ESTADO LIBRE ASOCIADO DE PUERTO RICO
Departamento de Salud

ASES
Administración de Seguros de Salud de Puerto Rico

PUERTO RICO MEDICAID PROGRAM

Cost Sharing Policy (Copayments) for Medicaid and CHIP Beneficiaries

Introduction

On July 15, 2013, the Centers for Medicare and Medicaid Services (CMS) published the final rule to update and simplify the Medicaid premium and cost sharing requirements, to promote the most effective use of services, and to assist states in identifying cost sharing flexibilities, (78 Federal Register page 42,100).

The federal regulation defines "*cost sharing*" as any copayment, coinsurance, deductible, or other similar charge. Copayment is a fixed amount (for example, $1) that the beneficiary pays directly to a provider for each covered health care service, usually when he or she receives at the time of the service.

The Puerto Rico Medicaid State Plan dictates that Medicaid beneficiaries may pay cost sharing. 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 (Copayments) for Medicaid and CHIP Beneficiaries" to establish copayment rules, as required by:

1. The Social Security Act (SSA), Sections 1916 and 1916A.

2. The federal regulation, 42 CFR §§447.50-447.57 (excluding 42 CFR §447.55) of the federal regulation.

3. The Puerto Rico State Plan Amendment (SPA) for Cost Sharing.

4. The New Cost Sharing (Copayment) Structure for Medicaid and CHIP Beneficiaries.

The federal regulation addresses the following topics:

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Medicaid Premiums and Cost Sharing

42 CFR §447.50 Premiums and cost sharing: Basis and purpose.

42 CFR §447.51 Definitions.

42 CFR §447.52 Cost sharing.

42 CFR §447.53 Cost sharing for drugs.

42 CFR §447.54 Cost sharing for services furnished in a hospital emergency department.

42 CFR §447.55 Premiums.

42 CFR §447.56 Limitations on premiums and cost sharing.

42 CFR §447.57 Beneficiary and public notice requirements.

The Policy establishes the following copayments rules, among others:

1. Medicaid beneficiaries are only subject to copayments and to no other form of cost sharing, such as coinsurances or deductibles.

2. CHIP beneficiaries (Children Health Insurance Program or Medicaid Optional Targeted Low-Income Children) do not pay cost sharing or any other form of cost sharing, such as coinsurances or deductibles.

3. Certain beneficiaries and services are exempt from any cost sharing, which mean that no copayment will be charged in these instances.

4. Copayment amounts can vary by coverage codes and by the type of covered health care service.

5. This Policy does not apply to individuals eligible for the Government Health Plan (GHP) as State or Commonwealth beneficiary.

Medicaid and CHIP Cost Sharing (Copayments) Structure Prior to July 1, 2016

Cost Sharing (Copayments) Policy for Medicaid and CHIP Beneficiaries:

1. The Cost Sharing (Copagos) Structure, coverage codes, and copayment amounts applied to all Medicaid and CHIP beneficiaries, were effective from November 1, 2011 through June 30, 2016.

2. The coverage codes were determined on the basis of the beneficiary Eligibility Monthly Income and the number of Members in the Family Unit. For example: if the Eligibility Income of a Medicaid beneficiary is $300 per month and the Members in the Family Unit is two (2), the coverage code assigned is 110. The evaluation uses Table I as follows:

   a. Eligibility Monthly Income = $300;

   b. Members in Family Unit = 2;

   c. Position on the row for Members in Family Unit of 2;

   d. Determine in which column of Coverage Codes on the row the Eligibility Monthly Income of $300 fits;

   e. The eligibility monthly income of $300 fits in range $249-UP which is under column 110; and

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f. Therefore, the beneficiary is assigned coverage code 110.

3. It does not apply to anyone who is eligible as a State or Commonwealth beneficiary.

The following three (3) tables illustrate the Cost Sharing (Copayments) Structure for Medicaid and CHIP Beneficiaries prior July 1, 2016:

1. Table I - Medicaid Coverage Codes, determined on the basis of eligibility monthly income and the number of members in the beneficiary's family unit.

2. Table II - CHIP Coverage Codes, determined on the basis of eligibility monthly income and the number of members in the beneficiary's family unit.

3. Table III - Medicaid and CHIP Coverage Codes and the applicable copayment amounts for each service.

TABLE I

Medicaid Cost Sharing (Copayments) Structure Prior to July 1st, 2016
Coverage Codes and Its Determination

Members in Family Unit	Eligibility Monthly Income Range by Coverage Code	
	100	**110**
1	$0-$200	$201-UP
2	$0-$248	$249-UP
3	$0-$295	$296-UP
4	$0-$343	$344-UP
5	$0-$390	$391-UP
6	$0-$438	$439-UP
7	$0-$485	$486-UP
8	$0-$533	$534-UP
9	$0-$580	$581-UP
10	$0-$628	$629-UP
11	$0-$675	$676-UP
12	$0-$723	$724-UP
13	$0-$770	$771-UP
14	$0-$818	$819-UP
15	$0-$865	$866-UP

TABLE II

CHIP Cost Sharing Structure (Copayments) Prior to July 1st, 2016 Coverage Codes and Its Determination	
Members in Family Unit	**Eligibility Monthly Income Range by Coverage Code**
	230
1	$551-$1,100
2	$551-$1,300
3	$551-$1,500
4	$551-$1,700
5	$551-$1,900
6	$551-$2,100
7	$551-$2,300
8	$551-$2,500
9	$551-$2,700
10	$551-$2,900
11	$551-$3,100
12	$551-$3,300
13	$551-$3,500
14	$551-$3,700
15	$551-$3,900

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TABLE III

Medicaid and CHIP Cost Sharing (Copayments) Structure Prior to July 1st, 2016
Applicable Copayment Amounts for Each Service by Coverage Code

Service	Coverage Codes and Copayments Amounts		
	Medicaid		CHIP
	100	110	230
Hospital Admission, (per entire stay)	$0.00	$3.00	$0.00
Non-emergency Services Provided in a Hospital Emergency Room (ER), (per visit)	$3.80	$3.80	$0.00
Visit to Primary Care Physician (PCP), (per visit)	$0.00	$1.00	$0.00
Visit to Specialist, (per visit)	$0.00	$1.00	$0.00
Visit to Sub-Specialist, (per visit)	$0.00	$1.00	$0.00
High-Tech Laboratories, (per procedure)	$0.00	$0.50	$0.00

TABLE III

Medicaid and CHIP Cost Sharing (Copayments) Structure Prior to July 1st, 2016
Applicable Copayment Amounts for Each Service by Coverage Code

Service	Coverage Codes and Copayments Amounts		
	Medicaid		CHIP
	100	110	230
Clinical Laboratories, (per procedure)	$0.00	$0.50	$0.00
X-Rays, (per procedure)	$0.00	$0.50	$0.00
Special Diagnostic Test, (per procedure)	$0.00	$1.00	$0.00
Therapy - Physical, (per procedure)	$0.00	$1.00	$0.00
Therapy - Respiratory, (per procedure)	$0.00	$1.00	$0.00
Therapy - Occupational, (per procedure)	$0.00	$1.00	$0.00
Dental - Preventative, (per procedure)	$0.00	$1.00	$0.00
Dental - Restorative, (per procedure)	$0.00	$1.00	$0.00
Pharmacy - Generic, (per drug)	$1.00	$1.00	$0.00
Pharmacy - Brand, (per drug)	$3.00	$3.00	$0.00
All Other Services or Items Not Specified Above	$0.00	$0.00	$0.00

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Medicaid and CHIP Cost Sharing (Copagos) Structure to be Effective On and After July 1, 2016

The New Cost Sharing Structure (Copayments) will apply to all Medicaid and CHIP beneficiaries and:

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. In Platino Plans, the New Cost Sharing Structure will be implemented on January 1st, 2017.

2. Assign the Medicaid and CHIP Coverage Codes on the basis of:

   a. MAGI: Obamacare provides a new method for determining eligibility of individuals for Medicaid and CHIP, based on what is called Modified Adjusted Gross Income (MAGI).

   b. At July 1, 2016 and until implementation of MAGI Methodologies for determining Medicaid and 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, as illustrates on Tables I and II.

   c. On and after implementation of MAGI Methodologies for determining Medicaid and CHIP eligibility:

(1) The Medicaid Program will be assigned the Medicaid and CHIP Coverage Codes for an individual on the basis of MAGI Monthly Income and MAGI Household Size of the individual.

(2) Coverage Codes vary by household monthly income ranges.

(3) Medicaid and CHIP Coverage Codes are based on ranges of MAGI Monthly Income as a percentage of the Puerto Rico Poverty Level (PRPL) in effect.

(4) Example: if the MAGI Monthly Income of a Medicaid beneficiary is $300 per month with a MAGI household size of two (2) the coverage code assigned is 110. The evaluation uses Table IV as follows:

(a) MAGI Monthly Income = 300;

(b) MAGI household size = 2;

(c) Position on the row for MAGI Household Size of 2;

(d) Determine in which column of Coverage Code 100, 110, 120 ó 130 on the row, the MAGI Monthly Income of $300 fits;

(e) MAGI Monthly Income of $300 fits in range $272-$542 which is under column 110; and,

(f) Therefore, the beneficiary is assigned coverage code 110.

3. Expand the number of coverage codes:

a. The new coverage codes 120, 130, and 220 and the copayments amounts associate with these codes will be implemented on and after MAGI eligibility evaluation system go-lives.

b. The new coverage codes will be assigned on the basis of MAGI Monthly Income and MAGI Household Size of the individual.

4. Revise some copayments amounts on existing coverage codes, and establish copayment amounts on new coverage codes.

a. Starting on July 1st, 2016:

(1) All Medicaid beneficiaries with the coverage codes 100 or 110 will pay the new the copayments amounts associate with these codes, as illustrate on Table VI.

(2) All CHIP beneficiaries with the coverage code 230 will continue paying the copayments amounts associate with this code, which remains as zero ($0) as illustrate on Table VI.

b. On and after the implementation of MAGI methodologies for determining Medicaid or CHIP eligibility:

(1) All Medicaid beneficiaries assigned the new coverage codes 120 and 130 will pay the copayment amounts associate with these codes, as illustrate on Table VI.

(2) All CHIP beneficiaries with the coverage code 220 will pay the copayments amounts associate with this codes, which is zero ($0) as illustrate on Table VI.

5. Copayment amount vary by coverage codes and by service.

The following three (3) tables illustrate the Cost Sharing (Coapyments) Structure for Medicaid or CHIP Beneficiaries to be effective on and after July 1st, 2016:

1. Table IV - Medicaid Coverage Codes, determined on the basis of MAGI Monthly Income and the MAGI Household Size of the individual. Coverage codes are assigned according to monthly income ranges defines as a percentage of the PRPL.

2. Table V - CHIP Coverage Codes, determined on the basis of MAGI Monthly Income and the MAGI Household Size of the individual. Coverage codes are assigned according to income ranges defines as a percentage of the PRPL.

3. Table VI - Medicaid and CHIP Coverage Codes and the applicable copayment amounts for each service.

TABLE IV

Medicaid Cost Sharing Structure (Copayments) to be Effective On and After July 1, 2016 Coverage Codes and Its Determination

MAGI Household Size	Puerto Rico Poverty Level (PRPL)	MAGI Monthly Income Range by Coverage Code			
		100	110	120	130
		Percentage of PRPL			
		0%-50%	51%-100%	101%-150%	151%-UP
1	$0-$459	$0-$230	$231-$459	$460-$689	$690-UP
2	$0-$542	$0-$271	$272-$542	$543-$813	$814-UP
3	$0-$626	$0-$313	$314-$626	$627-$939	$940-UP
4	$0-$709	$0-$355	$356-$709	$710-$1,064	$1,065-UP
5	$0-$792	$0-$396	$397-$792	$793-$1,188	$1,189-UP
6	$0-$876	$0-$438	$438-$876	$877-$1,314	$1,315-UP
7	$0-$959	$0-$480	$481-$959	$960-$1,439	$1,440-UP
8	$0-$1,043	$0-$522	$523-$1,043	$1,044-$1,565	$1,566-UP
9	$0-$1,126	$0-$563	$564-$1,126	$1,127-$1,689	$1,690-UP
10	$0-$1,210	$0-$605	$606-$1,210	$1,211-$1,815	$1,816-UP
11	$0-$1,293	$0-$647	$648-$1,293	$1,294-$1,940	$1,941-UP
12	$0-$1,377	$0-$689	$690-$1,377	$1,378-$2,066	$2,067-UP
13	$0-$1,460	$0-$730	$731-$1,460	$1,461-$2,190	$2,191-UP

TABLE IV

Medicaid Cost Sharing Structure (Copayments) to be Effective On and After July 1, 2016
Coverage Codes and Its Determination

MAGI Household Size	Puerto Rico Poverty Level (PRPL)	MAGI Monthly Income Range by Coverage Code			
		100	110	120	130
		Percentage of PRPL			
		0%-50%	51%-100%	101%-150%	151%-UP
14	$0-$1,544	$0-$772	$773-$1,544	$1,545-$2,316	$2,317-UP
15	$0-$1,627	$0-$814	$815-$1,627	$1,628-$2,441	$2,442-UP

TABLE V

CHIP Cost Sharing Structure (Copayments) to be Effective On and After July 1, 2016
Coverage Codes and Its Determination

MAGI Household Size	Puerto Rico Poverty Level (PRPL)	MAGI Monthly Income Range by Coverage Code	
		220	230
		Percentage of PRPL	
		0%-150%	151%-UP
1	$0-$459	$0-$689	$690-UP
2	$0-$542	$0-$813	$814-UP
3	$0-$626	$0-$939	$940-UP
4	$0-$709	$0-$1,064	$1,065-UP
5	$0-$792	$0-$1,188	$1,189-UP
6	$0-$876	$0-$1,314	$1,315-UP
7	$0-$959	$0-$1,439	$1,440-UP
8	$0-$1,043	$0-$1,565	$1,566-UP
9	$0-$1,126	$0-$1,689	$1,690-UP
10	$0-$1,210	$0-$1,815	$1,816-UP
11	$0-$1,293	$0-$1,940	$1,941-UP
12	$0-$1,377	$0-$2,066	$2,067-UP
13	$0-$1,460	$0-$2,190	$2,191-UP
14	$0-$1,544	$0-$2,316	$2,317-UP
15	$0-$1,627	$0-$2,441	$2,442-UP

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TABLE VI

Medicaid and CHIP Cost Sharing Structure (Copayments) to be Effective On and After July 1, 2016
Applicable Copayment Amounts for Each Service by Coverage Code

Service	Coverage Codes and Copayments Amounts					
	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 / 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 Drugs, (per drug)	$0.00	$1.00	$2.00	$3.00	$0.00	$0.00
Pharmacy - Non-Preferred Drugs, (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

Contracts between ASES and Managed Care Organizations (MCOs), Medicare Advantage Organizations (MAOs), Pharmacy Benefit Managers (PBMs), Managed Behavioral Healthcare Organizations (MBHOs), and Third Party Administrators (TPAs), among others, shall include this Cost Sharing Policy. Each entity is required by contract to make this Cost Sharing (Copayments) Policy known to beneficiaries and providers. Compliance with this Cost Sharing Policy will be monitored by ASES.

Medicaid Beneficiaries Enrolled in a Platino Plan

The Medicaid dual beneficiaries with Medicare Part A and B have the option to be 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 1, 2017.

MAO contracts, or Platino Plan contracts, are based on calendar year, from January 1st to December 31st of each year. The January 1st, 2017 implementation date will allow the changes in copayments to be incorporated under premiums and contract negotiation with each MAO, which will take effect in 2017.

Therefore, from July 1st to December 31s, 2016, MAOs will continue using the Cost Sharing Structure as indicated in Table I, II and III for the Platino Plans. The beneficiary will continue using his/her Platino ID Card up to December 31, 2016. If during the period from July 1st to December 31st 2016 the Medicaid Program:

1. Performs a Medicaid beneficiary determination or redetermination on a beneficiary who enrolls in, or is enrolled in, a Platino Plan, and

2. The beneficiary is assigned a coverage 120 or 130,

3. The MAO will treat that beneficiary as if the coverage code was assigned as 110.

On January 1st, 2017:

1. The MAOs will implement the New Cost Sharing Structure, as indicated in Tables IV, VI, and VI.

2. The MAOs will issue to each beneficiary a new ID Card with (i) the coverage code assigned by the Medicaid Program and (ii) copayments amount applicable to such code, as indicated in Table VI.

4. The beneficiary will discard the old ID Card and use the new ID Card.

5. The beneficiary will only be liable to pay the Table VI's copayments amount as a maximum.

A Platino 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".

MAOs cannot impose cost sharing requirements on specified Medicaid beneficiary with a Platino Plan that would exceed the amounts permitted under the Medicaid State Plan for Medicaid beneficiaries not enrolled in a Platino Plan. Therefore, MAOs are not allowed to charge any other cost sharing for Medicaid covered services except for the copayment amounts establish in the Puerto Rico Medicaid State Plan, as described in this "Cost Sharing Policy for Medicaid and CHIP Beneficiaries".

Contracts between ASES and MAOs shall include this Cost Sharing Policy. The MAOs are required by contract to make this Cost Sharing Policy knows to beneficiaries, providers, and any other person that provides health care services to beneficiaries. Compliance with this Cost Sharing Policy will be monitored by ASES.

Beneficiaries Copayments Exemptions

Pursuant to the federal regulation, 42 CFR §447.56(a)(1), Puerto Rico Medicaid State Plan states that certain groups of individuals are exempted from any copayments. No copayment will be charged to the following Medicaid or CHIP beneficiaries:

1. Children from 0 to less than 21 years of age.

2. Pregnant women, during pregnancy and the post-partum period. The post-partum period begins on the last day of pregnancy and extends through the end of the month in which a 60-day period following the last day of pregnancy ends. Example: If March 3 is the last day of pregnancy, May 2 is the end of the 60-days, and May 31 is the last day of the month in which post-partum ends.

3. Institutionalized Individuals, such as a nursing home.

4. Beneficiaries receiving hospice care. As defined in Section 1905(o) of the Social Security Act, hospice care means the care furnished by a hospice program to a terminally ill individual who has voluntarily elected to have payment made for hospice care.

5. American Indians and Alaskan Natives (AI/AN).

Contracts between ASES and MCOs, MAOs and PBMs include the requirement to exempt these group of beneficiaries, as defined at 42 CFR §447.56(a)(1). MCOs, MAOs, and PBMs are required by contract to make these exemptions known to beneficiaries, providers, and any other person that provides health care services to beneficiaries. Compliance with these cost sharing exemptions will be monitored by ASES.

Health Care Services Copayments Exemptions

Pursuant to the federal regulation, 42 CFR §447.56(a)(2), Puerto Rico Medicaid State Plan establishes that certain health care services are exempted from any copayments. All Medicaid and CHIP beneficiaries are exempt from copayments for the following services:

1. Emergency services, (including ambulatory, hospital, and post-stabilization services), as defined at Section 1932(b)(2) of the Social Security Act and in the federal regulation, 42 CFR §438.114(a).

2. Family planning services and supplies as described in Section 1905(a)(4)(C) of the Social Security Act, including contraceptives and pharmaceuticals for which the Puerto Rico claims or could claim Federal match at the enhanced rate under Section 1903(a)(5) of the Social Security Act for family planning services and supplies.

3. Preventive services provided to children under 18 years of age, as described in the federal regulation at 42 CFR §457.520 of chapter D.

4. Pregnancy-related services, including those services as defined in the federal regulation, 42 CFR §440.210(a)(2) and 42 CFR §440.250(p), and counseling services and drugs for cessation of tobacco use. All services provided to pregnant women, during pregnancy and the 60-day post-partum period, will be considered as pregnancy-related.

5. Provider-preventable services as defined in the federal regulation, 42 CFR §447.26(b).

Contracts between ASES and MCOs, MAOs and PBMs include the requirement to exempt these services, as defined in 42 CFR §447.56(a)(2). MCOs, MAOs, and PBMs are required by contract to make these exemptions known to beneficiaries, providers, and any other person that provides health care services to beneficiaries. Compliance with these cost sharing exemptions will be monitored by ASES.

Other Copayments Exemptions

Preferred Provider Network (PPN) Copayment Exemption:

1. The Preferred Provider Network is a subset of providers within the MCO General Network of Providers. The objectives of the Preferred Provider model are to:

   a. Increase access to Providers and needed services;

   b. Improve timely receipt of services;

   c. Improve the quality of beneficiary care;

   d. Enhance continuity of care; and

   e. Facilitate effective exchange of personal health information between providers and the MCO.

2. Copayments do not apply to any service provided to a Medicaid beneficiary by a provider participating in the Preferred Provider Network.

3. A provider who is a member of the Preferred Provider Network provides services to beneficiaries without the requirement for referrals and copayments.

4. The MCO's contracts with a provider who is a member of the Preferred Provider Network shall prohibit the provider from collecting copayments from Medicaid beneficiary.

5. The Medicaid beneficiary is not required to use the Preferred Provider Network. But, if the Medicaid beneficiary chooses a provider from the MCO General Network of Providers, he/she is subject to the applicable copayments amount.

6. If the Medicaid beneficiary needs a covered service and cannot have access to a specialist within the Preferred Provider Network within thirty (30) calendar days, the beneficiary shall have access to the specialist within the MCO General Network of Providers, without the imposition of copayments, but shall return to the PPN specialist once the PPN specialist is available to treat the beneficiary.

7. Dentists and Pharmacies are not part of the Preferred Provider Network.

8. For a Platino Plan, MAOs have to be in compliance with this exemption, if they operate a Preferred Provider Network model.

Medical Advice Service Line Copayment Exemption:

1. The Puerto Rico Medicaid State Plan does not allow charging copayment for non-emergency services provided in a hospital emergency room to a Medicaid or CHIP beneficiary when the beneficiary:

   a. Calls the MCO Medical Advice Service Line, prior to visiting the hospital emergency room;

   b. Receives a code or an identification number;

   c. Presents such number at the time of the visit to the hospital emergency room; and

   d. The hospital emergency room will waive the beneficiary copayment for non-emergency services provided in a hospital emergency room.

2. Regardless of whether the beneficiary uses or does not use the MCO Medical Advice Service Line, under no circumstance will a copayment be imposed on a Medicaid or CHIP Beneficiary for the treatment of an Emergency Medical Condition or Psychiatric Emergency provided.

3. For a Platino Plan, MAOs will comply with the "Medical Advice Service Line Copayment Exemption", as described herein.

Preventive Services:

All Medicaid beneficiaries do not pay copayments for the following diagnostics tests when these services are required as part of a preventive service.

1. High-Tech Laboratories.

2. Clinical Laboratories.

3. X-Rays.

4. Special Diagnostic Test.

Contracts between ASES and MCOs, MAOs, and PBMs include the requirement to exempt Medicaid beneficiaries from these copayments when he/she complies with the rules as described under this section. MCOs, MAOs, and PBMs are required by contract to make these exemptions known to beneficiaries, providers, and any other person that provides health care services to the beneficiaries. Compliance with this Policy Cost Sharing section will be monitored by ASES.

Copayment for Non-Emergency Services Provided in a Hospital Emergency Room (ER)

Pursuant the federal regulation, 42 CFR §447.51, *Non-Emergency Services* means any care or services that are not considered emergency services, as it concept is defined and described in 42 CFR §438.114 (Emergency and Post-Stabilization Services). Non-Emergency Services do not include any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment under Section 1867 of the Social Security Act, (Examination and Treatment for Emergency Medical Conditions and Women In Labor, also known as EMTALA).

Emergency and Post-Stabilization Services are defined as follows:

1. Emergency medical condition means a medical condition manifesting itself by 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 the following:

   a. 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;

   b. Serious impairment to bodily functions; and

   c. Serious dysfunction of any bodily organ or part.

2. Emergency services means covered inpatient and outpatient services that are:
   a. Furnished by a provider that is qualified to furnish these services under 42 CFR §438.114 and
   b. Needed to evaluate or stabilize an emergency medical condition.

3. Post-Stabilization care services means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition.

The Puerto Rico Medicaid State Plan allows charging cost sharing for non-emergency services provided in the hospital emergency room. It is expected that all participating hospital emergency rooms will charge the applicable copayment amount to all non-exempt Medicaid beneficiaries for the non-emergency services provided in a hospital emergency room.

The Puerto Rico Medicaid State Plan does not allow charging cost sharing for non-emergency services provided in the hospital emergency room in the following instances:

1. To Medicaid beneficiary when he/she:

   a. Calls the MCO Medical Advice Service Line, previous to visit the hospital emergency room,

   b. Receives a code or an identification number, and

   c. Presents such number at the time of the visit to the hospital emergency room. In this instance, the copayment is waived.

2. To Medicaid exempted groups of individuals listed in this Cost Sharing Policy under section "Copayments Are Not Charged To The Following Beneficiaries".

3. Copayments do not apply to any service provided to a Medicaid beneficiary by a hospital emergency room participating in the Preferred Provider Network (PPN).

4. For Medicaid beneficiaries with a Platino Plan, MAOs have to be in compliance with the "Preferred Provider Network (PPN) Copayment Exemption" and the "Medical Advice Service Line Copayment Exemption", as described under section "Other Copayments Exemptions".

If the beneficiary does not follow the copayment exemption describes under section "Medical Advice Service Line Copayment Exemption" of this Cost Sharing Policy, the non-preferred hospital's emergency room may charge the applicable copayment for this service only if, before providing non-emergency services and imposing the applicable copayment for such services, the hospital's emergency room must complies with the following requirements:

1. First, conducts an appropriate medical screening to determine
   a. Whether or not an emergency medical condition exists as required under 42 CFR §489.24 subpart G and
   b. That the individual does not need emergency services.

2. Second, if not an emergency medical condition exists and before providing non-emergency services and imposing cost sharing for such services, the hospital's emergency room:

   a. Informs the beneficiary of the amount of his or her copayment obligation for non-emergency services provided in the hospital emergency room;

   b. Provides the beneficiary with the name and location of an available and accessible alternative non-emergency services provider;

   c. Determines that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser copayment amount or no copayment if the beneficiary is otherwise exempt from copayment; and

   d. Provides a referral to coordinate scheduling for treatment by the alternative provider.

3. The federal regulation, 42 CFR §447.51, defines *Alternative Non-Emergency Services Provider* as a Medicaid provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar provider that can provide clinically appropriate services in a timely manner.

4. Therefore, the hospital emergency room cannot charge the copayment if it does not follow and comply with the process as described herein.

The Puerto Rico Medicaid Program and ASES ensure that:

1. Before providing non-emergency services and imposing the applicable copayment for such services the hospital's emergency room will comply with the above mentioned requirements.

2. There is a process in place to identify hospital emergency room services as non-emergency's room services for purposes of imposing cost sharing. This process does not:

   a. Limit hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Social Security Act (EMTALA); or

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b. 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 MCO (MAO for a Platino Plan).

3. As part of the New Cost Sharing Structure, all participating hospital emergency rooms located in Puerto Rico will have their payments reduced by the copayment amount for non-emergency services provided at the hospital emergency room.

4. Contracts between ASES and MCOs and MAOs include the non-emergency hospital emergency room copayment rules. MCOs and MAOs are required by contract to make these rules know to beneficiaries and providers. Compliance with these cost sharing rules will be monitored by ASES.

The Puerto Rico Medicaid State Plan does not allow charging the copayment for "Non-Emergency Services Provided in a Hospital Emergency Room" when the non-emergency services is provided in a non-hospital/freestanding emergency room. In non-hospital/freestanding emergency room facilities, the provider can only charge, per visit, the copayment applicable for "Non-Emergency Services Provided in a non-Hospital/Freestanding Emergency Room", as indicated in "TABLE VI".

The List of Hospital Emergency Rooms by MCO, that may charge the copayment for non-emergency services provided in the hospital emergency room, is available in any of the Medicaid Local Offices throughout the Island or at the ASES Central Office (physical address: #1549 Calle Alda, Urbanización Caribe, Río Piedras, Puerto Rico 00926-2712). Additionally, the list of MCO's Hospital Emergency Rooms can be downloaded, reviewed, and printed from the Medicaid Program website (https://www.medicaid.pr.gov/) or the ASES website (http://www.asespr.org/ or http://ases.pr.gov/).

The List of Hospital Emergency Rooms by MCO may be changed to add or remove its participating Hospital Emergency Rooms at any time. ASES will notify and post such changes through its ASES website.

Each MCO will post its Hospital Emergency Rooms List through its website, as well as any change to add or remove its participating Hospital Emergency Rooms at any time.

Each MAO will post its Hospital Emergency Rooms List through its website not later than January 1st, 2017, as well as any change to add or remove its participating Hospital Emergency Rooms at any time.

Contracts between ASES and MCOs, MAOs, and PBMs include these copayment rules. MCOs, MAOs, and PBMs are required by contract to make these rules known to beneficiaries, providers, and any other person that provides health care services to the beneficiaries. Compliance with these copayment rules will be monitored by ASES.

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Preferred Drug List

Pursuant to the federal regulation, 42 CFR §447.51, *preferred drugs* means drugs that the state has identified on a publicly available schedule as being determined by a pharmacy and therapeutics committee for clinical efficacy as the most cost effective drugs within each therapeutically equivalent or therapeutically similar class of drugs.

The Medicaid Program and ASES differentiate between preferred and non-preferred drugs. The Preferred Drug List (PDL) was revised to produce a new Drugs Formulary (*"Formulario de Medicamentos en Cubierta del Plan de Salud del Gobierno de PR"*). The review was performed by ASES' Pharmacy Administrative Committee, composed of a clinical pharmacist, an epidemiology analyst, a medical doctor from the Pharmacy Program Administrator (PPA), two clinical pharmacists, a system implementation manager from the contracted PBM, ASES Clinical Medical Doctor Representative, and ASES Clinical Department Manager. All drugs included have been previously approved by the ASES Pharmacy and Therapeutics Committee, composed of thirteen (13) voluntary community representatives, community medical doctors, and pharmacist representatives. All decisions have been managed and documented under the contracted PBM for such purposes.

For the determination of which medication will be covered as preferred or non-preferred drug, the Pharmacy Administrative Committee evaluated each therapeutic category based on the amount of alternatives available with similar efficacy, utilization frequency, and total cost impact. As a result of such analysis the majority of the generic drugs were considered as preferred drugs, with some exceptions where other more cost-effective drugs were available within the same therapeutic category. All branded products with contracted rebates were considered preferred drugs, but depending on availability on a class category, some non-rebatable, branded drugs were also considered preferred drugs.

The drugs in the Formulary are divided into two categories (Tiers): Preferred and Non-preferred drugs, as permitted by the federal regulation applicable to Medicaid. The criteria used for the drug classifications were based on their safety profile, established efficacy (cost-effectiveness), generic drug availability, and treatment cost. The Medicaid Program and ASES define both categories as follows:

Preferred Drugs means:

1. All generic drugs, except for:

    a. Those with a significantly higher cost compared to their therapeutic alternatives, in which case they are classified as non-preferred drugs.

    b. Those with a low safety profile compared to their therapeutic alternatives, in which case they are classified as non-preferred drugs.

2. Branded drugs that:

    a. Have no generic available and their net cost does not exceed a certain limit, otherwise they are classified as non-preferred.

    b. Their generic drug alternative is more expensive.

    c. Are contracted by ASES.

3. Specialty drugs contracted by ASES.

Non-Preferred Drugs means:

1. Branded drugs, except for:

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a. Those that have no generic drug available and their cost does not exceed a certain limit, in which case they are classified as preferred drug.

b. Those with a more expensive generic (net cost), in which case they are classified as preferred drug.

c. Are contracted by ASES, in which case they are classified as preferred drugs.

2. Generic drugs that their established safety, efficacy, and cost profile (cost-effectiveness) are low compared to their therapeutic alternatives.

3. Specialty drugs not contracted by ASES.

The Puerto Rico Medicaid State Plan allows charging copayments for preferred and non-preferred drugs. However, the Medicaid State Plan does not allow charging those copayments in the following instances:

1. To Medicaid beneficiaries exempted groups of individuals listed in this Cost Sharing (Copayments) Policy under section Beneficiaries Copayments Exemptions

2. To Medicaid exempted services as described in this Cost Sharing (Copayments) Policy under section Health Care Services Copayments Exemptions, such as contraceptives for family planning services and drugs for cessation of tobacco use.

3. For Platino Plans, MAOs will comply with this rule on January 1st, 2017.

The Puerto Rico Medicaid State Plan requires charging the applicable copayment for preferred drug instead of the non-preferred drug copayment in the following instances:

1. The beneficiary's prescribing provider determines based on medical necessity that:

   a. A Formulary non-preferred drug can be covered when a Formulary preferred drug for treatment of the same health condition either: (i) is less effective for the beneficiary health condition, (ii) has adverse effects for the beneficiary, or (iii) both.

   b. A non-Formulary drug can be covered when a Formulary preferred or non-preferred drug for treatment of the same health condition either: (i) is less effective for the beneficiary health condition, (ii) has adverse effects for the beneficiary, or (iii) both.

2. The MCOs and the provider follow the usual pre-authorization procedure to consider these cases.

   a. The exception process is utilized when there is an indication that there is a medically necessary reason to cover a non-preferred drug or non-Formulary drug.

   b. When an exception is requested by the beneficiary, the MCO will do a clinical evaluation to consider and review the justification given by the prescribing provider, beneficiary's medical records, and any other relevant documentation to determine medical necessity based on the following criteria:

      (1) Contraindications to the medication listed in the Formulary.

(2) History of adverse reactions to the medication listed in the Formulary.

(3) Therapeutic failure of all available alternatives in the Formulary.

(4) Non-existence of alternative therapy in the Formulary.

c. If the documents and information provided supports the exception, the preauthorization is granted.

d. The beneficiary has the right to file an appeal and request a fair hearing to review the determination that has been notified by the MCO.

3. If the authorization is granted, the Medicaid Program and ASES have a timely process in place in which the pharmacy only charges to the Medicaid beneficiary the copayment applicable to a preferred drug, which is: $1 to beneficiaries with coverage code 110, $2 with coverage code 120, and $3 with coverage code 130.

4. According with the federal regulation, 42 CFR §447.53(e), the Medicaid Program and ASES certify that in such cases the reimbursement to the pharmacy is based on the appropriate copayment amount.

5. For Platino Plans, MAOs will comply with this rule on January 1st, 2017.

In addition to, the Puerto Rico Medicaid State Plan indicates that:

1. In the event a beneficiary needs a drug or medicine that is not included in Puerto Rico Medicaid Formulary, the MCOs and providers will follow the usual pre-authorization procedure to allow beneficiaries to obtain drugs not included in the Formulary.

2. The use of bioequivalent medications and drugs approved by the FDA and local regulations is authorized, unless contraindicated for the beneficiary by the physician or dentist who prescribed the medication.

3. The absence of bioequivalent medications and drugs in stock does not exonerate the pharmacist from dispensing the medication nor does it entail the payment of additional surcharges by beneficiaries.

4. Brand name drugs will be dispensed if the bioequivalent is not available at the pharmacy.

5. All prescriptions shall be filled and dispensed at a participating pharmacy properly licensed under the laws of Puerto Rico freely chosen by the beneficiary.

6. Pharmacies and Dentists are not part of the Preferred Provider Network.

7. The MCO and/or provider cannot establish a different drug formulary nor limit in any way the drugs and medications included in the Puerto Rico Medicaid Formulary.

The Drugs Formulary is available in any of the Medicaid Local Offices throughout the Island or at ASES Central Office (physical address: #1549 Calle Alda, Urbanización Caribe, Río Piedras, Puerto Rico 00926-2712). Additionally, the Drugs Formulary can be downloaded, reviewed, and printed from the Medicaid Program website (https://www.medicaid.pr.gov/) or the ASES website (http://www.asespr.org/ or http://ases.pr.gov/).

The Drugs Formulary may be amended to add or remove drugs, as well as to classify a drug as a preferred or non-preferred, at any time according to the ASES' Pharmacy Administrative Committee. ASES will notify and post such changes through its ASES website.

Each MCO and PBM will post the *"Formulario de Medicamentos en Cubierta del Plan de Salud del Gobierno de PR"*, as well as any amendment approved by the ASES' Pharmacy Administrative Committee to add or remove drugs or to classify a drug as a preferred or non-preferred, through its website.

Each MAO has its own drugs formulary that has to be in compliance with Medicare and Medicaid federal regulation. The Medicaid beneficiaries with a Platino Plan will use the MAO's Drugs Formulary. The MAO's Drugs Formulary, as well as any amendment, will be posted through the MAO's website. Pursuant the federal regulation, each MAO must be in compliance with the copayment rules state under the Puerto Rico Medicaid State Plan and this Cost Sharing Policy.

Contracts between ASES and MCOs, MAOs, and PBMs include these copayment rules. MCOs, MAOs, and PBMs are required by contract to make these rules known to beneficiaries, providers, and any other person that provides health care services to the beneficiaries. Compliance with these copayment rules will be monitored by ASES.

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

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:

1. 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.

2. 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.

3. 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).

Each beneficiary has his/her own quarters, which are based on the eligibility month. For example, if the Medicaid Program determines that the individual is eligible starting in February, he/she's quarters are: February, March, and April (first quarter); May, June, and July (second quarter); August, September and October (third quarter); and November, December, and January (fourth quarter).

Any Medicaid beneficiary can request to the Medicaid Program a reassessment of his/her aggregate limit of 5 percent (5%) if he/she has a change in circumstances, such as:

1. Increase or decrease in income.

2. Increase or decrease in household size.

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 per quarter.

The New Cost Sharing Structure does not place beneficiaries at risk of reaching the copayment aggregate limit of 5% per quarter of the family unit or MAGI household income applied on a quarterly basis. The Medicaid Program and ASES have a "Process for Requesting Reimbursement of Excess Cost Sharing Payments" 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.

If, over the course of a period of Medicaid or CHIP eligibility, a Medicaid or CHIP beneficiary believes that copayments in a quarter have been paid in excess of the 5% cap, he/she can submit a Cost Sharing Reimbursement Request, which will be evaluated by ASES. The Process for Requesting Reimbursement of Excess Cost Sharing Payments establishes that:

1. The reimbursement requests must be submitted no later than two (2) calendar months after the end of the quarter.

2. Reimbursement requests must include all minimum mandatory information, as instructed on the reimbursement request form, and can be submitted:

   a. In person: at ASES Central Office (physical address: #1549 Calle Alda, Urbanización Caribe, Río Piedras, Puerto Rico 00926-2712) or in any of the Medicaid Local Offices throughout the Island;

   b. By mail, to following postal address: ASES Client Services, PO Box 195661, San Juan, PR, 00919-5661; or

   c. By Facsimile (Fax), to ASES Fax number: 787-474-3347.

3. ASES will conduct an investigation to evaluate reimbursement requests which will be completed no later than four (4) months from the end of the quarter for which the reimbursement request is made. The results of the investigation of any reimbursement request will be notified to the beneficiary no later than fifteen (15) calendar days from the limit date for the investigation. ASES will send a written communication to the beneficiary explaining the results of the reimbursement process investigation, and:

   a. If the amount to be reimbursed is five dollars ($5) or more, ASES will issue a reimbursement and will send a written communication to the beneficiary explaining the results of the reimbursement process investigation.

   b. If the amount to be reimbursed is less than five dollars ($5), the amount will be kept as a credit for a two (2) years period and can be added to the result of reimbursement request for another quarter.

4. The individual has the right to file an appeal and request a fair hearing to review the determination that has been notified by ASES. The appeal must be presented in writing and within a period of thirty (30) days, counting from the date of the ASES' notice. The appeal may be submitted:

a. In person: at the ASES Central Office (physical address: #1549 Calle Alda, Urbanización Caribe, Río Piedras, Puerto Rico, 00926-2712);

b. By mail, to following postal address: ASES Client Services, PO Box 195661, San Juan, PR, 00919-5661; or

c. By Facsimile (Fax), to ASES Fax number: 787-474-3347.

5. The determination will be final if the individual does not appeal within the term of thirty (30) days.

The "Process for Requesting Reimbursement of Excess Cost Sharing Payments" and the reimbursement request form (in English or Spanish) are available in any of the Medicaid Local Offices throughout the Island or at the ASES Central Office (physical address: #1549 Calle Alda, Urbanización Caribe, Río Piedras, Puerto Rico 00926-2712). These documents can also be downloaded, reviewed, and printed from the Medicaid Program website (https://www.medicaid.pr.gov/) or the ASES website (http://www.asespr.org/ or http://ases.pr.gov/).

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

A Medicaid beneficiary is expected to pay a copayment at the time of receiving the health care service. Therefore, the provider may request and collect the copayment amount each time a beneficiary receives a service.

A beneficiary does not have to pay copayments for any service provided by a provider participating in the Preferred Provider Network. The MCO's (MAO for a Platino Plan) contracts with a provider who is a member of the Preferred Provider Network shall prohibit the provider from collecting copayments from Medicaid beneficiary.

The Medicaid beneficiary, who chooses a provider from MCO's General Network of Providers (MAO for a Platino Plan) and with coverage code 110, 120 or 130, is subject to the applicable copayments amount.

Pursuant the federal regulation, 42 CFR §447.52(e), the Puerto Rico Medicaid State Plan dispone:

1. Beneficiaries with an eligibility monthly income at or below 100 percent (100%) of the PRPL:

   a. When copayment charge is allowed or the beneficiary is not part of an otherwise exempt group, the provider, including a pharmacy or dentist, may request the applicable copayment amount, but cannot not deny services to a beneficiary on account of the his/her inability to pay the copayment amount at the time of receiving a service.

   b. The beneficiary will receive the health care service without paying the cost sharing at the time of receiving the service.

   c. Although services may not be denied, the beneficiary is still obligated to pay the cost sharing unless it is waived by the provider.

   d. If the copayment is not waived, the provider may ask the beneficiary for outstanding copayments amount the next time the beneficiary comes in for a service and/or send a bill to the beneficiary.

e. In these cases, a hospital can charge the applicable copayment for non-emergency services furnished in its emergency room, if the conditions under 42 CFR 447.54(d) and the copayment rules for this service have been satisfied.

f. Nothing prohibits a provider from choosing to reduce or to waive the copayment on a case-by-case basis.

g. Medicaid beneficiaries identified by coverage code 100:

(1) Prior MAGI Implementation and as illustrate on Table VII, all Medicaid beneficiaries identified by coverage code 100 have an Eligibility Monthly Income unit below 100% of the PRPL.

(2) On and After MAGI Implementation and as illustrate on Table VIII, all Medicaid beneficiaries identified by coverage code 100 have a MAGI household monthly income below 100% of the PRPL.

h. Medicaid beneficiaries identified by coverage code 110:

(1) Prior MAGI Implementation and as illustrate on Table VII, there are some Medicaid beneficiaries identified by coverage code 110 have an Eligibility Monthly Income at or below 100% of the PRPL.

(2) On and After MAGI Implementation and as illustrate on Table VIII, all Medicaid beneficiaries identified by coverage code 110 have a MAGI household monthly income at or below 100% of the PRPL.

2. Beneficiaries with MAGI household monthly income above 100 percent (100%) of the PRPL:

a. When copayment charge is allowed or the beneficiary is not part of an otherwise exempt group, the provider, including a pharmacy and a dentist, may request the applicable copayment amount as a condition for receiving the service.

b. In these cases, a hospital can charge the applicable copayment for non-emergency services furnished in its emergency room, if the conditions under 42 CFR 447.54(d) and the copayment rules for this service have been satisfied.

c. Nothing prohibits a provider from choosing to reduce or to waive the copayment on a case-by-case basis.

d. Medicaid beneficiaries identified by coverage code 110: Prior MAGI Implementation and as illustrate on Table VII, there are some Medicaid beneficiaries identified by coverage code 110 have an Eligibility Monthly Income above 100% of the PRPL.

e. Medicaid beneficiaries identified by coverage code 120 or 130: On and After MAGI Implementation and as illustrate on Table VIII, all Medicaid beneficiaries identified by coverage code 120 or 130 have a MAGI household monthly income above 100% of the PRPL.

3. The following tables show Puerto Rico Poverty Level (PRPL) for Medicaid and CHIP and the coverage codes:

a. Table VII: Puerto Rico Poverty Level (PRPL) Prior MAGI Implementation.

b. Table VIII: Puerto Rico Poverty Level (PRPL) On and After MAGI Implementation.

TABLE VII					
Puerto Rico Poverty Level (PRPL) Prior MAGI Implementation					
Member in Family Unit	Puerto Rico Poverty Level (PRPL)	Eligibility Monthly Income Ranges by Coverage Codes			
		At or Below 100% of the PRPL		Above 100% of the PRPL	
		100	110	Ranges Above 100% PRPL	110
1	$0-$413.53	$0-$200	$201-$413.53	$413.54-UP	$413.54-$550
2	$0-$488.72	$0-$248	$249-$488.72	$488.73-UP	$488.73-$650
3	$0-$563.91	$0-$295	$296-$563.91	$563.92-UP	$563.92-$750
4	$0-$639.10	$0-$343	$344-$639.10	$639.11-UP	$639.11-$850
5	$0-$714.29	$0-$390	$391-$714.29P	$714.30-UP	$714.30-$950
6	$0-$789.47	$0-$438	$439-$789.47	$789.48-UP	$789.48-$1,050
7	$0-$864.66	$0-$485	$486-$864.66	$864.67-UP	$864.67-$1,150
8	$0-$939.85	$0-$533	$534-$939.85	$939.86-UP	$939.86-$1,250
9	$0-$1,015.04	$0-$580	$581-$1,015.04	$1,015.05-UP	$1,015.05-$1,350
10	$0-$1,090.23	$0-$628	$629-$1,090.23	$1,090.24-UP	$1,090.24-$1,450
11	$0-$1,165.41	$0-$675	$676-$1,165.41	$1,165.42-UP	$1,165.42-$1,550
12	$0-$1,240.60	$0-$723	$724-$1,240.60	$1,240.61-UP	$1,240.61-$1,650
13	$0-$1,315.79	$0-$770	$771-$1,315.79	$1,315.79-UP	$1,315.79-$1,750
14	$0-$1,390.98	$0-$818	$819-$1,390.98	$1,390.98-UP	$1,390.98-$1,850
15	$0-$1,466.17	$0-$865	$866-$1,466.17	$1,466.17-UP	$1,466.17-$1,950

TABLE VIII					
Puerto Rico Poverty Level (PRPL) To Be Effective Implemented On and After MAGI Implementation					
MAGI Household Size	Puerto Rico Poverty Level (PRPL)	MAGI Monthly Income Range by Coverage Code			
		100	110	120	130
		At or Below 100% of the PRPL		Above 100% of the PRPL	
		0%-50%	51%-100%	101%-150%	151%-UP
1	$0-$459	$0-$230	$231-$459	$460-$689	$690-UP
2	$0-$542	$0-$271	$272-$542	$543-$813	$814-UP
3	$0-$626	$0-$313	$314-$626	$627-$939	$940-UP

TABLE VIII

Puerto Rico Poverty Level (PRPL) To Be Effective Implemented On and After MAGI Implementation

MAGI Household Size	Puerto Rico Poverty Level (PRPL)	MAGI Monthly Income Range by Coverage Code			
		100	110	120	130
		At or Below 100% of the PRPL		Above 100% of the PRPL	
		0%-50%	51%-100%	101%-150%	151%-UP
4	$0-$709	$0-$355	$356-$709	$710-$1,064	$1,065-UP
5	$0-$792	$0-$396	$397-$792	$793-$1,188	$1,189-UP
6	$0-$876	$0-$438	$438-$876	$877-$1,314	$1,315-UP
7	$0-$959	$0-$480	$481-$959	$960-$1,439	$1,440-UP
8	$0-$1,043	$0-$522	$523-$1,043	$1,044-$1,565	$1,566-UP
9	$0-$1,126	$0-$563	$564-$1,126	$1,127-$1,689	$1,690-UP
10	$0-$1,210	$0-$605	$606-$1,210	$1,211-$1,815	$1,816-UP
11	$0-$1,293	$0-$647	$648-$1,293	$1,294-$1,940	$1,941-UP
12	$0-$1,377	$0-$689	$690-$1,377	$1,378-$2,066	$2,067-UP
13	$0-$1,460	$0-$730	$731-$1,460	$1,461-$2,190	$2,191-UP
14	$0-$1,544	$0-$772	$773-$1,544	$1,545-$2,316	$2,317-UP
15	$0-$1,627	$0-$814	$815-$1,627	$1,628-$2,441	$2,442-UP

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.

Contracts between ASES and MCOs, MAOs, and PBMs include this copayment rule. MCOs, MAOs, and PBMs are required by contract to make these rules known to beneficiaries, providers, and any other person that provides health care services to the beneficiaries. Compliance with these copayment rules will be monitored by ASES.

Mechanisms for Required Cost Sharing Charges and Payments to Providers

The MCOs, MAOs, and PBMs contracted by ASES may impose copayments on beneficiaries up to the amounts specified under the Puerto Rico Medicaid State Plan, and the requirements set forth in 42 CFR 447.50 through 447.57"as presented in this Policy.

Therefore, the ASES' contract with these entities will provide that any copayment charges the MCO, MAO or PBM impose on Medicaid and CHIP beneficiaries are implemented and administered in accordance with:

1. The Social Security Act (SSA), Sections 1916 and 1916A.

2. The federal regulation, 42 CFR §§447.50-447.57 (excluding 42 CFR §447.55) of the federal regulation.

3. The Puerto Rico Medicaid and CHIP State Plans.
   El Plan Estatal Medicaid y el de CHIP de Puerto Rico.

4. Cost Sharing Policy (Copayments) for Medicaid and CHIP Beneficiaries.

5. The New Cost Sharing (Copayment) Structure for Medicaid and CHIP Beneficiaries.

Payments to MCOs and MAOs:

1. ASES has contracted with more than one MCO (MAO for a Platino Plan) to deliver the health care services establish under Puerto Rico Medicaid State Plan.

2. ASES provides assurance that it calculates the payments to MCOs (MAOs for a Platino Plan) to take into account the copayments established under the Medicaid State Plan for beneficiaries or services not exempt from copayment, regardless of whether the MCO (MAO for a Platino Plan) imposes the copayment or the copayment is collected by the providers.

3. Any MCO, MAO, or PBM contracted by ASES is allowed to impose copayments on beneficiaries up to the amounts specified in this Cost Sharing (Copagos) Policy, but such MCO, MAO, or PBM cannot exceed the copayment amounts established under the Puerto Rico Medicaid State Plan, as shown in this Policy.

4. Contracts between ASES and MCOs, MAOs, and PBMs shall include this Cost Sharing Policy.

5. MCOs and PBMs are required by contract:

   a. To make these rules know to beneficiaries and providers.

   b. To comply with this Cost Sharing Policy and the Puerto Rico Medicaid State Plan.

6. For Platino Plans, MAOs have to be in compliance with this rule on January 1st, 2017.

7. ASES will monitor the compliance with this Cost Sharing Policy.

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Payments to Providers:

1. Except as provided under federal regulation 42 CFR §§447.56(c)(2) and (c)(3), each MCO must reduce the payment it makes to a provider by the amount of a beneficiary's copayment obligation, regardless of

whether the provider has collected the copayment or has waived the copayment. Where the MCO contracts a provider on a capitated basis, the beneficiary's copayment obligation is taken into account in calculating capitated rates.

2. Contracts between ASES and MCOs shall include this Cost Sharing (Copagos) Policy. ASES will monitor the MCOs compliance with this Cost Sharing Policy's requirement.

3. Contracts between ASES and MCOs and providers shall include this Cost Sharing Policy. MCOs will monitor the providers' compliance with this Cost Sharing Policy's requirement.

4. For Platino Plans, MAOs have to be in compliance with this rule on January 1st, 2017. ASES will monitor the MCOs compliance with this Cost Sharing Policy's requirement.

Notice of the Results of Coverage Code and Cost Sharing (Copayments) Determination

The Medicaid or CHIP Beneficiary is notified to his/her coverage code and copayments amount through:

1. The Medicaid Program notifies 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 or when the Results of Cost Sharing Determination is revised.

2. 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).

Before July 1st, 2016, each MCO contracted by ASES will send a certification coverage letter to the beneficiary to notify the coverage code assigned by the Medicaid Program and the copayments amount applicable to such code for each service. The beneficiary will use said letter as his/her ID Card up to his/her eligibility redetermination, when the MCO will issue a new ID Card. ASES will monitor the MCOs compliance with this Cost Sharing Policy's requirement.

For Platino Plans, the MAOs will implement the New Cost Sharing (Copayments) Structure on January 1st, 2017. The MAOs will issue to each beneficiary a new ID Card with the coverage code assigned by the Medicaid Program and copayments amount, as applicable to such code. The beneficiary will discard the old ID Card and use the new ID Card. ASES will monitor the MCOs compliance with this Cost Sharing Policy's requirement.

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.

Right to Appeal Coverage Code and Cost Sharing (Copayments) Determination

The beneficiary is entitled to file an appeal and to request a fair hearing to the Medicaid Program to review the "Results of Cost Sharing Determination" that it is notified through the MA-10 Form (Notification of Action Taken on Application and/or Recertification) 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 thirty (30) days, counting from the Certification Date shown on the MA-10. This request for review can be submitted:

1. In person: at any Puerto Rico Medicaid Program Local Office throughout the Island;

2. By mail, to the following postal address: Medicaid Program, Puerto Rico Department of Health, P.O. Box 70184, San Juan, P.R. 00936-8184; or

3. By Facsimile (Fax) to: (787) 759-8361.

Access to the Cost Sharing (Copayment) Policy

The Medicaid and CHIP Beneficiaries have access to the New Cost Sharing Structure (Copayments) through the Enrollee Handbook or Guide, which is provided by the MCO (MAO for a Platino Plan).

The Cost Sharing Policy and the Puerto Rico Medicaid SPA for a New Cost Sharing Structure are available in any of the Medicaid Local Offices throughout the Island or at the ASES Central Office (physical address: #1549 Calle Alda, Urbanización Caribe, Río Piedras, Puerto Rico, 00926-2712). These documents can also be downloaded, reviewed, and printed from the Medicaid Program website (https://www.medicaid.pr.gov/) or the ASES website (http://www.asespr.org/ or http://ases.pr.gov/).

In compliance with the federal regulation, 42 CFR §435.905(b), the Medicaid Program will provided access to this Policy, upon request, to individuals living with disabilities through the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

Attestation

The Medicaid Program and ASES assure that:

1. They administer the Medicaid and CHIP Cost Sharing (Copagos) Policy in accordance with:

   a. The Social Security Act (SSA), Sections 1916 and 1916A

   b. The federal regulation, 42 CFR §§447.50-447.57 (excluding 42 CFR §447.55) of the federal regulation,

   c. The Puerto Rico Medicaid and CHIP State Plan.

2. The cost sharing amount established for each service is always less than the amount that is paid for the service.

3. The contracts with the MCOs, MAOs, and PBMs provide that any copayment charges imposes on Medicaid or CHIP beneficiaries are in accordance with the Puerto Rico Medicaid State Plan and this Cost Sharing (Copayments) Policy.

The Medicaid Program and ASES, as required by the federal regulation (42 CFR 447.57):

1. Issued a Public Notice, in English and Spanish, to inform the beneficiaries, applicants, providers, and general public of the Cost Sharing SPA that specifies, among other topics:

   a. The copayment amounts for each service by coverage code.

   b. The beneficiaries who are subject to the copayment charges.

   c. The consequences, if any, for a beneficiary who does not pay a copayment amount.

2. Have provided a reasonable opportunity for stakeholder comments about the Medicaid SPA for the New Cost Sharing Structure.

Effective Date

This Cost Sharing (Copagos) Policy is effective on July 1st, 2016.

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CO-PAYS & CO-INSURANCE - effective on July 1st 2016											
SERVICES	Federal				CHIPs		Commonwealth				*ELA
	100	110	120	130	220	230	300	310	320	330	400
HOSPITAL											
Admissions	$0	$4	$5	$8	$0	$0	$15	$15	$15	$20	$50
Nursery	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EMERGENCY ROOM (ER)											
Emergency Room (ER) Visit	$0	$0	$0	$0	$0	$0	$2	$10	$15	$20	$20
Non-Emergency Services Provided in a Hospital Emergency Room, (per visit)	$0	$4	$5	$8	$0	$0	$20	$20	$25	$30	$20
Non-Emergency Services Provided in a Freestanding Emergency Room, (per visit)	$0	$2	$3	$4	$0	$0	$20	$20	$25	$30	$20
Trauma	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
AMBULATORY VISITS TO											
Primary Care Physician (PCP)	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$3
Specialist	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$7
Sub-Specialist	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$10
Pre-natal services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OTHER SERVICES											
High-Tech Laboratories**	$0	50¢	$1	$1.50	$0	$0	$2	$2	$5	$5	20%
Clinical Laboratories**	$0	50¢	$1	$1.50	$0	$0	$2	$2	$5	$5	20%
X-Rays**	$0	50¢	$1	$1.50	$0	$0	$2	$2	$5	$5	20%
Special Diagnostic Tests**	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$6	40%
Therapy – Physical	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5
Therapy – Respiratory	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5
Therapy – Occupational	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5
Vaccines	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Healthy Child Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DENTAL											
Preventive (Child)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Preventive (Adult)	$0	$1	$1.50	$2	$0	$0	$2	$2	$3	$5	$3
Restorative	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$6	$10
PHARMACY* **											
Preferred (Children 0-21)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5
Preferred (Adult)****	$0	$1	$2	$3	N/A	N/A	$3	$3	$5	$5	$5
Non-Preferred (Children 0-21)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10
Non-Preferred (Adult)****	$0	$3	$4	$6	N/A	N/A	$8	$8	$10	$10	$10
SERVICES	Federal				CHIPs		mmonwealth Populati				ELA
	100	110	120	130	220	230	300	310	320	330	400

APROVED: JUNE 16, 2016

NOTAS

1. **Independiente del código de cubierta, los siguientes beneficiarios a Medicaid / CHIP están exentos del pago de copagos –**
   - Niños y niñas menores de 21 años de edad (0-20 años, inclusive);
   - Mujeres embarazadas (durante el embarazo y el período de los 60 de post parto);
   - Indios Americanos o Nativos de Alaska (AI/AN, por sus siglas en inglés);
   - Beneficiarios que están en una institución, ejemplos: asilo de ancianos o casa de convalecencia (*nursing home*); y

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- Beneficiarios que reciben servicios de hospicio.

2. Los beneficiarios a Medicaid / CHIP están exentos del pago de copagos cuando reciban alguno de los siguientes servicios –

- Servicios de Emergencia, incluye servicios ambulatorios, hospitalarios y de post estabilización según se indica en la reglamentación federal 42 CFR §438.114(a);
- Planificación familiar, servicios y materiales o suministros médicos (supplies);
- Servicios Preventivos a menores de 18 años de edad (0-17 años, inclusive);
- Servicios relacionados con el embarazo; y
- Servicios prestados por condiciones de salud que se pudieron evitar, "Provider Preventable Conditions".

3. Los beneficiarios no pagaran copago alguno por los servicios provistos por un proveedor participante de la Red Preferida de Proveedores (RPP). Las farmacias y los dentistas no son parte de la Red Preferida de Proveedores (RPP).

4. El beneficiario no tendrá que pagar el copago por visita a sala de emergencia cuando no existe una emergencia si antes de visitar la sala de emergencia llama al centro de llamadas (call center) de la línea de orientación médica, el call center le provee un código y éste presenta el código numérico al momento de visitar la sala de emergencia.

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