

1 ENGROSSED HOUSE AMENDMENT
TO
2 ENGROSSED SENATE BILL NO. 1396 By: Hall of the Senate
3 and
4 Wallace of the House
5

6 [supplemental hospital offset payment program -
7 certain fee - effective date]
8

9 AUTHOR: Add the following House Coauthor: Randleman

10 AMENDMENT NO. 1. Strike the stricken title, enacting clause, and
11 entire bill and insert:

12 "An Act relating to the Supplemental Hospital Offset
13 Payment Program; amending 63 O.S. 2021, Section
14 3241.2, which relates to definitions in the
15 Supplemental Hospital Offset Payment Program Act;
16 defining terms; modifying definitions; amending 63
17 O.S. 2021, Section 3241.3, which relates to quality
18 care for Medicaid consumers; creating legislative
19 authority; restructuring amounts paid; directing
20 certain funds; setting compliance deadline;
21 modifying terms; granting agency review authority
22 for participation; creating participation
23 requirements; requiring timely reporting; amending
24 63 O.S. 2021, Section 3241.4, which relates to the
Supplemental Hospital Offset Payment Program Fund;
modifying terms; creating annual agency assessment;
requiring participants to report errors; authorizing
quarterly payments; assessing penalties; allowing
payments to eligible hospitals; requiring agency
determinations; requiring the agency to find federal
matching dollars; determining hospital payments
annually; directing payments from certain pools;
requiring the agency to fully fund certain funding
pools; creating payment methodologies; accounting
for certain refunds in certain situations; providing

1 contingency effective date; and declaring an
2 emergency.

3
4 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

5 SECTION 1. AMENDATORY 63 O.S. 2021, Section 3241.2, is
6 amended to read as follows:

7 Section 3241.2 As used in the Supplemental Hospital Offset
8 Payment Program Act:

9 1. "Authority" means the Oklahoma Health Care Authority;

10 2. "Base year" means a hospital's fiscal year as reported in
11 the Medicare Cost Report or as determined by the Authority if the
12 hospital's data is not included in the Medicare Cost Report. The
13 base year data shall be used in all assessment calculations;

14 3. "Directed payments" means payment arrangements allowed under
15 42 C.F.R. Section 438.6(c) that permit states to direct specific
16 payments made by managed care plans to providers under certain
17 circumstances and can assist states in furthering the goals and
18 priorities of their Medicaid programs;

19 4. "Eligible hospital" means an in-state hospital that is
20 eligible to participate in the Supplemental Hospital Offset Payment
21 Program and not otherwise exempt pursuant to subsection B of Section
22 3241.3 of this title;

23 5. "Hospital" means an institution licensed by the State
24 Department of Health as a hospital pursuant to Section 1-701 of this

1 title maintained primarily for the diagnosis, treatment, or care of
2 patients;

3 ~~5.~~ 6. "Hospital Advisory Committee" or "Committee" means the
4 Committee established ~~for the purposes of advising~~ to advise the
5 Oklahoma Health Care Authority ~~and recommending provisions within~~
6 ~~and approval of any state plan amendment or waiver affecting~~
7 ~~hospital reimbursement made necessary or advisable by the~~ regarding
8 the design and implementation of the Supplemental Hospital Offset
9 Payment Program Act. ~~In order to expedite the submission of the~~
10 ~~state plan amendment required by Section 3241.6 of this title, the~~
11 The Committee shall ~~initially be appointed by the Executive Director~~
12 ~~of the Authority~~ be composed of five (5) members from a list of
13 recommendations submitted by a statewide association representing
14 rural and urban hospitals. ~~The permanent Committee shall be~~
15 ~~appointed no later than thirty (30) days after November 1, 2011, and~~
16 ~~shall be composed of five (5) members from lists of names submitted~~
17 ~~by a statewide association representing rural and urban hospitals,~~
18 as follows:

- 19 a. one member, appointed by the Governor, who shall serve
20 as ~~chairman~~ chair, and
21 b. two members appointed each by the President Pro
22 Tempore of the Senate and the Speaker of the House of
23 Representatives.

24

1 ~~Members shall serve at the pleasure of the appointing authority~~ The
2 Committee shall meet no less than annually and shall be consulted by
3 the Authority at least thirty (30) days prior to any proposed state
4 plan amendment, proposed directed payment application, and state
5 regulations that may affect either the assessments or hospital
6 access payments authorized by this act;

7 7. "Managed care gap" means the difference between:

8 a. the maximum actuarially sound amount that can be paid
9 for hospital inpatient and outpatient services to
10 Medicaid managed care enrollees, and

11 b. the total amount of Medicaid managed care base rate
12 claims payments for hospital inpatient and outpatient
13 services. In calculating the managed care gap, the
14 Authority shall use a ninety percent (90%) average
15 commercial rates benchmark for determining the maximum
16 amount that will be paid for hospital inpatient and
17 outpatient services, and request federal approval for
18 the average commercial rate, subject to approval by
19 the federal Centers for Medicare and Medicaid
20 Services. The Authority may make the calculation in
21 this paragraph using good-faith reasonable estimates
22 if complete data does not exist or is not available;

1 ~~6.~~ 8. "Medicaid" means the medical assistance program
2 established in Title XIX of the federal Social Security Act and
3 administered in this state by the Oklahoma Health Care Authority;

4 ~~7.~~ 9. "Medicare Cost Report" means the Hospital Cost Report,
5 Form ~~CMS-2552-96~~ CMS-2552-10, or subsequent versions;

6 ~~8.~~ 10. "Net hospital patient revenue" means the gross hospital
7 revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines "Total
8 inpatient routine care services", "Ancillary services", and
9 "Outpatient services") of the Medicare Cost Report, multiplied by
10 the hospital's ratio of total net to gross revenue, as reported on
11 Worksheet G-3 (Column 1, Line "Net patient revenues") and Worksheet
12 G-2 (Part I, Column 3, Line "Total patient revenues");

13 ~~9.~~ 11. "Upper payment limit" means the maximum ceiling imposed
14 by 42 C.F.R., Sections 447.272 and 447.321 on hospital Medicaid
15 ~~reimbursement~~ fee-for-service reimbursements for inpatient and
16 outpatient services, other than to hospitals owned or operated by
17 state government; and

18 ~~10.~~ 12. "Upper payment limit gap" means the difference between
19 the upper payment limit and Medicaid fee-for-service payments ~~not~~
20 ~~financed using hospital assessments~~ made to all hospitals for
21 hospital inpatient and outpatient services, other than hospitals
22 owned or operated by state government.

23 SECTION 2. AMENDATORY 63 O.S. 2021, Section 3241.3, is
24 amended to read as follows:

1 Section 3241.3 A. For the purpose of assuring access to
2 quality care for Oklahoma Medicaid consumers, the Oklahoma Health
3 Care Authority, after considering input and recommendations from the
4 Hospital Advisory Committee, shall assess hospitals licensed in
5 Oklahoma, unless exempt under subsection B of this section, a
6 Supplemental Hospital Offset Payment Program fee.

7 B. The following hospitals shall be exempt from the
8 Supplemental Hospital Offset Payment Program fee:

9 1. A hospital that is owned or operated by the state or a state
10 agency, the federal government, a federally recognized Indian tribe,
11 or the Indian Health Service;

12 2. A hospital that provides more than fifty percent (50%) of
13 its inpatient days under a contract with a state agency other than
14 the Authority;

15 3. A hospital for which the majority of its inpatient days are
16 for any one of the following services, as determined by the
17 Authority using the Inpatient Discharge Data File published by the
18 State Department of Health, or in the case of a hospital not
19 included in the Inpatient Discharge Data File, using substantially
20 equivalent data provided by the hospital:

- 21 a. treatment of a neurological injury,
- 22 b. treatment of cancer,
- 23 c. treatment of cardiovascular disease,
- 24 d. obstetrical or childbirth services, and

1 e. surgical care, except that this exemption shall not
2 apply to any hospital located in a city of less than
3 five hundred thousand (500,000) population and for
4 which the majority of inpatient days are for back,
5 neck, or spine surgery;

6 4. A hospital that is certified by the federal Centers for
7 Medicare and Medicaid Services as a long-term acute care hospital or
8 as a children's hospital; and

9 5. A hospital that is certified by the federal Centers for
10 Medicare and Medicaid Services as a critical access hospital.

11 C. The Supplemental Hospital Offset Payment Program fee shall
12 be an assessment imposed on each eligible hospital, except those
13 exempted under subsection B of this section, for each calendar year
14 in an amount calculated as a percentage of each eligible hospital's
15 net hospital patient revenue.

16 1. Funds generated by the Supplemental Hospital Offset Payment
17 Program fee shall be disbursed for the following purposes in the
18 following priority order:

19 a. One Hundred Thirty Million Dollars (\$130,000,000.00)
20 to be transferred annually to the Medical Payments
21 Cash Management Improvement Act Programs Disbursing
22 Fund, unless other revenue is appropriated by the
23 Legislature to the Authority that reduces that need,
24

- 1 b. the nonfederal ~~portion share~~ of the ~~upper payment~~
2 ~~limit gap used to fund supplemental or directed~~
3 ~~payments or both,~~
- 4 ~~b.~~ the ~~annual fee to be paid to the Authority under~~
5 ~~subparagraph c of paragraph 1 of subsection G of~~
6 ~~Section 3241.4 of this title, and~~
- 7 ~~c.~~ the ~~amount to be transferred by the Authority to the~~
8 ~~Medical Payments Cash Management Improvement Act~~
9 ~~Programs Disbursing Fund under subsection C of Section~~
10 ~~3241.4 of this title:~~

- 11 (1) the upper payment limit,
- 12 (2) the managed care gap,
- 13 (3) the provider incentive pool to support health
14 care quality assurance and access improvement
15 initiatives, with the pool amount determined by
16 the Legislature. The pool will be calculated as
17 the amount in the directed payment program
18 funding pool attributable to the average
19 commercial rate method. For purposes of this
20 division, eligible network physicians and
21 dentists shall not include those employed by or
22 contracted with, or otherwise a member of, the
23 faculty practice plan of either: (1) a public,
24 accredited Oklahoma medical school, or (2) a

1 hospital or health care entity directly or
2 indirectly owned or operated by the entities
3 created pursuant to Section 3224 or 3290 of this
4 title,

5 (4) the annual fee to be paid to the Authority under
6 subparagraph c of paragraph 1 of subsection G of
7 Section 3241.4 of this title,

8 (5) Thirty Million Dollars (\$30,000,000.00) annually
9 to be transferred by the Authority to the Medical
10 Payments Cash Management Improvement Act Programs
11 Disbursing Fund under subsection C of Section
12 3241.4 of this title, and

13 (6) if the nonfederal share generated by the
14 Supplemental Hospital Offset Payment Program fee
15 is not sufficient for divisions (1) through (5)
16 of this subparagraph, all funds will be reduced
17 proportionally, and

18 c. the amount to be transferred by the Authority to the
19 Medical Payments Cash Management Improvement Act
20 Programs Disbursing Fund and any remaining funds shall
21 be deposited into the Rate Stabilization Fund.

22 2. ~~The assessment rate until December 31, 2012, shall be fixed~~
23 ~~at two and one-half percent (2.5%). For the calendar year ending~~
24 ~~December 31, 2022, the assessment rate shall be fixed at three~~

1 ~~percent (3%). For the calendar year ending December 31, 2023, the~~
2 ~~assessment rate shall be fixed at three and one half percent (3.5%).~~
3 ~~For the calendar year ending December 31, 2024 and for all~~
4 ~~subsequent calendar years, the assessment rate shall be fixed at~~
5 ~~four percent (4%)~~ Starting July 1, 2022, the Authority shall
6 calculate an annual assessment rate percentage that is equal to the
7 lesser of:

- 8 a. four percent (4%), or
- 9 b. the percentage rate that is less than four percent
10 (4%) needed to make all required and eligible
11 disbursements under subparagraph b of paragraph 1 of
12 this subsection, whichever is the lesser amount.

13 3. Net hospital patient revenue shall be determined using the
14 data from each eligible hospital's Medicare Cost Report contained in
15 the federal Centers for Medicare and Medicaid Services' Healthcare
16 Cost Report Information System file.

- 17 a. Through 2013, the base year for assessment shall be
18 the eligible hospital's fiscal year that ended in
19 2009, as contained in the Healthcare Cost Report
20 Information System file dated December 31, 2010.
- 21 b. For years after 2013, the base year for assessment
22 shall be determined by rules established by the
23 Oklahoma Health Care Authority Board and beginning
24

1 January 1, 2022, the base year for assessment shall be
2 determined annually.

3 4. If ~~a~~ an eligible hospital's applicable Medicare Cost Report
4 is not contained in the federal Centers for Medicare and Medicaid
5 Services' Healthcare Cost Report Information System file, the
6 eligible hospital shall submit a copy of ~~the hospital's~~ its
7 applicable Medicare Cost Report to the Authority in order to allow
8 the Authority to determine the eligible hospital's net hospital
9 patient revenue for the base year.

10 5. If ~~a~~ an eligible hospital commenced operations after the due
11 date for a Medicare Cost Report, the eligible hospital shall submit
12 its initial Medicare Cost Report to the Authority in order to allow
13 the Authority to determine the hospital's net patient revenue for
14 the base year.

15 6. Partial year reports may be prorated for an annual basis.

16 7. In the event that ~~a~~ an eligible hospital does not file a
17 uniform cost report under 42 U.S.C., Section 1396a(a)(40), the
18 Authority shall establish a uniform cost report for such facility
19 subject to the Supplemental Hospital Offset Payment Program provided
20 for in this section.

21 8. The Authority shall review ~~what~~ which hospitals are ~~included~~
22 eligible to participate in the Supplemental Hospital Offset Payment
23 Program provided for in this subsection and what hospitals are
24 exempted ~~from the Supplemental Hospital Offset Payment Program~~

1 pursuant to subsection B of this section. Such review shall occur
2 at a fixed period of time. This review and decision shall occur
3 within twenty (20) days of the time of federal approval and annually
4 thereafter in November of each year.

5 9. The Authority shall review and determine the amount of the
6 annual assessment. Such review and determination shall occur within
7 the twenty (20) days of federal approval and annually thereafter in
8 November of each year.

9 D. A An eligible hospital may not charge any patient for any
10 portion of the supplemental hospital offset payment program fee.

11 E. Closure, merger and new hospitals.

12 1. If a an eligible hospital ~~ceases to operate as a hospital or~~
13 ~~for any reason~~ ceases to be subject to the fee imposed under the
14 ~~Supplemental Hospital Offset Payment Program Act~~ an eligible
15 hospital for any reason, the assessment for the year in which the
16 cessation occurs shall be adjusted by multiplying the annual
17 assessment by a fraction, the numerator of which is the number of
18 days in the year during which the hospital is subject to the
19 assessment and the denominator of which is 365. Immediately upon
20 ceasing to ~~operate as a hospital, or otherwise ceasing to be subject~~
21 ~~to the supplemental hospital offset payment program fee~~ an eligible
22 hospital, the hospital shall pay the assessment for the year as ~~se~~
23 adjusted, to the extent not previously paid.

24

1 2. In the case of a an eligible hospital that did not operate
2 as a hospital throughout the base year, its assessment and any
3 potential receipt of a hospital access payment will commence in
4 accordance with rules for implementation and enforcement promulgated
5 by the Oklahoma Health Care Authority Board, after consideration of
6 the input and recommendations of the Hospital Advisory Committee.

7 F. 1. In the event that federal financial participation
8 pursuant to Title XIX of the Social Security Act is not available to
9 the Oklahoma Medicaid program for purposes of matching expenditures
10 from the Supplemental Hospital Offset Payment Program Fund at the
11 approved federal medical assistance percentage for the applicable
12 year, the portion of the Supplemental Hospital Offset Payment
13 Program fee attributable to the provisions of subparagraphs a and b
14 of paragraph 1 of subsection C of this section shall be null and
15 void as of the date of the nonavailability of such federal funding
16 through and during any period of nonavailability.

17 2. In the event of an invalidation of the Supplemental Hospital
18 Offset Payment Program Act by any court of last resort, the
19 Supplemental Hospital Offset Payment Program fee shall be null and
20 void as of the effective date of that invalidation.

21 3. In the event that the Supplemental Hospital Offset Payment
22 Program fee is determined to be null and void for any of the reasons
23 enumerated in this subsection, any Supplemental Hospital Offset
24 Payment Program fee assessed and collected for any period after such

1 invalidation shall be returned in full within twenty (20) days by
2 the Authority to the eligible hospital from which it was collected.

3 G. The Oklahoma Health Care Authority Board, after considering
4 the input and recommendations of the Hospital Advisory Committee,
5 shall promulgate rules for the implementation and enforcement of the
6 Supplemental Hospital Offset Payment Program fee. Unless otherwise
7 provided, the rules adopted under this subsection shall not grant
8 any exceptions to or exemptions from the hospital assessment imposed
9 under this section.

10 H. The Authority shall provide for administrative penalties in
11 the event a hospital fails to:

12 1. Submit the Supplemental Hospital Offset Payment Program fee
13 in a timely manner; or

14 2. ~~Submit the fee in a timely manner;~~

15 3. ~~Submit reports as required by this section; or~~

16 4. ~~Submit reports~~ in a timely manner.

17 I. The Oklahoma Health Care Authority Board shall have the
18 power to promulgate emergency rules to ~~enact~~ implement the
19 provisions of this act.

20 SECTION 3. AMENDATORY 63 O.S. 2021, Section 3241.4, is
21 amended to read as follows:

22 Section 3241.4 A. There is hereby created in the State
23 Treasury a revolving fund to be designated the "Supplemental
24 Hospital Offset Payment Program Fund".

1 B. The fund shall be a continuing fund, not subject to fiscal
2 year limitations, be interest bearing and consisting of:

3 1. All monies received by the Oklahoma Health Care Authority
4 from eligible hospitals pursuant to the Supplemental Hospital Offset
5 Payment Program Act and otherwise specified or authorized by law;

6 2. Any interest or penalties levied and collected in
7 conjunction with the administration of this section; and

8 3. All interest attributable to investment of money in the
9 fund.

10 C. ~~Notwithstanding any other provisions of law, the~~ The
11 Oklahoma Health Care Authority is authorized to transfer each fiscal
12 quarter from the Supplemental Hospital Offset Payment Program Fund
13 to the Authority's Medical Payments Cash Management Improvement Act
14 Programs Disbursing Fund all funds remaining after accounting for
15 the provisions of subparagraphs a and b of paragraph 1 of subsection
16 C of Section 3241.3 of this title.

17 D. Notice of Assessment.

18 1. The Authority shall send ~~a~~ an annual notice of assessment to
19 each eligible hospital informing the hospital of the assessment
20 rate, the ~~hospital's~~ net hospital patient revenue calculation, and
21 the assessment amount owed by the eligible hospital for the
22 applicable year.

23

24

1 2. ~~Annual notices~~ The annual notice of assessment shall be sent
2 to each eligible hospital at least thirty (30) days before the due
3 date for the first quarterly assessment payment of each year.

4 3. The first notice of assessment shall be sent within forty-
5 five (45) days after receipt by the Authority of notification from
6 the federal Centers for Medicare and Medicaid Services that the
7 assessments and payments required under the Supplemental Hospital
8 Offset Payment Program Act and, if necessary, the waiver granted
9 under 42 C.F.R., Section 433.68 have been approved.

10 4. ~~The~~ An eligible hospital shall have thirty (30) days from
11 the date of its receipt of a an annual notice of assessment to
12 ~~review and verify the assessment rate, the hospital's net patient~~
13 ~~revenue calculation, and the assessment amount~~ notify the Authority
14 of any error in the notice.

15 5. A An eligible hospital ~~subject to an assessment under the~~
16 ~~Supplemental Hospital Offset Payment Program Act~~ that has not been
17 previously licensed as a hospital in Oklahoma and that commences
18 hospital operations during a year shall pay the required assessment
19 computed under subsection E of Section 3241.3 of this title and
20 shall be eligible for hospital access payments under subsection E of
21 this section on the date specified in rules promulgated by the
22 Oklahoma Health Care Authority Board after consideration of input
23 and recommendations of the Hospital Advisory Committee.

24 E. Quarterly Notice and Collection.

1 1. The annual assessment imposed under ~~subsection~~ subsections A
2 and C of Section 3241.3 of this title shall be due and payable on a
3 quarterly basis. However, the first ~~installment~~ quarterly payment
4 of an annual assessment ~~imposed by the Supplemental Hospital Offset~~
5 ~~Payment Program Act~~ shall not be due and payable until:

- 6 a. the Authority issues written notice stating that the
7 annual assessment and payment methodologies required
8 under the Supplemental Hospital Offset Payment Program
9 Act have been approved by the federal Centers for
10 Medicare and Medicaid Services and, if necessary, the
11 waiver under 42 C.F.R., Section 433.68, ~~if necessary~~,
12 has been granted by the federal Centers for Medicare
13 and Medicaid Services,
- 14 b. the thirty-day verification period required by
15 paragraph 4 of subsection D of this section has
16 expired, and
- 17 c. the Authority issues a notice of assessment giving a
18 due date for the first quarterly payment.

19 2. After the ~~initial installment~~ first quarterly payment of an
20 annual assessment has been paid under this section, each subsequent
21 quarterly ~~installment~~ payment shall be due and payable by the
22 fifteenth day of the first month of the applicable quarter.

23 3. If a an eligible hospital fails to ~~timely pay the full~~
24 ~~amount of~~ a quarterly payment timely and in full assessment, the

1 eligible hospital shall pay the Authority ~~shall add to the~~
2 ~~assessment:~~

- 3 a. a penalty ~~assessment~~ fee equal to five percent (5%) of
4 the eligible hospital's unpaid quarterly ~~amount not~~
5 ~~paid on or before the due date~~ payment, and
6 b. ~~on the last day of each quarter after the due date~~
7 ~~until the assessed amount and the penalty imposed~~
8 ~~under subparagraph a of this paragraph are paid in~~
9 ~~full~~ if the quarterly payment and penalty fee are not
10 paid in full by the end of the quarter, an additional
11 ~~five-percent~~ penalty ~~assessment on any unpaid~~
12 ~~quarterly and unpaid penalty assessment amounts~~ fee of
13 five percent (5%) of the eligible hospital's unpaid
14 quarterly payment.

15 4. The quarterly ~~assessment~~ payment including applicable
16 ~~penalties and interest~~ penalty fees must be paid regardless of any
17 ~~appeals action~~ administrative review requested by the ~~facility~~
18 eligible hospital. If ~~a provider~~ an eligible hospital fails to pay
19 the Authority the assessment within the time frames noted on the
20 invoice to the ~~provider~~ eligible hospital, the assessment,
21 applicable penalty fees, and interest will be deducted from the
22 facility's payment. Any change in payment amount resulting from an
23 appeals decision will be adjusted in future payments.

24 F. Medicaid Hospital Access Payments.

1 1. To preserve the quality and improve access to ~~hospital~~
2 ~~services for hospital inpatient and outpatient services rendered on~~
3 ~~or after August 26, 2011,~~ the Authority shall make hospital access
4 payments ~~as set forth in this section~~ to eligible hospitals and
5 critical access hospitals to supplement reimbursements for inpatient
6 and outpatient services that are provided through Medicaid on both a
7 fee-for-service and managed care basis.

8 2. ~~The Authority shall pay all quarterly hospital access~~
9 ~~payments within fourteen (14) calendar days of the due date for~~
10 ~~quarterly assessment payments established in subsection E of this~~
11 ~~section.~~

12 3. ~~The Authority shall calculate the hospital~~ On an annual
13 basis prior to the start of each program year, the Authority shall
14 determine:

15 a. the upper payment limit gap for inpatient services
16 payable on a Medicaid fee-for-service basis for all
17 hospitals,

18 b. the upper payment limit gap for outpatient services
19 payable on a Medicaid fee-for-service basis for all
20 hospitals,

21 c. the managed care gap for inpatient services payable
22 through Medicaid managed care for all hospitals, and

23 d. the managed care gap for outpatient services payable
24 through Medicaid managed care for all hospitals.

1 3. In accordance with subsection C of Section 3241.3 of this
2 title, the Authority shall use assessment fees for the purposes of
3 accessing federal matching funds to make hospital access payments to
4 eligible hospitals and the critical access hospitals described in
5 paragraph 5 of subsection B of Section 3241.3 of this title.
6 Hospital access payments shall be made through supplemental payment
7 arrangements for services provided on a Medicaid fee-for-service
8 basis and through directed payment arrangements for services
9 provided on a Medicaid managed care basis, as approved by the
10 federal Centers for Medicare and Medicaid Services.

11 4. Hospital access payment amount up to but not to exceed the
12 upper payment limit gap for inpatient and outpatient services
13 payments shall be determined annually and paid quarterly from the
14 following funding pools:

- 15 a. a hospital inpatient fee-for-service payment pool
16 established from funds derived from the upper payment
17 limit gap for inpatient services,
- 18 b. a hospital inpatient managed care payment pool
19 established from funds derived from the managed care
20 gap for inpatient services,
- 21 c. a hospital outpatient fee-for-service payment pool
22 established from funds derived from the upper payment
23 limit gap for outpatient services,

1 d. a hospital outpatient managed care payment pool
2 established from funds derived from the managed care
3 gap for outpatient services, and

4 e. a critical access hospital payment pool established
5 from funds transferred from each pool established in
6 subparagraphs a through d of this paragraph shall be
7 required to:

8 (1) prior to the start of each program year, the
9 Authority shall determine an estimated amount
10 that each critical access hospital may be
11 entitled to receive for providing Medicaid
12 services, not to exceed that critical access
13 hospital's billed charges,

14 (2) the Authority shall fund the critical access
15 hospital payment pool in an amount equal to the
16 total estimated amount that all critical access
17 hospitals may be entitled to receive for
18 providing Medicaid services, as calculated in
19 division (1) of this subparagraph,

20 (3) the Authority shall consult with the Committee
21 regarding the calculations in divisions (1) and
22 (2) of this subparagraph, and

1 (4) the Authority shall fully fund this pool prior to
2 issuing any payment from the pools established in
3 subparagraphs a through d of this paragraph.

4 ~~4. All hospitals shall be eligible for inpatient and outpatient~~
5 ~~hospital access payments each year as set forth in this subsection~~
6 ~~except hospitals described in paragraph 1, 2, 3 or 4 of subsection B~~
7 ~~of Section 3241.3 of this title.~~

8 ~~5. A portion of the hospital access payment amount, not to~~
9 ~~exceed the upper payment limit gap for inpatient services, shall be~~
10 ~~designated as the inpatient hospital access payment pool.~~

11 ~~a.~~ 5. In addition to any other funds paid to eligible hospitals
12 for inpatient hospital services to Medicaid patients, each eligible
13 hospital shall receive ~~inpatient~~ hospital access payments each year
14 quarter from the hospital inpatient fee-for-service payment pool and
15 the hospital inpatient managed care payment pool in accordance with
16 the following methodologies:

17 ~~i. equal to the hospital's~~

18 a. the amount an eligible hospital shall receive from the
19 hospital inpatient fee-for-service payment pool shall
20 be the eligible hospital's pro rata share of the
21 hospital inpatient ~~hospital access~~ fee-for-service
22 payment pool ~~based upon~~ calculated as the eligible
23 hospital's total fee-for-service Medicaid payments for
24 inpatient services divided by the total Medicaid fee-

1 for-service payments for inpatient services of all
2 eligible hospitals. Each quarterly payment from the
3 hospital inpatient fee-for-service payment pool shall
4 be paid to the eligible hospital through a
5 supplemental payment. Prior to the start of a
6 Medicaid program year, the Authority shall consult
7 with the Committee to minimize potential payment
8 disparities to protect access to rural and independent
9 hospitals, ~~or~~ and

10 b. an eligible hospital shall receive from the hospital
11 inpatient managed care payment pool a per-discharge
12 uniform add-on amount to be applied to each eligible
13 hospital's Medicaid managed care discharges for that
14 program year. The per-discharge uniform add-on amount
15 shall be calculated by dividing the managed care gap
16 by total managed care inpatient discharges at eligible
17 hospitals contained in the data used to calculate the
18 managed care gap. To assure timely payment, the
19 Authority may make the calculation in this
20 subparagraph using good-faith reasonable estimates if
21 complete data does not exist or is not available.
22 Each quarterly payment from the hospital inpatient
23 managed care payment pool shall be paid to the
24 eligible hospital through a directed payment

1 ii. ~~through directed payments as approved by the~~
2 ~~Centers for Medicare and Medicaid Services.~~

3 b. ~~Inpatient hospital access payments shall be made on a~~
4 ~~quarterly basis.~~

5 6. ~~A portion of the hospital access payment amount, not to~~
6 ~~exceed the upper payment limit gap for outpatient services, shall be~~
7 ~~designated as the outpatient hospital access payment pool.~~

8 a. 6. In addition to any other funds paid to eligible hospitals
9 for outpatient hospital services to Medicaid patients, each eligible
10 hospital shall receive ~~outpatient~~ hospital access payments each ~~year~~
11 quarter from the hospital outpatient fee-for-service payment pool
12 and the hospital outpatient managed care payment pool in accordance
13 with the following methodologies:

14 i. ~~equal to the hospital's~~

15 a. the amount an eligible hospital shall receive from the
16 hospital outpatient fee-for-service payment pool shall
17 be the eligible hospital's pro rata share of the
18 hospital's outpatient ~~hospital access~~ fee-for-service
19 payment pool based upon calculated as the eligible
20 hospital's total fee-for-service Medicaid payments for
21 outpatient services divided by the total Medicaid fee-
22 for-service payments for outpatient services of all
23 eligible hospitals. Each quarterly payment from the
24 hospital outpatient fee-for-service payment pool shall

1 be paid to the eligible hospital through a
2 supplemental payment, or and

3 ~~ii. through directed payments as approved by the~~
4 ~~Centers for Medicare and Medicaid Services.~~

5 b. ~~Outpatient hospital access payments shall be made on a~~
6 ~~quarterly basis~~ an eligible hospital shall receive
7 from the hospital outpatient managed care payment pool
8 a uniform percentage add-on amount to be applied to
9 the base rate claims payments for hospital outpatient
10 Medicaid managed care encounters at eligible hospitals
11 for that program year. The uniform percentage add-on
12 amount shall be calculated by dividing the managed
13 care gap by total managed care base rate claims
14 payments for eligible hospitals within the data used
15 to calculate the managed care gap. To assure timely
16 payment, the Authority may make the calculation in
17 this subparagraph using good-faith reasonable
18 estimates if complete data does not exist or is not
19 available. Each quarterly payment from the hospital
20 outpatient managed care payment pool shall be paid to
21 the eligible hospital through a directed payment.

22 ~~7. A portion of the inpatient hospital access payment pool and~~
23 ~~of the outpatient hospital access payment pool shall be designated~~
24 ~~as the critical access hospital payment pool.~~

1 ~~a.~~ 7. In addition to any other funds paid to critical access
2 hospitals for inpatient and outpatient hospital services to Medicaid
3 patients, each in-state critical access hospital shall receive
4 hospital access payments each quarter from the critical access
5 hospital payment pool which shall be for:

- 6 ~~i.~~ ~~equal to the amount by which the payment for~~
7 ~~these services was less than one hundred one~~
8 ~~percent (101%) of the hospital's cost of~~
9 ~~providing these services, as determined using the~~
10 ~~Medicare Cost Report, or~~
- 11 ~~ii.~~ ~~through directed payments as approved by the~~
12 ~~Centers for Medicare and Medicaid Services.~~

13 a. each program year, a critical access hospital shall
14 receive from the critical hospital payment pool
15 quarterly amounts that shall total the estimated
16 amount the Authority calculated, not to exceed billed
17 charges, for that critical access hospital in
18 accordance with paragraph 4 of this subsection,

19 ~~b.~~ ~~The Authority shall calculate hospital access payments~~
20 ~~for critical access hospitals and deduct these~~
21 ~~payments from the inpatient hospital access payment~~
22 ~~pool and the outpatient hospital access payment pool~~
23 ~~before allocating the remaining balance in each pool~~
24 ~~as provided in subparagraph a of paragraph 5 and~~

1 ~~subparagraph a of paragraph 6 of this subsection. the~~
2 ~~quarterly hospital access payments made to each~~
3 ~~critical access hospital shall be through supplemental~~
4 ~~payments and directed payments in such proportions as~~
5 ~~necessary for the Authority to make the total hospital~~
6 ~~access payments to each critical access hospital in~~
7 ~~accordance with subparagraph a of this paragraph,~~

8 c. ~~Critical access hospital payments shall be made on a~~
9 ~~quarterly basis in the event Medicaid managed care is~~
10 ~~not implemented on a statewide basis, the Authority~~
11 ~~shall make supplemental payments to critical access~~
12 ~~hospitals to achieve one hundred one percent (101%) of~~
13 ~~Medicare's critical access hospitals' costs and a~~
14 ~~directed payment shall not be made.~~

15 8. The Authority shall pay each quarterly hospital access
16 payment referenced in paragraph 4 of this subsection within fourteen
17 (14) calendar days of the date in which each quarterly payment of an
18 annual assessment is due as required in subsection E of this
19 section.

20 9. In processing directed payments through Medicaid managed
21 care organizations, the following requirements shall apply:

22 a. the Authority shall provide each Medicaid managed care
23 organization with a listing of the hospital access
24 payments to be paid by each Medicaid managed care

1 organization to each eligible hospital and critical
2 access hospital in accordance with this subsection,

3 b. a Medicaid managed care organization shall pay
4 hospital access payments to eligible hospitals and
5 critical access hospitals within five (5) business
6 days of receiving a supplemental capitation payment
7 from the Authority,

8 c. a Medicaid managed care organization is prohibited
9 from withholding or delaying the payment of a hospital
10 access payment for any reason, and

11 d. the Authority shall utilize administrative discretion
12 regarding the mechanisms of payment that may be
13 necessary to assure that each eligible hospital and
14 critical access hospital receives full payment of all
15 hospital access payments to which it is entitled
16 pursuant to this subsection.

17 ~~8.~~ 10. A hospital access payment shall not be used to offset
18 any other payment ~~by Medicaid~~ for hospital inpatient or outpatient
19 services to Medicaid beneficiaries, including without limitation any
20 fee-for-service, managed care, per diem, private hospital inpatient
21 adjustment, or cost-settlement payment. In furtherance of this
22 paragraph, and notwithstanding any other provision of law to the
23 contrary, a managed care organization shall not implement any

1 hospital fee schedule that is less than the comparable fee schedule
2 utilized by the Authority on Medicaid fee-for-service basis.

3 11. Notwithstanding any other provision of law to the contrary:

4 a. the supplemental payment programs in this section
5 shall not be implemented if federal financial
6 participation is not available or if the provider
7 assessment waiver is not approved,

8 b. an eligible hospital's obligation to pay the portion
9 of the assessment attributable to the nonfederal share
10 of the upper payment limit gap and the nonfederal
11 share of the managed care gap as required by Section
12 3241.3 of this title and this section shall be reduced
13 in the event the federal Centers for Medicare and
14 Medicaid Services determines that federal financial
15 participation is not available to make hospital access
16 payments in accordance with this section. The
17 assessment on eligible hospitals shall be reduced to a
18 percentage that permits the Authority to obtain from
19 eligible hospitals an amount of nonfederal matching
20 funds for which federal financial participation is
21 available to implement any portion of hospital access
22 payments that the federal Centers for Medicare and
23 Medicaid Services approves, and

1 c. any assessments received by the Authority that cannot
2 be matched with federal funds shall be returned pro
3 rata to the eligible hospitals that paid the
4 assessments;

5 ~~9.~~ 12. If the federal Centers for Medicare and Medicaid
6 Services ~~finds that the Authority has made~~ disallows any hospital
7 access payments ~~to hospitals that exceed the upper payment limits~~
8 ~~determined in accordance with 42 C.F.R. 447.272 and 42 C.F.R.~~
9 ~~447.321, hospitals~~ made pursuant to this section on the basis that
10 such payments exceed the maximum allowable under federal law, each
11 hospital receiving such disallowed payments shall refund to the
12 Authority ~~a~~ an amount equal to that hospital's pro rata share of the
13 recouped federal funds that is proportionate to the hospitals'
14 hospital's positive contribution to the ~~upper payment limit~~
15 disallowed payment. This provision is triggered only if the
16 disallowance is considered final and all appeals have been
17 exhausted.

18 G. All monies accruing to the credit of the Supplemental
19 Hospital Offset Payment Program Fund are hereby appropriated and
20 shall be budgeted and expended by the Authority after consideration
21 of the input and recommendation of the Hospital Advisory Committee.

22 1. Monies in the Supplemental Hospital Offset Payment Program
23 Fund shall be used ~~only~~ for:
24

- 1 a. transfers to the Medical Payments Cash Management
2 Improvement Act Programs Disbursing Fund for the state
3 share of supplemental or directed payments or both for
4 Medicaid and SCHIP inpatient and outpatient services
5 to hospitals that participate in the assessment,
- 6 b. transfers to the Medical Payments Cash Management
7 Improvement Act Programs Disbursing Fund for the state
8 share of supplemental or directed payments or both for
9 critical access hospitals,
- 10 c. transfers to the Administrative Revolving Fund for the
11 state share of payment of administrative expenses
12 incurred by the Authority or its agents and employees
13 in performing the activities authorized by the
14 Supplemental Hospital Offset Payment Program Act but
15 not more than Two Hundred Thousand Dollars
16 (\$200,000.00) each year,
- 17 d. transfers to the Medical Payments Cash Management
18 Improvement Act Programs Disbursing Fund each fiscal
19 quarter ~~all funds remaining after accounting for the~~
20 ~~provisions of subparagraphs a, b and c of this~~
21 ~~paragraph~~ in accordance with subsection C of Section
22 3241.3 of this title, and
- 23 e. the reimbursement of monies collected by the Authority
24 from hospitals through error or mistake in performing

1 the activities authorized under the Supplemental
2 Hospital Offset Payment Program Act.

3 2. The Authority shall pay from the Supplemental Hospital
4 Offset Payment Program Fund quarterly installment payments to
5 hospitals ~~of amounts available for supplemental inpatient and~~
6 ~~outpatient payments or directed inpatient and outpatient payments or~~
7 ~~both, and supplemental payments for critical access hospitals or~~
8 ~~directed payments for critical access hospitals or both~~ as set forth
9 in this section.

10 3. ~~Except for the transfers described in subsection C of this~~
11 ~~section, monies~~ Monies in the Supplemental Hospital Offset Payment
12 Program Fund shall not be used to replace other general revenues
13 appropriated and funded by the Legislature or other revenues used to
14 support Medicaid.

15 4. The Supplemental Hospital Offset Payment Program Fund and
16 the program specified in the Supplemental Hospital Offset Payment
17 Program Act are exempt from budgetary reductions or eliminations
18 caused by the lack of general revenue funds or other funds
19 designated for or appropriated to the Authority.

20 5. No hospital shall be guaranteed, expressly or otherwise,
21 that any additional costs reimbursed to the facility will equal or
22 exceed the amount of the supplemental hospital offset payment
23 program fee paid by the hospital.

1 H. After considering input and recommendations from the
2 Hospital Advisory Committee, the Oklahoma Health Care Authority
3 Board shall promulgate rules that:

4 1. Allow for an appeal of the annual assessment of the
5 Supplemental Hospital Offset Payment Program payable under this act;
6 and

7 2. Allow for an appeal of an assessment of any fees or
8 penalties determined.

9 SECTION 4. This act shall become effective only if Engrossed
10 Senate Bill No. 1337 of the 2nd Session of the 58th Oklahoma
11 Legislature is enacted into law.

12 SECTION 5. It being immediately necessary for the preservation
13 of the public peace, health or safety, an emergency is hereby
14 declared to exist, by reason whereof this act shall take effect and
15 be in full force from and after its passage and approval."
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Passed the House of Representatives the 28th day of April, 2022.

Presiding Officer of the House of
Representatives

Passed the Senate the ____ day of _____, 2022.

Presiding Officer of the Senate

ENGROSSED SENATE
BILL NO. 1396

By: Hall of the Senate

and

Wallace of the House

[supplemental hospital offset payment program -
certain fee - effective date]

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 6. AMENDATORY 63 O.S. 2021, Section 3241.3, is
amended to read as follows:

Section 3241.3. A. For the purpose of assuring access to
quality care for Oklahoma Medicaid consumers, the Oklahoma Health
Care Authority, after considering input and recommendations from the
Hospital Advisory Committee, shall assess hospitals licensed in
Oklahoma, unless exempt under subsection B of this section, a
supplemental hospital offset payment program fee.

B. The following hospitals shall be exempt from the
supplemental hospital offset payment program fee:

1. A hospital that is owned or operated by the state or a state
agency, the federal government, a federally recognized Indian tribe,
or the Indian Health Service;

1 2. A hospital that provides more than fifty percent (50%) of
2 its inpatient days under a contract with a state agency other than
3 the Authority;

4 3. A hospital for which the majority of its inpatient days are
5 for any one of the following services, as determined by the
6 Authority using the Inpatient Discharge Data File published by the
7 State Department of Health, or in the case of a hospital not
8 included in the Inpatient Discharge Data File, using substantially
9 equivalent data provided by the hospital:

- 10 a. treatment of a neurological injury,
- 11 b. treatment of cancer,
- 12 c. treatment of cardiovascular disease,
- 13 d. obstetrical or childbirth services,
- 14 e. surgical care, except that this exemption shall not
15 apply to any hospital located in a city of less than
16 five hundred thousand (500,000) population and for
17 which the majority of inpatient days are for back,
18 neck, or spine surgery;

19 4. A hospital that is certified by the federal Centers for
20 Medicare and Medicaid Services as a long-term acute care hospital or
21 as a children's hospital; and

22 5. A hospital that is certified by the federal Centers for
23 Medicare and Medicaid Services as a critical access hospital.

24

1 C. The supplemental hospital offset payment program fee shall
2 be an assessment imposed on each hospital, except those exempted
3 under subsection B of this section, for each calendar year in an
4 amount calculated as a percentage of each hospital's net patient
5 revenue.

6 1. Funds generated by the supplemental hospital offset payment
7 program fee shall be disbursed for the following purposes in the
8 following priority order:

9 a. the nonfederal portion of the upper payment limit gap
10 used to fund supplemental or directed payments or
11 both,

12 b. the annual fee to be paid to the Authority under
13 subparagraph c of paragraph 1 of subsection G of
14 Section 3241.4 of this title, and

15 c. the amount to be transferred by the Authority to the
16 Medical Payments Cash Management Improvement Act
17 Programs Disbursing Fund under subsection C of Section
18 3241.4 of this title.

19 2. The assessment rate until December 31, 2012, shall be fixed
20 at two and one-half percent (2.5%). For the calendar year ending
21 December 31, 2022, the assessment rate shall be fixed at three
22 percent (3%). For the calendar year ending December 31, 2023, the
23 assessment rate shall be fixed at three and one-half percent (3.5%).
24 For the calendar year ending December 31, 2024 and for all

1 subsequent calendar years, the assessment rate shall be fixed at
2 four percent (4%).

3 3. Net hospital patient revenue shall be determined using the
4 data from each hospital's Medicare Cost Report contained in the
5 Centers for Medicare and Medicaid Services' Healthcare Cost Report
6 Information System file.

7 a. Through 2013, the base year for assessment shall be
8 the hospital's fiscal year that ended in 2009, as
9 contained in the Healthcare Cost Report Information
10 System file dated December 31, 2010.

11 b. For years after 2013, the base year for assessment
12 shall be determined by rules established by the
13 Oklahoma Health Care Authority Board and beginning
14 January 1, 2022, the base year for assessment shall be
15 determined annually.

16 4. If a hospital's applicable Medicare Cost Report is not
17 contained in the Centers for Medicare and Medicaid Services'
18 Healthcare Cost Report Information System file, the hospital shall
19 submit a copy of the hospital's applicable Medicare Cost Report to
20 the Authority in order to allow the Authority to determine the
21 hospital's net hospital patient revenue for the base year.

22 5. If a hospital commenced operations after the due date for a
23 Medicare Cost Report, the hospital shall submit its initial Medicare
24

1 Cost Report to the Authority in order to allow the Authority to
2 determine the hospital's net patient revenue for the base year.

3 6. Partial year reports may be prorated for an annual basis.

4 7. In the event that a hospital does not file a uniform cost
5 report under 42 U.S.C., Section 1396a(a)(40), the Authority shall
6 establish a uniform cost report for such facility subject to the
7 Supplemental Hospital Offset Payment Program provided for in this
8 section.

9 8. The Authority shall review what hospitals are included in
10 the Supplemental Hospital Offset Payment Program provided for in
11 this subsection and what hospitals are exempted from the
12 Supplemental Hospital Offset Payment Program pursuant to subsection
13 B of this section. Such review shall occur at a fixed period of
14 time. This review and decision shall occur within twenty (20) days
15 of the time of federal approval and annually thereafter in November
16 of each year.

17 9. The Authority shall review and determine the amount of the
18 annual assessment. Such review and determination shall occur within
19 the twenty (20) days of federal approval and annually thereafter in
20 November of each year.

21 D. A hospital may not charge any patient for any portion of the
22 supplemental hospital offset payment program fee.

23 E. Closure, merger and new hospitals.

24

1 1. If a hospital ceases to operate as a hospital or for any
2 reason ceases to be subject to the fee imposed under the
3 Supplemental Hospital Offset Payment Program Act, the assessment for
4 the year in which the cessation occurs shall be adjusted by
5 multiplying the annual assessment by a fraction, the numerator of
6 which is the number of days in the year during which the hospital is
7 subject to the assessment and the denominator of which is 365.
8 Immediately upon ceasing to operate as a hospital, or otherwise
9 ceasing to be subject to the supplemental hospital offset payment
10 program fee, the hospital shall pay the assessment for the year as
11 so adjusted, to the extent not previously paid.

12 2. In the case of a hospital that did not operate as a hospital
13 throughout the base year, its assessment and any potential receipt
14 of a hospital access payment will commence in accordance with rules
15 for implementation and enforcement promulgated by the Oklahoma
16 Health Care Authority Board, after consideration of the input and
17 recommendations of the Hospital Advisory Committee.

18 F. 1. In the event that federal financial participation
19 pursuant to Title XIX of the Social Security Act is not available to
20 the Oklahoma Medicaid program for purposes of matching expenditures
21 from the Supplemental Hospital Offset Payment Program Fund at the
22 approved federal medical assistance percentage for the applicable
23 year, the portion of the supplemental hospital offset payment
24 program fee attributable to the provisions of subparagraphs a and b

1 of paragraph 1 of subsection C of this section shall be null and
2 void as of the date of the nonavailability of such federal funding
3 through and during any period of nonavailability.

4 2. In the event of an invalidation of the Supplemental Hospital
5 Offset Payment Program Act by any court of last resort, the
6 supplemental hospital offset payment program fee shall be null and
7 void as of the effective date of that invalidation.

8 3. In the event that the supplemental hospital offset payment
9 program fee is determined to be null and void for any of the reasons
10 enumerated in this subsection, any supplemental hospital offset
11 payment program fee assessed and collected for any period after such
12 invalidation shall be returned in full within twenty (20) days by
13 the Authority to the hospital from which it was collected.

14 G. The Oklahoma Health Care Authority Board, after considering
15 the input and recommendations of the Hospital Advisory Committee,
16 shall promulgate rules for the implementation and enforcement of the
17 supplemental hospital offset payment program fee. Unless otherwise
18 provided, the rules adopted under this subsection shall not grant
19 any exceptions to or exemptions from the hospital assessment imposed
20 under this section.

21 H. The Authority shall provide for administrative penalties in
22 the event a hospital fails to:

- 23 1. Submit the supplemental hospital offset payment program fee;
- 24 2. Submit the fee in a timely manner;

1 3. Submit reports as required by this section; or

2 4. Submit reports timely.

3 I. The Oklahoma Health Care Authority Board shall have the
4 power to promulgate emergency rules to enact the provisions of this
5 act.

6 J. The supplemental hospital offset payment program fee shall
7 terminate effective December 31, 2055.

8 SECTION 7. This act shall become effective November 1, 2022.

9 Passed the Senate the 23rd day of March, 2022.

10
11 _____
12 Presiding Officer of the Senate

13 Passed the House of Representatives the ____ day of _____,
14 2022.

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16 _____
17 Presiding Officer of the House
18 of Representatives