

How States Would Fare Under Medicaid Block Grants or Per Capita Caps: Lessons from Puerto Rico

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ABSTRACT

ISSUE: Some federal and state policymakers support converting Medicaid into a block grant or “per capita cap” program.

GOALS: Examine how Puerto Rico’s long-standing experience operating under a Medicaid block grant may predict how states would fare under block grants and per capita caps that limit federal funding.

METHODS: Review of available data sources, policy analysis, and research related to Puerto Rico’s Medicaid program.

KEY FINDINGS AND CONCLUSION: Puerto Rico’s block grant funding led to large federal Medicaid funding shortfalls, which contributed to the commonwealth’s fiscal and debt crisis. Puerto Rico’s Medicaid program is already far less comprehensive than state Medicaid programs, with certain groups and benefits uncovered. Temporary federal Medicaid funding increases during the past decade sustained Puerto Rico’s existing program but led to only modest improvements in coverage and access. Puerto Rico’s experience suggests that capped federal Medicaid funding could shift significant costs to states and result in cuts to eligibility, benefits, and provider payments. One policy option that could facilitate substantial improvements to Puerto Rico’s Medicaid program would involve replacing Puerto Rico’s block grant with uncapped funding.

TOPLINES

- ▶ Puerto Rico’s Medicaid block grant has contributed to the commonwealth’s fiscal and debt crisis.
- ▶ Capping federal funding of Medicaid could shift significant costs to states, as it has done in Puerto Rico.



INTRODUCTION

In 2017, the Trump administration and congressional Republicans proposed converting Medicaid into a block grant or a “per capita cap” program. Under either option, federal funding would be capped, irrespective of states’ actual costs, with states receiving a fixed amount of funding for their Medicaid programs (see box). Although that effort has been unsuccessful in Congress, the Trump administration has continued to support block grants and per capita caps as part of its annual budgets.¹ In addition, in early 2020, the Trump administration issued guidance encouraging states to apply for Medicaid waivers that impose funding caps. One state, Oklahoma, has applied for such a waiver (though it subsequently withdrew its application) and another state, Tennessee, is seeking a block grant waiver outside of the guidance.²

Before such fundamental, structural financing changes are pursued, it is worth considering the case of Puerto Rico, which provides a real-life example of how states would likely fare under Medicaid block grants or per capita caps. Unlike the states and the District of Columbia, federal Medicaid funding for Puerto Rico and the other territories — American Samoa, Guam, the Northern Marianas Islands, and the U.S. Virgin Islands — is provided through a block grant.

FINDINGS

Puerto Rico’s Block Grant Financing Leads to Large Federal Medicaid Funding Shortfalls

Puerto Rico’s only permanent federal Medicaid funding is through its annual block grant, which provides federal funding well below the levels that Puerto Rico needs. For example, from 2012 to 2019, the annual block grant financed, on average, only 15 percent of Puerto Rico’s total Medicaid spending (Exhibit 1), even though Puerto Rico’s federal matching rate (known as the Federal Medical Assistance Percentage, or FMAP) is 55 percent.³ This is because of two factors: Puerto Rico’s initial block grant amounts were set at arbitrary, low levels unrelated to Puerto Rico’s actual spending needs, and the block grant is annually adjusted at a rate that fails to keep pace with Puerto Rico’s Medicaid costs.⁴

HOW MEDICAID BLOCK GRANTS AND PER CAPITA CAPS WORK

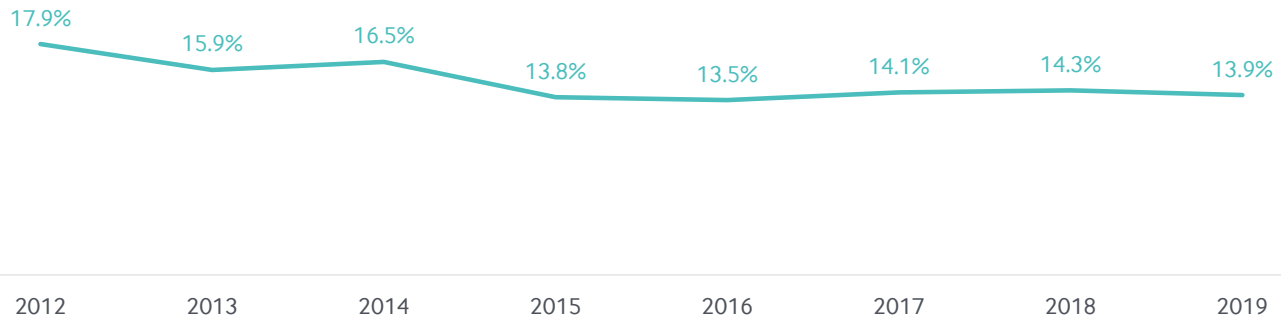
Under the existing federal–state financial partnership, the federal government pays a fixed percentage of states’ Medicaid costs, whatever those costs are. If state Medicaid costs rise because of increased enrollment or higher per-beneficiary costs, the federal government shares in those higher costs. Conversely, if state Medicaid costs fall, the federal government shares in those savings. This flexible financing structure ensures that federal Medicaid funding is responsive to state needs.

In contrast, a financing structure using block grants or per capita caps limits federal funding, irrespective of states’ actual costs. Under a block grant, states would receive a fixed amount of overall federal funding for their Medicaid programs. Under a per capita cap, states would receive a fixed amount of federal Medicaid funding for each beneficiary. Under either mechanism, states would be responsible for 100 percent of all Medicaid costs in excess of the funding cap.

Medicaid block grants and per capita caps are intended to produce federal savings by reducing how much the federal government spends on Medicaid, relative to current law. This is typically achieved by annually adjusting the capped funding amounts at a rate that does not keep pace with states’ Medicaid costs. This means that the federal funding cuts tend to grow much larger over time.

These cuts are even greater if Medicaid costs rise faster than anticipated because of unforeseen events such as economic downturns, pandemics and other public health emergencies, natural disasters, or expensive new drugs or treatments. Under capped funding, states are at full risk for these higher costs. No additional federal Medicaid funding would be automatically provided to states, which would exacerbate the effect of the Medicaid funding cuts they would face under a block grant or per capita cap.

Exhibit 1. Permanent Federal Block Grant Funding as Share of Total Medicaid Spending in Puerto Rico, 2012–2019



Data: Georgetown University Center for Children and Families (CCF) analysis.

Unlike the states, Puerto Rico does not automatically receive additional federal Medicaid funding when costs rise faster than expected. In recent years, Medicaid costs have increased in Puerto Rico because of economic downturns, public health emergencies like the Zika outbreak and the COVID-19 pandemic, and natural disasters like Hurricane Maria and earthquakes.

In addition, Puerto Rico's FMAP is set low compared to state levels. If Puerto Rico's FMAP was determined through the same formula used to calculate the FMAP for states (based on per capita income relative to national per capita income), it would equal 83 percent, the statutory maximum, not 55 percent (Exhibit 2).⁵ In other words, even if Puerto Rico did not receive its Medicaid funding through a block grant, the federal government would still pick up a much lower share of Medicaid costs — 55 percent — than it would if Puerto Rico were fully treated as a state (an 83% FMAP and uncapped funding).⁶

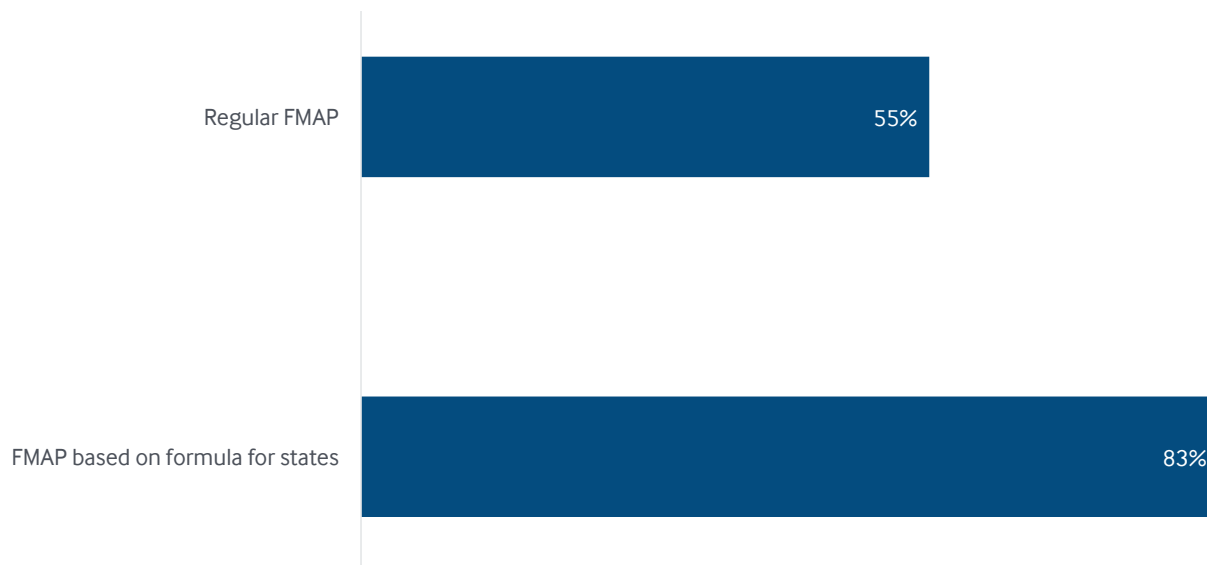
Puerto Rico's low block grant funding levels and reduced FMAP have necessitated greater contributions by the commonwealth government to sustain its Medicaid program over the decades. This has been a key factor

in Puerto Rico's severe, long-term fiscal problems and debt crisis.⁷ Puerto Rico's rapidly deteriorating debt burden led to Congress passing legislation in 2016 that gave a new Financial Oversight and Management Board broad authority over Puerto Rico's budget (including its Medicaid program) and debt restructuring.⁸

Meanwhile, Congress has provided multiple, temporary infusions of Medicaid funding since 2011 to assist Puerto Rico. Most recently, Congress enacted two years of additional funding in December 2019. These increases were essential to help address some of the block grant shortfalls over the past decade and avert Medicaid cuts, as Puerto Rico instituted overall budget cuts in response to its fiscal and debt crisis.⁹

As part of these funding increases, Congress also has temporarily increased Puerto Rico's FMAP from its regular rate of 55 percent: in the aftermath of Hurricane Maria, it was 100 percent, and it is now 76 percent through the end of fiscal year 2021. These funding increases have allowed Puerto Rico only to sustain its existing program, rather than make major improvements.

Exhibit 2. Puerto Rico's Regular FMAP Compared to Statutory Formula for States



Note: FMAP = Federal Medical Assistance Percentage.

Data: U.S. Government Accountability Office.

Puerto Rico's Medicaid Program Is Far Less Generous Than State Medicaid Programs

Medicaid is the backbone of health coverage in Puerto Rico, given residents' high poverty rate, limited access to employer-sponsored insurance, and greater health needs (Exhibit 3). About 1.4 million Puerto Ricans are covered by Medicaid and the Children's Health Insurance Program (CHIP) today.¹⁰ In 2018, 47.8 percent of all Puerto Ricans had Medicaid coverage, and 60.8 percent of children younger than age 19 were enrolled in Medicaid and CHIP. That kept the uninsured rate low at 6.4 percent for all residents and at less than 3 percent for children in 2018.¹¹

Restricted eligibility. Puerto Rico's Medicaid income eligibility levels are considerably lower than the eligibility levels in the states. Like other territories, Puerto Rico uses its own, sharply lower poverty level (known as the Puerto Rico Poverty Level, or PRPL) to determine Medicaid and CHIP eligibility (Exhibit 4).¹²

While Puerto Rico's Medicaid program covers pregnant women, parents, other adults, and children up to 138 percent of PRPL, this translates to only 59.6 percent of

the federal poverty level (FPL) for an individual and 44.8 percent of FPL for a family of four (as of July 2020).¹³ That is far below the federal minimum level for pregnant women and children and below the Medicaid expansion eligibility level of 138 percent of FPL (Exhibit 5). (Through CHIP-funded Medicaid, Puerto Rico covers children up to 88% of FPL, even though the median CHIP eligibility level nationwide is 255% of FPL.¹⁴)

Unlike FPL, which is adjusted annually, PRPL has been frozen at the same level since January 2014.¹⁵ As a result, the Medicaid income eligibility levels decline in real terms every year.

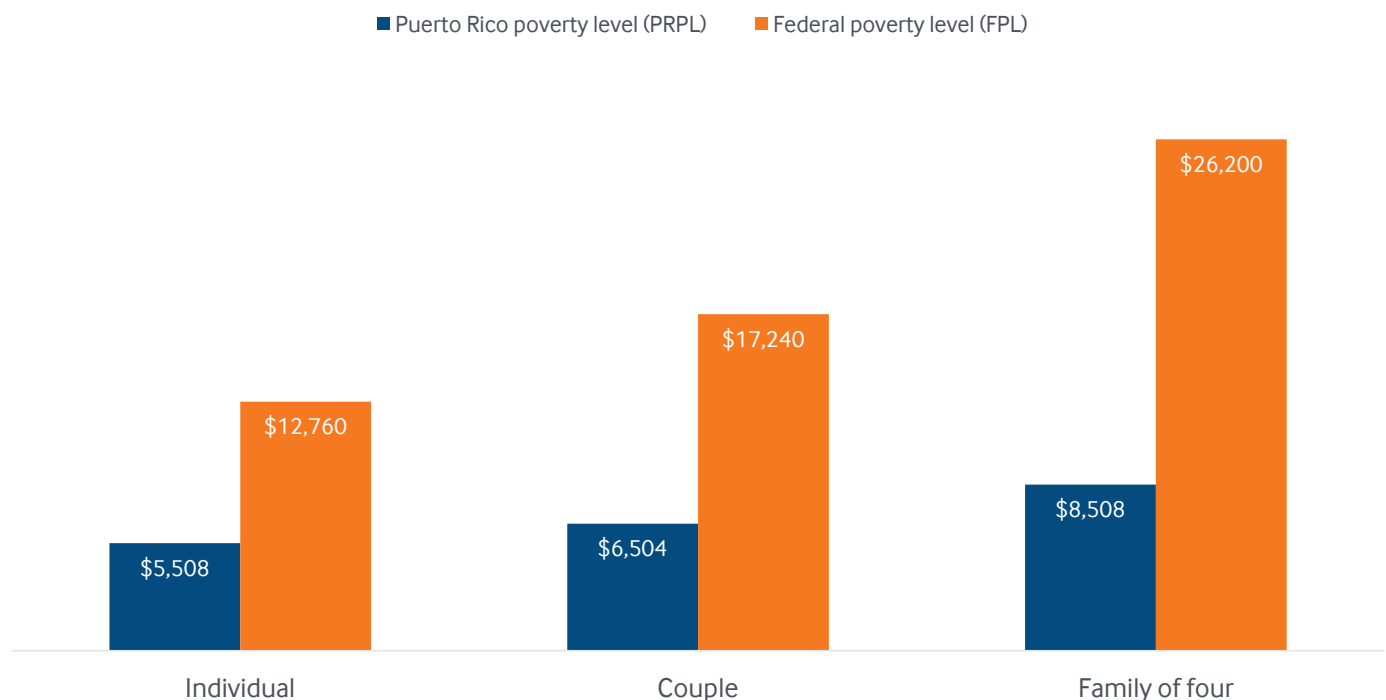
In addition, Puerto Rico's Medicaid program does not cover certain mandatory eligibility groups, such as low-income seniors and people with disabilities who are also enrolled in Medicare — who would otherwise be eligible for the Medicare Savings Programs (MSPs) but not for full Medicaid. The MSPs, which states are required to provide, pay for Medicare Part B premiums (equaling \$1,735 in 2020) for those with incomes up to 135 percent of FPL (and also deductibles and other cost-sharing for those with incomes below FPL).

Exhibit 3. Comparison of Poverty and Income, Health Coverage Source, and Health Conditions, Puerto Rico and Median State

	Puerto Rico	United States
Poverty and income (2018)		
Share of population in poverty	43.1%	13.1%
Share of children under age 18 in poverty	56.9%	18.0%
Median income	\$20,296	\$61,937
Health coverage source (2018)		
Share of population with private insurance	38.9%	67.5%
Share of population with public insurance	61.9%	35.6%
	Puerto Rico	Median state
Health conditions (2018)		
Share of adults diagnosed with high blood pressure	44.7%	32.3%
Share of adults diagnosed with diabetes	15.5%	10.9%
Share of adults diagnosed with asthma	18.5%	14.7%
Incidence of HIV/AIDS per 100,000	566.8	372.8

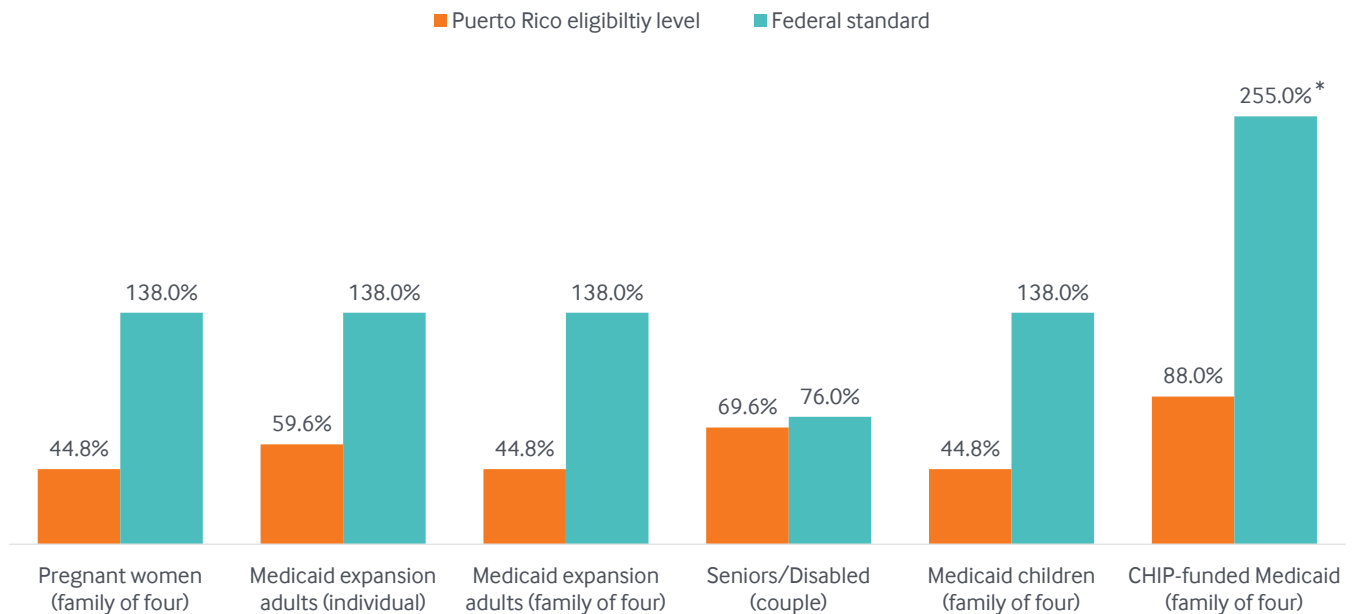
Data: Georgetown University Center for Children and Families (CCF) analysis of American Community Survey (ACS), Puerto Rico Community Survey (PRCS), Behavioral Risk Factor Surveillance System (BRFSS), and National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) data.

Exhibit 4. Comparison of Puerto Rico Poverty Level and Federal Poverty Level, July 2020



Data: Georgetown University Center for Children and Families (CCF) analysis. Comparison as of July 2020.

Exhibit 5. Comparison of Medicaid Eligibility Levels in Puerto Rico to Federal Standards, Percent of Federal Poverty Level (FPL), July 2020



* Federal = median state CHIP eligibility.

Data: Georgetown University Center for Children and Families (CCF) analysis. Comparison as of July 2020.

Limited coverage of services and drugs. Altogether, the Medicaid program in Puerto Rico does not cover seven of the 17 benefits that federal law requires states to cover. These excluded services include:

- nursing home care
- home health care
- nonemergency medical transportation
- nurse practitioner services
- nurse midwife services
- emergency care for individuals ineligible because of immigration status
- freestanding birth center services.

Puerto Rico's Medicaid program also does not cover optional home- and community-based long-term services and supports (LTSS), such as personal care and case management services. Other optional services also are excluded, like hospice care, private-duty nursing services, and services provided by an intermediate care facility for individuals with intellectual disabilities.¹⁶

Moreover, unlike the states, Puerto Rico is not part of the Medicaid Drug Rebate Program, which significantly reduces states' Medicaid prescription drug costs.¹⁷ This also means that Puerto Rico is not required to cover most outpatient prescription drugs. Instead, Puerto Rico uses a closed drug formulary (only a limited number of drugs are covered) to limit costs. But this also has an adverse impact on beneficiary access to medications. For example, Puerto Rico did not cover any drugs curing hepatitis C until 2020, even though such drugs first entered the U.S. market in 2014.¹⁸

Low provider reimbursement. Medicaid provider reimbursement rates in Puerto Rico are generally very low, which has likely contributed to the ongoing outmigration of health professionals and a financially stressed health care infrastructure.¹⁹ For example, Medicaid physician payment rates in 2016 were 19 percent of Medicare rates for primary care services and 50 percent of Medicare for obstetric care, well below the national average of 66 percent of Medicare for primary care and 81 percent of Medicare for obstetric care.²⁰

Low reimbursement rates may at least partially explain why 72 of Puerto Rico's 78 municipalities have been designated as medically underserved areas, and 32 municipalities have been designated as primary care shortage areas.²¹ And unlike the states, Puerto Rico does not have a Medicaid Disproportionate Share Hospital (DSH) program to provide supplemental payments that support safety-net hospitals serving Medicaid and uninsured patients.²²

Additional Federal Funding Has Led to Some Program Improvements

Congress's most recent infusion of federal Medicaid funding significantly increased Puerto Rico's block grant to a total of \$2.6 billion in fiscal year 2020 and \$2.7 billion in 2021.²³ The 2020 amount is more than seven times the block grant that would have otherwise been provided in that year.²⁴ Congress provided Puerto Rico an additional \$200 million for each of those two years to increase provider payment rates. Congress also increased Puerto Rico's matching rate to 76 percent for those two years, rather than the regular matching rate of 55 percent.²⁵

These enhanced federal funding levels have permitted Puerto Rico to make some modest improvements in its Medicaid program. For example, Puerto Rico's Medicaid program began covering its first drug to cure hepatitis C in March 2020.²⁶ Puerto Rico is also temporarily increasing (through September 30, 2021) physician payments to a minimum of 70 percent of Medicare rates, which is more in line with the national average for state Medicaid programs. It also is temporarily increasing capitation rates to primary care medical groups and payments to hospitals.²⁷

Finally, if Puerto Rico receives future approval from the Financial Oversight and Management Board, it plans to significantly raise its Medicaid eligibility levels over the long term. It would do so by submitting a Medicaid state plan amendment to the federal government increasing the PRPL used for Medicaid eligibility to 85 percent of FPL: an increase of two to two-and-a-half times the current PRPL. Under this proposed change, PRPL would also no longer be frozen and would be adjusted annually

for general inflation.²⁸ The Financial Oversight and Management Board has very recently permitted Puerto Rico to increase the PRPL, but only through September 30, 2021, when the latest federal Medicaid funding increase expires.²⁹

POLICY IMPLICATIONS

Two lessons emerge from examining the financing of Puerto Rico's Medicaid program.

First, converting federal Medicaid financing to block grants or per capita caps would likely result in large federal funding cuts that would increase for states over time. That, in turn, could lead to cuts to eligibility, benefits, and provider rates that could result in state Medicaid programs experiencing many of the serious challenges Puerto Rico faces, especially if states are given flexibility to cut eligibility and benefits in ways not permitted today. As a result, the incoming Biden administration could consider withdrawing the federal guidance encouraging states to apply for Medicaid waivers that impose such funding caps.

Second, providing sufficient federal Medicaid funding to Puerto Rico on a permanent basis — not just to sustain but also to expand its program — would help ensure that Puerto Rico could make significant improvements that place it more in line with the states. This would increase access to needed care for Puerto Rico's residents, who are disproportionately low-income and predominantly Latino (98.7% of Puerto Rico's residents are Latino, compared with 18.3% nationally).³⁰ This also would provide considerable relief for Puerto Rico's overall budget and help it emerge from its fiscal and debt crisis, which has been further exacerbated by the health and economic impact of the COVID-19 pandemic.

One policy option that may be considered in Congress would involve permanently eliminating Puerto Rico's federal funding cap. Under a House bill introduced last year (H.R. 3371), the federal government would pay a fixed percentage of Puerto Rico's Medicaid costs without limit (as it does for the states), with the matching rate equaling 83 percent based on Puerto Rico's low per capita income relative to the nation.

In exchange, Puerto Rico would be required to develop a transition plan describing the improvements it would make to come into fuller compliance with federal Medicaid requirements. Changes would likely include expanding eligibility to mandatory groups and providing nursing home care, home health care, nonemergency medical transportation, and comprehensive mental health care. If Puerto Rico fails to roll out these changes by certain milestones, its matching rate would be reduced. To help Puerto Rico plan for and implement these improvements, the bill also would temporarily increase the matching rate for administrative costs.³¹

The same approach could be applied to the other territories. The scheduled expiration of the latest Medicaid funding increases for Puerto Rico and the other territories in 2021 offers an opportunity to make similar Medicaid financing changes in American Samoa, Guam, the Northern Marianas Islands, and the U.S. Virgin Islands.

CONCLUSION

Puerto Rico's experience with its Medicaid block grant offers valuable lessons. Puerto Rico's Medicaid program demonstrates how capping federal funding would likely shift significant costs to states and adversely affect state budgets. It also would sharply limit the ability of state Medicaid programs to respond to future recessions, epidemics, and natural disasters, and lead to cuts to eligibility, benefits, and provider payments that reduce access to care for vulnerable, low-income beneficiaries.

A policy option permanently eliminating Puerto Rico's block grant and replacing it with the same federal funding structure available to states would allow Puerto Rico to expand access to needed care for its more than 3 million residents.

HOW WE CONDUCTED THIS STUDY

This study is based on an extensive examination of available data, policy analysis, and research related to Puerto Rico's Medicaid program. This includes federal Medicaid expenditure data from the Centers for Medicare and Medicaid Services (CMS); information from Puerto Rico's Medicaid State Plan; Puerto Rico Community Survey data from the U.S. Census Bureau; reports from the Medicaid and CHIP Payment and Access Commission (MACPAC), the U.S. Government Accountability Office, and the Congressional Research Service; and communication with Puerto Rico's Medicaid agency.

For estimates of Puerto Rico's Medicaid block grant amounts and comparisons of block grant amounts to total Medicaid spending for 2012 to 2019, this study relied on data from the House Ways and Means Committee's *2004 Green Book*; Consumer Price Index data from the Bureau of Labor Statistics; analysis of federal legislation that temporarily increased block grant amounts from 2003 to 2004, 2006 to 2007, and 2009 to 2010; and CMS-64 expenditure data for Puerto Rico.³² The estimates were then compared with similar MACPAC analysis to ensure accuracy. Because of the lack of publicly available CMS-64 data for 2019, MACPAC data for Puerto Rico's total Medicaid expenditures were used.

NOTES

1. Andy Schneider, “[Administration’s Budget Proposal Includes at Least \\$1 Trillion in Medicaid Cuts,](#)” *Say Ahhh! Blog*, Georgetown University Center for Children and Families, Feb. 12, 2020; Andy Schneider, “[Administration’s Budget Proposal Includes \\$1.5 Trillion in Medicaid Cuts,](#)” *Say Ahhh! Blog*, Georgetown University Center for Children and Families, March 11, 2019; Andy Schneider, “[Administration’s Budget Proposal Includes \\$1.4 Trillion in Medicaid Cuts,](#)” *Say Ahhh! Blog*, Georgetown University Center for Children and Families, Feb. 12, 2018.
2. Robin Rudowitz et al., *Implications of CMS’ New “Healthy Adult Opportunity” Demonstrations for Medicaid* (Henry J. Kaiser Family Foundation, Feb. 2020). Oklahoma became the first state to submit a request for a Healthy Adult Opportunity (HAO) waiver. Oklahoma, however, recently withdrew its waiver request because it is inconsistent with a ballot measure expanding Medicaid passed in June 2020. See Oklahoma Health Care Authority, *SoonerCare 2.0 Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application* (OHCA, 2020); Oklahoma Health Care Authority, “[Letter to Centers for Medicare and Medicaid Services,](#)” Aug. 11, 2020; and “[Oklahoma Withdraws Medicaid Block Grant Proposal,](#)” *Modern Healthcare*, Aug. 13, 2020. Prior to the development of the HAO guidance, Tennessee also applied for a Medicaid waiver to cap its program. The waiver is still pending. See Division of TennCare, “[TennCare II Demonstration: Amendment 42 Modified Block Grant and Accountability,](#)” TennCare, Nov. 20, 2019.
3. In 2018, for example, Puerto Rico’s block grant equaled nearly \$360 million, only about 14 percent of Puerto Rico’s total Medicaid spending of \$2.49 billion, based on Georgetown University Center for Children and Families (CCF) estimates of block grant amounts and Medicaid CMS-64 expenditure data (see “[How We Conducted This Study](#)”). It is difficult to estimate the block grant as a percentage of total expenditures before 2012 because Puerto Rico only reported an amount of total Medicaid expenditures needed to draw down its low federal block grant amount. When the Affordable Care Act temporarily increased federal Medicaid funding for Puerto Rico starting in July 2011, Puerto Rico began reporting total expenditures that were more reflective of its actual total Medicaid spending.
4. For the block grant amounts in the early years of Puerto Rico’s Medicaid program, see Ways and Means Committee, *2004 Green Book, Section 12: Social Welfare Programs in the Territories* (U.S. House of Representatives, Mar. 2004). Since 1995, Puerto Rico’s block grant has been annually adjusted by the medical component of the Consumer Price Index (CPI-M), which the Congressional Budget Office finds is considerably lower than expected growth in per-beneficiary Medicaid costs nationally, let alone expected growth in costs resulting from enrollment increases. See Congressional Budget Office, *Longer-Term Effects of the Better Care Reconciliation Act of 2017 on Medicaid Spending* (CBO, June 2017); and Edwin Park, *CBO: Senate Bills Cut Medicaid by More Than One-Third by 2036* (Center on Budget and Policy Priorities, June 29, 2017).
5. Prior to 2011, the FMAP for Puerto Rico was set at 50 percent, but the Affordable Care Act increased the FMAP to 55 percent for Puerto Rico and the other territories starting in July 2011. (The matching rate may vary for certain populations or types of spending. For example, under the Affordable Care Act’s Medicaid expansion, the matching rate equals 90 percent for certain low-income adults in Puerto Rico. As with the states, the matching rate equals 50 percent for administrative spending.) A state’s FMAP is based on its per capita income, relative to national per capita income, with a minimum of 50 percent and a maximum of 83 percent. Under this formula, the Government Accountability Office has estimated that Puerto Rico’s FMAP would equal 83 percent because of Puerto Rico’s lower per capita income. See U.S. Government Accountability Office, *Puerto Rico: Information on How Statehood Would Potentially Affect Selected Federal Programs and Revenue Sources*, GAO-14-31 (GAO, Mar. 2014).

6. For example, in 2018, if Puerto Rico was receiving uncapped funding with an FMAP of 83 percent, it would have received \$698 million more in federal Medicaid funding than if it was receiving uncapped funding with an FMAP of 55 percent. Estimates from the Georgetown University Center for Children and Families (CCF).
7. See, for example, Congressional Task Force on Economic Growth in Puerto Rico, *Report to the House and Senate* (Congressional Task Force, Dec. 20, 2016); U.S. Government Accountability Office, *Puerto Rico: Factors Contributing to the Debt Crisis and Potential Federal Actions to Address Them* GAO-18-387 (GAO, May 2018); Maria Levis, “Your Money or Your Life: Federal Policies and Health Disparities in Puerto Rico,” *Health Affairs Blog*, June 13, 2016; and Center for New Economy, *Policy Paper: Puerto Rico’s Looming 2019 Medicaid Fiscal Cliff* (CNE, Sept. 2019).
8. D. Andrew Austin, *The Puerto Rico Oversight, Management, and Economic Stability Act: PROMESA; H.R. 5278, S. 2328*, CRS R44532 (Congressional Research Service, July 1, 2016).
9. For example, the Medicaid and CHIP Payment and Access Commission projected that in the absence of additional federal funding by the end of 2019, Puerto Rico might have had to cut Medicaid enrollment by more than 450,000 beneficiaries, a reduction of 36 percent. See Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP* (MACPAC, June 2019). But in December 2019, Congress temporarily raised Puerto Rico’s Medicaid block grant funding for fiscal years 2020 and 2021 (P.L. 116-94).
10. See current Puerto Rico Medicaid enrollment data available at “[Estadísticas](#),” Medicaid Program, Puerto Rico Department of Health, Aug. 2020. This includes about 143,000 beneficiaries who are enrolled in a commonwealth-only funded program. The program remains separate from the federally funded Medicaid program due to lack of federal Medicaid funds. See MACPAC, *Report to Congress*, 2019.
11. Georgetown University Center for Children and Families (CCF) analysis of American Community Survey and Puerto Rico Community Survey data.
12. The permanent PRPL is \$5,508 for an individual and \$8,508 for a family of four in 2020. See Puerto Rico Department of Health, *Puerto Rico Medicaid State Plan* (PRDH, May 2019). In comparison, the federal poverty level (FPL) in 2020 equals \$12,760 for an individual and \$26,200 for a family of four. See “[2020 Poverty Guidelines](#),” Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Jan. 21, 2020.
13. Seniors and people with disabilities are eligible up to 75.2 percent of FPL as individuals but only up to 69.6 percent as a couple under the medically needy category (which is below the minimum 74 percent FPL level for seniors and people with disabilities under the supplemental security income eligibility category). The medically needy eligibility level in Puerto Rico for seniors and people with disabilities is \$400 per month for an individual, with an additional \$95 for each additional family member. That equals about 37.6 percent of FPL for an individual and 34.5 percent of FPL for a couple. But income disregards substantially increase eligibility to \$800 per month, plus \$200 for each additional family member. PRDH, *Puerto Rico Medicaid*, 2019.
14. Puerto Rico provides CHIP-funded Medicaid coverage up to 266 percent of the PRPL plus an income disregard of 5 percent of the PRPL. See PRDH, *Puerto Rico Medicaid*, 2019; and Tricia Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, and Cost-Sharing Policies as of January 2020: Findings from a 50-State Survey* (Henry J. Kaiser Family Foundation, Mar. 26, 2020).
15. Puerto Rico Department of Health, email message to author, July 10, 2020.
16. U.S. Government Accountability Office, *Medicaid and CHIP: Increased Funding in U.S. Territories Merits Improved Program Integrity Efforts*, GAO-16-324 (GAO, Apr. 2016). Note that in its 2018 Fiscal Plan,

- the Financial Oversight and Management Board (FOMB) of Puerto Rico indicated that some private-duty nursing services may be covered by Puerto Rico's Medicaid program. See Financial Oversight and Management Board of Puerto Rico, *New Fiscal Plan for Puerto Rico: Restoring Growth and Prosperity* (FOMB, Apr. 19, 2018).
17. As currently scheduled, Puerto Rico and the other territories will have the option to join the Medicaid Drug Rebate Program in April 2022. See *84 Fed. Reg. 64783* (Nov. 25, 2019). For an overview of the Medicaid Drug Rebate Program, see Edwin Park, *How to Strengthen the Medicaid Drug Rebate Program to Address Rising Medicaid Prescription Drug Costs* (Georgetown University Center for Children and Families, Jan. 2019).
 18. Carmen Heredia Rodriguez, "Medicaid Patients in Puerto Rico Don't Get Coverage for Drugs to Cure Hepatitis C," *Kaiser Health News*, Jan. 4, 2019; and "Hepatitis C: State of Medicaid Access Report Card Puerto Rico," Center for Health Law and Policy Innovation, Apr. 2020.
 19. Urban Institute, *Environmental Scan of Puerto Rico's Health Care Infrastructure* (Urban Institute, Jan. 2017).
 20. MACPAC, *Report to Congress*, 2019.
 21. MACPAC, *Report to Congress*, 2019.
 22. GAO, *Puerto Rico*, 2014.
 23. P.L. 116-94.
 24. Georgetown University Center for Children and Families (CCF) estimates of block grant amounts.
 25. Under current law, Puerto Rico's Medicaid funding would revert to its regular block grant amount starting in fiscal year 2022. The matching rate would also revert to 55 percent.
 26. Centers for Medicare and Medicaid Services, *Puerto Rico Medicaid State Plan Transmittal 20-0001* (CMS, June 2020).
 27. Financial Oversight and Management Board of Puerto Rico, *2020 Fiscal Plan for Puerto Rico: Restoring Growth and Prosperity* (FOMB, May 27, 2020).
 28. Puerto Rico Department of Health, email message to author, July 10, 2020.
 29. The Financial Oversight and Management Board of Puerto Rico had previously rejected any eligibility expansion, even a temporary one. Office of the Governor of Puerto Rico, "Gobernadora Wanda Vázquez Garced se reúne con el pleno de la Junta de Supervisión Fiscal en Nueva York para insistir en la aprobación del Plan Vital para 200,000 personas que no cuentan con plan médico," Office of the Governor, Oct. 7, 2020. But the Financial Oversight and Management Board of Puerto Rico has recently decided to permit Puerto Rico to increase the PRPL but only for the rest of fiscal year 2021 unless sufficient federal Medicaid funding is provided on a permanent basis. José Delgado, "Puerto Rico: Oversight Board Authorized Health Plan Expansion," *El Nuevo Día*, Oct. 17, 2020. The federal government approved this temporary PRPL increase in December 2020. Office of the Governor of Puerto Rico, "Gobernadora Wanda Vázquez Garced informa que CMS aprobó la extensión del Plan Vital para 200,000 personas que no cuentan con plan médico," Office of the Governor, Dec. 11, 2020.
 30. Georgetown University Center for Children and Families (CCF) analysis of American Community Survey and Puerto Rico Community Survey data.
 31. Edwin Park, "Sound House Bill Would Establish Pathway for a Sustainable, Improved Medicaid Program in Puerto Rico," *Say Ahhh! Blog*, Georgetown University Center for Children and Families, July 8, 2019.
 32. Ways and Means, *Green Book*, 2004.

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