

**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, 2013, 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 payment adjustment factor of 1.20, according to the following formula:

$$\text{MS-DRG reimbursement rate} \times 1.20 = \text{bureau reimbursement for hospital inpatient service.}$$

- (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:

$$1.20 \times [(\text{total approved amount for resident cost} + \text{total approved amount for allied health cost}) / \text{total inpatient days}] = \text{direct graduate medical education per diem.}$$

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) outlier reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system multiplied by a payment adjustment factor of 1.80, according to the following formula:

$$\text{MS-DRG outlier reimbursement rate} \times 1.80 = \text{bureau reimbursement for hospital inpatient service outlier.}$$

- (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 shall be determined as follows:

- (a) For 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, 2012, based on the hospitals' submitted cost report (CMS-2552-96), reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported operating cost-to-charge ratio (from the inpatient provider specific file in use by medicare on October 1, 2012) multiplied by

a payment adjustment factor of 1.14, not to exceed seventy per cent of the hospital's allowed billed charges.

(b) For 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, 2012, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the applicable FY13 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) multiplied by a payment adjustment factor of 1.14, not to exceed seventy per cent of the hospital's allowed billed charges.

(5) Reimbursement for inpatient services provided by hospitals and distinct-part units of hospitals that do not participate in the medicare program shall be calculated using the national standardized amount for FY 2013, full update, as found at 77 Fed. Reg. 53699 (2012).

(6) 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), 42 U.S.C. 1395ww(m), 42 U.S.C. 1395ww(o), and 42 U.S.C. 1395ww(q), as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 412 as published in the October 1, 2012 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' "42 CFR Parts 412, 413, 424 and 476 Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and fiscal year 2013 rates; hospitals' resident caps for graduate medical education payment purposes; quality reporting requirements for specific providers and for ambulatory surgical centers" final rule, 77 Fed. Reg. 53258 - 53750 (2012).

(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 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, 2012, based on the hospitals' cost report (CMS-2552-96), the hospital's allowable billed charges multiplied by the hospital's reported operating cost-to-charge ratio (from the inpatient provider specific file in use by medicare on October 1, 2012) multiplied by a payment adjustment factor of 1.14, not to exceed seventy per cent of the hospital's allowed billed charges;

(b) For 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, 2012,

the hospital's allowable billed charges multiplied by the applicable FY13 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) multiplied by a payment adjustment factor of 1.14, 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: 2/3/13  
Prior Effective Dates: 1/1/07, 4/1/07, 1/1/08, 2/1/09, 2/1/10, 2/1/11, 2/1/12