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, ~~2010~~ 2011, 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 ~~equal to one hundred twenty per cent of~~ 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 bureau adjustment of 1.0315 and further multiplied by a payment adjustment factor of 1.20, according to the following formula:

(MS-DRG reimbursement rate x 1.0315) 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 ~~equal to one hundred seventy-five per cent of~~ 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 bureau adjustment of 1.0315 and further multiplied by a

payment adjustment factor of 1.80, according to the following formula:

(MS-DRG reimbursement rate x 1.0315) 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 who submitted a hospital cost report (JFS 02930) to the Ohio department of job and family services for the ~~2008~~ 2009 state fiscal year, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported facility inpatient cost-to-charge ratio (from schedule B, line 101 of the hospital cost report) 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 ~~2008~~ 2009 state fiscal year and for out-of-state hospitals, reimbursement shall be equal to ~~sixty-two~~ sixty-one 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, ~~2009~~ 2010 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; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; and Changes to the Long-Term Care Prospective Payment System and Rate Years 2010 and 2009 Rates; Final Rule, "74 Fed. Reg. 43754 (2009)~~ "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; final rule." 75 Fed. Reg. 50041-50681 (2010).

(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 cost report (JFS 02930) to the Ohio department of job and family services for the ~~2008~~ 2009 state fiscal year, the hospital's allowable billed charges multiplied by the hospital's reported facility inpatient cost-to-charge ratio (from schedule B, line 101 of the hospital cost report) 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 ~~2008~~ 2009 state fiscal year and for out-of-state hospitals, ~~sixty-two~~ sixty-one 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:

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

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Certification

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Date

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Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
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