District of Columbia Medicaid Specialty Hospital Payment Method

Frequently Asked Questions

Version Date: October 1, 2026

Updates for October 1, 2026

The District's fiscal year (FY) 2027 rate for Hospital for Sick Children Pediatric Center (HSC) decreased 30.1% from FY 2026; FY 2027 rate for National Rehabilitation Hospital (NRH) decreased by 7.1% from FY 2026; and FY 2027 rate for Psychiatric Institute of Washington (PIW) decreased by 14.0% from FY 2026. In FY 2023, DHCF submitted a State Plan Amendment (SPA) and received approval from CMS delaying the rebasing of the per diem specialty hospitals to FY 2025. CMS has also approved an amendment to the permanent SPA that allows DHCF to account for cost as part of any rate change in non-rebasing years starting in FY 2023. Specialty hospital inpatient rates were rebased in FY 2027, with the next rebasing scheduled for FY 2031.

The FY 2027 Capitol Hill and National Harbor rates decreased 0.5% from FY 2026. Previously, a rate increase by inflation factor was mandated in the State Plan each year between rate rebasing years. However, as described above both inflation and costs are considered in non-rebasing years. Rates continue to be rebased every four years; Capitol Hill and National Harbor rates were last rebased in FY 2023 and FY 2027, with the next rebasing scheduled for FY 2031.

OVERVIEW QUESTIONS

1. What is the Specialty Hospital project?

The Department of Health Care Finance (DHCF) developed a new payment method for hospital inpatient services at specialty hospitals in the fee-for-service (FFS) Medicaid program effective October 1, 2014.

2. What providers are affected?

This payment method applies to five specialty hospitals previously paid flat per-diem rates. These hospitals include HSC, NRH, PIW, Capitol Hill, and National Harbor.

Based on their patient population, average length-of-stay and casemix, HSC, NRH and PIW are paid by the per-diem All Patient Refined-Diagnosis Related Groups (APR-DRGs) specialty hospital payment method. Capitol Hill and National Harbor hospitals are long-term acute care hospitals and are paid by the per-stay APR-DRG payment method.

3. Why has the change been made?

DHCF replaced the previous flat per-diem with a prospective payment method based on APR-DRGs that more closely aligns payment with hospital resource use and patient acuity.

4. How were hospitals previously paid?

The Department reimbursed the five hospitals with retrospective, cost-based hospital-specific per-diems that were not adjusted for the acuity of the patient.

5. What services are impacted?

For the five affected hospitals, the APR-DRG based method applies to all inpatient hospital fee-for-service claims.

6. Does the change affect payments from Medicaid managed care plans?

DC Medicaid managed care plans are required to use the same hospital payment methodologies as are used for the Medicaid fee-for-service program. However, managed care hospital-specific rates are the result of negotiations between the plans and the hospitals.

7. What is the DRG base rate?

Hospitals were paid hospital-specific transition rates for FY 2015 based on FY 2013 cost reports; these transitional rates were increased by an inflation factor each year until rebasing year. The final rates for FY 2015 were based on audited FY 2015/FY 2016 cost reports; subsequently, the final rate was inflated forward through FY 2018. Rates were rebased for NRH in FY 2018 and for HSC and PIW in FY 2019. Rates for Capitol Hill and National Harbor hospitals were rebased retrospectively for FY 2018, inflated for FY 2019, and held steady until rebasing in FY 2023. All the specialty hospitals were rebased in FY 2027, with the next rebasing scheduled for FY 2031.

8. How often will base rates be rebased?

The State Plan requires that the base rates be rebased every four years; FY 2019 was the first rebasing period since implementation of the new methods in October 2014. The next rebasing year for all specialty hospitals was supposed to be in FY 2023, however Per Diem hospitals were delayed until FY 2025. Both Per Diem and Per Stay hospitals were rebased in FY 2027, with the next rebasing scheduled for FY 2031.

All Patient Refined Diagnosis Related Groups (APR-DRGs)

9. Why were APR-DRGs chosen?

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially regarding neonatal, pediatric, and obstetric care. Furthermore, they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use.

10. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by Solventum Health Information Systems and the Children's Hospital Association (formerly National Association of Children's Hospitals and Related Institutions (NACHRI). According to Solventum, APR-DRGs are used by major payers, including Medicaid programs, commercial payers and by thousands of hospitals. APR-DRGs have been used to adjust for risk in analyzing hospital performance; examples are state "report cards" such as www.floridahealthfinder.gov and analyses done by organizations such as the Agency for Healthcare Research and Quality and the Medicare Payment Advisory Commission.

11. Does my hospital need to buy APR-DRG software to get paid?

No. The Medicaid claims processing system assigns the APR-DRG and calculates payment without any need for the hospital to put the DRG on the claim.

For hospitals interested in learning more about APR-DRGs, information is available at https://www.solventum.com/en-us/home/health-information-technology/support/. DHCF has no financial interest in APR-DRG software or in any business arrangements between hospitals and their vendors who license APR-DRGs.

12. What version of APR-DRGs was implemented?

The Department implemented version 31 of APR-DRGs on October 1, 2014, which was released October 1, 2013. The Department moved to version 33 of the grouper effective October 1, 2016, version 35 effective October 1, 2018 and version 38 (HSRV Blended) effective October 1, 2021. For October 1, 2023, the department implemented version 40 of the grouper with version 40 HSRV relative weights. Effective 10/1/25, the department implemented version 42 HSRV relative weights.

13. What is the APR-DRG format?

Initially, each stay is assigned to one of 342 base APR-DRGs (version 42 (HSRV)). Then, one of four levels of severity (minor, moderate, major or extreme) specific to the base APR-DRG is assigned. Severity depends on the number, nature and interaction of complications and comorbidities. For example, APR-DRG 139-1 is pneumonia, severity 1 minor, while APR-DRG 139-2 is pneumonia, severity 2 moderate.

For hospitals that choose to acquire APR-DRG software, staff should note that the software outputs the base APR-DRG and the severity of illness as two separate fields. The Department concatenates, or combines, these fields for the purpose of calculating payment. The APR-DRG is therefore four bytes (ignoring the hyphen).

14. Does the hospital have to submit the APR-DRG on the UB-04 paper form or the 837I electronic transaction? How will the DRG be assigned?

No. DHCF has acquired the Solventum™ All Patient Refined Diagnosis Related Groups (APR-DRGs) software and uses it to assign DRGs during claims processing.

15. Where do the APR-DRG relative weights come from?

DC Medicaid uses Hospital-Specific Relative Value (HSRV) national relative weights as developed and maintained annually by Solventum.

OTHER QUESTIONS

16. How does the Department ensure that adequate payment is made for very expensive or long lengths of stay often seen at the Specialty hospitals?

Medicare and other DRG payers typically make additional "outlier" payments on stays that are exceptionally expensive for a hospital. Some payers also have a payment reduction if a stay is exceptionally profitable for a hospital. Outlier adjustments typically affect 1-2% of all stays. The Department applies high and low-cost outlier adjustments to the per-stay specialty hospitals. The per-diem specialty hospital payments do not use any outlier adjustments as payment continues throughout the approved length of stay.

17. What changes, if any, were made to add-on payments?

Specialty hospital payments are hospital specific. As such, no additional add-on payments are applied.

18. How are transfers paid?

The per-diem hospitals incorporate a transfer payment rule. Historically, per-diem reimbursement did not pay for the last day of a hospital stay (day of discharge). Under the current payment methodology, if a patient is transferred to another acute care facility, the per-diem hospital will be paid for the last day of the stay, at the casemix adjusted per-diem amount.

Per-diem transfers are determined based on the patient status code found on the claim. The codes which are eligible for the additional last day payment are listed below in Table 1:

Table 1
Specialty Hospital Per -Diem Patient Status Codes for Transfer Adjustment

Code	Description
02	Discharged/transferred to other short term general hospital for inpatient care.
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care. (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.
04	Discharged/transferred to intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65.'
43	Discharged/transferred to a federal hospital (eff. 10/1/03).
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01).
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital (eff. 1/2002).
63	Discharged/transferred to a long-term care hospital (eff. 1/2002).
64	Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare (eff. 10/2002).
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code) (eff. 1/2005).
66	Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/2006).
70	Discharged/transferred to another type of health care institution not defined elsewhere in code list.

For the per-stay hospitals, transfer adjustments are applied in the same manner that is currently used for DRG-paid hospitals. DC Medicaid follows the Medicare model for transfers to another acute care hospital. For these stays, the transferring hospital is paid the lesser of:

- The DRG base payment; or

- A per-diem amount times the actual length of stay plus one day (to recognize the up-front costs of admission). The per-diem amount is the DRG base payment divided by the DRG-specific national average length of stay.

This policy aims to reduce the DRG base payment if the actual length of stay at the transferring hospital is less than the overall average length of stay minus one day. The receiving hospital is paid the full DRG payment. Previously, claims with a patient discharge status of 02 or 05, indicating an acute care transfer, were paid using this transfer logic applied to the transferring hospital only. Effective October 1, 2014, the Department adjusted transfer logic to include eight additional patient discharge status codes; see Table 2 for a listing of codes.

Table 2 Specialty Hospital Per - Stay Patient Status Codes for Transfer Adjustment	
Discharge Status Codes	**New Readmission Discharge Values that Parallel Current Discharge Status Codes**
02: Discharged/transferred to a short-term hospital for inpatient care	82: Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
05: Discharged/transferred to a designated cancer center or children's hospital	85: Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
63: Discharged/transferred to a long-term care hospital	91: Discharged/transferred to a Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient readmission
65: Discharged transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	93: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
66: Discharged/transferred to a critical access hospital	94: Discharged/transferred to a critical access hospital with a planned acute care hospital inpatient readmission

19. How does this affect the overall payment level?

The change to APR-DRGs is a change in payment *method*, not payment *level*. The overall payment level will continue to be determined each year through the budget process and by hospital costs.

20. How are high-cost outliers paid?

High-cost outliers apply to the per-stay payment method only. These outliers are paid using a standard high-cost outlier method. The method is as follows. First, it is determined whether a loss has occurred. If that loss reaches the outlier threshold, the stay qualifies for a high-cost outlier payment. The hospital cost-to-charge ratio (CCR) is multiplied by charges to calculate the estimated cost of the stay. The difference between the cost of the stay and DRG payment determines the estimated loss on the stay. If the estimated loss exceeds the outlier threshold, the stay qualifies for an outlier payment. The second step is to calculate the outlier payment as the estimated loss minus the threshold, times the marginal cost factor. There are no changes to the marginal cost factor of 80%, the high-cost outlier threshold of $60,000 or the low cost outlier threshold of $25,000.

21. How are low-cost outliers paid?

Low-cost outliers apply to the per-stay payment method only. The "gain" on a hospital claim is measured as charges multiplied by the CCR to obtain estimated costs and then subtracts the DRG payment. If the gain exceeds the marginal low-cost threshold, then the transfer policy methodology is used to calculate the reduced payment. There are no changes to the cost thresholds effective October 1, 2026.

22. How are interim claims paid?

The per-diem and per-stay specialty hospital payment methods allow for the billing of interim claims. However, the rules for interim claims differ between the two.

For the per-diem specialty hospitals, the hospital is allowed to submit an interim claim without limits to duration or cost. These claims must be submitted using the correct type of bill codes (0112 or 0113). The payment of the per-diem is based on the APR-DRG assignment and casemix adjustment to the base rate. When the patient is discharged, the hospital must supply a final interim claim (type 0114). The District engages in regular monitoring of the per-diem hospitals to confirm that proper interim billing processes are followed.

The per-stay specialty hospitals must follow the current DRG payment rules for interim claims. There has been no change to the current interim claim policy. Interim claims will continue to be accepted from in-District DRG hospitals for stays that exceed a threshold of 30 days or $500,000 in charges. The hospital can submit an interim claim (type of bill 0112 or 0113) and be paid an interim per-diem amount ($500) times the number of days. When the patient is discharged, the hospital voids the previous interim claims and submits one claim showing all charges, diagnoses, and procedures for the full admit through discharge period. Bill types 0114 (final interim claim) and 0115 (late charges) will be denied from DRG hospitals.

23. How are crossover claims paid?

There are no changes to Medicare crossover payment logic related to the APR-DRG project.

24. Are there any changes to the prior authorization policy?

All inpatient stays require preauthorization and concurrent review.

25. Are there any changes in billing requirements?

There are no changes to billing requirements.

26. Where can I go for more information?

- **FAQ.** Updates of this document are available on the DHCF website https://dhcf.dc.gov/page/rates-and-reimbursements.

- **DRG Grouping Calculator.** Solventum Health Information Systems agreed to provide all District hospitals with access to an APR-DRG Grouping Calculator at no charge. The calculator is a webpage that enables the user to enter diagnoses, procedures and other claims data and then shows the step-by-step assignment of the APR-DRG to a single claim. For the webpage address and password, contact Sharon Augenbaum (see "For Further Information" below).

- **Specialty Hospital DRG Pricing Calculator.** DHCF makes available an APR-DRG Pricing Calculator on their website https://dhcf.dc.gov/page/rates-and-reimbursements. It does not assign the APR-DRG but it does show how a given APR-DRG will be priced in different circumstances. The calculator includes a complete list of APR-DRGs and related information.

FOR FURTHER INFORMATION

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APPENDIX of DRG BACKGROUND

1. How do DRG payment methods work?

In general, every complete inpatient stay is assigned to a single diagnosis related group using a computerized algorithm that considers the patient's principal diagnosis, age, gender, major procedures

performed, and discharge status. Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in that DRG relative to the hospital resources needed to take care of the average patient. For example, if a DRG has a relative weight of 0.50 then that patient's stay is expected to be about half as expensive as the stay for an average patient.

The DRG relative weight is multiplied by a DRG base rate to arrive at the DRG base payment. For specialty hospital payments this base payment can either reflect the base per-diem, or the base payment for the entire stay. For example, if the DRG relative weight is 1.25 and the DRG base per-diem rate is $1,000 then the payment rate for that DRG is $1,250 per-diem.

2. Who uses DRG payment?

The Medicare program implemented payment by DRG on October 1, 1983. About two-thirds of state Medicaid programs use DRGs, as do many commercial payers and various other countries. Many hospitals in the United States use DRGs for internal management purposes. The District of Columbia has used a DRG payment methodology since 1998.

3. What are the characteristics of DRG payment?

- DRG payment defines "the product of a hospital," thereby enabling greater understanding of the services being provided and purchased.

- Payment does not depend on hospital-specific costs or charges, this method rewards hospitals for improving efficiency.

- DRGs for sicker patients have higher payment rates, this method encourages access to care across the full range of patient conditions.

- DRG payment rewards hospitals that provide complete and detailed diagnosis and procedure codes on claims, thereby giving payers and data analysts better information about services provided.

4. What other payment policies are typically included in DRG payment methods?

For approximately 90% of stays, payment is typically made using a "straight DRG" calculation—that is, payment equals the DRG relative weight times the DRG base rate, as described above. In special situations, payment may also include other adjustments such as those described below.

- ***Transfer pricing adjustment.*** Payment may be reduced for some stays where the patient is transferred to another acute care hospital.

- ***Cost outlier adjustment.*** Medicare and other DRG payers typically make additional "outlier" payments on stays that are exceptionally expensive for a hospital. Some payers also have a payment reduction if a stay is exceptionally profitable for a hospital. Outlier adjustments typically affect 1- 2% of all stays.

- ***Third party liability.*** The calculations described above determine the allowed amount. From the allowed amount, payers typically deduct other health coverage payments (e.g., workers' compensation) as well as the patient's share of cost.