-0009. In accordance with SMD #10-020, CMS has explained to the territory the option to resolve this issue separately from the approval of this SPA. The state informed CMS that it would like to address the steps needed to comply with federal policy on premium and cost sharing tracking and beneficiary reimbursement separately. This letter initiates that separate process.

Please respond within 90 days of receipt of this letter to provide written acknowledgement of receipt of this letter and confirmation of the terms described to bring territory operations into compliance with tracking requirements under 42 CFR §447.56(f) and reimbursement requirements under 42 CFR 447.10(d) and 447.25 and submit a state plan amendment accordingly. During these 90 days, CMS welcomes the opportunity to collaborate with you and your staff. Should you or your staff have any questions, please contact Ivelisse Salce at Ivelisse.salce@cms.hhs.gov or (212) 616-2411.

James G. Scott, Director
Division of Program Operations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0009

2. STATE: PR

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
1916, 1916A, 42 CFR 447.50 through 447.57 (excluding 447.55)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 2,514,284
b. FFY 2024 $ 3,177,964

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Sections G1, G2a, G3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Sections G1, G2a, G3 Section 4.18

9. SUBJECT OF AMENDMENT
This SPA proposes eliminating all cost-sharing except for copays associated with pharmacy and non-emergency use of the Emergency Room

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
Delegated to State Medicaid Director

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Dinorah Collazo-Ortiz, Esq., CHC

13. TITLE
Program Executive Director

14. DATE SUBMITTED
03/31/2023

15. RETURN TO
PUERTO RICO MEDICAID PROGRAM
PUERTO RICO DEPARTMENT OF HEALTH
PO BOX 70184
SAN JUAN PR 00936-8184

FOR CMS USE ONLY

16. DATE RECEIVED 03/31/2023

17. DATE APPROVED **01/19/2023**

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
01/01/2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

Instructions on Back

Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 23 - 0009

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

- ☐ The state includes an indicator in the Medicaid Management Information System (MMIS)
- ☒ The state includes an indicator in the Eligibility and Enrollment System
- ☐ The state includes an indicator in the Eligibility Verification System
- ☒ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
- ☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

- ■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
- ■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
- ■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

- [■] Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- [■] Provide a referral to coordinate scheduling for treatment by the alternative provider.

[✓] The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

Non-emergency services are all services or care not considered Emergency Services as determined by the attending physician when an enrollee visits the emergency department. Emergency Services are Physical or Behavioral Health Covered Services furnished by a qualified Provider in an emergency room that are needed to evaluate or stabilize an Emergency Medical Condition or a Psychiatric Emergency that is found to exist using the prudent layperson standard.

Emergency Medical Condition is a medical or Behavioral Health condition, regardless of diagnosis or symptoms, manifesting itself in acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, serious dysfunction of any bodily organ or part, serious harm to self or other due to an alcohol or drug abuse emergency, serious injury to self or bodily harm to others, or the lack of adequate time for a pregnant woman having contractions to safely reach another hospital before delivery. The Contractor may not impose limits on what constitutes an Emergency Medical Condition.

Psychiatric Emergency is a set of symptoms characterized by an alteration in the perception of reality, feelings, emotions, actions, or behavior, requiring immediate therapeutic intervention in order to avoid immediate damage to the patient, other persons, or property. A Psychiatric Emergency shall not be defined on the basis of lists of diagnoses or symptoms.

No copayment shall be required to provide non-emergency services to an Enrollee who visits a hospital emergency room to receive services if such enrollee, previous to visiting the Hospital Emergency Room, consults the Medical Advice Line and receives a call identification number, and presents such number at the time of the visit to the emergency department.

Cost Sharing for Drugs

The state charges cost sharing for drugs.	Yes
The state has established differential cost sharing for preferred and non-preferred drugs.	Yes

- [■] The state identifies which drugs are considered to be non-preferred.
- [✓] The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Medicaid Premiums and Cost Sharing

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

(1) Medicaid in Puerto Rico is covered by two distinct Commonwealth agencies -The Puerto Rico Medicaid Program (PR Medicaid Program), and The Puerto Rico Health Insurance Administration (PRHIA, Administraci6n de Seguros de Salud de Puerto Rico, or ASES, from its acronym in Spanish). Eligibility determination is handled by the PR Medicaid Program, while ASES contracts with MCOs to provide insurance coverage and enroll beneficiaries.

(2) A public schedule describing current copays is published on the ASES web site at http://www.asespr.gov/, the Puerto Rico Medicaid Program web site at https://www.medicaid.pr.gov/, and on the web sites of MCOs contracted by ASES.

(3) A "Beneficiary Manual" is distributed to all enrollees by MCOs and includes a section which details the co-pay structure.
(4) The Puerto Rico Department of Health (PRDoH), through the Puerto Rico Medicaid Program (Medicaid Program), and the Puerto Rico Health Insurance Administration have issued this "Cost Sharing Policy for Medicaid and CHIP Beneficiaries" to establish copayment rules, as required by the Sections 1916 and 1916A of the Social Security Act (SSA) and 42 CFR §§447.50-447.57 (excluding 42 CFR §447.55) of the federal regulation, the State Plan Amendment, and the New Cost Sharing Structure.

PRA Disclosure Statement

V.20160722

Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 23 - 0009

Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add						Remove

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Pharmacy: Preferred — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	50% PRPL	100% PRPL	1.00	$	Other	Notes: 1. Indicator of co-pay included on ID card that the beneficiary presents to the provider. 2. Co-pay charged for each covered drug dispensed. 3. Not applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.	Remove
Add	100% PRPL	150% PRPL	2.00	$	Other	See Notes 1, 2, and 3 above.	Remove
Add	150% PRPL	No upper limit	3.00	$	Other	See Notes 1, 2, and 3 above.	Remove

Service or Item: Pharmacy: Non-Preferred — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Medicaid Premiums and Cost Sharing

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	50% PRPL	100% PRPL	3.00	$	Other	Notes: 1. Indicator of co-pay included on ID card that the beneficiary presents to the provider. 2. Co-pay charged for each covered drug dispensed. 3. Not applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.	Remove
Add	100% PRPL	150% PRPL	4.00	$	Other	See Notes 1, 2, and 3 above.	Remove
Add	150% PRPL	No upper limit	6.00	$	Other	See Notes 1, 2 and 3 above.	Remove

Service or Item: Non emergency use of the Emergency Room

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	50% PRPL	100% PRPL	4.00	$	Visit	NOTES: 1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays. 2. Co-pay for non-emergency visit to hospital emergency room may be waived by calling the Medical Advice Line and receiving a code to waive the co-pay. 3. Indicator of co-pay included on ID card that the beneficiary presents to the provider. 4. Not Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.	Remove
Add	100% PRPL	150% PRPL	5.00	$	Visit	See notes 1,2,3, and 4 above.	Remove
Add	150% PRPL	No Upper Limit	8.00	$	Visit	See notes 1,2,3, and 4 above.	Remove

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.	No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	No

PRA Disclosure Statement

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 23 - 0009

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ■ 133% FPL; and
- ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ■ SSI Beneficiaries (42 CFR 435.120).
- ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

■ An individual receiving hospice care, as defined in section 1905(o) of the Act.

■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. **Yes**

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. **No**

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☐ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☒ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

Compliance with AI/AN cost sharing exemption will be monitored by ASES.

■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☐ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☒ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

(1) Contracts between ASES and MCOs include the requirement to exempt populations and services defined in 42 CFR 447.56(a). MCOs produce the cards with indicators as required by contract to make these exemptions know to beneficiaries and providers.

(2) Compliance with cost sharing exemptions will be monitored by ASES.

(3) ASES requires that PBMs inform providers whether the copayment for a specific service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the copayment, as a condition for receiving the service, through an indicator: 1. In the Eligibility and Enrollment System; 2. On the Beneficiary Identification Card. 3. Contracts between ASES and MCOs (MAOs for Platino Plans) and providers shall include the Cost Sharing Policy.

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

Medicaid Premiums and Cost Sharing

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- ◉ 5%
- ○ 4%
- ○ 3%
- ○ 2%
- ○ 1%
- ○ Other: [ ] %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ◉ Quarterly
- ○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **No**

Explain why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit:

Since July 1, 2016, Puerto Rico has implemented a cost-sharing structure that does not place beneficiaries at risk of reaching the aggregate limit.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **Yes**

Describe the appeals process used:

The Puerto Rico Medicaid Program assures that the New Cost Sharing Structure does not place beneficiaries at risk of reaching the aggregate limit. Nevertheless, the Program has a documented reimbursement request process for individuals that believe they have incurred cost sharing over the aggregate limit for the quarterly cap period, which includes an explanation of his/her right to appeal any decision and request a fair hearing. The written communication to the beneficiary under the process includes an explanation of his/her right to appeal any decision and request a fair hearing.

■ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

Puerto Rico has a Process to Request Reimbursement of Excess Cost-Sharing Payments, which allows a beneficiary to request a reimbursement when he/she understands that his/her aggregate limit for cost-sharing has been exceeded in a quarter. Reimbursement requests will be investigated to validate the beneficiary's eligibility and aggregate limit for the quarter. For validated requests, all service claims for the beneficiary's family in the quarter will be examined and the aggregate, incurred cost-sharing amount calculated and then compared to the aggregate cost-sharing limit for the beneficiary. For cases in which an excess cost-sharing amount has been incurred, a reimbursement amount will be calculated. In all cases, a written response will be sent to the beneficiary with an explanation of the results of the investigation. Where a reimbursement 1s due, the wntten response will be accompanied by a payment to the beneficiary of I the excess amount.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Any beneficiary who notifies the Medicaid Program of a change in circumstances will be re-evaluated and the family aggregate limit will be re-calculated as an inherent part of the re-evaluation process.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

PRA Disclosure Statement

V.20160722