Puerto Rico Medicaid State Plan
List of Attachments

Puerto Rico Department of Health
Medicaid Program

Mayo 2019
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Supersedes TN No. 92-2

Approval Date Oct 14 1992

Effective Date Jul 1 1992

HCFA ID: 7982E
As a condition for receipt of Federal funds under title XIX of the Social Security Act, the Department of Health (Single State Agency) submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  Attachment 1.1-A
MEDICAL ASSISTANCE PROGRAM
State of The Commonwealth of Puerto Rico

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

1. The Department of Health of Puerto Rico is the single State agency responsible for:

   [X] administering the plan.

   The legal authority under which the agency administers the plan on a Statewide basis is Article IV of the Constitution of the Commonwealth of Puerto Rico and Act No. 81 adopted on March 14, 1912, as amended.

   (statutory citation)

2. [ ] supervising the administration of the plan by local political subdivisions.

   The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

   (statutory citation)

3. The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is

   (statutory citation)

August 28, 1974

DATE

Rafael P. Moreno Cabrera
Signature

Acting Attorney General
Title
WAIVER(S) OF THE SINGLE STATE AGENCY REQUIREMENT GRANTED UNDER THE INTERGOVERNMENTAL COOPERATION ACT OF 1968

Waiver #1/1:

a. Waiver was granted on ____________________________
   (date)

b. The organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to ____________________________, and the resources and/or services of such agency to be utilized in administration of the plan are described below:

   NOT APPLICABLE

1/ (Information on any additional waivers which have been granted is contained in attached sheets.)
c. The methods for coordinating responsibilities among the several agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

NOT APPLICABLE
STATE: COMMONWEALTH OF PUERTO RICO

GENERAL EXPOSITION

GENERAL ORGANIZATION CHART

The Department of Health's Organization and Operation is divided in two large areas, which are:

I- Standards and Programmatic Area: and the

II- Operational Area

All advisory units belonging to the Office of the Secretary, from ordinary Staff offices through the Auxiliary Secretaryships are included under the Standards and Programmatic Area. The Operational Area comprises all activities of Health Facilities and Medical Services Administration and the Regional Offices of the Department.

The Office of Aid to the Medically Indigent's position correlates to Standards and Programmatic Area. This office holds a series of functional relationships with the total Department's structure. This is possible due to the fact that all monitoring related to the Medical Assistance Program is under its jurisdiction. Also, the functional interaction extends to the operational level particularly on the regions.
Public Law #26 of November 13, 1975, also known as the Health Facilities and Services Administration of Puerto Rico Act, created the Health Facilities and Services Administration of Puerto Rico. Accordingly, this agency will be responsible for all the operational aspects of the Department of Health.

The Department of Health, in turn, will maintain the policy making functions concerning the agency's general planning, evaluation, and auditing activities. It will, at the same time, establish regulations for the health services and facilities aiming its activities to both the public and the private sectors.

The aforementioned functions are carried on through the following fourteen Advisory Offices and eight Assistant Secretaryships:

I. Office of the Secretary of Health
   A. Advisory Offices
      1) Internal Auditing
      2) Legal Services
      3) Office of Aid to the Medically Indigent
      4) Administrative Services
      5) Quality Control of Health Services
      6) State Health Planning and Development
      7) Community Relations
      8) Federal Affairs Office
9) Women and Infant Care Program
10) Demographic Office
11) Office of Professional Standards, Regulations and Licence
12) Inmate Health Services
13) Laboratory Services Institute
14) OCASET

B. Assistant Secretariats

1) Special Affairs
2) Environmental Health
3) Emergency Medical Services
4) Family Health Preventive Services
5) Regulation and Accreditation of Health Facilities
6) Mental Health
7) Education to Health Professionals
8) Nursing Secretariarship

The Office of the Secretary of Health consists of the Secretary of Health, the Under Secretary, their assistants and their secretarial and clerical staff. The Secretary of Health is responsible of the overall administration of the Department of Health including the Health Services and Facilities Administration and the Administration created for the operation of the Puerto Rico Medical Center. As an integral part of the
office of the Secretary, the Under Secretary participates in the direction of the Department of Health and in other assignments he receives from the Secretary. He also functions as Acting Secretary and coordinates the regulatory and advisory component with the operational area of the health regions in coordination and through the Executive Director of the Health Facilities and Services Administration.

The overall direction of the Health Facilities and Services Administration is performed by the Secretary of Health through the Executive Director, following established policies, rules and regulations. Likewise, the Executive Director is the line of communication with the Secretary of Health for all official matters.

The general functions of the advisory and assistant secretaries offices are as follows:

A. Advisory

1) Internal Auditing Office

Performs the fiscal and operational auditing for all Department's facilities and programs to assure the most effective use of the resources and that the use of federal and state resources is in compliance with the applicable laws and regulations.
2) Legal Services Office

Provides the necessary legal advise and assistance to all Department of Health and HFSA dependencies.

3) Office of Aid to the Medically Indigent

Responsible for the administration of the Title XIX Program in the State.

4) Administrative Service

Performs the administrative functions of the Department of Health that were delegated to the Health Facilities and Services Administration.

5) Quality Control of Health Services

Responsible for the establishment of standards of quality services and for the continuous evaluation of the amount and scope of medical services.

6) State Planning and Development Office

Responsible for the development of the Global Strategic Health Plan of the Commonwealth of Puerto Rico in accordance with the federal and state laws. Formulates the necessary criteria needed for the evaluation, and certificacion of the health facilities and other special projects of the Department of Health. Undertakes the necessary studies related to the areas of health services.
7) Community Relations

Responsible to assist the Secretary of Health in the development and maintenance the public and community relations and to provide professional assistance in the public relations field to all Department and HFSA dependencies.

The basic activity of this office is to maintain the community informed about the programs and services available in the Department of Health.

8) Federal Affairs Office

Advises the Secretary of Health on federal regulations laws and programs funding.

9) Women and Infant Care Program

Administers Public Law 95-627 as amended by section 17 of Child Nutrition Act of 1966. It provides supplemental nutrition to mothers and infants at risk.

10) Demographic Office

Register and maintain vital statistics on Puerto Rico's population universe according to State Law 24 of April 22, 1931, as amended.
STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY
MEDICAL ASSISTANCE PROGRAM

STATE: COMMONWEALTH OF PUERTO RICO


12) Inmate Health Services
Provides institutional health services to inmates of public institutions.

13) Laboratory Services Institute
Administers and regulates the operations of clinical laboratory analysis and blood banks.

14) OCASET - Office of Services to Sexually Transmitted Diseases
Administers State Law 81 of June 1983, as amended for prevention and treatment of sexually transmitted diseases. It is correlated to CDC of Atlanta, Ga., the University of Puerto Rico School of Medicine and to Puerto Rico's Education Department, Social Services, Department of Services to Addiction (DSCA), Correctional Administration Department and Department of Justice. Community groups working against drug addiction, are also correlated to this office, such as CREA. This office comprise Puerto Rico's main efforts against AIDS.
B. Assistant Secretariat Offices

1) Special Affairs

Provides assistance to the Secretary of Health in establishing the administrative and operational policies for the Department of Health and in the special programs and affairs delegated.

2) Environmental Health

Responsible for the planning, development, implementation and performance of all environmental health policies in the state. Administers supervises and controls all sanitation activities.

3) Emergency Medical Services

Responsible for the planning, organization, and operation and administration of the emergency transportation services of the state health care system.

4) Family Health Preventive Services

Responsible for the planning, development, organization and supervision of the implementation and performance of the outpatient health services policy in the public health facilities.

5) Regulation and Accreditation of Health Facilities

Responsible for the implementation of the provisions of Act 101 of June 26, 1965 as amended, to license every health facility on compliance with standards and regulations.
STATE: COMMONWEALTH OF PUERTO RICO

6) Mental Health Services

Responsible for the planning, development, organization and supervision of the implementation and performance of mental health care and policies in the public sector.

7) Education to Health Professions

Performs the necessary functions for the planning, administration and implementation of medical and paramedical training programs and other human resources development.

8) Nursing Secretariarship

Responsible for the establishment of policies, on nursing services and to correlate as advisor on nursing matters to the Secretary's office and other pertinent dependencies.

In addition of the aforementioned functions the advisory and assistant secretaries' offices provide support to the State Health System in the following areas.

- by delegation and in coordination with the Secretary of Health, establish programs objectives and priorities that constitute the basis for the Department's public policy.
- Establish the operational component policies in line with federal, state, and municipal regulations.
Provides technical advise through the Executive Director of the Health Facilities and Services Administration and in coordination with the under Secretary of Health.

Evaluate the operational area and inform the Secretary of Health about accomplishments in policy implementation recommending changes in objectives in accordance with actual health services needs.

II. Health Facilities and Services Administration - H.F.S.A.

H.F.S.A. was created by Public Law #26 of November 13, 1975, as amended. This law enables the Secretary of Health to delegate in the Administration, prior authorization by the Governor, all management and operational matters involving health services delivery.

For this end, the Administration becomes the Department of Health main instrument of community accessibility to preventive, curative, and rehabilitative high quality services rendered at reasonable costs.

For optimum results, the law established the Administration as an independent body with unusual maximum operational flexibility in its administrative systems, such as those relating to personnel, budget, fiscal, purchase, and supply areas.
In order to facilitate its performance, the H.F.S.A. has adopted the following organizational structure which was approved by the Secretary of Health in July 1978.

1. Executive Directors Office

The Professional staff of this office is the Executive Director, the Deputy Director and their assistants. The Executive Director responds to the Secretary for the full management, operation and services rendered by the Administration. The Deputy Director shares these responsibilities with the Executive Director and substitutes him in his absence.

2. Operational Management Office

Responsible to the Executive Director for the design and implementation of procedures and systems leading to maximum operational efficiency. It will also perform special efficiency assessments of the different components of the Department.

3. Information System

The Information Systems Office consists of four basic areas of activity as follows:

a. Director's Office

Responsible of the planning, organization, development and direction of the Integrated Information System.
b. Office of Statistics Analysis and Control of Information Responsible for gathering, analysis and control of the statistics, computer data and development of management reports necessary for the different operational units.

c. Cooperative Health Statistics
Responsible to compile vital statistics data necessary for the Cooperative National Statistics System and submit the required information and reports.

d. Data Processing Center

4) Comptroller Area

A. Office of the Comptroller
Consists of the Comptroller (Assistant Director) his assistants, and a System and Financial Analysis Unit. It responds to the Executive Director for the Development of internal fiscal policies and procedures aiming to maximize income as well as utilization and preservation of resources.
It is also responsible for the design, implementation and maintenance of systems and procedures concerning fiscal policies.

The Comptroller Office also systematically analyses all the financial operations of the H.F.S.A. and makes recommendations to the Executive Director.

In line with the above, this office manages and supervises the following divisions:

- Financial, Budgeting, Accounting and Cost Analysis, Billing and Property Control.

B. System Analysis Financial Unit

Responsible for the analytical evaluation of the economic resources and expenditures of the H.F.S.A., revision of the proposed budgets and to provide assistance to the Executive Director and to the Regional Directors.

C. Finance Division

Responsible for the accounting system at all levels. Consequently, it keeps fiscal reports necessary for adequate monitoring on the use of funds and on the financial operations of the H.F.S.A., and the Department of Health.
D. Billing and Collection Division

Responsible for implementation and administration of the billing function to third party payors under State Law 56, of June 21, 1969. Provides technical assistance and monitoring to the billing and collections activities at regional levels.

E. Budgeting Division

Responsible for the direction, control, and coordination, as appropriate, of the preparation and management of both the H.F.S.A. and the Department's budget.

F. Cost Accounting Division

Responsible for the operation of the cost accounting systems in the medical facilities, programs, and services of the H.F.S.A., and the Department of Health. It procedures and submits reports required by Medicare and Medicaid Programs.

G. External Resources Division

Responsible for the analysis of federal and state legislation in order to search new financial resources for the operational H.F.S.A. It also provides assistance to the operational units of the H.F.S.A. related to the accountability and control of federal funds.
5) Personnel and Human Resources Area

A. Office of the Assistant Director

Responsible to the Executive Director for the operation of the human resources and personnel functions of the H.F.S.A.

B. H.F.S.A. Personnel Division

Responsible for the H.F.S.A. personnel functions.

C. H.F.S.A. Human Resources

Responsible for the H.F.S.A. operation related to human resources.

6) Office of Health Construction and Modernization of Health Facilities

Responsible for the maintenance of health facilities and the supervision of construction projects.

7) Office of Administrative Services

Responsible to the Executive Director of the Administration to provide the common services to the different dependencies of the H.F.S.A. such as, transportation, mail, security, warehouse, files, equipment repairs and housekeeping activities.

8) Office of Purchases and Supplies

Responsible for the acquisition of general supplies, drugs, and equipment needed by the H.F.S.A. and the Department of Health.
The Office of Aid to the Medically Indigent, correlates to the Standards and Programmatic Area of the Department of Health. This office holds a series of functional relationships with local Department structure. This is possible due to the fact that all monitoring related to health, and in particular, to the Medical Assistance Program is under its jurisdiction.

The Office has been established in response to the following needs of the Medical Assistance Program and the Department of Health in general. Among these are the adequate attention of the growing complexity of federal reports; improvement of third party payments; continuous follow-up upon federal legislation on health care financing; to strengthen the implementation of standards, plans, systems and procedures; to constantly keep surveillance on possible fraud and abuses regarding the utilization of health services and facilities; to analyze fiscal and managerial reports in order to identify and evaluate their impact and relevance; to keep up an active follow-up on the sources of federal, state and private funding; to monitor the rate-setting for hospital-ambulatory services; to provide an advise and monitor the

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TN # 79-12
economic aspects on the contract negotiations; to keep up an effective coordination with the Regions for an adequate Medicaid Program implementation; to be directly responsible for studies and reports on Medicaid Quality Control.

Medicaid Program operates within the Health Department Organization that establishes eight (8) health regions. Within these regions Medicaid Program has 38 local offices.

- Advisory Committee

The General Council of Health at Puerto Rico’s Department of Health, functions as the advisory committee to the Medicaid Program. It was created on State Law 11 of June 23, 1976 or accordance to PL-93-641 of 1974, as amended.

The General Health Counsel is composed of 25 members representing different geographical areas of Puerto Rico and among it's members there are health providers, consumers, financing executives, lawyers, and ex-oficio members from Social Services Department, Education, Addiction and State Insurance Funds Departments as well as the School of Medicine of the University of Puerto Rico.
The specific functions of each Division under the Director of the OAMI shall be as follows:

I. Medical Assistance Program Division (Title XIX)

Responsible for the administration, monitoring and coordination, islandwide of the Medicaid program thus providing consistent program direction in accordance with the Federal and State requirements.

These functions are channeled thru the following divisions:

1. Eligibility Determination and Standards Setting Section

   Responsible for the development of program policies and procedures; basic needs eligibility standards; production and updating of the necessary program manuals, and materials; and updating of state plan and state program manual and other manuals pertinent to IEVS.

Policy and Standards Division

1. Policy Unit:

   Studies the existing rules and guides, as well as their proceedings, and is kept aware of every change coming from federal level to keep them up to date and in compliance with: TN 92-11 Approval Date MAR 12 1995

   Supersedes TN 79-12 Effective Date OCT 1 - 1995
a. studies the questions sent by local annual regional personnel to clarify doubts and uniform procedures.

b. keeps up to date the Program's Policy and Procedures manual.

c. studies and keeps up to date the State Plan.

d. studies and keeps up to date the federal Medicaid manual (Parts 1-14)

**EPSDT Section**

Responsible for the coordination of EPSDT activities with the Department of Social Services and Title V. It will be responsible for the monitoring of the program activities and for the provision of program evaluation and reports.

**Disability Determination Board**

Evaluate the disabled individuals who apply for the Program benefits because of their disability and their socio-economic poverty.

**TN 92-11 Approval Date MAR 12 1993**

**Supersedes TN 79-12 Effective Date OCT 1-1992**
Validation Board

Certify the Blind Category applicants who comply with the socio-economic eligibility condition and requirements.

2. Field Operations Monitoring

This Division is responsible for the program monitoring operations statewide to provide technical assistance; assessment to the program and services administrative personnel.

Plans, organizes, directs and supervises the technical aspects of the Program at regional and local levels.

Advices the Regional Directors of the Medicaid Program on matters pertaining to the Program and in technical and evaluation areas leading to Program and services agreement.

Maintains continuous evaluation programs training, effective administrative techniques, organization, methodology, and procedures which submits to the Program Director for approval.

Coordinates Program and Information System activities with regional and local offices and participates on Program and System evaluation committees.
STATE: COMMONWEALTH OF PUERTO RICO

Participates and advises in evaluative studies regarding quality of health services.

a. Corrective Action Section - coordinates and establishes corrective action plans with central office staff to be implemented as pointed out by the Quality Control System.

b. Training Section - Studies, analyzes, organizes and evaluates training needs on the different Program Areas and develop an adequate training program to satisfy them.

c. Information System Section - Coordinates Program and Information System activities with ODSI, regional and local offices. Participates in Program system evaluation committees.

3. Financial Management Statistical Division

Responsible for the revision and approval of provider claims, selection of the sample for processing purposes, revision and approval of provider cost reports, preparation and submittal of federal reimbursement and budget.
3. Financial Management Division

Responsible for the operation and establishment of the cash management system and the capitation plan to distribute federal Title XIX funds.

Reviews and approves provider cost reports and prepares and submits federal reimbursement and budget reports.

Studies Reports and Economic Analysis Section

Responsible for the analysis and evaluation of providers cost reporting system and in the production of Program periodic and annual reports.

3.1 Statistics Division

Responsible for the gathering, analysis, and reporting of all statistical data necessary for the administration of the Programs and for providing other required reports.
- FRAUD and Abuse Unit - Medicaid Program contracted the Department of Justice's Fraud Unit to investigate, determine and process fraud situations of providers, employees or eligibles.

Hearings Boards - Processes claims and appeals received from applicants, beneficiaries and providers and submits necessary reports to the Medicaid Program Director.

5. **Administration Division**

Organizes and supervises the administrative aspects of the OAMI. Coordinates changes and improvements to provide necessary services. This division has six sections:

a. Personnel Section - Responsible of the coordination and supervision of the administrative procedures related with the human resources and personnel functions of the Program.

**TN 92-11 Approval Date MAR 12 1993**

**Supersedes TN 79-12 Effective Date OCT 1 1982**
b. Administrative Budget Section - Designs the internal and external work plan for the OAMI including the plan for evaluation on program operations, investigations and necessary studies for the establishment and revision of policies concerning the administration of the Program.

c. Purchases Section - Responsible for the acquisition of general supplies and the equipment needed by the OAMI. Coordinates and supervises the supply of the equipment and the materials requested.

d. Maintenance Section - Responsible for building maintenance.

e. Inventory and Warehouse Section - Keeps complete stock and control of required materials in accordance with the Department of Health rules and regulations.

f. Transportation Section - Responsible for providing transportation services and upkeeping the official vehicles.
6. Quality Control Division

Quality Control is a systematic and coordinated effort by State and Federal Government to assure proper and efficient administration of Medicaid. The primary purpose of the System is to supply State and Federal administration with information concerning correctness of eligibility determinations and payments amounts. The Quality Control System is designed to measure error rate levels and to provide information on the nature and causes of errors so that corrective actions may be undertaken.

The objectives of the Medicaid Eligibility Q.C. System are accomplished by means of a continuous review of recipients identified through statistically reliable samples. State Q.C., reviewers make full investigation, carry out face to face interviews make full investigation, carry out face to face interviews with the recipients involved and verify and document each element of eligibility.
The Division of Quality Control is centralized. The development of this activity on the regional level is performed by social service technicians (Q.C. reviewers) supervised by the Central level.

- Director

The Director of the System performs his job under general guidance and direction of the Director of the Medicaid Program. Is responsible for the direction of the Quality Control System, providing constant supervision of personnel and to all activities within the System; planning and establishing the scope and priorities of these. Maintains close coordination with the Agency's statistical staff, other administrative and normative staff within Program and other State Agencies. Assures to maintain the Program informed about the review findings and cases in error so that corrective action may be undertaken.

- Maintains an adequate staffed organization in order to keep all the required activities current and at a maximum quality level.

**Approval Date** <br> MAR 12 1993

**Effective Date** <br> OCT 1 1992

**Supersedes** TN 79-12
Quality Control Reviewers goes over the cases included in the monthly samples. The work of these reviewers consists in the revision of the eligibility determination of the sample cases certified eligible by the Medicaid Program. They will cover the revision of sample cases certified eligible as well as negative cases. Included also is a review of Ineligible AFDS and AABD cases receiving cash assistance to determine eligibility for Medicaid. As part of their duties, they will determine and identify the existence of Third Party Liability resources, and will perform the Claims Processing Q.C. Review.

The Quality Control reviewers are located in accordance to the Program's regional offices.

Central Office Quality Control staff keeps track of all completed sample cases of recipients certified eligible by Medicaid Program, and all Q.C. AFDC and AABD cases and edit the eligible sample cases.
performs the TPL review and the computations of misspent dollars of all cases in error including the AFDC and AABD cases. Desk reviews for all ineligible cases of this sample, are conducted for assignment to the regional reviewers for field investigation.

Quality Control Program Division will coordinate effectively with Fraud and Abuse Unit in order to adequately refer those situations that through their field investigations and/or desk reviews a possible fraud situation is suspected.
OVERALL INTERACTION OF THE
FUNCTIONS AND ORGANIZATION OF THE MEDICAL ASSISTANCE PROGRAM

As an answer to existing agreements among the Federal Government and
the Commonwealth of Puerto Rico it is deemed necessary, as part of the Medical
Assistance State Plan, to present the various internal and external relations-
ships of the Department in accordance with such agreements. Diagram III
illustrates such relationships with the Social Services Department; Auxiliary
Secretaryship of Ambulatory Services (Family and Health Planning) and other
Auxiliary Secretaryships; the Office of the Director of Certification and
Licenses; the Information System Office as well as the Office of Health Economy.
Besides, the diagram shows at the level of the Health Secretary the two
Advisory Committees, one for the Medical Assistance and another specifically
 EPSDT.

Through this organization the responsibilities of the Health
Department, as the single State Agency are delineated.
1) General Health Council

2) A Committee appointed by the Program Director composed by the Division's supervisors, prepares corrective action plans based on Quality Control findings. Analyzes, studies and answers to consults submitted by Regional Directors, Department of Health's officials or any other agency.

SECRETARY OF SOCIAL SERVICES

COMMONWEALTH OF PUERTO RICO
DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE PROGRAM FUNCTIONAL ORGANIZATION CHART

APPROVED BY: MIGUEL RIVERA DURÁN, M.D.
SECRETARY OF HEALTH
JANUARY 1, 1979
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: COMMONWEALTH OF PUERTO RICO

DEPARTMENT OF HEALTH OF PUERTO RICO
MEDICAL ASSISTANCE PROGRAM

Professional Medical and Supporting Staff for Title XIX:

Jaime Rivera Dueño, M.D.  Secretary of Health
Heriberto Morales, M.D.   Under Secretary of Health
Julio César Galarcé   Director Office of Health Economy
Irma Revilla de Ferrer   Director, Medical Assistance Program
Executive Director II (Vacancy)  APTD Medical Consultant
Physician IV (Part Time) - Vacancy  APTD Social Consultant
Zoé Suárez (Social Worker)  Statistics and Information System
Ramón Feliciano  Accounting and Fiscal Management
Héctor D. Maysonet Cardona  Certification Standards and Policies
Vacancy  Administrative and Personnel Officer
Francisco Olivo  E.P.S.D.T. Coordinator
Gloria Vázquez  Planning and Management Systems
Víctor P. Santiago  Consultant

Department of Health Staff Acting as Consultants for Title XIX:

Luis S. Miranda, M.D.  Planning and Development and Licensure and Certification of Health Facilities and Services
José E. Belardo Robles, M.D.  Ambulatory Services
Manuel Andrades, Architect  Health Facilities
Francisco Hernández Oquendo, M.D.  Oral Hygiene
Aída Guzmán, M.D.  Mental Health
Antonio Hernández Torres, M.D.  Environmental Health
Blanca Rivera (Attorney)  Legal Services
José Camacho  Administration and Health Manpower
Efraín Rodríguez Vigil, M.D.  Institutional Services
Emilia Hoyos Rucabado, B.S.P.H.  Pharmacy Consultant

ST. P. R. 3A Approved 1/29/80
Effective 1/1/80
RO Approved 2/26/80
The Puerto Rico Health Insurance Administration (PRHIA) was created by Commonwealth Law Number 72 effective September 7, 1993. PRHIA is a public corporation with full autonomy. It is responsible for implementing, administering and negotiating a health insurance system, through contracts with insurance underwriters that will eventually give all Island residents access to quality medical and hospital care, regardless of their financial condition and capacity to pay.

PRHIA has an agreement with the single State Medicaid Agency to carry out the provisions of Law Number 72. The Single State Medicaid Agency is the Department of Health. Within the Department, the Office of Economic Aid to the Medically Indigent has responsibility for the Medicaid Program.

PRHIA enters into risk contracts with entities/insurers organized under Commonwealth Law 152 (approved on May 9, 1942) to provide or arrange for comprehensive health care services. These consist of Basic Coverage and Special Coverage as detailed in the contract.

PRHIA contracts health insurance for one or more areas or regions, with one or more entities/insurers licensed to do health insurance business in Puerto Rico. Services are rendered following the regionalization system of the Department of Health, progressively establishing a network of participating purveyors throughout the Island. Within each region Primary Care Centers will be established. These must be staffed with consideration to the morbidity and mortality rates of the specific health area and must be sufficiently staffed to provide all the benefits included in the Plan. The entity/insurer must demonstrate to PRHIA the adequacy of its provider network in relation to the region or health area it will serve. Services will be as accessible to Medicaid enrollees as they are to non-enrolled Medicaid beneficiaries.

The entity/insurer must demonstrate financial soundness according to Commonwealth statute, etc., and must submit financial and other reports to the Administration as specified in the contract. If the entity or insurer is declared insolvent, files for bankruptcy, or is placed under liquidation, the Administration has the option to cancel and immediately terminate the contract. In the event that the entity or insurer is declared insolvent, files for bankruptcy, or is placed under liquidation, Medicaid enrollees will not be liable for its debts. The entity/insurer must guarantee to the Administration that the premium constitutes payment in full for the benefits under the program and that participating providers and/or their subcontractors cannot collect any additional amount from the beneficiaries.
The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy

42 CFR 436.110

1. All recipients of OAA, AB, APTD, AABD, this includes all individuals who are essential persons under the State plan and who could be recipients if the State plan were as broad as permitted for Federal financial participation. Also included are groups checked below which are covered under the approved State plan for financial assistance.

The standards for OAA, AB, APTD, AABD and payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

The definitions of blindness in terms of ophthalmic measurement and of permanent and total disability used in this plan are specified in Supplement 2 to ATTACHMENT 2.2-A.
A. Mandatory Coverage - Categorically Needy (Continued)

3. Individuals who would be eligible for OAA, AB, APTD, AABD, except for the increase in OASDI benefits under P.L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving OAA, AB, APTD, in August 1972.

- Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

- Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

- Not applicable with respect to intermediate care facilities; the State did or does not cover this service.
5. Families terminated from AFDC solely because of increased earnings or hours of employment, provided the family received AFDC in at least three months during the six-month period immediately preceding the month in which ineligibility began and provided that one member of the family is employed throughout the period specified in the next sentence. Medicaid is provided for four calendar months beginning with the month AFDC is terminated or, if AFDC is terminated retroactively, with the first month in which AFDC was erroneously paid.
<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(e)(5)</td>
<td>7. A woman who, while pregnant, was eligible and applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance for a 60-day period (beginning on the last day of pregnancy) and for any remaining days in the month in which the 60th day falls.</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Teritory: PUERTO RICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy (Continued)

1902(e)(4) of the Act

8. A child born to a woman who is eligible for and
receiving Medicaid on the date of the child's
birth. The child is deemed eligible for one year
from birth as long as the mother remains eligible
or would have remained eligible if still pregnant
and the child remains in the same household as
the mother.

1902(e)(5)

9. A pregnant woman who would otherwise lose
eligibility during the pregnancy or the
postpartum period because of an increase in
income.

B. Optional Groups Other Than the Medically Needy

42 CFR 436.210

X 1. Individuals described below who meet the income
and resource requirements of OAA, AB, APTD, AABD,
but who do not receive cash assistance.

X The State covers all individuals as
described above.

X The State covers only the following group
or groups of individuals:

1902(a)(10)
(a)(ii) and
1902(a) of
the Act

- Aged
- Blind
- Disabled
- Caretaker relatives
- Pregnant women

42 CFR 436.211

X 2. Individuals who would be eligible for OAA, AB,
APTD, AABD if they were not in a
medical institution.

X The State covers all individuals as
described above.

Transmittal No: 13-006 Effective Date: 01/01/2014
Partial Supersedes: Approval Date: 12/24/2014
Transmittal No: 92-4

TN No. 42-4 Supersedes Effective Date OCT 8 1992
TN No. 42-2 Approval Date JUL 1- 1992
### B. Optional Groups Other than Medically Needy (Continued)

3. Individuals who would be eligible for OAA, AB, APTD, AABD, if coverage under the State's plan for these programs were as broad as permitted under the Act:

- Individuals meeting a broader definition of permanent and total disability.
- Individuals meeting a broader definition of blindness.
- Others, as specified below:

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**Transmittal No:** 13-006  
**Effective Date:** 01/01/2014

**Partial Supersedes:**  
**Approval Date:** 12/24/2014

**Transmittal No:** 92-2
B. Optional Groups Other than Medically Needy (Continued)

4. The State deems as eligible those individuals who become otherwise ineligible for Medicaid while enrolled in an HMO qualified under title XIII of the Public Health Service Act or while enrolled in an entity described in sections 1903(m)(2)(B)(i)(I), (E), or (G) or section 1903(m)(6) of the Act, but who have been enrolled in the HMO or entity for less than the minimum enrollment period listed below. The HMO or entity must have a risk contract as specified in 42 CFR 434.20(a). Coverage under this section is limited to HMO services and family planning services described in section 1905(a)(4)(C) of the Act.

The minimum enrollment period is __________ (not to exceed six months).

The State measures the minimum enrollment period from:

1. The date beginning the period of enrollment in the HMO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

2. The date beginning the period of enrollment in the HMO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.
In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in §1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.

In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in §1634(d)(1)(A) in determining the income of the individual.
**B. Optional Groups Other Than the Medically Needy**

Continued

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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<tbody>
<tr>
<td></td>
<td>42 CFR 435.212 &amp; 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508 (section 4732)</td>
<td>3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.</td>
</tr>
</tbody>
</table>

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The State elects not to guarantee eligibility.

---

The State elects to guarantee eligibility.

The minimum enrollment period is ___ months (not to exceed six).

---

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

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*Agency that determines eligibility for coverage.

___ x ___ Not Applicable

---

**TN #** 03-09  
**Supersedes TN #** 92-10  
**Effective Date** 08/13/03  
**Approval Date** **FEB 24 2000**
B. Optional Groups Other Than Medically Needy (continued)

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCM's in accordance with the regulations at 42 CFR 438.56.

This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

Disenrollment rights are restricted for a period of _____ months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

No restrictions upon disenrollment rights.

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

<table>
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<th>TN #</th>
<th>03-03</th>
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<tr>
<td>Supersedes TN #</td>
<td>92-10</td>
</tr>
<tr>
<td>Effective Date</td>
<td>08/13/03</td>
</tr>
<tr>
<td>Approval Date</td>
<td>FEB 24/2004</td>
</tr>
</tbody>
</table>
B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.217  4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

Not Applicable

*Agency that determines eligibility for coverage.

Revision: HCFA-PM-91-10 (MB)  DECEMBER 1991
Attachment 2.2-A  Page 11

State/Territory: Puerto Rico

Agency*  Citation(s)  Groups Covered

42 CFR 435.217  4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

Not Applicable

*Agency that determines eligibility for coverage.

TN No. 91-10  Approval Date  OCT 14 1991  Effective Date  JUL 1 1992
Supersedes
TN No. 92-2  HCFA ID: 7983E
The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of:
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women
### B. Optional Groups Other Than the Medically Needy (Continued)

<table>
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<th>Agency</th>
<th>Citation(s)</th>
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<tbody>
<tr>
<td>DOH</td>
<td>42 CFR 436.230</td>
<td>X OAA, X AB, X APTD, X AABD</td>
</tr>
</tbody>
</table>

Spouse is living with and determined essential to the well being of the recipient of OAA, AB, APTD, or AABD, and his (her) needs are taken into consideration in determining the amount of financial assistance.
B. Optional Groups Other Than the Medically Needy (Continued)

14. Individuals--
   a. Who are 65 years old or older or are disabled as determined under section 1614 of the Act;
   b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
   c. Whose resources do not exceed the maximum amount allowed under SSI or under the State's medically needy program.

NOT APPLICABLE

Transmittal No: 13-006  Effective Date: 01/01/2014

Partial Supersedes:  Approval Date: 12/24/2014
Transmittal No: 92-4

TN No. 92-4  Approval Date: OCT 8 1982  Effective Date: JUL 1 - 1982

TN No. 92-2
C. Optional Coverage - Medically Needy

42 CFR 436.301 This plan includes the medically needy.

Yes. This plan covers:

1902(a)(10) (C)(ii)(II) of the Act

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the day the pregnancy ends. These women continue to remain eligible, as though they were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of pregnancy) and for any remaining days in the month in which the 60th day falls.

1902(a)(10) (C)(ii)(I) of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(I) of the Act.
C. Optional Coverage - Medically Needy (Continued)

X 5. a. Financially eligible individuals who are not described in section C.3. above and who are under the age of—

- 21
- 20
- 19
- 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

42 CFR 436.308 of the Act.
C. Optional Coverage - Medically Needy (Continued)

b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

   (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

   (a) In foster homes (and are under the age of ____).

   (b) In private institutions (and are under the age of ____).

   (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____).
C. Optional Coverage - Medically Needy (Continued)

- (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ___).

- (3) Individuals in NFs (who are under the age of ___). NF services are provided under this plan.

- (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ___).

- (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

- (6) Other denied groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
</table>
D. Optional Coverage - Qualified Medicare Beneficiaries

Qualified Medicare Beneficiaries--

1. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1816A of the Act);

2. Whose income does not exceed the percent of the Federal poverty level specified in Supplement 1 to ATTACHMENT 2,5-A ; and

3. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare cost-sharing as defined in section 1905(p)(3) of the Act).

Not Applicable
18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of 12 months.

19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid extenditures for an equivalent set of services. See Supplement II to Attachment 2.6-A.
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**Territory:** Puerto Rico

### COVERAGE AND CONDITIONS OF ELIGIBILITY

<table>
<thead>
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<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
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<tr>
<td>1902(e)(12) of the Act</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

20. A child under age ___ (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of ___ months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

---

Transmittal No: 13-006  
Effective Date: 01/01/2014

Partial Supersedes:  
Transmittal No: 98-001  
Approval Date: 12/24/2014
JUL 1 - 1993

Effective Date

JAN 11 1994 · Approval Date

Supersedes

TN No. 93-5

Effective Date JUL 1 - 1993

Not Applicable

Agency* Citation(s) Groups Covered

S. Optional Coverage - Qualified Disabled and Working Individuals

1902(a)(10) (E)(ii) and 1905(p)(4) of the Act

Qualified disabled and working individuals--
1. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;
2. Whose income does not exceed 200 percent of the Federal poverty level; and
3. Whose resources do not exceed twice the maximum standard under SSI.
4. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

(Medical assistance for this group is limited to cost-sharing as defined in section 1905(p)(3)(A)(i) of the Act.)

F. Optional Coverage - Specified Low-Income Medicare Beneficiaries

1902(a)(10)(E)(iii) and 1905(p)(4) of the Act

Specified low-income Medicare beneficiaries--
1. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
2. Whose income for calendar years beginning 1993 exceeds the percent of the Federal poverty level in D. 2., but is less than the percentage of the Federal poverty level specified in Supplement 1 to ATTACHMENT 2.6-A;
3. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to cost-sharing as defined in section 1905(p)(3)(A)(ii) of the Act.)

Not Applicable

TN No. 93-5

Supersedes

TN No. 92-2
C. Optional Coverage of Medically Needy (Continued)

12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of 12 months.

State: PUERTO RICO

Citation(s)

Groups Covered

1906 of the Act

Attachment: 2.2-A

Revision: HCFA-PM-91-8 (BPD)

October 1991

Page 26a

OMB No.: 0938-
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Puerto Rico

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER
THE AGE OF 21, 20, 19, AND 18
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Territory: Puerto Rico

A. DEFINITION OF BLINDNESS IN TERMS OF OPHTHALMIC MEASUREMENT

An individual is considered blind if he has central visual acuity of 20/200 or less in the better eye with correcting glasses or a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance of no greater than 20°.
B. DEFINITION OF PERMANENT AND TOTAL DISABILITY

"Permanently and totally disabled" means that the individual has some permanent physical or mental impediment disease or loss, or combination thereof, that substantially precludes him from engaging in useful occupations within his competence, such as holding a job.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

Not Applicable
**Medicaid Eligibility**

State Name: Puerto Rico

Transmittal Number: PR - 13 - 0006

Indicate which type of poverty level the territory uses:
- ☐ The Federal Poverty Level (FPL)
- ☑ The Local Poverty Level (LPL)

Enter the amount of the Local Poverty Level.

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</table>

Indicate whether the amounts entered above are monthly or yearly.

TN: 13 - 005

Approval Date: 12/24/2014

Effective Date: 01/01/2014
Medicaid Eligibility

Monthly
C Yearly

Wherever FPL is referenced in the other sections of the state plan, it means the Local Poverty Level.

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

The standard is as follows:

G Statewide standard
C Standard varies by region
C Standard varies by living arrangement
C Standard varies in some other way

<table>
<thead>
<tr>
<th>Household size</th>
<th>Standard ($)</th>
<th>Additional incremental amount</th>
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The dollar amounts increase automatically each year

C Yes G No

Increment amount $36
The standard is as follows:
- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

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</table>

Additional incremental amount
- Yes
- No

Increment amount $32

The dollar amounts increase automatically each year
- Yes
- No
Medicaid Eligibility

The dollar amounts increase automatically each year

- Yes  - No

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes  - No
The standard is as follows:
- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year
- Yes  - No
The state’s income standard used for infants under age one (which cannot be less than the highest effective income level for coverage of infants under age one in the state plan as of March 23, 2010) is:

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state’s highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III), (IV), (VI) and (VII), 1902(a)(10)(A)(ii)(IV) and (IX), 1931(b) and (d), and 1920A.

- Minimum income standard

The minimum income standard used for infants under age one is the state’s AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in 1145T Income Standards—Territories.

The state certifies that it has an approved MAGI conversion plan.

- Income standard chosen

The state’s income standard used for infants under age one (which cannot be less than the highest effective income level for coverage of infants under age one in the state plan as of March 23, 2010) is:

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state’s highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (poverty level-related infants), 1902(a)(10)(A)(ii)(IV) (institutionalized children), and 1902(a)(10)(A)(ii)(IX), converted to a MAGI-equivalent.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state’s highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, is used.

- MAGI-based income methodologies are used in calculating household income. Please refer as necessary to Title X MAGI-Based Income Methodologies, completed by the state.

- Children qualifying under this eligibility group must meet the following criteria:

  - Are under age 19
  - Have household income at or below the standard established by the state.

- Children qualifying under this eligibility group must meet the following criteria:

  - Are under age 19
  - Have household income at or below the standard established by the state.

- MAGI-based income methodologies are used in calculating household income. Please refer as necessary to Title X MAGI-Based Income Methodologies, completed by the state.

- The state attests that it operates this eligibility group in accordance with the following provisions:

  - Children qualifying under this eligibility group must meet the following criteria:
    - Are under age 19
    - Have household income at or below the standard established by the state.

- MAGI-based income methodologies are used in calculating household income. Please refer as necessary to Title X MAGI-Based Income Methodologies, completed by the state.

- Infants and Children under Age 19 - Territories

  - Infants and children under age 19 with household income at or below standards established by the state based on age group.

  - The state attests that it operates this eligibility group in accordance with the following provisions:

    - Children qualifying under this eligibility group must meet the following criteria:
      - Are under age 19
      - Have household income at or below the standard established by the state.

    - MAGI-based income methodologies are used in calculating household income. Please refer as necessary to Title X MAGI-Based Income Methodologies, completed by the state.

    - Income standard used for infants under age one
      - Minimum income standard

      The minimum income standard used for infants under age one is the state’s AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in 1145T Income Standards—Territories.

      - The state certifies that it has an approved MAGI conversion plan.
Medicaid Eligibility

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent.

The amount of the income standard for infants under age one is (if not the minimum):

- AFDC Need Standard in Effect As of July 16, 1996. The standard is described in S14T Income Standards-Territories.
- AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14T Income Standards-Territories.
- MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14T Income Standards-Territories.
- TANF payment standard. The standard is described in S14T Income Standards-Territories.
- MAGI-equivalent TANF payment standard. The standard is described in S14T Income Standards-Territories.
- Another income standard not already specified in S14T Income Standards-Territories.
- A percentage of the poverty level: 133%
- A dollar amount by family size

Income standard for children age one through age five, inclusive

Minimum income standard

The minimum income standard used for children age one through five is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14T Income Standards-Territories.

Income standard chosen

The state's income standard used for children age one through five (which cannot be less than the highest effective income level for coverage of children age one through five in the state plan as of March 23, 2010) is:
I

*if* higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the minimum income standard.


If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(f)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent.

Another income standard higher than the minimum standard allowed, provided it is higher than the highest effective income level for this age group under the state plan as of March 23, 2010.

The amount of the income standard for children age one through five is (if not the minimum):

- AFDC Payment Standard in Effect As of July 16, 1996. The standard is described in SI4T Income Standards-Territories.


- AFDC Need Standard in Effect As of July 16, 1996. The standard is described in SI4T Income Standards-Territories.

- AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in SI4T Income Standards-Territories.

- MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in SI4T Income Standards-Territories.

- TANF payment standard. The standard is described in SI4T Income Standards-Territories.

- MAGI-equivalent TANF payment standard. The standard is described in SI4T Income Standards-Territories.

Another income standard not already specified in SI4T Income Standards-Territories.

- A percentage of the poverty level: 133%

- A dollar amount by family size

TN: 13-006
Approval Date: 12/24/2014
Effective Date: 01/01/2014

PUERTO RICO
S30T
Medicaid Eligibility

- **Income standard for children age six through age eighteen, inclusive**
  - Minimum income standard
    - The minimum income standard used for children age six through eighteen is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14T Income Standards-Territories.
  - Income standard chosen
    - The state's income standard used for children age six through eighteen (which cannot be less than the highest effective income level for coverage of children age six through eighteen in the state plan as of March 23, 2010) is:
      - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the minimum income standard.
      - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent.
      - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent.
      - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent.
      - Another income standard higher than the minimum standard allowed, provided it is higher than the highest effective income level for this age group under the state plan as of March 23, 2010.

The amount of the income standard for children age six through eighteen is (if not the minimum):
  - AFDC Need Standard in Effect As of July 16, 1996. The standard is described in S14T Income Standards-Territories.
  - AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14T Income Standards-Territories.
  - MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14T Income Standards-Territories.
  - TANF payment standard. The standard is described in S14T Income Standards-Territories.
Medicaid Eligibility

- MAGI-equivalent TANF payment standard. The standard is described in S14T Income Standards-Territories.
- Another income standard not already specified in S14T Income Standards-Territories.
- A percentage of the poverty level: 133%
- A dollar amount by family size
- There is no resource test for this eligibility group.
- Presumptive Eligibility
  The state covers children when determined presumptively eligible by a qualified entity.

No
The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard. The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in 814 AFDC Income Standards. MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state. Income standard used for this group

Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in 814 AFDC Income Standards.

The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

Parents and Other Caretaker Relatives - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☐ The state attests that it operates this eligibility group in accordance with the following provisions:

☐ Individuals qualifying under this eligibility group must meet the following criteria:

☐ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☐ Options relating to the definition of caretaker relative (select any that apply):

☐ Options relating to the definition of dependent child (select the one that applies):

The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

☐ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

☐ Have household income at or below the standard established by the state.

☐ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☐ Income standard used for this group

☐ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in 814 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.
The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

The state's maximum income standard for this eligibility group is:

☐ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

☐ A percentage of the federal poverty level: [133] %

☐ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

☐ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

☐ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

☐ Other dollar amount

Income standard chosen:

Indicate the state's income standard used for this eligibility group:

☐ The minimum income standard

☐ The maximum income standard

☐ Another income standard in-between the minimum and maximum standards allowed

☐ There is no resource test for this eligibility group.

Puerto Rico

Approval Date: 12/24/2014  Effective Date: 01/01/2014
Medicaid Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes ☐ No ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☑ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

☑ Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan S25 - Parents and Other Caretaker Relatives.

☑ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☑ Income standard used for this group

☑ Minimum income standard

The state certifies that it has an approved MAGI conversion plan.

☑ The state certifies that it has an approved MAGI conversion plan.

☑ Income standard chosen

Indicate the state's income standard used for this eligibility group:

Medicaid Eligibility


- The state's highest effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent.
- The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent.
- Another income standard higher than the minimum standard allowed.

The amount of the income standard for this eligibility group is (if not the minimum):

- AFDC Need Standard in Effect As of July 16, 1996. The standard is described in S14T Income Standards-Territories.
- AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14T Income Standards-Territories.
- MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14T Income Standards-Territories.
- TANF payment standard. The standard is described in S14T Income Standards-Territories.
- MAGI-equivalent TANF payment standard. The standard is described in S14T Income Standards-Territories.
- Another income standard not already specified in S14T Income Standards-Territories.
- A percentage of the poverty level: 133%
- A dollar amount by family size

- There is no resource test for this eligibility group.
- Benefits for individuals in this eligibility group consist of the following:
  - All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
  - Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.
Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

No
Medicaid Eligibility

State Name: Puerto Rico
Transmittal Number: PR - 13 - 0006

42 CFR 435.150
1902(a)(10)(A)(i)(IX)

Former Foster Care Children - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

☐ The state attests that it operates this eligibility group under the following provisions:

☐ Individuals qualifying under this eligibility group must meet the following criteria:

☐ Are under age 26.

☐ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

☐ Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

☐ The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

☐ Yes ☐ No

☐ Yes ☐ No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

TN: 13-006
Approval Date: 12/24/2014
Effective Date: 01/01/2014

PUERTO RICO
Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

TN: 14-002-MM1
Puerto Rico

Approval Date: 05/30/2014
Effective Date: 01/01/2014

The state covers the Adult Group as described at 42 CFR 435.119.

☐ Yes ☐ No

□ Adult Group - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

□ Individuals qualifying under this eligibility group must meet the following criteria:

☐ Have attained age 19 but not age 65.

☐ Are not pregnant.

☐ Are not entitled to or enrolled for Part A or B Medicare benefits.

☐ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

☐ Have household income at or below 133% FPL.

☐ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to §10 MAGI-Based Income Methodologies, completed by the state.

☐ There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

☐ Under age 19, or

☐ A higher age of children, if any, covered under § 42 CFR 435.222 on March 23, 2010:

☐ Under age 20

☐ Under age 21

☐ Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

☐ Yes ☐ No
PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
The reasonable classification of children covered is:

- Income standard used for this classification.

- Minimum income standard

The income standard for this classification of children must exceed the lowest income standard chosen for children in the age group selected above, under the mandatory Infants and Children under Age 19 eligibility group.

- Maximum income standard

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

- Yes  ☐ No

The state attests that it operates this eligibility group in accordance with the following provisions:

- Individuals qualifying under this eligibility group must not be eligible for Medicaid under any mandatory eligibility group.

- MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-based Income Methodologies, completed by the state.

The state covered this eligibility group in the state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

☐ Yes  ☐ No

The state also covered this eligibility group in the state plan as of March 23, 2010.

☐ Yes  ☐ No

Until October 1, 2019, states must include at least those individuals covered as of March 23, 2010, but may cover additional individuals. Effective October 1, 2019, states may reduce or eliminate coverage for this group.

- Individuals are covered under this eligibility group, as follows:

  ☐ All children under age 18 or 19 are covered:

  ☐ Under age 19

  ☐ Under age 18

  ☐ The reasonable classification of children covered is:

  ☐ Income standard used for this classification.

  ☐ Minimum income standard

  The income standard for this classification of children must exceed the lowest income standard chosen for children in the age group selected above, under the mandatory Infants and Children under Age 19 eligibility group.

  ☐ Maximum income standard
The state certifies that it has submitted and received approval for its converted income standard(s) for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

- The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- 200% FPL.
- A percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

266% FPL

Income standard chosen, which must exceed the minimum income standard

Individuals qualify under the following income standard:

- The maximum income standard.

- The state's effective income level for this eligibility group under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

TN: 13-006
PUERTO RICO

Approval Date: 12/24/2014
Effective Date: 01/01/2014
254
Medicaid Eligibility

If higher than the effective income level used under the state plan as of March 23, 2010, a percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this eligibility group in the state plan as of March 23, 2010.

The income standard used for this eligibility group is: 266% FPL

- There is no resource test for this eligibility group.
- Presumptive Eligibility

Presumptive eligibility for this group depends upon the selection of presumptive eligibility for the Infants and Children under Age 19 eligibility group. If presumptive eligibility is done for that group, it is done for this group under the same provisions.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1830.
### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR Part 436, Subpart G</td>
<td>1. Is financially eligible to receive services.</td>
</tr>
<tr>
<td>42 CFR Part 436, Subpart F</td>
<td>2. Meets the applicable non-financial eligibility conditions.</td>
</tr>
<tr>
<td>1902(m) of the Act</td>
<td>(iii) For aged and disabled individuals with incomes up to the Federal poverty level covered under Section 1902(a)(10)(A)(11)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.</td>
</tr>
</tbody>
</table>

**Transmittal No:** 13-006  **Effective Date:** 01/01/2014

**Partial Supersedes:** 92-2  **Approval Date:** 12/24/2014
ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1905(p) of the Act</td>
<td>b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 436.</td>
</tr>
<tr>
<td>1905(s) of the Act</td>
<td>c. For qualified Medicare beneficiaries, meets the non-financial criteria of section 1905(p) of the Act.</td>
</tr>
<tr>
<td>1902(A)(10)(E)(iii) of the Act</td>
<td>d. For qualified disabled and working individuals, meets the non-financial criteria of section 1905(s).</td>
</tr>
<tr>
<td>1905(s) of the Act</td>
<td>e. For specified low-income Medicare beneficiaries, meets the non-financial criteria of section 1905(p) of the Act.</td>
</tr>
</tbody>
</table>

Not Applicable
### Citation Condition or Requirement

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 436.402</td>
<td>3. Is residing in the United States and --</td>
</tr>
<tr>
<td>Sec. 245A of the Immigration and Nationality Act</td>
<td>a. Is a citizen;</td>
</tr>
<tr>
<td>Sec. 245A(h)(3)(B) of the Immigration and Nationality Act</td>
<td>b. Is an alien lawfully admitted for permanent residence, or otherwise permanently residing in the United States under color of law, as defined in 42 CFR 435.408;</td>
</tr>
<tr>
<td>Sec. 245A(h)(3)(B) of the Immigration and Nationality Act</td>
<td>c. Is an alien granted lawful temporary resident status under sections 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of Public Law 96–422;</td>
</tr>
<tr>
<td>Sec. 245A(h)(3)(B) of the Immigration and Nationality Act</td>
<td>d. Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of c. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted eligibility); or</td>
</tr>
<tr>
<td>Sec. 245A(h)(3)(B) of the Immigration and Nationality Act</td>
<td>e. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services).</td>
</tr>
</tbody>
</table>
| P.L. 99-603 (Section 201) | f. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 433.1004</td>
<td>5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 15 residents, or certain child care institutions.</td>
</tr>
<tr>
<td>42 CFR 433.1004</td>
<td>b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program.</td>
</tr>
<tr>
<td>42 CFR 433.145 1912 of the Act</td>
<td>6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)</td>
</tr>
</tbody>
</table>
An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

Assignment of rights is automatic because of State law.

§36.901
42 CFR 36.901
7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1906 of the Act</td>
<td>10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).</td>
</tr>
</tbody>
</table>

**State/Territory:** Puerto Rico

**HCFA ID:** 7985E
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 436.403</td>
<td>4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address. State has interstate residency agreement with the following States: State has open agreement(s). Not applicable; no residency requirement.</td>
</tr>
</tbody>
</table>
| 42 CFR 436.1004 1905(a) | 5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.  
b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan. |
### Citation | Condition or Requirement
--- | ---
42 CFR 433.145 and 436.604 1912 of the Act | 6. Is required, as a condition of eligibility, to assign rights to medical support and to payment for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met.

Assignment of rights is automatic because of State law.

42 CFR 436.901 | 7. Is required, as a condition of eligibility, to and 435.910 furnish his/her social security account number (or numbers, if he/she has more than one number).
B. Post-Eligibility Treatment of Institutionalized Individuals

42 CFR 436.832

Required deductions.

The following amounts are deducted from gross income when computing the application of an individual's or couple's income to the cost of institutional care:

1. Personal Needs Allowance. $60 · Couple
   $50 · Individual

2. For maintenance of the non-institutionalized spouse only. $32.00

3. For non-institutionalized children, each family member. $32.00

4. Amounts for incurred medical expenses not subject to payment by a third party.
   a. Health insurance premiums, deductibles and coinsurance charges.
   b. Necessary medical or remedial care not covered under the Medicaid plan. (Reasonable limits on amounts are described in Supplement 2 to ATTACHMENT 2.6-A).

5. An amount for maintenance of a single individual's home for not longer than 6 months, if a physician has certified he or she is likely to return home within that period.

   Yes. Amount for maintenance of home $________
   No.

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Supersedes Approval Date: MAY 1, 1982
Effective Date: JAN 1, 1992

HCFA ID: 7984E
C. Financial Eligibility - Categorically and Medically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

1. Categorically Needy Income Levels

a. For categorically needy groups other than those specified in items C.1.b. and c. below, the financial eligibility income levels for the related cash assistance programs are applied.

b. Supplement 1 to ATTACHMENT 2.6 specifies the income eligibility levels for the following groups of individuals with incomes related to the Federal income poverty line:

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1) of the Act</td>
<td>6. Benefits paid under AB, APTD, or AABD to blind or disabled individuals during the initial 2 months in which the individuals receive care in a hospital, SNF, or ICF if the individuals are allowed to retain the benefits under agreement with the facility; or during a temporary stay in a hospital, SNF, or ICF, if it is determined that the individuals' stay is not likely to exceed 3 months and they must continue to maintain a home to which they may return upon leaving the institution.</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>1902(m) of the Act</td>
<td>(ii) Optional categorically needy groups of aged and disabled individuals covered under the provisions of section 1902(a)(10)(A)(ii)(X) of the Act; and</td>
</tr>
<tr>
<td>1902(a) of the Act</td>
<td>(iii) Optional groups of qualified Medicare beneficiaries under the provisions of section 1902(a)(A)(E)(1) of the Act.</td>
</tr>
<tr>
<td>1905(p)(4) of the Act</td>
<td>(iv) Optional groups of specified low-income Medicare beneficiaries under the provisions of section 1902(a)(10)(E)(iii) of the Act.</td>
</tr>
<tr>
<td>1905(p)(4) of the Act</td>
<td>c. For optional groups of qualified disabled and working individuals, the financial eligibility income levels specified in section 1905(a) of the Act are applied.</td>
</tr>
</tbody>
</table>

Transmittal No: 13-006  Effective Date: 01/01/2014
Partial Supersedes:  Approval Date: 12/24/2014

Revised: HCFA-PM-93-5  (MB)  MAY 1993
Territory: Puerto Rico
Page 8

Attachment 2.6-A
The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 5 to ATTACHMENT 2.6-A.

2. In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents under the children become 21.
The methods of the appropriate cash assistance program only; or

(2) The methods of the appropriate cash assistance program and/or more liberal methods described in Supplement 5 to ATTACHMENT 2.6-A.
The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day person after her pregnancy ends and any remaining days in the month in which the 60th day falls.

NOT APPLICABLE

Transmittal No: 13-006  Effective Date: 01/01/2014
Partial Supersedes: Approval Date: 12/24/2014
Transmittal No: 92-4
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(u) of the Act</td>
<td><strong>(h) COBRA Continuation Beneficiaries</strong></td>
</tr>
<tr>
<td></td>
<td>In determining countable income for COBRA continuation beneficiaries, the following disregard are applied:</td>
</tr>
<tr>
<td></td>
<td><strong>The disregards of the SSI program;</strong></td>
</tr>
<tr>
<td></td>
<td><strong>The agency uses methodologies for treatment of income more restrictive than the SSI program.</strong></td>
</tr>
<tr>
<td></td>
<td>These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.</td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).</td>
</tr>
</tbody>
</table>

**NOT APPLICABLE**
1902(e)(6) of the Act

f. In determining the income of pregnant women, the agency disregards all increases in income throughout the pregnancy and the postpartum period.

NOT APPLICABLE

Transmittal No: 13-006  Effective Date: 01/01/2014
Partial Supersedes:
Transmittal No: 92-4  Approval Date: 12/24/2014
### Condition or Requirement

<table>
<thead>
<tr>
<th>Citation</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1905(p)(1)(C) and (D) and 1902(r)(2) of the Act | g. For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the agency uses the following methods for treatment of income and resources:—
- The methods used under the SSI program.
- The methods used under SSI program and/or more liberal methods described in Supplements 5 and 6 of ATTACHMENT 2.6-A. |
| 1905(s) of the Act | h. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses the methods under the SSI program for treatment of income and resources. |
| 1902(a)(10)(E)(iii) of the Act | i. For specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, the agency uses the same methods as in g. for QMBs. |

*Not Applicable*
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1903(f)(2) of the Act</td>
<td>(3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.</td>
</tr>
</tbody>
</table>

NOT APPLICABLE
3. Medicaid Qualifying Trusts.

In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.

The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 4 to ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1903(f)(2) of the Act</td>
<td>(6) Spenddown payments made to the State by the individual.</td>
</tr>
</tbody>
</table>

**NOTE:** FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

**NOT APPLICABLE**
4. Medically Needy Income Levels

a. Medically needy income levels (MNILs) are based on family size.

b. The MNIL does not diminish by family size.

c. The MNIL at least equals the amount of the highest income standards used on or after January 1, 1966, to determine eligibility under the cash assistance programs related to the States covered medically needy groups or groups of individuals.

Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups.

5. Handling of Excess Income - Spend-down for Medically Needy

a. Income in excess of the MNIL is considered available for payment of medical care and services. The Medicaid agency measures available income for a period of one month(s) (not to exceed six months) to determine the amount of excess countable income applicable to the cost of medical care and services.
b. If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

   (i) Health insurance premiums, deductibles and co-insurance charges.

   (ii) Expenses for necessary medical and remedial care not included in the plan.

   (iii) Expenses for necessary medical and remedial care included in the plan.

   Reasonable limits on amounts of expenses deducted from income under (b)(i) and (ii) above are listed below.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(17) of the Act</td>
<td>Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.</td>
</tr>
</tbody>
</table>

- The agency elects not to deduct incurred expenses that are paid by a third party that is a program funded by a State or local government under its section 1902(f) option.

6. Resource Standard - Categorically Needy

   a. Except as specified in item 6.b. below, the resource standards are the same as those in the related cash assistance program.
7. Resource Standard - Medically Needy

a. The resource standard does not diminish by family size.

b. Resource standard equal to the highest resource standard used in the cash assistance programs related to the covered medically needy groups.

Transmission No: 13-006
Reference Standard - Medically Needy

a. The resource standard does not diminish by family size.

b. Resource standard equal to the highest resource standard used in the cash assistance programs related to the covered medically needy groups.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1905(p)(1), (c) and (d) and</td>
<td>5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources:</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1905(s) of the Act</td>
<td>1. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.</td>
</tr>
<tr>
<td>1902(u) of the Act</td>
<td>j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources:</td>
</tr>
<tr>
<td></td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

NOT APPLICABLE
QUALIFIED MEDICARE
BENEFICIARIES ARE NOT COVERED.
6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

<table>
<thead>
<tr>
<th>Condition or Requirement</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same as SSI resource standards</td>
<td></td>
</tr>
<tr>
<td>More restrictive</td>
<td></td>
</tr>
</tbody>
</table>

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1905(p)(1)(B) and (p)(2)(B) and 1902(a)(10)(E)(iii) of the Act</td>
<td>8. Resource Standard - Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries For qualified Medicare beneficiaries and specified low-income Medicare beneficiaries covered under sections 1902(a)(10)(E)(i) and 1902(a)(10)(E)(iii) of the Act, the resource standard is twice the SSI resource standard.</td>
</tr>
<tr>
<td>1905(s) of the Act</td>
<td>9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard is twice the SSI resource standard.</td>
</tr>
</tbody>
</table>

Not Applicable
For COBRA continuation beneficiaries, the resource standard is:

 Twice the SSI resource standard for an individual.

 More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

NOT APPLICABLE
Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

- Aged, blind, disabled.

- AFDC-related.

Citation | Condition or Requirement
---|---
10. Excess Resources - Categorically Needy and Medically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

Any excess resources make the individual ineligible.

11. Effective Date of Eligibility - Categorically Needy and Medically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

a. Groups other than qualified Medicare beneficiaries

(i) For the prospective period--

Coverage is available for the full month if the following individuals are eligible at any time during the month.

- Aged, blind, disabled.

- AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

- Aged, blind, disabled.

- AFDC-related.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

 Territory: PUERTO RICO

FINANCIAL ELIGIBILITY

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>

(ii) For the retroactive period—

Coverage is available for three months before the date of application if the following individuals are eligible.

- Aged, blind, disabled.
- AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

- X Aged, blind, disabled.
- X AFDC-related.

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Partial Supersedes: Approval Date: 12/24/2014
Transmittal No: 92-4   Approval Date: OCT 8  1992   Effective Date: JUL 1 - 1992
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(e)(8) and 1905(a) of the Act</td>
<td>b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act, coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The determination is valid for--</td>
</tr>
<tr>
<td>12 months</td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td></td>
</tr>
<tr>
<td>__ months (no less than 6 months and no more than 12 months).</td>
<td></td>
</tr>
</tbody>
</table>

Not Applicable
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Territory: Puerto Rico

INCOME ELIGIBILITY LEVELS

A. CATEGORICALLY NEEDY

Payment Standards for O A A, AB APTD And AFDC

<table>
<thead>
<tr>
<th>FAMILY SIZE</th>
<th>PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$32.</td>
</tr>
<tr>
<td>2</td>
<td>64.</td>
</tr>
<tr>
<td>3</td>
<td>96.</td>
</tr>
<tr>
<td>4</td>
<td>128.</td>
</tr>
<tr>
<td>5</td>
<td>160.</td>
</tr>
<tr>
<td>7 to 12 add. on $32.</td>
<td>192</td>
</tr>
<tr>
<td>13 add on $24</td>
<td></td>
</tr>
</tbody>
</table>

Approval Date: MAY 1 1992  
Effective Date: JAN 1 - 1992
3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows:

Based on ___ percent of the official Federal income poverty level:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$__________</td>
</tr>
<tr>
<td>2</td>
<td>$__________</td>
</tr>
<tr>
<td>3</td>
<td>$__________</td>
</tr>
<tr>
<td>4</td>
<td>$__________</td>
</tr>
<tr>
<td>5</td>
<td>$__________</td>
</tr>
</tbody>
</table>

Not Applicable
The levels for determining income eligibility for specified low-income Medicare beneficiaries under the provisions of sections 1905(p)(2)(A) and 1905(p)(4) of the Act are based on ___ percent of the official Federal poverty level.

D. OPTIONAL GROUP OF SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES

The levels for determining income eligibility for specified low-income Medicare beneficiaries under the provisions of sections 1905(p)(2)(A) and 1905(p)(4) of the Act are based on ___ percent of the official Federal poverty level.
### INCOME LEVELS - MEDICALLY NEEDED

<table>
<thead>
<tr>
<th>Family Size</th>
<th>(2) Net income level protected for Maintenance</th>
<th>(3) Net income level for persons living in rural areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$4,800.00</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>$5,940.00</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>$7,080.00</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>$8,220.00</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$9,360.00</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>$10,500.00</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>$11,640.00</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>$12,780.00</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>$13,920.00</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>$15,060.00</td>
<td></td>
</tr>
<tr>
<td>For each additional person, add: 1,140.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**JUL 1-1992**

**Effective Date**

**HCFA ID:** 0004P/0102A
PAYMENT STANDARDS FOR OAA, AB, APTD and AFDC

<table>
<thead>
<tr>
<th>FAMILY SIZE</th>
<th>PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$32</td>
</tr>
<tr>
<td>2</td>
<td>64</td>
</tr>
<tr>
<td>3</td>
<td>96</td>
</tr>
<tr>
<td>4</td>
<td>128</td>
</tr>
<tr>
<td>5</td>
<td>160</td>
</tr>
<tr>
<td>6</td>
<td>192</td>
</tr>
<tr>
<td>7 to 12</td>
<td>Add on $32.00</td>
</tr>
<tr>
<td>13 and up</td>
<td>Add on $24</td>
</tr>
</tbody>
</table>

NOTE: Adult and children categories have the same payment standards.
OFFICIAL

Revision: HCFA-PM-87-4 (BERC)SUPPLEMENT 2 TO ATTACHMENT 2.6-AMARCH 1987

Territory: Puerto Rico

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Territory: PUERTO RICO

5. Aged and Disabled Individuals and Qualified Medicare Beneficiaries
   - Same as resource levels under sections 1612 and 1613 of the Act.
   - Same as medically needy resource levels (applicable only if State has a medically needy program).

NOT APPLICABLE

Transmittal No: 13-006  Effective Date: 01/01/2014
Partial Supersedes: Approval Date: 12/24/2014
Transmittal No: 92-4

TN No. 92-4
Approval Date OCT 8 1992 Effective Date JUL 1-1992
B. MEDICALLY NEEDY

X Applicable to all groups, regardless of family size.

For each eligible family unit, $2,500 will be considered as the sole resource level.
CONSIDERATION OF MEDICAID QUALIFYING TRUSTS--UNDUE HARDSHIP

1902(k) of the Act, P.L. 99-272 (Section 9506)

The following criteria will be used to determine whether the agency will not count the funds in a trust as specified in ATTACHMENT 2.6-A, section C.3., because it would work an undue hardship for categorically and medically needy individuals:

Undue Hardship is not a consideration.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Territory: Puerto Rico

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

Not Applicable

TIN No. 22-2
Superseded
New

Approval Date May 1, 1992
Effective Date Jan 1, 1993

HCFA ID: 7984E
MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902(r)(2) OF THE ACT

Not Applicable
### LESS RESTRICTIVE METHODS OF TREATING INCOME UNDER SECTION 1902 (r)(2) OF THE ACT

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 436.320</td>
<td>For the Medically Needy Aged, Blind, and Disabled, Puerto Rico will disregard countable earned and unearned income equal to the difference between the medically needy income level standard for the appropriate family size*, and the income limits described in the chart displayed below.</td>
</tr>
<tr>
<td>42 CFR 436.321</td>
<td></td>
</tr>
<tr>
<td>42 CFR 436.322</td>
<td></td>
</tr>
<tr>
<td>42 CFR 436.320</td>
<td>For the Medically Needy Aged, Blind, and Disabled, the amount by which an individual’s Medicare Part B premium is reduced through enrollment in a Medicare Advantage Plan is disregarded from income.</td>
</tr>
<tr>
<td>42 CFR 436.321</td>
<td></td>
</tr>
<tr>
<td>42 CFR 436.322</td>
<td></td>
</tr>
</tbody>
</table>

*As defined in Supplement 1 to Attachment 2.6-A, Page 6

<table>
<thead>
<tr>
<th>Household size</th>
<th>Monthly Income Limit **</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$800</td>
</tr>
<tr>
<td>2</td>
<td>$1,000</td>
</tr>
<tr>
<td>3</td>
<td>$1,200</td>
</tr>
<tr>
<td>4</td>
<td>$1,400</td>
</tr>
<tr>
<td>5</td>
<td>$1,600</td>
</tr>
<tr>
<td>6</td>
<td>$1,800</td>
</tr>
<tr>
<td>7</td>
<td>$2,000</td>
</tr>
<tr>
<td>8</td>
<td>$2,200</td>
</tr>
<tr>
<td>Each Additional</td>
<td>Additional $200</td>
</tr>
</tbody>
</table>

** Net income limits.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: COMMONWEALTH OF PUERTO RICO

LESS RESTRICTIVE METHODS OF TREATING RESOURCES UNDER SECTION 1902 (r)(2) OF THE ACT

<table>
<thead>
<tr>
<th>Citation (s)</th>
<th>Provision (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(r)(2) of the Act</td>
<td>For medically needy aged, blind and disabled individuals Puerto Rico will disregard the difference between $10,000 and the medically needy resource standard.</td>
</tr>
</tbody>
</table>

Supersedes TN No. 07-011

Approved Date: MAR 05 2006
Effective Date: OCT 01 2007
Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

- The methodology as described in SMM section 3598.
- Another cost-effective methodology as described below.

1902(u) of the Act
The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size
- Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.
The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

☐ Age 19

☐ Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
ATTACHMENT 1 TO MAGI FORM S10

SUPERSEDED PAGES OF STATE PLAN MATERIAL

Transmittal Number:

PR-17-0001

State:

Puerto Rico

NEW

Notwithstanding any other provisions of the Puerto Rico Medicaid State Plan, the financial eligibility methodologies described in State Plan Amendment (SPA) PR-17-0001 will apply to all MAGI-Based Eligibility Groups covered under Puerto Rico’s Medicaid State Plan.

The MAGI financial methodologies set forth in 42 CFR § 435.603 apply to everyone, except those individuals described at 42 CFR § 435.603(j) for whom MAGI-Based Methods do not apply.

This State Plan Amendment supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-Based Eligibility Groups.
ATTACHMENT 2 TO MAGI FORM S10

MAGI-BASED INCOME METHODOLOGIES

Transmittal Number: PR-17-0001

State: Puerto Rico

Household Composition
• In determining Household Composition, the following provisions are not applicable: 42 CFR §435.603(f)(1), (f)(2), (f)(4), and (f)(5).
• Household Composition for all individuals is defined in accordance with 42 CFR §435.603(f)(3). It means that the Household Composition is established using the "Rules for individuals who neither file a tax return nor are claimed as a tax dependent."

Household Income
• In determining Household Income, the following provisions are not applicable: 42 CFR §435.603(d)(2), (d)(3), and (d)(4).
• Household Income for all individuals is defined in accordance with 42 CFR §435.603(d)(1) and (e). It means that the Household Income is established using the "Household income—(1) General rule" and "MAGI-based income."

Household Income Disregard
• Puerto Rico has elected in the S14T Income Standards - Territories state plan page to use the Local Poverty Level (LPL), which is the Puerto Rico Poverty Level (PRPL), instead of the Federal Poverty Level (FPL). As noted on the S14T, "Wherever FPL is referenced in the other sections of the State Plan; it means the Local Poverty Level."
• In determining the Medicaid eligibility of an individual using MAGI-Based Income, the Medicaid Program deducts from household income an amount equivalent to 5 percentage points of the PRPL for the applicable family size, consistent with 42 CFR §435.603(d)(4). The deduction is only to determine the eligibility of an individual for medical assistance under the MAGI-Based Eligibility Group with the highest income standard in the applicable Title of the Social Security Act, but not to determine eligibility for a particular eligibility group.

Household Income - Current Monthly Income
• The "Current monthly income" generally means the month of application.

Household Income - Cash Support
• The election on S10 page 1, to consider actually available cash support exceeding nominal amounts for individuals described in 42 CFR §435.603(f)(2)(i), is not applicable.
• Income received from absent parents, relatives, or non-relatives from inside or outside of Puerto Rico is not counted towards an individual's T-MAGI income calculation. Since household composition under T-MAGI is based on the non-filer rules, the only income...
that may be counted is the income from other family members in the household constructed using the non-filer rules. This includes the individual, spouse if living with the individual, children under age 19, in accordance with 42 CFR §435.603(f)(3).

**Household Income - Child's Income**

- **Living with One or Both Parent**
  
  A child's income will not count toward the household MAGI if:
  
  i. The child is in the household with one or both parent and
  
  ii. The child's income does not meet the IRS tax filing thresholds (i.e., when counting earned and/or unearned income) adjusted for the Puerto Rico standard of living.

  See Supplement 1 to Attachment 2 - “Child Income Threshold Test” - to determine if the child's income will count.

- **Living with Other Caretaker Relative or Unrelated Adult**

  If a child is not living with one or both parent, child’s income counts as a regular member for any household in which the child is a member, including the household in which the child is the member being evaluated.

  [As an example, a child who is living with a grandmother (caretaker relative) and siblings.]
SUPPLEMENT 1 TO ATTACHMENT 2
MAGI FORM S10: MAGI-BASED INCOME METHODOLOGIES

“CHILD INCOME THRESHOLD TEST”

When a child lives with at least one parent, determine whether the Child’s MAGI Income counts for households in which it is included by performing the following steps.

If, after step 6 the Child Income is marked as “Countable” then his/her income is to be included in the household income.

Use test values from Child Income Tax Threshold table for the appropriate year. For any calendar year use the prior Tax Year, e.g. – when evaluating a case in 2017, use lookup values from Tax Year 2016 in table.

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Calculate Unearned Income (U)</td>
<td>Add: Taxable Interest (1,2) Ordinary dividends Capital gains distributions Unemployment compensation Taxable social security benefits (3) Pensions Annuities Distribution of unearned income from a trust</td>
</tr>
<tr>
<td>2</td>
<td>Calculate Earned Income (E)</td>
<td>Add: Salaries/Wages/ Tips Professional fees Net self-employment income Taxable scholarship and fellowship grants</td>
</tr>
<tr>
<td>3</td>
<td>Calculate Gross Income (G)</td>
<td>U + E</td>
</tr>
<tr>
<td>4</td>
<td>Determine (T) as the larger amount between</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>UIL</td>
</tr>
<tr>
<td></td>
<td>E (to max of GL) + GI</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Test</td>
<td>U &gt; UIL</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>E &gt; EIL</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>G &gt; T</td>
</tr>
<tr>
<td>6</td>
<td>Determine -</td>
<td></td>
</tr>
<tr>
<td>IF step 5 is TRUE</td>
<td>Child Income is COUNTABLE</td>
<td></td>
</tr>
<tr>
<td>OTHERWISE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IF step 5 is FALSE</td>
<td>Child Income is NOT COUNTABLE</td>
<td></td>
</tr>
</tbody>
</table>
As an example:

- For any calendar year Puerto Rico will use the prior Tax Year, e.g. — when evaluating a case in 2017, use lookup values from Tax Year 2016 in table of the IRS Publication 501, (For 2017, see https://www.irs.gov/pub/irs-pdf/p505.pdf).

- For calendar year 2017, Puerto Rico will use the values as published for the IRS Publication 501 for Tax Year 2016.

- For a household of 1 member the monthly PRPL is $459 as established in the MAGI Form S14T that it is part of the SPA PR-13-0006, which was approved by CMS on December 24, 2014. The annual PRPL is $5,508 since July 1st 2017.

- For a household of 1 member, the monthly FPL for 2017 is $1,005 as published in the Federal Register on Tuesday, January 31, 2017, (82 Federal Register pages 8831-8832). The annual Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia is $12,060 for 2017, (12,060 / 12 = 1,005).

- The annual PRPL to FPL conversion ratio for 2017 and for each year so on is calculated as follows:
  - Calendar Year 2017:  
    PRPL = $5,508  
    FPL = $12,060  
    Ratio = 5,508 / 12,060 = 46% (applies to Tax Year 2016)

- The monthly PRPL represents a 46% of the FPL (459 / 1,005 = 0.456).

- The IRS Publication 501 for Tax Year 2016, Table 2 - 2016 Filing Requirements for Dependents on page 4, provides values for the formula as follows:
  - UIL (Unearned Income Limit) = $1,050  
  - EIL (Earned Income Limit) = $6,300  
  - GI (Gross earned income Increment) = $350  
  - GL (Gross earned income Limit) = $5,950.

- Applying the 46% to convert to the Puerto Rico levels results in:
  - UIL (Unearned Income Limit) = $483  
  - EIL (Earned Income Limit) = $2,898  
  - GI (Gross earned income Increment) = $161  
  - GL (Gross earned income Limit) = $2,737.

| Currently known values (as of April 2017) |
|-----------------------------|--------|--------|--------|--------|
| Value                        | 2016   | 2017   | 2018   | 2019   |
| Unearned Income Limit (UIL)  | $483.00|        |        |        |
| Earned Income Limit (EIL)    | $2,898.00|       |        |        |
| Gross earned income Increment (GI) | $161.00|       |        |        |
| Gross earned income Limit (GL)| $2,737.00|      |        |        |
NOTES

1. Report all taxable interest.
   - Taxable interest should be as delivered to taxpayer on Forms 1099-INT, Forms 1099-OID, or substitute statements.
   - Include interest from U.S. savings bonds series EE, H, HH, and I.


3. Effectively zero for children in income ranges eligible for Medicaid & CHIP.

Child Income Tax Threshold Table

<table>
<thead>
<tr>
<th>Value</th>
<th>Tax Year</th>
<th></th>
<th></th>
<th>Year n</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
<td>Year 2</td>
<td>...</td>
<td>9,999</td>
</tr>
<tr>
<td>Unearned Income Limit (UIL)</td>
<td>9,999</td>
<td>9,999</td>
<td></td>
<td>9,999</td>
</tr>
<tr>
<td>Earned Income Limit (EIL)</td>
<td>9,999</td>
<td>9,999</td>
<td></td>
<td>9,999</td>
</tr>
<tr>
<td>Gross earned income Increment (GI)</td>
<td>9,999</td>
<td>9,999</td>
<td></td>
<td>9,999</td>
</tr>
<tr>
<td>Gross earned income Limit (GL)</td>
<td>9,999</td>
<td>9,999</td>
<td></td>
<td>9,999</td>
</tr>
</tbody>
</table>

During any calendar year, the prior Tax Year's threshold values will be used as the most recently available.

The process for determining whether to count a child's income as described on the preceding page is based on IRS rules as found in Publication 501.

The values to be used in the IRS formula will be adjusted for the Puerto Rico standard of living based on the ratio of the Puerto Rico Poverty Level (PRPL) to the Federal Poverty Level (FPL).

This ratio will be calculated each calendar year based on the values for PRPL and FPL for that year and applied to the preceding tax year.

At the start of any calendar year, if the up to-date values are not yet known, the most recent table available will be used.
The Centers for Medicare & Medicaid Services (CMS) has determined that the authority granted in this letter is necessary to protect beneficiaries as the state completes the analysis necessary to move to a MAGI-based eligibility system. Accordingly, the authority is granted only to the extent to which Puerto Rico requires additional time to evaluate its MAGI income standards and is contingent upon regular updates from the state on the status of its data analysis and income conversion development.

In your request, you explained that Puerto Rico will implement MAGI systematically in the MEDITI system and operationally through local eligibility offices. For a period of 6 months after MAGI implementation “go-live”, Puerto Rico is approved to enroll in medical assistance, for a period of 12 months, new applicants and beneficiaries undergoing renewals who are found to have income above current MAGI income standards, but who would have been eligible under prior standards and methodologies while Puerto Rico conducts additional evaluation of the accuracy of the conversion of those prior standards to equivalent MAGI standards (the MAGI conversion). This temporary enrollment will protect beneficiaries from adverse effects should Puerto Rico determine that the SIPP-based MAGI conversion did not accurately maintain equivalent eligibility standards in the aggregate in Puerto Rico.

Dear Commissioner Padilla:

This letter is in response to Puerto Rico’s request, dated June 25, 2014, to assist the Territory as it implements the Medicaid and Children’s Health Insurance Program (CHIP) changes resulting from the Affordable Care Act. Under the authority of section 1902(e)(14) of the Social Security Act, we are approving your request to temporarily enroll individuals who do not meet current MAGI income standards, but who would have been eligible under prior standards and methodologies while Puerto Rico conducts additional evaluation of the accuracy of the conversion of those prior standards to equivalent MAGI standards (the MAGI conversion). This temporary enrollment will protect beneficiaries from adverse effects should Puerto Rico determine that the SIPP-based MAGI conversion did not accurately maintain equivalent eligibility standards in the aggregate.

In your request, you explained that Puerto Rico will implement MAGI systematically in the MEDITI system and operationally through local eligibility offices. For a period of 6 months after MAGI implementation “go-live”, Puerto Rico is approved to enroll in medical assistance, for a period of 12 months, new applicants and beneficiaries undergoing renewals who are found to have income above current MAGI income standards, but who would have been found to be eligible under the standards and methodologies in effect as of December 31, 2013. During the 6 month period described above, Puerto Rico will monitor the movement and potential movement of Medicaid recipients between Medicaid, CHIP and the Puerto Rico funded Commonwealth program. It will use the results of this evaluation to determine whether adjustment of the MAGI income standard is warranted through the submission of a SPA. We understand that this SPA could take the form of either a change in the MAGI income standard or a change to the local poverty level. We understand that Puerto Rico’s objective, taking into account its recent expansion, is to maintain Medicaid eligibility enrollment in the aggregate.

The Centers for Medicare & Medicaid Services (CMS) has determined that the authority granted in this letter is necessary to protect beneficiaries as the state completes the analysis necessary to move to a MAGI-based eligibility system. Accordingly, the authority is granted only to the extent to which Puerto Rico requires additional time to evaluate its MAGI income standards and is contingent upon regular updates from the state on the status of its data analysis and income conversion development.
Page 2 — Ricardo Padilla

The authority provided in this letter is subject to CMS receiving your written acknowledgement of this approval and acceptance of these new authorities within 30 days of the date of this letter.

If you have questions regarding this award, please contact Stephanie Kaminsky, Senior Policy Advisor, Children and Adults Health Programs Group, Centers for Medicaid & CHIP Services, at (410) 786-4653. We look forward to our continuing work together to achieve successful implementation of the Affordable Care Act.

Sincerely,

Cindy Mann
Director

cc: Michael Melendez, Associate Regional Administrator, Region II
Transfer of Resources

For transfer of resources made on or after July 1, 1988 the State is in compliance with provisions of 1917c of the Act as amended by the provisions of the Medicare Catastrophic Coverage Act of 1988, the Family Support Act of 1988 and the Omnibus Reconciliation Act of 1989.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDED

1. Inpatient hospital services other than those provided in an institution for mental diseases.
   - X Provided
   - X With limitations*

2.a. Outpatient hospital services.
   - X Provided
   - X With limitations*

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
   - X Provided
   - X With limitations*

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
   - X Provided
   - X With limitations*

2.d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Services Act to a pregnant woman or individual under 18 years of age.
   - X Provided
   - X With limitations*

3. Other laboratory and x-ray services.
   - X Provided
   - X With limitations*

*Description provided on attachment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Agency  Puerto Rico

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or order.

Provided       No Limitations    With limitations*
X Not Provided

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

X Provided      X No Limitations    ___ With limitations*

4.c. Family planning services and supplies for individuals of child-bearing age.

X Provided      ___ No Limitations    X With limitations*

4.d. 1) Face-to-Face Tobacco Cessation Counseling Services provided:

X (i) By or under supervision of a physician;

X (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (none are designated at this time)

2) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women

Provided: X No limitations    With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below. Please describe any limitations:

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

X Provided      ___ No Limitations    X With limitations*

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(8)(B) of the Act).

X Provided      ___ No Limitations    X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

X Podiatrists' services       ___ No Limitations    X With limitations*

*Description provided on attachment.

TN No. 13-004 Approval Date    JAN 28 2014    Effective Date
Supersedes
TN No. 03-001A

OCT 01 2013
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services
   ☑ Provided  □ No limitation  ☑ With limitations*  □ Not Provided

c. Chiropractors' services
   ☑ Provided  □ No limitation  ☑ With limitations*  □ Not Provided

d. Other practitioners' services
   ☑ Provided  □ No limitation  ☑ With limitations*  □ Not Provided

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.
   □ Provided  □ No limitation  □ With limitations*
   ☑ Not Provided under the PRHIA Health Reform Plan

b. Home health aide services provided by a home health agency.
   □ Provided  □ No limitation  □ With limitations*
   ☑ Not Provided under the PRHIA Health Reform Plan

c. Medical supplies, equipment, and appliances suitable for use in the home.
   □ Provided  □ No limitation  □ With limitations*
   ☑ Not Provided under the PRHIA Health Reform Plan

* Description provided on Attachment.

Transmittal No.: 14-008  Effective Date: July 1, 2014
Supersedes TN No.: 03-001-A  Approval Date: 1/1/41
d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

- Provided  - No limitations  - With limitations*
- X Not Provided under the PRHIA Health Reform Plan

8. Private duty nursing services.

- Provided  - No limitations  - With limitations*
- X Not Provided

*Description provided on attachment.
AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.
   _X_ Provided       _X_ No limitations       _X_ With limitations*

10. Dental services.
    _X_ Provided       _X_ No limitations       _X_ With limitations*

11. Physical therapy and related services.
    a. Physical therapy
       _X_ Provided       _X_ No limitations       _X_ With limitations*

    b. Occupational therapy
       _X_ Provided       _X_ No limitations       _X_ With limitations*

    c. Services for individuals with speech, hearing, and language disorders (provided
       by or under the supervision of a speech pathologist or audiologist)
       _X_ Provided       _X_ No limitations       _X_ With limitations*

*Description provided on attachment.
12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs
   ☑ Provided  ☐ No limitation  ☑ With limitations*  ☐ Not Provided

b. Dentures
   ☐ Provided  ☐ No limitation  ☐ With limitations*  ☑ Not Provided

c. Prosthetic devices
   ☑ Provided  ☐ No limitation  ☑ With limitations*  ☐ Not Provided

d. Eyeglasses
   ☑ Provided  ☐ No limitation  ☑ With limitations*  ☐ Not Provided
   (Provided based on EPSDT Guide)

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services
   ☑ Provided  ☐ No limitation  ☑ With limitations*  ☐ Not Provided

*Description provided on attachment.
b. Screening services

- Provided  No limitations  With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

- Provided  No limitations  With limitations*

(Based on medical necessity-Law 408)

b. Skilled nursing facility services

- Provided  No limitations  With limitations*

- Not Provided

c. Intermediate care facility services

- Provided  No limitations  With limitations*

- Not Provided

*Description provided on attachment.

______X______D03-02-1A______MAR 05 2004______AUG 13 2003
STATE/TERRITORY: PUERTO RICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☐ Provided   ☐ No limitation   ☐ With limitations*   ☒ Not Provided

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☐ Provided   ☐ No limitation   ☐ With limitations*   ☒ Not Provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided   ☒ No limitation   ☐ With limitations*   ☒ Not Provided

(Based on Medical Necessity under Law 408)

17. Nurse-midwife services

☐ Provided   ☐ No limitation   ☐ With limitations*   ☒ Not Provided

18. Hospice care (In accordance with section 1905(o) of the Act).

☐ Provided   ☐ No limitation   ☒ Not Provided

☒ Provided

In accordance with section 2302 of the Affordable Care Act

*Description provided on attachment.

TN No.: 14-003   Approval Date: JUL 10 2014   Effective Date: April 1, 2014
Supersedes: 03-001-A
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services
   a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

   X Provided  X With limitations*
   ___ Not Provided

   b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

   X Provided  X With limitations*
   ___ Not Provided

20. Extended services for pregnant women
   a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day fall.

   X Provided
   ___ Additional coverage ++

   b. Services for any medical conditions that may complicate pregnancy.

   X Provided
   ___ Additional coverage ++

   ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment. Post partum and pregnancy-related services after the pregnancy ends are covered beyond the 60th day if medically needed.

Services for any other medical conditions that may complicate pregnancy are provided without limitations.
State/Territory: Puerto Rico

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

______Provided  ____No limitations  _____With limitations*

____X____ Not Provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

______Provided  ____No limitations  _____With limitations*

____X____ Not Provided

23. Pediatric or family nurse practitioners' services.

____X____ Provided  ____No limitations  _____X___ With limitations*

(According to our Health Plan coverage and state licensing laws - general nurse practitioners)

*Description provided on attachment.
State/Territory: Puerto Rico

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation
   - Provided
   - No limitations
   - With limitations*

b. Services of Christian Science nurses
   - Provided
   - No limitations
   - With limitations*
   - Not Provided

c. Care and services provided in Christian Science sanitoria
   - Provided
   - No limitations
   - With limitations*
   - Not Provided

d. Nursing facility services for patients under 21 years of age.
   - Provided
   - No limitations
   - With limitations*
   - Not Provided

e. Emergency hospital services
   - Provided
   - No limitations
   - With limitations*

f. Personal care services in recipient’s home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse
   - Provided
   - No limitations
   - With limitations*
   - Not Provided

*Description provided on attachment.

TN No. 03-001
Supersedes 92-2

Superseded Approval Date 03-001 MAR 05 2004
Effective Date AUG 13 2003
State/Territory: Puerto Rico

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ Provided    _____ No limitations    _____ With limitations*

_____ X Not Provided

*Description provided on attachment.
### Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Categorically Needy

12.a. Prescribed Drugs: Description of Service Limitation

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935(d)(1)</td>
<td>Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.</td>
</tr>
<tr>
<td>1927(d)(2) and 1935(d)(2)</td>
<td>The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare prescription Drug Benefit—Part D.</td>
</tr>
</tbody>
</table>

- **The following excluded drugs are covered:**
  - "All" drug categories covered under the drug class
  - "Some" drug categories covered under the drug class
  - List the covered common drug categories not individual drug products directly under the appropriate drug class
  - "None" of the drugs under this drug class are covered

- (a) agents when used for anorexia, weight loss, weight gain are excluded as a general rule. **Puerto Rico provides coverage of medically-necessary mental health drugs when used in the treatment of anorexia according to the medical psychiatric practice accepted norms as required for the diagnosis, prevention, and treatment of the mental health disease.**

- (b) agents when used to promote fertility

- (c) agents when used for cosmetic purposes or hair growth

- (d) agents when used for the symptomatic relief of cough and colds
12.a. Prescribed Drugs: Description of Service Limitation

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e)</td>
<td>prescription vitamins and mineral products are excluded as a general rule, except prenatal vitamins and fluoride. Puerto Rico also covers some vitamins and mineral products when there are prescribed, medically necessary, and used in the treatment of cancer, renal disease, or HIV/AIDS.</td>
</tr>
<tr>
<td>(f) Nonprescription drugs or over-the-counter (OTC) drugs are excluded as a general rule. Puerto Rico covers some OTC drugs (Non Sedating Antihistamines, Antihistamine, Respiratory Agent, Antiplatelet, and Topical Antimycotic products) when they are prescribed and medically necessary according to the medical practice accepted norms as required for the diagnosis, prevention, and treatment of the disease.</td>
<td></td>
</tr>
<tr>
<td>(g)</td>
<td>Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)</td>
</tr>
<tr>
<td>(h)</td>
<td>Barbiturates for non-dually eligible. Puerto Rico does not provide coverage for dual eligible individuals with Medicare Part D, because of effective January 1, 2013. Part D covers these drugs when used in the treatment of epilepsy, cancer, or a chronic mental health disorder; except when these drugs are prescribed for a condition other than the three covered by Part D and during Part D donut hole period if it is medically necessary.</td>
</tr>
<tr>
<td>(i)</td>
<td>Benzodiazepines for non-dually eligible. Puerto Rico does not provide coverage for dual eligible individuals with Medicare Part D, because of effective January 1, 2013. Part D covers all indications for these drugs; except for dually eligible without Part D and during Part D donut hole period if it is medically necessary.</td>
</tr>
<tr>
<td>(j)</td>
<td>Smoking cessation drugs are excluded except for individuals under age 21 and for pregnant women when medically necessary and prescribed by a physician. In these cases the plan covers prescription and non-prescription aids as indicated by a physician and without cost-sharing.</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Agency: Puerto Rico

Coverage Template for Freestanding Birth Center Services

Attachment 3.1A: Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided:  No limitations  With limitations  X  None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided:  No limitations  With limitations  (please describe below)

X  Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

a. Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

b. Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.50 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

c. Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

d. *For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

JAN 28 2014  

Attachment 3.1A  
Page 11
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Description of Limitations

General Limitations

The following General Limitations and Exclusions apply to all services not just inpatient or outpatient services:

a. Services rendered while the beneficiary is not covered.
b. Services which result from illnesses or injuries not covered.
c. Services resulting from automobile accidents which are covered by the Automobile Accident Compensation Fund (ACAA).
d. Workman's compensation accidents covered by the "Fondo del Seguro del Estado".
e. Services covered by any other insurer or party that has the primary responsibility (other party liability).
f. Special nurses services for the convenience of the patient when it is not medically necessary.
g. Hospitalization for services which can be rendered in an ambulatory setting.
h. Admission of patients to hospitals for diagnostic purposes only.
i. Expenses for services and/or materials for the comfort of the patient, such as telephone, television, admission kit, etc.
j. Services rendered by second generation family members of patient (parents, offspring, siblings, grandparents, grandchildren, spouse, etc.).
k. Organ and tissue transplants, except as provided in Attachment 3.1-E.
l. Laboratories for which processing is not available in Puerto Rico and that have to be sent outside of Puerto Rico for processing.
m. Treatments with the purpose of controlling weight (obesity or weight increase) solely for esthetic purposes.
n. Sports Medicine, musical therapy, and natural medicine.
o. Tuboplasties, vasovasectomies and any other procedures or services for the purpose of returning the ability to procreate, are excluded:

Transmittal No.: 14-008   Effective Date: July 1, 2014
Supersedes TN No.: 03-001-A   Approval Date: 8/19/14
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Description of Limitations

p. Cosmetic surgery and treatment, solely to correct defects in the physical appearance, excluding also hospitalization, medical-surgical services and complications associated with this procedure, regardless of their medical justification.

q. Services, diagnostics tests and/or treatments ordered and/or provided by naturopaths, naturists, and iridologists.

r. Mammaplasty or plastic reconstruction of the breast solely for cosmetic purposes.

s. Ambulatory setting use of fetal monitor.

t. Services, treatment or hospitalizations which arise from an induced abortion (not therapeutic). The following are considered induced abortions:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>59840</td>
<td>Induced abortion, by dilation and curettage</td>
</tr>
<tr>
<td>59841</td>
<td>Induced abortion, by dilation and expulsion</td>
</tr>
<tr>
<td>59850</td>
<td>Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines);</td>
</tr>
<tr>
<td>59851</td>
<td>Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines); with dilation and curettage and/or evacuation.</td>
</tr>
<tr>
<td>59852</td>
<td>Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines); with hysterectomy (failed intra-amniotic injection).</td>
</tr>
</tbody>
</table>

Transmittal No.: 14-008  Effective Date: July 1, 2014

Supersedes TN No.: 03-001-A  Approval Date: 11/1/14
59855 Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and seculdines.

59856 Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with dilation and curettage and/or evacuation.

59857 Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with hysterectomy (omitted medical expulsion).

u. The Revetron drug
v. Services for epidural anesthesia.
w. Somnography studies.
x. Services which are not reasonable nor required according to the accepted standards of medical practice or services provided in excess of those normally required for the prevention, diagnosis, and treatment of a disease, injury or dysfunction of the organic system or pregnancy condition.
y. Hemodialysis and/or peritoneal dialysis services are excluded from the Basic Coverage; but included in the Special Coverage.
z. New and/or experimental procedures which have not been approved by the PRHIA for their inclusion as benefits in the basic and special coverage of the program.
aa. Custodial, rest or convalescence services, in cases where the acute medical condition requiring in-patient care is under control or in irreversible terminal cases.
bb. Expenses incurred in payments made by beneficiaries to participating providers that according to the terms of the program, the beneficiary was not supposed to pay.
cc. Services ordered and/or rendered by non-participating providers, except in cases of emergencies/immediate need or previously authorized by the HCOs or MCO.
dd. Neurological and cardiovascular surgery and related services are excluded from the Basic Coverage, but included in the Special Coverage.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: PUERTO RICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Description of Limitations

ee. Services received outside of the territorial limits of the Commonwealth of Puerto Rico, except for emergency services received in the United States.

ff. Expenses incurred for the treatment of conditions, resulting from procedures or benefits not covered under this Program. Maintenance prescriptions and required laboratories for the continuity of a stable health condition, as well as any emergencies which could result after the referred procedures, are covered.

gg. Travel expenses, even when ordered by the primary care physician or participating provider are excluded.

hh. Eyeglasses, lenses, and hearing aids are excluded, except for beneficiaries under age 21 when it is medically necessary and approved through a prior authorization process.

ii. Acupuncture services are excluded.

jj. Rent or purchase of wheelchair or any other vehicle (motor and/or electric) or expenses for the repair or alteration of these vehicles.

kk. Procedures with the purpose of changing the sex of the beneficiary.

ll. Treatment services for infertility and/or related to conception by artificial means.

1. Inpatient hospital services other than those provided in an institution for mental diseases

Inpatient services are provided within coverage under Health Reform Plan with limitations:

Limitations on inpatient services:

- **Bed in Semiprivate Room**: Coverage will be available twenty four (24) hours per day, every day of the year.
- **Isolation Room**: For medical reasons.
- **Specialized Diagnostic / Treatment**: Electrocardiograms, electroencephalograms, arterial gases, and other specialized diagnostic and/or treatment testing that are available in the hospital facilities and which are required to be performed while the patient is hospitalized.

TN No.: Approval Date: 02/16/2016  Effective Date: January 1, 2016

Supersedes: 03-001-A
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Description of Limitations

Limitations to inpatient services:

- **Short Term Rehabilitation Services**: To hospitalized patients, including physical, occupational, and speech therapy.
- **Blood**: Blood, plasma and their derivatives without limitations, to include irradiated and autologous blood; Monoclonal Factor IX per authorization of an certified hematologist; Anti-hemophilic Factor with intermediate purity concentration (Factor VIII); Anti-hemophilic Monoclonal Type Factor per authorization of a certified hematologist and Protrombin Activated Complex (Autoflex and Feiba) per authorization of a certified hematologist.

2a. Outpatient services are provided within coverage under Health Reform Plan.

2b. Rural health clinic and ambulatory services provided are those categorized benefits under the Basic and Special Coverage of Health Reform Plan.

2c. Federally Qualified services and other ambulatory services are those categorized benefits under the Basic and Special Coverage of Health Reform Plan.

Supersedes TN No. 84-3

Approval Date: MAR 05 2000
Effective Date: AUG 13 2003

TN No. 03-001A
3. Other laboratory and X-ray services.
   Diagnostic blood tests and X-rays are covered, but the following special procedures and
   diagnostic tests are provided subject to benefits included under the plan's special
   coverage and medical necessity criteria:
   a. Computerized tomography.
   b. Magnetic Resonance Tests Imaging
   c. Cardiac catheterization
   d. Holter Tests
   e. Doppler Tests
   f. Stress Tests
   g. Lithotripsy
   h. Electromyography
   i. Single Photon Emission Computerized – Tomography Test (SPECT)
   j. Ocular Plethysmography (OPG)
   k. Impedance Plethysmography
   l. Other invasive and non-invasive cardiovascular, cerebrovascular, and neurosurgical
   procedures
   m. Nuclear Medicine tests
   n. Endoscopies for diagnostic purposes
   o. Genetic Studies.

4.c. Family Planning Services: The coverage benefits of the Puerto Rico Medicaid and CHIP
   Programs provide the following Family Planning Services: (i) education and counseling,
   (ii) pregnancy testing, (iii) infertility assessment, (iv) sterilization services in accordance
   with 42 CFR 441.200 subpart F, (v) laboratory services, (vi) at least one of every class and
   category of FDA (Food and Drug Administration) approved contraceptive medication, (vii)
   cost and insertion/removal of non-oral products, such as long acting reversible
   contraceptives (LARC), and (viii) other FDA approved contraceptive medications or
   methods when it is medically necessary and approved through a prior authorization or
   exception process.

5.a. Physician services in the patient’s home are provided based on medical necessity.

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Transmittal No.: 15-001
Effective Date: April 1, 2015
Supersedes TN No.: 03-001-A
Approval Date: SEP 09 2015
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

5b. Medical and surgical services provided by dentist are limited to the coverage services description on item (10).

6a. Podiatrist services are provided as remedial and incidental care rendered for attending special conditions under the Health Reform Plan's special coverage.

6b. Optometrist services are limited to vision evaluations and exams.

6c. Chiropractic services as determined medically necessary. Initial 15 sessions available without prior authorization. Additional 15 sessions require prior authorization. The treatment limit is combined with the limit for physical therapy. An individual may receive a total of 30 physical therapy and/or chiropractic sessions combined. Additional session beyond 30 is allowed with medical necessity and requires a prior authorization process.

6d. Most types of practitioners are included, except for: alternative and sport medicine practitioners, iridologist, naturopaths, and cosmetic plastic surgeons.

7. Home Health Services
No FFP is claimed for Home Health Services.
9. Clinic services are provided according to and within the State Plan coverage and complaint with 42 CFR 440.90, including preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients: (a) services furnished at the clinic by or under the direction of a physician or dentist and (b) services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. These clinics include Department of Health Clinics, Prevent Clinics, Urgent Care Clinics, and Physician operated clinics.

10. Dental Services

a. Dental Services for Children Under 21 Years of Age
   • All preventive and corrective dental services are covered for children under age 21 (0-20) as indicated under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requirement.
   • Orthodontic services to EPSDT eligible children as medically necessary to prevent and restore oral structures to health and function are covered. Orthodontic services for cosmetic purposes are not covered.
   • Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21) and stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy.
   • Anesthesia services (subject to prior authorization) for a child with physical or mental handicaps in compliance with federal and local laws. Those special conditions include, but not limited to, the followings: (a) autism, (b) severe retardation, (c) severe neurologic impairment, (d) significant attention deficit disorders with hyperactivity, (e) significant or severe mental disorders, (f) disable or unable to follow commands, and (g) any other condition that at the dentist professional judgment, impaired the required patient cooperation and feasibility to adequately perform the dental procedure.
   • All limitations may be exceeded based on medical necessity and approved through a prior authorization or exception process.
10. Dental Services

b. Dental Services for Members Age 21 and Over When It is Medically Necessary
   - Preventive dental services
   - Restorative dental services
   - One (1) comprehensive oral examination per year
   - One (1) Periodic oral examination every six (6) months
   - One (1) defined problem-limited oral exam
   - One (1) full series of intra-oral radiographies, including bitewings, every three (3) years
   - One (1) initial periapical intra-oral radiography
   - Up to five (5) additional periapical/intra-oral radiographies per year
   - One (1) single film-bitewing radiography per year
   - One (1) two-film bitewings radiography per year
   - One (1) panoramic radiography every three (3) years
   - One (1) cleanse every six (6) months
   - One (1) Prophylaxis, every six (6) months
   - Amalgam restoration
   - Resin restorations
   - Root canal
   - Palliative treatment
   - Oral surgery
   - Anesthesia services (subject to prior authorization) for beneficiaries with physical or mental handicaps in compliance with local law
   - All limitations may be exceeded based on medical necessity and approved through a prior authorization or exception process.
Prescribed drugs
a. The PRHIA maintains a drug Formulary as the official formulary of drugs provided by the Health Reform Plan coverage, which contains most of the vast majority of therapeutic alternative categories available.
b. A preferred drug list (PDL) is also maintained as a cost-effective utilization tool in rendering prescription benefits under the Health Reform Plan.
c. The MCOs, MBHOs, and Direct Providers, that are contracted, agree to conduct the pharmacy billing and claims through the PRHIA's contracted Pharmacy Benefits Manager (PBM).
d. Under exceptional circumstances, a drug not included in the Formulary could be covered only through exceptional circumstances and procedure set forth below.
Limitations and Conditions of the Prescription Services

a. Contraceptives drugs are covered under the Health Reform Plan for the treatment of menstrual dysfunction and for birth control purposes, as follows:
   (i) At least one of every class and category of FDA (Food and Drug Administration) approved contraceptive medication,
   (ii) At least one of every class and category of FDA approved contraceptive method, and
   (iii) Other FDA approved contraceptive medications or methods when it is medically necessary and approved through a prior authorization or exception process.

b. Drugs required for the ambulatory or hospitalized treatment of diagnosed beneficiaries with AIDS or with an HIV positive factor are covered under the special coverage to include only antiretrovirals but excluding Protease inhibitors. The Protease inhibitors are not covered benefits financed under the Health Reform Plan, they are provided to Medicaid beneficiaries through coordination with the Regional Immunological Clinics of the Commonwealth Health Department's PASET Division.

c. Immunosuppressant drugs for all transplant patients are covered only to the extent of maintenance treatment post-surgery to ensure the continuity of health stability of the beneficiary, as well as emergencies that may result after surgery (as transplants are not covered).

d. New drugs for future inclusion are evaluated through an active process for revising on a continuous basis and evaluate the future inclusion of new medicines or the removal of medicines from the formulary. Considering the dynamic nature of this process, the PRHIA requires the inclusion or exclusion of medicines as changes and advances affect the standard practice for the treatment of conditions or developments of standard practices for the treatment of a condition or particular treatments.
AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Description of Limitations

e. No MCO, HCO, MBHO or providers can establish a different formulary from the one included in this addendum nor limit in any way the drugs and medications included in the formulary.
f. In the event a beneficiary needs a drug or medicine that is not included in the formulary, the MCO, MBHO and providers will follow the usual pre-authorization procedure, to obtain drugs not included in the formulary. The provider shall have to obtain the MCO’s prior approval considering and documenting the particular merits of each case, which could include among others the following criteria:
   1. A contraindication of drug that appears in the formulary.
   2. Adverse reaction history to the drug that appears in the formulary.
   3. Therapeutic failure to all available alternatives in the formulary.
g. For acute conditions, the amount of medication to be dispensed shall be limited to the needed therapy, but never for more than fifteen (15) days. When medically necessary, additional prescriptions are covered.
h. For chronic conditions (maintenance), the amount of the medication to be dispensed will be limited to a maximum of thirty (30) days. By prescribing physician recommendation, each prescription may be repeated up to six (6) times. When medically necessary, additional prescriptions are covered.
i. The indications on prescriptions issued for treatment of children with Special Health Care Needs will indicate clearly the (30) day coverage therapy and that it can be repeated up to six (6) times. When medically necessary additional prescriptions will be covered.
j. The use of bioequivalent medications and drugs approved by the FDA and local regulations is authorized, unless contraindicated for the beneficiary by the physician or dentist who prescribed the medication.
k. The absence of bioequivalent medications in stock does not exonerate the Pharmacist from dispensing the medication nor does it entail the payment of additional surcharges by beneficiaries. Brand name drugs will be dispensed if the bioequivalent is not available at the pharmacy.
l. All prescriptions shall be filled and dispensed at a participating pharmacy properly licensed under the laws of Puerto Rico freely chosen by the beneficiary.
m. All prescriptions shall be dispensed contemporaneously with the date and hour that the beneficiary receives the prescription and requests that it be dispensed.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: PUERTO RICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12c. Prosthetic devices

Those including all of the extremities of the body, the ocular therapeutic prosthesis and the segmentary instrumentation system trays for scoliosis surgery and fusion.

12d. Eyeglasses

Eyeglasses or lenses are covered for Medicaid beneficiaries under age 21 when those are medically necessary. Eyeglasses or lenses benefit consist of a single or multi-focal lenses and one standard frame every 24 months. All type of lenses needs to be preauthorized, except for intraocular lenses. The repair or replacement of eyeglasses within the 24-months term is covered when it is medically necessary and approved through a prior authorization process.

13a. Diagnostic Services

General clinical laboratories, x-rays, radiotherapy, pathology, pulmonary function and electroencephalograms if necessary for treatment and convalescent care are not subject to pre-authorizations by the PCP or HCO. For the special coverage diagnostic services described in item 3 above they are subject to necessity criteria and pre-authorization.

13b. Screening Services

Gynecological and Prostate Cancer screening according to accepted medical practice, including Papanicolaou test, mammographies, and P.S.A. as may be medically necessary and according to the age of the beneficiary. Accordingly to Puerto Rico’s Health Policies the age of forty (40) years have been established as the initial date to commence cancer screening by mammography.

Sigmoidoscopy for adults ages 50 and over with risk of colon cancer according to accepted medical practice.

TN No.: _ Approval Date: 02/16/2016 Effective Date: January 1, 2016
Supersedes: 03-001-A
Counseling in physical health, oral health, and nutrition will be provided in accordance with the preventive service benefit to address the individual needs of the beneficiaries based on their health conditions.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Description of Limitation

13d. Rehabilitative services
The rehabilitative services provided are ambulatory. Except for physical therapy, all rehabilitative services such as: respiratory, occupational, and speech therapies services are unlimited.
Physical therapy and/or chiropractic services (chiropractic manipulation sessions) as determined medically necessary. Initial 15 sessions available without prior authorization. Additional 15 sessions require prior authorization. The treatment limit is combined for chiropractic care and physical therapy. An individual may receive a total of 30 physical therapy and/or chiropractic sessions combined. Additional session beyond 30 is allowed with medical necessity and requires a prior authorization process.

19. Ambulatory treatment, hospitalization and other TB related services and case management are covered under the Special Coverage.

20. The extended services for pregnant women besides covering all pre-natal, delivery and post-partum care services, include all medical and obstetrical nursing services during the delivery, be it natural childbirth, cesarean section, or any other complication; hospitalization beyond minimum stay terms in case of maternity, high risk or secondary conditions to the pregnancy by medical recommendation.
The minimum stay term for hospitalization for both mother and newborn will not be limited to less than 48 hours for normal vaginal delivery without complications and in the case of childbirth following cesarean section, the stay may not be limited to less than 96 hours for both mother and child.

24.a. Transportation
Limited to ambulance services in emergency cases, ground, maritime, and aerial ambulance services are covered within the territorial limits of Puerto Rico. No pre-authorization or pre-certification will be required in order to access these services. In general, the service shall be accessed either by beneficiary calling 911 or calling the local ambulance provider contracted and as instructed by the HCO and the MCO in the area.
For non emergency transportation the Commonwealth follows the methods described in attachment 3.1-D of this plan.

Transmittal No.: 14-008  Effective Date: July 1, 2014
Supersedes TN No.: 03-001-A  Approval Date: 12/17/14
A. Target Group:

B. Areas of State in which services will be provided:
   - Entire State.
   - Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services:
   - Services are provided in accordance with section 1902(a)(10)(B) of the Act.
   - Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

E. Qualification of Providers:
F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

C. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
The following ambulatory services are provided.

"The Services provided to the medically needy are the same as those provided to the categorically needy".

*Description provided on attachment.*

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Supersedes</th>
<th>Approval Date</th>
<th>Effective Date</th>
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<tr>
<td>87-1</td>
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<td>MAY 26 1986</td>
<td>JAN. 1 1987</td>
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<td>82-8</td>
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</table>

HCFA ID: 0140P/0102A
OFFICIAL

State/Territory: __ Puerto Rico __

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ________________________________

1. Inpatient hospital services other than those provided in an institution for mental diseases.
   __ X Provided __ No limitations __ X With limitations *

2.a. Outpatient hospital services.
   __ X Provided __ No limitations __ X With limitations *

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
   __ X Provided __ No limitations __ X With limitations *

2.c. Federally qualified health center (FQHC) services and other ambulatory services furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
   __ X Provided __ No limitations __ X With limitations *

2.d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Services Act to a pregnant woman or individual under 18 years of age.
   __ X Provided: __ No limitations __ X With limitations *

3. Other laboratory and x-ray services.
   __ X Provided __ No limitations __ X With limitations *

*Description provided on attachment.

TN No. 03-001A
Supersedes 92-2
Approval Date MAR 0 5 2001 Effective Date AUG 1 3 2003
AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUPS

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided	No Limitations	With limitations*
X No Provided

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

Provided	No Limitations	With limitations*
X No Provided

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided	No Limitations	With limitations*
X No Provided

4.d. 1) Face-to-Face Tobacco Cessation Counseling Services provided:

X (i) By or under supervision of a physician;

X (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (none are designated at this time)

2) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women

Provided: X No limitations With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.

Please describe any limitations:

5.a. Physicians’ services whether furnished in the office, the patient’s home, a hospital, a nursing facility or elsewhere.

Provided	No Limitations	With limitations*
X No Provided

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided	No Limitations	With limitations*
X No Provided

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists’ services

Provided	No Limitations	With limitations*
X No Provided

*Description provided on attachment.

TN No. 13-004	Approval Date	JAN 28 2014	Effective Date	OCT 01 2013
Supersedes
TN No. 03-001A

Attachment 3.1.B
Page 2
7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

[ ] Provided  [ ] No limitation  [x] With limitations*

[ ] Not Provided under the PRHIA Health Reform Plan

b. Home health aide services provided by a home health agency.

[ ] Provided  [ ] No limitation  [ ] With limitations*

[ ] Not Provided under the PRHIA Health Reform Plan

c. Medical supplies, equipment, and appliances suitable for use in the home.

[ ] Provided  [ ] No limitation  [ ] With limitations*

[ ] Not Provided under the PRHIA Health Reform Plan

* Description provided on Attachment.
State/Territory: Puerto Rico

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): __________________________

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided    No limitations    With limitations*
X Not Provided under Health Reform Plan by PRHIA

8. Private duty nursing services.

Provided    No limitations    With limitations*
X Not Provided under Health Reform Plan by PRHIA

*Description provided on attachment.

TN No. 03-0DA Supersedes 03-0DA Approval Date MAR 05 2004 Effective Date AUG 13 2003
9. Clinic services.
   _X_ Provided  _No limitations_  _X_ With limitations*

10. Dental services.
    _X_ Provided  _No limitations_  _X_ With limitations*

11. Physical therapy and related services.
    a. Physical therapy
       _X_ Provided  _No limitations_  _X_ With limitations*
    
    b. Occupational therapy
       _X_ Provided  _X_ No limitations  _X_ With limitations*

    c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist)
       _X_ Provided  _X_ No limitations  _X_ With limitations*

*Description provided on attachment.
STATE/TERRITORY: PUERTO RICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices: and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
   a. Prescribed drugs
      ☑ Provided  ☐ No limitation  ☑ With limitations*  ☐ Not Provided
   b. Dentures
      ☐ Provided  ☐ No limitation  ☐ With limitations*  ☑ Not Provided
   c. Prosthetic devices
      ☑ Provided  ☐ No limitation  ☑ With limitations*  ☐ Not Provided
   d. Eyeglasses
      ☑ Provided  ☐ No limitation  ☑ With limitations*  ☐ Not Provided
      (Provided based on EPSDT Guide)

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.
   a. Diagnostic services
      ☑ Provided  ☐ No limitation  ☑ With limitations*  ☐ Not Provided

*Description provided on attachment.

TN No.: __________  Approval Date: __________  Effective Date: January 1, 2016
Supersedes: 03-001-A
State/Territory: Puerto Rico

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

b. Screening services
   - X Provided
   - No limitations
   - X With limitations*

c. Preventive services
   - X Provided
   - No limitations
   - X With limitations*

d. Rehabilitative services
   - X Provided
   - No limitations
   - X With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

   a. Inpatient hospital services
      - X Provided
      - X No limitations
      - __With limitations*
      (Based on medical necessity Law 408)
      - Not Provided

   b. Skilled nursing facility services
      - ___ Provided
      - ___ No limitations
      - ___ With limitations*

   c. Intermediate care facility services
      - ___ Provided
      - ___ No limitations
      - ___ With limitations*

*Description provided on attachment.

TN No. OJ-ODIA Superseded 87-1
Approval Date MAR 05 2004 Effective Date AUG 13 2003
STATE/TERRITORY: PUERTO RICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☐ Provided   ☐ No limitation   ☐ With limitations*   ☒ Not Provided

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☐ Provided   ☐ No limitation   ☐ With limitations*   ☒ Not Provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided   ☒ No limitation   ☐ With limitations*   ☒ Not Provided

(Based on Medical Necessity under Law 408)

17. Nurse-midwife services

☐ Provided   ☐ No limitation   ☐ With limitations*   ☒ Not Provided

18. Hospice care (in accordance with section 1905(o) of the Act).

☐ Provided   ☐ No limitation   ☒ Not Provided

☒ Provided   ☐ With limitations*

In accordance with section 2302 of the Affordable Care Act

*Description provided on attachment.

TN No.: 14-003  Approval Date: JUL 10 2014  Effective Date: April 1, 2014
Supersedes: 03-001-A
State/Territory: Puerto Rico

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): 

<table>
<thead>
<tr>
<th>19. Case management services and Tuberculosis related services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(s)(19) or section 1915(g) of the Act).</td>
<td></td>
</tr>
<tr>
<td>X Provided</td>
<td>X With limitations*</td>
</tr>
<tr>
<td>Not Provided</td>
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<tr>
<td>b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.</td>
<td></td>
</tr>
<tr>
<td>X Provided</td>
<td>X With limitations*</td>
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<tr>
<td>Not Provided</td>
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<thead>
<tr>
<th>20. Extended services for pregnant women</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day fall.</td>
<td></td>
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<tr>
<td>X Provided</td>
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<tr>
<td>X Additional coverage ++</td>
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<tr>
<td>b. Services for any medical conditions that may complicate pregnancy.</td>
<td></td>
</tr>
<tr>
<td>X Provided</td>
<td>X Additional coverage ++</td>
</tr>
<tr>
<td>++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.</td>
<td></td>
</tr>
<tr>
<td>* Description provided on attachment. Post partum and pregnancy-related services after the pregnancy ends are covered beyond the 60th day if medically needed.</td>
<td></td>
</tr>
<tr>
<td>Services for any other medical conditions that may complicate pregnancy are provided without limitations.</td>
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</tr>
</tbody>
</table>
21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1926 of the Act)

   _____ Provided   _____ No limitations   _____ With limitations*

   _____ Not Provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

   _____ Provided   _____ No limitations   _____ With limitations*

   _____ Not Provided

23. Pediatric or family nurse practitioners' services.

   _____ Provided   _____ No limitations   _____ With limitations*

   (According to our Health Plan coverage and state licensing laws - general nurse practitioners)

*Description provided on attachment.
State/Territory: Puerto Rico

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S)

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
   a. Transportation.
      
      X Provided    No limitations    X With limitations*

   b. Services of Christian Science nurses.
      
      Provided    No limitations    With limitations*

      X Not Provided

   c. Care and services provided in Christian Science sanitoria.
      
      Provided    No limitations    With limitations*

      X Not Provided

   d. Nursing facility services for patients under 21 years of age.
      
      Provided    No limitations    With limitations*

      X Not Provided

   e. Emergency hospital services.
      
      X Provided    X No limitations    With limitations*

   f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
      
      Provided    No limitations    With limitations*

      X Not Provided

*Description provided on attachment.

TN No. 03-00/1A Supersedes 88-1 Approval Date MAR 05 2004 Effective Date AUG 13 2003
AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided No limitations With limitations*

X Not Provided

*Description provided on attachment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Agency Puerto Rico

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

12.s. Prescribed Drugs: Description of Service Limitation

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935(d)(1)</td>
<td>Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.</td>
</tr>
<tr>
<td>1927(d)(2) and 1935(d)(2)</td>
<td>The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.</td>
</tr>
</tbody>
</table>

- The following excluded drugs are covered:
  - ("All" drugs categories covered under the drug class)
  - ("Some" drugs categories covered under the drug class)
  - (List the covered common drug categories not individual drug products directly under the drug class)
  - ("None" of the drugs under this drug class are covered)

- (a) agents when used for anorexia, weight loss, weight gain are excluded as a general rule. Puerto Rico provides coverage of medically-necessary mental health drugs when used in the treatment of anorexia according to the medical psychiatric practice accepted norms as required for the diagnosis, prevention, and treatment of the mental health disease.
  - (b) agents when used to promote fertility
  - (c) agents when used for cosmetic purposes or hair growth
  - (d) agents when used for the symptomatic relief of cough and colds

TN No. 13-002  
Supersedes  
TN No. New  
Attachment 3.1-B  
Page 10 a
12.a. Prescribed Drugs: Description of Service Limitation

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ (e) prescription vitamins and mineral products are excluded as a general rule, except prenatal vitamins and fluoride. <strong>Puerto Rico also covers some vitamins and mineral products when they are prescribed, medically necessary, and used in the treatment of cancer, renal disease, or HIV/AIDS.</strong></td>
<td></td>
</tr>
<tr>
<td>☑ (f) nonprescription drugs or over-the-counter (OTC) drugs are excluded as a general rule. <strong>Puerto Rico covers some OTC drugs (Non Sedating Antihistamines, Antihistamine, Respiratory Agent, Antiplatelet, and Topical Antimycotic products) when they are prescribed and medically necessary according to the medical practice accepted norms as required for the diagnosis, prevention, and treatment of the disease.</strong></td>
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<tr>
<td>☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)</td>
<td></td>
</tr>
<tr>
<td>☑ (h) barbiturates for non-dually eligible. <strong>Puerto Rico does not provide coverage for dual eligible individuals with Medicare Part D, because of effective January 1, 2013, Part D covers these drugs when used in the treatment of epilepsy, cancer, or a chronic mental health disorder; except when these drugs are prescribed for a condition other than the three covered by Part D and during Part D donut hole period if it is medically necessary.</strong></td>
<td></td>
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<tr>
<td>☑ (j) benzodiazepines for non-dually eligible. <strong>Puerto Rico does not provide coverage for dual eligible individuals with Medicare Part D, because of effective January 1, 2013, Part D covers all indications for these drugs; except for dually eligible without Part D and during Part D donut hole period if it is medically necessary.</strong></td>
<td></td>
</tr>
<tr>
<td>☑ (k) smoking cessation drugs are excluded except for individuals under age 21 and for pregnant women when medically necessary and prescribed by a physician. <strong>In these cases the plan covers prescription and non-prescription aids as indicated by a physician and without cost-sharing.</strong></td>
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</table>
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

Description of Limitations

General Limitations

The following General Limitations and Exclusions apply to all services not just inpatient or outpatient services:

a. Services rendered while the beneficiary is not covered.
b. Services which result from illnesses or injuries not covered.
c. Services resulting from automobile accidents which are covered by the Automobile Accident Compensation Fund (ACAA).
d. Workman's compensation accidents covered by the "Fondo del Seguro del Estado".
e. Services covered by any other insurer or party that has the primary responsibility (other party liability).
f. Special nurses services for the convenience of the patient when it is not medically necessary.
g. Hospitalization for services which can be rendered in an ambulatory setting.
h. Admission of patients to hospitals for diagnostic purposes only.
i. Expenses for services and/or materials for the comfort of the patient, such as telephone, television, admission kit, etc.
j. Services rendered by second generation family members of patient (parents, offspring, siblings, grandparents, grandchildren, spouse, etc.).
k. Organ and tissue transplants, except as provided in Attachment 3.1-E.
l. Laboratories for which processing is not available in Puerto Rico and that have to be sent outside of Puerto Rico for processing.
m. Treatments with the purpose of controlling weight (obesity or weight increase) solely for esthetic purposes.
n. Sports Medicine, musical therapy, and natural medicine.
o. Tuboplastics, vasovasectomies and any other procedures or services for the purpose of returning the ability to procreate, are excluded:

Transmittal No.: 14-008 Effective Date: July 1, 2014
Supersedes TN No.: 03-001-A Approval Date: 

Description for Attachment 3.1-B
Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines); with hysterectomy (failed intra-amniotic injection).
Description for Attachment 3.1-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

Page 3

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

Description of Limitations

59855  Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines

59856  Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with dilation and curettage and/or evacuation.

59857  Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with hysterectomy (omitted medical expulsion).

u. The Revetron drug.
v. Services for epidural anesthesia
w. Somnography studies.
x. Services which are not reasonable nor required according to the accepted standards of medical practice or services provided in excess of those normally required for the prevention, diagnosis, and treatment of a disease, injury or dysfunction of the organic system or pregnancy condition.
y. Hemodialysis and/or peritoneal dialysis services are excluded from the Basic Coverage; but included in the Special Coverage.
z. New and/or experimental procedures which have not been approved by the PRHIA for their inclusion as benefits in the basic and special coverage of the program.
aa. Custodial, rest or convalescence services, in cases where the acute medical condition requiring in-patient care is under control or in irreversible terminal cases.
bb. Expenses incurred in payments made by beneficiaries to participating providers that according to the terms of the program, the beneficiary was not supposed to pay.
cc. Services ordered and/or rendered by non-participating providers, except in cases of emergencies/immediate need or previously authorized by the HCOs or MCO.
dd. Neurological and cardiovascular surgery and related services are included from the Basic Coverage, but included in the Special Coverage.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: PUERTO RICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

Description of Limitations

e. Services received outside of the territorial limits of the Commonwealth of Puerto Rico, except for emergency services received in the United States.

ff. Expenses incurred for the treatment of conditions, resulting from procedures or benefits not covered under this Program. Maintenance prescriptions and required laboratories for the continuity of a stable health condition, as well as any emergencies which could result after the referred procedures, are covered.

gg. Travel expenses, even when ordered by the primary care physician or participating provider are excluded.

hh. Eyeglasses, lenses, and hearing aids are excluded, except for beneficiaries under age 21 when it is medically necessary and approved through a prior authorization process.

ii. Acupuncture services are excluded.

jj. Rent or purchase of wheelchair or any other vehicle (motor and/or electric) or expenses for the repair or alteration of these vehicles.

kk. Procedures with the purpose of changing the sex of the beneficiary.

ll. Treatment services for infertility and/or related to conception by artificial means.

1. Inpatient hospital services other than those provided in an institution for mental diseases

Inpatient services are provided within coverage under Health Reform Plan with limitations:

Limitations on inpatient services:

- **Bed in Semiprivate Room:** Coverage will be available twenty four (24) hours per day, every day of the year.
- **Isolation Room:** For medical reasons.
- **Specialized Diagnostic / Treatment:** Electrocardiograms, electroencephalograms, arterial gases, and other specialized diagnostic and/or treatment testing that are available in the hospital facilities and which are required to be performed while the patient is hospitalized.

TN No.: 03-001-A  Approval Date: 02/16/2016  Effective Date: January 1, 2016
Description for Attachment 3.1-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

Page 5

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

Description of Limitations

Limitations to inpatient services:

- **Short Term Rehabilitation Services:** To hospitalized patients, including physical, occupational, and speech therapy.
- **Blood:** Blood, plasma and their derivatives without limitations, to include irradiated and autologous blood; Monoclonal Factor IX per authorization of a certified hematologist; Antihemophilic Factor with intermediate purity concentration (Factor VIII); Antihemophilic Monoclonal Type Factor per authorization of a certified hematologist and Prothrombin Activated Complex (Autoflex and Feiba) per authorization of a certified hematologist.

2a. Outpatient services are covered by the Reforma Health Plan.

2b. Rural health clinic and ambulatory services provided are those categorized benefits covered according to our Reforma Health Plan.

2c. Federally Qualified Health Centers services and other ambulatory services are those benefits covered according to our Reforma Health Plan.

TN No. 03-001 A
Supersedes 84-3 Approval Date MAR 05 2004
Effective Date AUG 13 2003
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE / TERRITORY: COMMONWEALTH OF PUERTO RICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDED

3. Other laboratory and X-ray services. Diagnostic blood tests and X-rays are covered, but the following special procedures and diagnostic tests are provided subject to benefits included under the plan's special coverage and medical necessity criteria:
   a. Computerized tomography.
   b. Magnetic Resonance Tests Imaging
   c. Cardiac catheterization
   d. Holter Tests
   e. Doppler Tests
   f. Stress Tests
   g. Lithotripsy
   h. Electromyography
   i. Single Photon Emission Computerized – Tomography Test (SPECT)
   j. Ocular Plethysmography (OPG)
   k. Impedance Plethysmography
   l. Other invasive and non-invasive cardiovascular, cerebrovascular, and neurosurgical procedures
   m. Nuclear Medicine tests
   n. Endoscopies for diagnostic purposes
   o. Genetic Studies.

4.c. Family Planning Services: The coverage benefits of the Puerto Rico Medicaid and CHIP Programs provide the following Family Planning Services: (i) education and counseling, (ii) pregnancy testing, (iii) infertility assessment, (iv) sterilization services in accordance with 42 CFR 441.200 subpart F, (v) laboratory services, (vi) at least one of every class and category of FDA (Food and Drug Administration) approved contraceptive medication, (vii) cost and insertion/removal of non-oral products, such as long acting reversible contraceptives (LARC), and (viii) other FDA approved contraceptive medications or methods when it is medically necessary and approved through a prior authorization or exception process.

5.a. Physician services in the patient's home are provided based on medical necessity.

Transmittal No.: 15-001 Effective Date: April 1, 2015
Supersedes TN No.: 03-001-A Approval Date: SEP 09 2015
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

5b. Medical and surgical services provided by dentist are limited to the coverage services description on item (10).

6a. Podiatrist services are provided as remedial and incidental care rendered for attending special conditions under the Health Reform Plan's special coverage.

6b. Optometrist services are limited to vision evaluations and exams.

6c. Chiropractic services as determined medically necessary. Initial 15 sessions available without prior authorization. Additional 15 sessions require prior authorization. The treatment limit is combined with the limit for physical therapy. An individual may receive a total of 30 physical therapy and/or chiropractic sessions combined. Additional session beyond 30 is allowed with medical necessity and requires a prior authorization process.

6d. Most types of practitioners' are included, except for: alternative and sport medicine practitioners, iridologist, naturopaths, and cosmetic plastic surgeons.

7. Home Health Services
No FFP is claimed for Home Health Services.
11. Clinic services are provided according to and within the State Plan coverage and complaint with 42 CFR 440.90, including preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients: (a) services furnished at the clinic by or under the direction of a physician or dentist and (b) services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. These clinics include Department of Health Clinics, Preventive Clinics, Urgent Care Clinics, and Physician operated clinics.

12. Dental Services

a. Dental Services for Children Under 21 Years of Age
   - All preventive and corrective dental services are covered for children under age 21 (0-20) as indicated under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requirement.
   - Orthodontic services to EPSDT eligible children as medically necessary to prevent and restore oral structures to health and function are covered. Orthodontic services for cosmetic purposes are not covered.
   - Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21) and stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy.
   - Anesthesia services (subject to prior authorization) for a child with physical or mental handicaps in compliance with federal and local laws. These special conditions includes, but not limited to, the followings: (a) autism, (b) severe retardation, (c) severe neurologic impairment, (d) significant attention deficit disorders with hyperactivity, (e) significant or severe mental disorders, (f) disable or unable to follow commands, and (g) any other condition that at the dentist professional judgment, impaired the required patient cooperation and feasibility to adequately perform the dental procedure.
   - All limitations may be exceeded based on medical necessity and approved through a prior authorization or exception process.
10. Dental Services

b. Dental Services for Members Age 21 and Over When It is Medically Necessary:

- Preventive dental services
- Restorative dental services
- One (1) comprehensive oral examination per year
- One (1) Periodic oral examination every six (6) months
- One (1) defined problem-limited oral exam
- One (1) full series of intra-oral radiographies, including bitewings, every three (3) years
- One (1) initial periapical intra-oral radiography
- Up to five (5) additional periapical/intra-oral radiographies per year
- One (1) single film-bitewing radiography per year
- One (1) two-film bitewings radiography per year
- One (1) panoramic radiography every three (3) years
- One (1) cleanse every six (6) months
- One (1) Prophylaxis, every six (6) months
- Amalgam restoration
- Resin restorations
- Root canal
- Palliative treatment
- Oral surgery
- Anesthesia services (subject to prior authorization) for beneficiaries with physical or mental handicaps in compliance with local law
- All limitations may be exceeded based on medical necessity and approved through a prior authorization or exception process.
Description of Limitation

11.a. Physical therapy and or chiropractor services as determined medically necessary.
   a. Initial 15 sessions available without prior authorization.
   b. Additional 15 sessions require prior authorization.
   c. The treatment limit is combined with the limit for chiropractic care.
   d. An individual may receive a total of 30 physical therapy and/or chiropractic sessions combined.
   e. Additional session beyond 30 is allowed with medical necessity and requires a prior authorization process.

12.a. Prescribed drugs
   a. The PRHIA maintains a drug Formulary as the official formulary of drugs provided
      by the Health Reform Plan coverage, which contains most of the vast majority of
      therapeutic alternate categories available.
   b. A preferred drug list (PDL) is also maintained as a cost-effective utilization tool in
      rendering prescription benefits under the Health Reform Plan.
   c. The MCOs, MBHOs, and Direct Providers, that are contracted, agree to conduct
      the pharmacy billing and claims through the PRHIA's contracted Pharmacy Benefits
      Manager (PBM).
   d. Under exceptional circumstances, a drug not included in the Formulary could be
      covered only through exceptional circumstances and procedure set forth below.
Limitations and Conditions of the Prescription Services

a. Contraceptives drugs are covered under the Health Reform Plan for the treatment of menstrual dysfunction and for birth control purposes, as follows:
   (i) At least one of every class and category of FDA (Food and Drug Administration) approved contraceptive medication,
   (ii) At least one of every class and category of FDA approved contraceptive method, and
   (iii) Other FDA approved contraceptive medications or methods when it is medically necessary and approved through a prior authorization or exception process.

b. Drugs required for the ambulatory or hospitalized treatment of diagnosed beneficiaries with AIDS or with an HIV positive factor are covered under the special coverage to include only antiretrovirals but excluding Protease inhibitors. The Protease inhibitors are not covered benefits financed under the Health Reform Plan, they are provided to Medicaid beneficiaries through coordination with the Regional Immunological Clinics of the Commonwealth Health Department's PASET Division.

c. Immunosuppressant drugs for all transplant patients are covered only to the extent of maintenance treatment post-surgery to ensure the continuity of health stability of the beneficiary, as well as emergencies that may result after surgery (as transplants are not covered).

d. New drugs for future inclusion are evaluated through an active process for revising on a continuous basis and evaluate the future inclusion of new medicines or the removal of medicines from the formulary. Considering the dynamic nature of this process, the PRHIA requires the inclusion or exclusion of medicines as changes and advances affect the standard practice for the treatment of conditions or developments of standard practices for the treatment of a condition or particular treatments.
e. No MCO, HCO, MBHO or providers can establish a different formulary from the one included in this addendum nor limit in any way the drugs and medications included in the formulary.
f. In the event a beneficiary needs a drug or medicine that is not included in the formulary, the MCO, MBHO and providers will follow the usual pre-authorization procedure, to obtain drugs not included in the formulary. The provider shall have to obtain the MCOs prior approval considering and documenting the particular merits of each case, which could include among others the following criteria:
   1. A contraindication of drug that appears in the formulary.
   2. Adverse reaction history to the drug that appears in the formulary.
   3. Therapeutic failure to all available alternatives in the formulary.
g. For acute conditions, the amount of medication to be dispensed shall be limited to the needed therapy, but never for more than fifteen (15) days. When medically necessary, additional prescriptions are covered.
h. For chronic conditions (maintenance), the amount of the medication to be dispensed will be limited to a maximum of thirty (30) days. By prescribing physician recommendation, each prescription may be repeated up to six (6) times. When medically necessary, additional prescriptions are covered.
i. The indications on prescriptions issued for treatment of children with Special Health Care Needs will indicate clearly the (30) day coverage therapy and that it can be repeated up to six (6) times. When medically necessary additional prescriptions will be covered.
j. The use of bioequivalent medications and drugs approved by the FDA and local regulations is authorized, unless contraindicated for the beneficiary by the physician or dentist who prescribed the medication.
k. The absence of bioequivalent medications in stock does not exonerate the Pharmacist from dispensing the medication nor does it entail the payment of additional surcharges by beneficiaries. Brand name drugs will be dispensed if the bioequivalent is not available at the pharmacy.
l. All prescriptions shall be filled and dispensed at a participating pharmacy properly licensed under the laws of Puerto Rico freely chosen by the beneficiary.
m. All prescriptions shall be dispensed contemporaneously with the date and hour that the beneficiary receives the prescription and requests that it be dispensed.
Sigmoidoscopy for adults ages 50 and over with risk of colon cancer according to accepted medical practice.

13b. Screening Services

Gynecological and Prostate Cancer screening according to accepted medical practice, including Papanicolaou test, mammographies, and P.S.A. as may be medically necessary and according to the age of the beneficiary. Accordingly to Puerto Rico’s Health Policies the age of forty (40) years have been established as the initial date to commence cancer screening by mammography.

Sigmoidoscopy for adults ages 50 and over with risk of colon cancer according to accepted medical practice.
Counseling in physical health, oral health, and nutrition will be provided in accordance with the preventive service benefit to address the individual needs of the beneficiaries based on their health conditions.
24.a. Transportation
Limited to ambulance services in emergency cases, ground, maritime, and aerial ambulance services are covered within the territorial limits of Puerto Rico. No pre-authorization or pre-certification will be required in order to access these services. In general, the service shall be accessed either by beneficiary calling 911 or calling the local ambulance provider contracted and as instructed by the HCO and the MCO in the area.
For non-emergency transportation the Commonwealth follows the methods described in attachment 3.1-D of this plan.

Description of Limitation

13d. Rehabilitative services
The rehabilitative services provided are ambulatory. Except for physical therapy, all rehabilitative services such as: respiratory, occupational, and speech therapies services are unlimited.
Physical therapy and/or chiropractic services (chiropractic manipulation sessions) as determined medically necessary. Initial 15 sessions available without prior authorization. Additional 15 sessions require prior authorization. The treatment limit is combined for chiropractic care and physical therapy. An individual may receive a total of 30 physical therapy and/or chiropractic sessions combined. Additional session beyond 30 is allowed with medical necessity and requires a prior authorization process.

19. Ambulatory treatment, hospitalization and other TB related services and case management are covered under the Special Coverage.

20. The extended services for pregnant women besides covering all pre-natal, delivery and post-partum care services, include all medical and obstetrical nursing services during the delivery, be it natural childbirth, cesarean section, or any other complication; hospitalization beyond minimum stay terms in case of maternity, high risk or secondary conditions to the pregnancy by medical recommendation.
The minimum stay term for hospitalization for both mother and newborn will not be limited to less than 48 hours for normal vaginal delivery without complications and in the case of childbirth following cesarean section, the stay may not be limited to less than 96 hours for both mother and child.

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Approval Date: 12/11/14
The Department of Health is the state licensing agency for Hospitals, Nursing Homes and intermediate care health facilities. The Office of Licensure and Certification of Health Facilities determines, issues the standards and supervises the efficient operation of health facilities in Puerto Rico; except for free standing laboratories that are licensed by the Institute of Laboratories according to standards promulgated by the Secretary of Health.

A register of licensed hospitals and nursing homes in Puerto Rico is published annually by said Office. A Listing of licensed laboratories is published by the Institute.

The Office of Licensure and Certification of Health Facilities has a staff of qualified inspectors and consultants that visit periodically the licensed facilities to assure continuing eligibility. The Institute has its own staff that visits free standing laboratories regularly.

Standards and records relative to licensing and certification of health facilities and free standing laboratories are available to the Medical Assistance Program.
Methods utilized by the Department of Health for the Transportation of Medicaid Recipients of Services:

1. Transportation Services will be provided in Municipal and/or Department of Health ambulances including contract facilities for emergency cases, regardless of need.

2. Categorically needy and Medically needy persons who can not afford to pay their traveling expenses for services provided under this plan, other than emergency services, are eligible for emergency transportation services provided by the Department of Social Services.

3. Transportation other than ambulance services is provided in public cars and other means of public transportation, according to fees established by the Public Service Commission, or at customary local rates, whichever is applicable, and paid usually by the municipality.
STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Skin, bone, and corneal transplants are covered.

All other organ and tissue transplants are not covered including (i) expenses brought about by such transplants of organs and tissues not covered in the State Plan, and (ii) hospitalization, complications, and chemotherapy related to transplants not covered in the State Plan.

Maintenance prescriptions and required clinical laboratories for the continuity of a stable health condition, as well as any emergencies which could alter the effects of the previous procedure, are covered.

Immunosuppressant drugs for all transplant patients are covered only to the extent of maintenance treatment post-surgery to ensure the continuity of health stability of the beneficiary, as well as emergencies that may result after surgery (as transplants are not covered).