Ohio Administrative Code

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

Effective: May 1, 2024

(A) HPP.

Except as provided in paragraphs (A)(7) and (A)(8) of this rule, reimbursement for hospital inpatient services with a discharge date of February 1, 2024 or after will be calculated as follows:

(1)

(a) Reimbursement for hospital inpatient services, other than outliers as defined in paragraph (A)(3) of this rule, services provided by hospitals subject to reimbursement under paragraph (A)(4) of this rule, or acute or subacute inpatient detoxification services subject to reimbursement on a per diem basis under paragraph (A)(7) of this rule, will 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 1.181 plus a new technology add-on payment (if applicable), according to the following formula:

MS-DRG reimbursement rate x 1.181 + new technology add-on payment (if applicable) = bureau reimbursement for hospital inpatient service.

(b) In the event the centers for medicare and medicaid services makes subsequent adjustments to the medicare reimbursement rates under the medicare inpatient prospective payment system as implemented by the materials specified in paragraph (A)(10) of this rule other than technical corrections, including but not limited to adjustments related to federal budget sequestration pursuant to the Budget Control Act of 2011, 125 Stat. 239, 2 U.S.C. 900 to 907d as amended as of the effective date of this rule, the "applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system" as specified in this paragraph will be determined by the bureau without regard to such subsequent adjustments.

(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 will 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 will 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:

1.181 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 will not be applied to outliers as defined in paragraph (A)(3) of this rule, services provided by hospitals subject to reimbursement under paragraph (A)(4) of this rule, or acute or subacute inpatient detoxification services subject to reimbursement on a per diem basis under paragraph (A)(7) of this rule.

(3)

(a) Reimbursement for outliers as determined by medicare's inpatient prospective payment system outlier methodology will 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 1.181 plus the applicable medicare operating outlier amount and medicare capital outlier amount plus a new technology add-on payment (if applicable), according to the following formula:

(MS-DRG reimbursement rate x 1.181) + medicare operating outlier amount + medicare capital outlier amount + new technology add-on payment (if applicable) = bureau reimbursement for hospital inpatient service outlier.

(b) In the event the centers for medicare and medicaid services makes subsequent adjustments to the medicare reimbursement rates under the medicare inpatient prospective payment system as implemented by the materials specified in paragraph (A)(10) of this rule other than technical corrections, including but not limited to adjustments related to federal budget sequestration pursuant

to the Budget Control Act of 2011, 125 Stat. 239, 2 U.S.C. 900 to 907d as amended as of the effective date of this rule, the "applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system" as specified in this paragraph will be determined by the bureau without regard to such subsequent adjustments.

(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 will be determined as follows:

(a) For hospitals the department of health and human services, centers for medicare and medicaid services maintains hospital-specific cost-to-charge ratio information on, reimbursement will be equal to the hospital's allowable billed charges multiplied by the hospital's reported operating cost-to-charge ratio information referenced in paragraph (A)(10)(c) of this rule 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 does not maintain hospital-specific cost-to-charge ratio information on, reimbursement will be equal to the hospital's allowable billed charges multiplied by the applicable fiscal year 2024 urban or rural statewide average operating cost-to-charge ratio set forth in table 8A of the federal rule referenced in paragraph (A)(10)(b) of this rule (the Ohio average operating cost-to-charge ratio will 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 will be calculated in accordance with the applicable provisions of paragraphs (A)(1) and (A)(3) of this rule using the national standardized amount for fiscal year 2024, full update, as found at 88 Fed. Reg. 59356 (2023).

(6) Reimbursement for inpatient services provided by "new hospitals" as defined in 42 C.F.R. 412.300(b) as published in the October 1, 2023 Code of Federal Regulations will be calculated in the same manner as provided under paragraph (A)(4)(b) of this rule.

(7) Reimbursement for acute or subacute inpatient detoxification services will be calculated in accordance with the applicable provisions of paragraph (A) of this rule, unless the hospital elects to be reimbursed for these services on a per diem basis, in which case the hospital will be reimbursed the lesser of the charges billed by the hospital for the allowed services rendered, the all-inclusive per diem rates set forth in Table 1 of the appendix to this rule, or the rate the MCO contracted or negotiated with the hospital.

(8) Except for services subject to reimbursement on a per diem basis under paragraph (A)(7) of this rule, if the MCO has contracted or negotiated a different payment rate with a hospital pursuant to rule 4123-6-10 of the Administrative Code, reimbursement will be at the contracted or negotiated rate.

(9) For purposes of this rule, hospitals must report the applicable inpatient revenue codes for accommodation and ancillary services set forth in Table 2 of the appendix to this rule.

(10) For purposes of this rule, the "medicare severity diagnosis related group (MS-DRG) reimbursement rate," "medicare operating outlier amount," "medicare capital outlier amount," and "new technology add-on payment" will 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 to 1395lll as amended as of the effective date of this rule, excluding 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, 2023 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' "42 CFR Parts 411, 412, 419, 488, 489 and 495 medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and policy changes and fiscal year 2024 rates; quality programs and medicare promoting interoperability program requirements for eligible hospitals and critical access hospitals; rural emergency hospital and physician-owned hospital requirements; and provider and supplier disclosure of ownership; and medicare disproportionate share hospital (DSH) payments: counting certain days associated with section 1115 demonstrations in the medicaid fraction final rule," 88 Fed. Reg. 58640 - 59438 (2023).

(c) The department of health and human services, centers for medicare and medicaid services' hospital-specific cost-to-charge ratio information as of the July 2023 update to the department of health and human services, centers for medicare and medicaid services' inpatient provider specific file (IPSF).

(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 maintains hospital-specific cost-to-charge ratio information on, the hospital's allowable billed charges multiplied by the hospital's reported operating cost-to-charge ratio information referenced in paragraph (A)(10)(c) of this rule 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 does not maintain hospital-specific cost-to-charge ratio information on, the hospital's allowable billed charges multiplied by the applicable fiscal year 2024 urban or rural statewide average operating cost-to-charge ratio set forth in table 8A of the federal rule referenced in paragraph (A)(10)(b) of this rule (the Ohio average operating cost-to-charge ratio will 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.