



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Alternative Benefit Plan Populations

ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name:

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s).

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory.

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

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V.20131219



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Attachment 3.1-L-

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A) (i)(VIII) of the Act **ABP2a**

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

Puerto Rico submitted to CMS the Benchmark Plan and identified Triple S Optimo. Puerto Rico then formed formed a workgroup comprised of individuals from ASES and Medicaid to guide the development of the Alternative Benefit Plan. The workgroup provided oversight for the completion of a crosswalk of benefits to the benchmark plan and the current Puerto Rico State Plan and identified service revisions and potential substitution of services. The plans were aligned in most areas however the following benefits were identified for new service or substitution. Throughout the development process, Puerto Rico participated in weekly technical assistance calls led by Central and Regional CMS staff. Throughout these calls sections of the draft ABP were submitted informally and discussed. Each substitution of service and proposed SPA was reviewed by ASES Actuary to ensure alignment of the substitutions of service. Fiscal Impact/PMPM cost estimates were prepared by the actuary for new services. The benefits in the Alternative Benefit Plan are the same as those offered in the Puerto Rico State Plan. In addition the services included meet the requirements of all Essential Health Benefits.

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Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3

Select one of the following:

- The state/territory is amending one existing benefit package for the population defined in Section 1.
- The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package:

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- Secretary-Approved Coverage.
 - The state/territory offers benefits based on the approved state plan.
 - The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
 - The state/territory offers the benefits provided in the approved state plan.
 - Benefits include all those provided in the approved state plan plus additional benefits.
 - Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
 - The state/territory offers only a partial list of benefits provided in the approved state plan.
 - The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Selection of Base Benchmark Plan



Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option.

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name:

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

Puerto Rico assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP 5. Puerto Rico assures the accuracy of information in ABP 5 depicting amount duration and scope parameters of services authorized in the currently approved Medicaid state plan.

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Alternative Benefit Plan Cost-Sharing

ABP4

Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

No

Other Information Related to Cost Sharing Requirements (optional):

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Benefits Description	ABPS
The state/territory proposes a "Benchmark-Equivalent" benefit package. <input type="checkbox"/> No	
Benefits Included in Alternative Benefit Plan	
Enter the specific name of the base benchmark plan selected:	
Triple S Optimo	
Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."	
Secretary-Approved	



Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:

Physician Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Excludes ambulatory setting use of a fetal monitor, cosmetic surgery, procedures to re-establish the ability to procreate, induced abortion experimental procedures, surgeries for sexual transformation, intravenous or inhalation analgesic.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes Physicians services whether furnished in the office, the patient's home, a hospital or elsewhere. Excluded practitioners include alternative and sports medicine, iridologists, naturopaths, and cosmetic plastic surgeons. Induced abortion is covered when the pregnancy is a result of rape or incest and/or when the pregnancy puts the mothers life at-risk and in compliance with the Hyde Amendment.

Benefit Provided:

Clinic Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Excludes services rendered in an outpatient facility that may be performed in a physicians office.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Other Licensed Providers

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

Includes all licensed medical professionals required by Puerto Rico local law.

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Excludes non physician professionals including nurse and physician assistant except those required by local law such as podiatrist, optometrist, clinical psychologists and chiropractors.

Add



Alternative Benefit Plan

2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided:

Other Medical Services - Emergency Hospital

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Other Medical Services-Emergency Transportation

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Ground, maritime and aerial ambulance services are covered within the territorial limits of Puerto Rico for emergency cases

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Excludes hospitalization for services which can be rendered in an ambulatory setting, Admission of patients to hospitals for diagnostic purposes only, Expenses for services and/or materials for the comfort of patients only such as television.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Bariatric surgery limited to 1 per lifetime and requires prior authorization.
Transplant services limited to skin, bone and corneal transplants
Due diligence was applied to ensure this service is aligned with the base benchmark coverage.

Add



Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:

Physician Services - Maternity

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Inpatient Hospital services - Maternity

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Minimum Stay - 48 hours for vaginal delivery, 96 hours for cesarean delivery

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

Collapse All

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Benefit Provided:

Behavioral Health Outpatient - Rehab

Source:

State Plan Other

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Puerto Rico covers individual and group counseling, substance abuse treatment, partial hospitalization, psychiatric care and medication management for enrollees identified as having behavioral health needs without limitation. Provider qualifications are mandated by Puerto Rico law and licensing requirements and include psychologists and psychiatrists.

Benefit Provided:

Behavioral Health Inpatient - Rehab

Source:

State Plan Other

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes mental health and substance abuse services in facilities not designated as IMDs. Puerto Rico covers individual and group counseling, substance abuse treatment, residential treatment services, psychiatric care and medication management for enrollees identified as having behavioral health needs without limitation. Provider qualifications are mandated by Puerto Rico law and licensing requirements and include psychologists and psychiatrists.

Add



Alternative Benefit Plan

6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

Puerto Rico's ABP prescription Drug Benefit is the same as under the approved Medicaid State Plan for prescribed drugs.



Alternative Benefit Plan

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All

Benefit Provided:

Physical Therapy - Rehabilitation and Habilitation

Source:

State Plan 1905(a)(11)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

30 treatments per condition.

Duration Limit:

Per year

Scope Limit:

Combined limit of 30 sessions applies to habilitation and rehabilitation.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physical therapy is applied as a habilitative and rehabilitative service 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 with chiropractic care. An individual may receive a total of 30 physical therapy and/or chiropractic sessions combined. Additional session beyond 30 are allowed with medical necessity and require a prior authorization process.

Benefit Provided:

Home Health Services

Source:

Other state-defined

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The approved Puerto Rico State Plan does not cover Home Health services utilizing the Federal Definition. There are no home health agencies in the Commonwealth serving the Medicaid populations. Home Health refers to the location of services. Medicaid provides equipment and medical services to enrollees for at home when medically necessary and as a cost effective alternative to hospitalization. Any state plan service that is medically necessary may be provided in the home if a cost effective alternative to hospitalization Home Health services utilizing the Puerto Rico definition are requested and approved by the MCO and ASES on a case-by-case basis as determined medically necessary. PT services may be provided in the home as medically necessary. When there is a State Plan limit on services, any services provided in-home are counted towards those limitations.

Benefit Provided:

Home Health - Prosthetic Devices

Source:

State Plan 1905(a)



Alternative Benefit Plan

Authorization: None	Provider Qualifications: Medicaid State Plan	Remove
Amount Limit: None	Duration Limit: None	
Scope Limit: See below		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Includes prosthetic devices for all of the extremities of the body, ocular therapeutic prosthesis and segmentary system trays for scoliosis surgery and fusion. Other DME limited to equipment necessary for the delivery of oxygen.		
Benefit Provided: Chiropractic Care	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: 30 treatments per condition	Duration Limit: per year	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Chiropractic adjustments are provided as a habilitative and rehabilitative service 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 with physical therapy. An individual may receive a total of 30 physical therapy and/or chiropractic sessions combined. Additional session beyond 30 are allowed with medical necessity and require a prior authorization process.		
Benefit Provided: Respiratory Therapy	Source: State Plan 1905(a)	
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Offered as a habilitative and rehabilitative service as determined medically necessary.

Remove

Benefit Provided:

Occupational Therapy

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Offered as a habilitative and rehabilitative service as determined medically necessary

Benefit Provided:

Speech Therapy

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Offered as a habilitative and rehabilitative service as determined medically necessary.

Add



Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:

Diagnostic Lab

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage excludes laboratories for which processing is not available in Puerto Rico.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is not required when provided by a lab within the members Primary Medical Group (PMG). The PMG is a function of the MCO and describes the members selected provider and associated labs and specialist.

Benefit Provided:

Other lab and x-ray Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

General Clinical Labs, X-rays, Radiotherapy, Pathology, Pulmonary Function and Electroencephalograms if medically necessary do not require pre-authorization. Prior authorization is not required when provided by a lab within the members Primary Medical Group (PMG)

Add



Alternative Benefit Plan

9. Essential Health Benefit: Preventive and wellness services and chronic disease management

Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Source:

Remove

Authorization:

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care Collapse All

Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: <input type="text" value="State Plan 1905(a)"/> <input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>
Scope Limit: <input type="text" value="None"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>	



Alternative Benefit Plan

11. Other Covered Benefits from Base Benchmark.

Collapse All



Alternative Benefit Plan

12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All

Base Benchmark Benefit that was Substituted: Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Base Benchmark Benefit that was Substituted: Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Base Benchmark Benefit that was Substituted: Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Base Benchmark Benefit that was Substituted: Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Base Benchmark Benefit that was Substituted: Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Home Health Care Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Home Health Services EHB 7. The approved Puerto Rico State Plan does not cover Home Health services utilizing the Federal Definition. Home Health refers to the location of services. Medicaid provides equipment and medical services to enrollees for at home when medically necessary and as a cost effective alternative to hospitalization.
Base Benchmark: Defines Home Health in the same manner as the Medicaid State plan and limits services to 40 visits only that are initiated within 14 days of a hospitalization of at least 3 days and provided for the same condition as the hospitalization. Combined limit applies to physical, occupational and speech therapy.

Base Benchmark Benefit that was Substituted:

Emergency Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Other Medical Services -Emergency Services in EHB 2
Base Benchmark: No limitations.

Base Benchmark Benefit that was Substituted:

Emergency Transportation

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Other Medical Services - Emergency Transportation services EHB 2
Base Benchmark: Covered as reimbursement up to \$80.00 per trip

Base Benchmark Benefit that was Substituted:

Inpatient Hospital Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Inpatient Hospital Services EHB 3
Base Benchmark: Excludes services for personal comfort such as private rooms and for services or procedures that may be performed in an outpatient setting.

Base Benchmark Benefit that was Substituted:

Inpatient physician and surgical services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Inpatient Hospital Services EHB 3
Base Benchmark: No limitations



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: <input type="text" value="Skilled Nursing Facility"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Base Benchmark: Limits Skilled Nursing services to 120 days only if initiated within 14 days of a hospitalization of at least 3 days and provided for the same condition as the hospitalization. The substitution is based on unlimited respiratory therapy, occupational therapy and speech therapy identified in EHB 7."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Prenatal and Postnatal Care"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: covered under Medicaid state plan as Physician Services EHB 4. Base Benchmark: No Limitations"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Delivery/Inpatient services for Maternity Care"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: covered under Medicaid state plan as Inpatient Hospital Services - Maternity EHB 4 Base Benchmark: Delivery of baby 48 hour minimum for vaginal delivery and 96 hours for cesarean delivery."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Mental/Behavioral Health Outpatient Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: covered under Medicaid state plan as Behavioral Health Outpatient EHB 5 Base Benchmark: Limited to 15 units per year for group therapy"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Mental/Behavioral Health Inpatient Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: covered under Medicaid state plan as Behavioral Health Inpatient services EHB 5 Base Benchmark: Limited to 90 days per year."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Substance Abuse Outpatient Services"/>	Source: Base Benchmark	



Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Behavioral Health Outpatient EHB 5
Base Benchmark: Limited to 15 units per year for each type of service including group therapy, psychiatrist, clinical psychologist and collateral visits.

Remove

Base Benchmark Benefit that was Substituted:

Substance Abuse Inpatient Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Behavioral Health Inpatient services EHB 5
Base Benchmark: Limited to 90 days per year.

Base Benchmark Benefit that was Substituted:

Outpatient Rehabilitation Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Rehabilitative and Habilitative services EHB 7
Base Benchmark: Limited to 20 physical therapy sessions per year. Does not include occupational, speech therapies, prosthetics and implants orthopedics or cardiac rehabilitation.

Base Benchmark Benefit that was Substituted:

Habilitation Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Physical Therapy services EHB 7 and Speech Therapy, Respiratory and Occupational Therapy.
Base Benchmark: Limited to 20 physical therapy sessions per year

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: covered as prosthetic devices in the Medicaid state plan as Home Health - DME services EHB 7
Base Benchmark: Limited to \$5,000 per year for rental or purchase of oxygen and necessary equipment for its administration, wheelchair and hospital beds.

Base Benchmark Benefit that was Substituted:

Diagnostic Tests

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Laboratory Services services EHB 8 and Other Lab and



Alternative Benefit Plan

X-Ray services EHB 8 Base Benchmark: No limitations		Remove
Base Benchmark Benefit that was Substituted: Preventive Care/Screening and Immunization	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Duplication: covered under Medicaid state plan as Preventive services EHB 9 Base Benchmark: No limitations		
Base Benchmark Benefit that was Substituted: Routine Eye Exam for Children	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: covered under Medicaid state plan as EPSDT in EHB10 Base Benchmark: Limited to routine exam per year		
Base Benchmark Benefit that was Substituted: Eyeglasses for Children	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: covered under Medicaid state plan as EPSDT in EHB10 Base Benchmark: Limited to 1 per year		
Base Benchmark Benefit that was Substituted: Prescription Drugs	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Benchmark plan is the same as State Plan Coverage in Prescription Drugs EHB 6		
Base Benchmark Benefit that was Substituted: Chiropractic Care	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: covered under Chiropractic Care EHB 7		
Base Benchmark Benefit that was Substituted: Routine Foot Care	Source: Base Benchmark	



Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: Covered under Physicians Services in EHB 1"/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Transplant Services"/>	<input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="Duplication: Covered under Hospitalization EHB 3"/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Bariatric Services"/>	<input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="Duplication: Covered under Hospitalization EHB 3"/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Imaging"/>	<input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="Duplication: Covered under Diagnostic Lab EHB 8"/>		
		<input type="button" value="Add"/>



Alternative Benefit Plan

13. Other Base Benchmark Benefits Not Covered

Collapse: All



Alternative Benefit Plan

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:

Adult Dental

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See below

Duration Limit:

None

Scope Limit:

See below

Other:

Limited to (1) comprehensive and periodic exam and films per year. (1) prophylaxis per year. Amalgam and resin restorations, root canal therapy, oral surgery and palliative treatment. General anesthesia only for those with special conditions.

Other 1937 Benefit Provided:

Federally Qualified Health centers

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Other 1937 Benefit Provided:

Family Planning Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

Other:

Remove

Other 1937 Benefit Provided:

High Risk Pregnancy - Case Management

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covers only Medicaid eligible women identified as at-risk for pre-term birth or poor pregnancy outcome.

Other:

Other 1937 Benefit Provided:

Extended Services for Pregnant Women

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

All medical and obstetrical services that are medically necessary due to complications of pregnancy including hospitalization beyond minimum stay terms.

Other 1937 Benefit Provided:

Tuberculosis Related Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:	
<input type="text" value="None"/>	<input type="button" value="Remove"/>
Other:	
<input type="text" value="All medically necessary services related to Tuberculosis care for individuals who receive a diagnosis of Tuberculosis."/>	
Other 1937 Benefit Provided:	Source:
<input type="text" value="Adult vision Exam"/>	<input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>
	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:
<input type="text" value="Other"/>	<input type="text" value="Medicaid State Plan"/>
Amount Limit:	Duration Limit:
<input type="text" value="1 per year"/>	<input type="text" value="None"/>
Scope Limit:	
<input type="text" value="Annual eye exam for adults"/>	
Other:	
<input type="text"/>	
<input type="button" value="Add"/>	



Alternative Benefit Plan

15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All

PRA Disclosure Statement

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V.20131219



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Benefits Assurances

ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age.

Yes

The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

Through an Alternative Benefit Plan.

Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how EPSDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.



Alternative Benefit Plan

- The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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V.20131219



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Service Delivery Systems

ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- Managed care.
 - Managed Care Organizations (MCO).
 - Prepaid Inpatient Health Plans (PIHP).
 - Prepaid Ambulatory Health Plans (PAHP).
 - Primary Care Case Management (PCCM).

- Fee-for-service.
- Other service delivery system.

Managed Care Options

Managed Care Assurance

- The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

ASES and Medicaid began work on the development of the ABP in partnership with Triple S (the Benchmark plan provider), Department of Health, Clinical Consultant Dr. Max Miranda, ABARCA Health, and Mercer. In presentations to groups and associations related to the health segment, ASES Director Ricardo Rivera has discussed the ABP and our plan going forward in order to comply with CMS and ACA. Puerto Rico issued public notice on the ASES and Medicaid websites and in circular newspapers. The announcement is attached.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

Yes

The managed care program is operating under (select one):

- Section 1915(a) voluntary managed care program.
- Section 1915(b) managed care waiver.
- Section 1932(a) mandatory managed care state plan amendment.
- Section 1115 demonstration.
- Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.



Alternative Benefit Plan

Identify the date the managed care program was approved by CMS:

Describe program below:

Currently Puerto Rico delivers physical health services through a single contracted PIHP, behavioral health is delivered through a MBHO and pharmacy services are contracted with a pharmacy benefit manager (PBM). Puerto Rico is currently in an open Procurement for full-risk MCOs to deliver fully integrated physical and behavioral health services under one contract by region. The proposal and evaluation process is complete and Puerto Rico is currently engaged in contract negotiations. The MCO contract is in final stages of review by CMS and includes services as described in the ABP. Puerto Rico will continue to utilize the PBM for pharmacy services. The new MCO's and contract will be implemented April 2015.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

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V.20131219



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Employer Sponsored Insurance and Payment of Premiums

ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

No

The state/territory otherwise provides for payment of premiums.

No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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V.20131219



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

General Assurances

ABP10

Economy and Efficiency of Plans

- The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.

Yes

Compliance with the Law

- The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.
- The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).
- The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20131219



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Payment Methodology

ABP11

Alternative Benefit Plans - Payment Methodologies

- The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

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V.20131219

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

OFFICIAL

State Commonwealth of Puerto RicoStandards:

The Department of Health is the State Standard-setting body authorized to license all hospitals and related health facilities in Puerto Rico (Act No. 101 of June 1965). To be eligible for a license, institutions must meet the following requirements:

I- Hospitals:

- a. Organization of the Medical Staff, with by-laws, rules and regulations.
- b. Maintenance of medical record, and its contents, to evaluate quality of care through consultation, special reports, treatment orders, etc. Complete and up-to-date records must be kept for all out and inpatients;
- c. Staff Physicians and registered nurses must be on duty or on call at all times. Trained personnel should be responsible for services such as Dietary, Medical Records, Laboratory, Pharmacy, Radiology, etc.
- d. Fire safety, sanitation and maintenance of physical plan are stressed;
- e. Facilities are evaluated as to adequacy of space and equipment in all services and departments according to services offered to both out and inpatients;
- f. All patients admitted must be under the care of a physician duly licensed to practice licensed to practice medicine in Puerto Rico.

II- Nursing Homes:

Nursing home standards are similar to those pertaining to hospitals with the following exceptions:

- (1) There is no need for an organized medical staff, and
- (2) The number of registered nurses is more limited due to the nature of the services offered.

JR

6/20/74

10/15/74

4/1/74

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Commonwealth of Puerto Rico

The Title XIX Program has cooperative arrangements as follows:

1. Department of Social Services for quality control and determination of permanent and total disability.
2. Department of Social Services for Vocational and rehabilitation services.
3. Assistant Secretariat for Maternal and Child Health Services of the Department of Health for early and periodic screening diagnosis and treatment for persons under 21 years of age.
4. Office of Licensure and Certification of Health Facilities of the Department of Health for licensing and Certification of facilities under Title XIX.

PR

6/20/74

10/15/74

4/1/74



Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 16 - 0002

Expiration date: 10/31/2014

Cost Sharing Requirements

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

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

Yes

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

General Provisions

- The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.
- No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).
- The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):
- The state includes an indicator in the Medicaid Management Information System (MMIS)
 - The state includes an indicator in the Eligibility and Enrollment System
 - The state includes an indicator in the Eligibility Verification System
 - The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
 - Other process
- Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

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

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

Yes

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



Medicaid Premiums and Cost Sharing

- Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- Provide a referral to coordinate scheduling for treatment by the alternative provider.
- The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

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

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

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

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

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

Cost Sharing for Drugs

The state charges cost sharing for drugs.

Yes

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

Yes

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



Medicaid Premiums and Cost Sharing

Beneficiary and Public Notice Requirements

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

Other Relevant Information

- (1) Medicaid in Puerto Rico is covered by two distinct Commonwealth agencies -- The Puerto Rico Medicaid Program (PR Medicaid Program), and The Puerto Rico Health Insurance Administration (ASES). Eligibility determination is handled by the PR Medicaid Program, while ASES contracts with MCOs to provide insurance coverage and enroll beneficiaries.
- (2) A public schedule describing current copays is published on the ASES web site at <http://www.asespr.gov/>, the Puerto Rico Medicaid Program web site at <https://www.medicaid.pr.gov/>, and on the web sites of MCOs contracted by ASES.
- (3) A "Beneficiary Manual" is distributed to all enrollees by MCOs and includes a section which details the co-pay structure.
- (4) The Puerto Rico Department of Health (PRDoH), through the Puerto Rico Medicaid Program (Medicaid Program), and the Puerto Rico Health Insurance Administration (PRHIA, Administración de Seguros de Salud de Puerto Rico, or ASES, from its acronym in Spanish) have issued this "Cost Sharing Policy for Medicaid and CHIP Beneficiaries" to establish copayment rules, as required by the Sections 1916 and 1916A of the Social Security Act (SSA) and 42 CFR §§447.50-447.57 (excluding 42 CFR §447.55) of the federal regulation, the State Plan Amendment, and the New Cost Sharing Structure.

PRA Disclosure Statement

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V.20140415



Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 16 - 0002

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals G-2

1916
1916A
42 CFR 447.52 through 54

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

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

Service or Item	Amount	Dollars or Percentage	Unit	Explanation
		\$	Visit	

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Hospital: Admission Remove Service or Item

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

Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation
0% PRPL	50% PRPL	0.00	\$	Entire Stay	NOTES: 1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.
50% PRPL	100% PRPL	4.00	\$	Entire Stay	See Notes 1 and 2 above.
100% PRPL	150% PRPL	5.00	\$	Entire Stay	See Notes 1 and 2 above.
150% PRPL	No upper limit	8.00	\$	Entire Stay	See Notes 1 and 2 above.
0% PRPL	150% PRPL	0.00	\$	Entire Stay	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.



Medicaid Premiums and Cost Sharing

Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation
150% PRPL	No Upper Limit	0.00	\$	Entire Stay	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.

Service or Item:

Remove Service or Item

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

Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation
0% PRPL	50% PRPL	0.00	\$	Visit	NOTES: 1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.
50% PRPL	100% PRPL	1.00	\$	Visit	See Notes 1 and 2 above.
100% PRPL	150% PRPL	1.50	\$	Visit	See Notes 1 and 2 above.
150% PRPL	No upper limit	2.00	\$	Visit	See Notes 1 and 2 above.
0% PRPL	150% PRPL	0.00	\$	Visit	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.
150% PRPL	No upper limit	0.00	\$	Visit	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.

Service or Item:

Remove Service or Item

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



Medicaid Premiums and Cost Sharing

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation
+	0% PRPL	50% PRPL	0.00	\$	Procedure	NOTES: 1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.
+	50% PRPL	100% PRPL	0.50	\$	Procedure	See Notes 1 and 2 above.
+	100% PRPL	150% PRPL	1.00	\$	Procedure	See Notes 1 and 2 above.
+	150% PRPL	No upper limit	1.50	\$	Procedure	See Notes 1 and 2 above.
+	0% PRPL	150% PRPL	0.00	\$	Procedure	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.
+	150% PRPL	No upper limit	0.00	\$	Procedure	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.

Service or Item:

Remove Service or Item

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

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation
+	0% PRPL	50% PRPL	0.00	\$	Procedure	NOTES: 1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.
+	50% PRPL	100% PRPL	1.00	\$	Procedure	See Notes 1 and 2 above.
+	100% PRPL	150% PRPL	1.50	\$	Procedure	See Notes 1 and 2 above.



Medicaid Premiums and Cost Sharing

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	150% PRPL	No upper limit	2.00	\$	Procedure	See Notes 1 and 2 above.	X
+	0% PRPL	150% PRPL	0.00	\$	Procedure	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X
+	150% PRPL	No upper limit	0.00	\$	Procedure	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X

Service or Item:

Remove Service or Item

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

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% PRPL	50% PRPL	0.00	\$	Procedure	Notes: 1. Indicator of co-pay included on ID card that the beneficiary presents to the provider. 2. Dental providers are not part of the Preferred Provider Network (PPN).	X
+	50% PRPL	100% PRPL	1.00	\$	Procedure	See Notes 1 and 2 above.	X
+	100% PRPL	150% PRPL	1.50	\$	Procedure	See Notes 1 and 2 above.	X
+	150% PRPL	No upper limit	2.00	\$	Procedure	See Notes 1 and 2 above.	X
+	0% PRPL	150% PRPL	0.00	\$	Procedure	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X
+	150% PRPL	No upper limit	0.00	\$	Procedure	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X

Service or Item:

Remove Service or Item

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



Medicaid Premiums and Cost Sharing

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% PRPL	50% PRPL	0.00	\$	Other	Notes: 1. Indicator of co-pay included on ID card that the beneficiary presents to the provider. 2. Co-pay charged for each covered drug dispensed. 3. Pharmacies are not part of the Preferred Provider Network (PPN).	X
+	50% PRPL	100% PRPL	1.00	\$	Other	See Notes 1, 2, and 3 above.	X
+	100% PRPL	150% PRPL	2.00	\$	Other	See Notes 1, 2, and 3 above.	X
+	150% PRPL	No upper limit	3.00	\$	Other	See Notes 1, 2, and 3 above.	X
+	0% PRPL	150% PRPL	0.00	\$	Other	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X
+	150% PRPL	No upper limit	0.00	\$	Item	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X

Service or Item:

Remove Service or Item

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

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% PRPL	50% PRPL	0.00	\$	Other	Notes: 1. Indicator of co-pay included on ID card that the beneficiary presents to the provider. 2. Co-pay charged for each covered drug dispensed. 3. Pharmacies are not part of the Preferred Provider Network (PPN).	X
+	50% PRPL	100% PRPL	3.00	\$	Other	See Notes 1, 2, and 3 above.	X
+	100% PRPL	150% PRPL	4.00	\$	Other	See Notes 1, 2, and 3 above.	X
+	150% PRPL	No upper limit	6.00	\$	Other	See Notes 1, 2, and 3 above.	X
+	0% PRPL	150% PRPL	0.00	\$	Other	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X
+	150% PRPL	No upper limit	0.00	\$	Other	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X



Medicaid Premiums and Cost Sharing

Service or Item: **Non-Emergency Services Provided in a Hospital Emergency Room (ER)**

Remove Service or Item

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

Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation
0% PRPL	50% PRPL	0.00	\$	Visit	<p>NOTES:</p> <p>1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays.</p> <p>2. Co-pay for non-emergency visit to hospital emergency room may be waived by calling the Medical Advice Line and receiving a code to waive the co-pay.</p> <p>3. Indicator of co-pay included on ID card that the beneficiary presents to the provider.</p>
50% PRPL	100% PRPL	4.00	\$	Visit	See Notes 1, 2, and 3 above.
100% PRPL	150% PRPL	5.00	\$	Visit	See Notes 1, 2, and 3 above.
150% PRPL	No upper limit	8.00	\$	Visit	See Notes 1, 2, and 3 above.
0% PRPL	150% PRPL	0.00	\$	Visit	<p>Notes:</p> <p>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.</p> <p>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.</p>
150% PRPL	No upper limit	0.00	\$	Visit	<p>Notes:</p> <p>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.</p> <p>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.</p>

Service or Item: **Non-Emergency Services Provided in a non-Hospital / Freestanding Emergency Room**

Remove Service or Item

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



Medicaid Premiums and Cost Sharing

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% PRPL	50% PRPL	0.00	\$	Visit	NOTES: 1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X
+	50% PRPL	100% PRPL	2.00	\$	Visit	See Notes 1 and 2 above.	X
+	100% PRPL	150% PRPL	3.00	\$	Visit	See Notes 1 and 2 above.	X
+	150% PRPL	No upper limit	4.00	\$	Visit	See Notes 1 and 2 above.	X
+	0% PRPL	150% PRPL	0.00	\$	Visit	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X
+	150% PRPL	No upper limit	0.00	\$	Visit	Notes: 1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP. 2. Indicator of co-pay included on ID card that the beneficiary presents to the provider.	X

Add Service to Item

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

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

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.

No

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

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

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.

No



Medicaid Premiums and Cost Sharing

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



Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 16 - 0002

Expiration date: 10/31/2014

Cost Sharing Applies to Medically Needy Individuals	CAH
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to <u>all</u> medically needy individuals.	<input type="checkbox"/> Yes
The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals.	<input type="checkbox"/> Yes

PRA Disclosure Statement

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V.20140415



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: PR - 16 - 0002

Expiration date: 10/31/2014

Cost Sharing - Premiums - Exemptions

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals.

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



Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 16 - 0002

Expiration date: 10/31/2014

42 CFR 447.56
1916
1916A

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

Exemptions

Groups of Individuals - Mandatory Exemptions

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

- Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
 - 133% FPL; and
 - If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- Disabled or blind individuals under age 18 eligible for the following eligibility groups:
 - SSI Beneficiaries (42 CFR 435.120).
 - Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
 - Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- An individual receiving hospice care, as defined in section 1905(o) of the Act.
- Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).



Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

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

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

Yes

Indicate below the age of the exemption:

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

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs.

No

Services - Mandatory Exemptions

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

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

Enforceability of Exemptions

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

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



Medicaid Premiums and Cost Sharing

Other procedure

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

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

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

- The MMIS system flags recipients who are exempt
- The Eligibility and Enrollment System flags recipients who are exempt
- The Medicaid card indicates if beneficiary is exempt
- The Eligibility Verification System notifies providers when a beneficiary is exempt
- Other procedure

Description:

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

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

(3) ASES requires that the MCOs, MAOs, and PBMs inform providers whether the copayment for a specific service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the copayment, as a condition for receiving the service, through an indicator:

1. In the Eligibility and Enrollment System;
2. In the Eligibility Verification System; and
3. On the Beneficiary Identification Card.
4. Contracts between ASES and MCOs (MAOs for Platino Plans) and providers shall include the Cost Sharing Policy. MCOs and MAOs will monitor the providers' compliance with the Cost Sharing Policy's requirement.

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

Payments to Providers

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

Payments to Managed Care Organizations

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

Yes

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



Medicaid Premiums and Cost Sharing

Aggregate Limits

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

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

5%

4%

3%

2%

1%

Other: %

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

Quarterly

Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation.

No

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

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

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

Yes

Describe the appeals process used:

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

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

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



Medicaid Premiums and Cost Sharing

investigation. Where a reimbursement is due, the written response will be accompanied by a payment to the beneficiary of the excess amount.

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

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

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5).

No

PRA Disclosure Statement

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V.20140415

STATE: COMMONWEALTH OF PUERTO RICO

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Methods and Standards for Establishing Payments of Reasonable Costs of Inpatient Hospital Services.

General Statements:

Inpatient hospital services are limited to those rendered in public facilities including contract facilities.

Medicaid will not pay for services with inappropriate level of care.

Claims are processed by State Agency.

Prospective Rate Determination:

An all inclusive simple prospective per-diem reimbursement rate for inpatient hospital services will be established. The system still use the Medicare audited cost reports as the base for Medicaid rates.

Base Year:

The base year for 1985 and subsequent year Medicaid rates will be the individual hospitals Medicare TEFRA base year.

Inflation Factor:

PRDOH, using TEFRA base year rates as base period will increase such rates by 100% of the published TEFRA increase as an inflation factor. Compatibility with Puerto Rico health care costs was the determining factor in reaching the decision to use the TEFRA increase.

Allowable Costs:

The Medicare definition of allowable cost, plus other Medicaid costs such as Professional Services including Group Practice Contracts, Intern and Residents and Nursery costs shall be used to establish Medicaid Inpatient Costs.

TN 91-2 Approval Date NOV 7 1991
Supersedes TN 84-4 Effective Date III 1 1991

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Rates Appeals Procedure;

Due to unique characteristic of our Medicaid Program where all participating providers are public facilities or contracted hospitals, the rates appeals procedure is not a significant part of our methods and standards for setting rates. Nevertheless, any provider of inpatient services may request a review of their rate in the event that the provider encounters extraordinary circumstances or a change in the case mix as described in federal regulations placing a ceiling in the rate of hospital cost increases.

Upper Limits:

The necessary mechanism for insuring that the lower of costs or changes will be paid according to 42 CFR 447-271 and Medicare cost limits will be applied as per 42CFR 405.463.

Hospitals which serve disproportionate number of low income patients:

All participating hospitals, public and contract operated, serve a large number of low income patients, and none disproportionately so.

PR has no DSH program, by statute

Determination of Patient Days:

Patient Days-unit which stands for services rendered to an inpatient for a 24 hour interval. The standard to be used in calculating this unit are as follows:

- a. The 24 hour interval between the census-taking hour on two consecutive days.
- b. Admission day count as a patient day, but not so the discharge day or the day of death.
- c. Total patient day for a specific day will be that day census plus one additional day for each patient that is admitted and discharged or deceased on the same day.
- d. A patient day must never be divided or reported as a fraction day.
- e. In Puerto Rico, three newborn patient days equal to one adult patient day.

Assurance for change of Ownership (DEFRA 2314)

In Puerto Rico, only Government owned or contracted hospitals are paid to provide services to Medicaid eligibles. Consequently, a change of ownership would become a private hospital which would not receive any

84-4 superseded NEW

Approval Date SEP. 30 1988

Effective Date OCT. 1 1984

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payment for Medicaid Eligibles. In the case of contracted hospitals, while a transfer of plant and equipment takes place, the transfer is valid only for the duration of the contract and does not involve reevaluation of assets.

Therefore, it is hereby assured that payments to hospitals in Puerto Rico under the Medicaid Program will not be increased solely as a result of change of ownership.

84-4
supersedes
NEW

Approval Date SEP. 30 1986

Effective Date OCT. 1 1984

PUERTO RICO STATE PLAN

OMB No: 0938-1136
CMS Form: CMS-10364

Attachment 4.19 A
Page 4

Citation

42 CFR 447, 434, 438, AND 1902 (a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payments under Section 4.19 A of this State Plan.

- Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement surgery or hip replacement surgery in pediatric and obstetric patients.

Other Provider Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 A of this state Plan.

- Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below

Effective May 2, 2013, reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Provider Preventable Conditions are defined as two distinct categories: Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC).

In Puerto Rico, managed care entities and third party administrators' contract with provider and pay provider; there is no fee for service program. The managed care entities and third party administrators shall exclude payment for diagnoses not present on admission for any HCAC. The managed care entities and third party administrators shall report to Puerto Rico on the occurrence of HCACs, OPPCs and the corresponding reductions in payment on a [monthly] basis.

No payment shall be made for inpatient services for OPPCs. OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure on the wrong patient.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the provider.

Reductions in provider payment may be limited to the extent that the following apply:

- i. The Identified PPC(s) would otherwise result in an increase in payment.
- ii. The Territory can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, PPC(s)

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

TN No: 12-001

Supersedes TN No: NEW Approval Date: MAY 15 2013 Effective Date: May 2, 2013

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Commonwealth of Puerto RicoMethods and Standards for Establishing Payment Rates for each of the other Types of Care or Services

1a. Outpatient hospital services: Reasonable cost as specified in federal Reg. 250.30 (B) (3) (ii). There is an all-inclusive rate for services provided in governmental medical installations including contract facilities.

1b. Rural Health Clinics:

"Provider clinics" will be reimbursed on the basis of the principles specified in the Medicare regulations located at 42-CFR-405 Part D.

"Non-provider clinics" will be paid for each ambulatory service, other than rural health clinic services, at rates or charges established by the State, subject to the upper limits specific in 42-CFR-447.321. Rural health clinic services will be paid at the Medicare reimbursement rate per visit, as specified in 42-CFR-405-2426, - 405-2429.

c. Federally Qualified Health Care Centers

These will be reimbursed based upon the principles specified in the Medicare regulations at 42 CFR 405.

2. Other laboratory and X-ray services-

Reimbursement on basis of an all-inclusive out-patient hospital or clinic rates.

3. Skilled nursing home services-

Limited to services provided in public facilities.
No FFP presently claimed for these services.

4. Physicians' Services

a) Physicians and other practitioners on salary in clinics and other organized systems-Actual cost included in the clinic fee.

b) Private practitioners: will be paid according to a standard fee regulated by the Secretary of Health.

5. Dental Services-

Limited to services provided in public facilities including contract facilities. Reimbursement as part of an all inclusive out-patient hospital or clinic rate.

6. Prescribed drugs and medical supplies-

90-2

SEP 07 1990

Supersedes TN 84-3

APR 01 1990

Reimbursement on basis of an all inclusive out-patient hospital or clinic rate.

7. Clinic Services

Reasonable cost as specified in Federal Reg. 250.30 (B) (3) (ii). There is an all inclusive rate for services provided in governmental medical installations including contract facilities.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: COMMONWEALTH OF PUERTO RICO

Payment Rates for Obstetrical and Pediatric Services are in accord with Section 6402 of the Omnibus Budget Reconciliation Act of 1989. (P.L. 101-239)

All Medicaid services are furnished through public facilities, and all public facilities furnish services. There are no true fee-for service payment rates. However, obstetrical and pediatric services (furnished through the public system) are available to Medicaid recipients to the same extent that they are available to the general population.

TN 90-2
Supersedes TN NEW

Approval Date SEP 07 1990
Effective Date APR 01 1990

OFFICIAL

STATE PLAN UNDER THE SOCIAL SECURITY ACT
STATE Commonwealth of Puerto Rico

Methodology to Establish a Prospective Payment System (PPS) for Federally Qualified Health Centers and Rural Health Centers in accordance with the Benefits Improvement and Protection Act of 2000 (BIPA)

The Medicaid State Agency will determine the total costs of the Medicaid covered services furnished by the FQHCs/RHCs during fiscal years 1999 and 2000 and divide these costs by the total number of visits made to the FQHC/RHC by Federally matchable Medicaid beneficiaries. The resulting quotient will be the FQHC/RHC prospective payment rate (PPS) for 2001. This PPS rate will be updated annually in accordance with the Medicare Economic index (MEI) as published by the Centers for Medicare and Medicaid Services. PPS rates will also be adjusted for a change in the scope of services. A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services.

For new providers (entities first qualifying as FQHC/RHC after December 31, 2000), interim PPS rates will be calculated. These rates will be subject to final settlements through December 31 of the initial and second year of the FQHC/RHC's existence. New FQHC/RHC's rate years will be calendar years, thus the initial year may represent less than a full year of operation. The interim PPS encounter rate will be the Commonwealthwide average PPS encounter rate. After the first two years, the PPS encounter rate will be based on the average of the first two years' encounter rates, as determined at final settlement, adjusted by the MEI and any changes in scope of services.

TN

02-01

Approved date

APR 08 2003

SupercedesTN

New
new

Effective date

JUL 01 2002

STATE PLAN UNDER THE SOCIAL SECURITY ACT
STATE Commonwealth of Puerto Rico

OFFICIAL

Methodology for Wrap around payments to Federally Qualified Health Centers/Rural Health Centers (FQHC/RHC)

Wrap around payments to Federally Qualified Health Centers and Rural Health Centers serving Federally matched Medicaid beneficiaries in managed care plans will be made on a quarterly basis. Effective for managed care encounters provided on or after January 1, 2001, the amount of the wrap around will be calculated based on the FQHC/RHC PPS encounter rate. The FQHC/RHC will receive 100% of the difference between what it would have received under PPS and the revenues received from the managed care organization for services rendered to Federally matchable Medicaid beneficiaries. In the event that the revenues received from the managed care organization are equal to or in excess of what the FQHC/RHC would have received under PPS, no wrap around payment will be made. In the event that the Medicaid Agency erroneously overpays the FQHC/RHC (e.g., makes a wrap around payment when none was due), the provider must reimburse the Commonwealth for the amount of the overpayment within 90 days of being notified of the overpayment.

TN **02-01**

Supercedes TN **New**
new

Approved date **APR 08 2003**

Effective date **JUL 01 2002**

8. Family Planning Services-

No reimbursement with FFP

9. Early and Periodic Screening, Diagnosis, and Treatment of Conditions Found-

Reimbursement either as out-patient clinic or inpatient hospital services on the basis of an all inclusive rate, except for screening services for which no FFP is presently claimed.

11. Transportation

Ambulance provided and reimbursed as part of all inclusive rate. Other, provided but not reimbursed with FFP.

12. Home Health Services-

No reimbursement with FFP.

13a. Physical Therapy and related services

Limited to services provided in certain public facilities including contract facilities.
Reimbursement on basis of all inclusive outpatient or clinic rate.

13b. Occupational therapy

Limited to services provided in certain public facilities including contract facilities.
Reimbursement on the basis of all inclusive outpatient or clinic rate.

13c. Speech, hearing, and related services-

Limited to services provided in certain public facilities including contract facilities.
Reimbursement on the basis of an all inclusive outpatient or clinic rate.

14. Other diagnostic, etc.-

Limited to services provided in public facilities including contract facilities. Reimbursement on basis of all inclusive outpatient or clinic rate.

TN# 843
supersedes
TN #848

approval date MAY 24 1985
effective date OCT 1 1984

OFFICIAL

15. Emergency Hospital Services-

Limited to services provided on an outpatient basis in public facilities including contract facilities. Reimbursement on basis of all inclusive outpatient or clinic rate.

OFFICIAL

PUERTO RICO STATE PLAN

OMB No: 0938-1136
CMS Form: CMS-10364

Attachment 4.19 B
Page 4

Citation

42 CFR 447, 434, 438, AND 1902 (a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 B of this State Plan.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below

Effective May 2, 2013 reimbursement for non-institutional services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

In Puerto Rico, managed care entities and third party administrators' contract with provider and pay provider; there is no fee for service program. The managed care entities and third party administrators shall exclude payment for diagnoses not present on admission for any HCAC. The managed care entities and third party administrators shall report to Puerto Rico on the occurrence of HCACs, OPPCs and the corresponding reductions in payment on a [monthly] basis.

No payment shall be made for services for OPPCs. OPPC in one category of PPC as identified by the Centers for Medicare & Medicaid Services and apply broadly to any health care setting where an OPPC may occur. OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the provider.

Reductions in provider payment may be limited to the extent that the following apply:

- i. The identified PPC(s) would otherwise result in an increase in payment.
- ii. The Territory can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC(s)

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

TN No: 12-001

Supersedes TN No: NEW Approval Date: MAY 15 2013 Effective Date: May 2, 2013

OFFICIAL

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Supplement 1 to ATTACHMENT 4.19-B
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

Not Applicable

TN No. 92-1
Supersedes _____ Approval Date APR 8 1992 Effective Date JUL 1 1991
TN No. **New** HCFA ID: 7982E

OFFICIAL

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Supplement 1 to ATTACHMENT 4.19-B
Page 2
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs: Part A ___ Deductibles ___ Coinsurance
 Part B ___ Deductibles ___ Coinsurance

Other Part A ___ Deductibles ___ Coinsurance
Medicaid
Recipients Part B ___ Deductibles ___ Coinsurance

Dual Part A ___ Deductibles ___ Coinsurance
Eligible
(QMB Plus) Part B ___ Deductibles ___ Coinsurance

Not Applicable

TN No. 92-1 Approval Date APR 8 1992 Effective Date JUL 1 1991
Superseded **New**
TN No. New

HCFA ID: 7982E

OFFICIAL

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

Supplement 1 to ATTACHMENT 4.19-B
Page 3
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Not Applicable

TN No. 92-1
Supersedes New Approval Date APR 8 1992 Effective Date JUL 1 1991
TN No. New

HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

OFFICIAL

State Commonwealth of Puerto Rico

No claims are being made for Federal matching for patients receiving nursing home services.

St. P.R. Tr. 11/12/76 Incorp. 12/17/76 Effective 12/31/76

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of COMMONWEALTH OF PUERTO RICO

The definition of a claim for purposes of meeting the requirements of 42 CFR 447.45 is as follows:

for all services covered Under State Plan;
A Bill for Services.

P.R. 9/28/79 Incorp. 11/9/79 10-1-79

14-1

OFFICE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Commonwealth of Puerto Rico

Conditions for Direct Payment for Physicians and Dentists Services.

Not applicable. No direct payments are made under Title XIX.

PR 6/20/74 10/15/74 4/1/74

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

Requirements for Third Party Liability -
Identifying Liable Resources

1. The agency will perform matches specified in 42 CFR 433.138 (d) (1) on a monthly basis, in 433.138 (d) (3) on a continuing basis, and does not yet perform the matches in 433.138 (d) (4).
2. The agency follows on all match results immediately; but never later than 45 days. The information is then included in the master file.
3. At the time these matches are operationalized, the information will be added to the master file at once, but not later than 45 days. Since the provider of services is also the agency, new information on all other potential payers is immediately incorporated.
4. Since the agency is the provider, such services are identified upon admission and no claim is generated if there is another available payor. If new information regarding other payers is uncovered it is added in the file immediately, but never later than 45 days.

OFFICIAL

TN No. 88-3

Supersedes

TN No. 84-3

Approval Date OCT 20 1988

Effective Date 4/1/88

HCFA ID: 1076P/0019P

(ATT. 4.22 A PAGE 1 & 2)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

Requirements for Third Party Liability -
Payment of Claims

Puerto Rico has established methods through which providers have to screen first for TPL payments where third party liability is known to exist, prior to submitting claims to Medicaid.

In the scarce cases where Medicaid has to seek third party reimbursement, input will be accepted in any amount offered.

In determining pursue of recovery for the Medicaid Program, the following threshold figures are used:

Source of recovery	Amount
(a) Insurance such as:	
1. Blue Cross	\$500
2. Triple S	\$500
3. Other Health Insurance	\$500
4. Tort Liability	\$500

Recovery in cases which fall below these figures will not be sought because pursuit of reimbursement has proven not to be cost effective.

OFFICIAL

TN No. 88-3
Supersedes
TN No. NEW

Approval Date OCT 20 1987 Effective Date _____

ORIGINAL

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 4.22-C
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans
	Not Applicable

TN No. 92-8
Supersedes
Approval Date OCT 14 1992
Effective Date JUL 1 1992
TN No. New
HCFA ID: 7985E

OFFICIAL

SUPPLEMENT TO ATTACHMENT 4.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Commonwealth of Puerto Rico

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(A)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

TN# 12-002

Effective Date: APR 01 2012
Approval Date: SEP 06 2012

State/Territory: Puerto Rico

Citation

Sanctions for Psychiatric Hospitals

1902(y)(1),
1902(y)(2)(A),
and Section
1902(y)(3)
of the Act
(P.L. 101-508,
Section 4755(a)(2))

(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.

1902(y)(1)(A)
of the Act

(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.

1902(y)(1)(B)
of the Act

(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:

1. terminate the hospital's participation under the State plan; or
2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.

1902(y)(2)(A)
of the Act

(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

Not Applicable

TN No. 93-1
Supersedes
TN No. **New**

Approval Date JAN 11 1994

Effective Date JUL 1 - 1993

State: [Puerto Rico] Citation1932(e)
42 CFR 438.726Sanctions for MCOs and PCCMs

- (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:

Pursuant to the terms and conditions of Commonwealth's Law 72 of November 7, 1993 and the existing Cooperative Agreement with the Department of Health, the Puerto Rico Health Administration (PRHIA) monitors violations for actions and failures as specified under 42CFR Part I 438 in accordance with the process and procedures set forth on the MCOs and PIHPs contracts and through the Plan Compliance Program's work plan, which serves as an instrumental tool for all programmatic and contract provisions monitoring.

Intermediate Sanctions: The PRHIA may impose intermediate sanctions to MCOs and PIHPs if they engage in any of the practices as set forth:

- (1) Fails to substantially provide medically necessary services to enrollees under this contract;
- (2) Imposes on enrollees premiums and charges in excess of the ones permitted under this contract;
- (3) Discriminates among enrollees on the basis of their health status or requirements for health care (such as terminating an enrollment or refusing to reenroll) except as permitted under the Program or engages in practices to discourage enrollment by recipients whose medical condition or history indicates need for substantial medical services;
- (4) Misrepresents or falsifies information that is furnished to CMS, to the PRHIA, to an enrollee, potential enrollee or provider of services;
- (5) Distributes, directly or indirectly through any agent, independent contractor, marketing material not approved by the PRHIA, or that contains false or misleading information;
- (6) Fails to comply with the requirements for physician incentive plans in section 1876 (i) (8) of the Social Security Act, and at 42 CFR 417.479, or fails to submit to the PRHIA its physician incentive plans as requested in 42 CFR 438.6(h);
- (7) Has violated any other applicable requirements of section 1903(m) or 1932 of the Social Security Act and any implementing regulations.

TN # 03-12
Supersedes TN # New **New**

Effective Date 08/13/03
Approval Date 02/24/04

State: Puerto Rico

Types of intermediate sanctions the PRHIA may impose:

The following types of intermediate sanctions may be imposed: Civil monetary penalties, termination, temporary management and granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll; suspension of all new enrollment, including default enrollment after effective date of a sanction; suspension of payment for enrollees after the effective date of the sanction and until CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur and temporary management.

Sanctions for MCOs and PCCMs

Civil Monetary Penalties(CMP) amounts thresholds are the following:

- (i) Between (\$500) to a maximum of (\$25,000) dollars for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; or marketing violations; or engages in behavior contrary to any requirements of section 1903(m) and 1932 of the Social Security Act and any implementing regulations;
 - (ii) A maximum (\$100,000) for each determination of discrimination, or misrepresentation, or false statements to CMS or the PRHIA pursuant to 438 CFR 704(b) (2);
 - (iii) A maximum (\$15,000) per incident up to a maximum of \$100,000 for each enrollee that was not enrolled because of a discriminatory practice;
 - (iv) A maximum (\$25,000), or double amount of excess charges, whichever is greater, for charging premiums or charges in excess of amounts permitted under Medicaid regulations.
- (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

Special Rule: Temporary management only if it finds that egregiously or repeatedly behavior have been engaged in any of the stated practices on paragraph (a) of this article; or places a substantial risk on the health of enrollees; or engages in behavior contrary to any requirements of sections 1903(m) and 1932 of Title XIX, or there is a need to assure the health and safety of enrollees during an orderly termination, reorganization of the MCO, or while improvements are being made to correct violations. When imposing temporary management PRHIA must permit enrollees the right to terminate enrollment without cause, as described in 42 CFR 438.702(a) (3) and must notify enrollees of their right to disenroll.

TN # 03-12
Supersedes TN # New **Now**

Effective Date 08/13/03
Approval Date 02/24/04

State: [Puerto Rico]

- (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

— Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

TN # 03-12
Supersedes TN # New **New**

Effective Date 08/13/03
Approval Date 02/24/04

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Commonwealth of Puerto Rico

4.32 Income and Eligibility Verification System

The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (Section 1137 of the Act and 42 CFR 435.940 through 435.960)

(c) ATTACHMENT 4.32-A describes in accordance with 42 CFR 435.948(a)(6) the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

TN# 12-003

Effective Date: APR 01 2012

Approval Date: SEP 20 2012

Revision: HCFA-PM-86-9 (BERC)
MAY 1986

OFFICIAL

ATTACHMENT 4.32-A
Page 1
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Territory: PUERTO RICO

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

TN No. 86-2
Supersedes
TN No. NEW

Approval Date MAR. 17 1987

Effective Date SEP. 5 1986

HCFA ID: 0124P/0002P

OFFICIAL

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

ATTACHMENT 4.33-A
Page 1
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

Cards are not mailed to recipients, they are issued
at interview at the local eligibility unit.

TN No. 88-1
Supersedes
TN No. NEW

Approval Date 10/20/89

Effective Date 4/1/88

HCFA ID: 1080P/0020P

Revision: HCFA-PM-90- 2 (BPD)
JANUARY 1990

ATTACHMENT A.35-A
Page 1
OMB No.: 0938-0193

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

CRITERIA FOR THE APPLICATION OF SPECIFIED REMEDIES FOR
SKILLED NURSING AND INTERMEDIATE CARE FACILITIES
(When and how each remedy is applied, the amounts of any fines,
and the severity of the remedies)

At present, we are not paying skilled nursing facilities.

Puerto Rico will indicate compliance with skilled nursing
facilities requirements at the future, when and if they are
developed.

TN 90-1 Approval Date APR 22 1990
Supersedes TN NEW Effective Date APR 01 1990

Revision: HCFA-PM-90-2 (BPD)
JANUARY 1990

OFFICIAL

ATTACHMENT 4.35-B
Page 1
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ALTERNATIVE REMEDIES TO SPECIFIED REMEDIES FOR
SKILLED NURSING AND INTERMEDIATE
CARE FACILITIES

At the time and if Puerto Rico establishes a skilled nursing facility, we will present the alternatives to specified remedies.

TN 90-1 Approval Date AUG 22 1990
Supersedes TN NEW Effective Date APR 01 1990

OFFICIAL

Revision: HCFA-PM-91-10

(BPD)

ATTACHMENT 4.38

Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

TN No. 92-10

Superseded
TN No. **New**

Approval Date OCT 14 1992

Effective Date JUL 1 1992

HCFA ID:

OFFICIAL

Revision: HCFA-PM-91-10

(BPD)

ATTACHMENT 4.38A

Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

JUL 1 1992

TN No. 92-10

Supersedes

TN No.

New

Approval Date OCT 14 1992

Effective Date JUL 1 1992

HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Puerto Rico

DEFINITION OF SPECIALIZED SERVICES

Not Applicable

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Puerto Rico

CATEGORICAL DETERMINATIONS

Not Applicable

TN No. PR 93-3
Supersedes New Approval Date JAN 12 1994 Effective Date JUL 1 - 1993
TN No. New

OFFICIAL

Revision: HCFA-PM-92-3
APRIL 1992

(HSQB)

Attachment 4.40-A
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

Not Applicable

TN No. 92-6

Superseded

TN No.

New

Approval Date

OCT 14 1992

Effective Date

JUL 1 1992

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(HSQB)

Attachment 4.40-B
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

Not Applicable

TN No. 92-6

Supersedes

TN No.

New

Approval Date OCT 14 1992

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Attachment 4.40-C
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Puerto Rico

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

Not Applicable

TN No. 92-6
Supersedes
TN No. **New**

Approval Date OCT 14 1992

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Attachment 4.40-D
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

Not Applicable

TN No. 92-6
Supersedes
TN No.

New

Approval Date OCT 14 1992

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

- (i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;
- (ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or
- (iii) the State has reason to question the compliance of the facility with such requirements.

Not Applicable

TN No. 92-6
Supersedes
TN No. **New**

Approval Date OCT 14 1992

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HCFA ID: _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Commonwealth of Puerto Rico

METHOLODOLGY FOR THE IMPLEMENTATION OF THE
EMPLOYEE EDUCATION ABOUT FALSE CLAIMS ACT

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The Department of Health, as the Single State Agency, instructs its sub-grantee, the Puerto Rico Health Insurance Administration (ASES), to require all contracted entities, no later than June 15, 2010; to provide evidence of compliance with Section 1902(a)(68) of the Social Security Act. For calendar years 2007, 2008 and 2009, all entities who in federal fiscal years (FFY) 2006, 2007 and 2008 met the \$5,000,000 dollar annual threshold, attest certifying to the fact that they were in compliance with Section 1902(a)(68) of the Social Security Act.

For subsequent years beginning with calendar year 2010, the Puerto Rico Health Insurance Administration, on behalf of the Single State Agency, will require that all contracted entities who meet the \$5,000,000 dollar threshold as of September 30th, provide the items listed below no later than December 30, of each year as evidence of compliance with Section 1902(a)(68) of the Social Security Act. Contracted entities who fail to comply with these requirements will be fined by the ASES.

- a) Acknowledgment of Compliance with Section 1902(a)(68) of the Social Security Act.
- b) Copy of Policies and Procedure developed to comply with Section 1902(a)(68) of the Social Security Act. A copy of the employee handbook should also be provided if the contracted entity has an employee handbook.

The ASES will provide the Single State Agency a copy of each document listed above from each contracted entity who meets the requirements.

TN No. 07-12
Supersedes _____
TN No. _____

Approval Date APR 16 2010 Effective Date JAN 01 2007

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Attachment 4.46

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Commonwealth of Puerto Rico

4.46 Provider Screening and Enrollment

Citation

1902(a)(77)
1902(a)(39)
1902(kk);
P.L. 111-148 and
P.L. 111-152

The State Medicaid agency gives the following assurances:

42 CFR 455
Subpart E

PROVIDER SCREENING

_____ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

442 CFR 455.410

ENROLLMENT AND SCREENING OF PROVIDERS

_____ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.

_____ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.

42 CFR 455.412

VERIFICATION OF PROVIDER LICENSES

_____ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.

42 CFR 455.414

REVALIDATION OF ENROLLMENT

_____ Assures that providers will be revalidated regardless of provider type at least every 5 years.

42 CFR 455.416

TERMINATION OR DENIAL OF ENROLLMENT

_____ Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420

REACTIVATION OF PROVIDER ENROLLMENT

_____ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422

APPEAL RIGHTS

_____ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

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OFFICIAL

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Attachment 4.46

- 42 CFR 455.432 SITE VISITS
_____ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.
- 42 CFR 455.434 CRIMINAL BACKGROUND CHECKS
_____ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.
- 42 CFR 455.436 FEDERAL DATABASE CHECKS
_____ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.
- 42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER
_____ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.
- 42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS
_____ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.
- 42 CFR 455.460 APPLICATION FEE
_____ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.
- 42 CFR 455.470 TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS
_____ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

74-1

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State: Commonwealth of Puerto Rico

Methods of Administration: Civil Rights

The Civil Rights of all persons in need of services under Title XIX are protected by the Bill of Rights of the constitutions of the United States and of the Commonwealth of Puerto Rico.

Article II, of the Constitution of the Commonwealth of Puerto Rico defines the specific rights of citizens.

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