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

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for hospital inpatient services shall be as follows:

(A) ~~Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for hospital inpatient services, excluding outliers as defined in paragraph (B) of this rule, shall be equal to one hundred fifteen percent of the applicable diagnosis related group (DRG) reimbursement rate for the hospital inpatient service under the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 as amended.~~Reimbursement for hospital inpatient services, other than outliners as defined in paragraph (C) of this rule or services provided by hospitals subject to reimbursement under paragraph (D) of this rule, shall be equal to one hundred fifteen percent of the applicable diagnosis related group (DRG) reimbursement rate for the hospital inpatient service under the medicare program.

(B) In addition to the payment specified by paragraph (A) 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 October 1 of each year, using the most current cost report data available from the Centers for Medicare and Medicaid Services, according to the following formula:

1.15 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 (C) of this rule or services provided by hospitals subject to reimbursement under paragraph (D) of this rule.

~~(B)~~(C) Reimbursement for outliers shall be determined as follows:

(1) For hospitals with a ~~reported~~ 2004 total inpatient cost-to-charge ratio as reported to Ohio medicaid, outliers shall be defined as hospital inpatient stays in which the hospital's allowable billed charges multiplied by the hospital's ~~reported~~ 2004 total impatient cost-to-charge ratio as reported to Ohio medicaid is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to the hospital's allowable billed charges multiplied by the hospital's ~~reported~~ 2004 total inpatient cost-to-charge ratio as reported to Ohio medicaid, not to exceed sixty percent of the hospital's allowable billed charges;

(2) For hospitals without a ~~reported~~ 2004 total inpatient cost-to-charge ratio as reported to Ohio medicaid and out-of-state hospitals, outliers shall be defined as hospital inpatient stays in which sixty percent of the hospital's allowable billed charges is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to sixty percent of the hospital's allowable billed charges.

(D) Reimbursement for inpatient services provided by hospitals and distinct-part units of hospitals designated by the medicare program as exempt from DRG-based reimbursement shall be determined as follows:

(1) For Ohio hospitals with a 2004 total inpatient cost-to-charge ratio as reported to Ohio medicaid, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio plus twelve percentage points, not to exceed seventy percent of the hospital's allowed billed charges.

(2) For Ohio hospitals without a 2004 total inpatient cost-to-charge ratio as reported to Ohio medicaid and out-of-state hospitals, reimbursement shall be equal to sixty-six percent of the hospital's allowed billed charges.

For purposes of this rule, the "applicable diagnosis related group (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 as amended, as implemented by the following materials, which are incorporated by reference:

(a) 42 CFR Part 412 as published in the October 1, 2006 Code of Federal Regulations;

(b) Department of Health and Human Services, Centers for Medicare and Medicaid Services' "42 CFR Parts 409, 410, 412, 413, 414, 424, 485, 489, and 505 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Fiscal Year 2007 Occupational Mix Adjustment to Wage Index; Health Care Infrastructure Improvement Program; Selection Criteria of Loan Program for Qualifying Hospitals Engaged in Cancer-Related Health Care and Forgiveness of Indebtedness; and Exclusion of Vendor Purchases Made Under the Competitive Acquisition Program (CAP) for Outpatient Drugs and Biologicals Under Part B for the Purpose of Calculating the Average Sales Price (ASP)." Federal Register, Volume 71, Number 160, Pages 47869-47918, August 18, 2006;

(c) Department of Health and Human Services, Centers for Medicare and Medicaid Services' "42 CFR Parts 409, 410, 412, 413, 414, 424, 485,

489, and 505 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Correction." Federal Register, Volume 71, Number 191, Pages 58286-58287, October 3, 2006;

(d) Department of Health and Human Services, Centers for Medicare and Medicaid Services' "Medicare Program; Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates: Final Fiscal Year 2007 Wage Indices and Payment Rates After Application of Revised Occupational Mix Adjustment to Wage Index" Federal Register, Volume 71, Number 196, Page 59885-60043 October 11, 2006.

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Certification

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