DEPARTAMENTO DE
SALUD
GOBIERNO DE PUERTO RICO

October 30, 2025

The Honorable Mike Crapo
Chairperson
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Brett Guthrie
Chairperson
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
United States House of Representatives
2107 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairperson Crapo, Chairperson Guthrie, Ranking Member Wyden, and Ranking Member Pallone:

On behalf of the Puerto Rico Department of Health, the single State Medicaid Agency, I am pleased to submit the attached 2025 Puerto Rico Annual Report to Congress, as required under the Consolidated Appropriations Act of 2023 (P.L. 117-328). This report fulfills the requirements outlined in Section 1108(g)(9) of the Social Security Act.

P.L. 117-328 reinstated annual reporting for Federal Fiscal Year (FFY) 2023 and each subsequent fiscal year through FFY 2027, contingent upon Puerto Rico receiving either an increase in its capped Medicaid allotment or an enhanced Federal Medical Assistance Percentage (FMAP). This report details how these increases have been utilized to expand access to healthcare for Medicaid-eligible residents of Puerto Rico.

We are deeply grateful for the increased federal capped allotment and the funding stability provided through 2027. These resources have been instrumental in ensuring interim fiscal

stability for Puerto Rico's Medicaid Program and in expanding access to essential healthcare services for individuals with low incomes.

Puerto Rico remains committed to transparency and accountability. This report outlines how the annual capped allotment under P.L. 117-328 has supported the program's fiscal stability, while also highlighting persistent gaps that stem from the absence of state-like Medicaid funding.

Included in this report are:

- An overview of Puerto Rico's Medicaid Program
- The operational landscape and challenges unique to the territory
- Updates on infrastructure improvements and ongoing program enhancements

As we continue to strengthen Medicaid operations and pursue long-term improvements, we look forward to working closely with our federal partners and Congress to build on the progress made and advocate for permanent, equitable funding. This report reflects our commitment to the beneficiaries we serve and our capacity to operate a robust and responsive Medicaid program.

Should you have any questions or require further information, please feel free to contact my office at 787-765-2929 or via email at drvictor.ramos@salud.pr.gov.

Sincerely,

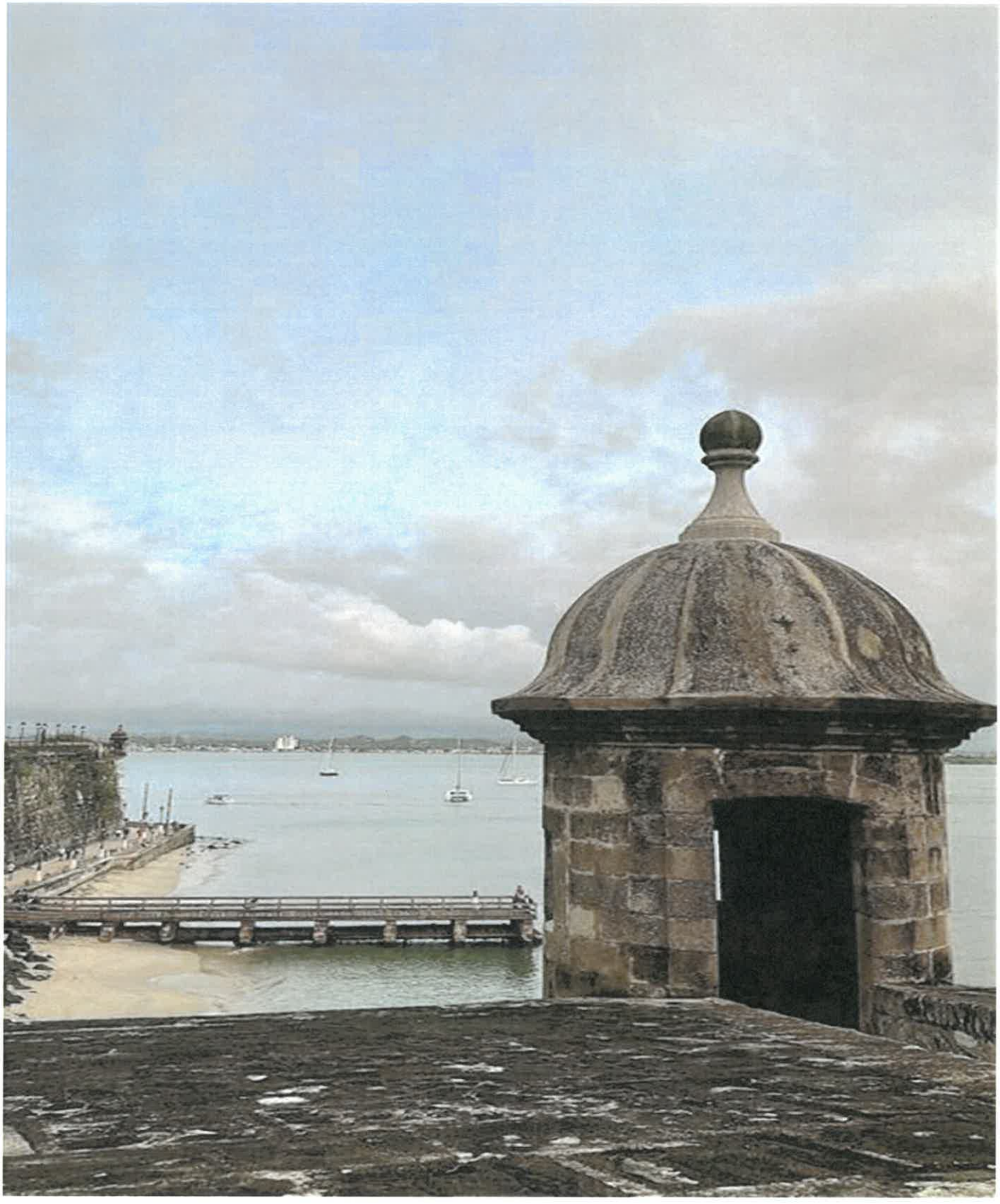
Dr. Víctor M. Ramos Otero

Secretary

Puerto Rico Department of Health

2025 Annual Report to Congress

Public Law 117-328: Consolidated Appropriations Act, 2023



Government of Puerto Rico, Department of Health,
Puerto Rico Medicaid Program

October 2025

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1. Executive Summary

This 2025 Annual Report provides Puerto Rico's (Territory's) response to comply with Section 1108(g)(9) of the Social Security Act (SSA) and describes the current landscape of the Medicaid Program in Puerto Rico, the improvements made since the submission of the 2024 report, and the Territory's plans to continue program improvements.

This report incorporates the following sections: **Section 1.** Executive Summary, **Section 2.** Introduction, **Section 3.** Difference in Medicaid Funding Between the States and Puerto Rico/Other Territories, **Section 4.** Landscape of Puerto Rico's Medicaid Program, **Section 5.** Program Governance and Oversight, **Section 6.** Impact of Program Investments, **Section 7.** Looking Ahead to State-Like Medicaid Funding, and **Section 8.** Conclusion.

The Medicaid Program in Puerto Rico is composed of the Puerto Rico Department of Health (PRDoH), the Puerto Rico Medicaid Program (PRMP), and the Puerto Rico Health Insurance Administration (PRHIA, commonly referred to as Administración de Seguros de Salud [ASES] in Spanish). (See Section 1). These entities collectively oversee the delivery of Medicaid and Children's Health Insurance Program (CHIP) services and appreciate the opportunity to report on Puerto Rico's progress and initiatives within our Medicaid Program since the 2024 Annual Report to Congress.

PRDoH is the single State Medicaid Agency (SMA). Within PRDoH, PRMP determines Medicaid eligibility of residents and is responsible for the operation of the Medicaid Management Information System (MMIS), provider enrollment, and the eligibility system (MEDITI3G). PRHIA was created in 1993 to oversee, monitor, and evaluate services offered by managed care organizations (MCOs) under contract with PRHIA. All Medicaid beneficiaries in Puerto Rico are enrolled in managed care (see Section 2).

The Puerto Rico Medicaid Program is funded on an annual basis with a federal capped dollar amount (capped allotment). Over the years, the capped allotment has been increased by temporary funding adjustments, some of which were awarded in response to natural disasters and the COVID-19 public health crisis. While these increased annual capped allotments were extremely helpful and provided interim stability and resources, Puerto Rico continues to have limitations with funding some mandatory and optional services. In July 2024, Puerto Rico expanded its program to include coverage for home health, hospice, durable medical equipment (DME), and non-emergency medical transportation (NEMT). While this expansion reflects Puerto Rico's strong commitment to improving healthcare access and quality of life, implementing these services within the constraints of the existing capped allotment has introduced significant financial strain. As a result, the program is now actively evaluating options to scale back or limit service utilization to ensure long-term sustainability. Figure 1 shows the history of Medicaid funding in Puerto Rico.

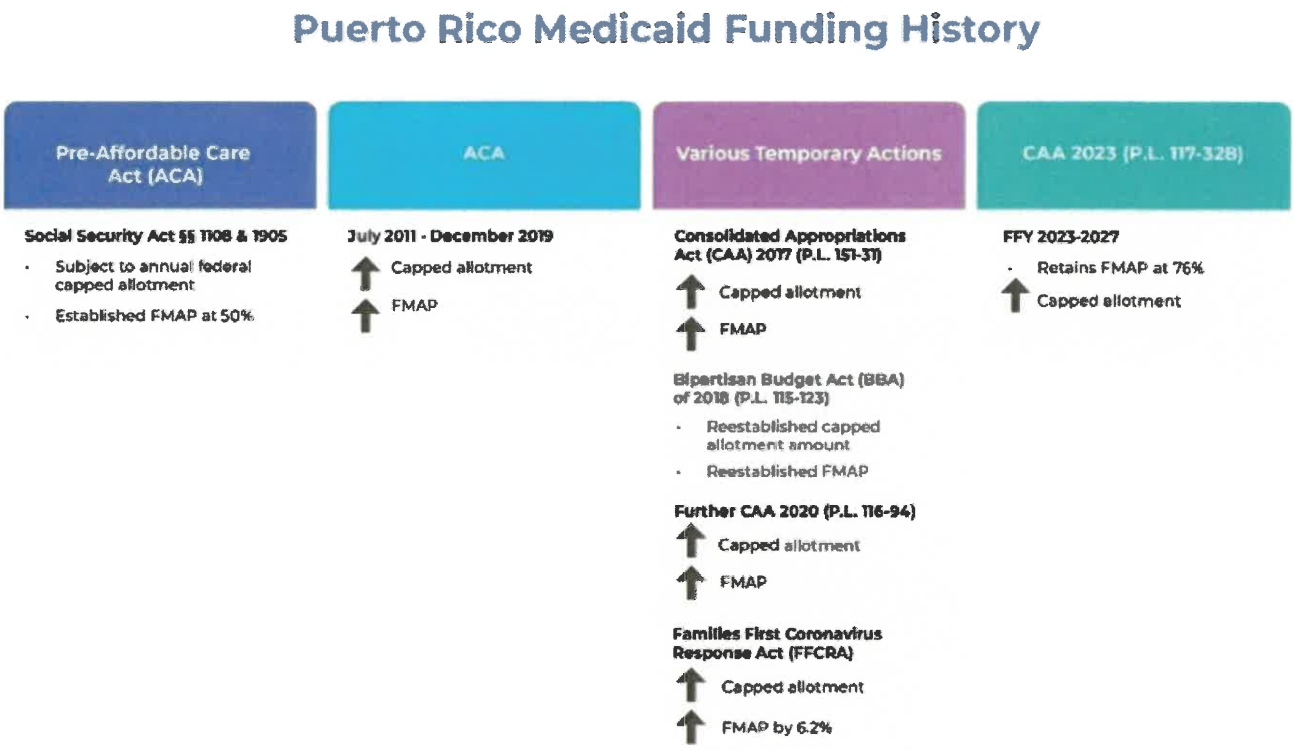

Figure 1: Puerto Rico Medicaid Funding History[1]

In December 2022, Congress passed the Consolidated Appropriations Act (CAA), 2023, which extended the 76% Federal Medical Assistance Percentage (FMAP) for Puerto Rico until the end of federal fiscal year (FFY) 2027. It also provides incremental increases in the annual capped allotment over five years (FFY 2023 – 2027). This aims to ensure continued, medium-term fiscal stability and, therefore, increases access to needed care for families and individuals with low incomes (see Section 4.2). Without congressional action, the incremental increases to the annual capped allotment expire at the end of FFY 2027; however, if adequate state-like funding is achieved, PRMP will have the opportunity to make further programmatic improvements to benefit the people of Puerto Rico, such as investing in long-term services and supports (LTSS) to support our aging population and individuals with disabilities.

The Puerto Rico Medicaid Program faces longstanding challenges stemming from unequal treatment. Increased Medicaid funds and a 76% FMAP have been secured by Congress until the end of FFY 2027. As this temporary federal funding nears expiration, we could face a Medicaid funding cliff that can destabilize care for over 1.3 million beneficiaries under Plan Vital, the government-administered health insurance program. ASES seeks to partner with CMS as Puerto Rico works with Congress to secure permanent FMAP parity and ensure stable financing for rate certification, provider solvency, and managed care continuity. Concurrently, ASES is advancing system-wide modernization—2026 rate reforms, Medical Loss Ratio (MLR) oversight, MMIS and data integration, and valued-based payment

[1] Congressional Research Service. June 22, 2023. "Legislative History of Medicaid Financing for the Territories." *Congressional Research Service.* https://www.everycrsreport.com/files/2023-06-22_R47601_a8b408e9224568ef24c5b49c245e910420059e86.pdf

pilots to improve efficiency and quality. Together, these initiatives aim to strengthen Puerto Rico's Medicaid infrastructure, align with federal standards, and safeguard equitable access to care amid fiscal uncertainty.

Funding challenges have caused Puerto Rico increased difficulties with provider access. Puerto Rico faces large-scale professional emigration and an aging provider population. As noted in Section 6.1.1, Puerto Rico continues to take action to help stabilize provider access through provider reimbursement increases, raising rates for most providers to a minimum of 75% of Medicare and some to levels that are on par with Medicare rates. While these needed rate increases help address provider access, the increases create additional strain on Puerto Rico's capped allotment. Balancing the capped allotment and provider access is important because approximately half the island's population is enrolled in Medicaid or CHIP, and many have chronic conditions, which puts increased stress on provider availability. New enrollees in the Puerto Rico Medicaid program are estimated to have a morbidity rate 10% higher than those who are already enrolled. Puerto Rico has the capacity, talent, and infrastructure to be a national model in primary care medicine, but it needs equitable resources to sustain and expand that impact.

Puerto Rico faces systemic exclusion from critical federal health programs that serve as lifelines for vulnerable populations across the United States. Recently, the One Big Beautiful Bill Act (OBBBA) (Public Law 119-21) excluded Puerto Rico and the other U.S. territories from the Rural Health Transformation (RHT) Program authorized under Section 71401 of the Act.[2] (See Section 3). There are also long-standing exclusions, such as benefits for low-income seniors. Governor Jenniffer González-Colón has identified the pursuit of federal program parity as a key policy priority for her administration. She acknowledges that, despite being home to more than 3 million U.S. citizens, Puerto Rico's residents remain ineligible for programs such as Supplemental Security Income (SSI), the Medicare Savings Program (MSP), and the Extra Help subsidy under Medicare Part D. These long-standing exclusions limit access to essential benefits available to residents of the fifty states. The Governor's administration, in coordination with the PRHIA, the Medicaid Program, and the Puerto Rico Federal Affairs Administration (PRFAA), is evaluating pathways to align these programs and strengthen advocacy efforts at the federal level. See additional information in Section 7.

Pharmacy providers have not benefited from the aforementioned rate increases; however, Governor González seeks to pay pharmacies in the Plan Vital network a reasonable dispensing fee that best reflects their actual costs of providing services. To accomplish this, the Governor plans to commission a study to determine a reasonable dispensing fee that accurately reflects the true cost of service delivery subject to the availability of funds.

Puerto Rico continues to prioritize program oversight by enhancing program integrity processes to address fraud, waste, and abuse (FWA) and increasing program transparency. These efforts are directed toward bolstering program oversight, improving program quality, and strengthening program integrity. The Medicaid Program Integrity Division includes a program integrity lead and staff who are focused on ensuring Medicaid funds are utilized appropriately. The division continues to prioritize coordination with other investigatory agencies (see Section 5.2.1). Puerto Rico continues to operate a robust procurement office by wisely using federal funds when procuring technology and services to support our Medicaid

[2] Centers for Medicare & Medicaid Services. 2025. "Rural Health Transformation (RHT) Program." *CMS.gov.* Rural Health Transformation (RHT) Program | CMS

program through a diligent procurement process. This procurement process complies with Section 1108 of the SSA, specifically paragraphs (7)(A)(v)(II) and (III), which requires the designation of a Contracting and Procurement Oversight Lead, which is through the Procurement Unit led by the procurement oversight lead (See Section 5.2.1 and 5.2.3.1). The procurement oversight lead's position description is detailed in section 5.2.3.1.

Puerto Rico remains focused on improving its governance and program management functions. Efforts center on key high-level improvements of the Medicaid Enterprise Systems (MES) Division, with priority on enhancing enterprise governance, data governance, information technology projects, and program standardization. Through these improvements, PRMP can align data-strengthening priorities with clear leadership and decision-making processes. Improved data governance helps support performance in a variety of program areas, including financial oversight and quality metrics reporting. Program standardization and our program and project management structures have continued to strengthen vendor contract oversight (see Section 5.2.3).

In the area of technology, PRMP has continued to enhance the use of the online application for Medicaid eligibility (see Section 6.3) and is planning for additional upgrades to its eligibility system, which will be accompanied by continued updates of the eligibility manual. In parallel, PRMP has upgraded the financial and reporting capabilities of its MMIS, with CMS certification of the MMIS financial solution earlier this year (see Section 5.1.2). Puerto Rico has more MMIS enhancements planned and remains committed to working with its selected Asset Verification System (AVS) vendor and other stakeholders to meet the January 1, 2026, implementation timeline for AVS, per the CAA.

As important as the administrative improvements are, they are in the service of providing better care to Medicaid beneficiaries, particularly the most vulnerable populations. Even as Puerto Rico seeks to provide better care for Medicaid beneficiaries, Puerto Rico is challenged to do so under the capped allotment. For example, Puerto Rico continues efforts to sustain coverage of the services added in 2024, which include home health, durable medical equipment (DME), hospice, and non-emergency medical transportation (NEMT). These new services are challenging Puerto Rico's capped allotment with current expenditure projections indicating that Puerto Rico may exceed the capped annual allotment by 500 million in future years.

Further, the capped allotment limits Puerto Rico's ability to fund LTSS. Puerto Rico is using grant funding received under the Money Follows the Person (MFP) program to explore the structure needed and the additional federal funding that would be required to implement a continuum of LTSS. As noted in Section 7.2, state-like funding would support Medicaid coverage of LTSS for the American citizens living in Puerto Rico who need these services.

As Puerto Rico plans for state-like funding, PRMP is taking steps to meet requirements imposed on states, as feasible within budget constraints. For example, Puerto Rico has been moving forward with efforts to implement the CAA, 2023, Section 5121 services for justice-involved youth (see Section 6.3.2) and continues to collect and report on Child and Adult Core Set measures (see Section 4.1). Puerto Rico is the only Territory required to participate in Medicaid Payment Error Rate Measurement (PERM) and completed our first pilot cycle and conducted Puerto Rico's first Medicaid Eligibility Quality Control (MEQC) pilot (see Section 5.2.2). In addition, Puerto Rico continues its participation in the Medicaid Drug Rebate Program (MDRP), allowing rebates to be reinvested in services (see Section 6.2.4).

Despite these improvements, current Medicaid funding results in a Medicaid Program that lags behind how state Medicaid programs are funded. The island's health system is strained by lack of funding and a dwindling provider population. A state-like funding structure for Puerto Rico Medicaid can support provision of these services. Puerto Rico looks forward to continuing to work with Congress to achieve state-like funding to support the goal of a healthier Puerto Rico for the U.S. citizens who reside on the island.

2. Introduction

In FFYs 2020 and 2021, Puerto Rico submitted an Annual Report to Congress, as required by Section 202 of the Further Consolidated Appropriations Act 2020, Public Law (P.L.) 116-94. The contents of the Annual Report were set forth in Section 1108(g)(9) of the SSA. On December 29, 2022, the CAA, 2023, (P.L. 117-328) was enacted. This act amended SSA 1108(g)(9) by reinstating annual reporting requirements for Puerto Rico for FFY 2023 and each subsequent year before FFY 2028 if Puerto Rico receives a Medicaid capped allotment increase or an increase in the FMAP for such FFY. This 2025 Annual Report provides Puerto Rico's response to comply with the reporting requirement.

PRMP's funding and governance structures differ from the U.S. SMAs. There are four major entities that influence Medicaid in Puerto Rico:

Puerto Rico Department of Health (PRDoH), which is the single SMA administering the Puerto Rico Medicaid Program (PRMP). There is a long-standing sister agency relationship between PRDoH and PRHIA, defined by an interagency memorandum of understanding (MOU). PRMP, a department under the PRDoH, oversees the Medicaid State Plan, determines Medicaid eligibility of residents, and is responsible for the operation of the MMIS, the Provider Enrollment Portal (PEP), and the eligibility system (MEDITI3G). PRDoH leads coordination between the agencies to deliver the Medicaid Program.

Puerto Rico Health Insurance Agency (PRHIA) was created in 1993 to oversee, monitor, and evaluate services offered by MCOs under contract. Healthcare services to Medicaid-eligible individuals are delivered under managed care through networks of providers located throughout our geographic regions. All individuals who are eligible for Medicaid receive services through a managed care arrangement. PRHIA is a public corporation overseen and monitored by a **board of directors** (BOD). The Puerto Rico Health Reform Program (Plan Vital) created a government health insurance program under a managed care delivery system. PRHIA is responsible for the program design and implementation of Plan Vital contracts with MCOs. PRHIA is responsible for implementing coverage changes, assisting PRMP in evaluating potential program changes, and/or estimating the cost of implementing new services or changes in reimbursement levels or payment methodology. PRHIA is also responsible for communications with beneficiaries about benefit changes and with providers about benefit or reimbursement changes.

PRHIA is governed by a BOD made up of 11 members; six are ex-officio members and five are appointed by the Governor of Puerto Rico with the advice and consent of Puerto Rico's Senate. The Secretary of Health has initiated a plan to merge PRMP and the PRHIA to maximize resources and implement operational efficiencies. This plan is pending law and regulation amendments.

The **Financial Oversight and Management Board (FOMB)** is a federally mandated oversight agency, which helps ensure fiscal responsibility in the contracting procedures of the island's government agencies. The FOMB was created under the federal Puerto Rico Oversight, Management and Economic Stability Act (PROMESA) of 2016. The FOMB consists of seven members appointed by the president of the United States and one ex-officio member designated by the Governor of Puerto Rico. The FOMB is tasked with working with the people and the

Government of Puerto Rico to create the necessary foundation for economic growth and to restore opportunity to the people of Puerto Rico. The FOMB must approve government contracts, including Medicaid contracts, in the amount of $10 million or more and can audit other contracting processes at its discretion. All proposed contracts or amendments stemming from the rate negotiations between PRHIA and Plan Vital MCOs must be submitted to the FOMB for review and approval prior to execution. Also, certain proposed rules, regulations, administrative orders, and executive orders must be submitted for FOMB review prior to enactment. Unfortunately, the FOMB process creates an unnecessary burden and is detrimental to program efficiencies.

Puerto Rico is a U.S. commonwealth with a large population that has significant health needs and faces heightened challenges due to its geography, including hurricanes, power outages, earthquakes, and high dependence on imported health technology. Notably, hurricanes have been detrimental and require years of recovery. In September 2017, Hurricanes Irma and Maria caused widespread destruction to infrastructure, businesses, and homes, resulting in billions of dollars in damage.[3] Recovery efforts were slowed due to additional damage caused by Hurricane Fiona in September 2022.[4] Hundreds of thousands of residents needed assistance to meet basic needs for an extended period.[5] The hurricanes shut down electricity, water, and sewer services, hindered first responders' ability to dispatch 911 calls, and halted transportation.[6] Schools and some healthcare facilities were forced to close, and hospitals had to rely on emergency generators.[7] Recovery work continues, although more than seven years of work has occurred to rebuild from recent hurricane destruction.[8] The challenge of island recovery and rebuilding the economy further complicates Puerto Rico's financial situation. Governor Jenniffer González-Colón recognizes that the ongoing hurricane recovery continues to shape the daily lives of Puerto Ricans. Her administration has reaffirmed its commitment to accelerating the use of federal recovery funds and supporting infrastructure projects that strengthen Puerto Rico's health system, energy grid, and public facilities. These efforts build upon multi-agency recovery work coordinated by the Central Office for Recovery, Reconstruction and Resiliency (COR3), and federal partners such as the Federal Emergency Management Agency (FEMA) and Housing and Urban Development (HUD).

Despite the challenges, Puerto Rico Medicaid continues to explore program enhancements to better serve our Medicaid beneficiaries. Our efforts are accompanied by activities that simultaneously strengthen our program's governance, technology, and oversight. Accordingly, as Puerto Rico Medicaid demonstrates the capability to implement a Medicaid Enterprise with structures for robust contract oversight, program integrity, and data transparency, Puerto Rico, under the leadership of Governor González and Secretary of Health Ramos, continues to advocate for state-like funding of our program, which will improve access to necessary healthcare services for our Medicaid beneficiaries. This Annual Report aligns with Governor González intent to continue to raise awareness to Congress about Puerto

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[3] Central Office for Recovery, Reconstruction, and Resiliency. August 8, 2018. "Transformation and Innovation in the Wake of Devastation: An Economic and Disaster Recovery Plan for Puerto Rico." *Central Office for Recovery, Reconstruction, and Resiliency.* https://recovery.pr.gov/documents/pr-transformation-innovation-plan-congressional-submission-080818.pdf

[4] Congressional Research Service. November 14, 2022. "Hurricane Fiona Recovery: Context and Challenges." https://crsreports.congress.gov/product/pdf/IN/IN12044/1

[5] Central Office for Recovery, Reconstruction, and Resiliency. August 8, 2018. "Transformation and Innovation in the Wake of Devastation: An Economic and Disaster Recovery Plan for Puerto Rico." *Central Office for Recovery, Reconstruction, and Resiliency.* https://recovery.pr.gov/documents/pr-transformation-innovation-plan-congressional-submission-080818.pdf

[6] *Ibid.*

[7] *Ibid.*

[8] U.S. Government Accountability Office. February 13, 2024. Puerto Rico Disasters: Progress Made, but the Recovery Continues to Face Challenges. https://www.gao.gov/products/gao-24-105557

Rico's need for additional Medicaid funding not only to sustain the current program eligibility levels and services, but also to be able to include all mandatory services and provide long-term care.

As Puerto Rico manages Medicaid program operations and explores options for program improvements, we look forward to maintaining a strong relationship with federal partners to advance the program's positive momentum and advocate for a commensurate funding structure. This report captures actions Puerto Rico has taken and demonstrates our capacity and commitment to the beneficiaries served by operating a strong Medicaid program.

3. Difference in Medicaid Funding Between the States and Puerto Rico/Other Territories

Medicaid is the primary federal program and source of funds that provides access to healthcare to qualifying individuals with limited resources, including many of the nation's most vulnerable populations. Medicaid is jointly funded by the state and federal government, with the federal government matching a percentage of the state's program expenses based on a formula that considers per capita income relative to the national average. The formula results in a state-specific FMAP. The funding for states is open-ended, and the FMAP rates range from 50% to 83%.

The Medicaid Program, including CHIP, is arguably the most consequential federal program in Puerto Rico because, as of August 2025, it provides healthcare services to about 1.3 million[9] people, which is almost half of the island's population. In addition, as of September 2025, Puerto Rico used CHIP funds to provide coverage for approximately 17,979 children, who are enrolled in its Medicaid Expansion CHIP.[10] However, our program differs in fundamental ways when compared to state Medicaid programs.

Territories do not receive federal Medicaid funding based on the same calculations as states. Puerto Rico is subject to an annual Medicaid capped allotment pursuant to Section §1108(g) of the SSA. This means the federal government will match Puerto Rico's Medicaid spending up to the capped allotment, and any Medicaid spending above that is the sole responsibility of Puerto Rico. This is unlike states that have open-ended Medicaid funding. Figure 2 depicts this difference in funding.[11] CHIP funding in Puerto Rico is determined using the same methodology used for U.S. states, which is an annual capped allotment, as established under Section 2014 of the SSA. CHIP has a separate enhanced FMAP that is about 15% higher than the regular Medicaid FMAP.

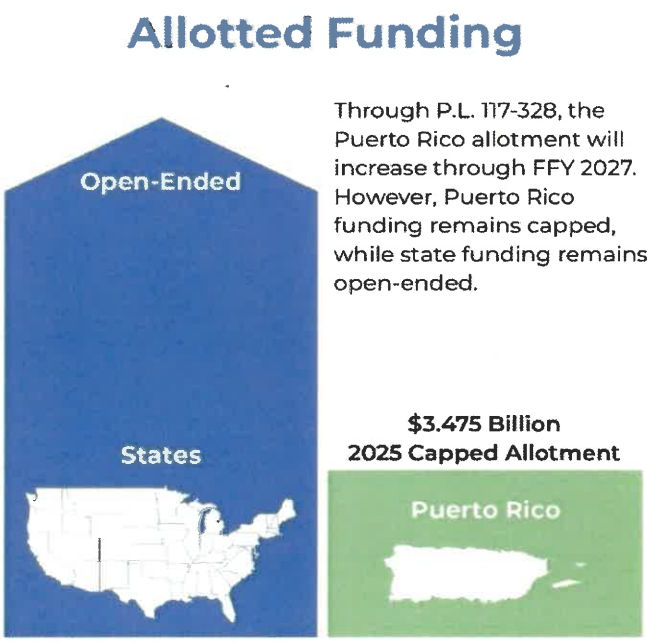

Figure 2: Allotted Medicaid Funding

The FMAP for Puerto Rico was set in statute at 50% in 1968, increased to 55% by the Affordable Care Act (ACA) of 2010, and raised to 76% through FFY 2027 via congressional actions, including P.L. 117-328. Although other U.S. territories have received permanent FMAP increases to 83%, the Puerto Rico FMAP would revert

[9] Departmento De Salud. September 2025. "Programa Medicaid Statistics." *Departmento De Salud.* Programa Medicaid - Departamento de Salud. September 22, 2025. https://medicaid.pr.gov/Info/Statistics/.
[10] *Ibid*
[11] Consolidated Appropriations Act, H.R. 2617, Pub. L. 117-328 (2023). H.R. 2617 - 117th Congress (2021-2022): Consolidated Appropriations Act, 2023 | Congress.gov | Library of Congress

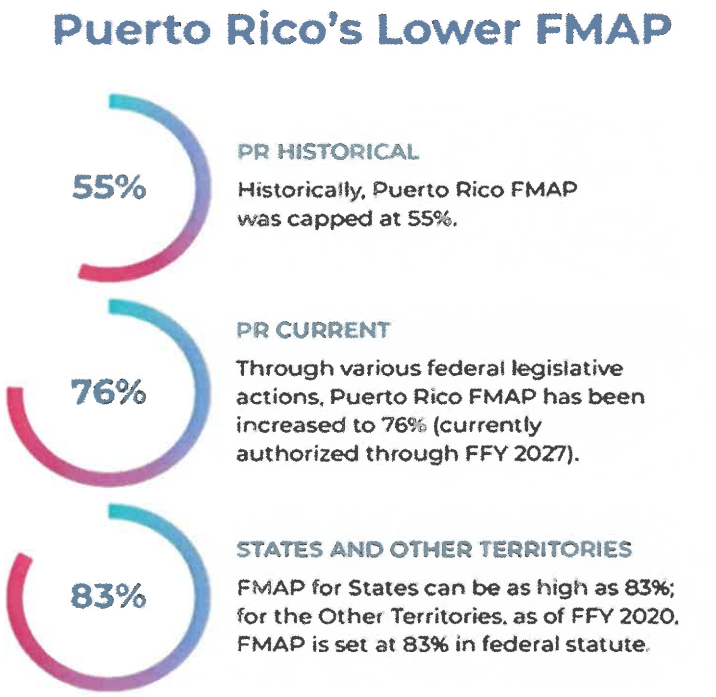

Figure 3: Puerto Rico's Lower FMAP

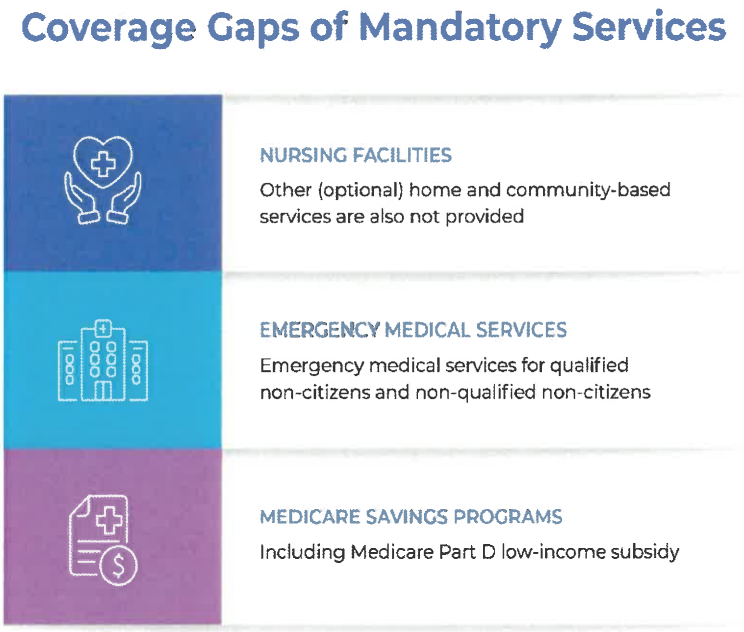

Figure 4: Mandatory Service Coverage Gaps

to 55% if no additional congressional action is taken before the end of FFY 2027. These FMAP differences are depicted in Figure 3.

The territory also faces ongoing challenges with access to care, including provider migration off-island, and has been unable to cover certain critical benefits. Figure 4 shows mandatory services that are not covered, as well as Puerto Rico's fiscal inability to opt into the MSP. Despite Puerto Rico's financial challenges, Puerto Rico implemented coverage for home health, hospice, DME, and NEMT in July 2024 and doing so within the current capped allotment has increased financial challenges for the program. Specifically, current expenditure projections suggest that Puerto Rico will exceed the capped allotment by 500 million dollars in future years. Puerto Rico is actively working to maintain coverage for these important services while balancing the pressure that these services put on Puerto Rico's capped allotment. Even though the expansion of benefits is a demonstration of Puerto Rico's ongoing commitment to improve healthcare access and quality of life for residents, the financial strain caused by implementing these services has forced the program to evaluate options to withdraw these services or significantly limit service utilization.

Even though Puerto Rico faces the aforementioned challenges, as well as challenges that also adversely impact rural states, the Rural Health Transformation (RHT) Program, authorized under Section 71401 of the OBBBA (Public Law 119-21), excludes Puerto Rico and the other U.S. Territories from the grant opportunity.[12] As stated by CMS, "In accordance with the authorizing statute, only the 50 U.S. states are eligible to receive an RHT Program award; the District of

[12] Centers for Medicare & Medicaid Services. 2025. "Rural Health Transformation (RHT) Program." *CMS.gov*. Rural Health Transformation (RHT) Program | CMS

Columbia and U.S. Territories are not eligible."[13] The grant application process and eligibility criteria are tailored exclusively to states, with no mention of territorial pathways. This exclusion is structurally embedded in the statutory framework of the OBBBA, disqualifying Puerto Rico from participating in state-targeted grants like the RHT Program.

Therefore, Puerto Rico is systematically disadvantaged when it comes to accessing federal health resources, despite facing persistent poverty and significant geographic health disparities. Excluding Puerto Rico from applying for this grant is a missed opportunity to address health disparities in Puerto Rico and should have congressional review to ensure that future funding opportunities are inclusive of all states and territories.

Puerto Rico experiences significantly higher poverty rates than the mainland United States. Based on United States Census data, all 78 municipalities in Puerto Rico have been in persistent poverty from 1989 to 2019.[14] As of 2021, nearly 43% of Puerto Ricans lived below 100% of the federal poverty level (FPL), which was over three times the national average of 12.6%.[15]

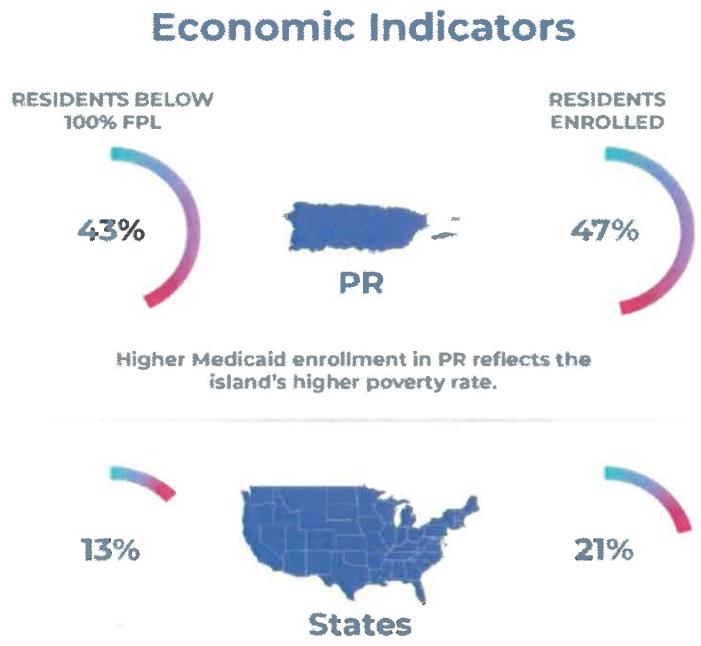

Figure 5: Economic Indicators

In 2023, over 47% of the island's total population was enrolled in Medicaid and CHIP, which is 13 points higher than the next closest state (34% for New Mexico) and 26% higher than the U.S. average of 21% (the U.S. average does not include Puerto Rico).[16] Figure 5 illustrates the differences in the economic indicators of residents below 100% FPL and residents enrolled in Medicaid. Due to persistently high poverty levels in Puerto Rico, Medicaid remains widely used to support residents, despite differences in funding compared to other state Medicaid agencies. The Territory also uses its own funds to support coverage for over 23,000 individuals under the Commonwealth program.

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[13] *Ibid.*

[14] Benson, Craig; Bishaw, Alemayeuhu. 2024. "Persistent Poverty in Puerto Rico and the U.S. Island Areas." *United States Census Bureau. Accessed September 5, 2025.* Persistent Poverty in Puerto Rico and the U.S. Island Areas

[15] Colon Mendez, Laura; I Figueroa-Lazu, Damayra; Soldevila Irizarry, Jorge; Vergas-Ramos, Carlos/Center for Puerto Rican Studies, Hunter College CUNY. September 22, 2023. *Pervasive Poverty in Puerto Rico: a Closer Look.* Accessed August 22, 2024. https://centropr.hunter.cuny.edu/reports/pervasive-poverty-in-puerto-rico/

[16] Kaiser Family Foundation. 2023. "Health Insurance Coverage of the Total Population." *Kaiser Family Foundation.* Accessed September 3, 2025. Health Insurance Coverage of the Total Population | KFF

4. Landscape of Puerto Rico's Medicaid Program

To better understand the Puerto Rico Medicaid Program and the additional and ongoing funding needs, the Puerto Rico Medicaid landscape is described in the following section, including our healthcare data and program reporting, the program's funding, and program enrollment and eligibility.

4.1 Healthcare Data and Program Reporting

As of August 2025, nearly half of Puerto Rico's population is enrolled in Medicaid and CHIP.[17] To provide the best possible service for beneficiaries, Puerto Rico continues to evaluate services to consider for coverage changes, enhance collaborative efforts with various agencies for data collection, and subsequently utilize this data for making well-informed decisions, particularly in support of vulnerable populations.

Collecting and reporting Medicaid data is essential to learn more about the health care needs of beneficiaries, monitor efforts to access preventive care, evaluate services and interventions, and track utilization. Implementation of reporting on Child and Adult Core Sets marks a significant milestone in program monitoring and quality improvement efforts. In compliance with federal requirements, Puerto Rico has submitted its Medicaid and CHIP Child and Adult Core Set reports, continuing to affirm its commitment to align with federal expectations.

The Medicaid and CHIP Child and Adult Core Sets contain measures that, analyzed across all Medicaid programs, can be used to understand factors affecting the overall national quality of services provided to Medicaid and CHIP beneficiaries. While Puerto Rico is mindful of the requirements for Child and Adult Core Set reporting and the important data available through the reporting, PRHIA continues to require annual reports from MCOs on the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS measures are a set of standardized performance indicators used to assess the quality of care and services provided by health plans and organizations. The primary purpose of HEDIS is to provide a consistent framework for evaluating health plan performance, identifying gaps in care, and promoting accountability. Puerto Rico uses HEDIS data to monitor outcomes, guide quality improvement initiatives, and support care programs. These measures help enhance patient care, improve health outcomes, and ensure that resources are used effectively.

The combination of the Core Set and HEDIS reporting assists PRHIA with monitoring and evaluating the MCO operations and the corresponding services rendered by providers. Please refer to Appendix A for MCO HEDIS results for the most recent RY 2024.

In addition, PRHIA uses the Health Care Improvement Program (HCIP) to monitor and evaluate the MCOs. Through the HCIP, PRHIA establishes measures which will be evaluated on a quarterly basis. A portion of each MCO premium is retained and placed in a Retention Fund, and quarterly performance on the scored drives MCO reimbursement from the Retention Fund. In addition to performance measurement, HCIP is used to assess the effectiveness and efficiency of quality or improvement initiatives on selected indicators.

Data from reporting efforts reflect both challenges and areas of focused improvement. For example, for

[17] Departmento De Salud. August 2025. "Programa Medicaid Statistics." *Departmento De Salud.* Programa Medicaid - Departamento de Salud. August 21, 2025. https://medicaid.pr.gov/Info/Statistics/

Child Core Set Measures, under the Care of Acute and Chronic Conditions domain, 88% of children aged 5 – 11 are effectively managing their asthma medications, a positive indicator of appropriate services and care interventions. However, a strategic focus area for Puerto Rico has been behavioral health, with data showing that only 51% of children prescribed antipsychotic medications received appropriate metabolic monitoring, a critical measure under the Child Behavioral Health Core Set.

Data from Puerto Rico's reporting efforts also highlight both progress and ongoing challenges across Adult Core Set Measures. Under the Primary Care Access and Preventive Care domain, 70% of eligible adults aged 50 – 64 received breast cancer screenings, indicating interest in and access to preventive care. However, in the Behavioral Health Care domain, only 18% of individuals aged 18 – 64 received depression screening and a follow-up plan, underscoring an area for improvement.

Puerto Rico is committed to transparency, and its prioritization of healthcare measures underscores that commitment. For more detailed information on Puerto Rico's Core Set measures for RY 2024, please refer to the Appendix B.

In addition to a focus on reporting, Puerto Rico remains committed to the early screening of children to identify and address potential issues before they reach adulthood. According to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) report submitted to CMS for FFY 2024, a total of 368,029 screenings were expected for individuals aged 20 and under, with 334,436 screenings completed. This corresponds to a screening ratio of 0.91, exemplifying the strong commitment to screening and early intervention efforts.

4.2 Funding

This section describes Puerto Rico's specific funding model and how that funding is utilized. The current state of the program, including improvements and reforms, was made possible by various federal funding extensions and temporary increases.

The CAA, 2023, P.L. 117-328, extends the 76% FMAP for Puerto Rico for five years (through the end of the FFY 2027).18 P.L. 117-328 also allocates annual increases of Medicaid funding in Puerto Rico through FFY 2027. With the end of FFY 2027 now two years away, Puerto Rico looks forward to working with Congress to establish the level of funding needed to support the current Puerto Rico Medicaid Program operations, as well as parity with services offered in states, such as LTSS.

[18] Consolidated Appropriations Act, H.R. 2617, Pub. L. 117-328 (2023). H.R.2617 - 117th Congress (2021-2022): Consolidated Appropriations Act, 2023 | Congress.gov | Library of Congress

Medicaid Program Expenditures			
	FFY 2023	FFY 2024	FFY 2025 (Projected)
Medicaid MAP (Net of Drug Rebates)	$4,051,497,318	$4,005,004,138	$4,561,233,691
Enhanced Allotment Plan (EAP)	$83,503,967	$96,613,069	$105,729,430
CHIP (Net of Drug Rebates)	$133,174,336	$88,086,080	$44,267,581
PRMP Administration	$32,890,084	$40,147,427	$22,505,245
ASES Administration	$16,000,000	$16,000,000	$16,000,000
American Rescue Plan	$15,796,743	$-	$-
Eligibility & Enrollment	$13,792,594	$64,036,985	$43,292,663
Medicaid Management Information System (MMIS)	$50,700,609	$57,371,762	$54,319,121
HIT Implementation	$4,325,188	$-	$-

Table 1. Medicaid Program Expenditures

P.L. 117-328 further establishes criteria for an additional $375 million annually for the Puerto Rico Medicaid Program if specific requirements are satisfied.[19] The requirements and Puerto Rico actions include:

> Puerto Rico is eligible to receive $300 million in additional funding by establishing a reimbursement floor for physician services at 75% of Medicare reimbursement. Puerto Rico amended its contracts with MCOs to include the 75% reimbursement floor, and CMS approved Puerto Rico's submission of a state direct payment (SDP) arrangement, which establishes a minimum fee schedule for primary care services at 75% of Medicare reimbursement, in accordance with requirements of the CAA, 2023.
>
> Puerto Rico is also eligible for an additional $75 million for FFY 2023 through FFY 2027. To receive this funding specifically for FFY 2023 through FFY 2025, Puerto Rico must satisfy the requirements in Paragraph (7)(A)(i) of Section 1108 of the SSA, which requires the designation of an officer (other than the director of such agency) to serve as the program integrity lead, which Puerto Rico established to satisfy the requirement.
>
> To continue to receive the additional $75 million in FFYs 2026 and 2027, Puerto Rico must continue to meet the requirements for the program integrity lead, and designate Contracting and Procurement Oversight Lead who is fulfilling the requirements in paragraphs (7)(A)(v)(II) and (7)(A)(v)(III) of Section 1108 of the SSA. Puerto Rico has a designated Contracting and Procurement Oversight Lead and anticipates no difficulties in receiving the additional $75 million

[19] Consolidated Appropriations Act, H.R. 2617, Pub. L. 117-328 (2023). H.R.2617 - 117th Congress (2021-2022): Consolidated Appropriations Act, 2023 | Congress.gov | Library of Congress

through FFY 2027.

Puerto Rico appreciates this additional support and acknowledges receipt of the additional $375 million for FFY 2025 and looks forward to continuing to comply with the requirements of P.L. 117-328 to receive this funding for FFYs 2026 and 2027.

4.3 Program Enrollment and Eligibility

As of September 2025, Puerto Rico provides Medicaid coverage to approximately 1.3 million individuals out of a total population of 3.2 million residents.[20] An additional 17,979 children under the age of 19 are covered under the island's Medicaid Expansion CHIP.[21] The number of Medicaid and CHIP enrollees has declined, primarily a result of Puerto Rico unwinding from continuous Medicaid enrollment, which had been required by the Families First Coronavirus Response Act (FFCRA). The remaining waivers established to support the unwinding process and help eligible beneficiaries maintain coverage expired in June 2025. Puerto Rico continues to monitor the outcomes from the unwind recertifications to help ensure eligible beneficiaries are not left without access to healthcare coverage.

Puerto Rico is also one of the most rapidly aging populations in the world. Compared to mainland states, Puerto Rico is the jurisdiction with the second highest percentage of the population aged 18 years or older.[22] This is due to the reduction of births across the island as well as the outmigration of many adults.[23] The growing generation gap in Puerto Rico greatly impacts the number of Medicaid-eligible beneficiaries.

[20] "Puerto Rico Profile" United States Census Bureau. Accessed September 22, 2025. https://www.census.gov/geographies/island-areas/puerto-rico.html

[21] Puerto Rico Department of Health. September 2025. "Beneficiaries by Program as of September 2025." *medicaid.pr.gov*. September 22, 2025. https://medicaid.pr.gov/Info/Statistics/

[22] America Counts Staff. August 25, 2021. Puerto Rico Population Declined 11.8% From 2010 to 2020. United States Census Bureau. Accessed October 2, 2025 https://www.census.gov/library/stories/state-by-state/puerto-rico.html#age

[23] Amílcar Matos-Moreno, Ashton M Verdery, Carlos F Mendes de Leon , Vivianna M De Jesús-Monge, and Alexis R Santos-Lozada . June 13, 2022. Aging and the Left Behind: Puerto Rico and Its Unconventional Rapid Aging. The Gerontologist. Accessed October 2, 2025 https://pmc.ncbi.nlm.nih.gov/articles/PMC9372893/

5. Program Governance and Oversight

This section provides an overview of the Puerto Rico Medicaid Program's governance structure and operational priorities. It also highlights PRMP's commitment to advancing standardization, accountability, and compliance through collaborative governance structures, including the Program Management Office (PgMO) and Enterprise Project Management Office (ePMO). It also details key initiatives, recent milestones, and ongoing Program Integrity, PERM, MEQC, Procurement, and Contracting efforts that position PRMP to meet federal requirements, improve beneficiary access, and drive innovation across Medicaid operations.

5.1 Puerto Rico Medicaid Program

As noted in Section 2, the Puerto Rico Medicaid Program is influenced by PRDoH, PRHIA, the PRHIA BOD and FOMB. While PRDoH is the single SMA and retains ultimate responsibility for the Medicaid Program, PRDoH works collaboratively with PRHIA to achieve the program's ultimate goal of providing healthcare services to individuals eligible for Medicaid. Anchored to this shared vision, PRDoH knows that we must continue to add rigor, structure, and standardization across departments and projects to bolster accountability, improve performance, and strengthen governance structures. We believe a strong governance structure, with underlying processes that support that structure, will help the Medicaid Program achieve its goals, realize its vision, and provide for its strategic direction. Figure 6 below shows the governance structure of the Puerto Rico Medicaid Program.

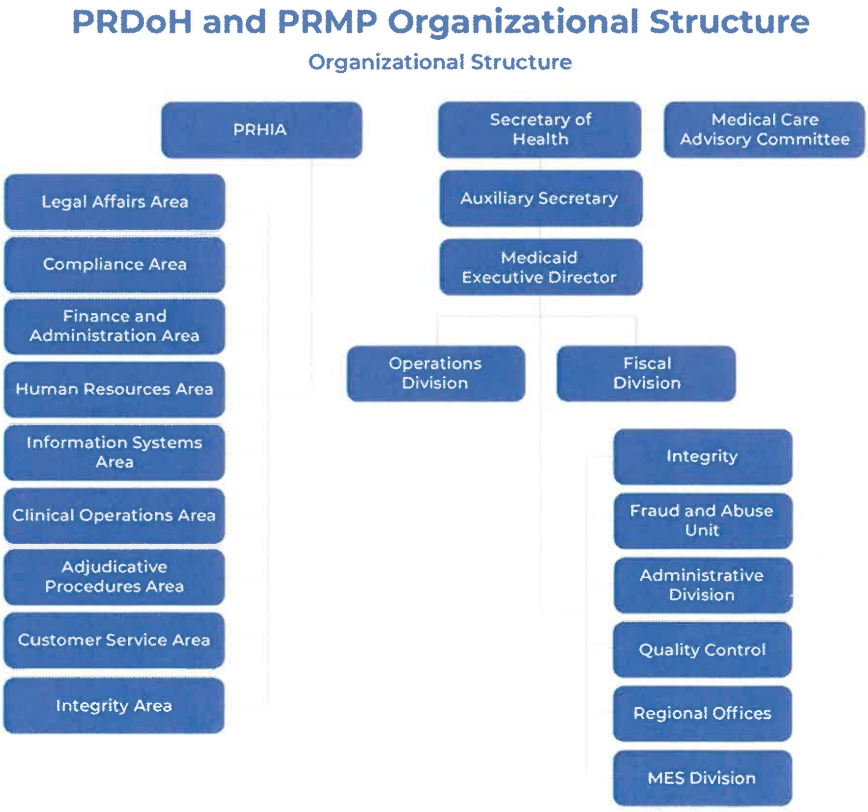

Figure 6: PRDoH and PRMP Organizational Chart

The PRMP MES Division comprises modular, interoperable IT solutions and resources that work together to manage the Medicaid Program. In recent years, PRMP has strengthened MES governance by establishing the PgMO governance body for strategic program oversight and the ePMO governance body for tactical project execution. While each has a different focus, the two governance bodies collaboratively operate to promote consistency, standardize processes, and enhance predictability in MES outcomes, communications, and decision-making. This minimizes the risk of program failure while increasing the program's efficiency.

Figure 7 shows in greater detail the governance functions of the PgMO and the ePMO within PRMP's MES.

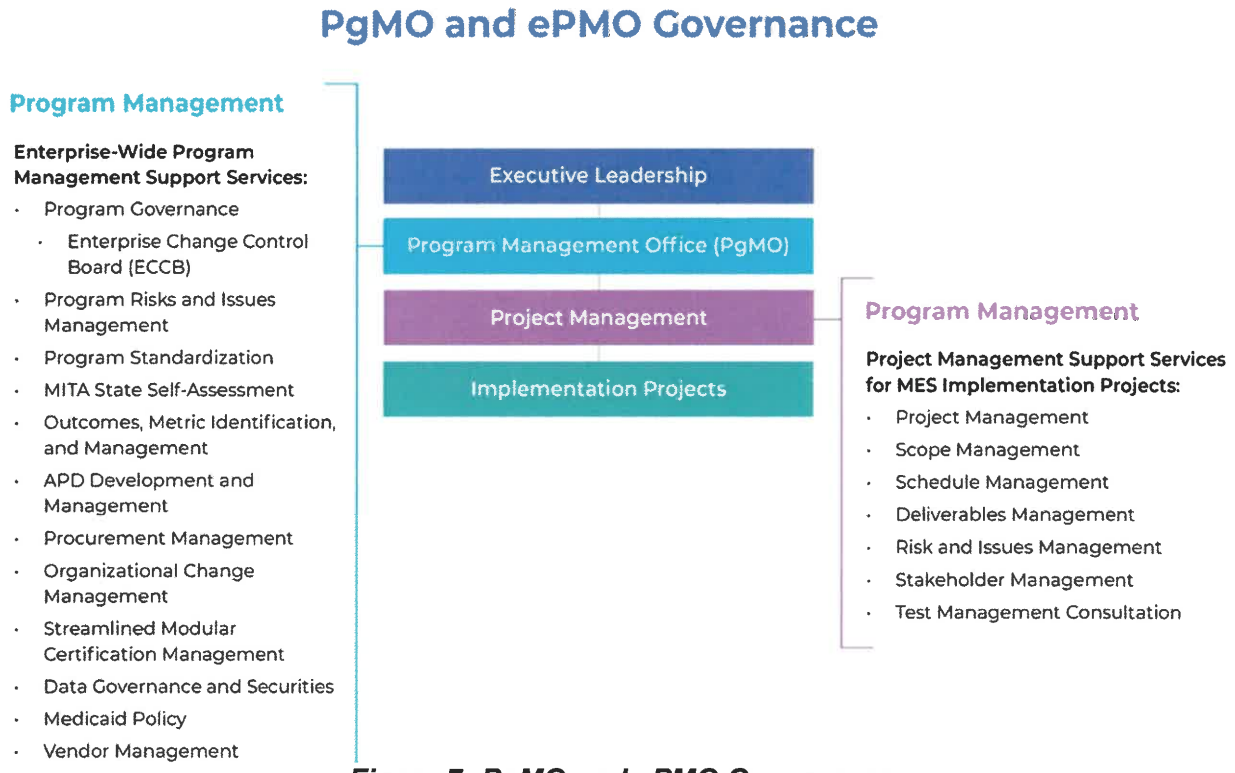

Figure 7: PgMO and ePMO Governance

The distinct and separate PgMO and ePMO roles are central to advancing governance for Puerto Rico's MES. The design and functions of the PgMO and ePMO are aligned with industry best practices and have received recognition and support from CMS' Data Systems Group (DSG). The PgMO, led by PRMP staff and supported by vendors, oversees strategic planning, program management, risk management, operations, and federal compliance, while the ePMO, also led by PRMP staff and supported by vendors as needed, manages project execution, standardization, budget, timelines, and reporting.

5.1.1 MES Division

PRMP's MES Division is one of the governing bodies within PRMP. It is primarily guided by four governance-related artifacts: the MES Program Management Roadmap, the MES Roadmap, the Medicaid Information Technology Architecture State Self-Assessment (MITA SS-A), and the PgMO Plan Aids. These artifacts continue to guide the iterative advancement of the MES to help ensure its

effectiveness and success. Collectively, these documents are maintained by the PgMO and help establish the strategic direction of the MES' technology and program-related initiatives.

The following sections provide greater detail on each of these MES governance-related documents.

5.1.1.1 MES Program Management Roadmap

The MES Program Management Roadmap is PRMP's strategic guide for incrementally maturing program management capabilities and strengthening governance across the MES. Updated annually, it aligns with industry best practices (PMI®, DAMA-DMBOK2®, ITIL-4) and focuses on four key business areas: Program Management, Enterprise Architecture, Business Operations, and Data Governance.

By leveraging this roadmap, the PgMO directs IT initiatives, builds on completed projects, and drives ongoing improvements, ensuring PRMP's IT investments effectively support Medicaid program operations and long-term governance goals.

5.1.1.2 MES Roadmap

The MES Roadmap provides a current snapshot of PRMP's MES strategic plans and priority initiatives for 2025 and beyond. Used by the PgMO and PRMP leadership to communicate strategy to CMS and other stakeholders, the MES Roadmap is updated at least twice a year to guide resource prioritization, project timing, and planning discussions.

PRMP is also establishing a process for more frequent tracking of roadmap initiatives between updates, which will help ensure priorities stay on course and enable proactive management of risks and issues.

Additional details on the MES Roadmap and the priority initiatives of focus for PRMP can be found in Section 5.1.2.

5.1.1.3 MITA SS-A

Under federal regulations at 42 CFR 433.112(b)(11) and 433.116(b), (c), and (i), states and territories must submit a MITA SS-A to qualify for enhanced federal matching for MES expenditures. In response to evolving CMS and industry guidance, PRMP has realigned its approach to MITA SS-As and related documentation, creating an alternative format with a focus on predefined maturity ratings to addressing current operational challenges, define future system goals, and identify measurable improvement targets. The MITA IT Investment Strategy document, last revised in September 2023, outlines how PRMP's approach aligns with MITA principles and CMS expectations for Federal Financial Participation (FFP). PRMP also produces MITA Concept of Operations (ConOps) for nearly all MES initiatives, previously referred to as MITA Pre-Assessments, to assess and plan for business needs. PRMP's alternative format emphasizes outcome measures over predefined maturity scores, enhancing the usefulness of MITA activities and fostering collaboration with advance planning document (APD) and outcomes-based procurement teams.

By integrating MITA ConOps and Roadmaps, PRMP can translate strategic planning into actionable governance and roadmap activities more effectively. This strategy supports MES projects and initiatives that enhance service delivery for the beneficiaries of Puerto Rico through data-driven decision-making and technology-enabled solutions. PRMP continues to monitor work from the MITA NextGen Workgroup and related sub-workgroups to ensure alignment with future CMS MITA framework releases, driving

innovation and operational excellence.

5.1.1.4 PgMO Plan Aids

PgMO Plan Aids are a set of 14 standardized tools and templates that guide key aspects of program and project management for PRMP's MES Division. These aids cover areas such as change, communications, cost, performance, quality, and risk and issue management. Through clear processes and best practices, the PgMO Plan Aids help PRMP ensure consistency, accountability, and alignment across MES initiatives, making it easier to onboard vendors, manage projects, and achieve strategic goals.

5.1.2 Priority Initiatives

As detailed in Section 5.1.1.2, PRMP uses the MES Roadmap to define the current and future desired state of the MES. The MES Roadmap is used to align PRMP's collective initiatives to help generate enterprise awareness, support, and positive momentum toward successful completion.

Since the last Annual Report to Congress, PRMP has accomplished several MES priority initiatives, some of which include:

- **Certification of Phase III of the MMIS:** PRMP successfully completed the certification review for the MMIS Financial Management solution on December 10, 2024, and received CMS certification on March 13, 2025. This milestone confirms that PRMP's financial system meets CMS outcomes and requirements for enhanced funding and helps mature PRMP's managed care capitation payment processes. As a result, PRMP has gained better insight into payment projections, streamlined business processes and data exchanges for CMS-64 reporting, and improved federal reporting accuracy—reducing the drawdown timeline from over six months to just 30 days.

- **Completion of Changes to Medicaid Online Application:** PRMP has completed nearly all of the CMS-requested changes to the program's online application and is awaiting additional CMS feedback.

- **Implementation of Technology to Support "No Touch" Applications:** In 2024, PRMP implemented a MEDITI3G system enhancement to implement "No Touch" cases. "No Touch" cases are fully automated and require no caseworker intervention. From August 2024 through August 2025, PRMP has processed a total of 5,334 "No Touch" applications.

- **Transformed Medicaid Statistical Information System (T-MSIS) Updates**: PRMP updated the T-MSIS solution in August 2025, to align with CMS-required updates. In addition, PRMP has implemented several changes in system logic to address data quality issues. PRMP continues to address data challenges with the claims and encounter data submitted by the MCOs to help ensure that the data submitted to T-MSIS by PRMP meets T-MSIS Data Quality targets for the Outcomes-Based Assessments.

PRMP's current MES Roadmap reinforces its commitment to system implementations and other initiatives to help ensure compliance with local and federal regulations, including:

- **AVS:** PRMP released an AVS Request for Proposal (RFP) in September 2024 and issued an award notification in March 2025. PRMP is in the process of finalizing the contract with the selected vendor. PRMP remains committed to working with its selected AVS vendor and other stakeholders to meet the January 1, 2026, implementation timeline for AVS, per the CAA. Puerto Rico has also researched other SMAs' AVSs and has begun to coordinate with local and federal agencies to help ensure success of the AVS implementation.

- **Electronic Visit Verification (EVV):** Pursuant to Subsection (l) of Section 1903 of the SSA (42 United States Code (U.S.C.).S.C.1396b), PRMP has made meaningful progress toward implementing an EVV solution. While full implementation has not yet occurred, PRMP has demonstrated a good faith effort to comply and has faced unavoidable delays. PRMP has worked collaboratively with CMS to determine the path forward for an EVV solution, including the development and approval of a state plan amendment (SPA) in September 2024, which added home health services. Further, PRMP conducted outreach to stakeholders potentially impacted by an EVV solution implementation, including releasing a survey to gather EVV-relevant information from MCOs. Through extensive stakeholder discussions and further marketplace research, PRMP developed an alternatives analysis, which resulted in PRMP selecting the Open Vendor model for an EVV solution. Subsequently, PRMP developed a MITA EVV Pre-Assessment, Roadmap, and RFP to procure an EVV solution and supporting vendor. The EVV project is currently on hold as PRMP collaborates with CMS and other stakeholders to determine an appropriate path forward that balances local needs with federal regulatory requirements.

- **Verify Lawful Presence (VLP) – Interface:** PRMP previously completed design and development for the implementation of a VLP interface using Systematic Alien Verification for Entitlements (SAVE) Version 37; however, the United States Citizenship and Immigration Services (USCIS) has transitioned VLP to Version 38. The new version includes updates in the data accepted for requests, the responses provided to requests, and modernized technical architecture. PRMP is reviewing the required changes to transition to VLP version 38 to determine a firm implementation date, with an expected implementation of the interface in 2026. Unti the interface using version 38 is complete, PRMP will continue to use the online SAVE VLP web services.

- **Electronic Data Warehouse (EDW):** PRMP is working to implement an EDW that integrates MES data sources into a central repository and enables self-service analytics and business intelligence (BI) functionality. These efforts help clear a path for achieving CMS' Quadruple Aim framework for enhanced experience and quality, lower costs, and improved health outcomes. Data sources planned for the EDW implementation to provide self-service analytics and BI include: MEDIT3G, Health Information Exchange, MMIS, Birth and Death Registry (Demographic Registry), and the Vaccination Registry. Though the system is not required to go through formal CMS certification, PRMP plans to execute a certification-like process to help ensure the system meets all conditions for enhanced funding and PRMP's stated outcomes for the system.

- **Spenddown:** Because Puerto Rico covers medically needy groups, use of a spenddown process in accordance with SSA 1903(f)(2) and 42 CFR 436.831 is required. Because Puerto Rico's Medicaid Program is 100% managed care, implementing spenddown presents unique challenges,

and PRMP is actively designing a solution in collaboration with all stakeholders to ensure effective implementation. PRMP is targeting the launch of the spenddown process in late 2026.

- **Increasing Access to Care for Medicaid Transitional Individuals Post-Incarceration:** On January 10, 2025, PRMP was notified of a federal award through Section 206(a) of the CAA of 2024 under the grant titled: "Increase Access to Care for Medicaid Transitional Individuals Post-Incarceration by Building a Strong and Supportive Infrastructure with Community Partners." Since that time, while PRMP awaits the monetary award, PRMP has begun to work with the Department of Corrections and Rehabilitation and service provider contractors to identify changes needed to achieve grant outcomes, specifically implementing changes required by Section 5121 of the CAA for eligible juveniles (See Section 6.3.2). The first items for MES focus will be the MEDITI3G and MMIS changes needed to support enhanced eligibility procedures and information sharing as well as covering new required screenings and pre- and post-release targeted case management (TCM) for eligible juveniles.

- **APR-DRG:** As noted in Section 6.1.2, Puerto Rico is preparing to transition to an All Patient Refined-Diagnosis Related Group (APR-DRG) for short-term acute hospital billing. PRMP will be implementing the necessary system changes, including updates to the billing and response transactions and to the T-MSIS interfaces. APR-DRG offers improved financial and clinical transparency and incentivizes high-quality, efficient care (see Section 6.1.2).

- **Third-Party Liability (TPL):** In further support of 42 CFR 433 Subpart D, PRMP is planning to enhance its TPL efforts to allow PRMP to identify additional third parties liable for Medicaid costs and will support better monitoring of the MCOs' TPL efforts. PRMP is currently procuring a TPL vendor and is planning to execute a TPL contract in January of 2026.

As PRMP achieves major milestones and adapts to evolving requirements, the MES Roadmap ensures that efforts remain focused on innovation, efficiency, and compliance, positioning PRMP to successfully manage current operations and advance future program goals.

5.2 Program Oversight

Puerto Rico continues to strengthen its infrastructure and oversight processes in alignment with federal mandates, including those introduced under the CAA, 2023. By aligning its governance and compliance structures with federal standards, Puerto Rico continues to demonstrate its commitment to operating—and therefore being funded—in the same capacity as states. The following sub-sections describe the current efforts related to program integrity, PERM and MEQC, and Procurement and Contract Oversight, Reform, and Management. While these efforts are well under way, the Puerto Rico Medicaid Program is simultaneously working to establish an overarching Medicaid compliance unit.

5.2.1 Program Integrity

Puerto Rico remains committed to advancing program integrity efforts that align with federal requirements and will continue strengthening initiatives in staffing, policy, procedures, governance, and the coordination of program integrity activities.

Puerto Rico continues to comply with Section 1108 of the SSA, specifically Paragraph (7)(A)(i), which requires the designation of an officer, other than the director of the agency, to serve as the program integrity lead. The Puerto Rico Medicaid Program Integrity Unit (PRMPIU), managed by the program integrity lead, is charged with ensuring compliance, efficiency, accountability, and coordination within Medicaid and its contracted entities. Its mission is to detect and prevent FWA, ensuring that Medicaid, CHIP, and territorial funds are spent in accordance with federal and territory requirements. These responsibilities include ensuring that contracted MCOs establish and implement policies and procedures to address FWA, as well as conducting audits to verify compliance with the contract provisions and program requirements.

Staffing and capacity development remain the greatest challenges for program integrity. Puerto Rico has realigned responsibilities so that the Program Integrity Unit (PIU) now directly oversees the Provider Unit; however, the loss of three staff across both units has resulted in gaps and additional challenges for the program.

In response to these staffing and capacity challenges, Puerto Rico is actively reinforcing its program integrity framework through targeted policy enhancements and data-driven oversight strategies. These efforts support the detection of FWA and include conducting targeted provider audits and investigations. In addition, standardized metrics and review processes are being implemented to improve consistency and ensure accurate identification of improper payments and abnormal provider billing practices or expenditures.

5.2.2 PERM and MEQC

5.2.2.1 PERM

The PERM program measures improper payments in Medicaid and CHIP and calculates improper payment rates for each program. Puerto Rico successfully completed its PERM pilot cycle for reporting year (RY) 2024. Through collaboration with stakeholders, including PRHIA and the Pharmacy Benefit Manager, Puerto Rico's PERM pilot resulted in no error citations for eligibility and medical record reviews and one error for data processing reviews.

Based on these findings, Puerto Rico received an error rate of 2.51%, which is below the PERM target rate of 3%. Puerto Rico has identified and implemented corrective actions to address the data processing error. Puerto Rico submitted the corrective action plan (CAP) to CMS in February 2025 and will begin reporting periodic CAP updates to CMS beginning in December 2025.

Puerto Rico successfully completed data submission for the 2024 PERM financial audit with a favorable outcome. Discrepancies between payments and enrollment were significantly lower than the national average (4% versus 12%).

PRMP is working with CMS contractors to provide documentation as requested and preparing quarterly claims data submissions. As of October 15, 2025, PRMP has completed the submission of the First Quarter 2025 PERM Data Extracts. PRMP will build on the process improvement efforts identified during the RY 2024 pilot PERM cycle to help ensure a more efficient experience during the RY 2027 PERM cycle, which is currently underway with pre-cycle activities. In addition, PRMP will continue to strengthen its collaboration with PRHIA to support ongoing coordination throughout the RY 2027 PERM cycle.

5.2.2.2 MEQC

Under MEQC, states design and implement an ongoing process of evaluating eligibility determinations by reviewing a selection of samples from the universe of active cases for Medicaid and CHIP as well as actions taken on negative cases. The results of these evaluations are used to help improve procedures for eligibility determinations. States have conducted MEQC reviews, which are similar to PERM reviews, for many years. States have flexibility in designing their studies and submit their proposed design through the MEQC Pilot Planning Document.

Puerto Rico's MEQC Pilot Planning Document was approved in December 2023, authorizing the pilot MEQC review for January 1, 2024, through December 31, 2024. Puerto Rico has since completed the pilot MEQC review and submitted the case-level report and CAP to CMS on August 1, 2025.

5.2.3 Procurement and Contract Oversight, Reform, and Management

Puerto Rico's vision is to be recognized as a leader in ethics and transparency in procurement and contracting. We are striving to achieve this vision by continuous evolution of our procurement and contract processes that help ensure our procurement efforts achieve results with the best possible impact for our beneficiaries, all at a lower cost to taxpayers. Puerto Rico continues to work toward this goal by strengthening our staff resources, increasing accountability, developing new processes and tools, and establishing criteria for non-competitive procurements.

Table 2 describes the guiding principles that drive PRMP's contracting and procurement processes.

Contracting and Procurement Guiding Principles	
Enhance the strategy and planning efforts in our procurements	Strive to align the procurement and contracting processes with the mission and goals of Puerto Rico Medicaid and CMS and engage our multiple agencies within the enterprise in this effort. The procurement process will drive innovative strategies to advance the Medicaid Enterprise.
Further drive competition across procurements	Seek to procure high-quality goods, works, and services in a competitive manner.
Standardize and unify our processes	Use a common structure to standardize and formalize procurement and contracting processes.
Increase transparency	Make most procurement scoring decisions and other relevant information easily accessible to internal and external stakeholders.
Use data to inform our operations	Make data central to our procurement processes and derive insights from that data to drive procurement decisions.
Promote efficient and cost-effective processes	Strive to maximize value by considering existing and expected organizational demands, capabilities, availability of resources, and funding without compromising the efficient provision of goods and services that best serve beneficiaries' needs.
Seek value for money and good stewardship of public	Spend public money wisely and focus on reducing waste and abuse of taxpayer dollars.

Contracting and Procurement Guiding Principles	
funds	
Create a culture of ownership, accountability, and continuous learning	Define clearly and openly communicate roles and responsibilities across parties throughout the procurement and contracting process. Stakeholders will work cooperatively and collaboratively to continually improve contracting and procurement processes.

Table 2. Contracting and Procurement Guiding Principles

PRHIA also has its own Procurement Unit, formally known as the Proposal Adjudication Area (PAA). The creation of PRHIA's PAA was part of a larger commitment by PRHIA to improve, standardize, and make procurement practices more rigorous. The PAA is responsible for conducting competitive procedures within PRHIA and ensuring compliance with the PRHIA Contracting Transparency and Competitive & Non-Competitive Procurement Process Standard Operating Procedure (Procurement Standard Operating Procedure [SOP]), as approved on December 18, 2024. PRHIA's Procurement SOP aligns with the broader Medicaid Enterprise vision to be a leader in ethical and transparent procurement and contracting. While the PAA resides within PRHIA and outside of PRMP, PRHIA's procurement processes and procedures are aligned with PRMP's.

The procurement and contracting branches at PRMP work in close partnership to jointly manage PRMP's procurement and contract-related processes and outcomes and often collaborate on shared tasks. Each branch is governed by the same SOP, which was updated in March 2025. This SOP lays the foundation for PRMP's procurement and contracting branches to efficiently and effectively collaborate to achieve PRMP's guiding principles, as described above. The SOP includes the following themes:

- Clarifying Governance and Roles
- Managing the Procurement Lifecycle
- Safeguarding Integrity and Mitigating Risk
- Overseeing Performance and Vendor Accountability
- Ensuring Documentation and Audit Readiness

5.2.3.1 Procurement

Puerto Rico continues to comply with Section 1108 of the SSA, specifically paragraphs (7)(A)(v)(II) and (III), which requires the designation of a Contracting and Procurement Oversight Lead, which is through the Procurement Unit led by the procurement oversight lead. The procurement oversight lead manages the rest of the staff in the Procurement Unit, also known as the Proposal Adjudication Unit (PAU), and is the primary point of contact for all procurement-related matters. The procurement oversight lead reports to the PRMP executive director.

The procurement oversight lead's position description is detailed within the SOP and includes responsibilities such as:

- Developing procurement protocol(s); establishing, communicating, and implementing long-term goals for the office to promote effectiveness and efficiency

- Serving as the primary contact for most procurement-related questions, training, policy and procedure interpretation, and alignment by all departments
    - Inquiries from prospective vendors are routed to the PAU's solicitation coordinator, who is the lead point of contact for all vendor inquiries
- Developing and implementing innovative procurement strategies to maximize spending, reduce risk, and generate savings
- Supporting evaluation and technical committee reviews and other activities
- Monitoring the procurement procedures and policies of PRDoH/PRMP to ensure compliance with federal standards and, in certain exceptions, with territory regulations applicable to purchasing goods and services using Medicaid funds

PRHIA's Procurement Unit is led by the principal proposal adjudicator (PPA), a licensed attorney with broad knowledge of public sector contracting practices. The PPA, who was recruited in December 2024, oversees professional services procurement and acts as a liaison with the PRMP procurement oversight lead. In accordance with the CAA of 2023, the PPA has consistently submitted timely quarterly certifications for all contracts exceeding an annual value of $150,000. These certifications include a detailed explanation of compliance with procurement standards under 45 CFR §§ 75.327, 75.328, and 75.329 or an explanation of any extenuating circumstances.

PRHIA's Procurement SOP reinforces the general procurement principles federally recognized in 45 CFR § 75.327 (a) and outlines the responsibilities of PRHIA's staff to ensure compliance with such principles. The Procurement SOP was designed to achieve the following goals:

- Streamline PRHIA's operations and increase efficiency by bringing consistency to the proposal evaluation process, thereby increasing organizational capacity
- Increase transparency by identifying clear process owners
- Decrease training time for new/transitioning employees by providing a written resource detailing the process steps related to competitive and non-competitive procurements
- Provide consistent procedures for the application of CMS regulations as well as other federal and Territory regulations
- Facilitate easier reviews and audits of contracting processes

PRHIA's PPA leverages the SOP to provide training and guidance to PRHIA staff. For example, the PPA facilitates annual training sessions for PRHIA's staff on procurement principles and offers daily guidance to managerial staff and the PRHIA executive director. The PPA is also in the process of planning for the use of new technological resources to strengthen procurement processes and assisting managerial staff with more effective planning strategies.

5.2.3.2 Contract Management

In addition to substantial progress toward improving Puerto Rico's Medicaid procurement processes and making them more competitive, Puerto Rico has improved its contract management processes. Contract

management applies to the support necessary to guide contracts through the various review and approval processes and to provide essential oversight once contracts are executed and contract activities begin.

PRMP's Contracting Unit is led by a PRMP administrative director. The administrative director manages the rest of the staff in the Contracting Unit and is the primary point of contact for all contract-related matters. The administrative director reports to the PRMP executive director.

For pre-contract execution activities, the Contracting Unit works closely with the Procurement Unit to help ensure continuity across processes so that all relevant procurement inputs and outcomes are appropriately managed throughout the contracting lifecycle. This is a critical point of integration across these two units. The single governance structure outlined by the centralized procurement and contracting SOP helps to promote collaboration and continuity and mitigate disjointedness as each unit carries out its responsibilities. There are additional contract management responsibilities after the contract review and approval process, once the contract is executed and activities begin. PRMP has made significant progress in this area in the past year and has further plans for the coming year related to the implementation of a vendor management framework. Responsibilities of the administrative director related to contracting include:

- Monitoring and reviewing contract performance regularly to ensure timely and satisfactory completion
- Serving as the primary contact for resolving disputes and issues and providing periodic updates to contracting parties
- Evaluating and reporting discrepancies or non-compliance to relevant personnel and authorities
- Convening meetings to discuss and resolve issues, recommending corrective actions, and reviewing performance metrics
- Scheduling regular meetings or on-site visits with contractors to monitor progress, document disputes, and request contract amendments if needed
- Identifying and addressing complex contract transition issues with new and existing vendors

PRMP's contract management and oversight continues to evolve to meet industry standards and local and federal guidance. As we continue to mature our oversight of these critical areas, we are committed to continuous improvement, including working with vendors on contractual terms, implementing a vendor management program, moving to outcomes-based procurements, and adhering to new and existing requirements and standards to help improve outcomes for PRMP, its beneficiaries, and other relevant stakeholders.

6. Impact of Program Investments

As demonstrated in Section 5, Puerto Rico has achieved exceptional results despite federal funding limitations. With a fair investment of federal funding, Puerto Rico could scale those achievements. Puerto Rico continues to work toward enhancing our controls, compliance, and oversight activities; being good stewards of program funds; and enhancing public trust in the execution of our Medicaid Program. In addition, Puerto Rico continues efforts that help ensure the program achieves its ultimate goal of providing healthcare for those citizens who qualify for Medicaid.

This section highlights some of our key investments that support the goal to improve the Medicaid experience for beneficiaries. Puerto Rico strives to improve the ability to access care when it is needed and ensure that the care received is high-quality.

In addition to the continued internal enhancements discussed earlier in this report, over the past several years, the Puerto Rico Medicaid Program has covered more services and supported our provider community by increasing reimbursement rates across provider settings and types. The program must have a provider network that can meet the needs of Medicaid beneficiaries; therefore, Puerto Rico continues to prioritize provider recruitment and retention, and these investments will help ensure providers continue to participate in the Medicaid Program.

While the previous annual capped allotment increases allowed Puerto Rico to implement various program and reimbursement enhancements, the full financial impact of those changes is still being realized. Puerto Rico finds it must balance the cost of continuing to support the prior-year enhancements with the desire to consider additional changes. For this reporting period, sustaining the previously implemented enhancements while continuing to enhance administrative and oversight infrastructure was prioritized.

6.1 Increase Provider Payments

According to information published in September 2024 from the Puerto Rico Medical Defense Insurance Company, the number of licenses issued by the Puerto Rico Medical Licensing Board increased from 12,279 in 2019 to 12,793 in 2023 and the number of actively practicing physicians also increased from 9,295 to 9,809 during that time.[24] However, during the same period , there has been a reduction of 22 physicians practicing in medical specialties.[25] While the increase in the number of licenses and actively participating physicians is promising, due to disparities in geographic location, enrollment with Medicaid, and availability of appointments, the statistics do not fully equate to Medicaid beneficiary access.

Therefore, Puerto Rico must sustain and enhance efforts to adequately reimburse physicians (and other Medicaid providers) for services rendered. To that end, we remain focused on ensuring access to services, a key element of which is offering a robust provider network. Some of the identified challenges to maintaining that network include the availability of certain provider types island-wide and low reimbursement levels for providers. Increased funding to the Medicaid Program has allowed Puerto Rico to take steps to increase reimbursement levels for current and future providers.

[24] Puerto Rico Medical Defense Insurance Co. "Market Research: Medical Practice in Puerto Rico"; September 2024; https://estadisticas.pr/files/BibliotecaVirtualPrivado/Estudio_de_Mercado_Practica_Medica_en_Puerto_Rico.pdf
[25] *Ibid.*

6.1.1 Increases to Reimbursement for Physician Services

The minimum Medicaid reimbursement for physician services under the Plan Vital managed care program increased from 70% to 75% of the Medicare Part B fee schedule in January 2023. This minimum fee schedule is consistent with the requirements in the CAA, 2023. In 2024, FOMB approved an increase to the minimum Medicaid reimbursement for physician services to 100% of the Medicare Part B fee schedule retroactive to October 1, 2023.

Between October 2021 and June 2025, there were five reporting periods for physician services fee schedules. Fee increases aim to sustain and improve beneficiaries' access to physician services. Table 3 shows fee schedule updates for physician services from October 2021 through June 2025.

Fee Schedule Updates for Physician Services from October 2021 Through June 2025 – Excluding Incurred But Not Reported (IBNR)		
Timeline	**Updates**	**Total MCO payments**
Oct 2021 – Sept 2022[26]	Increase payment for physician services to a minimum of 70% of the Medicare Part B Fee Schedule.	$147,279,102
Oct 2022 – Dec 2022[26]	Increase payment for physician services to a minimum of 70% of the Medicare Part B Fee Schedule.	$38,543,864
Jan 2023 – Sept 2023[26]	Increase payment for physician services to a minimum of 75% of the Medicare Part B Fee Schedule.	$194,543,697
Oct 2023 – April 2024[26]	Increase payment for physician services to a minimum of 100% of the Medicare Part B Fee Schedule.	$110,532,237
May 2024 – Sept 2024[27]	Increase payment for physician services to a minimum of 100% of the Medicare Part B Fee Schedule.	$142,723,141
Oct 2024 – June 2025[27]	Increase payment for physician services to a minimum of 100% of the Medicare Part B Fee Schedule.	$220,723,561

Table 3. Fee Schedule Updates for Physician Services from October 2021 Through June 2025

6.1.2 Inpatient Hospital Payments

The short-term acute care (STAC) hospital payments, calculated separately for public and private hospitals, aim to sustain access to inpatient hospital services, and support payment and delivery system transformation activities, which include incentivizing hospitals to code completely and accurately. Public hospitals in Puerto Rico are essential for Plan Vital beneficiaries to access care and to maintain a strong network of hospitals. The STAC payments help hospitals stay operational.

Complete and accurate coding supports program oversight efforts and PRHIA's ability to monitor services provided. PRHIA designed, in collaboration with Puerto Rico hospitals, a DRG-based payment system, which is a step toward using value based strategies for the Puerto Rico Medicaid program within its managed care delivery system. DRG implementation was slated for October 1, 2025; however, to provide additional time for hospitals to prepare and test claim coding and submission processes, PRHIA recently

[26] These periods have data run out through April 2024.
[27] These periods have data run out through July 2025.

notified FOMB and CMS of its plan to postpone implementation with an expected implementation date of January 1, 2026.

PRHIA plans to continue to provide local hospitals and providers with transitional STAC payments to support the payment and delivery system transformation activities, to help the inpatient hospitals have more predictable revenue, and to remain operational during the transition to a new payment system.

Table 4 shows the total expenditures for STAC payments for FFY 2022 – FFY 2025.

STAC Payments		
Timeline	**Updates**	**Total Dollar Amount**
Oct 2021 – Sept 2022	Uniform increase to qualifying STAC hospitals	$102,978,450
Oct 2022 – Sept 2023	Uniform increase for eligible inpatient hospital services	$102,978,450
Oct 2023 – Sept 2024	Uniform increase for eligible inpatient hospital services	$135,978,450
Oct 2024 – Sept 2025	Uniform increase for eligible inpatient hospital services	$123,350,308

Table 4. STAC Payments

6.1.3 Sub-Capitated Providers

This directed payment institutes a minimum fee schedule for the sub-capitated payments negotiated between the MCOs and primary care providers (PCPs). Medicaid beneficiaries are assigned a primary medical group (PMG) to deliver and coordinate primary and covered services. PMGs play a critical role in providing access to preventive care, primary care, and management of chronic conditions. The sub-capitated payment represents payment in full for services during the month based on assigned membership.

In 2025, PRHIA maintained the increase to sub-capitated reimbursements at the minimum established in 2023. The minimum fee schedule for sub-capitated payments made to PMGs/PCPs improves and helps sustain access to primary care. The availability of providers supports timely access to services, improved health outcomes, and beneficiary satisfaction. Table 5 shows the sub-capitation payments between October 2021 and June 2025.

Sub-Capitation Payments Made from October 2021 to June 2025* **These amounts are not compared the prior periods. They represent the sub-capitated amounts paid to providers during the time frames listed.*		
Timeline	**Updates**	**Payments to PCPs**
Oct 2021 – Sept 2022[28]	Minimum $4.50 PMPM	$68,802,253
Oct 2022 – Dec 2022[28]	Minimum $4.50 PMPM	$17,528,107
Jan 2023 – Sept 2023[28]	Minimum $18.00 PMPM	$212,313,152
Oct 2023 – April 2024[28]	Minimum $18.00 PMPM	$157,458,478

[28] These periods have data run out through April 2024.

Sub-Capitation Payments Made from October 2021 to June 2025* *These amounts are not compared the prior periods. They represent the sub-capitated amounts paid to providers during the time frames listed.*		
Timeline	**Updates**	**Payments to PCPs**
May 2024 – Sept 2024[29]	Minimum $18.00 PMPM	$100,069,470
Oct 2024 – June 2025[29]	Minimum $18.00 PMPM	$174,240,526

Table 5. Sub-Capitation Payments

6.1.4 Increased Reimbursement for Behavioral Health Services

In January 2023, Puerto Rico increased the minimum reimbursement for behavioral health services from 70% to 80% of the Medicare Part B fee schedule. Reimbursement increases for behavioral health services provide financial incentives for physicians and other providers to maintain Medicaid provider status and render behavioral health services to Medicaid beneficiaries. Furthermore, enhancing minimum reimbursement helps achieve uniform reimbursement across MCOs and engage a provider network, which is essential to help ensure access to critical behavioral health services that support improved health outcomes and beneficiary satisfaction. Table 6 shows the increases made for behavioral health services between October 2021 and June 2025.

Table 6 includes only behavioral health services paid for on a sub-capitated basis, such as a fixed PMPM, between the providers and the MCOs. A portion of behavioral health services are paid for by the MCOs to providers on a per service basis according to a negotiated fee schedule. As with other physician services, these negotiated fee schedules are required to be set at a minimum of 100% of the Medicare Part B fee schedule. The impact of which is captured above in Table 4 along with other physician services.

Fee Schedule Updates for Behavioral Health Services Between October 2021 and June 2025 *Increases reported are based on comparison to September 2019 – June 2020*		
Timeline	**Updates**	**Increase***
Oct 2021 – Sept 2022[30]	70% Medicare Part B as the minimum fee schedule for behavioral health services	$32,467,000
Oct 2022 – Dec 2022[30]	70% Medicare Part B as the minimum fee schedule for behavioral health services	$8,185,000
Jan 2023 – Sept 2023[30]	80% Medicare Part B as the minimum fee schedule for behavioral health services	$31,675,000
Oct 2023 – April 2024[30]	80% Medicare Part B as the minimum fee schedule for behavioral health services	$19,309,000
May 2024 – Sept 2024[31]	80% Medicare Part B as the minimum fee	$18,702,000

[29] These periods have data run out through June 2025.
[30] These periods have data run out through April 2024.
[31] These periods have data run out through July 2025.

Fee Schedule Updates for Behavioral Health Services Between October 2021 and June 2025 **Increases reported are based on comparison to September 2019 – June 2020*		
Timeline	**Updates**	**Increase***
	schedule for behavioral health services	
Oct 2024 – Jun 2025[31]	80% Medicare Part B as the minimum fee schedule for behavioral health services	$5,890,000

Table 6. Fee Schedule Updates for Behavioral Health Services Between October 2021 and June 2025

6.1.5 Increases in Reimbursement for Dental Services

Between October 2021 and Jun 2025, there were five reporting periods for the payment rate for Medicaid dental services. To establish appropriate payment rates for Medicaid dental services, Puerto Rico evaluated the billed amounts for services and other payer fee schedules. Utilizing the data, a revised minimum fee schedule was implemented on October 1, 2023. The updated payment rates were accepted by the Puerto Rico College of Dental Surgeons. The Medicaid minimum fee schedule helps ensure that an adequate network of dental providers are available to provide comprehensive dental services ranging from preventive care through surgical care. Dental providers are necessary to support continued access to medically necessary dental services, including improved preventive care screening. Table 7 includes updates for dental services payments over the span of four reporting periods between October 2021 and June 2025.

Fee Schedule Updates for Dental Services Between October 2021 and June 2025		
Timeline	**Updates**	**Total MCO Payments**
Fiscal Year 2022		
Oct 2021 – Sept 2022[32]	Alternative fee schedule established for dental services provided by network dentists and dental surgeon providers	$12,716,836
Fiscal Year 2023		
Oct 2022 – Dec 2022[32]	A minimum fee schedule established for dental services	$3,502,798
Jan 2023 – Sept 2023[32]	A minimum fee schedule established for dental services incorporated in the capitation rates through a risk-based rate adjustment	$12,048,860
Fiscal Year 2024		
Oct 2023 – April 2024[32]	A minimum fee schedule established for dental services incorporated in the capitation rates through a risk-based rate adjustment	$7,911,516
May 2024–Sep	A minimum fee schedule established for dental services incorporated in the capitation rates through a	$10,343,135

[32] These periods have data run out through April 2024.

Fee Schedule Updates for Dental Services Between October 2021 and June 2025		
Timeline	**Updates**	**Total MCO Payments**
2024[33]	risk-based rate adjustment	
Fiscal Year 2025		
Oct 2024-June 2025[33]	A minimum fee schedule established for dental services incorporated in the capitation rates through a risk-based rate adjustment	$14,205,664

Table 7. Fee Schedule Updates for Dental Services Between October 2021 and June 2025

6.2 Expanded Services

6.2.1 Coverage of Home Health, Durable Medical Equipment, Hospice and Non-Emergency Medical Transportation

Increased funding also allowed Puerto Rico Medicaid to implement coverage for home health, DME, hospice, and NEMT services, effective July 2024. Except for hospice, these services are mandatory Medicaid services, but Puerto Rico was previously unable to fully implement these services due to a lack funding to cover the expenditures. As awareness of the availability of the new services increased and the utilization of the services followed, we are actively monitoring the financial impact to try to maintain these important services within the capped allotment. Table 8 shows the expenditures for these services for dates of service July 1, 2024, through June 30, 2025.

Expenditures for Services Added in July 2024	
Service	**Total Expenditure to Date**
Home Health	$85,290,970
DME	$72,875,000
Hospice	$2,316,983
NEMT	$13,502,235

Table 8. Expenditures for July 2024 Coverage Added

6.2.2 Expanded Adult Dental Services

In January 2023, Puerto Rico added periodontal scaling and root planing, as well as partial dentures for adults, as covered services. Table 9 includes expenditures for adult dental services from January 2023 through June 2025.

A small volume of claims for these services was reported by the MCOs through April 2024, and the same trend has been observed in the submitted data after April 2024. The claims for these services appear to have been paid under a sub capitated arrangement, resulting in no direct expenditures.

[33] These periods have data run out through July 2025.

Adult Dental Service Expenditures		
Dentures		
Timeline	**Units**	**Total Expenditures**
Jan 2023 – Sept 2023[34]	626	$16,426
Oct 2023 – April 2024[34]	2,650	$40,449
May 2024 – Sept 2024[35]	3	$0
Oct 2024 – June 2025[35]	20	$0
Periodontal Scaling and Root Planing		
Timeline	**Units**	**Total Expenditures**
Jan 2023 – Sept 2023[34]	0	$0
Oct 2023 – April 2024[34]	408	$966
May 2024 – Sept 2024[35]	1	$0
Oct 2024 – June 2025[35]	7	$0

Table 9. Adult Dental Service Expenditures

6.2.3 Expanded Adult Vaccines

In 2023, Puerto Rico added coverage of all vaccines and related administration costs for Medicaid-eligible adults, as recommended by the Advisory Committee on Immunization Practices (ACIP). Previously, coverage had only been available for higher-risk adults. Table 10 shows the total expenditures for adult vaccines for 2023 as well as FFY 2024 and FFY 2025 through June 2025.

Adult Vaccination		
Timeline	**Units**	**Total Expenditure**
Jan 2023 – Sept 2023[36]	42,000	$4,631,000
Oct 2023 – Apr 2024[36]	51,000	$5,328,000
May 2024 – Sept 2024[37]	22,000	$3,076,000
Oct 2024 – June 2025[37]	37,000	$5,773,000

Table 10. Adult Vaccination Units and Expenditures

6.2.4 Medicaid Drug Rebate Program (MDRP)

On January 1, 2023, Puerto Rico joined the MDRP. As part of the MDRP implementation, Puerto Rico also made our drug coverage policies more flexible to allow Puerto Rico to be more agile in responding to changes in pharmaceutical innovation and costs. Drug manufacturers are invoiced each quarter based

[34] These periods have data run out through April 2024.
[35] These periods have data run out through July 2025.
[36] These periods have data run out through April 2024.
[37] These periods have data run out through July 2025.

on utilization for the current quarter as well as previous quarters. The rebate amounts for the current and prior quarters continue to change due to reversals, conversion changes, and pricing changes. Table 11 shows the drug rebates posted through July 2025, by quarter, since PRMP joined the MDRP. The rebate totals posted include both the federal and territory share.

MDRP Rebates Received as of July 31, 2025	
Period	**Total**
2023, Q1	$141,598,658
2023, Q2	$143,086,048
2023, Q3	$144,735,481
2023, Q4	$144,470,693
2024, Q1	$129,054,969
2024, Q2	$133,681,713
2024, Q3	$136,908,741
2024, Q4	$138,349,594
2025, Q1	$131,553,032

Table 11. MDRP Rebate Amounts

6.2.5 Hepatitis C Elimination Effort

As part of the efforts to eliminate Hepatitis C in Puerto Rico by 2030, PRMP received CMS approval in 2020 to cover the treatment of Hepatitis C. Table 12 shows utilization and expenditures for Hepatitis C treatment for FFYs 2021 – 2024 and through August 2025 for FFY 2025.

Hepatitis C Treatment Utilization and Expenditures					
	FFY 2021	**FFY 2022**	**FFY 2023**	**FFY 2024**	**FFY 2025 (Through August)**
Unique Patients	591	710	704	649	646
Total Paid (Millions)	$14.6	$17.4	$17.8	$15.8	$15.1
Services	1,182	1,376	1,380	1,248	1,258

Table 12. Hepatitis C Treatment Utilization and Expenditures

6.3 Member Experience

Puerto Rico is committed to delivering high-quality, accessible care and has continued to invest in enhancing eligibility processes, improving quality of services, and increasing access to care for members.

Typically, the first interaction a resident of Puerto Rico has with the Medicaid Program is when they apply for Medicaid coverage. Recognizing the importance of consistent and accurate eligibility determination processes, PRMP prioritizes reviews and updates to its Puerto Rico Medicaid Policy and Procedures

Manual. This manual is used by eligibility caseworkers and details Medicaid requirements related to Medicaid eligibility and outlines the application, evaluation, verification, and case maintenance processes. PRMP has established processes to ensure the manual is updated when program changes are made that impact eligibility determinations.

A companion to having consistent processes is the Medicaid application. PRMP's Medicaid application is accessible to applicants online through the Citizen Portal, which enables applicants to complete a Medicaid application remotely, at any time. The online application process provides applicants with the convenience of saving progress and resuming as needed. Additionally, the online application supports a streamlined eligibility process by facilitating electronic submission and verification, thereby reducing the burden on applicants. PRMP continues to collaborate with CMS on the online application to help ensure compliance and further enhance the applicant experience. During the past year, PRMP has made significant enhancements to the interfaces for Hacienda, ASUME, and Department of Labor to improve the member experience by helping ensure verification is collected timely. In addition, system rules for household composition in retroactive months were simplified to create an application experience that is more user-friendly. To further improve the member experience, PRMP is currently working to align recertification dates for all members of the same household to reduce beneficiary burden. The investments and reforms described throughout Section 6 have been made with the focus of improving the experience of Medicaid members in Puerto Rico. The following areas augment and support the efforts noted above related to provider rates and expanded services.

6.3.1 Eligibility Policy Changes

Over the past several years, with the increase in funding appropriated through the CAA, Puerto Rico has implemented eligibility policy changes that have supported Medicaid coverage for low-income Puerto Ricans. These changes include increasing the eligibility level used for Medicaid to 100% of the FPL. Prior to the increase, due to funding constraints, Puerto Rico had to deflate the poverty level to a local poverty level (LPL), which meant Puerto Rico residents had to have lower incomes to qualify for Medicaid than U.S. state residents.

Puerto Rico also expanded coverage for Former Foster Care Children (FFCC) and implemented 12-month continuous eligibility for children and protections for when a spouse applies for Medicaid. As part of its commitment to the citizens of Puerto Rico, the Medicaid Program continues to look for opportunities to enhance coverage opportunities and improve the eligibility experience for individuals applying for Medicaid coverage.

To ensure our program can plan for anticipated federal changes, we have reviewed the Medicaid eligibility and policy changes included in the OBBBA or House of Representative 1 (H.R.1), which was signed into law on July 4, 2025.

H.R.1 will postpone the implementation of the *Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes* final rule, and Puerto Rico is reviewing the previously planned system, policy, process, and operational changes to ensure compliance with H.R.1 provisions.

Puerto Rico has reviewed the Alien Medicaid provision (Section 71109) in H.R.1 and confirmed that local Medicaid eligibility is limited to only those groups explicitly identified in the statute. Puerto Rico is also

currently reviewing its E&E process to comply with Section 71112: Reducing State Medicaid Costs. Planned changes include updates to the eligibility system (MEDITI3G) rules, eligibility policy manual, application materials, and online and printed Medicaid Program information. PRMP will be reviewing federal guidance, as it is issued, to ensure applicable program changes are made and are communicated to PRMP staff, providers, and MCOs.

6.3.2 Services for Justice-Involved Youth

In accordance with Section 5121 of the CAA, 2023, Puerto Rico has analyzed the required provisions and developed an operational plan to prepare for the coverage and eligibility requirements related to pre- and post-release services for justice-involved youth. PRDoH continues to collaborate with the Department of Corrections and federal partners to help ensure compliance with the Section 5121 requirements.

On January 10, 2025, Puerto Rico was notified of a federal award through Section 206(a) of the CAA of 2024 under the grant titled: "*Increase Access to Care for Medicaid Transitional Individuals Post-Incarceration by Building a Strong and Supportive Infrastructure with Community Partners.*" Puerto Rico's primary focus the first year is to work toward compliance with the new requirements under Section 5121 of the CAA of 2023, including implementing enhanced eligibility procedures, new pre- and post-release TCM, and diagnostic and screening services for eligible juveniles. Puerto Rico looks forward to CMS releasing the grant funding and our collaborative efforts to *Increase Access to Care for Medicaid Transitional Individuals Post-Incarceration by Building a Strong and Supportive Infrastructure with Community Partners.*

6.3.3 Reduced Beneficiary Cost Sharing

On January 1, 2023, Puerto Rico eliminated copays on all non-pharmacy services other than non-emergency use of the ER. With the increased capped allotments received as part of the CAA, PRMP has maintained the elimination of the copays, which has helped improve the Medicaid member experience by reducing the barrier to access needed services.

6.3.4 Child and Adult Core Set Reporting

Child and Adult Core Set Measures play a vital role in enhancing the member experience within Puerto Rico's Medicaid Program. These measures, developed by CMS, are designed to assess and improve the quality of care provided to Medicaid and CHIP enrollees. In Puerto Rico, where approximately half of the population relies on Medicaid coverage, the implementation of these measures is especially important. Please see additional information on the most recent measure reporting in Section 4.1.

6.3.5 Telemedicine

While the use of telemedicine for delivering certain healthcare services had been gaining popularity, during the public health emergency (PHE), those seeking healthcare services, as well as providers and payers, quickly pivoted to telemedicine as a reliable option for ensuring access to services and continuity of care. PRMP, like other SMAs, adopted flexibilities offered by CMS to support telemedicine efforts and ensure beneficiaries received services.

Table 13 shows the higher use of telemedicine for rendering services in FFYs 2020 and 2021 as compared to FFY 2022 to the present. The reduced use of telemedicine post pandemic was expected, as some beneficiaries prefer to receive services face-to-face. However, seeing the higher expenditures during the PHE signals the "readiness" of beneficiaries, providers, and PRMP to use telemedicine in similar emergency situations, such as post hurricane. PRMP will continue tracking telemedicine expenditures to understand utilization trends and plan for future expanded use of telemedicine.

Telemedicine Expenditures	
Timeline	**Total**
FFY 2020[38]	$8,185,000
FFY 2021[38]	$9,966,000
FFY 2022[38]	$4,260,000
FFY 2023[38]	$3,335,000
FFY 2024[39]	$2,736,000
FFY 2025[39]	$2,779,000

Table 13. Telemedicine Expenditures

During the 2025 legislative sessions, Puerto Rico passed Ley 8, which helps remove barriers to using telemedicine by providing that any physician or health professional with a current license in Puerto Rico may render services via telemedicine without any additional certification.

Ley 8 also requires PRHIA to pay providers the same amount for a service rendered via telemedicine as a service rendered in person. This requirement is meant to incentivize providers and provide enhanced access to services. Promoting virtual clinics and telemedicine is a territory-wide focus to promote public health and prevention efforts. As a stated initiative of the Governor, ASES and PRDoH are collaborating to expand telemedicine infrastructure and reimbursement, particularly to reach residents in rural and underserved municipalities. These efforts aim to strengthen care continuity, reduce geographic disparities, and improve management of chronic and behavioral health conditions through virtual platforms.

6.3.6 Centers of Excellence: Advancing Chronic-Disease Care and System Integration

The Government of Puerto Rico, under the leadership of Governor González and in alignment with FOMB's health-system improvement framework, is evaluating the establishment of Centers of Excellence (Centros de Excelencia) as a cornerstone for strengthening chronic-disease management, care integration, and equitable access to specialized services.

This initiative draws from the FOMB's 2025 policy proposal, "Four Initiatives to Improve Healthcare in Puerto Rico," which recommended creating Centers of Excellence specializing in chronic-disease care as a pilot program to reach high-need populations, including older adults and residents of rural

[38] These periods have data run out through April 2024.
[39] These periods have data run out through July 2025.

municipalities. The model envisions multidisciplinary teams providing coordinated, continuous services to reduce avoidable hospitalizations and improve outcomes for conditions such as diabetes, hypertension, cardiovascular disease, chronic respiratory disorders, and mental health comorbidities.

While formal program design is underway, the Centers of Excellence concept aligns directly with the Governor's policy priorities reported in this Annual Report, expanding access to primary and specialty care, promoting telemedicine and virtual-clinic networks, incentivizing preventive health, and modernizing Puerto Rico's Medicaid delivery infrastructure. The approach would allow the Territory to pilot performance-based care delivery mechanisms within Plan Vital, emphasizing outcome metrics over volume and fostering local innovation consistent with federal quality improvement standards.

In coordination with PRHIA, PRMP, and PRDOH, the preliminary planning activities include the following:

- Identifying target geographic regions based on epidemiologic data and provider availability.
- Defining qualifying provider networks and credentialing requirements consistent with Law 72-1993 and the Medicaid State Plan.
- Developing measurable clinical and operational indicators, such as control rates for Hemoglobin A1c (HbA1c) and hypertension, adherence to care-management plans, and hospital readmission reductions.
- Integrating telehealth and electronic-record interoperability to ensure real-time data sharing with PRHIA's Mi Portal Especial (MiPE) and MMIS platforms.
- Exploring federal match opportunities under Medicaid administrative claiming, Section 1115 innovation waivers, and Health Resources and Services Administration (HRSA) or Substance Abuse and Mental Health Services Administration (SAMHSA) cooperative agreements that support chronic-care coordination.

Governance and Evaluation: PRHIA and PRMP intend to structure the pilot within existing fee-for-service and managed care contracts to enable transparent cost reporting and outcome evaluation. Each Center of Excellence would operate under a Memorandum of Understanding between PRHIA, PRDOH, and the participating provider organization, ensuring compliance with Medicaid integrity and program-evaluation requirements.

Long-Term Vision: If successful, the Centers of Excellence pilot could serve as a platform for broader system transformation—linking reimbursement to quality and prevention outcomes and positioning Puerto Rico as a model jurisdiction for sustainable, population-based Medicaid reform in U.S. territories.

This initiative remains under development and reflects the Territory's commitment to evidence-based innovation rather than a formally adopted program at this stage.

7. Looking Ahead to State-Like Medicaid Funding

The enhancements that PRMP has made over the past several years with the enhanced funding that has been appropriated has allowed Puerto Rico to move closer to a Medicaid Program where eligibility levels and service array are more "on par" with state Medicaid programs. As we continue to plan for the future and build on our incremental changes, we remain committed to contract reform and similar initiatives to combat FWA. The following initiatives align directly with the priorities established by Governor Jenniffer González-Colón to strengthen Puerto Rico's healthcare infrastructure and achieve parity with state Medicaid programs. With continued support from Congress and CMS, Puerto Rico seeks to consolidate past progress—modernizing managed care oversight, enhancing provider payment equity, and improving access to care—while advancing toward permanent fiscal and structural parity under the federal Medicaid framework.

7.1 Proposed Funding Policy Changes

7.1.1 Federal Capped Allotment

Because of the annual Section 1108 capped allotment, Puerto Rico can only access federal dollars up to the allotment ceiling, which historically has not been sufficient to fund the Medicaid Program each year. Even with the annual increases to our capped allotment, Puerto Rico finds it increasingly difficult to sustain the cost of continuing the program enhancements made over the past several years while also strategizing how the remaining eligibility and coverage gaps can be eliminated. If Puerto Rico exhausts its capped allotment, it must fund its Medicaid operations with territory-only funds.

Removing the Section 1108 allotment ceiling, consistent with other state Medicaid programs, will provide adequate, sustained funding to Puerto Rico.

7.1.2 FMAP

The FMAP in Puerto Rico is statutorily set at 55%, and even though there is currently an increase to the FMAP (76% through September 2027), the level of federal funding for Medicaid expenditures continues to be much lower than if the state FMAP formula were applied to Puerto Rico. If the FMAP for Puerto Rico was established the same as SMAs, it would likely result in an FMAP of 83%.

Puerto Rico is simultaneously seeking action for both the FMAP formula and the §1108 capped allotment because increasing the FMAP without an increase in the capped allotment will only result in Puerto Rico exhausting its allotment ceiling faster.

7.1.3 Medicaid Disproportionate Share (DSH)

Based on federal statute (§1923(f)(9)), Puerto Rico does not receive a separate Medicaid DSH allotment as do SMAs and, therefore, is unable to make DSH payments to hospitals in Puerto Rico. As noted in Section 6.1.2, Puerto Rico has an SDP for STAC hospital stays to compensate for operating losses as a result of providing services to Medicaid beneficiaries. Having a separate DSH allotment would allow Puerto Rico to authorize Medicaid DSH payments, which would allow hospitals to receive funding to offset any shortfalls related to Medicaid payments and costs related to uncompensated care for serving uninsured residents.

DSH funding is one component of the critical funding needed to enable continued hospital care and to promote health equity in all areas of the island.

7.1.4 Low-Income Subsidy (LIS) for Medicare Part D

According to federal statute (§1860D-14(a)(3)(F)), Puerto Rico residents are not eligible for the Medicare Part D LIS. Instead, Puerto Rico has received EAP Medicaid funds to assist dual-eligible-only people with the cost of prescription drugs and must match the EAP funds at the Medicaid FMAP. In contrast, in the 50 states, the LIS for Medicare Part D premium assistance is paid directly by the federal government with no requirement for the state to provide a match. Allowing dual-eligible Medicare beneficiaries in Puerto Rico to access the LIS program would help dual-eligible Puerto Ricans obtain Medicare Part D assistance.

With state-like funding and policy, consistent with the LIS for Medicare Part D stateside, dual-eligible Medicare beneficiaries residing in Puerto Rico with incomes up to 150% of FPL could receive assistance for Part D premiums, copayments, and deductibles.

7.2 Program Improvements

Puerto Rico continues to use a 2023 Gap Analysis Report, commissioned by PRMP, to prioritize and resolve gaps between the Puerto Rico Medicaid State Plan, the eligibility policy and procedure manual, managed care contracts, and operations. During the past year, the focus of resolving gap findings was primarily on those items that did not include a fiscal impact; however, some gap findings can only be resolved with state-like Medicaid funding. These gaps are discussed below.

7.2.1 Mandatory Eligibility Groups

Puerto Rico has sustained its July 2023 increase to the poverty level used for eligibility determinations; however, we are still unable to cover all mandatory eligibility groups. Due to the current limitations of the capped allotment, Puerto Rico has been unable to move forward with covering the Transitional Medicaid and Emergency Medicaid coverage groups. With state-like funding, Puerto Rico would be able to prioritize efforts to include coverage for Transitional Medicaid and Emergency Medicaid.

7.2.2 Covered Benefits and Mandatory Services

Establishing Medicaid-funded LTSS by covering nursing facilities and home and community-based services (HCBS) would enhance services to individuals with low incomes and disabilities needing extra support for daily living. In addition, due to the requirements of the EPSDT provisions, all optional Medicaid services must be provided to beneficiaries under 21. Puerto Rico currently does not cover a broad array of LTSS under EPSDT due to funding constraints. In 2022, Puerto Rico applied for and was awarded an MFP Demonstration Grant. The period of performance for the MFP grant was extended by CMS through September 30, 2028. The MFP staff will be leveraging the results of the MFP Rapid Needs Assessment (completed in July 2024), the MFP LTSS Needs Assessment (completed in August 2025), and the MFP NEMT Gap Analysis (to be completed in April 2026) to draft the MFP Operational Protocol (OP), which are due before the period of performance ends.

The findings from Rapid and LTSS Needs Assessments and continued MFP efforts are helping Puerto

Rico plan future MFP activities and build capacity for eventual LTSS. The MFP staff have identified the following elements as part of future plans:

- **Develop a Comprehensive MFP Program** that will focus on developing and expanding home-based care services, including home health aides, personal care, housekeeping, and meal delivery services
- **Improve Healthcare Access** to HCBS and improve transportation
- **Support Family Caregivers** including respite care services, caregiver training, and financial assistance
- **Strengthen Community Support** including social activities, meal programs, and health education
- **Policy and System Changes** to support the development and sustainability of HCBS and NEMT programs, including securing funding and influencing regulatory frameworks

Puerto Rico sought the MFP Demonstration Grant and has continued to invest considerable effort in MFP activities to prepare for the implementation of Medicaid-funded LTSS, including NEMT for LTSS recipients, anticipating state-like funding to do so. Because Puerto Rico currently exhausts its annual capped allotment in the absence of Medicaid-funded LTSS, the current capped allotment will not be sufficient to support Puerto Rico adding LTSS to its Medicaid service array.

7.2.3 Medicare Part B Buy-In

Federal statute (§ 1905[p][4][A] of the SSA) exempts Puerto Rico from providing Part B premium and cost sharing assistance to low-income Medicare beneficiaries, and the current level of the annual capped allotment does not afford Puerto Rico the ability to opt into the MSP. With state-like funding, Puerto Rico would initiate participation in the MSP to extend financial support for Medicare premiums and cost sharing to the Qualified Medicare Beneficiary (QMB) Program and Specified Low-Income Medicare Beneficiary (SLMB) Program populations.

8. Conclusion

The Government of Puerto Rico appreciates the opportunity to provide Congress with a report about how the capped allotment Puerto Rico receives from P.L. 117-328 supports our Medicaid Program and has allowed Puerto Rico the opportunity to increase access to healthcare for Medicaid beneficiaries. Federal financial support provides Puerto Rico the ability to enhance services and make program improvements that support the health and well-being of U.S. citizens living in Puerto Rico. This report describes how the territory has used the Medicaid capped allotment and FMAP increases to impact healthcare for Puerto Rican citizens eligible for Medicaid and sustain changes made in prior years.

Puerto Rico also recognizes the importance of transparency and is providing this report as a response to how the annual capped allotment received from P.L. 117-328 supports interim fiscal stability of the Medicaid Program. The report also demonstrates gaps in the Medicaid Program that persist due to lack of state-like Medicaid funding.

Over the past decade, Congress has funded temporary increases in FMAP and the annual capped allotment. The most recent increase, the federal funding appropriated to Puerto Rico in P.L. 117-328, has allowed our program to continue supporting Medicaid providers to deliver care while making foundational investments in program advancements. These increases have helped Puerto Rico provide the most basic healthcare services for its citizens. To allow Puerto Rico to build on the accomplishments that the recent funding has allowed for, Puerto Rico continues to seek Congressional support for permanent state-like Medicaid funding. Puerto Rico has and will continue to invest additional federal funding to ensure the most vulnerable are eligible for program services, to enhance provider reimbursement rates, and to cover additional Medicaid benefits.

Puerto Rico continues to implement and explore options for program improvements that improve processes and help ensure low-income residents can access Medicaid benefits. We remain diligent in our commitment to maturing the program through strengthening governance, developing technological capacity and infrastructure, improving program oversight, and increasing program transparency practices.

As we support Medicaid program operations and explore program improvement options, we look forward to maintaining a strong relationship with our federal partners and Congress to advance our program's momentum and build on the current capped allotment funding with permanent state-like funding. This report captures actions we have taken and demonstrates our capacity and commitment to the beneficiaries we serve by operating a strong Medicaid program.

9. Acronyms/Terms

Acronym/Term	Definition
AAFAF	Fiscal Agency and Financial Advisory Authority
AAP	Adults' Access to Preventive/Ambulatory
ACA	Affordable Care Act
ACIP	Advisory Committee on Immunization Practices
ADHD	Attention Deficit Hyperactivity Disorder
APD	Advance Planning Document
ARP	American Rescue Plan
ASES	Administración de Seguros de Salud
ASSMCA	Administrator of the Administration of Mental Health and Addiction Services
AVS	Asset Verification System
BBA	Bipartisan Budget Act of 2018
BOD	Board of Directors
BRFSS	Behavioral Risk Factor Surveillance System
CAA	Consolidated Appropriations Act
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Center of Disease Control
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CoC	Change of Circumstance
COMP	Comprehensive Oversight Monitoring Program
COPD	Chronic Obstructive Pulmonary Disease
COR3	Central Office for Recovery, Reconstruction and Resiliency
CR	Continuing Resolution
D-III	Division of Integrity, Investigations, and Intelligence
DME	Durable Medical Equipment
DMH	Diagnosed Mental Health Disorders
DRG	Diagnosis Related Group
DSG	Data Systems Group

Acronym/Term	Definition
DSH	Disproportionate Share
DSU	Diagnosed Substance Abuse Disorders
EAP	Enhanced Allotment Plan
ED	Emergency Department
EDW	Electronic Data Warehouse
E&E	Eligibility and Enrollment
ENT	Ear, Nose, and Throat
ePMO	Enterprise Project Management Office
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ER	Emergency Room
EVV	Electronic Visit Verification
FEMA	Federal Emergency Management Agency
FFCC	Former Foster Care Children
FFCRA	Families First Coronavirus Response Act
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FOMB	Financial Oversight and Management Board
FPL	Federal Poverty Level
FWA	Fraud, Waste, and Abuse
GAO	Government Accountability Office
HbA1c	Hemoglobin A1c
HCBS	Home and Community-Based Services
HCIP	Health Care Improvement Program
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health & Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
HUD	Housing and Urban Development
IBNR	Incurred But Not Reported

Acronym/Term	Definition
IEG	Intelligent Evidence Gathering
LARC	Long-Acting Reversible Contraception
LIS	Low-Income Subsidy
LPL	Local Poverty Level
LPN	Licensed Practical Nurse
LTSS	Long-Term Services and Supports
MAFU	Medicaid Anti-Fraud Unit
MAO	Medicare Advantage Organization
MCO	Managed Care Organization
MDRP	Medicaid Drug Rebate Program
MEDITI3G	Medicaid Integrated Technology Initiative, 3rd Generation
MEQC	Medicaid Eligibility Quality Control
MES	Medicaid Enterprise Systems
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MiPE	Mi Portal Especial
MITA SS-A	Medicaid Information Technology Architecture State Self-Assessment
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NEMT	Non-Emergency Medical Transportation
OCM	Organizational Change Management
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMP	Outcomes Management Plan
OP	Operational Protocol
ORW	Operational Reporting Workbook
P.L. 116-94	Public Law 116–94; Further Consolidated Appropriations Act, 2020
P.L. 117-328	Public Law 117-328; Consolidated Appropriations Act, 2023
PARIS	Public Assistance Reporting Information System
PCP	Primary Care Provider
PEP	Provider Enrollment Portal

Acronym/Term	Definition
PERM	Payment Error Rate Measurement
PgMO	Program Management Office
PHE	Public Health Emergency
PMG	Primary Medical Group
PMPM	Per Member Per Month
PRDoH	Puerto Rico Department of Health
PRHIA	Puerto Rico Health Insurance Administration
PRMP	Puerto Rico Medicaid Program
PRMPIU	Puerto Rico Medicaid Program Integrity Unit
PROMESA	Puerto Rico Oversight, Management and Economic Stability Act
QMB	Qualified Medicare Beneficiary
RAC	Recovery Audit Contractors
RAID	Risk, Action Item, Issue, Decision
RFP	Request for Proposal
RFQ	Request for Quotation
RN	Registered Nurse
RY	Reporting Year
SAMHSA	Substance Abuse and Mental Health Services Administration
SAVE	Systematic Alien Verification for Entitlements
SDP	State Direct Payment
SIU	Special Investigation Unit
SLA	Service Level Agreement
SLMB	Specified Low-Income Medicare Beneficiaries
SMA	State Medicaid Agency
SMC	Streamlined Modular Certification
SOP	Standard Operating Procedure
SPA	State Plan Amendment
SSA	Social Security Act
STAC	Short-Term Acute Care
TPL	Third-Party Liability
URI	Upper Respiratory Infection

Acronym/Term	Definition
VLP	Verify Lawful Presence

10. Appendices

Appendix A

Puerto Rico Medicaid Managed Care Organization (MCO)
Healthcare Effectiveness Data and Information Set (HEDIS) Measures
Reporting Year 2024*

Measure Domain	Measure Name	Age Range	Eligible Population	Rate
Effectiveness of Care	Comprehensive Diabetes Care – BP Control (<140/90 mm Hg) *Hybrid methodology is required, administrative is optional.	18 – 75	32,558	52.76
	Comprehensive Diabetes Care – Eye Exam *Hybrid methodology is required, administrative is optional.	18 – 75	32,558	40.22
	Appropriate Treatment for Upper Respiratory Infection	3 months – 17 years	44,526	71.83
		18 – 64	34,852	56.47
		65+	1,288	57.30
		Total	80,666	64.96
	Kidney Health Evaluation for Patients With Diabetes	18 – 64	27,679	40.70
		65 – 75	4,124	40.79
		76 – 85	1,983	42.26
		Total	33,786	40.80
	Diagnosed Mental Health Disorders	1 – 17	88,760	25.06
		18 – 64	234,476	21.55
		65+	20,445	25.30
		Total	343,681	22.68
	Diagnosed Substance Use Disorders – Alcohol Disorder	13 – 17	30,831	0.01
		18 – 64	234,476	0.82
		65+	20,445	1.42
		Total	285,752	0.78
	Diagnosed Substance Use	13 – 17	30,831	0.01

*Data Provided by Puerto Rico Health Insurance Administration (ASES)

Measure Domain	Measure Name	Age Range	Eligible Population	Rate
	Disorders – Opioid Disorder	18 – 64	234,476	0.69
		65+	20,445	0.32
		Total	285,752	0.59
	Diagnosed Substance Use Disorders – Other or Unspecified Drugs	13 – 17	30,831	0.25
		18 – 64	234,476	1.74
		65+	20,445	1.00
		Total	285,752	1.52
	Diagnosed Substance Use Disorders – Any Substance Use Disorder	13 – 17	285,752	0.59
		18 – 64	234,476	0.82
		65+	20,445	1.42
		Total	285,752	0.78
Access and Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP)	20 – 44	30,831	0.01
	Adults' Access to Preventive/Ambulatory Health Services (AAP)	45 – 64	234,476	0.69
	Adults' Access to Preventive/Ambulatory Health Services (AAP)	65+	20,445	0.32
	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Total	285,752	0.59

*Data Provided by Puerto Rico Health Insurance Administration (ASES)
Appendix A

Appendix B

Puerto Rico Medicaid
Child and Adult Core Set Reporting Measures
Reporting Year 2024

Child Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
Behavioral Health Care	Follow-Up Care for Children Prescribed ADHD Medication – *Initiation*	6 – 12	1,123	48.17
	Follow-Up Care for Children Prescribed ADHD Medication – *Continuation and Management*	6 – 12	116	60.34
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Blood Glucose*	1 – 11	543	61.51
		12 – 17	682	64.66
		1 – 17	1225	63.27
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Cholesterol*	1 – 11	543	51.75
		12 – 17	682	56.60
		1 – 17	1,225	54.45
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Blood Glucose and Cholesterol*	1 – 11	543	50.28
		12 – 17	682	54.84
		1 – 17	1,225	52.82
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	1 – 11	253	57.31
		12 – 17	309	53.40
		1 – 17	562	55.16
	Screening for Depression and Follow-Up Plan	12 – 17	31,136	30.06
	Follow-Up After Emergency Department Visit for Substance Use – *7 day*	13 – 17	12	8.33
	Follow-Up After Emergency Department Visit for Substance Use – 30 *day*	13 – 17	12	8.33
	Follow-Up After Hospitalization for Mental Illness – *7-day*	6 – 17	443	36.79

*Data Provided by Puerto Rico Health Insurance Administration (ASES)

Child Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
	Follow-Up After Hospitalization for Mental Illness – 30-day	6 – 17	443	71.11
	Follow-Up After Emergency Department Visit for Mental Illness – *7-day*	6 – 17	44	47.73
	Follow-Up After Emergency Department Visit for Mental Illness – *30-day*	6 – 17	44	70.45
Care of Acute and Chronic Conditions	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	3 Months – 17 Years	5,440	62.65
	Asthma Medication Ratio	5 – 11	755	88.08
		12 – 18	377	86.74
		5 – 18	1,132	87.63
Dental and Oral Health Services	Oral Evaluation, Dental Services	<3	11,639	33.14
		3 – 5	15,182	63.54
		6 – 14	56,886	60.92
		15 – 20	42,628	48.92
		<21	126,335	54.63
	Sealant Receipt on Permanent First Molars - One Sealant	1 – 10	5,822	31.23
	Sealant Receipt on Permanent First Molars - Four Sealant	1 – 10	5,822	21.95
	Topical Fluoride for Children – Dental or Oral Health Services	1 – 2	7,797	10.77
		3 – 5	12,770	22.94
		6 – 14	49,293	21.72
		15 – 20	37,022	10.23
		1 – 20	106,882	17.09
Maternal and Perinatal	Contraceptive Care –	15 – 20	285	3.86

***Data Provided by Puerto Rico Health Insurance Administration (ASES)**

Child Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
Health	Postpartum Women – *Most or Moderately Effective Contraceptive Method 3 days*			
	Contraceptive Care – Postpartum Women – *Most or Moderately Effective Contraceptive Method 90 days*	15 – 20	285	25.96
	Contraceptive Care – All Women – *Most or Moderately Effective Contraceptive Method*	15 – 20	17,631	4.08
	Contraceptive Care – Postpartum Women – *Long-Acting Reversible Contraception Method 3 days*	15 – 20	285	0.00
	Contraceptive Care – Postpartum Women – *Long-Acting Reversible Contraception Method 90 days*	15 – 20	285	1.40
	Contraceptive Care – All Women Ages – *Long-Acting Reversible Contraception Method*	15 – 20	17,631	0.05
	Postpartum Depression Screening	<21	548	0.00
	Prenatal Immunization Status-Influenza	<21	400	13.25
	Prenatal Immunization Status-Tdap	<21	400	9.00
	Prenatal Immunization Status-Combination	<21	400	5.00
	Prenatal and Postpartum Care: Timeliness of Prenatal Care	<21	549	72.68

***Data Provided by Puerto Rico Health Insurance Administration (ASES)**

Child Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
	*Hybrid methodology is required, administrative is optional.			
	Prenatal and Postpartum Care: Postpartum Care *Hybrid methodology is required, administrative is optional.	<21	549	37.89
Primary Care Access and Preventive Care	Chlamydia Screening in Women	16 – 20	4,760	67.04
	Childhood Immunization Status – *Combo 10*	0 – 2	4,060	0.42
	Childhood Immunization Status – *Combo 3*	0 – 2	4,060	6.75
	Childhood Immunization Status – Combo 7	0 – 2	4,060	4.61
	Childhood Immunization Status – *DTaP*	0 – 2	4,060	23.87
	Childhood Immunization Status – Hep A	0 – 2	4,060	69.31
	Childhood Immunization Status – *Hep B*	0 – 2	4,060	11.16
	Childhood Immunization Status – *HiB*	0 – 2	4,060	52.44
	Childhood Immunization Status – *Influenza*	0 – 2	4,060	8.99
	Childhood Immunization Status – *MMR*	0 – 2	4,060	70.99
	Childhood Immunization Status – *IPV*	0 – 2	4,060	34.93
	Childhood Immunization Status – *Pneumococcal Conjugate*	0 – 2	4,060	23.62
	Childhood Immunization Status – *Rotavirus*	0 – 2	4,060	25.44
	Childhood Immunization Status – *VZV*	0 – 2	4,060	70.39

***Data Provided by Puerto Rico Health Insurance Administration (ASES)**

Child Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
	Developmental Screening in the First Three Years of Life – *Total*	1 – 3	12,408	0.00
	Developmental Screening in the First Three Years of Life – *12 Months*	12 Months	3,967	0.00
	Developmental Screening in the First Three Years of Life – *24 Months*	24 Months	4,073	0.00
	Developmental Screening in the First Three Years of Life – *36 Months*	36 Months	4,368	0.00
	Immunizations for Adolescents – HPV	1 – 13	6, 347	43.14
	Immunizations for Adolescents – Combo 1	1 – 13	6,347	63.56
	Immunizations for Adolescents – Meningococcal	1 – 13	6,347	65.42
	Immunizations for Adolescents – Tdap	1 – 13	6,347	64.72
	Immunizations for Adolescents – Combo 2	1 – 13	6,347	41.63
	Well-Child Visits in the First 30 Months of Life	Birth – 15 months	3,565	10.80
	Well-Child Visits in the First 30 Months of Life	15 months – 30 months	4,172	46.93
	Child and Adolescent Well-Care Visits	3 – 11	43,526	51.56
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *BMI Percentile*	3 – 11	31,183	39.24
		12 – 17	22,382	41.41
		3 – 17	53,565	40.15
	Weight Assessment and Counseling for Nutrition and	3 – 11	31,183	311.79
		12 – 17	22,382	33.17

*Data Provided by Puerto Rico Health Insurance Administration (ASES)

Child Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
	Physical Activity for Children/Adolescents – *Counseling for Nutrition*	3 – 17	53,565	32.36
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Physical Activity*	3 – 11	31,183	26.29
		12 – 17	22,382	29.30
		3 – 17	53,565	27.55

Adult Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
Behavioral Health Care	Antidepressant Medication Management - *Acute Phase*	18 – 64	6,425	49.85
		65+	366	61.20
	Antidepressant Medication Management - *Continuation Phase*	18 – 64	6,425	31.94
		65+	366	42.62
	Screening for Depression and Follow-Up Plan	18 – 64	220,471	18.21
		65+	22,767	21.07
	Follow-Up After Emergency Department Visit for Substance Use – *7 days*	18 – 64	328	19.51
		65+	19	26.32
	Follow-Up After Emergency Department Visit for Substance Use – *30 days*	18 – 64	328	27.74
		65+	19	36.84
	Follow-Up After Hospitalization for Mental Illness – *7-day follow-up for ED visit: Ages 18 and older*	18 – 64	2,048	31.25
		65+	56	23.21
	Follow-Up After Hospitalization for Mental Illness – *30-day follow-up for ED visit: Ages 18 and older*	18 – 64	2,048	56.88
		65+	56	42.86
		18 – 64	281	19.22

***Data Provided by Puerto Rico Health Insurance Administration (ASES)**

Adult Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
	Follow-Up After Emergency Department Visit for Mental Illness – *7-day follow-up for ED*	65+	27	40.74
	Follow-Up After Emergency Department Visit for Mental Illness – 30-*day follow-up for ED*	18 – 64	281	43.77
		65+	27	48.15
	Diabetes Care for People with Serious Mental Illness – *Glycemic Status >9.0%* *Administrative methodology is required, hybrid is optional.	18 – 64	956	19.35
	Diabetes Care for People with Serious Mental Illness –Glycemic Control *>9.0%* *Administrative methodology is required, hybrid is optional.	65 – 75	165	19.39
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – Alcohol*	18 – 64	1,405	30.11
		65+	195	22.56
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – Opioid Abuse or Dependence*	18 – 64	683	53.88
		65+	23	26.09
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – Other Drugs*	18 – 64	2,634	33.86
		65+	112	9.82
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – TOTAL*	18 – 64	4,722	35.64
		65+	330	18.48

*Data Provided by Puerto Rico Health Insurance Administration (ASES)

Adult Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – Alcohol*	18 – 64	1,405	7.40
		65+	195	3.59
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – Opioid Abuse or Dependence*	18 – 64	683	21.38
		65+	23	13.04
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – Other Drugs*	18 – 64	2,634	9.15
		65+	112	3.57
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – TOTAL*	18 – 64	4,722	10.40
		65+	330	4.24
	Use of Pharmacotherapy for Opioid Use Disorder – *Total*	18+	1,826	37.46
		65+	80	25.00
	Use of Pharmacotherapy for Opioid Use Disorder – *Buprenorphine*	18+	1,828	37.09
		65+	1,828	25.00
	Use of Pharmacotherapy for Opioid Use Disorder – *Oral Naltrexone*	18+	1,828	0.38
		65+	1,828	0.00
	Use of Pharmacotherapy for Opioid Use Disorder – *Long-Acting, Injectable Naltrexone*	18+	1,828	0.00
		65+	1,828	0.00
	Use of Pharmacotherapy for Opioid Use Disorder – *Methadone*	18+	1,828	0.00
		65+	80	0.00
	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	18+	2,409	75.88

***Data Provided by Puerto Rico Health Insurance Administration (ASES)**

Adult Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications – *Total*	18 – 64	2,667	72.59
	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications – *Schizophrenia*	18 – 64	1,625	71.50
	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications – *Bipolar*	18 – 64	1,042	73.29
Care of Acute and Chronic Conditions	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	18 – 64	2,776	45.17
		65+	170	41.18
	Asthma Medication Ratio	19 – 50	2,199	70.62
		51 – 64	1,884	69.11
		19 – 64	4,083	69.92
	Controlling High Blood Pressure *Hybrid methodology is required, administrative is optional.	18 – 64	33,619	53.38
		65 – 85	6,967	51.76
	Concurrent Use of Opioids and Benzodiazepines	18 – 64	1,278	11.82
		65+	139	10.07
	Glycemic Status Assessment: Glycemic status <8% *Hybrid methodology is required, administrative is optional.	18 – 64	28,327	36.28
		65 – 75	4,231	39.99
		18 – 64	28,327	57.79

*Data Provided by Puerto Rico Health Insurance Administration (ASES)

Adult Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
	Glycemic Status Assessment: Glycemic status >9% *Hybrid methodology is required, administrative is optional.	65 – 75	4,231	54.74
	HIV Viral Load Suppression	18 – 64	2,861	7.13
		65+	435	7.36
	Plan All-Cause Readmissions	18 – 64	13,974	87.14
	Diabetes Short-Term Complications Admission Rate *per 100,000 beneficiary months	18 – 64	3,369,947	7.86
		65+	270,316	9.62
	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate *per 100,000 beneficiary months	40 – 64	1,622,878	39.13
		65+	270,316	120.97
	Heart Failure Admission Rate *per 100,000 beneficiary months	18 – 64	3,369,947	17.72
		65+	270,316	141.69
	Asthma in Younger Adults Admission Rate *per 100,000 beneficiary months	18 – 39	1,747,069	10.47
Primary Care Access and Preventive Care	Adult Immunization Status-Influenza	19 – 65	221,266	3.66
		66+	17,294	8.23
	Adult Immunization Status-Td/Tdap	19 – 65	221,266	5.75
		66+	17,294	4.54
	Adult Immunization Status-Zoster	50 – 65	67,371	0.38
		66+	17,294	0.57
	Adult Immunization Status-Pneumococcal	66+	17,294	7.11

***Data Provided by Puerto Rico Health Insurance Administration (ASES)**

Adult Measures				
Measure Domain	**Measure Name**	**Age Range**	**Eligible Population**	**Rate**
	Breast Cancer Screening	50 – 64	31,544	69.81
		65 – 74	5,760	61.48
	Cervical Cancer Screening	21 – 64	108,498	53.89
	Chlamydia Screening in Women	21 – 24	5,500	68.85
	Colorectal Cancer Screening	46 – 50	20,603	41.39
		51 – 65	60,627	55.28
		66 – 75	9,294	55.79

*Data Provided by Puerto Rico Health Insurance Administration (ASES)