GOBIERNO DE PUERTO RICO
ADMINISTRACIÓN DE SEGUROS DE SALUD

March 26, 2025

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 October 1, 2025.

The APR DRG reimbursement system is a prospective rate system where 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 expenditure levels to target a budget neutral system in the aggregate, future payments are not limited to this aggregate amount. APR DRG payments effective for Plan Vital on October 1, 2025, 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 regularly 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.***

While the grouper software is not planned for release until July 1, 2025, Puerto Rico hospitals are set up to access Solventum's Patient Classification Methodologies website. This website offers access to the definition manuals for the methodologies that will be utilized by ASES. For APR DRGs, an easy-to-use assignment 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.

Please submit any requests for additional information to the following link:
Plan Vital APR DRG Questions and Inquiries

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 historically has been and continues to be the exclusive distributor for Solventum software products to hospitals and providers in Puerto Rico. There is no exclusivity by any entity over distribution of APR DRG software or services to payers by any Solventum business partner. If your organization does want 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. This will allow them to get started on their technical implementation and perform analytics in advance of the Puerto Rico-specific software being released.

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

The case mix for each hospital is calculated using all of the inpatient claims, excluding transfers and short stays, for the period under review, taking the weights for each claim's assigned APR DRG multiplied by the number of 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 October 2024 in the "Hospital Summary — DRG and SOI" tab. Column E of this tab is the DRG weight for each DRG and its corresponding Severity of Illness (SOI). Column F 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.

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

The Plan Vital APR DRG reimbursement system includes four payment types: DRG base payments, short stay 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 special 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, or 82 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:

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

Outlier Payment

A day outlier payment is applied 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 one of the following criteria:

- The geometric trimmed ALOS for the DRG/SOI plus 10 days
- The geometric trimmed ALOS for the DRG/SOI plus two times the untrimmed standard deviation of the DRG/SOI.

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

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

Short Stay Payment

The Plan Vital APR DRG system will include a short term payment for certain inpatient stays that are significantly less than the ALOS for the DRG/SOI. This payment is being adopted to help ensure fair payment by adjusting downwards for exceptionally short stays that might not reflect the true cost of care. This type of policy also supports more accurate reimbursement based on the actual care provided to patients, not just the number of admissions, and manages healthcare costs by discouraging unnecessary short admissions. The threshold for a short stay payment is where a patient is discharged with a length of stay less than one standard deviation from the ALOS of the associated DRG. The calculation of the short stay payment is as follows:

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

6. ***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 October 1, 2025 for Plan Vital Medicaid beneficiaries.***

ASES will be adopting a transition payment pool for Year 1 of the APR DRG implementation to ease the transition from the current per diem system. This transition payment pool will ensure no hospital is disproportionally harmed in transition from the current per diem methodology to an APR DRG system due to coding and documentation difficulties.
The transition payment pool is a portion of the funding traditionally allocated for STAC directed payments (that hospitals have received since January 2020). The estimated amount of the transition payment pool for Year 1 of the APR DRG implementation is $60 million.

Hospitals will be grouped as follows.

Table 3

Tier One Hospitals	If total APR DRG payments are less than 95% of the payments made to the hospital under the prior system.
Tier Two Hospitals	If total APR DRG payments are between 95% and 100% of the payments made to the hospital under the prior system.
Tier Three Hospitals	If total APR DRG payments exceed 100% of the payments made to the hospital under the prior system.

The payment for hospitals will be calculated in a two-step process.

1. The first step is the hospitals in Tier One will receive a payment to bring their payments under the APR DRG reimbursement system to 95% of the claims payments (adjusted for rate increases and STAC payments) received under the per diem payment methodology.
2. The second step in the payment process will be to bring the hospitals that moved from Tier One to Tier Two based on the initial transition payment and hospitals originally reported in Tier Two to an amount as close to 100% of the claims payments (adjusted for rate increases and STAC payments) received under the per diem payment methodology using the remaining funding available.

The goal of the transition payment pool is to ensure every hospital reaches the 95% threshold at a minimum. Once all hospitals meet the 95% threshold, the goal is to get these hospitals as close to 100% of their per diem reimbursement as possible in the

first year. Mercer has discussed on numerous occasions with Puerto Rico Hospital Association (PRHA), the hospitals, and the MCOs that it is ASES' decision to include additional funding into the transition payment pool to allow every hospital to reach 100% of its per diem reimbursement level.

The payment of the Transition Payment Pool will be a two-step process similar to the STAC directed payment process. From the final APR DRG simulation, the projected transition payment for each hospital will be calculated for FFY 2026. The amount for each hospital will be sent to the Plan Vital MCOs on a quarterly basis for distribution to the hospitals. These payments will be incorporated into the pre-print forms that ASES will submit to CMS for approval of the State Directed Payment. The Transition Payment Pool, much like the STAC payment, will have a reconciliation to actual payments. The STAC payment reconciliation is done on an annual basis. Because of the uncertainty in each hospital's improvement in coding and documentation, the Transition Payment Pool will have reconciliations done on a six-month interval beginning after April 1, 2026. A comparison of DRG Payments + Transitional Payments will be compared to Per Diem + STAC directed payments to determine whether any recoupment is needed from a hospital and reallocation of recouped funds to other hospitals. The specific methodology of the reconciliation is under development and will be outlined for the Plan Vital MCOs and hospitals during the meetings covering the final base rates.

7. ***Please explain how the amounts provided in the hospital exhibits distributed to hospitals during October 2024 were developed. Specifically, how were the reductions in payments of hospitals calculated for the transition payment pool, short stays/transfer payment pool, and outlier payment pool?***

ASES and its contract managers presented findings from an initial simulation of the APR DRG reimbursement system in June 2024 and distributed hospital specific information in hospital exhibits and virtual meetings in October 2024. The following methodology explains how amounts were determined in the initial simulation of the APR DRG reimbursment system.

Payments from Claims Data

The Plan Vital claims for Medicaid beneficiaries with discharge dates beginning on or after January 1, 2021, and ending on or before December 31, 2022, were accumulated to complete the initial DRG simulation. All claims processed with paid dates through December 31, 2023, for the date range in the preceding sentence were used in the analysis.

These claims were processed through the APR DRG Version 40 Grouper to determine the applicable DRG and corresponding SOI. If the claim did not have sufficient information, a

DRG of 955 (PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS) or 956 (UNGROUPABLE) were assigned. Because claims assigned to these two DRGs do not have a weight that allows for payment of the claim or assist in the calculation of case-mix, the discharges and payments on the claims were eliminated from the calculation of the hospital's base rate.

Given that the initial simulation and the subsequent final simulation rely on historical claim information, the payments made for those discharges may not reflect what the payment would be for discharges that occur on or after October 1, 2025. The goal of simulation of base rates and subsequent payments under the DRG system is to have base rates in line with what hospitals were being paid prior to the implementation of the DRG system. Therefore, the rate increases for inpatient hospital services should be incorporated into the calculations. A 5% rate increase for inpatient hospital services was approved by ASES effective October 1, 2021, January 1, 2023, and October 1, 2023. Because of the these rate increases, the amount paid on a claim was increased as follows:

Time Periods	Claim Payment Increase Factor
Discharges On or After January 1, 2021, and Before or Equal to September 30, 2021	1.1576
Discharges On or After October 1, 2021, and Before or Equal to December 31, 2022	1.1025

For example, if a patient was discharged on April 28, 2021, and the payment to the hospital was $3,285, the trended payment in the DRG simulation would be $3,802.72 ($3,250 x 1.1576).

STAC Directed Payments Included in the Initial Simulation

The federal fiscal year 2024 (FFY 2024) STAC directed payments were included in the calculation of the base rates. Because the initial 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. For example, if the FFY 2024 STAC payment was $4,856,373, the hospital exhibit provided for this hospital would show $9,712,746 as the STAC payments incorporated into the base rate.

The FFY 2025 STAC directed payments will be used in the final simulation of APR DRG base rates.

Creation of Transition Payment Pool

The transition payment pool will be created by setting aside a portion of the funding traditionally allocated for short-term acute care (STAC) directed payments that hospitals have received since January 2020 for Year 1 of the APR DRG system. The estimated amount of the transition payment pool for Year 1 of the APR DRG implementation is $60 million.

Each hospital had a portion of their STAC payment withheld to create the $60 million projected transition pool for Year 1.

> *Hospital Portion of Transition Pool = Hospital STAC Directed Payment ÷ Total STAC Directed Payments x $60 Million*

The Hospital Portion of Transition Pool are multiplied by two in the hospital exhibits provided in October 2024.

Creation of Short Stay/Transfer Payment Pool and Outlier Payment Pool

To develop a revenue neutral base year, separate payment pools must be developed for the transition payments, short stay payments, transfer payments, and outlier payments. Because short stay payments and transfer payments are excluded from the calculation of base rates, these two payment pools have been combined for the initial simulation of the Plan Vital DRG reimbursement system.

Each hospital was placed into a grouping based on the average length of stay (ALOS) for the hospital based on the claims data in the simulation, and a sliding scale was applied to decrease a hospital's portion of the pool as the ALOS increases.

Similarly for the outlier payment pool for the DRG system, we used a sliding scale based on average length of stay (ALOS), where the percentage withheld for each hospital increases as the ALOS increases. The sliding scale increases because the hospitals with longer ALOS have a higher probablity of incurring outliers.

Determination of Payments For Base Rate Calculation

After the adjustments for the transition payment pool, short stays/transfer payment pool, and outlier payment pool, the remaining payments are used for the calculation of each hospital's base rate. The total payments used for the base rate calculation is as follows:

Trended Claim Payments Valid DRGs
Plus: 2 Year Modification STAC Directed Payments FFY 2024
Less: Hospital Portion of Transition Payment Pool
Less: Hospital Portion of Short Stay/Transfer Payment Pool
Less: Hospital Portion of the Outlier Payment Pool
Equals: Net Hospital Payments for Base Rate Calculations

Determination of Discharges For Base Rate Calculation

The total discharges for each hospital for claims with discharges on or after January 1, 2021, and on or before December 31, 2022, are used in determining the hospital base rate.The total discharges must be adjusted as follows:

Total Discharges in Claims Data
Less: Discharges for Invalid DRGs
Less: Short Stay Discharges
Less: Discharges for Patients Transferred from Hospital
Equals: DRG Discharges for Base Rate Calculation

Calculation of Hospital Specific Base Rate

The Net Hospital Payments for Base Rate Calculations are divided by the DRG Discharges to determine the unadjusted hospital specific base rate. The unadjusted hospital specific base rate is divided by the hospital's case-mix to determine the case-mix hospital specific base rate. The case-mix hospital specific base rate will be used in the APR DRG reimbursement system for each hospital.

8. How long will the transition period last? 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 given all of the implementation delays.

The transition period has been established for one year at time. An analysis will be done during FFY 2026(October 1, 2025-September 30, 2026) to determine whether an additional year of transition payments is necessary.

The transition payments will be made on a quarterly basis developed from the final simulation model. Additionally, a reconciliation will be done to compare the actual payments made under APR DRGs to an estimated amount paid under the current per diem methodology. Recoupments and/or additional payments may be made to the hospitals based on the reviews done every six months.

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.

9. 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.

10. Why was a paid date run out 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 and 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 PRHA, a one-year run out 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 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 that occur 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.

11. 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 run out 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 STAC directed payments) in the aggregate for Plan Vital.

The base rate would be applied to all claims paid for discharges that occur 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.

12. How will APR DRG base rates be updated?

Prior to submission of the Medicaid State Plan Amendment, ASES will determine the time period for rebasing base rates. Upon determination that claims data is sufficient to determine the cost of claims, the basis of the base rates will shift from historical payments to historical cost trended to the effective date of the rates. For rate years where rebase does not occur, ASES will determine rate increases in the same manner as rate increases have been done under the per diem methodology.

13. If outliers are adjusted to 80% due to intensity, would it be fair for Short Stays to be adjusted to 120% due to intensity on first days? Additionally, if the outlier threshold is set at the greater of the ALOS plus 10 days or the ALOS plus two standard deviations from the ALOS, would it be fair for the Short Stay Threshold to be two standard deviations less than the ALOS?

Regarding the difference in the parameters of outliers versus short stay payments, the 80% adjustment factor is made to the outliers to maintain the maximum amount in the base rate payment pool. The goal of the APR DRG implementation is to establish a reimbursement system that equals the trended paid claims from the static period of time (with STAC directed payments) in the aggregate for Plan Vital. Additionally, the use of the threshold in the outliers allows for maximization of payments in the DRG base payments while providing additional funding for exceptionally long inpatient stays. Increasing the payments to short stay discharges using an intensity adjustment will decrease the pool for the DRG base payments.

The use of short stay payments or low-cost discharges (when cost can be accurately calculated) is not a Puerto Rico-only payment in an APR DRG system. Michigan and the

District of Columbia are two examples of Medicaid agencies that employ this type of payment. Given that the payment methodology will be incorporated into the APR DRG software, these payments will be made through the Plan Vital MCO systems and will not cause increased complication regarding the implementation of the APR DRG reimbursement system.

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

For discharges that occur after the expiration of eligibility, the hospital shall receive a full APR DRG payment if the length of stay under Medicaid eligibility is greater than the trimmed geometric ALOS for the DRG. Outlier provisions will apply for length of stay under Medicaid eligibility.

For discharges for which the length of stay for Medicaid eligibility is less than the trimmed geometric ALOS for the DRG, a per diem will be paid for each day under Medicaid eligibility. For example, if the ALOS of the DRG/SOI is seven days and the patient loses Medicaid eligibility five days into the hospital stay, the hospital would receive a per diem payment using the following calculation.

$$\left(\begin{array}{l}\text{Hospital}\\ \text{Base}\\ \text{Rate}\end{array} \times \begin{array}{l}\text{DRG/SOI}\\ \text{Relative}\\ \text{Weight}\end{array}\right) \div \begin{array}{l}\text{DRG/SOI}\\ \text{ALOS}\end{array} \times \begin{array}{l}\text{Medicaid}\\ \text{Eligible}\\ \text{Inpatient}\\ \text{Days}\end{array} = \begin{array}{l}\text{Payment}\\ \text{Made}\\ \text{Under}\\ \text{Plan Vital}\end{array}$$

If the patient was in the hospital eight days before losing Medicaid eligibility, the hospital will receive the full DRG payment for the claim.

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

To align the APR DRG reimbursement system with the non-risk sharing portion of the Plan Vital MCO contracts, certain drugs that have been excluded from the risk arrangement for the Plan Vital MCOs will be excluded from reimbursement under the APR DRG methodology.

Additionally, policy adjustments will be made on other drugs and contraceptive implant devices to determine whether any should be excluded from the APR DRG reimbursement methodology. For example, many states exclude LARC devices from reimbursement under the APR DRG system for Medicaid beneficiaries. The procedure to insert the device is included in the APR DRG reimbursement but the LARC is billed separately.

Devices listed as new technologies under the CMS inpatient final rule for the FFY of the discharge for the patient will be billed separately.

ASES and Mercer will develop a listing of drugs and new technologies that are either non-risk drugs or excluded by ASES determination and provide the listing to both the Plan Vital MCOs and the hospitals. Additionally, the listing will be published on the ASES DRG Implementation website, as well as guidance for the hospitals and Plan Vital MCOs to ensure the selected drugs and devices are billed properly.

16. Will cost report audits be required for hospitals?

Due to the coding issues related to claims being used in the base rate simulations, cost reports are not being used to determine base rates. The base rates are currently being developed based on historical payments trended to the implementation date. As the APR DRG reimbursement system progresses, the goal is to have improvement in coding on claims to allow the use of cost reports to determine a cost benchmark. At the time that cost reports are used in the rate setting process, a determination will be made as to whether there should be any auditing of the cost reports being used.

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

Mercer will work with ASES to provide language guidance to the Plan Vital MCOs to incorporate into contracts with the hospitals.

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

During the kickoff meetings in June and the Town Hall in August, Mercer presented that bundling of outpatient services would not be incorporated into the APR DRG methodology. Mercer will be conducting meetings with ASES to determine if any change should occur for final rate setting. If so, any change will be communicated to the Plan Vital MCOs and hospitals as soon as a decision is made.

19. 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.

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

The reimbursement of implants routinely used in surgical procedures will be incorporated into the DRG reimbursement and not paid separately as is the current process. The rationale for this decision is that the payment for the implant device is incorporated into the national DRG weights. The complexity of designing payment adjustment factors for each DRG impacted by implants will place a significant burden on the design of the claims processing system for each Plan Vital MCOs and the logic incorporated into Puerto Rico's Medicaid Agency's Medicaid Management Information System to recalculate the payment of the claim as required under 42 CFR §438.242.

Although some hospitals do not bill for these items for Medicaid purposes and allow the vendor to bill the Plan Vital MCOs, the hospitals have purchasing arrangements and policies in place to include the charges for these implant devices on the inpatient hospital bill when billing Medicare Fee-for-Service.
Mercer recommends that ASES and MCOs collaborate with the vendor community to ensure the amounts agreed upon by the vendors for payment by the MCOs is extended to hospitals to avoid an artificial increase in healthcare cost due to this change.
To align the APR DRG reimbursement system with the non-risk sharing portion of the Plan Vital MCO contracts, certain drugs that have been excluded from the risk arrangement for the Plan Vital MCOs will be excluded from reimbursement under the APR DRG methodology.

Additionally, policy adjustments will be made on other drugs and contraceptive implant devices to determine if any should be excluded from the APR DRG reimbursement methodology. For example, many states exclude Long-Acting Reversible Contraception (LARC) devices from reimbursement under the APR DRG system for Medicaid beneficiaries. The procedure to insert the device is included in the APR DRG reimbursement but the LARC is billed separately.

Devices listed as new technologies under the CMS inpatient final rule for the FFY of the discharge for the patient will be billed separately.

ASES and Mercer will develop a listing of drugs and new technologies that are either non-risk drugs or excluded by ASES determination and provide the listing to both the Plan Vital MCOs and the hospitals. Additionally, the listing will be published on the ASES DRG

Implementation website along with guidance for the hospitals and Plan Vital MCOs to ensure the selected drugs and devices are billed properly.

21. 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 QRO is a policy decision outside the scope of the implementation of the DRG reimbursement system.

22. Will payment adjustments such as outliers, transfers and short stay payments by system made or manual adjustments by the Plan Vital MCOs?

The system will be set up to make all payment adjustments to be completed as part of the system processing of the claim.

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

During the final simulation of base rates, an island-wide APR DRG base rate will be determined. Any hospital that begins services prior to the next rebasing of base rates will be paid at the island-wide base rate until historical data is provided that is sufficient to establish the hospital's unique base rate, at time of rebasing.
If two hospitals merge during a FFY that is not subject to rebasing, the base rate of the hospital that maintains its Medicare provider identification number will be used for the merged facility.

24. How will services added <u>after</u> December 31, 2022, be accounted for in the calculation? What about services added <u>during</u> the 24-month base period where the experience not fully accounted for during the base period?

Typically, Medicaid agencies use one year of claims data to develop base rate 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. The base rate is calculated using the static data. Changes in utilization or new services added will be applied to the base rate using the national DRG weights developed by Solventum. Additionally, the increase in utilization and shifting in services is incorporated into the actuarial determination of the hospital spend portion of the capitated payments.

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

25. How will contractual adjustments made after December 31, 2022, be considered in the calculation of base rates?

Rate increases mandated by ASES have been incorporated into the initial simulation and will be incorporated into the final APR DRG simulation. The contracting between hospitals and MCOs will not be reviewed to determine if additional increases above the ASES mandated increases have occurred.