Plan Vital APR DRG Implementation: Frequently Asked Questions

Based on directives from the Financial Oversight and Management Board (FOMB), Administración de Seguros de Salud (ASES) is implementing an All Patient Refined Diagnosis-Related Group (APR DRG) reimbursement system to be administered by the Plan Vital managed care organizations (MCOs) effective January 1, 2026.

The APR DRG reimbursement system is a prospective rate system in which the hospital-specific base rate is a predetermined amount, but the future calculated payment for each inpatient hospital discharge relies on the APR DRG classification, associated relative weight, and eligibility for other Plan Vital policies (e.g., transfer policy, outlier policy), resulting in varied payments for each discharge.

It is important to note that although the hospital-specific base rates are calculated using historical expenditures to target a budget neutral amount across providers, future payments are not limited to this aggregate amount. APR DRG payments effective for Plan Vital on January 1, 2026, will be calculated for each inpatient hospital discharge based on the APR DRG classification, associated relative weight, and eligibility for other Plan Vital policies based on the coding on the claim.

This document provides information to assist hospitals, Plan Vital MCOs, and other interested parties with the implementation of the APR DRG reimbursement system in Puerto Rico. This document will be updated periodically as ASES receives questions or comments.

1. ***The hospitals are concerned that receiving the APR DRG grouper software three months before the October 2025 implementation date is not enough lead time and could put at risk the already weak financial conditions of the hospitals.***

The grouper software was released on June 26, 2025. The implementation date for the APR DRG methodology has been moved from October 1, 2025, to January 1, 2026. This additional time will allow hospitals to become more familiar with the grouper software and work with the MCOs to test claims, ensuring that the flow of information will be as smooth as possible. In addition, Puerto Rico hospitals can access Solventum's Patient Classification Methodologies website, which includes definition manuals for the methodologies that will be utilized by ASES and an easy-to-use assignment tool. This tool will allow users to enter minimal demographic information plus the diagnosis and procedure codes to generate an output report showing the calculated APR DRG assignment and the Severity of Illness score. The report identifies and explains each of the 18 steps the grouper goes through for each inpatient discharge.

2. ***Do hospitals need to purchase the APR DRG reimbursement software? How much does the APR DRG reimbursement software cost?***

Hospitals are not required to purchase the APR DRG grouper software to receive payment from the Plan Vital MCOs. However, hospitals are able to purchase the software to ensure and anticipate accurate payment. Infomedika is the exclusive distributor for Solventum software products *to hospitals and providers* in Puerto Rico. However, for payers, there is no exclusivity by any entity over distribution of APR DRG software or services by any Solventum business partner. If your organization wants to purchase the software, organizations are able to license the APR DRG general software at any time and gain access to the grouper and weights. Please contact Jeff Turnipseed (jsturnipseed@solventum.com) to inquire about licensing the general software. The pricing varies by hospital, as it is dependent on volume (number of inpatient admissions).

3. ***Why did ASES decide to implement APR DRGs as opposed to Medicare Severity Diagnosis Related Groups used by Medicare for fee-for-service?***

The APR DRG reimbursement system is the most common system used by Medicaid agencies within the United States to reimburse hospitals for services provided to Medicaid beneficiaries. The APR DRG relative weights reflect all payer experience while Medicare Severity Diagnosis Related Groups (MS-DRGs) are based on the Medicare population. Because the APR DRG system relies on data from all payers, there are DRGs for newborns, delivery, and pediatric care, which do not exist in the MS-DRG system.

4. ***How is the DRG and the SOI determined for each discharge?***

The assignment of a specific DRG is driven by the following:

- Principal diagnosis
- Procedures performed
- Most additional or secondary diagnoses
- Patient age
- Patient gender

The above information is submitted on the UB04 paper claim form or the 837I electronic claim form.
Based on the Solventum Methodology Overview (https://www.solventum.com/en-us/home/h/f/b5005024009/#accordion-70c4823d8c-item-3c51822417), the assignment of the severity of illness (SOI) can be summarized as follows.

> *The assignment of a patient to a severity of illness or risk of mortality subclass takes into consideration not only the level of the secondary diagnoses but also the interaction among secondary diagnoses, age, principal diagnosis, and the presence of certain OR (operating room) procedures and non-OR procedures.*

The process of determining the severity of illness or risk of mortality subclass of a patient consists of three phases. In Phase I, the level of each secondary diagnosis is determined. Once the level of each individual secondary diagnosis is established, then Phase II determines a base subclass for the patient based on all of the patient's secondary diagnoses. In Phase III, the final subclass for the patient is determined by incorporating the impact of principal diagnosis, age, OR procedure, non-OR procedures, multiple OR procedures, and combinations of categories of secondary diagnoses. A detailed description of the determination of the severity of illness subclass and the risk of mortality subclass will be presented separately.

5. ***Will the DRG/SOI for a patient stay be determined based on diagnosis codes at the time of discharge or time of the admission?***

The APR DRG system identifies both an admission APR DRG and discharge APR DRG for each patient stay. The admission APR DRG requires a present on admission indicator for each diagnosis. Since the principal diagnosis is defined as the condition established after careful study to be chiefly responsible for occasioning the patient's admission to the hospital, the DRG/SOI determined at time of discharge will be used for payment purposes.

6. ***Please explain how the case-mix index is calculated for each hospital.***

The case mix for each hospital equals the sum of the weights for all of the valid inpatient claims (excluding transfers) for the period under review based on the assigned APR DRG divided by the count of total discharges. The formula is as follows.

Σ ((DRG/SOI #1 Weight x DRG/SOI #1 Discharges), (DRG/SOI #2 Weight x DRG/SOI #2 Discharges), …..) ÷ Total Discharges for All DRG/SOIs

Each hospital was provided with the necessary information to calculate the case-mix index from the hospital exhibits provided in November 2025 (refer to the "DRG and SOI" tab). Column E of this tab is the DRG weight for each DRG and its corresponding SOI. Column G is the discharges for each DRG and its corresponding SOI. The total weight for each DRG/SOI would be calculated as detailed above. The total of all weights for every DRG/SOI would be divided by the total discharges to determine the case-mix index.

7. ***What are the various payments made under the APR DRG reimbursement system and what is the reasoning for each of the payments?***

Based on the final methodology decisions from ASES as of November 2025, the Plan Vital APR DRG reimbursement system includes three payment types: DRG base payments, transfer payments, and outlier payments.

DRG Base Payment

The DRG base payment equals the hospital-specific base rate multiplied by the relative weight for the DRG/SOI determination. These payments are made to reflect the consumption of resources during a typical inpatient hospital discharge for the DRG/SOI selected.

Transfer Payment

A transfer payment is made to a hospital that admits a patient and subsequently transfers that patient to another hospital. Claims with a patient discharge status code of 02, 05, 07, 82, or 85 will be paid the transfer payment as opposed to the DRG base payment. The transfer payment is the lessor of a per diem payment times the number of days; or the DRG base payment. The per diem payment is calculated as follows:

$$\left(\left(\text{Hospital Base Rate} \times \text{DRG/SOI Relative Weight} \times \text{Policy Adjuster}\right) \div \text{DRG/SOI ALOS}\right) \times \text{Inpatient Days} = \text{Transfer Payment}$$

Outlier Payment

A day outlier payment applies for discharges with an exceptionally high amount of days in relation to the Average Length of Stay (ALOS) for the assigned DRG/SOI. Outlier payments are made in addition to the DRG base payment. For a claim to qualify for an outlier payment, the inpatient stay must meet the outlier threshold where the length of stay meets the greater of the following criteria:

- The geometric trimmed ALOS for the DRG/SOI plus 15 days.
- The geometric trimmed ALOS for the DRG/SOI plus three times the untrimmed standard deviation of the DRG/SOI.

If the claim meets the outlier threshold, the outlier payment will be calculated as follows:

$$\left(\left(\text{Hospital Base Rate} \times \text{DRG/SOI Relative Weight} \times \text{Policy Adjuster}\right) \div \text{DRG/SOI ALOS}\right) \times \text{Inpatient Days Above Threshold} \times \text{80\% Payment Adjustment} = \text{Outlier Payment}$$

8. ***Please explain the difference in "Adjusted MCO Payments for All Encounters" in the MCO Summary tab and the "Adjusted MCO Payments for Encounters Included in Base Rates" in the Simulation Impact and Base Rate tab of the Hospital Exhibits distributed in November 2025.***

The values in the hospital exhibits differ slightly due to variations in the claims included for the base rate calculation compared to those included in the simulated DRG calculations; however,

both rely on discharges that occurred between October 1, 2021, and September 30, 2023, with paid dates through September 30, 2024 .

The base rate calculation includes only typical claims for each hospital, trimming to remove the atypical claims to minimize the impact of those that were identified with abnormally large and small per diems in the historical data. This trimmed amount represents the “Adjusted MCO Payments for Encounters Included in Base Rates” in the *Simulation Impact and Base Rate* tab of the Hospital Exhibits issued in November 2025.

Once the base rate is calculated for each hospital, it is applied to all of the hospital's Plan Vital inpatient encounters for federal fiscal year (FFY) 2022 and 2023 with a valid DRG to calculate the expected payments under the APR DRG system ("Simulated APR DRG Payments"). The Encounters and Adjusted MCO Payments associated with atypical per diem payments are excluded from the APR DRG Base Rate Calculation, but are included in the Simulated APR DRG Payments.

The “Adjusted MCO Payments for All Encounters” will be higher than the “Adjusted MCO Payments for Encounters Included in Base Rates” for all hospitals on the *Simulated Impact and Base Rate* tab within the hospital exhibits issued in November 2025.

9. ***Please explain how ASES will ensure that hospitals do not see dramatic reductions in payments when inpatient hospital reimbursement shifts to an APR DRG reimbursement system on January 1, 2026 for Plan Vital Medicaid beneficiaries.***

ASES will be monitoring the reimbursement under the APR DRG system to review billing practices, identify how MCOs and hospitals are adjusting to the new system, and evaluate reimbursement levels. In addition, ASES decided to implement a transition payment pool for Year 1 of the APR DRG implementation, paid to the hospitals through a directed payment, to support the transition from the current per diem system. The goal of the transition payment pool is to provide additional funding to hospitals in the transition from the current per diem methodology to an APR DRG system as coding and documentation improves. This transition payment will be a state directed payment that must meet the guidelines under 42 CFR §438.6 Special contract provisions related to payment and receive approval from the Centers for Medicare & Medicaid Services (CMS).

The transition payment pool is a portion of the funding historically allocated for Short-Term Acute Care (STAC) directed payments (that hospitals have received since January 2020). Upon approval from CMS, ASES will present the final transition payment program to both the Plan Vital MCOs and the hospitals.

10. Please explain how the amounts provided in the hospital exhibits distributed to hospitals during July 2025 were developed. Specifically, how were the reductions in hospital payments calculated for the transition payment pool, short stays/transfer payment pool, and outlier payment pool?

The following information explains how amounts were determined in the final simulation of the APR DRG reimbursment system and presented in exhibits distributed to hospitals in November 2025.

STAC Directed Payments and Creation of Transition Payment Pool

The FFY 2025 STAC directed payments were included in the calculation of the base rates. Because the DRG simulation includes two years of claims data, the STAC directed payment for an individual hospital was multiplied by two prior to being included in the base rate calculations.

To develop a revenue neutral base rate period, separate payment pools must be developed for the transition payments, transfer payments, and outlier payments. The transition payment pool for Year 1 of the APR DRG system is created by setting aside a portion of the funding historically allocated for STAC directed payments that hospitals have received since January 2020.

Each hospital had a portion of their STAC directed payment withheld to create the transition pool for Year 1. The percentage withheld is based on the proportion of the STAC directed payment for that hospital divided by all STAC directed payments across all hospitals, applied to the expected transition pool amount.

Creation of Transfer Payment Pool

Because transfer payments are excluded from the calculation of base rates, it is necessary to calculate this payment pool for each hospital. The Transfer Payment Pool is determined based on each hospital's discharges for transfers in the historical period divided by the total discharges and this percentage informs the historical payments to set aside for the transfer pool.

This payment pool is removed from the calculation of the base rate and serves as a "reserve" for transfer payments that are paid out through the DRG methodology.

Creation of the Outlier Payment Pool

The final pool that needs to be determined for appropriate calculation of the base rates is the outlier payment pool. This pool is determined based on the total outlier days for each hospital as a proportion of their total inpatient days, and this percentage informs the historical payments to set aside for the outlier pool.

This payment pool is removed from the calculation of the base rate and serves as a "reserve" for outlier payments that are paid out through the DRG methodology.

11. How long will the transition period last? Hospitals request that the transition period should be three years to ensure payment optimization.

Although APR DRGs are a new reimbursement method under Plan Vital, Puerto Rico hospitals are currently using the coding and documentation approach that is needed for APR DRGs through its Medicare fee-for-service (for payment under Medicare Severity DRGs) within the Medicare Inpatient Prospective Payment System. In addition, ASES has been supporting a transition to APR DRGs with PRHA, the hospitals, and MCOs for over six years based on the initiation of this conversion from FOMB in 2018.

Currently, ASES has established the transition period for one year at time. An analysis will be done during FFY 2026 to determine whether an additional year of transition payments is necessary. The expectation is that the transition payments will be made on a quarterly basis developed from the final simulation model.

CMS issued the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule in April 2024. Within the final rule, CMS has restricted the ability for states to perform a retroactive review and make changes to State Directed Payments for rate years beginning after July 2027. As such, the transitional payment structure cannot be applied to a third year for Plan Vital.

12. Will implants be incorporated into the APR DRG Methodology for the period of discharges occurring on and between January 1, 2026, and September 30, 2026?

Due to the concerns of the hospitals and MCOs related to the hospitals being able to negotiate the rates paid by the MCOs to the implant providers under Plan Vital, ASES has decided to postpone the inclusion of implants in the reimbursement under APR DRGs. The implant vendor or hospital shall bill for the implant device separately on an 837P claim form (professional claim) with a site of service code 21, and these will continue to be paid as they are paid today. However, ASES is further reviewing implant reimbursement arrangements to adjust this approach in the future.

13. Why was a paid date runout of 365 days set for calculating the base rates? How will unpaid claims or denied claims which are on the hospital's accounts receivable after the final paid date be handled? How will cases with partial payments and pending balances after the final paid date be handled?

Unpaid services cannot be included in the calculation of APR DRG base rates because an adjudicated claim is not available. The APR DRG base rate for each hospital is a prospectively-set rate; therefore, it is calculated on a static period of time. The use of a static period of time is common practice in all DRG systems (Medicare and other Medicaid programs) as well as in Solventum's, formerly 3M's, calculation of national DRG weights and ALOS.

The hospital-specific APR DRG base rates are determined using a specific time period of claims. Based on conversations with the Puerto Rico Hospital Association (PRHA), a one-year runout of paid claims was agreed upon to ensure the vast majority of paid claims are captured in the base rates. As directed by ASES, the hospital-specific base rates are calculated to result in a payment simulation that equals the trended paid claims from the static period of time (with a proportion of the STAC directed payments) in the aggregate for Plan Vital.

The hospital-specific APR DRG base rate would be applied to all claims paid for discharges with a discharge date during the FFY that the base rate is effective regardless of the paid date of the claim. The static period of time for base rate determination allows policy decisions by ASES, such as budget neutrality, to be factored into the establishment of the base rate.

14. How will the Final Base Rate formula account for Administrative Denials Adjustments such as Time Limit?

Administrative denials such as claims that exceed billing time limits cannot be included in the calculation of APR DRG base rates because an adjudicated claim is not available. The implementation of the APR DRG reimbursement system does not eliminate Plan Vital MCO claim processing time limits that currently exist.

The hospital-specific base rates are determined using a specific time period of claims. Based on conversations with the PRHA, a one-year runout of paid claims was agreed upon to ensure the vast majority of claims are captured in the base rates. As directed by ASES, the hospital-specific base rates are calculated to result in a payment simulation that equals the trended paid claims from the static period of time (with a proportion of the STAC directed payments) in the aggregate for Plan Vital.

The base rate would be applied to all claims paid for discharges with a discharge date during the FFY that the base rate is effective regardless of the paid date of the claim. The static period of time for base rate determination allows policy decisions by ASES, such as budget neutrality, to be factored into the establishment of the base rate.

15. How will APR DRG base rates be updated?

ASES will monitor reimbursement after APR DRGs are implemented in Plan Vital and determine the plan for updating base rates. A future goal is to shift the basis of the base rates from historical payments to historical costs (trended to the effective date) rates once it is determined that claims data is sufficient to estimate accurate costs of claims and valid Medicaid cost report data is available. For rate years in which rebase does not occur, ASES plans to consider rate increases in the same manner as rate increases have been done under the per diem methodology.

16. Please discuss the payment made for an individual that loses Medicaid coverage during the hospital stay.

Refer to the Reimbursement Guide posted on the ASES APR DRG website for further information on this topic: ASES APR DRG

17. Are there services that will be paid outside of the APR DRG reimbursement methodology?

Most covered services provided during an inpatient stay are considered hospital inpatient services reimbursed under APR DRG payment methodology. However, there are some services that are not paid through the APR DRG payment methodology. Refer to the Reimbursement Guide posted on the ASES APR DRG website for further information on "Separately Reimbursable Services Outside the APR DRG Payment": ASES APR DRG

ASES will post a listing of drugs and new technologies that are excluded on the ASES DRG Implementation website to ensure the selected drugs and devices are billed properly.

18. Will cost report audits be required for hospitals?

As the APR DRG reimbursement system progresses, the goal is to see improvement in claims coding to support the use of cost reports when calculating a cost benchmark. At the time, ASES will decide whether there should be any auditing of the cost reports being used.

19. Will the contract language between Hospitals and MCOs correspond to the DRG payment implementation standard from ASES?

Please refer to **Normative Letter 25-1212** dated December 12, 2025 in ASES website under the section: *Comunicaciones/Cartas Normativas y Circulares/2025* for reference to contract language between MCOs and Hospitals.

20. Will ASES consider the bundling of outpatient services to a related diagnostic hospital admission (72-hour rule)?

ASES decided that bundling of outpatient services would not be incorporated into the APR DRG methodology for the January 2026 implementation. ASES will continue to evaluate this policy to determine if any change should occur.

21. How will discounted payments to hospitals for non-participating billing be handled in determining the base rate for the hospitals?

Due to the inability to know what a per diem amount would have been between the hospital and the Plan Vital MCO that did not agree to a contract, no adjustment factor can be applied to hospital payments from MCOs where no contract was agreed upon.

Rate adjustments to the claims paid in rate setting will be adjusted by ASES-approved rate increases.

22. How will implants not billed as part of the inpatient claim be incorporated into the APR DRG reimbursement system?

The reimbursement of implant devices will be made outside of the APR DRG payment per recent ASES decisions. The implant vendor or hospital shall bill for the implant device separately on an 837P claim form (professional claim) with a site of service code 21, and these will continue to be paid as they are paid today. However, ASES is further reviewing implant reimbursement arrangements to adjust this approach in the future.

23. Is concurrent review required? Denied services, days, discharges, allowed? If so, is ASES considering a mandate for contracting an approved QRO as Medicare does? Or will it be each MCOs responsibility and internal process as it is today?

The issue of concurrent reviews and contracting an approved Quality Review Organization (QRO) is a policy decision outside the scope of the implementation of the DRG reimbursement system.

24. Will payment adjustments such as outliers and transfer payments be system made or manual adjustments by the Plan Vital MCOs?

The APR DRG software system (developed by Solventum and used by the MCOs for claim processing and reimbursement) will be set up to make all payment adjustments as part of the system processing of the claim.

25. How will base payment rates for new hospitals be determined? How will base payment rates be determined for hospitals that merge?

Refer to the Reimbursement Guide posted on the ASES APR DRG website for further information on this topic: ASES APR DRG

26. How will services added <u>after</u> September 30, 2023, be accounted for in the calculation? What about services added <u>during</u> the 24-month base period where the experience is not fully accounted for during the base period?

The standard approach for developing APR DRG base rates is to calculate a prospective payment rate using a static period of claims experience. Typically, Medicaid agencies use one year of claims data to develop base rates for DRGs. Due to the concern that one year may not

accurately resemble a hospital's utilization, a two-year period was selected for Puerto Rico for smoothing of spikes in utilization between years.

However, any new services provided by a hospital after the base period would receive appropriate reimbursement through the application of the relative weight associated with the assigned DRG/SOI.

If services added do not result in changes in the DRG distribution of the hospital, there would be no adjustment in payments.

27. How will contractual adjustments made after September 30, 2023, be considered in the calculation of base rates?

Rate increases mandated by ASES during the base period used in the base rate calculations have been incorporated into the APR DRG rate development. Subsequent changes to contracting between hospitals and MCOs will not be incorporated to determine if additional increases (or decreases) have occurred.

28. What hospitals are excluded from the APR DRG reimbursement methodology?

Refer to the Reimbursement Guide posted on the ASES APR DRG website for further information on this topic: ASES APR DRG

29. What type of clinical coding training is being recommended to ensure an effective transition to the APR-DRG system in Puerto Rico, considering the importance of diagnostic severity and the impact on reimbursement? From a coding perspective, what are the main areas of preparation that hospitals in Puerto Rico should prioritize for a successful implementation of the APR-DRG system, especially regarding code assignment accuracy, condition severity, and ongoing staff training?

ASES is coordinating training for the hospitals on coding with a professional organization (Afamep). In addition, there was a presentation provided in October 2024 (Coding for APR DRGs) that has some helpful information and links to available resources. Hospitals should prioritize accurate and complete physician documentation for each inpatient stay to ensure the billing documentation can be populated with complete diagnosis codes, procedure codes, revenue codes, and other key elements of the UB-04 billing document.