DEPARTMENT OF HEALTH
MEDICAID
GOVERNMENT OF PUERTO RICO

2026 Annual Report to Congress

Public Law 117-328: Consolidated Appropriations Act, 2023



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

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1. Executive Summary

In compliance with Section 1108(g)(9) of the Social Security Act (SSA), Puerto Rico submits the Annual Report to Congress for 2026, which describes the current landscape of the Medicaid program, improvements made since the submission of the 2025 report, and the plans for continued program improvements.

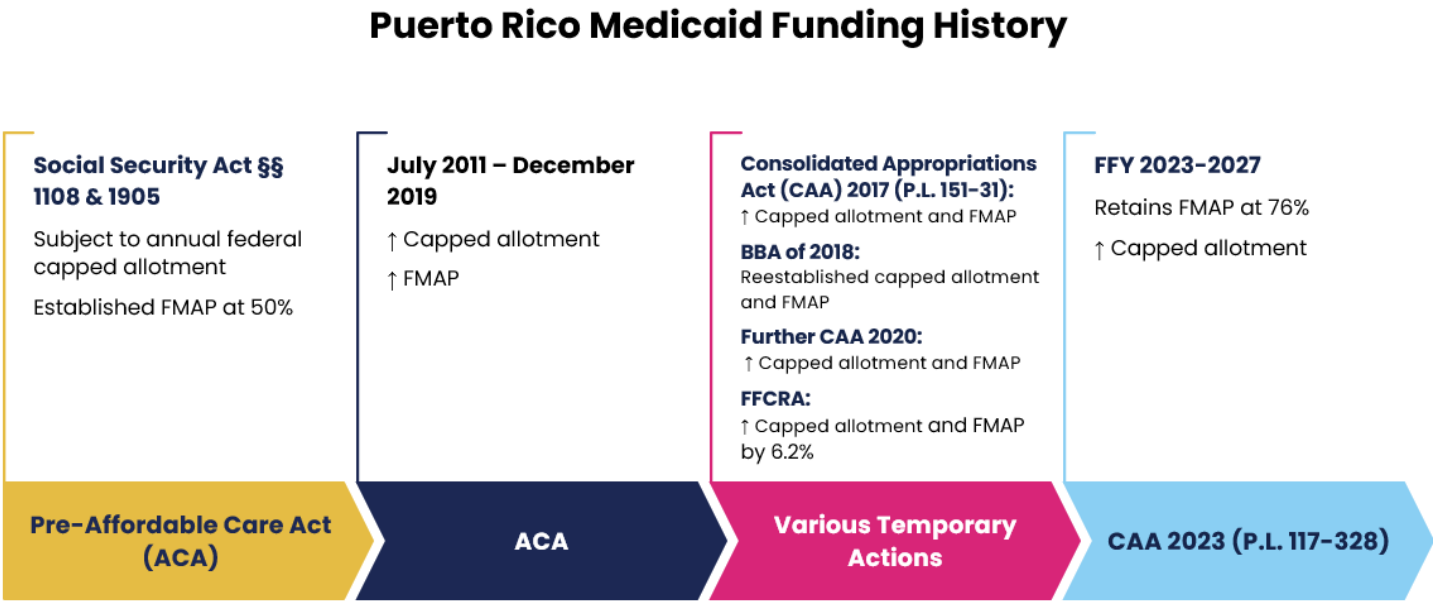
The Medicaid program in Puerto Rico is composed of the Puerto Rico Department of Health (PRDoH), the Puerto Rico Medicaid Program (PRMP), and the Puerto Rico Health Insurance Administration (PRHIA, commonly referred to in Spanish as Administración de Seguros de Salud [ASES]) (see Section 1). These entities collectively oversee the delivery of Medicaid and Children's Health Insurance Program (CHIP) services.

PRDoH is the single State Medicaid Agency (SMA). PRDoH works with PRMP and PRHIA to administer the Medicaid program in Puerto Rico. PRMP, a division under PRDoH, determines Medicaid eligibility 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).

Puerto Rico's 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 instrumental in providing interim stability and resources, Puerto Rico continues to experience limitations in funding federally mandatory and optional Medicaid 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 these expansions reflect Puerto Rico's strong commitment to improving health care access and quality of life, the addition of these services has increased program expenditures and underscores the importance of sustainable, long-term federal Medicaid funding to maintain and build upon recent program improvements. Figure 1 shows the history of Medicaid funding in Puerto Rico.

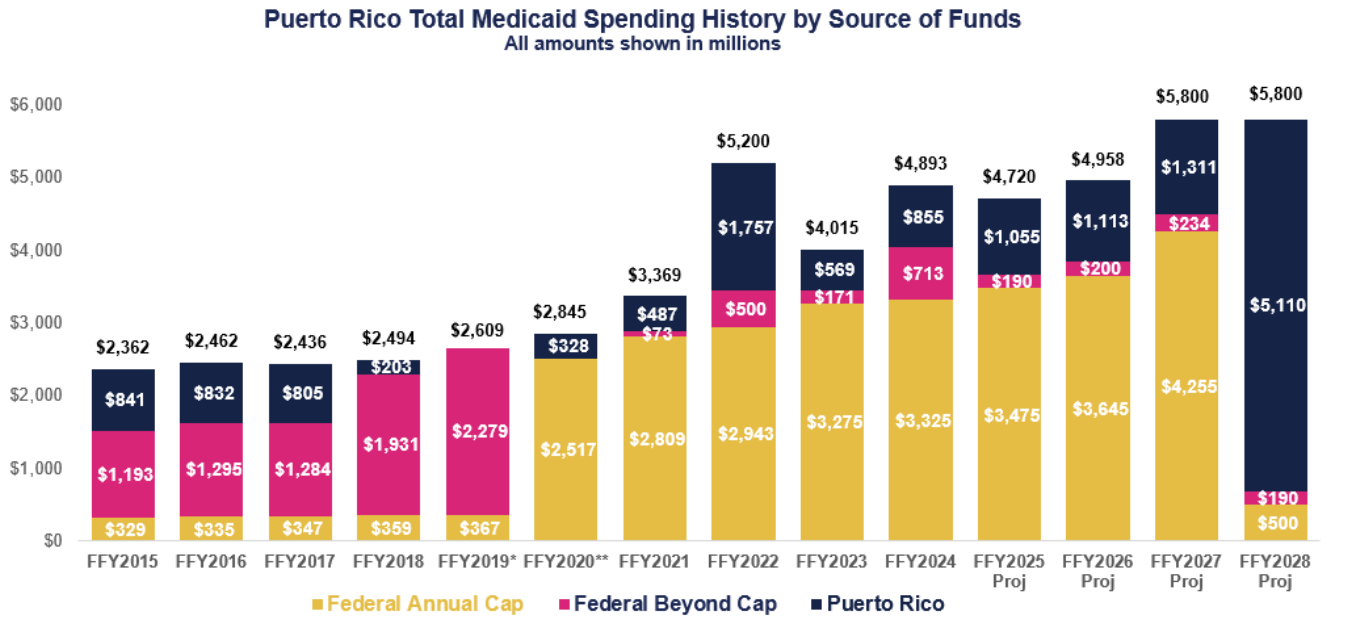
Figure 1: Puerto Rico Medicaid Funding History



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 Fiscal Year (FY) 2027. It also provided incremental increases in the annual capped allotment over five years, FY 2023 – FY 2027. These changes provided medium-term fiscal stability and, therefore, increased access to care for families and individuals (see Section 4.2). Absent congressional action, the increases to the annual capped allotment expire at the end of FY 2027. However, if adequate state-like funding is enacted, PRMP will have the opportunity to make further programmatic improvements to benefit the U.S. citizens of Puerto Rico, such as investing in long-term services and supports (LTSS) for the island's aging population and individuals with disabilities. Puerto Rico defines state-like funding as permanent, predictable funding that includes an equitable FMAP and treats Puerto Rico Medicaid as an entitlement program that is not subject to an annual Medicaid capped allotment pursuant to Section 1108(g) of the SSA.

Puerto Rico's Medicaid Program faces long-standing challenges stemming from capped federal funding. As this temporary federal funding nears expiration, Puerto Rico faces a Medicaid funding cliff that would destabilize care for over 1.3 million beneficiaries. Figure 2 shows the total Medicaid spending history for Puerto Rico by source of funds with the FY 2028 projection representing the funding cliff scenario.

Figure 2: Puerto Rico Total Medicaid Spending History by Source of Funds



*Reported 2019 spending is less than the sum of detail due to negative prior period adjustments and temporary 100% FMAP
**Federal cap was above total federal spending for 2020

Sources: 2015-2024 MACPAC Archive Exhibit 16, Congressional Research Service: Legislative History of Medicaid Financing for the Territories, H.R. 2617 (ENR) - Consolidated Appropriations Act, 2023, FOMB Revised Certified Fiscal Plan

[1]

PRMP and ASES continue to partner with the Centers for Medicare & Medicaid Services (CMS) as Puerto Rico works with Congress to secure permanent FMAP parity and help ensure stable financing for beneficiary eligibility, rate certification, provider solvency, and managed care continuity. Concurrently, ASES continues to advance several system-wide modernization initiatives, including annual managed care rate reviews, Medical Loss Ratio (MLR) oversight, MMIS and data integration, and evaluation of value-based and other payment models 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 exacerbated difficulties in accessing health care providers in Puerto Rico. The island faces large-scale professional outmigration and has an aging provider population. As noted in Section 6.1.1, Puerto Rico continues to take action to help stabilize provider access through 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 and retention, they create

[1] In addition to the annual capped amount, Puerto Rico has received $375 million from FY 2023- FY 2027, which brings the total federal funding amount for FY 2027 to $4.2 billion.

additional strain on Puerto Rico's capped allotment. Providers in Puerto Rico are under constant pressure because they do not receive the same compensation for services as their counterparts in the states, yet they must meet the same high standards of care and quality, creating an economic burden on their practices.

Although Puerto Rico has been able to increase rates for some Medicaid providers, pharmacy providers have not benefited. Recognizing the important role of pharmaceuticals in the continuum of care, Governor Jenniffer González-Colón is evaluating the adequacy of dispensing fees compared to costs. Discussions have included the potential use of studies and other analyses to assess dispensing fee methodologies, and Puerto Rico plans to leverage these analyses to inform future policy considerations, subject to available funding and program priorities.

Puerto Rico is excluded from critical federal health programs that serve as lifelines for vulnerable populations across the United States. Governor González-Colón has identified the long-term federal support for Puerto Rico's health care programs as a key priority for her administration. In her June 17, 2026, testimony before the U.S. Senate Committee on Energy and Natural Resources, the governor emphasized the need for equitable and long-term Medicaid funding beyond FY 2027 and the importance of Congress addressing funding disparities affecting Medicaid and Medicare Advantage beneficiaries and providers on the island. 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 exclusions limit access to essential benefits available to residents of the 50 states. The governor's administration, in coordination with PRHIA, the Medicaid program, and the Puerto Rico Federal Affairs Administration (PRFAA), continues to advocate for greater access to health care programs and to strengthen advocacy efforts at the federal level. See additional information in Section 7.

Puerto Rico continues to prioritize program oversight by enhancing integrity processes to counter fraud, waste, and abuse (FWA) and increasing transparency. These efforts are directed toward bolstering oversight, improving 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 properly utilized. The division continues to prioritize coordination with other investigatory agencies (see Section 5.2.1). Puerto Rico also continues to operate a robust procurement office, known as the Proposal Adjudication Unit (PAU), which ensures funds are carefully used when procuring technology and services to support the program through a diligent procurement process. This procurement process complies with

Section 5101(e) of the CAA, 2023, which requires the designation of a Contracting and Procurement Oversight Lead, referred to as the Procurement Oversight Lead (POL) (see Section 5.2.1 and 5.2.3.1). The POL'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, prioritizing the enhancement of enterprise governance, data governance, information technology modernization, and program standardization. Through these improvements, PRMP can align data-strengthening priorities with clear leadership and decision-making processes. Enhanced data governance helps support performance in a variety of program areas, including financial oversight, program integrity, and quality metric reporting. Program standardization and strengthened program and project management structures have continued to improve vendor contract oversight (see Section 5.2.3).

In the area of technology, PRMP has continued to enhance the online application for Medicaid eligibility through the Asset Verification System (AVS), which has been implemented; and the Third-Party Liability (TPL) system, which is at an advanced stage of implementation; as well as simplification of household composition rules, and efforts to align household recertification dates and reduce beneficiary burden (see Section 6.3). PRMP continues modernizing its eligibility system, which is aligned with ongoing updates of the eligibility manual. Puerto Rico continues working with its vendor and stakeholders on ongoing operations and future enhancements. In parallel, PRMP has upgraded the financial and reporting capabilities of its MMIS, achieved four CMS certifications of the MMIS Financial Management solution, and continued advancing key Medicaid Enterprise modernization initiatives (see Section 5.1.2).

Puerto Rico has also made advancements in the implementation of the Health Information Exchange (HIE), positioning the PRMP as a leader in health data modernization. These administrative improvements are in the service of providing better care to Medicaid beneficiaries, particularly the most vulnerable populations. Yet these initiatives also place additional demands on the capped allotment and highlight the importance of sustainable, long-term, state-like Medicaid funding to support continued access to care and future program improvements.

Further, the capped allotment limits the ability to fund LTSS. Puerto Rico continues to leverage 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.

The PRMP is taking steps to meet state requirements, as feasible within budget constraints. For example, Puerto Rico is making progress toward implementation of 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 U.S. territory required to participate in Medicaid Payment Error Rate Measurement (PERM) and continues to build upon prior PERM and Medicaid Eligibility Quality Control (MEQC) activities to strengthen program oversight and compliance efforts (see Section 5.2.2). PRMP had a successful PERM pilot with only one finding identified. The first official PERM review is currently under way. In addition, Puerto Rico continues to participate in the Medicaid Drug Rebate Program (MDRP), Supplemental Rebates, and is participating in the GENErating cost Reductions for U.S. Medicaid (GENEROUS) Model, allowing for rebates to be reinvested in services (see Section 6.2.4) and decreasing the cost of the program.

Despite these improvements, Puerto Rico continues to operate under a Medicaid funding structure that is significantly different from state Medicaid programs. The island's health system continues to face challenges related to funding constraints and a dwindling provider population.

Puerto Rico has consistently complied with CAA, 2023 legal and operational requirements, and implemented additional measures to combat fraud, waste, and abuse, as required to receive additional federal funding. As such, Puerto Rico has demonstrated its strong commitment to preventing, detecting, and addressing fraud, waste, and abuse in the Medicaid Program and maintaining alignment with federal rules and regulations.

Facing a possible Medicaid funding cliff at the end of FY 2027, Puerto Rico requests that Congress take the following actions:

- **Remove the allotment ceiling**, consistent with state Medicaid programs, to provide adequate, sustained funding to Puerto Rico;
- **Utilize the same formula as the states to determine the FMAP**, which would likely result in an FMAP of 83%. It is important to note that increasing the FMAP without increasing the allotment would result in Puerto Rico exhausting its allotment faster;
- Include Puerto Rico in other federal programs from which it is currently excluded, like **disproportionate share payments** for hospitals to help address uncompensated or

under-compensated care and, once sufficient funds are available, the **Medicare Savings Program**, which helps pay Medicare premiums and cost-sharing; and

- Extend access to Long-Term Services and Supports (LTSS). Should sufficient funding not become available for Puerto Rico to establish LTSS island-wide, Congress could consider providing funds for a regional pilot program. This would allow the island to focus long-term care services in certain areas while still controlling federal spending.

In the absence of congressional action, Puerto Rico faces the following consequences:

- A decrease in federal funding beginning in FY 2028, dropping the allotment ceiling to **~$500 million at a 55% FMAP.**
- Drop in federal funding of approximately **$3.36 billion annually.**
- An estimated 860,000 to 1 million beneficiaries could lose coverage.
- **Uninsured rate to increase to approximately 30% (from 5.7% in 2024).**
- **Increased outmigration to the U.S. mainland,** where health care services are more expensive, costing more to the federal government.

2. Introduction and Legal Framework

In FY 2020 and FY 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 FY 2023 and each subsequent year before FY 2028 if Puerto Rico receives a Medicaid capped allotment increase or an increase in the FMAP for such fiscal year.

Puerto Rico's Medicaid funding and governance structures differ from those of the states, with three major entities working with the program:

PRDoH is the single SMA administering Medicaid for Puerto Rico. PRDoH works with PRMP and PRHIA to administer the program.

PRMP, a department under 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), as well as several other ancillary systems described in Section 5.1.1.2 of this report "MES Roadmap". PRDoH leads coordination between the agencies to deliver the Medicaid program.

PRHIA was created in 1993 to oversee, monitor, and evaluate services offered by MCOs under contract. The relationship between PRDoH and PRHIA is defined by an interagency memorandum of understanding (MOU). The Puerto Rico Health Reform Program created a government health insurance program, called Plan Vital, which provides health care services through a managed care delivery system, including Medicaid services. PRHIA is a public corporation overseen and monitored by a board of directors (BOD) and is responsible for program design and implementation of Plan Vital contracts with MCOs. It is also 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, as well as contacting beneficiaries and providers to inform them of changes in benefits and reimbursement for services.

The PRHIA BOD includes eleven members; six are ex officio members and five are appointed by the governor of Puerto Rico with the advice and consent of the Puerto Rico Senate. The BOD works in a transparent way, oversees compliance with federal rules and regulations, and provides guidance on the use of funds and reporting.

The **Financial Oversight and Management Board (FOMB)** is a federally mandated oversight agency tasked with securing 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 must approve government contracts, including Medicaid contracts, with a cost of $10 million or more and can audit other contracting processes at its discretion. All proposed contracts or amendments stemming from 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. These review requirements impact the timing of contract execution and implementation activities associated with the Medicaid program.

While PRDoH, PRHIA, and the FOMB serve as the primary entities influencing the administration, oversight, and financing of Puerto Rico's Medicaid program, the broader health care landscape is also shaped by Puerto Rico's unique geographic, economic, and disaster recovery challenges. Addressing these challenges requires coordination among additional local and federal entities that support recovery, infrastructure, and resilience initiatives affecting the delivery of health care services across the island.

Puerto Rico's population has significant health needs and faces heightened challenges due to its geography, including hurricanes, power outages, earthquakes, and a high dependence on imported health technology. Notably, hurricanes have required 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. Recovery efforts were impacted by additional damage caused by Hurricane Fiona in September 2022. Hundreds of thousands of residents needed assistance to meet basic needs for an extended period. The hurricanes shut down electricity, water, and sewer services, hindered first responders' ability to dispatch 911 calls, and halted transportation. Schools and some health care facilities were forced to close, and hospitals had to rely on emergency generators. The challenge of recovery and rebuilding the economy further complicates Puerto Rico's financial situation.

Despite the challenges, PRMP continues to explore program enhancements to better serve Medicaid beneficiaries. These efforts are accompanied by activities that simultaneously strengthen the program's governance, technology, and oversight. Accordingly, Puerto Rico Medicaid has been able to implement a Medicaid Enterprise with structures for robust

contract oversight, program integrity, and data transparency.

Complementing Puerto Rico's efforts to secure state-like Medicaid funding and, in accordance with Governor Jenniffer González-Colón's Executive Order 2026-006, the Multisectoral Working Group to Ensure Fair and Equitable Funding for Federal Health Programs was established to develop a report that provides an overview of the PRMP, highlighting both recent progress and remaining structural challenges, and supporting the case for sustained and enhanced federal Medicaid funding beyond FY 2027. The report incorporates multisectoral input from state agencies, providers, advocates, and additional stakeholders who have signed an MOU that guides their work together. The report's main objective is to provide a clear, data-driven baseline for federal policy discussions concerning Puerto Rico's Medicaid financing structure, the operation of the SSA §1108 allotment ceiling, and alternatives for financing beyond FY 2027.

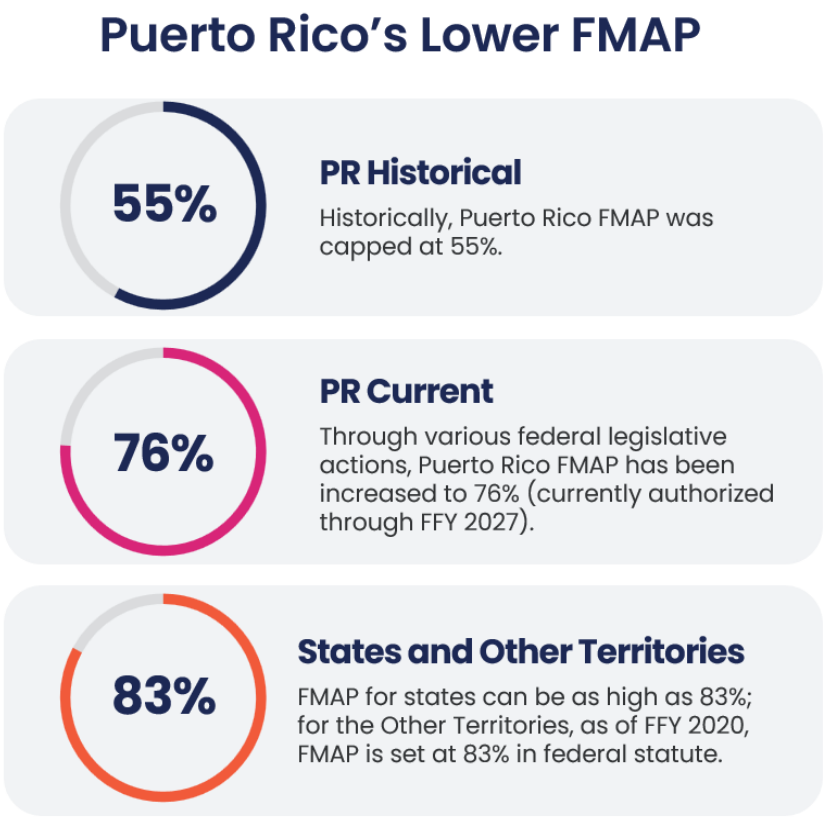
Puerto Rico looks forward to maintaining a strong relationship with its federal partners and Congress to build on PRMP's progress, support program options, and explore alternatives for improvement. The FY 2026 report includes actions taken to strengthen the program and demonstrates Puerto Rico's capacity and commitment to beneficiaries by operating a strong Medicaid program.

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

The Medicaid program, including CHIP, is arguably one of the most consequential federal programs in Puerto Rico. As of September 2026, it provides health care services to about 1.3 million people, which is about 40% of the island's population. Also, Puerto Rico used CHIP funds to provide coverage for over 19,000 children who are enrolled in its Medicaid Expansion CHIP. However, the program differs in fundamental ways when compared to state Medicaid programs.

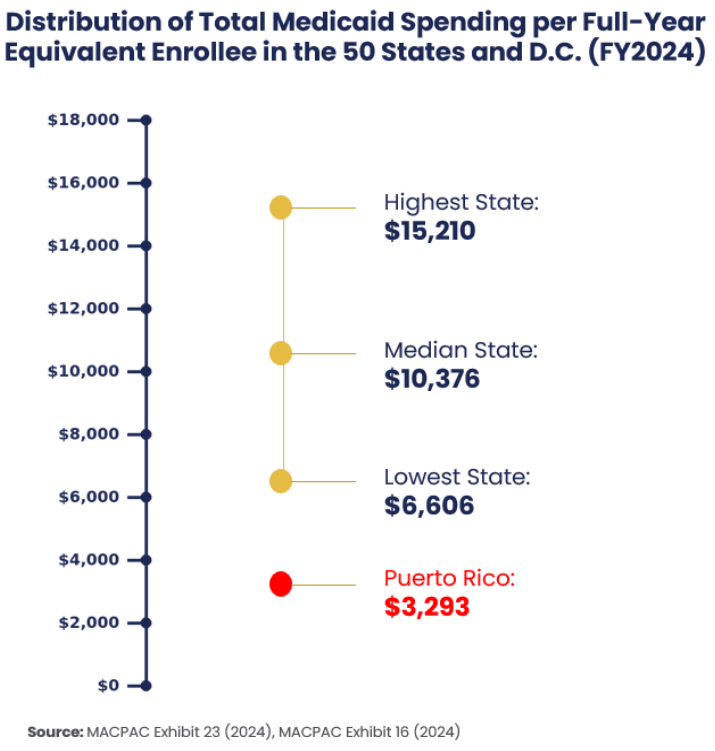
Unlike the states, Puerto Rico is subject to an annual Medicaid capped allotment pursuant to Section 1108(g) of the SSA. This means the federal government will match Puerto Rico's Medicaid spending up to the capped allotment, and any spending above that is the sole responsibility of the island. Figure 3 depicts this difference in funding. CHIP funding in Puerto Rico is determined by using the same methodology used for states, which is an annual capped allotment, as established under Section 2104 of Title XXI of the SSA. CHIP has an enhanced FMAP that is about 15% higher than the regular Medicaid FMAP. The FMAP for Puerto Rico was set in statute at 50% in 1968, increased to 55% by the Patient Protection and Affordable Care Act (ACA) of 2010, and most recently raised to 76% through FY 2027 per P.L. 117-328. Although other U.S. territories have received permanent FMAP increases to 83%, the Puerto Rico FMAP would revert to 55% if no additional congressional action is taken before the end of FY 2027. These FMAP differences are depicted in Figure 3.

Figure 3: Puerto Rico's Lower FMAP



Puerto Rico is also able to receive an additional $375 million in federal funds by complying with requirements in CAA, 2023, which include establishing a floor for Medicaid physician payment rates equivalent to 75% of the Medicare Part B rate, and specific program integrity, reporting, and procurement oversight requirements. Puerto Rico was able to quickly implement the required Physician Fee Schedule changes effectively in January 2023, with an increase to 100% of the Medicare Physician Fee Schedule in October of the same year. Puerto Rico has been able to maintain those increases and assessed other fee schedules as well, implementing similar fee updates for behavioral health and dental services. The program has met and exceeded the integrity and reporting requirements, which are discussed in Section 5.2 below, continues maintaining compliance and searching for ways to expand on the progress made since 2023.

Figure 4: Distribution of Total Medicaid Spending



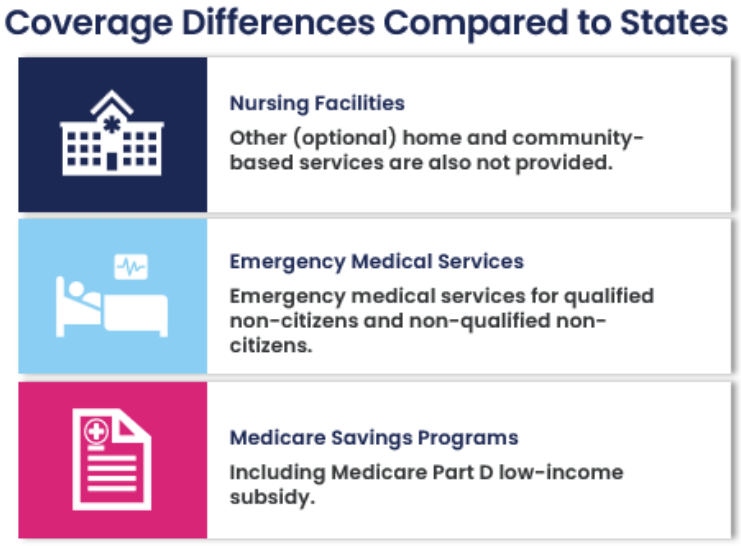
Source: MACPAC Exhibit 23 (2024), MACPAC Exhibit 16 (2024)

Another notable difference is the cost of Medicaid services in Puerto Rico compared to the states. Furnishing services on the island for one year is significantly less than the lowest per-beneficiary cost in the states, as demonstrated in Figure 4.

The difference in per beneficiary spending is partially due to the lack of Medicaid-funded LTSS in Puerto Rico's Medicaid Program but also points to a broader lower cost of health care provided on the island.

The island also faces ongoing challenges with access to care, including provider migration, and is unable to cover certain critical benefits. Figure 5 shows mandatory services that are not covered, as well as Puerto Rico's fiscal inability to opt into the MSP. Despite financial challenges, it implemented coverage for home health, hospice, DME, and NEMT in July 2024, and an All Patient Refined Diagnosis Related Group (APR-DRG) inpatient hospital reimbursement methodology effective January 1, 2026, to modernize inpatient hospital reimbursement and support payment and delivery system transformation efforts.

Figure 5: Coverage Difference Compared to States



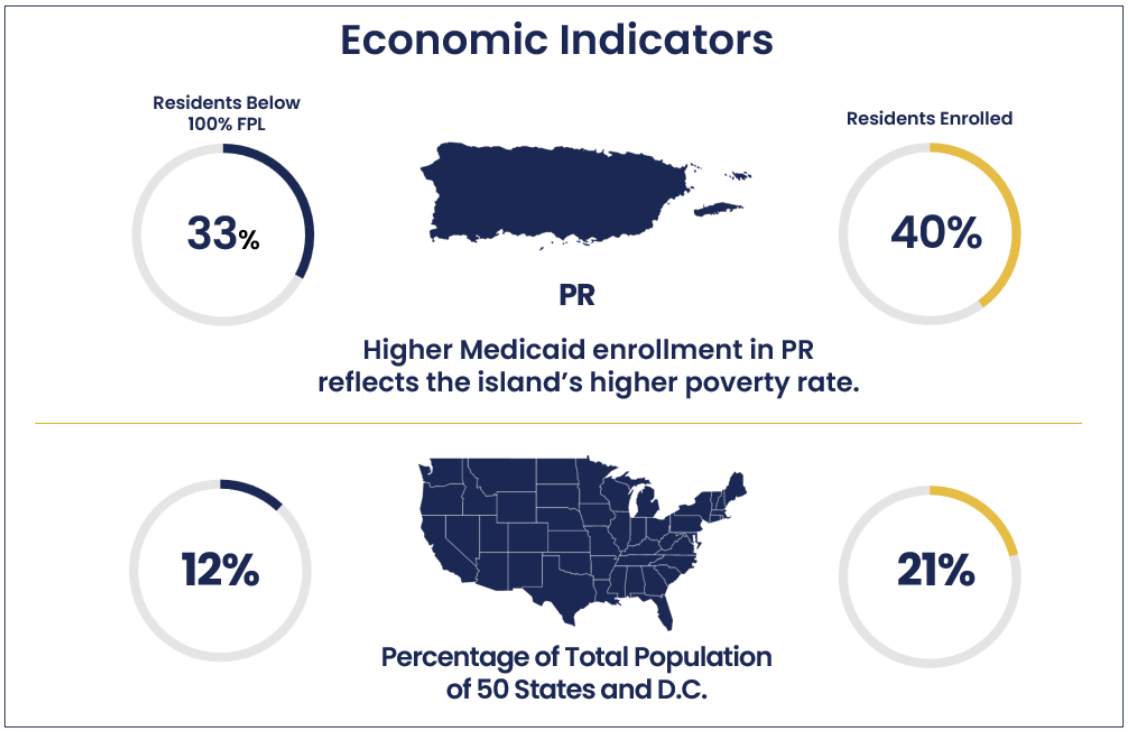
While these initiatives are expected to improve care coordination, support access to community-based services, and strengthen the health care delivery system, implementing new services within Puerto Rico's capped Medicaid allotment has increased financial pressures and raised concerns regarding long-term sustainability. Puerto Rico is actively working to maintain coverage for these important services while balancing the pressure they place on the capped allotment. The ongoing commitment to improve health care access and quality of life for island residents, as well as the resulting financial pressures combined with uncertainty regarding future federal funding, could require the program to consider service reductions, utilization limits, or other measures to preserve long-term sustainability.

Puerto Rico has higher poverty rates compared to the mainland United States. Based on U.S. Census data, all 78 municipalities in Puerto Rico have been in persistent poverty from 1989 to 2019.[2] As of 2024, 37% of Puerto Ricans lived below 100% of the federal poverty level (FPL), which was over three times the national average of 12%.[3]

[2] 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*
[3] United States Census Bureau. 2026. "Puerto Rico Profile." United States Census Bureau. Accessed August 27, 2026. Puerto Rico Profile. https://data.census.gov/profile/Puerto_Rico?g=040XX00US72#income-and-poverty

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 percentage points higher than the U.S. average of 21% (the U.S. average does not include Puerto Rico).[4]

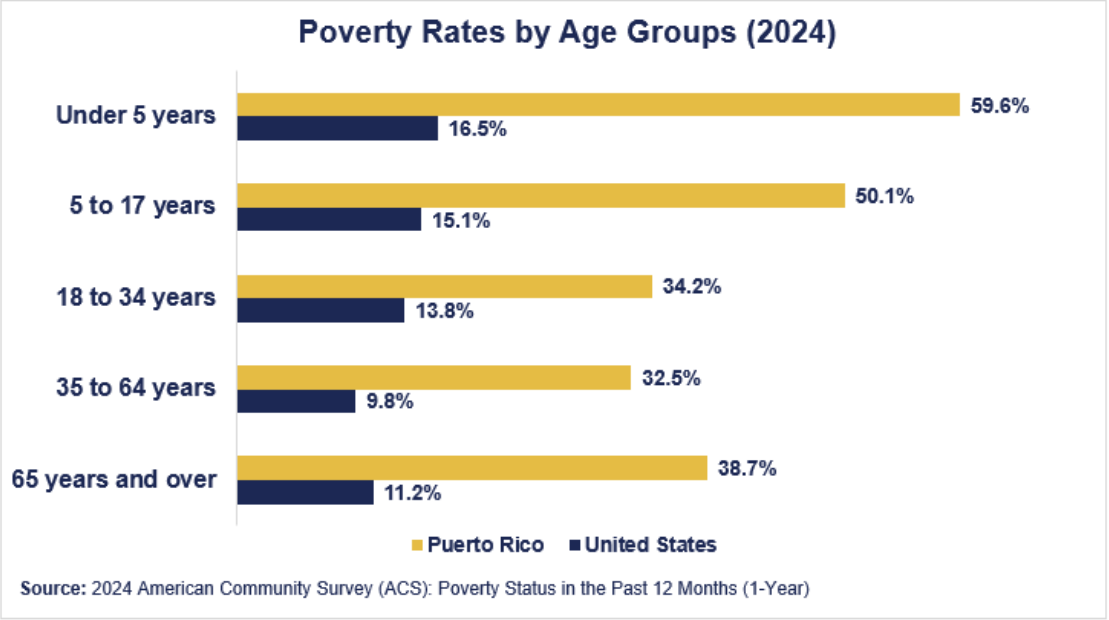
Figure 6: Economic Indicators



Although enrollment has declined following the unwinding of the COVID-19 continuous coverage requirement, approximately 40% of Puerto Rico's population remains enrolled in Medicaid and CHIP, which, as Figure 6 demonstrates, is about double the percentage points of residents enrolled in state Medicaid programs. High enrollment in Medicaid clearly shows the program's continued importance as a critical source of health coverage. Figure 6 also illustrates the difference in the number of residents below 100% FPL in Puerto Rico compared to the 50 states and District of Columbia. Figure 7 demonstrates the impact of poverty on residents under the age of 18, showing the poverty rate for children in Puerto Rico exceeds 50%.

[4] 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

Figure 7: Poverty Rates by Age Groups



High poverty levels in Puerto Rico have contributed to a significant reliance on Medicaid among residents, despite differences in funding compared to other U.S. jurisdictions. The island also uses its own funds to support coverage for over 20,000 individuals under the program.[5]

[5] Puerto Rico Medicaid Program (PRMP), Estadísticas, accessed September, 2026, Puerto Rico Medicaid Statistics.

4. Landscape of Puerto Rico's Medicaid Program

The following sections describe the PRMP, including health care data and program reporting, funding, enrollment, and eligibility.

4.1 Health Care Data and Program Reporting

As of September 2026, 40% of Puerto Rico's population is enrolled in Medicaid and CHIP.[6] To provide the best possible service for beneficiaries, Puerto Rico continues to evaluate services to consider for coverage changes, enhance collaborative efforts with other agencies for data collection, and subsequently utilize this data to make 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 marked 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 annually, 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 made available through this reporting, PRHIA continues to require annual reports from MCOs on 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 help ensure that resources are used effectively.

The combination of the Core Set and HEDIS reporting assists PRHIA with monitoring and evaluating MCO operations and the corresponding services rendered by providers. Please

[6] Departmento De Salud. September, 2026. "Programa Medicaid Statistics." *Departmento De Salud.* Programa Medicaid - Departamento de Salud.September 22, 2026. https://medicaid.pr.gov/Info/Statistics/

refer to Appendix A for MCO HEDIS results for the most recent reporting year (RY), 2025.

In addition, PRHIA uses the Health Care Improvement Program (HCIP) to monitor and evaluate the MCOs. Through the HCIP, PRHIA establishes measures that are 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 measure drives MCO reimbursement from the retention fund. In addition to performance measurement, the 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 for improvement. For example, Child Core Set Measures, under the Care of Acute and Chronic Conditions domain, show that 86% of children age 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 57% of children who were 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 highlights both progress and ongoing challenges across Adult Core Set Measures. Under the Primary Care Access and Preventive Care domain, 61% of Medicaid-eligible adults age 18 – 64 received breast cancer screenings, indicating interest in and access to preventive care. However, in the Behavioral Health Care domain, only 11% of individuals age 18 – 64 received depression screening and a follow-up plan, showing an area for improvement.

Puerto Rico is committed to transparency, and its prioritization of health care measures underscores that commitment. For more detailed information on Puerto Rico's Core Set measures for RY 2025, please refer to 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. Puerto Rico submitted CMS 416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation report for FY 2025 and is reviewing the data to identify opportunities for improvement.

4.2 Funding

This section describes Puerto Rico's funding model and how funds are utilized. The current state of the program, including improvements and reforms, was made possible by multiple 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 FY 2027.[7] It also provides annual increases of Medicaid funding for Puerto Rico through FY 2027. With the end of FY 2027 now only one year away, Puerto Rico looks forward to working with Congress to secure the funds needed to support PRMP operations, as well as access to services offered in the states, such as LTSS.

Table 1: Medicaid Program Expenditures

Category	FY 2024	FY 2025	FY 2026 (Projected)
Medicaid (Net of Drug Rebates)	$3,988,025,435	$4,531,533,346	$4,741,725,862
Enhanced Allotment Plan (EAP)	$96,613,069	$105,729,430	$299,444,952
CHIP (Net of Drug Rebates)	$87,855,535	$46,602,843	$48,593,831
PRMP Administration	$45,912,215	$45,156,318	$71,461,613
ASES Administration	$16,000,000	$16,000,000	$16,000,000
Eligibility & Enrollment	$61,202,014	$39,483,269	$79,835,700
MMIS	$57,036,058	$53,252,776	$83,102,574

P.L. 117-328 established criteria for an additional $375 million annually for Puerto Rico's Medicaid Program if specific requirements are satisfied.[8]

The island 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 its submission of a state direct payment (SDP) arrangement, which establishes a

[7] 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

[8] 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

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 FY 2023 through FY 2027. To receive this funding for FY 2023 through FY 2025, it must satisfy the requirements in Section 1108(7)(A)(i) of the SSA, which requires the designation of an officer (other than the director of such agency) to serve as the Program Integrity Lead. Puerto Rico has complied with this requirement.

In order to continue receiving the additional $75 million in FY 2026 and FY 2027, Puerto Rico must meet the requirement for the Program Integrity Lead and designate the Contracting and Procurement Oversight Lead, fulfilling the requirements in Section 1108(7)(A)(v)(II) and (7)(A)(v)(III) of the SSA. Puerto Rico has a designated Contracting and POL and anticipates no difficulties with receiving the additional $75 million through FY 2027.

Puerto Rico appreciates this additional support, acknowledges receipt of the additional $375 million for FY 2026, and will continue to comply with the requirements of P.L. 117-328 to receive this funding for FY 2027. The program's continued compliance and established service and reimbursement levels are now an integral part of the program and overseen by CMS. As such, Puerto Rico supports making these funds a permanent part of federal support of the PRMP.

4.3 Program Enrollment and Eligibility

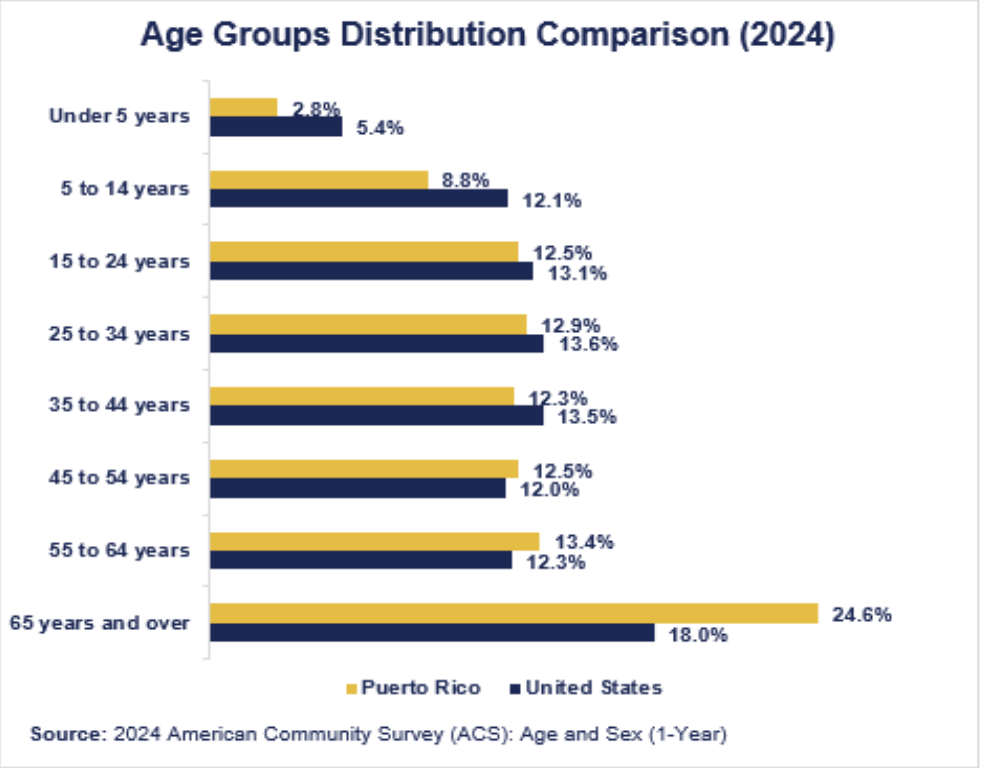
As of September 2026, Puerto Rico provides Medicaid coverage to approximately 1.3 million individuals out of a total population of 3.2 million residents.[9] Additionally, over 19,000 children under the age of 19 are covered under the island's Medicaid Expansion CHIP.[10] The number of Medicaid and CHIP enrollees has declined since 2023, primarily a result of unwinding the continuous Medicaid enrollment, which had been required by the Families First Coronavirus Response Act (FFCRA).

Puerto Rico is also one of the most rapidly aging populations in the world. Figure 8 reflects the 2024 age group distribution compared to the United States.

[9] "Puerto Rico Profile" United States Census Bureau. Accessed September 23, 2026. https://www.census.gov/geographies/island-areas/puerto-rico.html

[10] Puerto Rico Department of Health. September 2026. "Estadísticas." medicaid.pr.gov. September 22, 2026, Puerto Rico Medicaid Statistics.

Figure 8: Age Groups Distribution Comparison

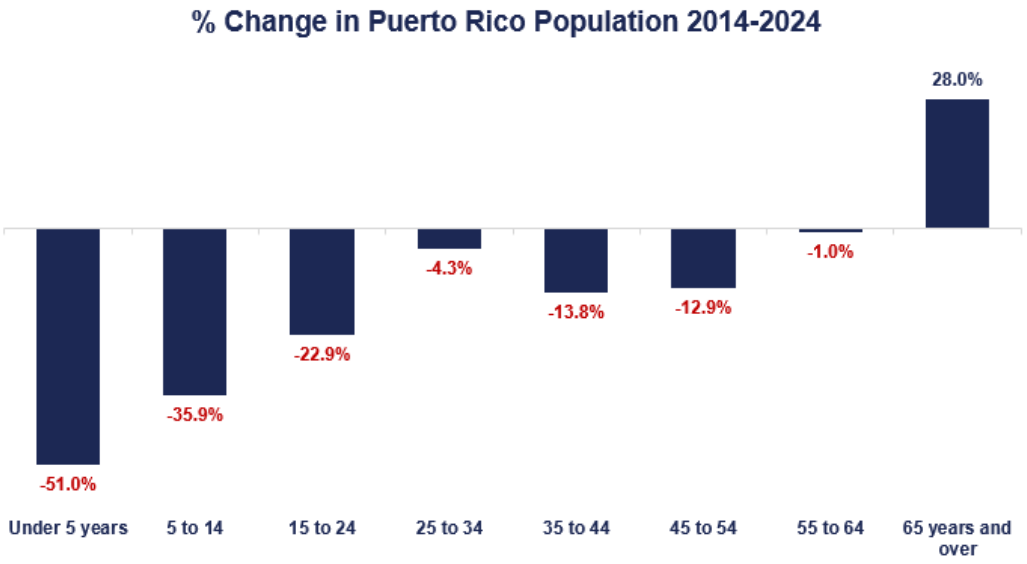


Compared to the states, Puerto Rico is the jurisdiction with the second highest percentage of the population age 18 or older.[11] This is due to a reduction of births across the island as well as the outmigration of many adults.[12] Figure 9 shows the change in population, by age group, comparing data from 2014 and 2024. The growing generation gap in Puerto Rico greatly impacts the number of Medicaid-eligible beneficiaries.

[11] 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

[12] 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/

Figure 9: Change in Puerto Rico Population



Sources: 2014 American Community Survey (ACS) Demographic and Housing Estimates (1-Year), 2024 American Community Survey (ACS) Demographic and Housing Estimates (1-Year)

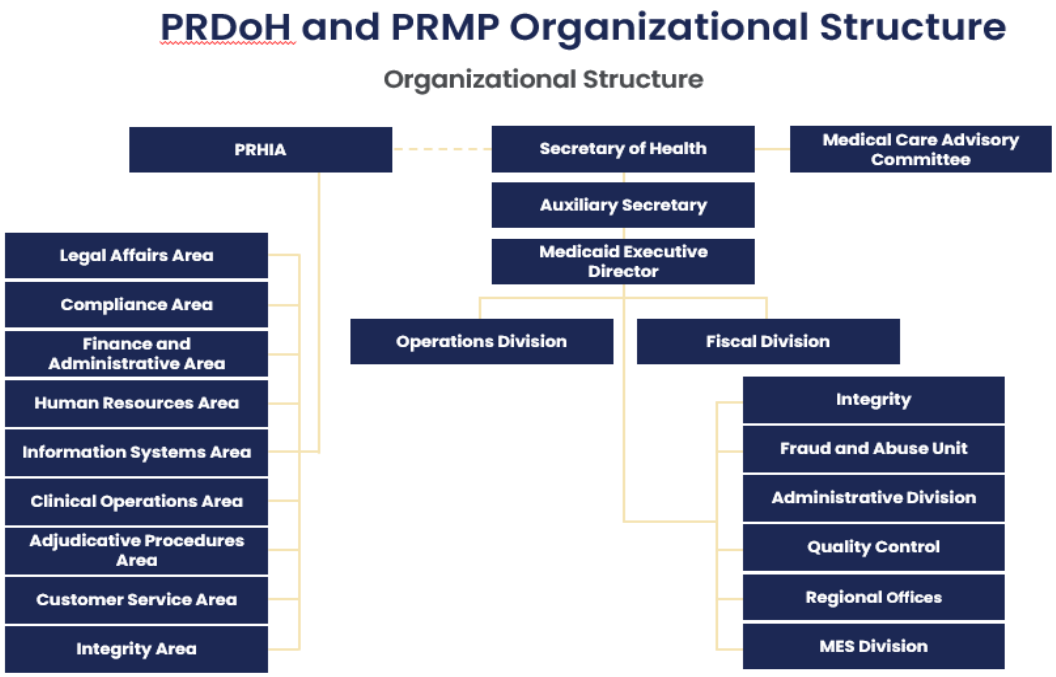
5. Program Governance and Oversight

This section provides an overview of PRMP's governance structure and operational priorities. It also highlights PRMP's commitment to advance 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 better 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, Puerto Rico's Medicaid Program is influenced by PRDoH, PRHIA, and the 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 goal of providing health care services to individuals eligible for Medicaid. Anchored to this shared vision, PRDoH continuously works to add rigor, structure, and standardization across departments and projects to bolster accountability, improve performance, and strengthen governance structures. PRMP and PRHIA maintain a strong partnership and, for the first time, are led by the same Executive Director. Puerto Rico continues to explore opportunities to reduce administrative expenses and enhance operational efficiencies. It also recognizes that a strong governance structure, with underlying processes that support this structure, will help the Medicaid program achieve its goals, realize its vision, and provide for its strategic direction. Figure 10 shows the current governance structure of PRMP and PRHIA.

Figure 10: 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 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 collaborate 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 11 shows in greater detail the governance functions of the PgMO and the ePMO within PRMP's MES.

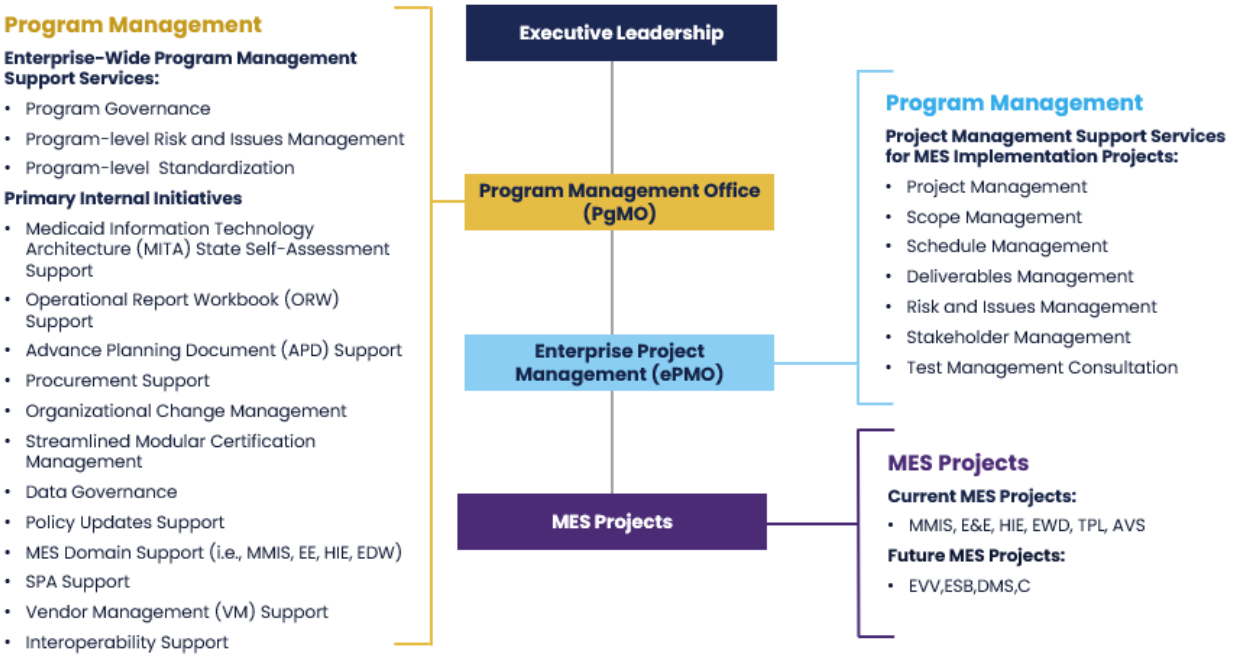


Figure 11: PgMO and ePMO Governance

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, provides oversight of governance, strategic planning, program and risk management, operations, and federal compliance. The ePMO, also led by PRMP staff and supported by vendors, focuses on project execution, standardization, budget management, 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 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 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®) and focuses on four key business areas: Program Management, Enterprise Architecture, Business Operations, and Data Governance.

By leveraging this roadmap, the PgMO supports alignment of MES initiatives, builds on completed projects, and drives ongoing improvements, ensuring PRMP's IT investments and governance activities 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 2026 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 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 evolved its MITA approach from a traditional maturity-focused assessment to a strategic outcomes-based framework that supports MES modernization, business-driven decision-making, and measurable program improvements. PRMP has realigned its approach to MITA SS-As and related documentation by creating an alternative format focused on performance outcomes to address current operational challenges, define future system goals, and identify measurable improvement targets. PRMP also produces MITA concept of operations (ConOps) and roadmaps for nearly all MES initiatives to assess and plan for business needs and support the Outcomes-Based Procurement (OBP) process. This approach enhances the usefulness of MITA activities and

fosters collaboration with the Advance Planning Document (APD), OBP, CMS Streamlined Modular Certification (SMC), and Organizational Change Management (OCM) teams.

Over the past year, PRMP has advanced MITA 4.0 concepts through participation in national MITA 4.0 pilot activities, alternative MITA reporting approaches, and outcomes-based planning activities. Puerto Rico is the only U.S. territory participating in the MITA 4.0 pilot program alongside 3 states. By integrating MITA planning, roadmap development, certification activities, and enterprise governance, PRMP is strengthening alignment between business objectives, technology investments, and modernization initiatives while remaining actively engaged in CMS and MITA NextGen efforts to support future MITA 4.0 adoption.

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 industry 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. To maintain relevance and alignment with evolving MES priorities, governance expectations, and industry best practices, the PgMO Plan Aids are reviewed and updated annually.

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.

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

- **AVS Implementation:** PRMP has implemented an AVS to improve eligibility determination accuracy and strengthen program integrity through electronic asset verification. Puerto Rico formally submitted SPA 26-0002 regarding implementation of an AVS. As required by the CAA, the effective date of this amendment is January 1, 2026. PRMP has completed contracting activities, conducted design, development, and implementation (DDI) efforts with the selected vendor, and advanced system planning, testing, and certification-related activities. Phase 1 of the electronic

verification was implemented in June 2026. PRMP worked with the system vendor and PgMO to define outcomes and metrics, which, since August 2026, are being reported in the CMS operational reporting workbook (ORW). AVS Phase II will support asset verification activities for the Program Integrity Unit (PIU) and require enhancements to MEDIT3G. AVS and MEDIT3G vendors are working with PRMP and the PIU to finalize requirements and design decisions, with Phase II deployment targeted for March 2027.

- **MMIS Enhancement – APR-DRG:** PRMP is implementing enhancements to the MMIS to support the capture and reporting of APR-DRG data for MCOs. PRMP continues to advance system design, testing, and implementation activities in support of the transition to APR-DRG.
- **Enterprise Data Warehouse (EDW) Business Intelligence Support and Implementation:** PRMP continues implementation of its EDW to provide a holistic view of key health data and serve as a trusted source for data quality, analytics, and reporting across the MES. The EDW went live in February 2026 with MEDITI3G and Demographic Registry (birth and death) data. PRMP is continuing to work with the EDW vendor to integrate and test MMIS data sources to expand enterprise reporting and business intelligence capabilities. MMIS data is expected to be released into the EDW in late 2026.
- **Health Information Exchange (HIE) Contracting, Operations, and Governance Support:** PRMP achieved several milestones in 2026 that position Puerto Rico as a leader in health data modernization. The enactment of the Puerto Rico Health Information Exchange Law (Act 86-2026), completion of the Puerto Rico Health Data Utility (HDU) Roadmap 2026 – 2030, and successful procurement of a new HIE operator and technology solution collectively establish the governance framework, strategic direction, and operational foundation for the next generation of health information exchange in Puerto Rico. These accomplishments strengthen interoperability, support coordinated and data-driven care and create a clear path toward realizing Puerto Rico's vision for a sustainable statewide Health HDU.
- **MITA 4.0 Adoption and Implementation:** PRMP continues to adopt and implement the MITA 4.0 framework to support Medicaid Enterprise modernization, strategic planning, and maturity assessment activities. PRMP has maintained MITA planning tools, completed annual and quarterly MITA reporting activities, and participated in CMS MITA 4.0 pilot efforts to support alignment with the evolving federal framework. In May 2026, PRMP aligned its MES Roadmap to the MITA 4.0 framework.

- **State Plan Amendment (SPA) Alignment:** PRMP continues to implement the SPA Gap Remediation Plan to address findings identified through the State Plan Gap Analysis by updating state plan language, policy, operational processes, and supporting information technology systems. In addition, PRMP evaluates state plan impacts related to program priorities and initiatives. To help ensure alignment of state plan, operations, and Medicaid systems, PRMP coordinates remediation activities across business and system domains to support compliance with federal requirements and/or state plan changes.
- **OCM Support and Implementation:** PRMP continues to mature its OCM program to support readiness, adoption, and organizational alignment across Medicaid Enterprise initiatives. In 2026, PRMP completed OCM maturity assessment activities, provided change management support for key initiatives including AVS, EDW, HIE, and TPL, and expanded stakeholder engagement and communication efforts to strengthen enterprise adoption of system and process changes.
- **Section 5121 Implementation:** PRMP is continuing to make progress in its planning efforts to implement Section 5121 requirements to support coverage of certain screening, diagnostic, and targeted case management services for eligible justice-involved youth. In 2026, PRMP strengthened coordination with CMS, the Puerto Rico Department of Corrections and Rehabilitation, and other stakeholders, while advancing implementation planning and operational frameworks needed to support future policy and system enhancements.
- **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. PRMP continues implementing its spenddown solution to provide coverage to medically needy individuals who exceed traditional Medicaid income eligibility thresholds. Progress has continued toward implementation readiness and alignment of policy and system planning, including stakeholder engagement with MCOs and updates to medical expense verification policies to strengthen program integrity and support future implementation.
- **TPL:** In further support of 42 CFR 433 Subpart D, PRMP is moving forward to enhance its TPL efforts, which will allow PRMP to identify additional third parties liable for Medicaid costs and will support better monitoring of the MCOs' TPL efforts. PRMP expects to implement its TPL solution in March of 2027.

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 subsections describe the current efforts related to program integrity, PERM and MEQC, and Procurement and Contract Oversight, Reform, and Management. While these efforts are well underway, PRMP is simultaneously working to establish an overarching Medicaid compliance unit.

5.2.1 Program Integrity

Puerto Rico remains committed to strengthening its program integrity framework and advancing efforts that align with federal requirements. In accordance with Section 1108 of the SSA, the PIU is led by a designated Program Integrity Officer who is responsible for ensuring accountability, compliance, efficiency, and coordination of program integrity activities across the Medicaid program and its contracted entities.

The PIU's mission is to prevent, detect, and investigate FWA while ensuring Medicaid, CHIP, and territorial funds are used in accordance with federal and local requirements. Puerto Rico continues to strengthen its program integrity efforts through enhanced governance, interagency collaboration, targeted provider audits and investigations, data-driven oversight strategies, and provider education initiatives. In addition, standardized metrics and review processes are being implemented to improve consistency and help ensure accurate identification of improper payments and abnormal provider billing practices or expenditures.

The PIU employs a comprehensive and collaborative approach to preventing, identifying, and addressing FWA within PRMP. Through strong partnerships with federal, state, and law enforcement agencies, advanced data analytics, provider oversight activities, and ongoing education and outreach efforts, PIU works to safeguard program integrity and help ensure compliance with applicable federal and state requirements. The following activities highlight PIU's key coordination, investigative, monitoring, and prevention initiatives designed to detect potential fraud risks and support timely corrective actions.

Interagency Collaboration and Coordination

- PIU maintains strong partnerships with the Puerto Rico Medicaid Fraud Control Unit (PRMFCU) and the Puerto Rico Office of Inspector General (PR OIG). PIU has a five-year MOU with PRMFCU, utilizes formal referral processes, shares relevant policies, and conducts monthly case discussion meetings.
- PIU reviews the PR OIG exclusion database monthly and maintains ongoing communication with the OIG to facilitate the exchange of information. The unit incorporates OIG high-risk provider designations into its annual work plan for further evaluation and investigation.
- PIU conducts regular coordination meetings with stakeholders, including PR OIG, the Department of Justice (DOJ), CMS, ASES, MCO special investigation units (SIUs), PRMFCU, and other partners. These meetings support information sharing, case status updates, referral tracking, documentation requirements, and investigative coordination efforts.
- PIU facilitates quarterly workgroup meetings with MCOs, Medicare Advantage Organization (MAOs), and compliance staff to discuss billing requirements, emerging fraud trends, regulatory updates, and other program integrity topics. PIU also participates in quarterly FWA Task Force meetings with law enforcement partners, including PR OIG and PRMFCU.

Data Analytics, Provider Monitoring, and Investigations

- PIU utilizes monthly surveillance reports generated from the Surveillance and Utilization Review (SUR) system to identify providers exhibiting billing patterns exceeding two standard deviations from established norms. Providers identified through this process are evaluated for potential irregular billing practices or noncompliance with federal and state requirements. When warranted, PIU initiates formal investigations and refers cases involving credible allegations of fraud to PRMFCU or PR OIG.
- PIU reviews concerns identified through multiple sources, including provider enrollment and screening activities, off-cycle revalidations, OIG reports, and internal program integrity investigations.

Provider Education and Outreach

- PIU develops and distributes a quarterly provider newsletter focused on FWA prevention, program integrity requirements, and provider education.
- PIU conducts ongoing FWA outreach and awareness campaigns to promote compliance and strengthen program integrity efforts across the provider community.

Eligibility Fraud Detection Initiatives

- PIU implemented a targeted spenddown case review initiative to identify potential eligibility fraud. Under this effort, each case is reviewed by a registered nurse, who compares information documented on the MA-34 form against MMIS business objects data. Discrepancies identified through this analysis are evaluated for potential fraud indicators and referred for further review as appropriate.

5.2.2 PERM and MEQC

5.2.1.1 PERM

The PERM program measures improper payments in Medicaid and CHIP and calculates improper payment rates for each program. Puerto Rico is currently participating in the RY 2027 PERM cycle, which focuses exclusively on Medicaid and CHIP eligibility reviews.

PRMP has completed the quarterly claims data submissions process as of July 15, 2026. Consistent with CMS requirements, Puerto Rico has been engaged in eligibility case review activities, responding to documentation requests, and supporting the review of eligibility determinations and verification processes. Current efforts include coordination with CMS and the Eligibility Review Contractor (ERC) to facilitate case reviews, provide requested documentation, and address any identified findings through the established review and documentation process.

PRMP will continue building on the process improvement efforts identified during the RY 2024 pilot PERM cycle to ensure a more efficient experience during the RY 2027 PERM cycle. In addition, PRMP will continue to strengthen its collaboration with PRHIA to support ongoing coordination throughout the RY 2027 PERM cycle.

5.2.1.2 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 flexibility in designing their studies and submit their proposed design through the MEQC Pilot Planning Document.

Puerto Rico's MEQC Planning Document for the review period starting January 1, 2027, through December 31, 2027, is due to CMS by November 1, 2026.

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. The program strives to achieve this vision by continuous evolution of procurement and contract processes. Puerto Rico continues strengthening 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.

Table 2: Contracting and Procurement Guiding Principles

Contracting and Procurement Guiding Principles	
Enhance strategy and planning efforts related to procurements	Strive to align the procurement and contracting processes with the mission and goals of Puerto Rico Medicaid and CMS and engage 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, work, and services in a competitive manner.
Standardize and unify processes	Use a common structure to standardize and formalize procurement and contracting processes. To help ensure that these structures are on par with the best practices and meet all required regulations, PRMP underwent a standard operating procedure (SOP) review and update process that was approved in August 2026.
Increase transparency	Make most procurement scoring decisions and other relevant information easily accessible to internal and external stakeholders.
Use data to inform operations	Make data central to procurement processes and derive insights from that data to drive procurement decisions.

Contracting and Procurement Guiding Principles	
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 beneficiary needs.
Seek value and good stewardship of public funds	Spend public funds wisely and focus on reducing waste and abuse of taxpayer dollars. PRMP encourages vendors to give best and final offers (BAFOs) to help ensure PRMP gets the best value.
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.

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 August 2026, and lays the foundation for PRMP's procurement and contracting branches. 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
- Educating Stakeholders in the PRMP Procurement and Contracting Processes (Training): The PRMP POL leverages the SOP to provide training and guidance to PRMP staff. For example, the POL facilitates annual training sessions for PRMP's staff on procurement principles and offers daily guidance to managerial staff and the PRMP and PRHIA Executive Director. The POL is also in the process of planning for the use of new technological resources to strengthen procurement processes and assist managerial staff with more effective planning strategies. PRHIA has a separate procurement unit, 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 SOP (Procurement 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 is working on aligning its procurement processes and procedures to PRMP's SOP.

5.2.1.3 Procurement

Puerto Rico continues to comply with Section 5101 (e) of the CAA, 2023, which requires a designated Contracting and Procurement Oversight Lead through the PAU led by the POL. The POL manages the staff in the PAU and reports to the U.S. Department of Health and Human Services (HHS) and the PRDoH Secretary.

The POL'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 help ensure compliance with federal standards, and in certain cases with local regulations applicable to purchasing goods and services using Medicaid funds

PRHIA's Procurement Adjudication Area 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 serves as a liaison with the PRMP POL. The PPA is responsible for the PRHIA Procurement SOP and its updates or revisions. In accordance with the CAA, 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 2 CFR §§ 200.317- 200.327 and/or an explanation of any extenuating circumstances.

PRHIA's Procurement SOP reinforces the general procurement principles federally recognized in 2 CFR § 200.318 (a) and outlines the responsibilities of PRHIA's staff to help 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 local regulations
- Facilitate easier reviews and audits of contracting processes

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 affairs supervisor. The administrative affairs supervisor manages the rest of the staff in the Contracting Unit and is the primary point of contact for all contract-related matters. The administrative affairs supervisor reports to the PRMP Executive Director.

For pre-contract execution activities, the Contracting Unit works closely with the PAU 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 following 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 affairs supervisor related to contracting include:

- Monitoring and reviewing contract performance regularly to help 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 noncompliance 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 continue to evolve to meet industry standards and local and federal guidance. As we mature 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 OBPs, and adhering to new and existing requirements and standards to help improve outcomes for PRMP, its beneficiaries, and additional relevant stakeholders.

6. Impact of Program Investments

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

This section highlights some 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 the delivery of high-quality care.

In addition to the continued internal enhancements discussed earlier in this report, over the past several years, Puerto Rico's Medicaid Program has covered more services and supported the 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.

While the annual capped allotment increases have allowed Puerto Rico to implement multiple 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 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 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 increased from 9,295 to 9,809 during that time.[13] However, there has been a

[13] 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

reduction of 22 physicians practicing in medical specialties during the same period.[14] While the increase in the number of licenses and actively participating physicians alongside provider rate increases is promising, due to disparities in geographic location, enrollment with Medicaid, and availability of appointments, these 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, the island remains focused on ensuring access to services, a key element of which is offering a robust provider network. Some of the identified challenges to maintain 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.

6.1.1 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. Subsequently, FOMB approved an increase to the minimum Medicaid reimbursement for physician services to 100% of the Medicare Part B fee schedule, effective October 1, 2023.

Table 3 shows the total MCO payments and utilization for physician services for each fiscal year from October 2021 through March 2026.

Table 3: Payment for Physician Services

Total Payments for Physician Services from October 2021 Through March 2026 – Excluding Incurred But Not Reported (IBNR)

Timeline	Updates	Total Utilization	Total MCO Expenditures
Oct 2021 – Sept 2022[15]	Payment for physician services at a minimum of 70% of the Medicare Part B Fee Schedule	23,725,694	$691,861,708
Oct 2022 – Dec 2022[13]	Payment for physician services at a minimum of 70% of the Medicare	5,730,379	$168,569,674

[14] *Ibid.*

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

Total Payments for Physician Services from October 2021 Through March 2026 – Excluding Incurred But Not Reported (IBNR)

Timeline	Updates	Total Utilization	Total MCO Expenditures
	Part B Fee Schedule		
Jan 2023 – Sept 2023[15]	Increase payment for physician services to a minimum of 75% of the Medicare Part B Fee Schedule	19,514,773	$588,200,182
Oct 2023 – Sept 2024[15]	Increase payment for physician services to a minimum of 100% of the Medicare Part B Fee Schedule	24,801,045	$864,186,584
Oct 2024 – Sept 2025	Payment for physician services at a minimum of 100% of the Medicare Part B Fee Schedule	34,122,085	$1,012,590,133
Oct 2025 – Mar 2026[14]	Payment for physician services at a minimum of 100% of the Medicare Part B Fee Schedule	27,164,859	$432,102,857

6.1.2 Inpatient Hospital Payments

As noted in previous sections, Puerto Rico implemented an APR-DRG inpatient hospital reimbursement methodology effective January 1, 2026. In collaboration with Puerto Rico hospitals, PRHIA designed this DRG-based payment system, which strengthens complete and accurate coding and supports program oversight efforts, as well as PRHIA's ability to monitor services provided. Use of the DRG-based payment system modernizes inpatient hospital reimbursement and supports payment and delivery system transformation efforts.

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.

PRHIA continues to provide local hospitals and providers with transitional STAC payments to support the payment and delivery system transformation activities and help the inpatient hospitals have more predictable revenue. Table 4 shows the total expenditures for STAC

payments for FY 2022 – FY 2026. Since the APR-DRG change was implemented January 1, 2026, and inpatient hospital claims take longer to be fully reported, the APR-DRG payment data is limited and not available for this reporting period.

Table 4: 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
Oct 2025 - Sept 2026	Uniform increase for eligible inpatient hospital services	$76,100,308

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 to 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 March 2026.

Table 5: Sub-Capitation Payments Made from October 2021 to March 2026*

Timeline	Updates	Payments to PCPs
Oct 2021 – Sept 2022[16]	Minimum $4.50 PMPM	$68,802,253
Oct 2022 – Dec 2022[16]	Minimum $4.50 PMPM	$17,528,107
Jan 2023 – Sept 2023[16]	Minimum $18.00 PMPM	$212,313,152
Oct 2023 – Sept 2024[16]	Minimum $18.00 PMPM	$257,527,948
Oct 2024 – Sept 2025	Minimum $18.00 PMPM	$228,508,752
Oct 2025 - Mar 2026	Minimum $18.00 PMPM	$115,156,379

***These amounts are not compared the prior periods. They represent the sub-capitated amounts paid to providers per member per month (PMPM) during the time frames listed.**

6.1.4 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. Maintaining this increase for behavioral health services has helped provide a financial incentive for physicians and other providers to maintain Medicaid provider status and render behavioral health services to Medicaid beneficiaries. Furthermore, this enhanced 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 total MCO payments and member months for behavioral health services between October 2021 and March 2026.

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 is paid for by the MCOs to providers on a per-service basis according to a negotiated fee schedule. As with other physician services as of October of 2023, these negotiated fee schedules are required to be set at a minimum of 100% of the Medicare Part B fee schedule.

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

The total expenditures for these services are captured above in Table 5 along with other physician services.

Table 6: Total Expenditures and Member Months for Behavioral Health Services Between October 2021 and March 2026

Timeline	Updates	Member Months	Total MCO Expenditures
Oct 2021 – Sept 2022[17]	70% Medicare Part B as the minimum fee schedule for behavioral health services	15,116,934	$135,584,613
Oct 2022 – Dec 2022[17]	70% Medicare Part B as the minimum fee schedule for behavioral health services	3,834,793	$34,308,313
Jan 2023 – Sept 2023[17]	80% Medicare Part B as the minimum fee schedule for behavioral health services	11,459,371	$107,703,576
Oct 2023 – Sept 2024[17]	80% Medicare Part B as the minimum fee schedule for behavioral health services	13,918,074	$140,147,509
Oct 2024 – Sept 2025	80% Medicare Part B as the minimum fee schedule for behavioral health services	12,716,546	$100,141,688
Oct 2025 – Mar 2026	80% Medicare Part B as the minimum fee schedule for behavioral health services	6,413,585	$46,276,971

6.1.5 Reimbursement for Dental Services

To establish payment rates for Medicaid dental services that will support provider participation and an adequate provider network, Puerto Rico evaluated the billed amounts for services and other payer fee schedules. Utilizing this 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 is available to provide comprehensive dental services ranging from preventive care through surgical care. Dental providers are

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

necessary to support continued access to medically needed 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.

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

Timeline	Updates	Utilization	Total MCO Expenditures
Fiscal Year 2022			
Oct 2021 – Sept 2022[18]	Alternative fee schedule established for dental services provided by network dentists and dental surgeon providers	3,462,703	$86,344,107
Fiscal Year 2023			
Oct 2022 – Sept 2023	A minimum fee schedule established for dental services. Effective Jan 2023, a minimum fee schedule established for dental services incorporated in the capitation rates through a risk-based rate adjustment	3,738,958	$94,232,596
Fiscal Year 2024			
Oct 2023 – Sept 2024[18]	A minimum fee schedule established for dental services incorporated in the capitation rates through a risk-based rate adjustment	3,705,909	$101,200,217
Fiscal Year 2025			
Oct 2024 – Sept 2025 Error! Bookmark not defined.	A minimum fee schedule established for dental services incorporated in the capitation rates through a risk-based rate adjustment	3,795,430	$105,295,448
Oct 2025 - Mar 2026	A minimum fee schedule established for dental services incorporated in the capitation rates through a risk-based rate adjustment	1,732,455	$49,226,278

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

6.2 Expanded Services

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

Increased funding has 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 of funding to cover the expenditures. As awareness of the availability of the new services increased and the utilization of the services followed, the financial impact has been actively monitored 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 March 2026.

Table 8: Expenditures for Services Added in July 2024

Service	Total Expenditure to Date
Home Health	$136,878,794
DME	$145,208,720
Hospice	$5,902,903
NEMT	$10,497,794

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. Tables 9 and 10 include expenditures for adult dental services from January 2023 through March 2026.

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 were paid under a sub-capitated arrangement, resulting in no direct expenditure.

Table 9: Adult Dental Service Expenditures – Dentures

Timeline	Units	Total Expenditures
Jan 2023 – Sept 2023[19]	626	$16,426
Oct 2023 – April 2024[19]	2,650	$40,449
May 2024 – Sept 2024[20]	3	$0
Oct 2024 – Sept 2025[20]	10	$1,120
Oct 2025 - Mar 2026	24	$3,840

Table 10: Adult Dental Service Expenditures – Periodontal Scaling and Root Planing

Timeline	Units	Total Expenditures
Jan 2023 – Sept 2023[19]	0	$0
Oct 2023 – April 2024[19]	408	$966
May 2024 – Sept 2024[20]	1	$0
Oct 2024 – Sept 2025[20]	46	$1,340
Oct 2025 - Mar 2026	739	$54,167

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 11 shows the total expenditures for adult vaccines for 2023 as well as FY 2024, FY 2025, and FY 2026 through March 2026.

Table 11: Adult Vaccination Units and Expenditures

Timeline	Units	Total Expenditure
Jan 2023 – Sept 2023[21]	42,000	$4,631,000
Oct 2023 – Apr 2024[21]	51,000	$5,328,000
May 2024 – Sept 2024[22]	22,000	$3,076,000

[19] These periods have data run out through April 2024.
[20] These periods have data run out through July 2025.
[21] These periods have data run out through April 2024.
[22] These periods have data run out through July 2025.

Oct 2024 – Sept 2025[22]	130,151	$10,674,113
Oct 2025 - Mar 2026	72,932	$6,794,621

6.2.4 Medicaid Drug Rebate Program

On January 1, 2023, Puerto Rico joined the Medicaid Drug Rebate Program (MDRP). As part of the MDRP implementation, it also made drug coverage policies more flexible to allow the island to be more agile in responding to changes in pharmaceutical innovation and costs. Drug manufacturers are invoiced each quarter based 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 12 shows the drug rebates posted through July 31, 2026, by quarter, since PRMP joined the MDRP. The rebate totals posted include both the federal and local share.

Table 12: MDRP Rebate Amounts Received as of July 31, 2026

Period	Total
2023, Q1	$141,979,471
2023, Q2	$143,660,557
2023, Q3	$146,925,734
2023, Q4	$149,440,641
2024, Q1	$133,328,403
2024, Q2	$136,390,199
2024, Q3	$142,445,617
2024, Q4	$142,321,701
2025, Q1	$132,656,241
2025, Q2	$162,985,541
2025, Q3	$169,047,178
2025, Q4	$161,926,164

To further preserve Medicaid funding, Puerto Rico is participating in the CMS GENErating cost Reductions for U.S. Medicaid (GENEROUS) Model, which aims to reduce Medicaid prescription drug costs through innovative purchasing and cost-containment strategies. PRMP completed the application and entered into the required agreement effective September 2026.

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 13 shows utilization and expenditures for Hepatitis C treatment for FY 2021 – 2025 and through March 2026 for FY 2026.

Table 13: Hepatitis C Treatment Utilization and Expenditures

	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026 (Through March)
Unique Patients	591	710	704	649	646	420
Total Paid (Millions)	$14.6	$17.4	$17.8	$15.8	$15.1	$7.3
Services	1,182	1,376	1,380	1,248	1,258	674

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, an individual's first interaction with the program occurs when applying 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, details Medicaid requirements related to Medicaid eligibility, and outlines the application, evaluation, verification, and case maintenance processes. PRMP has established processes to help 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 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 applicant experience. The investments and reforms described throughout Section 6 have been made with the objective 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 increased funding appropriated through the CAA, 2023, Puerto Rico has implemented eligibility policy changes that have supported Medicaid coverage for low income residents. These changes include increasing the eligibility level used for Medicaid to 100% of the FPL. Prior to the increase, due to limited funds, Puerto Rico had to deflate the poverty level to a local poverty level (LPL), which meant residents had to have lower incomes to qualify for Medicaid compared with U.S. state residents.

The Medicaid program continues to look for opportunities to enhance coverage opportunities and improve the eligibility experience for individuals applying for Medicaid coverage. For example, this year Puerto Rico implemented 12-month postpartum coverage effective July 1.

Some Medicaid eligibility and policy changes included in Public Law 119-21 are also in the process of being implemented. This law 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.

Puerto Rico has implemented the Alien Medicaid provision (Section 71109) and confirmed that Medicaid eligibility is limited to only those groups explicitly identified in statute. This island is also currently reviewing eligibility processes to comply with Section 71112: Reducing State Medicaid Costs. Planned changes include a SPA submission, updates to the eligibility system (MEDITI3G) rules, eligibility policy manual, application materials, and online and printed Medicaid program information. PRMP will review federal guidance, as it is issued, to help ensure applicable program changes are made and 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 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 continues to work toward compliance with the new requirements under Section 5121 of the CAA, 2023, including implementing enhanced eligibility procedures, new pre- and post-release targeted case management (TCM), and diagnostic and screening services for eligible juveniles.

6.3.3 Reduced Beneficiary Cost Sharing

On January 1, 2023, Puerto Rico eliminated co-pays on all non-pharmacy services other than non-emergency use of the emergency room (ER). With the increased capped allotments received under the CAA, 2023 PRMP has maintained the elimination of the co-pays, which has helped improve the Medicaid member experience by reducing the barrier to accessing 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 nearly 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 health care services had been gaining popularity, during the public health emergency (PHE), those seeking health care services, as well as providers and payers, quickly pivoted to telemedicine as a reliable option to access services and continuity of care. PRMP, like other SMAs, adopted flexibilities offered by CMS to support telemedicine efforts and ensure beneficiaries received services.

Table 14 shows greater use of telemedicine for rendering services in FY 2020 and FY 2021 compared with FY 2022 to the present. The reduced use of telemedicine post-pandemic was expected, as some beneficiaries prefer in-person services. However, the higher expenditures during the PHE demonstrates the "readiness" of beneficiaries, providers, and PRMP to use telemedicine in similar emergency situations, such as following a hurricane. PRMP will continue tracking telemedicine expenditures to understand utilization trends and plan for future expanded use of telemedicine.

Table 14: Telemedicine Expenditures

Timeline	Total
FY 2020[23]	$8,185,000
FY 2021[23]	$9,966,000
FY 2022[23]	$4,260,000
FY 2023[23]	$3,335,000
FY 2024[24]	$2,736,000
FY 2025	$4,749,467
FY 2026[25]	$2,873,016

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

Act 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 an island-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

[23] These periods have data run out through April 2024.
[24] These periods have data run out through July 2025.
[25] This amount represents all MCO payments for the time period indicated, summarized from MedInsight using data paid through March 2026.

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-Colón 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 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.

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 allows the island 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.

The Centers of Excellence in Youth Diabetes Prevention has developed a program to prevent Type 2 diabetes in adolescents between the ages of 12-17, with pre-diabetes, insulin resistance or a family history of Type 2 diabetes.

If successful, the Centers of Excellence pilot program 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.

7. Looking Ahead to State-Like Medicaid Funding

Improvements made over the past several years with enhanced federal funds have allowed Puerto Rico to move closer to a Medicaid program where eligibility levels and the range of covered services are more closely aligned with state Medicaid programs. As Puerto Rico continues to plan and build on incremental progress, PRMP remains committed to contract reform and similar initiatives to combat FWA. The following funding changes and program improvements align directly with the priorities established by Governor González-Colón to strengthen Puerto Rico's health care infrastructure and secure comparable access to state Medicaid programs. With continued support from Congress and CMS, Puerto Rico seeks to amplify 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 the 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 to enhance the Medicaid program areas that lag behind state Medicaid agencies due to the limited funds. If Puerto Rico exhausts its capped federal allotment, it must fund its Medicaid operations exclusively with local funds. Temporary increases, while appreciated, prevent Puerto Rico from being able to rely on increases beyond an expiration date. This leaves the island, providers, and beneficiaries having to prepare for the possible reduction or termination of payment, eligibility, and service levels prior to each expiration date. Removing the federal capped allotment ceiling will allow Puerto Rico to focus on providing necessary, quality medical services to beneficiaries in the most efficient and responsible manner possible.

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

7.1.2 Federal Medical Assistance Percentage

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 lower than if the state FMAP formula were applied to Puerto Rico. If the FMAP for Puerto Rico was established using the same formula as SMAs, it would likely result in an FMAP of 83%. The FMAP formula for SMAs has been the standard for funding the Medicaid program and has supported compliance and adequate programs in the states. Puerto Rico would like the same opportunity to provide adequate and reliable services to beneficiaries and payments to its providers.

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

Based on federal statute (SSA §1923(f)(9)), Puerto Rico does not receive a separate Medicaid disproportionate share (DSH) allotment as SMAs, and, therefore, is unable to make DSH payments to hospitals. As noted in Section 6.1.2, Puerto Rico has an SDP for STAC hospital stays to compensate for operating losses resulting from 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 access in all areas of the island.

7.1.4 Low-Income Subsidy for Medicare Part D

According to federal statute (SSA §1860D-14(a)(3)(F)), Puerto Rico residents are not eligible for the Medicare Part D Low-Income Subsidy (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 residents obtain Medicare Part D assistance.

With state-like funding, policy and the LIS for Medicare Part D, dual-eligible Medicare beneficiaries residing in Puerto Rico with incomes up to 150% of FPL could receive assistance for Part D premiums, co-payments, 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. The focus of resolving gap findings has primarily been 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, the program is 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 the Transitional Medicaid and Emergency Medicaid coverage groups. With state-like funding, the island 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 income and disabilities who need 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 (completed in April 2026) to draft the MFP Operational Protocol (OP), which are due before the period of performance ends.

Moving through the remainder of the performance period ending September 30, 2028, PRMP will maintain its structured progression toward full operational readiness. MFP priority focus areas include:

1. **OP Submission:** Efforts include iterative drafting, financial modeling, and formal review with CMS federal officers.
2. **Stakeholder and Advisory Governance:** PRMP is formalizing the governance structure for the MFP Advisory Committee to support ongoing stakeholder participation, program review, and community integration throughout program development and implementation. The committee will review and provide recommendations on key planning documents, including the OP and MFP Work Plan; advise on the design of a feasible and person-centered MFP pilot; identify implementation challenges and coordination needs; provide feedback on proposed policies and operational approaches; and promote collaboration among beneficiaries, government agencies, providers, advocates, community organizations, and other partners across Puerto Rico's LTSS continuum.
3. **HCBS Infrastructure and Transition Planning for MFP Beneficiaries:** Efforts include establishing SOPs, eligibility verification mechanisms, and provider capacity frameworks.

By the conclusion of the performance period in September 2028, PRMP will have completed the statutory, administrative, and operational groundwork required for implementation once the OP is approved by CMS. 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. The need for these services is growing with Puerto Rico's aging population, and Puerto Rico urges Congress to include funding for LTSS to provide the necessary services for these beneficiaries.

7.2.3 Medicare Part B Buy-In

Federal statute (SSA § 1905[p][4][A]) 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 could 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 share how the increased federal Medicaid allotments provided under P.L. 117-328 have supported the PRMP, enabled the implementation of critical services and program improvements that expand beneficiary access to care, and further aligned the PRMP with federal requirements and state Medicaid program standards. This report describes how the island has used the Medicaid capped allotment and FMAP increases to improve access to health care for residents eligible for Medicaid and sustain changes made in prior years.

Puerto Rico recognizes the importance of transparency and is providing this report to demonstrate how the annual capped allotment received from P.L. 117-328 supports interim fiscal stability of the Medicaid program. It also shows the areas in which the lack of state-like Medicaid funding causes the PRMP to lag behind state Medicaid programs.

Over the past decade, Congress has funded temporary increases in FMAP and the annual capped allotment. The most recent increase appropriated for Puerto Rico in P.L. 117-328 has allowed the program to continue supporting Medicaid providers to deliver care while making foundational investments in program advancements. These increases have helped Puerto Rico sustain essential health care services and advance program improvements. To build on these accomplishments, Puerto Rico continues to seek congressional support for permanent, state-like Medicaid funding. Puerto Rico will continue to invest additional federal resources to help ensure the most vulnerable are eligible for program services, support an adequate provider network through sustainable reimbursement rates, and provide critical Medicaid services and benefits.

Puerto Rico continues to implement and explore options for program enhancements that improve processes and help ensure residents with low income can access Medicaid benefits. The Government of Puerto Rico remains committed to maturing the program by strengthening governance, developing technological capacity and infrastructure, improving program oversight, and increasing program transparency practices.

Puerto Rico looks forward to maintaining a strong relationship with its federal partners and Congress to sustain the PRMP's progress, support program options, explore options for improvement, and build on the current capped allotment funding with permanent state-like funding.

9. Appendices

Appendix A

Table 15: Acronyms and Terms

Acronym/Term	Definition
AAP	Adults' Access to Preventive/Ambulatory
ACA	Patient Protection and Affordable Care Act
ACIP	Advisory Committee on Immunization Practices
ADHD	Attention Deficit Hyperactivity Disorder
APD	Advance Planning Document
APR-DRG	All Patient Refined Diagnosis Related Group
ASES	Administración de Seguros de Salud
ASUME	Administración para el Sustento de Menores/Child Support Administration
AVS	Asset Verification System
BAFOs	Best and Final Offers
BOD	Board of Directors
CAA	Consolidated Appropriations Act
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
COR3	Central Office for Recovery, Reconstruction and Resiliency
DDI	Design, Development, and Implementation
DME	Durable Medical Equipment
DRG	Diagnosis Related Group
DSG	Data Systems Group
DSH	Disproportionate Share

Acronym/Term	Definition
EAP	Enhanced Allotment Plan
ED	Emergency Department
EDW	Electronic Data Warehouse
ePMO	Enterprise Project Management Office
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EVV	Electronic Visit Verification
FEMA	Federal Emergency Management Agency
FFCC	Former Foster Care Children
FFCRA	Families First Coronavirus Response Act
FFP	Federal Financial Participation
FY	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
GENEROUS	GENErating cost Reductions fOr U.S. Medicaid
HbA1c	Hemoglobin A1c
HCBS	Home and Community-Based Services
HCIP	Health Care Improvement Program
HEDIS	Health care Effectiveness Data and Information Set
HHS	Health & Human Services
HIE	Health Information Exchange
H.R.1	House of Representative 1
HRSA	Health Resources and Services Administration
HUD	Housing and Urban Development
IBNR	Incurred But Not Reported

Acronym/Term	Definition
LIS	Low-Income Subsidy
LPL	Local Poverty Level
LTSS	Long-Term Services and Supports
MAO	Medicare Advantage Organization
MAP	Medicaid Advantage Plus
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
MSP	Medicare Savings Program
MFP	Money Follows the Person
MiPE	Mi Portal Especial
MITA SS-A	Medicaid Information Technology Architecture State Self-Assessment
MLR	Medical Loss Ratio
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NEMT	Non-Emergency Medical Transportation
OBBBA	One Big Beautiful Bill Act
OBP	Outcomes-Based Procurement
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

Acronym/Term	Definition
P.L. 117-328	Public Law 117-328; Consolidated Appropriations Act, 2023
PAA	Proposal Adjudication Area
PAU	Proposal Adjudication Unit
PCP	Primary Care Provider
PEP	Provider Enrollment Portal
PERM	Payment Error Rate Measurement
PgMO	Program Management Office
PHE	Public Health Emergency
PMG	Primary Medical Group
PMPM	Per Member Per Month
POL	Procurement Oversight Lead
PPA	Principal Proposal Adjudicator
PRDoH	Puerto Rico Department of Health
PRFAA	Puerto Rico Federal Affairs Administration
PRHIA	Puerto Rico Health Insurance Administration
PRMFCU	Puerto Rico Medicaid Fraud Control Unit
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
RFP	Request for Proposal
RHT	Rural Health Transformation
RY	Reporting Year
SAMHSA	Substance Abuse and Mental Health Services Administration
SDP	State Direct Payment
SIU	Special Investigation Unit
SLMB	Specified Low-Income Medicare Beneficiaries

Acronym/Term	Definition
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
TCM	Targeted Case Management
TPL	Third-Party Liability

Appendix B

Puerto Rico Medicaid Managed Care Organization (MCO) Health Care Effectiveness Data and Information Set (HEDIS) Measures

Reporting Year 2025*

Table 16: Puerto Rico Medicaid Managed Care Organization HEDIS Measures

***Note for all tables**: "NR" represents "not reported," as some MCOs did not report values for certain measures. Numbers shown in parentheses indicate age ranges in years unless otherwise noted.*

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
Effective-ness of Care	Comprehensive Diabetes Care – BP Control (<140/90 mm Hg) (18 – 75) *Hybrid methodology is required, administrative is optional.	42.67	58.17	59.94	62.82
	Comprehensive Diabetes Care – Eye Exam (18 – 75) *Hybrid methodology is required, administrative is optional.	24.70	42.56	37.86	37.35
	Appropriate Treatment for Upper Respiratory Infection (3 Months – 17 Years)	76.45	74.17	24.30	69.41
	Appropriate Treatment for Upper Respiratory Infection (18 – 64)	67.89	55.85	42.16	55.23
	Appropriate Treatment for Upper Respiratory Infection (65+)	68.04	51.73	43.64	53.20
	Appropriate Treatment for Upper Respiratory Infection (Total)	72.12	65.95	31.70	62.63
	Kidney Health Evaluation for Patients With Diabetes (18 – 64)	39.53	51.72	52.15	36.03
	Kidney Health Evaluation for Patients With Diabetes (65 – 75)	38.06	53.44	51.99	38.90
	Kidney Health Evaluation for	39.19	54.06	60.61	39.41

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Patients With Diabetes (76 – 85)				
	Kidney Health Evaluation for Patients With Diabetes (Total)	39.30	52.07	52.69	36.68
	Diagnosed Mental Health Disorders (1 – 17)	18.17	27.21	29.15	23.74
	Diagnosed Mental Health Disorders (18 – 64)	13.68	23.26	22.96	20.68
	Diagnosed Mental Health Disorders (65+)	11.65	25.93	25.03	22.01
	Diagnosed Mental Health Disorders (Total)	14.76	24.43	24.88	21.53
	Diagnosed Substance Use Disorders – Alcohol Disorder (13 – 17)	0.02	0.03	0.01	0.03
	Diagnosed Substance Use Disorders – Alcohol Disorder (18 – 64)	0.21	0.81	0.85	0.70
	Diagnosed Substance Use Disorders – Alcohol Disorder (65+)	0.21	1.41	1.39	0.81
	Diagnosed Substance Use Disorders – Alcohol Disorder (Total)	0.18	0.77	0.78	0.64
	Diagnosed Substance Use Disorders – Opioid Disorder (13 – 17)	0.00	0.01	0.02	0.01
	Diagnosed Substance Use Disorders – Opioid Disorder (18 – 64)	0.49	0.65	0.65	0.60
	Diagnosed Substance Use Disorders – Opioid Disorder (65+)	0.05	0.28	0.50	0.22
	Diagnosed Substance Use Disorders – Opioid Disorder (Total)	0.39	0.55	0.56	0.50
	Diagnosed Substance Use Disorders – Other or Unspecified Drugs (13 – 17)	0.07	0.26	0.30	0.24
	Diagnosed Substance Use Disorders	0.48	1.80	1.78	1.33

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	– Other or Unspecified Drugs (18 – 64)				
	Diagnosed Substance Use Disorders – Other or Unspecified Drugs (65+)	0.08	1.06	1.96	0.94
	Diagnosed Substance Use Disorders – Other or Unspecified Drugs (Total)	0.40	1.58	1.61	1.18
	Diagnosed Substance Use Disorders – Any Substance Use Disorder (13 – 17)	0.09	0.59	0.31	0.25
	Diagnosed Substance Use Disorders – Any Substance Use Disorder (18 – 64)	1.04	0.82	2.65	2.12
	Diagnosed Substance Use Disorders – Any Substance Use Disorder (65+)	0.34	1.42	3.57	1.81
	Diagnosed Substance Use Disorders – Any Substance Use Disorder (Total)	0.87	0.78	2.43	1.90
Access and Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP) (20 – 44)	NR	0.01	NR	NR
	Adults' Access to Preventive/Ambulatory Health Services (AAP) (45 – 64)	NR	0.69	NR	NR
	Adults' Access to Preventive/Ambulatory Health Services (AAP) (65+)	NR	0.32	NR	NR
	Adults' Access to Preventive/Ambulatory Health Services (AAP) (Total)	NR	0.59	NR	NR

Appendix C

Puerto Rico Medicaid Child and Adult Core Set Reporting Measures

Reporting Year 2025

Table 17: Puerto Rico Medicaid Child and Adult Core Set Reporting Measures

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
Behavioral Health Care	Follow-Up Care for Children Prescribed ADHD *Medication – Initiation* (6 – 12)	43.57	46.82	52.10	58.89
	Follow-Up Care for Children Prescribed ADHD Medication – *Continuation and Management* (6 – 12)	38.71	63.13	62.86	73.58
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Blood Glucose* (1 – 11)	31.83	60.62	59.61	67.83
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Blood Glucose* (12 – 17)	38.52	66.71	64.26	68.29
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Blood Glucose* (Total)	35.34	63.93	62.14	68.09
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Cholesterol* (1 – 11)	32.73	48.69	47.84	59.97
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Cholesterol* (12 – 17)	38.52	57.22	54.43	67.48
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Cholesterol* (Total)	35.77	53.32	51.43	64.20
	Metabolic Monitoring for Children	45.65	47.88	45.49	52.27

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	and Adolescents on Antipsychotics – *Blood Glucose and Cholesterol* (1 – 11)				
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Blood Glucose and Cholesterol* (12 – 17)	49.18	56.67	53.44	61.54
	Metabolic Monitoring for Children and Adolescents on Antipsychotics – *Blood Glucose and Cholesterol* (1 – 17)	47.50	52.65	49.82	57.50
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1 – 11)	51.14	48.95	42.71	61.19
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12 – 17)	58.13	53.37	46.31	53.49
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1 – 17)	N/R	51.51	NR	NR
	Screening for Depression and Follow-Up Plan (12 – 17)	11.72	27.52	6.49	9.96
	Follow-Up After Emergency Department Visit for Substance Use – *7 day* (13 – 17)	0.00	40.00	0.00	12.50
	Follow-Up After Emergency Department Visit for Substance Use – 30 *day* (13 – 17)	0.00	45	4.29	25.00
	Follow-Up After Hospitalization for Mental Illness – *7-day* (6 – 17)	52.00	55.42	60.08	54.79
	Follow-Up After Hospitalization for Mental Illness – 30-day (6 – 17)	86.40	88.54	85.38	84.29

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Follow-Up After Emergency Department Visit for Mental Illness – *7-day* (6 – 17)	18.52	29.32	38.74	31.47
	Follow-Up After Emergency Department Visit for Mental Illness – *30-day* (6 – 17)	43.21	46.60	64.86	49.75
Care of Acute and Chronic Conditions	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months – 17 Years)	75.35	62.76	62.91	66.51
	Asthma Medication Ratio (5 – 11)	88.04	86.80	80.11	89.96
	Asthma Medication Ratio (12 – 18)	76.32	87.54	84.89	86.10
	Asthma Medication Ratio (Total)	87.71	87.04	81.48	88.56
Dental and Oral Health Services	Oral Evaluation, Dental Services (<3)	NR	35.63	35.63%	NR
	Oral Evaluation, Dental Services (3 – 5)	NR	66.74	66.74	NR
	Oral Evaluation, Dental Services (6 – 14)	NR	62.97	62.97	NR
	Oral Evaluation, Dental Services (15 – 20)	NR	50.65	50.65	NR
	Oral Evaluation, Dental Services (<21)	60.93	56.52	56.53	56.50
	Sealant Receipt on Permanent First Molars - One Sealant (1 – 10)	0.00	34.62	24.30	32.20
	Sealant Receipt on Permanent First Molars - Four Sealant (1 – 10)	0.00	24.91	15.55	5.74
	Topical Fluoride for Children – Dental or Oral Health Services (1 – 20)	0.05	15.43	13.82	17.71
Maternal and Perinatal Health	Contraceptive Care – Postpartum Women – *Most or Moderately Effective Contraceptive Method 3 days* (15 – 20)	0.00	1.54	1.67	1.31

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Contraceptive Care – Postpartum Women – *Most or Moderately Effective Contraceptive Method 90 days* (15 – 20)	0.17	24.23	25.83	21.57
	Contraceptive Care – All Women – *Most or Moderately Effective Contraceptive Method* (15 – 20)	0.00	4.63	4.43	3.90
	Contraceptive Care – Postpartum Women – *Long-Acting Reversible Contraception Method 3 days* (15 – 20)	0.00	0.00	0.00	0.00
	Contraceptive Care – Postpartum Women – *Long-Acting Reversible Contraception Method 90 days* (15 – 20)	0.17	3.08	2.50	2.61
	Contraceptive Care – All Women Ages – *Long-Acting Reversible Contraception Method* (15 – 20)	0.00	0.06	0.18	0.05
	Postpartum Depression Screening (<21)	NR	0.00	38.46	0.00
	Prenatal Immunization Status-Influenza (<21)	NR	14.04	NR	NR
	Prenatal Immunization Status-Tdap (<21)	NR	16.01	NR	NR
	Prenatal Immunization Status-Combination (<21)	NR	8.11	NR	NR
	Prenatal and Postpartum Care: Timeliness of Prenatal Care (<21) *Hybrid methodology is required, administrative is optional.	0.00	75.83	89.13	2.21
	Prenatal and Postpartum Care: Postpartum Care (<21) *Hybrid methodology is required,	0.00	52.58	54.35	33.25

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	administrative is optional.				
Primary Care Access and Preventive Care	Chlamydia Screening in Women (16-20)	60.17	65.18	61.57	59.38
	Childhood Immunization Status – *Combo 10* (0 – 2)	0.00	0.95	1.34	8.78
	Childhood Immunization Status – *Combo 3* (0 – 2)	0.49	39.03	7.17	51.17
	Childhood Immunization Status – Combo 7 (0 – 2)	0.36	32.83	5.42	44.28
	Childhood Immunization Status – *DTaP* (0 – 2)	4.67	49.63	36.77	61.12
	Childhood Immunization Status – Hep A (0 – 2)	46.70	77.38	78.85	83.32
	Childhood Immunization Status – *Hep B* (0 – 2)	2.29	54.58	13.69	64.99
	Childhood Immunization Status – *HiB* (0 – 2)	16.46	71.52	57.23	79.05
	Childhood Immunization Status – *Influenza* (0 – 2)	2.51	10.29	15.68	13.26
	Childhood Immunization Status – *MMR* (0 – 2)	38.18	76.50	57.98	81.99
	Childhood Immunization Status – *IPV* (0 – 2)	9.78	62.37	45.98	73.33
	Childhood Immunization Status – *Pneumococcal Conjugate* (0 – 2)	4.85	47.41	34.85	58.42
	Childhood Immunization Status – *Rotavirus* (0 – 2)	6.91	49.83	37.12	59.39
	Childhood Immunization Status – *VZV* (0 – 2)	38.49	76.89	67.25	80.70
	Developmental Screening in the First Three Years of Life – *Total* (1 – 3)	0.00	0.00	35.67	33.37

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Developmental Screening in the First Three Years of Life – *12 Months* (12 Months)	0.00	0.00	32.69	24.44
	Developmental Screening in the First Three Years of Life – *24 Months* (24 Months)	0.00	0.00	38.68	38.88
	Developmental Screening in the First Three Years of Life – *36 Months* (36 Months)	0.00	0.00	36.04	37.14
	Immunizations for Adolescents – HPV (1 – 13)	17.34	47.13	63.83	61.48
	Immunizations for Adolescents – Combo 1 (1 – 13)	41.44	66.73	83.26	80.37
	Immunizations for Adolescents – Meningococcal (1 – 13)	42.59	68.58	83.63	81.40
	Immunizations for Adolescents – Tdap (1 – 13)	42.50	67.88	84.29	81.17
	Immunizations for Adolescents – Combo 2 (1 – 13)	16.52	45.26	63.21	60.50
	Well-Child Visits in the First 30 Months of Life (Birth – 15)	3.19	12.16	14.45	18.94
	Well-Child Visits in the First 30 Months of Life 15 months – 30 months)	21.46	47.81	60.23	62.67
	Child and Adolescent Well-Care Visits (3 – 11)	25.97	53.73	59.98%	57.91
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *BMI Percentile* (3 – 11)	0.08	39.98	63.42	65.08
	Weight Assessment and Counseling for Nutrition and Physical Activity for	0.10	42.09	61.68	60.43

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Children/Adolescents – *BMI Percentile* (12 – 17)				
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *BMI Percentile* (3 – 17)	NR	40.88	NR	NR
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Nutrition* (3 – 11)	2.07	31.59	52.92%	58.16
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Nutrition* (12 – 17)	2.53	32.31	50.07%	53.37
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Nutrition* (3 – 17)	NR	31.90	NR	NR
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Physical Activity* (3 – 11)	0.33	25.01	42.87	41.18
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Physical Activity* (12 – 17)	0.48	26.73	42.55	38.32
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Physical Activity* (3 – 17)	NR	25.74	NR	NR

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
Behavioral Health Care	Screening for Depression and Follow-Up Plan (18 – 64)	10.46	19.48	4.12	9.25
	Screening for Depression and Follow-Up Plan (65+)	NR	21.84	4.22	9.67
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – *7 days* (18 – 64)	5.59	16.98	8.46	20.45
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – *7 days* (65+)	8.33	9.52	22.22	21.43
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence Substance Use – *30 days* (18 – 64)	15.53	27.99	23.08	29.17
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – *30 days* (65+)	16.67	14.29	22.22	28.57
	Follow-Up After Hospitalization for Mental Illness – *7-day follow-up for ED visit: Ages 18 and older* (18 – 64)	40.47	47.11	46.10	52.02
	Follow-Up After Hospitalization for Mental Illness – *7-day follow-up for ED visit: Ages 18 and older* (65+)	50.00	43.42	21.21	51.85
	Follow-Up After Hospitalization for Mental Illness – *30-day follow-up for ED visit: Ages 18 and older* (18 – 64)	68.37	75.70	73.87	76.39
	Follow-Up After Hospitalization for Mental Illness – *30-day follow-up for ED visit: Ages 18 and older (65+)*	83.33	76.31	57.58	70.37

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Follow-Up After Emergency Department Visit for Mental Illness – *7-day follow-up for ED* (18 – 64)	8.95	20.00	20.10	19.50
	Follow-Up After Emergency Department Visit for Mental Illness – *7-day follow-up for ED* (65+)	9.84	19.40	23.08	20.90
	Follow-Up After Emergency Department Visit for Mental Illness – 30-*day follow-up for ED* (18 – 64)	26.44	37.38	36.96	37.91
	Follow-Up After Emergency Department Visit for Mental Illness – 30-*day follow-up for ED* (65+)	21.31	45.52	43.59	44.03
	Diabetes Care for People with Serious Mental Illness – *Glycemic Status >9.0%* (18 – 64) *Administrative methodology is required, hybrid is optional.	79.83	19.39	73.60	20.47
	Diabetes Care for People with Serious Mental Illness –Glycemic Control *>9.0%* (65 – 75) *Administrative methodology is required, hybrid is optional.	NR	13.13	84.85	18.12
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – Alcohol* (18 – 64)	73.03	25.95	25.88	23.29
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – Alcohol* (65+)	50.00	14.29	20.00	14.89
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation* –	89.91	45.19	39.11	47.69

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Opioid Abuse or Dependence (18 – 64)				
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – Opioid Abuse or Dependence* (65+)	100.00	9.09	0.00	16.67
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – Other Drugs* (18 – 64)	87.11	24.32	21.67	27.49
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – Other Drugs* (65+)	100.00	11.21	3.19	10.74
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – TOTAL* (18 – 64)	84.75	27.32	25.18	29.16
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Initiation – TOTAL* (65+)	63.16	12.86	9.71	12.78
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – Alcohol* (18 – 64)	10.11	4.97	4.00	5.00
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – Alcohol* (65+)	0.00	1.65	0.00	0.00
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment –	21.56	15.72	13.37	21.85

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Engagement – Opioid Abuse or Dependence (18 – 64)				
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – Opioid Abuse or Dependence* (65+)	0.00	0.00	0.00	8.33
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – Other Drugs* (18 – 64)	13.16	5.38	3.84	5.41
	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – Other Drugs* (65+)	0.00	1.87	0.00	0.83
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – TOTAL* (18 – 64)	14.73	6.52	5.16	7.74
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – *Engagement – TOTAL* (65+)	0.00	1.61	0.00	0.88
	Use of Pharmacotherapy for Opioid Use Disorder – *Total* (18 – 64)	0.00	43.21	51.31	43.71
	Use of Pharmacotherapy for Opioid Use Disorder – *Total* (65+)	NR	21.95	29.73	33.82
	Use of Pharmacotherapy for Opioid Use Disorder – *Buprenorphine* (18 – 64)	NR	42.93	50.93	42.82
	Use of Pharmacotherapy for Opioid Use Disorder – *Buprenorphine* (65+)	NR	21.95	29.73	32.35
	Use of Pharmacotherapy for Opioid	NR	0.28	0.75	1.05

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Use Disorder – *Oral Naltrexone* (18 – 64)				
	Use of Pharmacotherapy for Opioid Use Disorder – *Oral Naltrexone* (65+)	NR	0.00	0.00	1.47
	Use of Pharmacotherapy for Opioid Use Disorder – *Long-Acting, Injectable Naltrexone* (18+)	NR	0.00	0.00	0.00
	Use of Pharmacotherapy for Opioid Use Disorder – *Long-Acting, Injectable Naltrexone* (65+)	NR	0.00	0.00	0.00
	Use of Pharmacotherapy for Opioid Use Disorder – *Methadone* (18+)	NR	0.00	0.00	0.00
	Use of Pharmacotherapy for Opioid Use Disorder – *Methadone* (65+)	NR	0.00	0.00	0.00
	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (18+)	1.10	77.34	77.00	79.63
	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications – *Total* (18 – 64)	57.36	74.39	71.35	68.85
	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications – *Schizophrenia* (18 – 64)	NR	75.49	NR	67.38
	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications – *Bipolar* (18 – 64)	NR	72.86	NR	71.54
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18 – 64)	58.02	46.63	44.88	50.08

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	58.82	35.32	31.67	47.06
	Asthma Medication Ratio (19 – 64)	88.48	73.22	74.84	72.51
	Controlling High Blood Pressure (18 – 64) *Hybrid methodology is required, administrative is optional.	43.80	66.79	68.16	68.16
Care of Acute and Chronic Conditions	Controlling High Blood Pressure (65+) *Hybrid methodology is required, administrative is optional.	38.60	60.38	62.50	69.57
	Concurrent Use of Opioids and Benzodiazepines (18 – 64)	0.11	11.73	11.32	0.39
	Concurrent Use of Opioids and Benzodiazepines (65+)	NR	5.56	14.81	0.00
	Glycemic Status Assessment: Glycemic status <8% (18 – 75) *Hybrid methodology is required, administrative is optional.	29.03	34.18	26.52	45.11
	Glycemic Status Assessment: Glycemic status >9% (18 – 75) *Hybrid methodology is required, administrative is optional.	73.44	60.92	69.59	47.88
	HIV Viral Load Suppression (18 – 64)	NR	7.25	0.00	2.05
	HIV Viral Load Suppression (65+)	NR	6.34	0.00	1.65
	Plan All-Cause Readmissions (18+)	7.16	83.39	6.84	95.21
	Diabetes Short-Term Complications Admission Rate (18 – 64) *per 100,000 beneficiary months	51.92	6.76	7.75	5.89

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Diabetes Short-Term Complications Admission Rate (65+) *per 100,000 beneficiary months	36.36	5.81	3.01	3.87
	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (40 – 64) *per 100,000 beneficiary months	23.89	25.28	21.82	17.54
	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (65+) *per 100,000 beneficiary months	25.00	36.63	21.72	21.69
	Heart Failure Admission Rate (18 – 64) *per 100,000 beneficiary months	27.78	10.34	11.63	9.43
	Heart Failure Admission Rate (65+)	28.57	51.81	68.27	20.52
	Asthma in Younger Adults Admission Rate (18 – 39) *per 100,000 beneficiary months	13.31	7.03	3.49	5.78
	Adult Immunization Status-Influenza (19+)	1.19	8.03	7.62	7.39
	Adult Immunization Status-Td/Tdap (19+)	3.41	20.22	18.08	16.03
	Adult Immunization Status-Zoster (19+)	0.14	3.92	3.56	3.79
	Adult Immunization Status-Pneumococcal (66+)	3.86	23.25	19.71	17.41
Primary Care Access and Preventive Care	Breast Cancer Screening (18 – 64)	42.35	67.79	70.98	64.15
	Breast Cancer Screening (65+)	40.15	63.64	63.37	57.84
	Cervical Cancer Screening (18 – 64)	40.31	53.49	55.28	52.73
	Chlamydia Screening in Women (21 – 24)	56.71	68.14	67.98	54.80

Measure Domain	Measure Name	First Medical	Triple S	PSM	MMM
	Colorectal Cancer Screening (46 – 50)	30.12	35.78	38.28	33.00
	Colorectal Cancer Screening (51 – 65)	41.40	46.21	52.04	43.33
	Colorectal Cancer Screening (66 – 75)	43.19	47.25	51.51	42.72