Grupo Nexos Inc.

innovación - investigación - comunidad

AT THE MEDICAID CLIFF:

WHAT'S AT STAKE FOR MATERNAL AND INFANT HEALTH IN PUERTO RICO

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Executive Summary

Puerto Rico relies heavily on Medicaid to finance maternal and infant health care. Plan Vital, Puerto Rico's Medicaid program, finances approximately 65.8% of births on the island and provides coverage across pregnancy, childbirth, the postpartum period, infancy, and childhood. This reliance occurs in a context in which several maternal and infant health indicators remain above national estimates and established targets. Maternal mortality stands at 59.2 deaths per 100,000 live births, compared with the Healthy People 2030 target of 15.7. Infant mortality and preterm birth rates also exceed national estimates and established targets, while approximately one in five municipalities is classified as a maternity care desert. The 2025 *March of Dimes Report Card*, which assesses maternal and infant health indicators across U.S. states and territories, assigned Puerto Rico an F based on its preterm birth rate.

Access to maternal health services is also shaped by changes in obstetric capacity and broader workforce pressures. Over the past decade, the number of labor and delivery units declined while obstetric services remain unevenly distributed across the island. Puerto Rico's healthcare workforce is also aging, a trend that is particularly pronounced among obstetrician-gynecologists and several other specialties. A reduction in Medicaid financing would therefore land on a system whose capacity is already contracted. Puerto Rico's exposure to recurring Medicaid financing shortfalls is rooted in its federal financing structure. Under Section 1108(g) of the Social Security Act, federal Medicaid funding for Puerto Rico is subject to an annual statutory cap, unlike the open-ended federal matching structure available to the states. Congress has repeatedly provided temporary increases in federal funding and matching rates, including the current enhanced 76% Federal Medical Assistance Percentage (FMAP). Without additional congressional action, the current enhanced financing provisions are scheduled to expire on September 30, 2027.

Beginning in FY2028, federal Medicaid funding is projected to decline in two stages, from approximately $3.8 billion in FY2027 to approximately $1.4 billion in FY2028 and roughly $500 million annually beginning in FY2029. At full effect, this reduction is projected to create a recurring annual financing gap of approximately $3.7 to $4.0 billion. Because Medicaid financing flows through Puerto Rico Health Insurance Administration (ASES) and managed care

organizations to hospitals, physicians, clinics, and other providers, a reduction of this magnitude would occur within a health system in which maternal health services already face financial, operational, access, and workforce pressures.

This report applies a descriptive, multidisciplinary policy analysis to examine projected changes in Medicaid financing and their implications for maternal and infant health in Puerto Rico. It integrates documentary review, quantitative secondary data, qualitative evidence from families and stakeholders, and descriptive fiscal analysis. Triangulation across these sources was used to develop a comprehensive, evidence-informed understanding of the policy issue.

Findings

1. Medicaid is a central source of financing for maternal and infant health care in Puerto Rico.
2. Puerto Rico faces significant maternal and infant health challenges before the projected Medicaid funding reductions take effect.
3. Access to obstetric care is becoming more limited as labor and delivery capacity and workforce availability decline.
4. Financial pressures on labor and delivery services may increase their vulnerability of providers due reductions in Medicaid financing.
5. Gaps in Medicaid coverage can create barriers to timely prenatal care.
6. Access to and continuity of perinatal mental health services remain an important challenges.
7. Workforce capacity and community-based supports are both important to sustaining maternal and infant health services.

Policy Options

Policy

1. Maintaining an enhanced federal matching rate beyond September 30, 2027 is one financing scenario that could reduce the projected FY2028 gap
2. Longer-term financing alternatives under Section 1108(g) warrant further analysis as potential approaches to improve predictability and stability
3. Assess opportunities to strengthen coverage of services relevant to maternal and infant health.

4. Recognize and strengthen the integration of midwives and doulas within Puerto Rico's maternal health system.
5. Consider adopting presumptive eligibility for pregnant women at the point of care.

Practice

6. Integrate perinatal mental health screening, referral, and treatment across prenatal, obstetric, and postpartum care.
7. Strengthen shared-care models for low-risk pregnancies by integrating obstetricians, midwives, doulas, community health workers, family medicine professionals, and other maternal health professionals into coordinated care teams, supported by telehealth where appropriate.
8. Explore regional models for maintaining access to obstetric services, including hub-and-spoke approaches and reimbursement strategies that support the sustainability of labor and delivery services.

Program

9. Strengthen Medicaid administrative, documentation, and program-integrity capacity, including a PERM-readiness roadmap and beneficiary and provider verification process.
10. Develop and maintain a reliable provider directory and strengthen care-navigation supports for families.
11. Strengthen maternal and infant health surveillance and develop indicators to monitor changes in coverage, access, utilization, provider availability, and health outcomes.

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I. Introduction

Puerto Rico is home to some of the highest rates of Medicaid dependency and some of the worst maternal and infant health outcomes of any jurisdiction in the United States. It is also a jurisdiction whose federal Medicaid funding can simply run out.

Beginning September 30, 2027, the expiration of current federal Medicaid funding provisions is projected to result in a substantial reduction in federal Medicaid funding for Puerto Rico, ultimately creating an estimated annual financing gap of $3.7 to $4 billion.[1] This report examines the possible effects of this reduction for maternal and infant health, particularly for the mothers, infants, and families who rely on Plan Vital, Puerto Rico's Medicaid program, for coverage and care during pregnancy, childbirth, the postpartum period, and early childhood.

Why This Is Possible: The Structure of Medicaid Financing in Puerto Rico

For the fifty states, Medicaid operates through an open-ended federal matching structure. The federal government matches state Medicaid spending through the Federal Medical Assistance Percentage (FMAP), allowing federal funding to adjust as eligible expenditures and program needs change.[2] This financing structure enables state Medicaid programs to respond to changes in enrollment, health care costs, and other circumstances that may increase demand for services.

Puerto Rico operates within a different financing structure. Under Section 1108(g) of the Social Security Act, federal Medicaid funding for Puerto Rico is subject to an annual statutory cap.[3] Puerto Rico's statutory FMAP is 55%, but

[1] Financial Oversight and Management Board for Puerto Rico. (2026, June 19). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW

[2] Pillai, A., Pillai, D., Artiga, S., & Rudowitz, R. (2024, October 28). Recent changes in Medicaid financing in Puerto Rico and other U.S. territories. KFF. https://www.kff.org/elections/recent-changes-in-medicaid-financing-in-puerto-rico-and-other-u-s-territories/

[3] Social Security Act, 42 U.S.C. § 1308(g) (2023). https://www.govinfo.gov/app/details/USCODE-2023-title42/USCODE-2023-title42-chap7-subchapXI-partA-sec1308

federal matching funds are available only within the limits of that annual allotment. Once the federal allotment is exhausted, additional Medicaid expenditures are not eligible for the same federal matching arrangement available to states. This combination of a statutory FMAP and a capped federal allotment is therefore central to understanding Puerto Rico's exposure to periodic Medicaid financing shortfalls.

Understanding how these federal funds move through Puerto Rico's health system is equally important to assessing the expected implications of a reduction in funding. Federal Medicaid funds flow through the Centers for Medicare & Medicaid Services (CMS) to the Puerto Rico Health Insurance Administration (ASES), which administers Puerto Rico's Medicaid program through Plan Vital pursuant to the *Puerto Rico Health Insurance Administration Act*, Act No. 72 of September 7, 1993, as amended (Act No. 72-1993).[4] ASES contracts with managed care organizations (MCOs) and provides capitated payments on a per-member-per-month (PMPM) basis. The MCOs, in turn, manage networks of hospitals, physicians, clinics, and other health care providers through which covered services are delivered.

This financing and delivery structure connects changes in federal Medicaid funding to the resources available throughout Plan Vital and its provider network. This connection is particularly important given the program's reach: Plan Vital provides health coverage to more than four in ten Puerto Rico residents and finances a substantial share of maternal and infant health services. The following sections examine how this financing structure intersects with existing maternal and infant health needs and the implications of the projected federal funding reductions beginning in FY2028.

Figure 1.

Key federal instruments governing Medicaid in Puerto Rico

- Title XIX of the Social Security Act, the statutory basis for Medicaid
- Section 1108(g) of the Social Security Act (42 U.S.C. Section 1308(g)), the annual federal funding cap

[4] Puerto Rico Health Insurance Administration Act, Act No. 72 of September 7, 1993, as amended, 24 L.P.R.A. §§ 70017054. https://presupuesto.pr.gov/BUDGET20112012/Aprobado2012Ingles/suppdocs/baselegal_ingles/187/72-1993.pdf

- Section 1905(b), the FMAP formula
- Puerto Rico Health Reform Act, Act No. 72 of 1993, local administration through ASES and Plan Vital

What Is at Stake

What would happen to maternal and infant health in Puerto Rico if the Medicaid system faces a reduction of approximately $4 billion a year beginning in FY2028?

The question is not abstract. Medicaid plays a particularly important role in Puerto Rico given the socioeconomic conditions affecting many families: 37.3% of residents live below the federal poverty level, compared with 12.1% nationally[5], and more than half of children under age 18 live in poverty.[6] Plan Vital therefore serves as an important source of health coverage within a context of persistent maternal and infant health challenges, several of which exceed national estimates and established targets (see Section II).

The projected FY2028 financing reduction is also part of a longer pattern of periodic Medicaid funding shortfalls. Congress has responded to previous financing needs through temporary measures enacted in 2010, 2018, 2021, and 2022 (see Table 4), providing additional federal support without permanently changing Puerto Rico's underlying Medicaid financing structure.[7] The approaching FY2028 reduction therefore raises renewed questions about the long-term stability of Medicaid financing and how reduced federal funding could affect a health system already experiencing access, workforce, and service-capacity challenges.

[5] Benson, C. (2025). Poverty in states and metropolitan areas: 2024. U.S. Census Bureau. https://www2.census.gov/library/publications/2025/demo/acsbr-026.pdf

[6] U.S. Census Bureau. (2024). American Community Survey 1-year estimates: Puerto Rico profile. United States Department of Commerce. https://data.census.gov/profile/Puerto_Rico?g=040XX00US72

[7] Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 50101, 132 Stat. 64 (2018). https://www.govinfo.gov/content/pkg/PLAW-115publ123/html/PLAW-115publ123.htm; Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, § 5101, 136 Stat. 4459 (2022). https://www.govinfo.gov/content/pkg/PLAW-117publ328/html/PLAW-117publ328.htm; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2005, 124 Stat. 119 (2010). https://www.govinfo.gov/content/pkg/PLAW-111publ148/html/PLAW-111publ148.htm

Figure 2.

The FY2028 Medicaid Cliff at a glance

- Deadline: September 30, 2027, the end of Federal Fiscal Year 2027
- Federal funding: the capped Medicaid allotment falls from approximately $3.56 billion to about $500 million a year, a decline of about 86 percent, in a two-step reduction that completes in FY2029
- Projected annual funding gap: $3.7 to $4 billion
- Affected program: Plan Vital, which covers approximately 42% of Puerto Rico's population.

Organization of This Report

The report is organized in seven parts. This Introduction sets out the legal and fiscal framework and the stakes. Section II documents Medicaid's role as critical infrastructure for maternal and infant health. Section III examines the fiscal cliff and the compounding effects of the OBBBA, tracing how a reduction of roughly $4 billion would move from federal statute through ASES and the managed care organizations to the point of care. Section IV presents the findings, joining the quantitative record to the testimony of clinicians, midwives, hospital leaders, and mothers. Section V sets out policy options for relevant governmental entities. Section VI concludes.

The analysis triangulates three kinds of evidence: documentary and policy review of federal and Puerto Rico law, Medicaid financing documents and fiscal plans; quantitative secondary data on maternal and infant health and on Medicaid financing; and in-depth conversations with 15 families and stakeholders conducted between February and May 2026. The financing figures are a descriptive analysis of published sources rather than a projection of how the government of Puerto Rico would respond to a reduction of this magnitude; Appendix A sets out the methodology, the derivations behind Table 3, and the limitations of each component.

II. Medicaid as Critical Infrastructure for Maternal and Infant Health

What Plan Vital Finances

Plan Vital covers a broad range of maternal and infant health services, including preconception and prenatal care, diagnostic testing, obstetric services, delivery, neonatal intensive care, postpartum follow-up, and early pediatric care, as well as the management of chronic conditions and perinatal mental health needs before, during, and after pregnancy.[8] In 2024, Plan Vital financed 11,855 births, representing 65.8% of all births in Puerto Rico, compared with about 4 in 10 nationally.[9]

Plan Vital's reach also extends across different stages of the maternal and child health continuum. In 2023, the program covered 59.5% of infants under age one, 74.6% of children ages one to nine, 77.8% of children with special health care needs, and 53% of women of reproductive age.[10] Similarly, data from the Pregnancy Risk Assessment Monitoring System (PRAMS)[11]illustrate Medicaid's role across the perinatal period. Between 2021 and 2022, approximately 60% of mothers were covered by the Government Health Plan in the month before pregnancy, 63% during pregnancy, and 65% during the postpartum period.[12]

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[8] Smith, J. C., Heberlein, E., Snyder, A., & Minyard, K. (2024). Driving access, health equity, and innovation in maternal healthcare through Medicaid. In D. Cilenti, The practical playbook III (pp. 463–475). Oxford University Press. https://doi.org/10.1093/oso/9780197662984.003.0041

[9] March of Dimes. (2025). 2025 March of Dimes report card: The state of maternal and infant health for American families. https://www.marchofdimes.org/peristats/assets/s3/reports/documents/March-of-Dimes-2025-Full-Report-Card.pdf

[10] Puerto Rico Department of Health, Maternal and Child Health Program. (2024). III.C.2.b.i MCH population health status – Puerto Rico – 2024. Health Resources and Services Administration. https://mchb.tvisdata.hrsa.gov/Narratives/IIIC2biMCHPopulationHealthStatus/32d283c1-5745-4d05-b06b-626c004cbb6d

[11] The PRAMS is a population-based surveillance system developed by the Centers for Disease Control and Prevention (CDC) in collaboration with participating jurisdictions. It collects information from women who recently gave birth about their experiences and health before, during, and shortly after pregnancy.

[12] Departamento de Salud de Puerto Rico, Sección Madres, Niños y Adolescentes. (2024). Sistema de Evaluación y Monitoreo de Riesgos en el Embarazo (PRAMS Puerto Rico): Informe de hallazgos 2021-2022 [Pregnancy Risk Assessment Monitoring System (PRAMS Puerto Rico): Findings report 2021–2022]. Gobierno de Puerto Rico.

Socioeconomic and Health Care Context

The role of Medicaid in maternal and infant health must also be understood within the socioeconomic conditions affecting many families in Puerto Rico. PRAMS 2021–2022 data show that approximately 52% of participating mothers reported annual household incomes at or below $16,000, while nearly 82% received benefits from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[13] Among children and youth, 61% live in single-parent households and 78% live in communities characterized by high levels of poverty.[14] These conditions are relevant to maternal and infant health because factors such as income, housing, food security, transportation, and exposure to violence can influence access to care and health outcomes.[15]

These socioeconomic conditions intersect with challenges in the availability and geographic distribution of maternal health services. Over the past decade, the number of labor and delivery units in Puerto Rico declined from 36 in 2017 to 25 in 2026, representing the closure of 11 units and an approximately 30% reduction in obstetric capacity. Access to obstetric professionals is also geographically uneven. A 2026 investigation identified 63 obstetricians providing care throughout pregnancy and delivery, with practices located in only 24 of Puerto Rico's 78 municipalities. Of the 56 who were accepting new patients, approximately 47 accepted Plan Vital. The investigation also found more limited availability of obstetric services in the western, central, and eastern regions, including Vieques and Culebra (see Figure 3).[16]

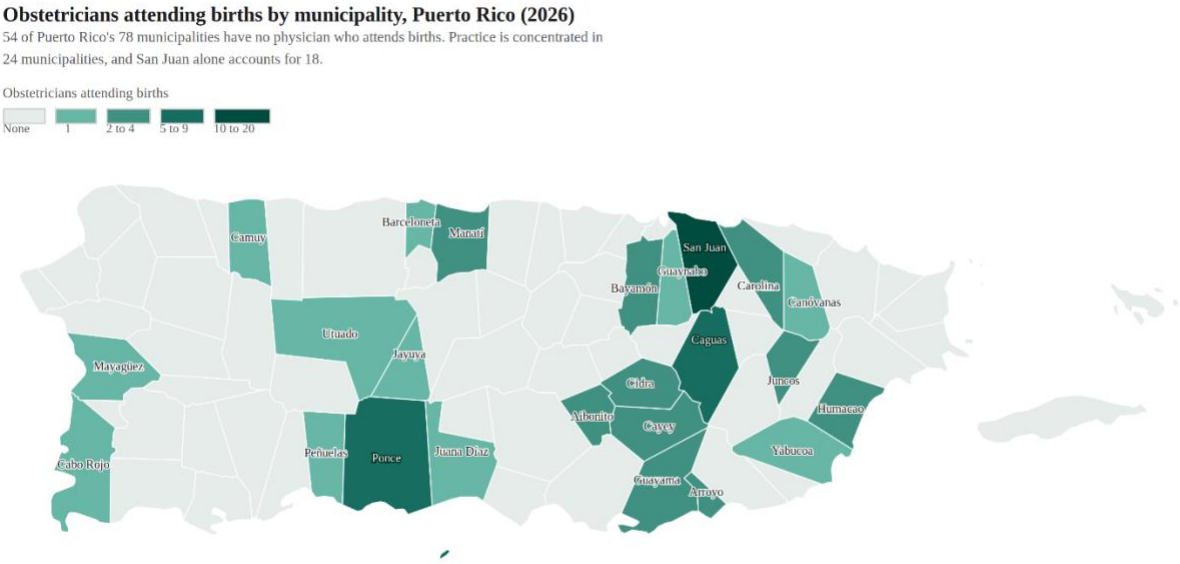
[13] Departamento de Salud de Puerto Rico, Sección Madres, Niños y Adolescentes. (2024). Sistema de Evaluación y Monitoreo de Riesgos en el Embarazo (PRAMS Puerto Rico): Informe de hallazgos 2021-2022 [Pregnancy Risk Assessment Monitoring System (PRAMS Puerto Rico): Findings report 2021–2022]. Gobierno de Puerto Rico.

[14] The Annie E. Casey Foundation. (2026). 2026 KIDS COUNT data book: State trends in child well-being. The Annie E. Casey Foundation. https://www.aecf.org/databook; U.S. Census Bureau. (2024). American Community Survey 1-year estimates: Puerto Rico profile. United States Department of Commerce. https://data.census.gov/profile/Puerto_Rico?g=040XX00US72

[15] World Health Organization. (2025). World report on the social determinants of health equity. https://www.who.int/teams/social-determinants-of-health/equity-and-health/world-report-on-social-determinants-of-health-equity

[16] Dávila-Santiago, G. (2026, May 11). Puerto Rico perdió cerca del 30% de su capacidad obstétrica en menos de una década [Puerto Rico lost close to 30% of its obstetric capacity in less than a decade]. Todas. https://todaspr.com/pregnant-women-puerto-rico-obstetric-services-scarce/

Figure 3.



Source: Dávila-Santiago, G. (2026, May 11). Puerto Rico perdió cerca del 30% de su capacidad obstétrica en menos de una década [Puerto Rico lost close to 30% of its obstetric capacity in less than a decade]. Todas. https://todaspr.com/pregnant-women-puerto-rico-obstetric-services-scarce/

These geographic access challenges are also reflected in the presence of maternity care deserts. Approximately 20% of Puerto Rico's municipalities are classified as maternity care deserts, affecting more than 117,000 women and approximately 3,851 births annually.[17] Fewer delivery units, an uneven distribution of obstetric professionals, and the presence of maternity care deserts compound one another: a closure in one municipality lengthens the journey for every municipality around it.

Evidence also highlights the importance of timely prenatal care for maternal and infant health. Findings based on U.S. national PRAMS data indicate that initiating prenatal care during the third trimester was associated with approximately twice the likelihood of developing gestational hypertension. The absence of prenatal care was also associated with a higher likelihood of neonatal intensive care unit (NICU) admission and preterm birth, as well as a

[17] Fontenot, J., Lucas, R., Stoneburner, A., Brigance, C., Hubbard, K., Jones, E., & Mishkin, K. (2023). El lugar donde usted vive importa: Áreas sin cuidado de maternidad y la crisis de acceso e igualdad en Puerto Rico. [Where you live matters: Maternity care deserts and the access and equity crisis in Puerto Rico]. March of Dimes. https://marchofdimes.org/mcdr-pr

lower likelihood of breastfeeding.[18] Prenatal care the points at which a gap in coverage converts most directly into a health outcome.

Within this context, Tables 1 and 2 present selected maternal, neonatal, and infant health indicators for Puerto Rico, alongside U.S. estimates and, where available, Healthy People 2030 targets.

Table 1. Maternal health indicators: Puerto Rico, the United States, and Healthy People 2030

Indicator[19]	Puerto Rico	United States	Healthy People 2030
Smoking[20]	0.2%	3.0%	N/A
Diabetes	1.3%	1.3%	N/A
Hypertension	2.6%	3.4%	N/A
Unhealthy weight	36.9%	34.8%	N/A
Hypertension in pregnancy [21]	5.3%	10.4%	N/A

[18] Malin, K. J., Vance, A. J., Moser, S. E., Zemlak, J., Edwards, C., White-Traut, R., Koerner, R., McGrath, J., & McGlothen-Bell, K. (2025). The impact of social determinants of health on infant and maternal health using a reproductive justice lens. BMC Pregnancy and Childbirth, 25, Article 577. https://doi.org/10.1186/s12884-025-07693-y

[19] March of Dimes reports smoking, hypertension, unhealthy weight, and diabetes as conditions present before pregnancy, based on information recorded on the birth certificate. Hypertension in pregnancy is reported separately and reflects hypertension occurring during pregnancy. More than one condition may be present in the same birth.

[20] March of Dimes. (2025). 2025 March of Dimes report card: The state of maternal and infant health for American families. March of Dimes. https://www.marchofdimes.org/peristats/reports/united-states/report-card

[21] This table reports the birth-certificate figures published by March of Dimes because they are measured the same way for Puerto Rico and the United States. PRAMS-Puerto Rico 2021–2022, a maternal self-report survey, reports higher prevalences for the same conditions: high blood pressure during pregnancy at 15.3% (95% CI: 12.9–18.0) and gestational diabetes at 7.8% (95% CI: 6.1–10.0). The two sets are not interchangeable. PRAMS asks women to report conditions after the fact and uses a broad definition of high blood pressure that includes preeclampsia, while birth-certificate reporting captures what a clinician recorded at delivery and separates gestational hypertension from preeclampsia; self-reported prevalence is generally the higher of the two. Both are informative and they answer different questions, but no United States PRAMS counterpart is available for either measure, so a PRAMS figure cannot be placed beside a national one. Gestational diabetes appears in neither column because no birth-certificate figure is published for Puerto Rico. The Puerto Rico Title V maternal and child health narrative reports the same PRAMS indicators at 11.4% and 8.3%, so these estimates vary by survey cycle and the cycle should be stated wherever they are used.

Indicator[19]	Puerto Rico	United States	Healthy People 2030
Low-risk (NTSV) cesarean delivery[22]	47.1%	26.6%	23.6%
Depression during most recent pregnancy	8.7%[23]	9.7%[2425]	N/A
Postpartum depression	17.7%[26]	12.8%[2728]	N/A
Severe maternal morbidity (per 10,000 hospital deliveries) [29]	307.0	93.1	64.4[30]

[22] Low-risk cesarean delivery is defined by March of Dimes as a cesarean delivery in an NTSV birth, that is, in a first-time mother, at term (≥37 weeks), with a single fetus in cephalic presentation
[23] Departamento de Salud de Puerto Rico, Sección Madres, Niños y Adolescentes. (2024). Sistema de Evaluación y Monitoreo de Riesgos en el Embarazo (PRAMS Puerto Rico): Informe de hallazgos 2021–2022 [Pregnancy Risk Assessment Monitoring System (PRAMS Puerto Rico): Findings report 2021–2022]. Gobierno de Puerto Rico. This figure corresponds to women with a live birth who reported depression during their most recent pregnancy.
[24] Gardner, R. M., Sultan, P., Bernert, R. A., & Simard, J. F. (2025). Trends in prevalence and treatment of antepartum and postpartum depression in the United States: Data from the National Health and Nutrition Examination Survey (NHANES) 2007 to 2018. PLOS ONE, 20(4), Article e0322536. https://doi.org/10.1371/journal.pone.0322536.
[25] National estimate based on NHANES 2007–2018, corresponding to the prevalence of depression among pregnant women.
[26] PRAMS Puerto Rico 2021–2022. This figure corresponds to women with a live birth who reported depressive symptoms during the postpartum period.
[27] Gardner, R. M., Sultan, P., Bernert, R. A., & Simard, J. F. (2025). Trends in prevalence and treatment of antepartum and postpartum depression in the United States: Data from the National Health and Nutrition Examination Survey (NHANES) 2007 to 2018. PLOS ONE, 20(4), Article e0322536. https://doi.org/10.1371/journal.pone.0322536.
[28] National estimate based on NHANES 2007–2018, corresponding to the prevalence of depression among women within 12 months after childbirth.
[29] National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019 to 2023; Puerto Rico Health Insurer Commissioner, 2022.
[30] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). Reduce severe maternal complications identified during delivery hospitalizations (MICH-05). Healthy People 2030. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-severe-maternal-complications-identified-during-delivery-hospitalizations-mich-05

Indicator[19]	Puerto Rico	United States	Healthy People 2030
Maternal mortality (per 100,000 live births)[31][32]	59.2	23.5	15.7[33]

Note: Healthy People 2030 is the U.S. Department of Health and Human Services' set of national, data-driven objectives for improving health over the current decade. Its targets represent the levels established as the national public health goal, not averages of current performance. Maternal mortality, severe maternal morbidity, pre-pregnancy diabetes, hypertension in pregnancy, and low-risk cesarean delivery are drawn from the March of Dimes 2025 Report Card, which applies birth-certificate and vital-statistics data to Puerto Rico and the United States on the same basis. The two depression measures rest on survey data: Puerto Rico from PRAMS-Puerto Rico 2021–2022, and the United States from Gardner et al. (2025) based on NHANES 2007–2018. Survey-reported and administratively recorded prevalence are not interchangeable, and the two groups of indicators should be read separately. Pre-pregnancy diabetes and hypertension in pregnancy are distinct measures: the first records diabetes present before conception, the second hypertension arising during the pregnancy. The first four indicators describe conditions recorded as present before or at the start of pregnancy; the remainder describe conditions arising during pregnancy, care received, and outcomes. Puerto Rico is at or below the United States on three of the four entry risk factors, with unhealthy weight the exception at a 2.1 percentage point difference.

[31] March of Dimes. (2025). 2025 March of Dimes report card for Puerto Rico. https://www.marchofdimes.org/peristats/reports/puerto-rico/report-card
[32] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). Reduce cesarean births among low-risk women with no prior births (MICH-06). Healthy People 2030. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-cesarean-births-among-low-risk-women-no-prior-births-mich-06
[33] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). Reduce cesarean births among low-risk women with no prior births (MICH-06). Healthy People 2030. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-cesarean-births-among-low-risk-women-no-prior-births-mich-06

Table 2. Neonatal and infant health indicators: Puerto Rico, the United States, and Healthy People 2030

Indicator	Puerto Rico	United States	Healthy People 2030
Births financed by Medicaid[34][35]	65.8%	40%[36][37]	N/A
Preterm birth[38][39]	12.2%	10.4%	9.4%
Low birthweight[40]	10.7%[41]	8.6%[42]	N/A
Infant mortality (per 1,000 live births)[43]	7.1[44]	5.6[45]	5.0

Note. All Puerto Rico and United States figures except low birthweight are drawn from the March of Dimes 2025 Report Card. Infant mortality is reported for 2023, the most recent year in the Report Card's series; the remaining indicators are for 2024. Low birthweight comes from

[34] March of Dimes. (2025). 2025 March of Dimes report card: The state of maternal and infant health for American families. March of Dimes. https://www.marchofdimes.org/peristats/reports/united-states/report-card

[35] These figures correspond to births occurring in 2024. Plan Vital covered 11,855 of live births in Puerto Rico.

[36] March of Dimes. (2025). 2025 March of Dimes report card: The state of maternal and infant health for American families. https://www.marchofdimes.org/peristats/reports/united-states/report-card

[37] Underlying infant mortality data are drawn from the National Center for Health Statistics's final period-linked infant birth and death data, 2013–2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

[38] March of Dimes. (2025). 2025 March of Dimes report card: The state of maternal and infant health for American families. March of Dimes. https://www.marchofdimes.org/peristats/reports/united-states/report-card

[39] Preterm birth figures correspond to births occurring before 37 weeks of gestation in 2024. Puerto Rico recorded 2,217 preterm births, ranking 48th of 52 jurisdictions.

[40] The percentage of low birthweight (<2,500 g) corresponds to 2023, according to national birth statistics published by the National Center for Health Statistics (NCHS).

[41] March of Dimes. (2026). Low birthweight: Puerto Rico, 2023 [Data set]. PeriStats. National Center for Health Statistics, territories file, final natality data. https://www.marchofdimes.org/peristats

[42] March of Dimes. (2026). Low birthweight: United States, 2023 [Data set]. PeriStats. National Center for Health Statistics, final natality data. https://www.marchofdimes.org/peristats

[43]March of Dimes. (2025). 2025 March of Dimes report card: The state of maternal and infant health for American families. March of Dimes. https://www.marchofdimes.org/peristats/reports/united-states/report-card

[44]The infant mortality rate corresponds to deaths among children under one year of age per 1,000 live births in 2023 the most recent year in the Report Card's series. Puerto Rico recorded 132 infant deaths that year.

[45] Ely, D. M., & Driscoll, A. K. (2026). Infant mortality in the United States, 2024: Data from the period linked birth/infant death file (National Vital Statistics Reports Vol. 75, No. 3). National Center for Health Statistics. https://doi.org/10.15620/cdc/252441

National Center for Health Statistics birth data for 2023. Healthy People 2030 targets are as defined in the note to Table 1.

The tables describe a system operating well beyond the margins that national standards deem acceptable: a maternal mortality ratio nearly four times the Healthy People 2030 target, infant and preterm birth rates above both the national average and the national goal, and a cesarean rate at double the target. These are the outcomes the current financing sustains. The following section examines what happens to them when that financing is withdrawn.

III. Medicaid Financing Changes

This section examines the projected changes in federal Medicaid financing beginning in FY2028 and the additional federal policy changes that may affect Medicaid coverage, benefits, and health care delivery in Puerto Rico. It first establishes the current financing baseline and the projected two-step reduction, then considers how these changes may interact with existing program and health system conditions.

The Current Baseline: FY2027

Puerto Rico's Medicaid program currently operates under a temporarily elevated federal match. The Consolidated Appropriations Act of 2023 set Puerto Rico's FMAP at 76% through September 30, 2027, well above the 55% statutory rate that applies once that provision lapses, and provided access to more than $19.4 billion over federal fiscal years 2023 through 2027.[46] Under this arrangement, total Medicaid program spending in FY2027 is projected at roughly $5.2 billion, of which federal funds cover approximately $3.8 billion and Puerto Rico covers the remaining $1.4 billion, about 28%, through its General Fund and Special Revenue Fund.[47] That financing sustains coverage for approximately 1.35 million people, about 42% of Puerto Rico's population and a higher share than any other jurisdiction; the mainland state with the highest

[46]Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, § 5101(b), 136 Stat. 4459 (2022). https://www.govinfo.gov/content/pkg/PLAW-117publ328/html/PLAW-117publ328.htm; Social Security Act § 1905(b), 42 U.S.C. § 1396d(b) (2023). https://www.govinfo.gov/app/details/USCODE-2023-title42/USCODE-2023-title42-chap7-subchapXIX-sec1396d; Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/

[47]Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/

Medicaid coverage, New Mexico, sits near 34%.[4849] Of those beneficiaries, approximately 1.31 million are enrolled in federally matched Medicaid, with the remainder in CHIP or in a locally financed program that draws no federal match. Enrollment is down from roughly 1.5 million before eligibility redeterminations resumed in April 2023.50 [51]

This is not a stable baseline. It is a temporary ceiling attached to a temporary allotment, set to expire on a fixed statutory date.

The Cliff: A Two-Step Reduction Beginning FY2028

The implementation of the reduction is incremental, reaching its sharpest depth in FY 2029. Puerto Rico's fiscal year begins July 1, while the enhanced funding expires October 1, 2027. FY2028 therefore still captures one quarter of pre-cliff funding, and the full reduction lands in FY2029.

In FY2028 federal Medicaid funding falls from roughly $3.8 billion to approximately $1.4 billion. From FY2029 onward, under current law, it falls to approximately $500 million a year, the figure the Congressional Budget Office scored for the reversion to the capped allotment.[52] Not all federal Medicaid funding falls. CHIP and the Enhanced Allotment Plan, which finances prescription drug coverage for beneficiaries also enrolled in Medicare, are authorized separately and are not subject to the Section 1108(g) cap; both continue past September 30, 2027, though at reduced federal shares once the enhanced matching rate expires. Together they account for $210 million of the FY2027 federal total, $125 million in CHIP and $85 million in EAP, declining to $190 million in FY2028. What the cliff removes is the capped Medicaid allotment, which falls from approximately $3.6 billion to roughly $500 million a year.[53] As federal funding falls while total program cost continues to rise, Puerto Rico's share of the cost climbs from about 28% today to roughly 73% in

[48] U.S. Census Bureau. (2025). Total population: Puerto Rico (Table B01003) [Data set]. American Community Survey. https://data.census.gov
[49] Population estimate 3,234,309. Coverage shares throughout this report use this denominator.
[50] KFF. (2023, June 29). Medicaid state fact sheets [Interactive data tool]. https://www.kff.org/interactive/medicaid-state-fact-sheets/
[51] Centers for Medicare & Medicaid Services. (2026). Medicaid & CHIP in Puerto Rico. Medicaid.gov. https://www.medicaid.gov/state-overviews/puerto-rico.html
[52] Congressional Budget Office. (2023, January 12). CBO estimate for divisions O through MM of H.R. 2617, the Consolidated Appropriations Act, 2023, enacted as Public Law 117-328 on December 29, 2022. https://www.cbo.gov/publication/58901
[53] Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. Exhibit 32. https://oversightboard.pr.gov/fiscal-plans/#link-CW

FY2028 and to approximately 91% at full depth. The added annual burden over the FY2027 baseline reaches approximately $3.7 billion in FY2029 and surpasses $4 billion by FY2032, equivalent to roughly a quarter of the entire General Fund.[54]

Table 3. Puerto Rico Medicaid financing: current baseline, transition year, and full cliff

Concept	FY2027 (current)	FY2028 (transition)	FY2029+ (full cliff)
Federal Medicaid funding	~$3.8B	~$1.4B	~$0.5B
Statutory FMAP	76%	reverts Oct. 1, 2027	55% (capped)
Total program cost	~$5.2B	~$5.3B	~$5.6B and rising
Puerto Rico / local share	~$1.4B (~28%)	~$3.9B (~73%)	~$5.1B (~91%)
Added annual burden vs. FY2027	—	~$2.4B	~$3.7B, rising to ~$4B by FY2032

Sources: Second Revised 2024 Fiscal Plan for Puerto Rico: Restoring Growth and Prosperity (FOMB, certified June 19, 2026), Exhibits 31, 32 and 36; CBO scoring of P.L. 117-328 Section 5101 CHIP and Enhanced Allotment Plan funds are not subject to the Section 1108(g) cap and continue separately. The FY2027 and FY2028 federal figures are Exhibit 32 totals and therefore include them; the capped Medicaid allotment alone is approximately $3.56 billion in FY2027 and approximately $1.25 billion in FY2028. The FY2029 federal figure reflects the capped allotment only. CHIP and Enhanced Allotment Plan funds of roughly $190 million would continue in addition, which would reduce the local residual by a corresponding amount. FY2028 figures are drawn from Exhibits 32 and 36. FY2029 and later figures extend beyond the Fiscal Plan's projection horizon: total program cost is grown from the FY2028 exhibit value at the Puerto Rico healthcare inflation index for Medicaid and Medicare of 5.7%, and federal funding follows the Congressional Budget Office's scoring of the reverted capped allotment.

Municipalities also contribute to the financing of Puerto Rico's public health insurance system. Under Act No. 72-1993, municipalities are required to make annual contributions to ASES as part of the financing structure for the Government Health Plan. These contributions totaled approximately $164

[54]Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW https://oversightboard.pr.gov/fiscal-plans/

million annually before a 2018 agreement allowed municipalities to reduce their collective contribution to approximately $85 million in years when Puerto Rico's FMAP exceeded 55%.[55] If the FMAP returns to the statutory 55% rate as projected, this reduction would no longer apply, increasing the collective municipal contribution by approximately $79 million annually. This change is relevant because municipalities would face the increased contribution alongside their existing fiscal and service responsibilities. Its potential effects may also vary across municipalities, including those with more limited access to maternal health services.

Unlike the fifty states, where eligible Medicaid expenditures receive federal matching funds without an annual statutory cap, Puerto Rico operates with both a statutory FMAP and a capped federal allotment.[56] This distinction is central to understanding the magnitude and timing of the projected financing changes beginning in FY2028.

A Pattern of Temporary Federal Funding Measures

Puerto Rico has faced similar Medicaid financing challenges at several points over the past two decades. In response, Congress has enacted a series of temporary measures that increased federal Medicaid funding or enhanced Puerto Rico's FMAP for defined periods. These measures provided additional federal resources while leaving the underlying statutory financing structure established under Section 1108(g) unchanged.

Table 4. Federal responses to Puerto Rico's Medicaid financing shortfalls

Year	Legislative action	Effect
2010	Affordable Care Act (P.L. 111-148, Sec. 2005)	$5.4B in supplemental Medicaid funding; exhausted faster than projected
2010	Affordable Care Act territories funding (P.L. 111-152, Sec. 1204)	$925M added to the Section 1108 limitation, available through December 2019

[55] Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW
[56] Social Security Act, 42 U.S.C. § 1396d(b) (2023). https://www.govinfo.gov/app/details/USCODE-2023-title42/USCODE-2023-title42-chap7-subchapXIX-sec1396d

2017	Consolidated Appropriations Act, 2017	$296M interim measure as ACA funds neared exhaustion
2018	Bipartisan Budget Act (P.L. 115-123, Sec. 50101)	$4.8B following Hurricane Maria, at a 100 percent federal match through September 2019
2019–20	Further Consolidated Appropriations Act, 2020	$2.8B and $2.9B in successive years; FMAP raised to 76 percent
2020	Families First Coronavirus Response Act	$90M and $93M in successive years; FMAP temporarily raised to 82.2 percent
2021	CMS interpretation of Section 1108(g)	$2.9B, growing with the medical care component of CPI-U, October 2021 through December 2022
2023	Consolidated Appropriations Act (P.L. 117-328, Sec. 5101)	Extended 76 percent FMAP and >$19.4B allotment through Sept. 30, 2027
2025	One Big Beautiful Bill Act (P.L. 119-21)	Did not extend the 76 percent FMAP or amend Section 1108(g)
2027–29	FY2028 transition, then full cliff (projected)	Federal funding falls to ~$1.4B, then to ~$0.5B a year under current law

Between FY2011 and FY2023, Puerto Rico received an average of about $2 billion a year in federal Medicaid support through this sequence of measures.[57] The Fiscal Plan itself characterizes the government's response to date as ad hoc legislation offering isolated solutions, a fragmented response that cannot replace comprehensive, long-term holistic planning.[58] In each instance before 2025, Congress supplied a temporary infusion rather than a structural change, and in each instance the gap reasserted itself once the money ran out. The FY2028 cliff is the next iteration of a financing structure that has repeatedly required emergency correction without ever being permanently resolved.

[57]Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW
[58]Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW

Differences in Federal Program Structure

Puerto Rico's Medicaid financing structure exists within a broader federal policy context in which several major social programs operate differently in Puerto Rico than in the fifty states. For example, residents of Puerto Rico are not eligible for Supplemental Security Income (SSI), a distinction upheld by the U.S. Supreme Court in *United States v. Vaello Madero* (2022).[59] Nutrition assistance is provided through the Nutrition Assistance Program (NAP), which operates as a capped block grant, rather than through the Supplemental Nutrition Assistance Program (SNAP) available in the states.[60] Medicaid's capped financing structure under Section 1108(g) represents another example of these differences in federal program design.

These differences exist within a broader fiscal relationship between Puerto Rico and the federal government. Puerto Rico residents contribute to federal revenues through payroll and self-employment taxes and, in certain circumstances, federal income taxes. The Internal Revenue Service reported gross internal revenue collections of approximately $5.54 billion from Puerto Rico in fiscal year 2025.[61] Receiving more in federal spending than residents pay in federal taxes is common across United States jurisdictions: measured in total dollars, 47 of the 50 states had a positive balance of payments with the federal government in federal fiscal year 2023.[62] This broader context is relevant when considering differences in how federal programs are financed and structured

[59] United States v. Vaello Madero, 596 U.S. 159 (2022).

[60] Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity (Section 2.3.1.4). https://oversightboard.pr.gov/fiscal-plans/#link-CW
The Nutrition Assistance Program operates under 7 U.S.C. § 2028, which provides consolidated block grants for Puerto Rico and American Samoa in place of participation in the Supplemental Nutrition Assistance Program.

[61] Internal Revenue Service. (2026). Internal Revenue Service data book, 2025 (Publication 55-B), Table 1-5, Gross collections, by type of tax and state. U.S. Department of the Treasury. https://www.irs.gov/pub/irs-pdf/p55b.pdf
Gross internal revenue collections from Puerto Rico totaled $5,541,476 thousand in fiscal year 2025. This figure covers internal revenue collections and does not include customs duties, which are collected by U.S. Customs and Border Protection.

[62] Holland, L., & Schumacher, P. (2025, August). *Giving or getting? New York's balance of payments with the federal government*. Rockefeller Institute of Government. https://rockinst.org/wp-content/uploads/2025/07/2025-bop-report-web.pdf
The Rockefeller Institute defines the balance of payments as the net difference between federal revenue collected from a state and federal expenditures within that state, allocating federal budget receipts and outlays to states using agency geographic distribution data. The figure cited here is measured in total dollars; rankings calculated on a per capita basis differ. The analysis covers the fifty states and does not include Puerto Rico.

in Puerto Rico. Taken together, these program structures provide additional context for understanding Puerto Rico's Medicaid financing framework and how projected federal funding changes could affect the island's health system and population.

Medicaid Benefit Coverage

Puerto Rico's Medicaid financing structure is also associated with differences in the benefits that Plan Vital is required to cover compared with state Medicaid programs. While states are required to provide the full set of mandatory Medicaid benefits established under federal law, Puerto Rico is not required to cover all of these benefit categories.[63] Among the mandatory benefits not currently covered are nurse-midwife services, certified pediatric and family nurse practitioner services, freestanding birth center services, and non-emergency medical transportation.

Several of these benefit differences are particularly relevant to maternal and infant health and align with needs identified during conversations with families and stakeholders conducted for this report. Participants described the value of integrating midwives, doulas, and other professionals into coordinated models of maternal care, rather than providing these supports separately from the broader health care system. One obstetrician-gynecologist practicing in western Puerto Rico emphasized the potential contribution of midwifery and the importance of integrating midwives into existing models of care:

> *"Support que pudiésemos recibir si la partería se regulara en PR, la ayuda que sería para el sistema de salud [...] También incluirlas como parte integral de los servicios."*
>
> *("The support we could receive if midwifery were regulated in Puerto Rico, the help it could provide to the health care system [...] Also include them as an integral part of the services.")*
>
> — S#8, obstetrician-gynecologist

[63] Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW

A second obstetrician-gynecologist similarly described the value of incorporating doulas and midwives directly into hospital-based care:

> *"Yo creo que [...] tener realmente [...] un personal que de verdad tenga doulas, que sean del hospital, que ya sean parte de nuestro grupo, tener parteras que sean parte."*
>
> *("I think [...] really having [...] a team that includes doulas who are part of the hospital, who are already part of our group, and having midwives who are part of the team.")*
>
> — S#4, obstetrician-gynecologist,

Families also described the value of these supports during pregnancy. One mother reflected on the role that access to a doula played in her pregnancy:

> *"Lo que yo creo que enriqueció mi embarazo fue el tener una doula con conocimiento, el yo poder escribirle a mi doula, el yo tener dudas e inquietudes y acercarme a ella, las clases de parto [...]"*
>
> *("What I think enriched my pregnancy was having a knowledgeable doula, being able to write to my doula, having questions and concerns and being able to reach out to her, [and] the childbirth classes [...]")*
>
> — F#8, mother

Transportation represents another important dimension of access. Non-emergency medical transportation is a mandatory Medicaid benefit for states but is not included among Puerto Rico's covered mandatory benefits.[64] Conversations with providers illustrate how transportation barriers can intersect with geography and the frequency of prenatal appointments. One obstetrician-gynecologist described caring for patients traveling from Vieques, Culebra, Cabo Rojo, and other areas to receive services:

[64] Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW

"Yo veo pacientes de Vieques, de Culebra, de Cabo Rojo, o sea pacientes que vienen en la guagua, que pagaron 20 pesos y si no nos movemos las dejan aquí tiradas."

("I see patients from Vieques, Culebra, Cabo Rojo—patients who come by bus, who paid 20 dollars, and if we do not act, they can be left here without transportation.")

— S#4, obstetrician-gynecologist

Taken together, these benefit differences and the experiences described by families and stakeholders point to the same opportunity: bringing midwifery, doula, transportation and other supportive services into the covered benefit, where they would complement obstetric care rather than sit outside of it.

From Fiscal Cliff to Clinical Consequence

A reduction of this scale does not resolve itself in a budget line. It moves through ASES's capitation rates to the managed care organizations, through provider networks, and into the rooms where pregnant women receive prenatal care and newborns receive intensive care. Because obstetric services already operate at or below break-even for most institutions, as the testimony in Section IV makes plain, they are among the first exposed when rates tighten.

The pressure compounds because the cap does not keep pace even without a cliff. The federal allotment grows at the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U), which has averaged under 3% a year, while Puerto Rico's own healthcare inflation index for Medicaid and Medicare averaged 5.7% from FY2020 to FY2023 and is projected at 4.8% by FY2053. The Fiscal Plan states the consequence directly: the CPI-U measure includes factors that lower it by roughly 1 to 3 percentage points, so the federal funding cap will not keep up with actual increases in expenditures.[65] The gap between what the program costs and what the cap provides widens every year, cliff or no cliff.

Preterm birth is the clearest illustration of the cost logic. The first-year medical cost of a preterm infant is roughly $49,140, against $13,024 for a full-term infant,

[65]Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW

a difference of about $36,000 per birth.[66] Puerto Rico's preterm birth rate is 12.2%, one of the highest documented among the 52 U.S. jurisdictions[67]. March of Dimes analysis expects this will worsen under any contraction of prenatal access. Puerto Rico recorded 2,217 preterm births in 2024. At the difference in first-year medical cost between a preterm and a full-term infant, roughly $36,100, prematurity at the current rate accounts for approximately $80 million a year in first-year medical costs, of which approximately $53 million falls within Medicaid. Each additional percentage point of preterm birth adds approximately $6.5 million, and closing the gap to the Healthy People 2030 target of 9.4% would avoid approximately $18 million annually.[68] The pathway is not speculative: the Commonwealth Fund has documented that Medicaid funding cuts produce measurable increases in maternal mortality, and Puerto Rico's maternal mortality ratio of 59.2 per 100,000 already sits nearly four times the Healthy People 2030 target (see Table 1).[69] A system that far outside the target has no margin to absorb further loss of access without a corresponding, and predictable, cost in lives.

The Beautiful Bill Act: One Big Implications for Puerto Rico

OBBBA was signed into law on July 4, 2025.[70] It reshaped Medicaid financing and program-integrity rules nationally. For Puerto Rico, the most important feature of the law is what it left untouched. It did not extend the 76% FMAP past September 30, 2027. It did not amend Section 1108(g). The cliff described above is entirely unaffected by it.

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[66]Waitzman, N. J., Jalali, A., & Grosse, S. D. (2021). Preterm birth lifetime costs in the United States in 2016: An update. Seminars in Perinatology, 45(3), Article 151390. https://doi.org/10.1016/j.semperi.2021.151390

[67] March of Dimes. (2025). 2025 March of Dimes report card: The state of maternal and infant health for American families. March of Dimes. https://www.marchofdimes.org/peristats/reports/united-states/report-card

[68] Illustrative estimate. The preterm birth count of 2,217 for 2024 and the 12.2% preterm birth rate are reported directly in the March of Dimes 2025 Report Card for Puerto Rico, which also gives 11,855 Medicaid-financed births at 65.8% of all births. First-year medical costs of $49,140 for a preterm infant and $13,024 for a full-term infant are United States national averages in 2016 dollars, applied here to 2024 Puerto Rico births; the estimate is therefore conservative. These are first-year medical costs only. Lifetime costs, including special education, long-term services and lost productivity, are substantially higher.

[69]Joyce, D., Marceno, L., & Eisen, H. (2025, May 20). Medicaid cuts could increase maternal mortality and jeopardize women's health. To the Point (blog). Commonwealth Fund. https://www.commonwealthfund.org/blog/2025/medicaid-cuts-could-increase-maternal-mortality-and-jeopardize-womens-health

[70]Pub. L. No. 119-21, § 71112, 139 Stat. 72 (2025) (commonly known as the One Big Beautiful Bill Act). https://www.congress.gov/119/plaws/publ21/PLAW-119publ21.htm

OBBBA does exempt Puerto Rico from several new requirements imposed on states, including work requirements, biannual eligibility redeterminations, and certain cost-sharing and staffing mandates. But it adds new compliance obligations on top of a financing structure it left unresolved, and one of those obligations falls directly on pregnant women.

Workforce: Puerto Rico was experiencing healthcare workforce challenges before the enactment of OBBBA. According to Association of American Medical Colleges (AAMC) data cited in the Fiscal Plan, more than 47% of actively practicing physicians in Puerto Rico are age 60 or older, the highest proportion among the U.S. states and territories analyzed; Puerto Rico has a ratio of graduate medical education residents and fellows to undergraduate medical students of 0.4, the lowest reported; and approximately half of graduates from Puerto Rico's medical schools remain in active practice on the island.[71] The *Puerto Rico Healthcare Workforce Study*[72] also identifies an aging workforce across several specialties, with this trend particularly pronounced in pediatrics, rheumatology, obstetrics and gynecology, and surgery.[73] These findings raise concerns about future workforce availability as experienced professionals approach retirement or reduce their clinical capacity.

Beginning in July 2026, OBBBA also establishes new federal student loan limits for graduate and professional education. These changes may be relevant to several health and behavioral health professions that require graduate education, including social work and other disciplines involved in maternal, infant, and perinatal care.

Coverage and prenatal care: Beginning January 1, 2027, OBBBA reduces retroactive Medicaid coverage for traditional Medicaid populations, including pregnant women, from three months to two months.[74] Retroactive coverage can help cover eligible health services received before a Medicaid application is completed and approved. This change is particularly relevant during

[71] Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW
[72] The Puerto Rico Healthcare Workforce Study, commissioned by the Financial Oversight and Management Board for Puerto Rico and conducted by FTI Consulting in collaboration with IMPACTIVO, assesses the current and projected supply and demand of Puerto Rico's healthcare workforce.
[73] FTI Consulting, Inc., & Impactivo. (2025). Puerto Rico healthcare workforce study. Financial Oversight and Management Board for Puerto Rico. https://oversightboard.pr.gov/puerto-rico-healthcare-workforce-study-an-in-depth-look-at-healthcare-in-puerto-rico/
[74] Pub. L. No. 119-21, § 71112, 139 Stat. 72 (2025) (commonly known as the One Big Beautiful Bill Act). https://www.congress.gov/119/plaws/publ21/PLAW-119publ21.htm

pregnancy, when delays in enrollment may overlap with the period in which prenatal care begins.

Presumptive eligibility for pregnant women, available in most states, is not currently provided in Puerto Rico. This mechanism allows eligible individuals to receive temporary Medicaid coverage while their eligibility determination is pending. Puerto Rico has also experienced changes in Medicaid enrollment since the end of the COVID-19 continuous enrollment requirement. According to the Fiscal Plan, enrollment declined by approximately 180,000 beneficiaries through FY2025 after eligibility redeterminations resumed in April 2023.[75] The shorter retroactive period, the absence of presumptive eligibility, and the recent enrollment trends all push in the same direction, toward more women reaching prenatal care later, and all three take effect before the financing reduction does.

Program integrity: OBBBA also introduces changes to Medicaid program integrity requirements. Nationally, CMS reported a Medicaid improper payment rate of 5.09% for FY2024, with a substantial proportion of improper payments associated with insufficient documentation rather than findings that services were not delivered, or beneficiaries were ineligible.[76] OBBBA introduces additional requirements related to eligibility error rates beginning in FY2030.

These provisions are particularly relevant for Puerto Rico as it continues to develop its experience with the Payment Error Rate Measurement (PERM) program. Puerto Rico completed its first PERM pilot in 2024 and therefore has a more limited historical baseline for assessing performance under the new requirements. The Fiscal Plan also identifies broader limitations in Puerto Rico's health data infrastructure, including gaps in standardized data collection and participation in certain national health data systems.[77] As implementation moves forward, technical assistance, data infrastructure, and

[75] Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW
[76] Centers for Medicare & Medicaid Services. (2024, November 15). Fiscal Year 2024 improper payments fact sheet. https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2024-improper-payments-fact-sheet; Hinton, E., Mathers, J., & Rudowitz, R. (2025, March 18). 5 key facts about Medicaid program integrity – Fraud, waste, abuse and improper payments. KFF. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-program-integrity-fraud-waste-abuse-and-improper-payments/
[77] Financial Oversight and Management Board for Puerto Rico. (2026). Second revised 2024 fiscal plan for Puerto Rico: Restoring growth and prosperity. https://oversightboard.pr.gov/fiscal-plans/#link-CW

administrative capacity may be important considerations for supporting compliance while maintaining continuity of coverage and services.

IV. Findings

The preceding sections document three key points: that Medicaid is the financial foundation of maternal and infant care in Puerto Rico, that the system it sustains is already performing below every benchmark that defines adequate care, and that a fixed statutory deadline will remove roughly 86% of the federal financing behind it. These findings together with the testimony of clinicians, midwives, hospital leaders, and mothers, describe a system already operating under strain and facing a shock it has limited capacity to absorb.

Finding 1. Medicaid is a central source of financing for maternal and infant health care in Puerto Rico.

Plan Vital finances approximately two of every three births in Puerto Rico and provides coverage to a substantial share of infants and women of reproductive age. Given this level of reliance, the projected reduction in federal Medicaid funding has implications for the financing and continuity of maternal and infant health services across the island.

> *"Una paciente embarazada con Vital, yo puedo decir que tiene, por lo menos por guía, lo que necesita".*
> *(Based on the clinical guidelines a pregnant patient on Plan Vital has the bare minimum needed.).*
> — S#8, obstetrician-gynecologist

Finding 2. Puerto Rico faces significant maternal and infant health challenges before the projected Medicaid funding reductions take effect.

Maternal mortality, infant mortality, preterm birth, and other key indicators remain above U.S. estimates and, where established, Healthy People 2030 targets. These outcomes occur alongside challenges in health care access and workforce availability that can make it more difficult for patients to obtain services. Stakeholders described how

workforce shortages can translate into practical barriers to accessing care, including extended waiting times:

> *"Hay una falta de enfermería, falta de doctor, falta de lo que sea; se llega a un punto en que esos son escollos, trabas que hacen más difícil el cumplimiento de lo otro. El sistema te obligó a que, en vez de ir a una cita que era a las 8, llegué a las 8 y salí a las 5:00 de la tarde".*
>
> *(There is a shortage of nursing, a shortage of doctors, a shortage of everything; you reach a point where those become obstacles, barriers that make everything else harder to keep up with. The system forced it so that, instead of an appointment at 8, I arrived at 8 and left at 5:00 in the afternoon.)*
>
> — S#1, legislator

The importance of monitoring maternal and infant health outcomes against national benchmarks was also reflected in stakeholder conversations. One hospital administrator described using these measures to help providers understand Puerto Rico's current position and encourage improvement:

> *"...cuando salió lo del mapa [March of Dimes] se los puse por todos lados. Que ellos se mantuvieran informados de dónde estamos respecto a la métrica, cuál es el benchmark nacional [...] para que ellos pudieran motivarse a hacer un cambio."*
>
> *("...when [the March of Dimes map] came out, I put it everywhere. So that they would stay informed about where we are in relation to the metric, what the national benchmark is [...] so that they could be motivated to make a change.")*
>
> — S#6, hospital administrator

Finding 3. Access to obstetric care is becoming more limited as labor and delivery capacity and workforce availability decline.

The access challenges documented in Section II were also reflected in participants' experiences. Mothers described difficulty finding obstetricians accepting new patients, while providers raised concerns about limited

workforce availability and the capacity to replace obstetric professionals as they leave practice.

One mother recalled the difficulty she experienced finding an available obstetrician after becoming pregnant:

> *"yo comencé a llamar ginecólogos obstetras en el área oeste. [...] todos me decían que estaban llenos. Todos me decían que no tenían espacio, todos me decían que verdad no habían disponibles"*
>
> *("I started calling obstetrician-gynecologists in the western area. [...] Everyone told me they were full. Everyone told me they had no space; everyone told me there really weren't any available.")*
>
> — F#8, mother

A midwife similarly described concerns about the availability of obstetric professionals and the ability to replace providers as they leave the workforce:

> "*Antes había 300 o 400 haciendo partos; ahora quedan menos de 100. Obviamente ellos no tienen por qué escoger los pueblos... Lo vemos venir hace años*".
> *(There used to be 300 or 400 attending births; now fewer than 100 remain. Of course they do not have to choose the rural towns... We have seen this coming for years.)*
> — S#7, midwife

Finding 4. Financial pressures on labor and delivery services may increase their vulnerability of providers due reductions in Medicaid financing.

Reductions in Medicaid financing can move through Puerto Rico's health care financing structure, from ASES and managed care organizations to the provider networks through which covered services are delivered. Within this context, the financial position of labor and delivery services is particularly relevant. A hospital administrator described labor and delivery as a service that can represent a possible financial loss for hospitals, even when institutions continue to maintain it because of its broader value to the communities they serve. At the provider level, an obstetrician-gynecologist also described

providing clinically necessary services that may not be covered, as well as administrative and documentation requirements that can affect reimbursement and add to provider workload. Together, these accounts illustrate existing financial pressures at different levels of obstetric care that could become more consequential under reductions in Medicaid financing.

> *"En esto que son básicamente cero o negativo, o sea, una sala de parto es un centro de costo. De pérdida potencialmente para los hospitales, esa es la realidad. [...] Pero nosotros, por compromiso con la comunidad uno y dos, porque entendemos que hay un valor añadido en una sala de parto."*
>
> *("In this area, which is basically zero or negative, a labor and delivery unit are costly. A potential loss for hospitals; that is the reality. [...] But for us, first, because of our commitment to the community, and second, because we understand that there is added value in having a labor and delivery unit.")*
>
> — S#6, hospital administrator

A similar tension was described at the provider level:

> *"[...] yo me vi en una situación donde yo terminaba haciendo mi trabajo gratis [...] y no podía cobrar [...] porque son cosas colaterales que no cubre y yo no las puedo dejar de hacer."*
>
> *("[...] I found myself in a situation where I ended up doing my work for free [...] and I could not bill for it [...] because these are additional services that are not covered and that I cannot simply stop providing.")*
>
> — S#8, obstetrician-gynecologist

Financial conditions vary across hospitals and obstetric providers. What these accounts share is the direction of the pressure: reimbursement, coverage limits, and the cost of providing obstetric care all push the same service line toward the margin.

Finding 5. Gaps in Medicaid coverage can create barriers to timely prenatal care.

Family experiences illustrate how gaps or delays in obtaining health coverage can interfere with timely access to prenatal and obstetric care. One mother described being unable to seek hospital care while waiting for health coverage:

> *"Yo tenía ese miedo de perder el bebé, pero no podía ir al hospital porque no tenía plan médico. Iba a la oficina del plan y explicaba la situación entre llanto, y me decían que esos procesos siempre tardan, que había que esperar".*
>
> *(I had that fear of losing the baby, but I could not go to the hospital because I had no health insurance. I would go to the plan office and explain the situation in tears, and they would tell me those processes always take time, that I had to wait.)*
>
> — F#2, mother

A father similarly described a period during his partner's pregnancy when the family did not have health coverage and the difficulty they subsequently experienced in finding an obstetrician:

> *"Nosotros estábamos sin plan médico, como hubo unos casi 2 o 3 meses sin plan médico porque yo estaba asustado porque sinceramente mi esposa estaba en la semanita [cinco o diez] de embarazo. Yo no tenía plan médico ni ella tampoco [...] pero al final de todo, pues nos dieron plan médico gracias a Dios, al tercero o cuarto mes, y ahí fue en busca de ginecólogo. Este fue un poquito difícil porque ya como mi esposa tenía ya la semanita un poquito adelantada, pues era muy difícil que le cogieran a ella un espacio."*
>
> ("We were without health insurance for almost two or three months, and I was worried because, honestly, my wife was around [five or ten] weeks pregnant. Neither she nor I had health insurance. [...] Eventually, thank God, we received health insurance around the third or fourth month, and that was when we began looking for an obstetrician. It was a little difficult because my wife was already further along in her pregnancy, so it was very difficult to find an obstetrician who could take her as a patient.")
>
> — F#6, father

Clinicians also described encountering patients who reached delivery with limited or no prenatal care:

> *"Yo diría que los últimos meses hemos visto muchas, muchas pacientes con pobres cuidados prenatales. Hace como dos semanas eran un montón de pacientes que no tenían cuidado prenatal y llegaron todas a parir."*
>
> *("I would say that in recent months we have seen many, many patients with poor prenatal care. About two weeks ago, there were a number of patients who had received no prenatal care and they all arrived to give birth.")*
>
> — S#4, obstetrician-gynecologist

Together, these accounts illustrate how gaps or delays in coverage can intersect with access to prenatal care. In this context, the absence of presumptive eligibility and the forthcoming reduction in retroactive Medicaid coverage are important considerations for monitoring continuity of coverage and timely access to prenatal services.

Finding 6. Access to and continuity of perinatal mental health services remain an important challenges.

Access to appropriate mental health services can be complicated by the availability of professionals, insurance coverage, cost, and the time required to move through referral processes. These challenges can be particularly relevant when specialized services are needed during pregnancy and the postpartum period. Family experiences illustrate difficulties identifying professionals with expertise in perinatal mental health, obtaining services covered by their health plan, and receiving timely referrals.

One mother described searching specifically for mental health professionals focused on pregnancy and childbirth:

> *"Fue como un poco traumático y justamente por eso yo busqué ayuda a través de Comienzo Saludable para los servicios de terapia porque no encontraba. Ahora, casualmente me salen muchas psicólogas este enfocadas en el área de embarazo, de parto, por aquí para allá. Pero*

cuando yo estuve embarazada no encontraba y cuando llamaba era bien costoso. Los servicios no lo cubría el plan."

("It was somewhat traumatic, and that is precisely why I sought help through Healthy Start for therapy services, because I could not find them. Now, coincidentally, I come across many psychologists focused on pregnancy and childbirth. But when I was pregnant, I could not find them, and when I called, it was very expensive. The services were not covered by the health plan.")

— F#3, mother

Another mother described delays as she moved through different stages of the mental health referral process:

"Realmente cuando me mandaron al fin con una psicóloga, porque es un proceso, primero te mandan con trabajador social, que básicamente lo que hace es llenar papeleo. No te escucha ni nada. Luego vuelven y te mandan con trabajador social. Vuelve y llena papeleo, vuelve y no te escucha nada y entonces él entiende que es necesario mandarte con psicóloga, te manda con la psicóloga, llegaste con la psicóloga. Ya a estas alturas del partido ha pasado 1 o 2 meses entre cada cita."

("When I was finally referred to a psychologist, because it is a process, they first send you to a social worker, who basically fills out paperwork. They do not listen to you or anything. Then they send you back to a social worker, who fills out the paperwork again and again does not listen to you, and then decides that it is necessary to refer you to a psychologist. By that point, one or two months had passed between each appointment. I probably would have already killed myself. But the appointment with the psychiatrist was scheduled for after I gave birth.")

— F#2, mother

An obstetrician-gynecologist also raised questions about continuity of mental health screening and follow-up during the postpartum period. Describing her own practice, she explained that she screens patients for postpartum depression at two weeks but questioned who continues that monitoring after patients are no longer routinely seen:

"Cuando hablamos de postparto, de screen, de depresión, yo hago un screen a las dos semanas [...] pero yo las veo dos semanas y yo no las veo más. ¿Quién las ve?"

("When we talk about postpartum, depression screening, I conduct a screening at two weeks [...] but I see them at two weeks and then I do not see them again. Who sees them?")

— S#8, obstetrician-gynecologist

Finding 7. Workforce capacity and community-based supports are both important to sustaining maternal and infant health services.

Puerto Rico's maternal and infant health system is affected by broader workforce challenges, including an aging healthcare workforce and concerns about the future availability and retention of providers. As discussed earlier in this report, these pressures are particularly relevant to maternal health given the aging of the OB/GYN workforce and broader challenges in training and retaining healthcare professionals. These concerns were also reflected in the experiences of maternal health providers. One obstetrician-gynecologist emphasized the importance of retaining physicians:

"[...] retener la clase médica yo creo que ahora mismo es crucial."

("[...] I think retaining the medical workforce is crucial right now.")

— S#8, obstetrician-gynecologist

These workforce and demographic pressures also underscore the role of community-based services in complementing clinical care. Programs such as Healthy Start and doula services do not replace obstetric care but can support a shared-care approach by providing families with education, navigation, continuity of support, and connections to other services throughout pregnancy and the postpartum period. In a context of limited obstetric workforce capacity, these complementary roles can support clinicians and the broader maternal health system while providing families with forms of support that extend beyond clinical care. One mother described the importance she placed on these services:

> *"Comienzo Saludable, Una Doula para Cada Familia. Sin esos programas... esto debería ser algo del Gobierno, literalmente, tan mandatorio como el plan médico."*
>
> *("Healthy Start, a doula for every family. Without those programs... this should be something the government provides, literally, as mandatory as the health plan itself.")*
>
> — F#2, mother

Both dimensions matter, and they are not substitutes for one another. Retaining physicians and other clinicians remains the binding constraint, while community-based services extend what a smaller clinical workforce can reach.

V. Policy Options

Based on the findings presented in Section IV, the policy options are organized into three tiers:

- Policy options focus on federal and Puerto Rico policy actions related to Medicaid financing, eligibility, and coverage.
- Practice options focus on strengthening the delivery and coordination of maternal and infant health services across Puerto Rico's health system.
- Program options focus on the administrative, data, and monitoring infrastructure needed to support implementation, continuity of care, and accountability.

Certain financing scenarios would require federal action, while others may be advanced under existing Puerto Rico authority. Across all three tiers, implementation requires coordination among the federal government, the government of Puerto Rico, ASES, managed care organizations, hospitals, healthcare professionals, community and third-sector organizations, and the families the system serves.

Table 5. Policy Options

Policy Options	Timeframe	Rationale
1. Maintaining an enhanced federal matching rate beyond September 30, 2027 is one financing scenario that could reduce the projected FY2028 gap.	Before Sept. 30, 2027	Extending the enhanced FMAP would help maintain federal Medicaid financing beyond the current authorization period and reduce the magnitude of the projected financing gap. Given that Plan Vital finances approximately two of every three births in Puerto Rico, continuity in federal Medicaid financing is particularly relevant to maternal and infant health services. An extension would provide additional time to pursue longer-term changes to Puerto Rico's Medicaid financing structure.
2. Longer-term financing alternatives under Section 1108(g) warrant further analysis as potential approaches to improve predictability and stability.	Concurrent with FMAP extension	Puerto Rico's recurring reliance on temporary federal funding measures underscores the need for a structural financing solution rather than another time-limited extension.
3. Assess opportunities to strengthen coverage of services relevant to maternal and infant health.	Near to medium term	Puerto Rico's Medicaid benefit structure differs from that available in the states in several areas relevant to maternal and infant health. Continued

Policy Options	Timeframe	Rationale
		assessment and expansion of covered benefits could strengthen access to services across pregnancy, childbirth, and the postpartum period and support greater continuity of care.
4. Recognize and strengthen the integration of midwives and doulas within Puerto Rico's maternal health system.	Near to medium term	Midwives and doulas can play distinct but complementary roles in maternal health care. Clearer mechanisms for their recognition, integration, and, where applicable, reimbursement could support shared-care approaches by expanding the range of professionals and community-based supports available to families throughout pregnancy, childbirth, and the postpartum period. These approaches should reflect the distinct scopes and roles of midwives and doulas and maintain appropriate coordination and referral pathways with obstetric and other clinical services.
5. Consider adopting presumptive eligibility	Before January 2027	Puerto Rico does not currently provide presumptive eligibility for

Policy Options	Timeframe	Rationale
for pregnant women at the point of care.		pregnant women. Beginning January 1, 2027, OBBBA reduces Medicaid retroactive coverage for pregnant women and other traditional Medicaid populations from three months to two months before the month of application. Presumptive eligibility could provide temporary coverage while a full eligibility determination is pending and support earlier access to prenatal care.

Table 6. Practice Options

Practice Options	Timeframe	Rationale
6. Integrate perinatal mental health screening, referral, and treatment across prenatal, obstetric, and postpartum care.	Ongoing	Postpartum depression affects a substantial share of mothers in Puerto Rico, while the findings identify challenges in accessing and navigating mental health services. Strengthening integration across prenatal, obstetric, primary care, behavioral health, and postpartum services can support earlier identification, referral, and continuity of treatment. (Finding 6)

Practice Options	Timeframe	Rationale
7. Strengthen shared-care models for low-risk pregnancies by integrating obstetricians, midwives, doulas, community health workers, family medicine professionals, and other maternal health professionals into coordinated care teams, supported by telehealth where appropriate.	Ongoing; begin now	Limited and uneven obstetric availability supports exploring coordinated shared-care models that extend maternal health capacity while maintaining appropriate clinical pathways for higher-risk pregnancies.
8. Explore regional models for maintaining access to obstetric services, including hub-and-spoke approaches and reimbursement strategies that support the sustainability of labor and delivery services.	Near to medium term	The decline in labor and delivery units and uneven geographic distribution of obstetric services warrant consideration of regional approaches that connect hospitals and specialized obstetric capacity with providers and services in areas with more limited access. Reimbursement strategies should also be examined in light of the financial and operational pressures described by hospitals and maternal health providers.

Table 7. Program Options

Program Options	Timeframe	Rationale
9. Strengthen Medicaid administrative, documentation, and program-integrity capacity, including a PERM-readiness roadmap and beneficiary and provider verification processes.	Before FY2030	Puerto Rico's participation in PERM introduces additional administrative, eligibility, and documentation requirements. Developing readiness processes in advance can strengthen data quality, verification, compliance, and Puerto Rico's capacity to respond to future federal requirements.
10. Develop and maintain a reliable provider directory and strengthen care-navigation supports for families.	Near term; ongoing	Families described difficulties identifying providers who were available, accepting new patients, or participating in their health plan. More reliable provider information, combined with navigation support, can reduce the administrative burden placed on families when seeking prenatal, obstetric, behavioral health, and other services.
11. Strengthen maternal and infant health surveillance and develop indicators to monitor changes in coverage, access, utilization, provider	Ongoing; begin now	Existing maternal and infant health indicators provide an important baseline for monitoring changes over time. Strengthening PRAMS and

Program Options	Timeframe	Rationale
availability, and health outcomes.		linking or coordinating available Medicaid, hospital, workforce, and maternal and infant health data could support earlier identification of changes in coverage, access, utilization, and outcomes as federal Medicaid financing and policy changes are implemented.

VI. Conclusion

This report asked a central question: ***What would happen to maternal and infant health in Puerto Rico if the Medicaid system faces a reduction of approximately $4 billion a year beginning in FY2028?***

The findings indicate that a reduction of this magnitude would place additional pressure on Puerto Rico's capacity to finance and sustain maternal and infant health services and could affect access to and continuity of care for pregnant women, infants, and families. Medicaid finances approximately two of every three births in Puerto Rico and supports care throughout pregnancy, childbirth, the postpartum period, infancy, and childhood. The projected reduction would therefore affect a major source of financing for maternal and infant health care at a time when Puerto Rico already faces significant challenges in maternal and infant health outcomes, fewer labor and delivery units, uneven availability of obstetric services, financial and operational pressures among providers and hospitals, gaps in access to perinatal mental health services, and broader healthcare workforce pressures.

The precise effects would depend on how the financing reduction is implemented and how Puerto Rico responds, including decisions about

eligibility, benefits, reimbursement, provider networks, and the allocation of available resources. The findings nevertheless identify several areas where existing pressures could be compounded: provider capacity and availability, continuity of Medicaid coverage and care, access to obstetric and perinatal mental health services, and the ability of hospitals and other providers to sustain maternal health services. The effects would also be unlikely to be experienced uniformly across Puerto Rico, particularly given existing differences in the geographic availability of obstetric care and other maternal health services.

The projected funding reduction also reflects a longer-standing feature of Puerto Rico's Medicaid financing structure. Although Congress has repeatedly provided temporary increases in federal funding and matching rates, Puerto Rico remains subject to the capped federal financing structure established under Section 1108(g). Extending the current 76% FMAP would address the immediate reduction projected for FY2028, while a longer-term financing approach could provide greater stability and predictability for Medicaid and the health system that depends on it. Scenarios that maintain an enhanced federal matching rate beyond FY2027 would reduce the magnitude of the projected FY2028 financing gap

Federal financing, however, is only one part of the response. The findings also identify actions that can be advanced within Puerto Rico to strengthen maternal and infant health services, including improving continuity of Medicaid coverage during pregnancy; integrating perinatal mental health screening, referral, and treatment; strengthening the recognition and integration of midwives and doulas; developing shared-care approaches for low-risk pregnancies; improving provider information and care navigation; supporting workforce capacity and retention; and strengthening data systems to monitor changes in coverage, access, utilization, provider availability, and maternal and infant health outcomes.

Ultimately, the implications of the Medicaid cliff for maternal and infant health will be shaped both by federal financing decisions and by the actions Puerto Rico takes to prepare for and respond to them. The evidence presented in this report supports a two-part response: addressing the immediate financing risk while simultaneously strengthening the services, workforce, community-based supports, and infrastructure that contribute to continuity of maternal

and infant health care. The period before September 30, 2027 therefore represents an opportunity not only to address the projected financing reduction, but also to strengthen the capacity of Puerto Rico's maternal and infant health system for the longer term.

As one participant emphasized, decisions about financing and health policy should also be informed by the realities and needs of the people who experience the system:

> *"Necesitamos que las personas que toman las decisiones a gran escala estén realmente empapadas de lo que es el embarazo, los riesgos, las necesidades."*
>
> *("We need the people making decisions at a large scale to truly understand what pregnancy involves, its risks, and its needs.")*
>
> — S#8, obstetrician-gynecologist

The experiences shared by families also highlight what continuity, choice, and patient-centered maternal care can mean in practice. As one mother described, a maternal health system that responds to families' needs includes the ability to make decisions about where to give birth and to receive care in a setting where they feel comfortable and supported:

> *"Yo debo escoger donde poder parir, donde yo me sienta cómoda y no ser penalizada por ello... Ese es el sistema que yo entiendo que todos los puertorriqueños y puertorriqueñas merecemos, porque las familias de verdad necesitan eso".*
>
> *(I should be able to choose where to give birth, where I feel comfortable, and not be penalized for it... That is the system I believe all Puerto Ricans deserve, because families genuinely need that.)*
>
> — F#2, mother

Appendix A. Methodology

Policy Analysis Approach

This report applies a descriptive, multidisciplinary policy analysis approach to examine projected changes in Medicaid financing and their implications for maternal and infant health in Puerto Rico. Policy analysis draws on knowledge and methods from multiple disciplines to develop and critically assess information relevant to public policy and practical policy problems.[78] Within this broader framework, descriptive policy analysis uses social science knowledge to examine policies and the conditions and consequences associated with them.[79]

Policy analysis is not limited to a single method or disciplinary perspective; different methods and forms of evidence may be used according to the nature of the policy problem being examined.[80] Consistent with this multidisciplinary approach, the report integrates documentary review, quantitative secondary data, qualitative evidence from families and stakeholders, and descriptive economic and fiscal analysis. Triangulation across these sources was used to examine areas of convergence, complementarity, and divergence and to develop a more comprehensive understanding of the policy problem. Together, these components provide complementary perspectives on Medicaid financing, maternal and infant health outcomes, access to services, healthcare workforce and system capacity, and the experiences of families and stakeholders.

Documentary Review. The analysis used triangulation of information from multiple sources, including documentary and policy review, quantitative secondary data, and in-depth conversations with families and stakeholders. Documentary sources included federal and Puerto Rico laws and policies, Medicaid financing and program documents, government reports, fiscal plans, health surveillance data, workforce studies, and other relevant maternal and infant health sources. Information across these sources was examined

[78] Dunn, W. N. (2018). Public policy analysis: An integrated approach (6th ed.). Routledge.
[79] Dunn, W. N. (2018). Public policy analysis: An integrated approach (6th ed.). Routledge.
[80] Yang, Y., Tan, X., Shi, Y., & Deng, J. (2023). What are the core concerns of policy analysis? A multidisciplinary investigation based on in-depth bibliometric analysis. Humanities and Social Sciences Communications, 10, Article 190. https://doi.org/10.1057/s41599-023-01703-0

together to identify areas of convergence and complementarity and to assess Puerto Rico's Medicaid financing structure, relevant policy changes, maternal and infant health outcomes, access to services, and healthcare workforce conditions. This approach to treating federal and Puerto Rico policy documents, program materials, and fiscal reports as primary sources of evidence is consistent with established qualitative document analysis methods, in which existing texts serve as valid empirical data when interpreted in relation to other sources of evidence.[81]

Participants. The qualitative evidence draws on in-depth conversations conducted between February and May 2026. A total of 15 participants were included: eight family participants—seven mothers and one father—and seven stakeholders, including one legislator, two obstetrician-gynecologists, one nurse, one health educator, one hospital administrator, and one midwife. Participants were recruited through purposive and convenience sampling based on established eligibility criteria and referrals from programs connected to the original project. Family participants were 21 years of age or older, had recent lived experience interacting with maternal and infant health services, and resided in the southern or western regions of Puerto Rico. Stakeholders were 21 years of age or older and had direct or indirect involvement in maternal, perinatal, or infant health services or policy in Puerto Rico and/or recent experience working with families in the southern or western regions. This combination of sampling strategies reflects accepted qualitative research practice, in which purposive and convenience sampling are frequently used together, with the understanding that findings generalize only to the subpopulation from which the sample was drawn rather than to the general population.[82]

Data Collection. Conversations were conducted virtually or in person, lasted approximately 45 to 90 minutes, and were recorded and transcribed. Prior to participation, individuals completed an informed consent process addressing voluntariness, confidentiality, recording, and the right to withdraw at any time. The conversations included in this report were completed before Institutional Review Board approval for a separate research protocol was received on June

[81] Morgan, H. (2022). Conducting a qualitative document analysis. The Qualitative Report, 27(1), 64–77. https://doi.org/10.46743/2160-3715/2022.5044
[82] Andrade, C. (2021). The inconvenient truth about convenience and purposive samples. Indian Journal of Psychological Medicine, 43(1), 86–88. https://doi.org/10.1177/0253717620977000

23, 2026. Participants were assigned alphanumeric codes (F for families and S for stakeholders), and identifying information was removed from the report. Family participants were coded F#1–F#8. Stakeholder participants were coded S#1–S#8; S#5 was not used because that conversation was not conducted. The conversations were conducted in Spanish. Participant quotations selected for inclusion in this report were translated into English using Claude Sonnet 5, an AI language model developed by Anthropic[83]; translations were not independently reviewed by a bilingual researcher.

Analysis. The qualitative analysis followed an iterative and reflexive process involving repeated review of the transcripts, identification of recurring patterns and units of meaning, and organization into thematic categories. Themes included access to health services; coverage and financing; mental health and emotional well-being; comprehensive care during pregnancy and childbirth; complementary supports; social determinants of health; health system capacity; governance and public policy; and policy options for improving the system.

Economic and Fiscal Analysis

The economic component of this report characterizes the size, timing and incidence of the projected change in federal Medicaid financing, and illustrates one channel through which that change carries a measurable cost. It is a descriptive fiscal analysis built from published federal and Puerto Rico sources. It is not a microsimulation, and it does not model how the government of Puerto Rico would respond to a reduction of this magnitude.

Sources and provenance. Financing figures are drawn from the *Second Revised 2024 Fiscal Plan for Puerto Rico: Restoring Growth and Prosperity*, certified by the Financial Oversight and Management Board on June 19, 2026. Three exhibits carry the underlying data: Exhibit 31, the expected Medicaid funding cap; Exhibit 32, baseline federal funds estimates; and Exhibit 36, projected Medicaid and CHIP expenditures. All three are stated on a Puerto Rico fiscal year basis. Where this report gives a figure that appears in those exhibits, it is the Board's. Where it gives a figure derived from them, such as

[83] Anthropic. (2026). *Claude Sonnet 5* [Large language model]. https://claude.ai

the local share of program cost, that derivation is described below. The Fiscal Plan does not publish a local Medicaid share.

Financing baseline. For FY2027, Exhibit 36 gives total program spending of $5,214 million and Exhibit 32 gives federal funds of $3,768 million. The difference, $1,446 million or approximately 28%, is the local share financed through the General Fund and Special Revenue Fund. Both exhibits exclude the same Department of Health expenditures covering the federal match on Federally Qualified Health Centers and Medicaid program operations, which is what makes the subtraction valid. The 76% Federal Medical Assistance Percentage derives from Section 5101 of the Consolidated Appropriations Act, 2023; the 55% rate that applies on expiration is set by Section 1905(b) of the Social Security Act, and the annual cap by Section 1108(g).

Federal Medicaid funding for Puerto Rico is reported on two calendars and at two scopes, and figures that appear to conflict often do not. Section 1108(g) of the Social Security Act sets a statutory allotment of $3,825 million for federal fiscal year 2027. The Consolidated Appropriations Act, 2023 added $300 million conditioned on a physician payment floor and $75 million conditioned on program integrity and procurement requirements, neither counted against the cap, for a total potential federal contribution of $4,200 million on a federal fiscal year basis. This report instead uses the Fiscal Plan's Puerto Rico fiscal year projections. On that basis, Exhibit 32 reports total federal funding of $3,768 million for FY2027, comprising $3,557 million in capped Medicaid funding, $125 million in CHIP, and $85 million in the Enhanced Allotment Program. Puerto Rico's fiscal year begins July 1 and the federal fiscal year begins October 1, so the two sets are not directly comparable. Unless stated otherwise, figures in this report are on the Puerto Rico fiscal year.

Scope of the reduction. Not all federal Medicaid funding is subject to the cap. CHIP and the Enhanced Allotment Plan are authorized separately and are not subject to the Section 1108(g) cap; both continue past September 30, 2027, though at reduced federal shares once the enhanced matching rate expires. Together they account for $210 million of the FY2027 federal total, $125 million in CHIP and $85 million in EAP, declining to $190 million in FY2028. What the cliff removes is the capped Medicaid allotment, which Exhibit 32 reports at $3,557 million in FY2027 and $1,246 million in FY2028.

Timing. The two-step profile in Table 3 follows from the misalignment of two fiscal calendars rather than from any assumption made here. Puerto Rico's fiscal year begins July 1, while the enhanced federal financing expires at the close of the federal fiscal year on September 30, 2027. Puerto Rico's FY2028 therefore contains one quarter funded at the enhanced level and three at the capped level. Applying those weights to Exhibit 32's capped Medicaid figures implies a post-expiration annual rate of approximately $476 million, consistent with the roughly $500 million the Congressional Budget Office scored for the reversion in its estimate of Section 5101.

Projection beyond the Fiscal Plan. Exhibit 36 ends at FY2028. FY2029 and later figures in Table 3 extend past the Board's horizon. Total program cost is grown forward from the FY2028 exhibit value using the Puerto Rico healthcare inflation index for Medicaid and Medicare, which the Fiscal Plan reports averaged 5.7% from FY2020 to FY2023 and projects at 4.8% by FY2053. Federal funding follows the Congressional Budget Office scoring. Local share and added burden are computed from those two figures.

Structural drift between the cap and program cost. The federal allotment grows at the medical care component of the Consumer Price Index for All Urban Consumers, under Section 1108(g)(2)(A)(i), which has averaged under 3% a year. Puerto Rico's own healthcare inflation index runs substantially higher. The Fiscal Plan states the consequence directly: the Consumer Price Index measure includes factors that lower it by roughly 1 to 3 percentage points, so the federal funding cap will not keep up with actual increases in expenditures. This comparison shows that the gap between program cost and capped federal support widens independently of the FY2028 expiration.

Illustrative cost of preterm birth. To show how a change in access converts into a measurable cost, published unit costs are applied to Puerto Rico's birth counts. Total annual births are derived from the report's own coverage figures: Plan Vital financed 11,855 births in 2024, representing 65.8% of all births, which implies approximately 18,000 total births. Puerto Rico's preterm birth rate of 12.2% gives approximately 2,200 preterm births annually. First-year medical costs of $49,140 for a preterm infant and $13,024 for a full-term infant, from Waitzman, Jalali and Grosse (2021), give an excess of approximately $36,100 per preterm birth and approximately $79 million annually, of which approximately $52 million falls within Medicaid. On the same basis each additional

percentage point of preterm birth adds approximately $6.5 million, and closing the gap to the Healthy People 2030 target of 9.4% would avoid approximately $18 million annually.

These figures are illustrative rather than predictive. They quantify the cost of prematurity at current rates; they do not estimate how much prematurity would increase under a given reduction in prenatal access. The documented association between Medicaid financing reductions and maternal health outcomes is treated as evidence from the literature, not as a modeled relationship.

What the analysis does not do. It does not model Puerto Rico's policy response, and therefore does not project changes in eligibility, benefits, reimbursement rates or provider participation. It does not estimate the number of people who would lose coverage, or model health outcomes under any scenario. Where the report describes how a financing reduction moves through ASES and the managed care organizations to the point of care, that description traces an existing payment structure; it is not a quantitative allocation of the reduction across services or providers.

Limitations

The qualitative component is not intended to be representative of all families, healthcare professionals, organizations, or regions in Puerto Rico, nor is it used to estimate prevalence or establish causal relationships. Rather, participants' experiences and perspectives provide contextual evidence that complements the documentary, policy, and quantitative analysis. Participants were recruited from the southern and western regions of Puerto Rico. Conditions affecting access to maternal health services vary across the island, and the experiences described here may not reflect those in the San Juan metropolitan area or in other regions.

Financing projections beyond FY2028 extend past the Fiscal Plan's horizon. Exhibit 36 ends at FY2028, so the FY2029 and later figures in Table 3 are calculated for this report by growing total program cost at the Puerto Rico healthcare inflation index for Medicaid and Medicare and applying the Congressional Budget Office's scoring of the reverted allotment. They are projections under current law rather than the Board's own estimates, and they are sensitive to the growth rate assumed. These financing scenarios are

intended to illustrate potential fiscal conditions under current law and do not predict how the Government of Puerto Rico would respond to changes in federal Medicaid financing.

The preterm birth cost estimate is illustrative. It applies United States national first-year medical costs, expressed in 2016 dollars, to Puerto Rico birth counts for 2024. It covers first-year medical costs only and excludes special education, long-term services, and lost productivity, which are substantially larger. It quantifies the cost of prematurity at current rates; it does not estimate how much prematurity would increase under any given reduction in prenatal access.

Health indicators are drawn from sources that measure the same conditions in different ways, and the notes to Tables 1 and 2 identify where this occurs. Birth-certificate and survey-reported prevalence are not interchangeable, and self-reported prevalence is generally the higher of the two. Puerto Rico is also reported separately from the fifty states in several federal data systems, including the National Center for Health Statistics natality files, and is not included in others. Where a comparable national figure was not available on the same basis, none is presented rather than pairing measures that are not equivalent.

Enrollment figures reflect a point in time and change as eligibility redeterminations proceed. Coverage shares use the American Community Survey population estimate identified in the notes; other population series in circulation would produce slightly different shares.

Finally, this analysis reflects federal and Puerto Rico law and published fiscal projections as of September 2026. Congressional action on the enhanced FMAP or on Section 1108(g), further guidance implementing the One Big Beautiful Bill Act, or a subsequent certified Fiscal Plan would change the financing figures presented here.

Conflict of Interest

The authors declare no conflicts of interest.

Disclaimer

This report was developed by Grupo Nexos, Inc. for research, educational, and public policy analysis purposes. It summarizes available evidence regarding Medicaid financing and maternal and infant health in Puerto Rico and identifies policy, programmatic, and practice options arising from that analysis. Nothing in this report is intended to constitute lobbying, a call for legislative action, an endorsement or opposition to specific legislation, or a request that any public official or governmental entity take a particular legislative action. References to federal or Puerto Rico governmental entities are included to describe their respective roles, authorities, and responsibilities within the Medicaid financing and health care system.