SB1396 FULLPCS2 Marcus McEntire-KN
4/19/2022 4:26:48 pm

COMMITTEE AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend SB1396
Of the printed Bill

Page _____ Section _____ Lines _____
Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: Marcus McEntire

Adopted: _____

_____
Reading Clerk

STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

PROPOSED
COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL NO. 1396 By: Hall of the Senate

and

Wallace of the House

PROPOSED COMMITTEE SUBSTITUTE

[supplemental hospital offset payment program - certain fee - emergency]

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

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

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

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

2. "Base year" means a hospital's fiscal year as reported in the Medicare Cost Report or as determined by the Authority if the

hospital's data is not included in the Medicare Cost Report. The base year data shall be used in all assessment calculations;

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

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

~~4.~~ 5. "Hospital" means an institution licensed by the State Department of Health as a hospital pursuant to Section 1-701 of this title maintained primarily for the diagnosis, treatment, or care of patients;

~~5.~~ 6. "Hospital Advisory Committee" or "Committee" means the Committee established ~~for the purposes of advising~~ to advise the Oklahoma Health Care Authority ~~and recommending provisions within and approval of any state plan amendment or waiver affecting hospital reimbursement made necessary or advisable by the~~ regarding the design and implementation of the Supplemental Hospital Offset Payment Program ~~Act~~. ~~In order to expedite the submission of the state plan amendment required by Section 3241.6 of this title, the~~ The Committee shall ~~initially be appointed by the Executive Director~~

~~of the Authority~~ be composed of five (5) members from a list of recommendations submitted by a statewide association representing rural and urban hospitals~~. The permanent Committee shall be appointed no later than thirty (30) days after November 1, 2011, and shall be composed of five (5) members from lists of names submitted by a statewide association representing rural and urban hospitals~~, as follows:

a. one member, appointed by the Governor, who shall serve as chairman, and

b. two members appointed each by the President Pro Tempore of the Senate and the Speaker of the House of Representatives.

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

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

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

b. the total amount of Medicaid managed care base-rate claims payments for hospital inpatient and outpatient

services. In calculating the managed care gap, the Authority shall use an average commercial rates benchmark for determining the maximum actuarially sound amount and request federal approval for at least ninety percent (90%) of the average commercial rate benchmark allowed by the federal Centers for Medicare and Medicaid Services;

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

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

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

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

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

SECTION 2. 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;

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

3. A hospital for which the majority of its inpatient days are for any one of the following services, as determined by the Authority using the Inpatient Discharge Data File published by the

State Department of Health, or in the case of a hospital not included in the Inpatient Discharge Data File, using substantially equivalent data provided by the hospital:

a. treatment of a neurological injury,

b. treatment of cancer,

c. treatment of cardiovascular disease,

d. obstetrical or childbirth services, and

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

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

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

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

1. Funds ~~generated by~~ received by the State Treasury through the supplemental hospital offset payment program fee shall be

disbursed for the following purposes in the following priority order:

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

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

~~c. the amount to be transferred by the Authority to the Medical Payments Cash Management Improvement Act Programs Disbursing Fund under subsection C of Section 3241.4 of this title~~ required to fully fund supplemental payments to eligible hospitals and critical access hospitals for hospital inpatient and hospital outpatient services for fee-for-service Medicaid patients; and the nonfederal portion of the managed care gap required to fully fund directed payments to eligible hospitals and critical access hospitals for hospital inpatient and hospital outpatient services to Medicaid managed care patients, all in accordance with subsection F of Section 3241.4 of this title,

b. an amount up to Thirty Million Dollars ($30,000,000.00) to support the nonfederal share of

the cost for physician services to the Medicaid population,

c. an amount up to Forty-five Million Dollars ($45,000,000.00) to support the nonfederal share of the cost for hospital services to the Medicaid expansion population,

d. the annual fee to be paid to the Authority for the state share of payment of administrative expenses incurred by the Authority or its agents and employees in performing the activities authorized by the Supplemental Hospital Offset Payment Program Act, but not more than Two Hundred Thousand Dollars ($200,000.00) each year,

e. an amount up to Thirty Million Dollars ($30,000,000.00) to support the nonfederal share of the costs for health care quality assurance and access improvement initiatives developed in collaboration with the Committee. The funds for this disbursement shall not be included in calculating the annual assessment percentage rate, and shall not be disbursed from funds collected herein, unless Medicaid managed care is implemented on a statewide basis,

f. an amount up to Four Million Dollars ($4,000,000.00) to be used on health information exchange initiatives

developed or agreed upon in collaboration with the Committee. The funds for this disbursement shall not be included in calculating the annual assessment percentage, and shall not be disbursed from funds collected herein, unless Medicaid managed care is implemented on a statewide basis, and

g. any remaining funds shall be deposited into the Rate Stabilization Fund.

2. ~~The~~ Prior to the start of each Medicaid program year, the Authority shall calculate the total funds necessary to make the disbursements in subparagraphs a through f of paragraph 1 of this subsection, excluding from the total funds any disbursement that fails to comply with a condition for inclusion. The Authority shall calculate an annual assessment percentage rate for that Medicaid program year. The annual assessment percentage rate determined for each Medicaid program year shall be equal to the lesser of:

a. four percent (4%), or

b. the annual assessment percentage rate needed to collect the total funds necessary to make all required, and eligible, disbursements in subparagraphs a through f of paragraph 1 of this subsection. In the event the total funds necessary to make all eligible disbursements would require the annual assessment percentage rate to exceed four percent (4%), then the

Authority shall not exceed four percent (4%) but shall prioritize payment of the disbursements in the order of the subparagraphs as listed within paragraph 1 of this subsection ~~until December 31, 2012, shall be fixed at two and one-half percent (2.5%). For the calendar year ending December 31, 2022, the assessment rate shall be fixed at three percent (3%). For the calendar year ending December 31, 2023, the assessment rate shall be fixed at three and one-half percent (3.5%). For the calendar year ending December 31, 2024 and for all subsequent calendar years, the assessment rate shall be fixed at four percent (4%)~~.

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

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

b. For years after 2013, the base year for assessment shall be determined by rules established by the Oklahoma Health Care Authority Board and beginning

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

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

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

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

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

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

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

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

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

E. Closure, merger and new hospitals.

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

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

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

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

3. In the event that the supplemental hospital offset payment program fee is determined to be null and void for any of the reasons enumerated in this subsection, any Supplemental Hospital Offset Payment Program fee assessed and collected for any period after such

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

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

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

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

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

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

~~4. Submit reports~~ timely.

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

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

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

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

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

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

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

C. ~~Notwithstanding any other provisions of law, the~~ The Oklahoma Health Care Authority is not authorized to transfer ~~each fiscal quarter~~ any funds from the Supplemental Hospital Offset Payment Program Fund to the Authority's Medical Payments Cash Management Improvement Act Programs Disbursing Fund ~~all funds remaining after accounting for the provisions of subparagraphs a and b of paragraph 1 of~~ unless such transfer is expressly authorized in accordance with subsection C of Section 3241.3 of this title.

D. Notice of Assessment.

1. The Authority shall send ~~a~~ an annual notice of assessment to each eligible hospital containing all information necessary so that the eligible hospital may validate the Authority's calculation of the assessment, including, but not limited to, ~~informing the hospital of~~ the assessment rate, the ~~hospital's~~ net hospital patient

revenue calculation, and the assessment amount owed by the eligible hospital for the applicable year.

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

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

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

5. ~~A~~ An eligible hospital ~~subject to an assessment under the Supplemental Hospital Offset Payment Program Act~~ that has not been previously licensed as a hospital in Oklahoma and that commences hospital operations during a year shall pay the required assessment computed under subsection E of Section 3241.3 of this title and shall be eligible for hospital access payments under subsection E of this section on the date specified in rules promulgated by the

Oklahoma Health Care Authority Board after consideration of input and recommendations of the Hospital Advisory Committee.

E. Quarterly Notice and Collection.

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

a. the Authority issues written notice stating that the annual assessment and payment methodologies required under the Supplemental Hospital Offset Payment Program Act have been approved by the federal Centers for Medicare and Medicaid Services and, if necessary, the waiver under 42 C.F.R., Section 433.68, ~~if necessary,~~ has been granted by the federal Centers for Medicare and Medicaid Services,

b. the thirty-day verification period required by paragraph 4 of subsection D of this section has expired, and

c. the Authority issues a notice of assessment giving a due date for the first quarterly payment.

2. After the ~~initial installment~~ first quarterly payment of an annual assessment has been paid under this section, each subsequent

quarterly ~~installment~~ payment shall be due and payable by the fifteenth day of the first month of the applicable quarter.

3. If ~~a~~ an eligible hospital fails to ~~timely~~ pay ~~the full amount of~~ a quarterly payment timely and in full ~~assessment~~, the eligible hospital shall pay the Authority ~~shall add to the assessment~~:

a. a penalty ~~assessment~~ fee equal to five percent (5%) of the eligible hospital's unpaid quarterly payment ~~amount not paid on or before the due date~~, and

b. ~~on the last day of each quarter after the due date until the assessed amount and the penalty imposed under subparagraph a of this paragraph are paid in full~~ if the quarterly payment and penalty fee are not paid in full by the end of the quarter, an additional ~~five-percent~~ penalty ~~assessment on any unpaid quarterly and unpaid penalty assessment amounts~~ fee of five (5) percent of the eligible hospital's unpaid quarterly payment.

4. The quarterly ~~assessment~~ payment including applicable penalties fees ~~and interest~~ must be paid regardless of any ~~appeals action~~ administrative review requested by the ~~facility~~ eligible hospital. If ~~a provider~~ an eligible hospital fails to pay the Authority the assessment within the time frames noted on the invoice to the ~~provider~~ eligible hospital, the assessment, applicable

penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments.

F. Medicaid Hospital Access Payments.

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

2. ~~The Authority shall pay all quarterly hospital access payments within fourteen (14) calendar days of the due date for quarterly assessment payments established in subsection E of this section.~~ On an annual basis prior to the start of each program year, the Authority shall determine:

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

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

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

d. the maximum allowable managed care gap for outpatient services payable through Medicaid managed care for all hospitals;

3. In accordance with subsection C of Section 3241.3 of this title, the Authority shall use assessment fees for the purposes of accessing federal matching funds to make hospital access payments to Eligible Hospitals and the critical access hospitals described in paragraph 5 of subsection B of Section 3241.3 of this title. Hospital access payments shall be made through supplemental payment arrangements for services provided on Medicaid fee-for-service basis and through directed payment arrangements for services provided on a Medicaid managed care basis. Such supplemental payment arrangements and directed payment arrangements shall be designed to achieve the maximum payments to in-state hospitals permitted by federal law and as approved by the federal Centers for Medicare and Medicaid Services;

~~3.~~ 4. ~~The Authority shall calculate the hospital~~ Hospital access ~~payment amount up to but not to exceed the upper payment limit gap for inpatient and outpatient services~~ payments shall be determined annually and paid quarterly from the following funding pools:

a. a hospital inpatient fee-for-service payment pool established from funds derived from the maximum allowable upper payment limit gap for inpatient services,

b. a hospital inpatient managed care payment pool established from funds derived from the maximum allowable managed care gap for inpatient services,

c. a hospital outpatient fee-for-service payment pool established from funds derived from the maximum allowable upper payment limit gap for outpatient services,

d. a hospital outpatient managed care payment pool established from funds derived from the maximum allowable managed care gap for outpatient services, and

e. a critical access hospital payment pool established from funds transferred from each pool established in subparagraphs a through d of this paragraph:

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

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

(3) the Authority shall consult with the committee regarding the calculations in subparagraphs 1 and 2 of this paragraph,

(4) the Authority shall fund the critical access hospital payment pool in an amount equal to the total estimated maximum amount that all critical access hospitals may be entitled to receive for providing Medicaid services, as calculated in subparagraph 1 of this paragraph,

(5) the Authority shall fully fund this pool prior to issuing any payment from the pools established in paragraphs a through d of this paragraph, and

(6) the Authority shall fund this pool from the pools established in paragraphs a through d of this paragraph according to such proportions as necessary to assure that each critical access hospital receives the maximum hospital access payments as permitted by federal law.

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

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

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

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

a. the amount an eligible hospital shall receive from the hospital inpatient fee-for-service payment pool shall be the eligible hospital's pro rata share of the hospital inpatient ~~hospital access~~ fee-for-service payment pool ~~based upon~~ calculated as the eligible hospital's total fee-for-service Medicaid payments for inpatient services divided by the total Medicaid fee-for-service payments for inpatient services of all eligible hospitals. Each quarterly payment from the hospital inpatient fee-for-service payment pool shall

be paid to the eligible hospital through a supplemental payment. Prior to the start of a Medicaid program year, the Authority shall consult with the Committee to minimize potential payment disparities to protect access to rural and independent hospitals, or

b. an eligible hospital shall receive from the hospital inpatient managed care payment pool a per discharge uniform add-on amount to be applied to each eligible hospital's Medicaid managed care discharges for that program year. The per discharge uniform add-on amount shall be calculated by dividing the managed care gap by total managed care inpatient discharges at eligible hospitals within the data used to calculate the managed care gap. Each quarterly payment from the hospital inpatient managed care payment pool shall be paid to the eligible hospital through a directed payment

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

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

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

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

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

a. the amount an eligible hospital shall receive from the hospital outpatient fee-for-service payment pool shall be the eligible hospital's pro rata share of the hospital's outpatient ~~hospital access~~ fee-for-service payment pool calculated as ~~based upon~~ the eligible hospital's total fee-for-service Medicaid payments for outpatient services divided by the total Medicaid fee-for-service payments for outpatient services of all eligible hospitals. Each quarterly payment from the hospital outpatient fee-for-service payment pool shall be paid to the eligible hospital through a supplemental payment, ~~or~~ and

b. an eligible hospital shall receive from the hospital outpatient managed care payment pool a uniform

percentage add-on amount to be applied to the base-rate claims payments for hospital outpatient Medicaid managed care encounters at eligible hospitals for that program year. The uniform percentage add-on amount shall be calculated by dividing the managed care gap by total managed care base-rate claims payments for eligible hospitals within the data used to calculate the managed care gap. Each quarterly payment from the hospital outpatient managed care payment pool shall be paid to the eligible hospital through a directed payment

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

~~b. Outpatient hospital access payments shall be made on a quarterly basis~~.

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

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

~~i. equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services, as determined using the Medicare Cost Report, or~~

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

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

b. ~~The Authority shall calculate hospital access payments for critical access hospitals and deduct these payments from the inpatient hospital access payment pool and the outpatient hospital access payment pool before allocating the remaining balance in each pool as provided in subparagraph a of paragraph 5 and subparagraph a of paragraph 6 of this subsection~~ the quarterly hospital access payments made to each critical access hospital shall be through supplemental

payments and directed payments in such proportions as necessary for the Authority to make the total hospital access payments to each critical access hospital in accordance with subparagraph a of this paragraph,

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

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

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

a. the Authority shall provide each Medicaid managed care organization with a listing of the hospital access payments to be paid by each Medicaid managed care organization to each eligible hospital and critical access hospital in accordance with this subsection,

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

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

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

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

a. a managed care organization shall not implement any hospital fee schedule that is less than the comparable

fee schedule utilized by the Authority on Medicaid fee-for-service basis, and

b. neither the Authority nor a managed care organization shall establish hospital reimbursement base rates that are less than those in effect as of January 1, 2022;

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

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

b. an eligible hospital's obligation to pay an assessment as required by Section 3241.3 of this title and this section shall be reduced in the event the federal Centers for Medicare and Medicaid Services determines that federal financial participation is not available to make hospital access payments in accordance with this section. The assessment on eligible hospitals shall be reduced to a percentage that permits the Authority to obtain from eligible hospitals an amount of nonfederal matching funds for which federal financial participation is available to implement any portion of hospital access payments that the federal Centers for Medicare and Medicaid Services approves, or

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

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

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

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

~~a. transfers to the Medical Payments Cash Management Improvement Act Programs Disbursing Fund for the state~~

~~share of supplemental or directed payments or both for Medicaid and SCHIP inpatient and outpatient services to hospitals that participate in the assessment,~~

~~b. transfers to the Medical Payments Cash Management Improvement Act Programs Disbursing Fund for the state share of supplemental or directed payments or both for critical access hospitals,~~

~~c. transfers to the Administrative Revolving Fund for the state share of payment of administrative expenses incurred by the Authority or its agents and employees in performing the activities authorized by the Supplemental Hospital Offset Payment Program Act but not more than Two Hundred Thousand Dollars ($200,000.00) each year,~~

~~d. transfers to the Medical Payments Cash Management Improvement Act Programs Disbursing Fund each fiscal quarter all funds remaining after accounting for the provisions of subparagraphs a, b and c of this paragraph, and~~

~~e. the reimbursement of monies collected by the Authority from hospitals through error or mistake in performing the activities authorized under the Supplemental Hospital Offset Payment Program Act~~ in accordance with subsection C of Section 3241.3 of this title.

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

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

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

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

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

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

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

SECTION 4. NEW LAW A new section of law not to be codified in the Oklahoma Statutes reads as follows:

This act shall only become effective if Senate Bill No. 1337 of the Second Session of the 58th Oklahoma Legislature is enacted into law.

SECTION 5. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

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