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Departamento de Salud

ASES
Administración de Seguros de Salud de Puerto Rico

**PUBLIC NOTICE**

**Amendment to the Puerto Rico Medicaid and CHIP State Plans**

In compliance with the federal regulation, 42 CFR §447.57, 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) notify their intent to submit an amendment to the Puerto Rico Medicaid and CHIP State Plans to establish a New Cost Sharing Structure to be approved for the Centers for Medicare & Medicaid Services (CMS). This Public Notice and the State Plan Amendment (SPA) will not apply to individuals eligible for the Government Health Plan as State or Commonwealth beneficiaries.

The Medicaid Program and ASES have issued a "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. This Public Notice provides a summary of said Policy: (i) Medicaid beneficiaries are only subject to copayments and to no other form of cost sharing, such as coinsurances or deductibles; (ii) CHIP beneficiaries (Medicaid Optional Targeted Low-Income Children) do not pay copayments or any other form of cost sharing, such as coinsurances or deductibles; and (iii) certain beneficiaries and services are exempt from any cost sharing. The Policy also indicates that the New Cost Sharing Structure will apply to all Medicaid and CHIP beneficiaries and will:

1. Be effective on July 1st, 2016; except for those Medicaid dual beneficiaries with Medicare Part A and B and who are enrolled in a Medicare Advantage (MA) Plan contracted with ASES, commonly known as Platino Plan. For Platino Plans, the New Cost Sharing Structure will be implemented on January 1st, 2017.
2. The Medicaid and CHIP Coverage Codes: (i) At July 1st, 2016 and until implementation of MAGI Methodologies for determining Medicaid & CHIP eligibility, the Medicaid Program will continue assigning Medicaid and CHIP Coverage Codes for a beneficiary on the basis of the eligibility monthly income and the number of members in the family unit of the beneficiary. (ii) On and after implementation of MAGI Methodologies for determining Medicaid & CHIP eligibility, the Medicaid Program will be determined the Medicaid and CHIP Coverage Codes for an individual on the basis of MAGI Monthly Income and MAGI Household Size of the individual. Coverage Codes vary by household income ranges measured as a percentage of the Puerto Rico Poverty Level (PRPL) in effect. [Note: Obamacare provides a new method for determining eligibility of individuals for Medicaid and CHIP, based on what is called Modified Adjusted Gross Income (MAGI).]
3. Expand the number of coverage codes: The new coverage codes 120, 130, and 220 and the copayments amounts associate with these codes will be implemented when MAGI eligibility evaluation system go-lives.
4. Revise some copayments amounts on existing coverage codes, and establish copayment amounts on new coverage codes. Starting on July 1st, 2016, all Medicaid beneficiaries with the coverage codes 100 or 110 will pay the new the copayments amounts associate with these codes and all CHIP beneficiaries with the coverage code 230 will continue paying the copayments amounts associate with these codes, which remains as zero ($0). After implementation of MAGI methodologies for determining Medicaid and CHIP eligibility, all Medicaid beneficiaries assigned the new coverage codes 120 and 130 will pay the copayment amounts associate with these codes and all CHIP beneficiaries with the coverage code 220 will pay the copayments amounts associate with this codes, which is zero ($0).
5. Copayment amount vary by coverage codes and by service, as shown in the following table.

| Cost Sharing Structure for Medicaid and CHIP Beneficiaries | | | | | | |
|---|---|---|---|---|---|---|
| Services | Copayment Amounts by Coverage Code | | | | | |
| | Medicaid | | | | CHIP | |
| | 100 | 110 | 120 | 130 | 220 | 230 |
| Hospital Admission, (per entire stay) | $0.00 | $4.00 | $5.00 | $8.00 | $0.00 | $0.00 |
| Non-Emergency Services Provided in a Hospital Emergency Room, (per visit) | $0.00 | $4.00 | $5.00 | $8.00 | $0.00 | $0.00 |
| Non-Emergency Services Provided in a non-Hospital or Freestanding Emergency Room, (per visit) | $0.00 | $2.00 | $3.00 | $4.00 | $0.00 | $0.00 |
| Visit to Primary Care Physician (PCP), (per visit) | $0.00 | $1.00 | $1.50 | $2.00 | $0.00 | $0.00 |
| Visit to Specialist, (per visit) | $0.00 | $1.00 | $1.50 | $2.00 | $0.00 | $0.00 |
| Visit to Sub-Specialist, (per visit) | $0.00 | $1.00 | $1.50 | $2.00 | $0.00 | $0.00 |
| High-Tech Laboratories, (per procedure) | $0.00 | $0.50 | $1.00 | $1.50 | $0.00 | $0.00 |
| Clinical Laboratories, (per procedure) | $0.00 | $0.50 | $1.00 | $1.50 | $0.00 | $0.00 |
| X-Rays, (per procedure) | $0.00 | $0.50 | $1.00 | $1.50 | $0.00 | $0.00 |
| Special Diagnostic Test, (per procedure) | $0.00 | $1.00 | $1.50 | $2.00 | $0.00 | $0.00 |
| Therapy - Physical, (per procedure) | $0.00 | $1.00 | $1.50 | $2.00 | $0.00 | $0.00 |
| Therapy - Respiratory, (per procedure) | $0.00 | $1.00 | $1.50 | $2.00 | $0.00 | $0.00 |
| Therapy - Occupational, (per procedure) | $0.00 | $1.00 | $1.50 | $2.00 | $0.00 | $0.00 |
| Dental - Preventative, (per procedure) | $0.00 | $1.00 | $1.50 | $2.00 | $0.00 | $0.00 |
| Dental - Restorative, (per procedure) | $0.00 | $1.00 | $1.50 | $2.00 | $0.00 | $0.00 |
| Pharmacy - Preferred, (per drug) | $0.00 | $1.00 | $2.00 | $3.00 | $0.00 | $0.00 |
| Pharmacy - Non-Preferred, (per drug) | $0.00 | $3.00 | $4.00 | $6.00 | $0.00 | $0.00 |
| All Other Services or Items Not Specified Above | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

**Medicaid Beneficiaries Enrolled in a Platino Plan**

The New Cost Sharing Structure will be implemented on January 1st, 2017 for those Medicaid dual beneficiaries with Medicare Part A and B who are enrolled in a Medicare Advantage Plan contracted with ASES, commonly known as a Platino Plan. From July 1st to December 31st 2016, this beneficiary will continue using his/her current ID Card. If during the period from July 1st to December 31st 2016, the Medicaid Program performs a Medicaid beneficiary determination or redetermination on a beneficiary who enrolls in, or is enrolled in, a Platino Plan, and the beneficiary is assigned a coverage code 120 or 130, the MAO will treat that beneficiary as if the coverage code was assigned as 110. A Platino Plan Beneficiary can submit a reimbursement request as soon as he/she believes he/she has exceeded the 5% limit per quarter as it is described under the section "Five Percent (5%) Limit or Cap Per Quarter on All Copayments".

**Copayments are not Charged to the Following Groups of Beneficiaries**

The federal regulation, 42 CFR §447.56(a)(1), states that there are certain groups of individuals who are exempted from any copayments. The following beneficiaries do not have to pay any copayment: (i) children from 0 to less than 21 years of age; (ii) pregnant women, during pregnancy and the post-partum period; (iii) institutionalized individuals; (iv) an individual receiving hospice care; and (v) American Indians and Alaskan Natives (AI/AN).

**Copayments are not Charged for the Following Services**

The federal regulation, 42 CFR §447.56(a)(2), states that certain health care services are exempted from any copayments. The beneficiaries do not have to pay any copayment for the following services: (i) emergency

services as defined at section 1932(b)(2) of the SSA and 42 CFR §438.114(a); (ii) family planning services and supplies (contraceptives); (iii) preventive services under 42 CFR §457.520; (iv) pregnancy-related services; and (v) provider-preventable services as defined in 42 CFR §447.26(b).

**Other Copayment Exemptions**

1. Exemption for Receiving Services within the Preferred Provider Network: (i) A beneficiary does not have to pay any copayment when the service is provided by a provider who is part of the Preferred Provider Network. (ii) Dentists and Pharmacies are not part of the Preferred Provider Network.
2. Exemption for Calling the Medical Advice Service Line: A beneficiary does not have to pay any copayment for non-emergency services provided in a hospital emergency room when he/she: (i) calls the Medical Advice Service Line, prior to visiting the hospital emergency room; (ii) receives from the Service Line a code or an identification number, and (iii) presents such code or identification number at the time of the visit to the hospital emergency room.
3. Exemption for Preventive Services: A beneficiary does not have to pay any copayment for the following diagnostics tests when the test is provided as part of a preventive service: (i) high-tech laboratories; (ii) clinical laboratories; (iii) x-rays; and (iv) special diagnostic test.

**Copayment for Non-Emergency Services Provided in a Hospital Emergency Room**

The Puerto Rico Medicaid State Plan allows charging copayment for non-emergency services provided in the hospital emergency room, unless (i) the beneficiary or the service is exempted from any copayments, (ii) the beneficiary has a coverage code 100, or (iii) the beneficiary follows one of the copayment exemptions describes under item "Exemption for Receiving Services within the Preferred Provider Network" or "Exemption for Calling the Medical Advice Service Line". If the beneficiary does not comply with one these copayment exemptions, the hospital's emergency room may charge the applicable copayment for this service only if it complies with the following requirements: (i) conducts an appropriate medical screening to determine that the beneficiary does not need emergency services, as required by the federal regulation (42 CFR §489.24); and (ii) before providing non-emergency services and imposing cost sharing for such services: inform the beneficiary of the amount of his/her copayment obligation for non-emergency services provided in the hospital emergency room; provide the beneficiary with the name and location of an available and accessible alternative non-emergency services provider; determine that the alternative provider can provide services to the beneficiary in a timely manner with the imposition of a lesser copayment amount or no copayment if the beneficiary is otherwise exempt from copayment; and provide a referral to coordinate scheduling for treatment by the alternative provider.

**Preferred Drugs List**

The Medicaid Program and ASES differentiate between preferred and non-preferred drugs. The Puerto Rico Medicaid State Plan will allow charging copayments for preferred and non-preferred drugs, unless the beneficiary or the services is exempted from any copayments.

**Five Percent (5%) Limit or Cap Per Quarter on All Copayments**

1. The federal regulation, 42 CFR §447.56(f), provides that Medicaid or CHIP copayments incurred by all eligible beneficiary in his/her Medicaid and CHIP household may not exceed an aggregate limit of five percent (5%) of the household's income applied on a quarterly basis. The 5% cap on total copayments per quarter is determined on the basis of: (i) at July 1st, 2016 and until implementation of MAGI Methodologies for determining Medicaid & CHIP eligibility, the Medicaid Program will continue determining the 5% cap on total copayments per quarter for a beneficiary on the basis of the eligibility monthly income and the number of members in the family unit of the beneficiary; and (ii) on and after implementation of MAGI Methodologies for determining Medicaid & CHIP eligibility, the Medicaid Program will determine the 5%

cap on total copayments per quarter for a beneficiary on the basis of his/her MAGI Monthly Income and his/her MAGI Household Size. For example: if a beneficiary Monthly Income is $300 per month, his/her quarterly copayment limit will be $45 ($300 x 3 months = $900 x 5% = $45).

2. A beneficiary's 5% cap or limit will be reached, if copayments paid in a quarter by his/her family unit or MAGI household members who are Medicaid and CHIP are summed together and the result exceeds the calculated 5% cap amount. The New Cost Sharing Structure does not place beneficiaries at risk of reaching the aggregate limit of 5% of the family unit or MAGI household income applied on a quarterly basis. Nevertheless, the Medicaid Program and ASES have a documented reimbursement request process for individuals that believe they have incurred cost sharing over the aggregate limit for a quarterly cap period, which includes an explanation of his/her right to appeal any decision and request a fair hearing.

**The Consequences for a Beneficiary Who Does Not Pay a Cost Sharing Charge**

When copayments charge are allowed, the provider, dentist, or pharmacy: (i) in the case of beneficiaries with an eligibility monthly income at or below 100% of the PRPL in effect, may request the applicable copayment amount but may not deny services to an eligible beneficiary on account of the his/her inability to pay the applicable copayment amount at the time of receiving a service, but the beneficiary will still be obligated to the provider for the amount of the unpaid copayment; and (ii) in the case of beneficiaries with a eligibility monthly income above 100% of the PRPL in effect, may request and collect the applicable copayment amount and deny services if the copayment is not paid.

**Mechanism for Required Cost Sharing Charges and Payments to Providers**

The MCOs, MAOs, and PBMs contracted by ASES (i) can impose copayments on beneficiaries up to the amounts specified under the Puerto Rico Medicaid State Plan, and presented in this Public Notice; and (ii) must reduce 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.

**Notice of the Results of Cost Sharing Determination**

The Medicaid Program notifies to the beneficiary the "Results of Cost Sharing Determination" through the MA-10 Form (Notification of Action Taken on Application and/or Recertification), which is provided after a determination or redetermination of eligibility, and/or when cost sharing coverage code or 5% cap are revised. ASES notifies to the beneficiary the assign coverage code and the copayments amounts through the ID Card, which is provided by the MCO (MAO for a Platino Plan).

**Appeals of Cost Sharing Determination**

The beneficiary is entitled to file an appeal and request a fair hearing to review the "Results of Cost Sharing Determination" that it is notified through the MA-10 when he/she is not in agreement with the decision made in his/her case. The request for review must be presented in writing and within a period of 30 days, counting from the Certification Date shown on the MA-10.

**Access to the Documents**

The following documents are available at any of the Medicaid Local Offices throughout the Island; at ASES Central Office (physical address: #1549 Calle Alda, Urbanización Caribe, Río Piedras, Puerto Rico 00926-2712); the Medicaid Program website (https://www.medicaid.pr.gov/); and ASES website (http://www.asespr.org/ or http://ases.pr.gov/).

1. Medicaid SPA for a New Cost Sharing Structure;
2. Cost Sharing Policy for Medicaid and CHIP Beneficiaries;
3. List of Hospital Emergency Rooms by MCO, that may charge the copayment for non-emergency services provided in the hospital emergency room;

4. Preferred and Non-Preferred Drugs Formulary, which is called *"Formulario de Medicamentos en Cubierta del Plan de Salud del Gobierno de PR"*; and
5. Process for Requesting Reimbursement of Excess Cost Sharing Payments and the reimbursement request form.

**State Plan Amendment Public Comment Period**

Any person may submit comments about the Medicaid SPA for the New Cost Sharing Structure within a term of thirty (30) calendar days from the publication of this Public Notice. The comments can be submitted: (i) by mail, to the following postal address: Mrs. Luz E. Cruz-Romero, MBA; Director of Operations Division (Medicaid SPA); Medicaid Program Central Office; P.O. Box 70184; San Juan, P.R. 00936-8184; (ii) in person at Puerto Rico Medicaid Program Central Office, at the following physical address: World Plaza; 268 Muñoz Rivera Avenue, 5th Floor; Hato Rey, Puerto Rico 00918; or (iii) by Facsimile (Fax), to the Operations Division Fax number: 787-759-8361.

**Disclosure**

The PRDoH (Medicaid Program) and ASES filed with the Commonwealth of Puerto Rico, Puerto Rico State Elections Commission, a certification to attest that this Public Notice is required by the federal regulation applicable to the Medicaid Program.

Authorized by the State Elections Commission (CEE) #CEE-C-16-055
Submitted on January 13, 2016
Announcement required by Law

Autorizado por la Comisión Estatal de Elecciones (CEE) #CEE-C-16-055
Sometido a la CEE el 13 de enero de 2016
Anuncio Requerido por Ley