4123-6-37.1 **Payment of hospital inpatient services.**

(A) HPP.

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-10 of the Administrative Code, reimbursement for hospital inpatient services with a discharge date of February 1, ~~2011~~2012, or after shall be as follows:

(1) Reimbursement for hospital inpatient services, other than outliers as defined in paragraph (A)(3) of this rule or services provided by hospitals subject to reimbursement under paragraph (A)(4) of this rule, shall be calculated using the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system, multiplied by a ~~2011~~2012 bureau adjustment of ~~1.0315~~1.029 and further multiplied by a payment adjustment factor of 1.20, according to the following formula:

(MS-DRG reimbursement rate x ~~1.0315~~1.029) x 1.20 = bureau reimbursement for hospital inpatient service.

(2) In addition to the payment specified by paragraph (A)(1) of this rule, hospitals operating approved graduate medical education programs and receiving additional reimbursement from medicare for costs associated with these programs shall receive an additional per diem amount for direct graduate medical education costs associated with hospital inpatient services reimbursed by the bureau. Hospital specific per diem rates for direct graduate medical education shall be calculated annually by the bureau effective February first of each year, using the most current cost report data available from the centers for medicare and medicaid services, according to the following formula:

1.20 x [(total approved amount for resident cost + total approved amount for allied health cost)/ total inpatient days] = direct graduate medical education per diem.

Direct graduate medical education per diems shall not be applied to outliers as defined in paragraph (A)(3) of this rule or services provided by hospitals subject to reimbursement under paragraph (A)(4) of this rule.

(3) Reimbursement for outliers as determined by medicare's inpatient prospective payment system outlier methodology shall be calculated using the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system multiplied by a ~~2011~~2012 bureau adjustment of ~~1.0315~~1.029 and further multiplied by a payment adjustment factor of 1.80, according to the following formula:

(MS-DRG reimbursement rate x ~~1.0315~~1.029) x 1.80 = bureau reimbursement for hospital inpatient service outlier.

(4) Reimbursement for inpatient services provided by hospitals~~,~~ and distinct-part units of hospitals designated by the medicare program as exempt from the medicare inpatient prospective payment system~~, and hospitals enrolled or certified by the bureau as psychiatric hospitals~~ shall be determined as follows:

(a) For ~~Ohio~~ hospitals the department of health and human services, centers for medicare and medicaid services maintained hospital-specific cost-to-charge ratio information on as of October 1, 2011, based on the hospitals'~~who~~ submitted ~~a hospital~~ cost report (~~JFS 02930~~CMS-2552-96) ~~to the Ohio department of job and family services for the 2009 state fiscal year~~, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported ~~facility inpatient~~operating cost-to-charge ratio (from ~~schedule B, line 101 of the hospital cost report~~the inpatient provider specific file in use by medicare on October 1, 2011) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges.

(b) For ~~Ohio~~ hospitals ~~who did not submit a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2009 state fiscal year and for out-of-state hospitals~~ the department of health and human services, centers for medicare and medicaid services did not maintain hospital-specific cost-to-charge ratio information on as of October 1, 2011, reimbursement shall be equal to ~~sixty-one per cent of~~ the hospital's ~~allowed~~ allowable billed charges multiplied by the applicable FY12 urban or rural statewide average operating cost-to-charge ratio set forth in table 8A of the federal rule referenced in paragraph (A)(5)(b) of this rule (the Ohio average operating cost-to-charge ratio shall be used for hospitals outside the United States) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges.

(5) For purposes of this rule, the "applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate" or "value" shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 et seq. as amended, excluding 42 U.S.C. 1395ww(d)(4)(D) and 42 U.S.C. 1395ww(m), as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 412 as published in the October 1, ~~2010~~2011 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' ~~"42 C.F.R. Parts 412, 413, 415, et al. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system changes and FY2011 rates; provider agreements and supplier approvals; and hospital conditions of participation for rehabilitation and respiratory care services; medicaid program: accreditation for providers of inpatient psychiatric services~~ "42 CFR Parts 412, 413, and 476 Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and FY 2012 rates; hospitals' FTE resident caps for graduate medical education payment"~~;~~ final rule~~." 75 Fed. Reg. 50041-50681 (2010)~~ and corrections, 76 Fed. Reg.51476-51846 and 59263-59265 (2011).

(B) QHP or self insuring employer (non-QHP):

A QHP or self-insuring employer may reimburse hospital inpatient services at:

(1) The applicable rate under the methodology set forth in paragraph (A) of this rule; or

(2)

(a) For ~~Ohio~~ hospitals ~~who submitted a hospital~~ the department of health and human services, centers for medicare and medicaid services maintained hospital-specific cost-to-charge ratio information on as of October 1, 2011, based on the hospitals' cost report (~~JFS 02930~~CMS-2552-96) ~~to the Ohio department of job and family services for the 2009 state fiscal year~~, the hospital's allowable billed charges multiplied by the hospital's reported ~~facility inpatient~~ operating cost-to-charge ratio (from ~~schedule B, line 101 of the hospital cost report~~the inpatient provider specific file in use by medicare on October 1, 2011) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges;

(b) For ~~Ohio~~ hospitals ~~who did not submit a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2009 state fiscal year and for out-of-state hospitals, sixty-one per cent of~~the department of health and human services, centers for medicare and medicaid services did not maintain hospital-specific cost-to-charge ratio information on as of October 1, 2011, the hospital's ~~allowed~~allowable billed charges multiplied by the applicable FY12 urban or rural statewide average operating cost-to-charge ratio set forth in table 8A of

the federal rule referenced in paragraph (A)(5)(b) of this rule (the Ohio average operating cost-to-charge ratio shall be used for hospitals outside the United States) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges; or

(3) The rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

Effective: 02/01/2012

R.C. 119.032 review dates: 11/01/2014

CERTIFIED ELECTRONICALLY

Certification

12/21/2011

Date

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.44, 4121.441, 4123.66
Prior Effective Dates: 1/1/07, 4/1/07, 1/1/08, 2/1/09, 2/1/10, 2/1/11