



# Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: PR - 16 - 0002

Expiration date: 10/31/2014

## Cost Sharing Limitations

G3

42 CFR 447.56  
1916  
1916A

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

### Exemptions

#### Groups of Individuals - Mandatory Exemptions

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

- Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher
  - 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
- 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
- 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

Description:

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



# Medicaid Premiums and Cost Sharing

- The state runs periodic claims reviews
- The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
- The Eligibility and Enrollment and MMIS systems flag exempt recipients
- Other procedure

Description:

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.

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

## Payments to Managed Care Organizations

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

Yes



# Medicaid Premiums and Cost Sharing

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

## Aggregate Limits

- Medicaid premiums and cost sharing 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.

- Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

- As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.
- Managed care organization(s) track each family's incurred cost sharing, as follows:



# Medicaid Premiums and Cost Sharing

Other process:

- Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

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

Yes

Describe the appeals process used:

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

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

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

Description of additional aggregate limits:



# 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