

1                           **HOUSE OF REPRESENTATIVES - FLOOR VERSION**

2   STATE OF OKLAHOMA

3                           2nd Session of the 58th Legislature (2022)

4 COMMITTEE SUBSTITUTE  
5 FOR ENGROSSED  
6 SENATE BILL NO. 1396

By: Hall of the Senate

and

Wallace of the House

7  
8  
9  
10   COMMITTEE SUBSTITUTE

[ supplemental hospital offset payment program -

certain fee -

emergency ]

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16 ~~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

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

3 3. "Directed payments" means payment arrangements allowed under  
4 42 C.F.R. Section 438.6(c) that permit states to direct specific  
5 payments made by managed care plans to providers under certain  
6 circumstances and can assist states in furthering the goals and  
7 priorities of their Medicaid programs;

8 4. "Eligible hospital" means an in-state hospital that is  
9 eligible to participate in the Supplemental Hospital Offset Payment  
10 Program and not otherwise exempt pursuant to subsection B of Section  
11 3241.3 of this title;

12 ~~4.~~ 5. "Hospital" means an institution licensed by the State  
13 Department of Health as a hospital pursuant to Section 1-701 of this  
14 title maintained primarily for the diagnosis, treatment, or care of  
15 patients;

16 ~~5.~~ 6. "Hospital Advisory Committee" or "Committee" means the  
17 Committee established ~~for the purposes of advising~~ to advise the  
18 Oklahoma Health Care Authority ~~and recommending provisions within~~  
19 ~~and approval of any state plan amendment or waiver affecting~~  
20 ~~hospital reimbursement made necessary or advisable by the~~ regarding  
21 the design and implementation of the Supplemental Hospital Offset  
22 Payment Program Act. ~~In order to expedite the submission of the~~  
23 ~~state plan amendment required by Section 3241.6 of this title, the~~  
24 The Committee shall initially be appointed by the Executive Director

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

- 8 a. one member, appointed by the Governor, who shall serve  
9 as chairman, and
- 10 b. two members appointed each by the President Pro  
11 Tempore of the Senate and the Speaker of the House of  
12 Representatives.

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

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

- 20 a. the maximum actuarially sound amount that can be paid  
21 for hospital inpatient and outpatient services to  
22 Medicaid managed care enrollees, and
- 23 b. the total amount of Medicaid managed care base-rate  
24 claims payments for hospital inpatient and outpatient

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

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

11 ~~7.~~ 9. "Medicare Cost Report" means the Hospital Cost Report,  
12 Form ~~CMS-2552-96~~ CMS-2552-10, or subsequent versions;

13 ~~8.~~ 10. "Net hospital patient revenue" means the gross hospital  
14 revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines "Total  
15 inpatient routine care services", "Ancillary services", and  
16 "Outpatient services") of the Medicare Cost Report, multiplied by  
17 the hospital's ratio of total net to gross revenue, as reported on  
18 Worksheet G-3 (Column 1, Line "Net patient revenues") and Worksheet  
19 G-2 (Part I, Column 3, Line "Total patient revenues");

20 ~~9.~~ 11. "Upper payment limit" means the maximum ceiling imposed  
21 by 42 C.F.R., Sections 447.272 and 447.321 on hospital Medicaid fee-  
22 for-service reimbursement reimbursements for inpatient and  
23 outpatient services, other than to hospitals owned or operated by  
24 state government; and

1        ~~10.~~ 12. "Upper payment limit gap" means the difference between  
2 the upper payment limit and Medicaid fee-for-service payments ~~not~~  
3 ~~financed using hospital assessments~~ made to all hospitals for  
4 hospital inpatient and hospital outpatient services, other than  
5 hospitals owned or operated by state government.

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

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

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

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

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

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

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

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

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

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

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

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

1 disbursed for the following purposes in the following priority  
2 order:

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

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

9 ~~c. the amount to be transferred by the Authority to the~~  
10 ~~Medical Payments Cash Management Improvement Act~~  
11 ~~Programs Disbursing Fund under subsection C of Section~~  
12 ~~3241.4 of this title required to fully fund~~  
13 ~~supplemental payments to eligible hospitals and~~  
14 ~~critical access hospitals for hospital inpatient and~~  
15 ~~hospital outpatient services for fee-for-service~~  
16 ~~Medicaid patients; and the nonfederal portion of the~~  
17 ~~managed care gap required to fully fund directed~~  
18 ~~payments to eligible hospitals and critical access~~  
19 ~~hospitals for hospital inpatient and hospital~~  
20 ~~outpatient services to Medicaid managed care patients,~~  
21 ~~all in accordance with subsection F of Section 3241.4~~  
22 ~~of this title,~~

23 b. an amount up to Thirty Million Dollars

24 (\$30,000,000.00) to support the nonfederal share of

1 the cost for physician services to the Medicaid  
2 population,

3 c. an amount up to Forty-five Million Dollars  
4 (\$45,000,000.00) to support the nonfederal share of  
5 the cost for hospital services to the Medicaid  
6 expansion population,

7 d. the annual fee to be paid to the Authority for the  
8 state share of payment of administrative expenses  
9 incurred by the Authority or its agents and employees  
10 in performing the activities authorized by the  
11 Supplemental Hospital Offset Payment Program Act, but  
12 not more than Two Hundred Thousand Dollars  
13 (\$200,000.00) each year,

14 e. an amount up to Thirty Million Dollars  
15 (\$30,000,000.00) to support the nonfederal share of  
16 the costs for health care quality assurance and access  
17 improvement initiatives developed in collaboration  
18 with the Committee. The funds for this disbursement  
19 shall not be included in calculating the annual  
20 assessment percentage rate, and shall not be disbursed  
21 from funds collected herein, unless Medicaid managed  
22 care is implemented on a statewide basis,

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



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

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

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

17 a. four percent (4%), or

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

1 Authority shall not exceed four percent (4%) but shall  
2 prioritize payment of the disbursements in the order  
3 of the subparagraphs as listed within paragraph 1 of  
4 this subsection ~~until December 31, 2012, shall be~~  
5 ~~fixed at two and one-half percent (2.5%). For the~~  
6 ~~calendar year ending December 31, 2022, the assessment~~  
7 ~~rate shall be fixed at three percent (3%). For the~~  
8 ~~calendar year ending December 31, 2023, the assessment~~  
9 ~~rate shall be fixed at three and one-half percent~~  
10 ~~(3.5%). For the calendar year ending December 31,~~  
11 ~~2024 and for all subsequent calendar years, the~~  
12 ~~assessment rate shall be fixed at four percent (4%).~~

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 an eligible hospital for any reason  
14 ~~subject to the fee imposed under the Supplemental Hospital Offset~~  
15 ~~Payment Program Act~~, 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 an~~  
21 eligible hospital ~~subject to the supplemental hospital offset~~  
22 ~~payment program fee~~, the hospital shall pay the assessment for the  
23 year as ~~se~~ 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~~ timely.

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

18 D. Notice of Assessment.

19 1. The Authority shall send ~~a~~ an annual notice of assessment to  
20 each eligible hospital containing all information necessary so that  
21 the eligible hospital may validate the Authority's calculation of  
22 the assessment, including, but not limited to, informing the  
23 ~~hospital of~~ the assessment rate, the ~~hospital's~~ net hospital patient  
24

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

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

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

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

17 5. A An eligible hospital ~~subject to an assessment under the~~  
18 ~~Supplemental Hospital Offset Payment Program Act~~ that has not been  
19 previously licensed as a hospital in Oklahoma and that commences  
20 hospital operations during a year shall pay the required assessment  
21 computed under subsection E of Section 3241.3 of this title and  
22 shall be eligible for hospital access payments under subsection E of  
23 this section on the date specified in rules promulgated by the  
24



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

3 E. Quarterly Notice and Collection.

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

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

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

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

22 2. After the ~~initial installment~~ first quarterly payment of an  
23 annual assessment has been paid under this section, each subsequent  
24

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

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

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

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

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

4 F. Medicaid Hospital Access Payments.

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

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

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

23  
24

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

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

7           3. In accordance with subsection C of Section 3241.3 of this  
8           title, the Authority shall use assessment fees for the purposes of  
9           accessing federal matching funds to make hospital access payments to  
10           Eligible Hospitals and the critical access hospitals described in  
11           paragraph 5 of subsection B of Section 3241.3 of this title.

12           Hospital access payments shall be made through supplemental payment  
13           arrangements for services provided on Medicaid fee-for-service basis  
14           and through directed payment arrangements for services provided on a  
15           Medicaid managed care basis. Such supplemental payment arrangements  
16           and directed payment arrangements shall be designed to achieve the  
17           maximum payments to in-state hospitals permitted by federal law and  
18           as approved by the federal Centers for Medicare and Medicaid  
19           Services;

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

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

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

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

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

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

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

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

7           (3) the Authority shall consult with the committee  
8           regarding the calculations in subparagraphs 1 and  
9           2 of this paragraph,

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

11       a. the amount an eligible hospital shall receive from the  
12 hospital outpatient fee-for-service payment pool shall  
13 be the eligible hospital's pro rata share of the  
14 hospital's outpatient ~~hospital access~~ fee-for-service  
15 payment pool calculated as ~~based upon~~ the eligible  
16 hospital's total fee-for-service Medicaid payments for  
17 outpatient services divided by the total Medicaid ~~fee-~~  
18 for-service payments for outpatient services of all  
19 eligible hospitals. Each quarterly payment from the  
20 hospital outpatient fee-for-service payment pool shall  
21 be paid to the eligible hospital through a  
22 supplemental payment, ~~or~~ and

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

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

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

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

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

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

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

- 10       a. each program year a critical access hospital shall  
11       receive from the critical hospital payment pool  
12       quarterly amounts that shall total the estimated  
13       maximum amount the Authority calculated, not to exceed  
14       billed charges, for that critical access hospital in  
15       accordance with paragraph 4 of this subsection,  
16       ~~b. The Authority shall calculate hospital access payments~~  
17       ~~for critical access hospitals and deduct these~~  
18       ~~payments from the inpatient hospital access payment~~  
19       ~~pool and the outpatient hospital access payment pool~~  
20       ~~before allocating the remaining balance in each pool~~  
21       ~~as provided in subparagraph a of paragraph 5 and~~  
22       ~~subparagraph a of paragraph 6 of this subsection the~~  
23       quarterly hospital access payments made to each  
24       critical access hospital shall be through supplemental

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

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

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

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

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

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

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

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

15           ~~8.~~ 10. A hospital access payment shall not be used to offset  
16 any other payment ~~by Medicaid~~ for hospital inpatient or outpatient  
17 services to Medicaid beneficiaries, including without limitation any  
18 fee-for-service, managed care, per diem, private hospital inpatient  
19 adjustment, or cost-settlement payment. In furtherance of this  
20 paragraph, and notwithstanding any other provision of law to the  
21 contrary:

22           a. a managed care organization shall not implement any  
23           hospital fee schedule that is less than the comparable  
24

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

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

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

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

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

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 positive contribution to the ~~upper payment limit~~ disallowed payment.  
15 This provision is triggered only if the disallowance is considered  
16 final and all appeals have been exhausted.

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

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

23            ~~a. transfers to the Medical Payments Cash Management~~  
24            ~~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,~~
- e. ~~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.~~



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

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

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

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

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

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

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

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

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

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

15  
16 COMMITTEE REPORT BY: COMMITTEE ON APPROPRIATIONS AND BUDGET, dated  
17 04/21/2022 - DO PASS, As Amended.

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19  
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