STATE OF OKLAHOMA

1st Session of the 59th Legislature (2023)

SENATE BILL 293 By: Hall

AS INTRODUCED

An Act relating to hospitals; amending 63 O.S. 2021, Section 1-701, which relates to definitions; modifying and adding definitions; updating statutory reference; amending 63 O.S. 2021, Sections 3241.3 and 3241.4, as amended by Sections 2 and 3, Chapter 398, O.S.L. 2022 (63 O.S. Supp. 2022, Sections 3241.3 and 3241.4), which relate to the Supplemental Hospital Offset Payment Program; modifying applicability of certain provisions; and providing an effective date.

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

SECTION 1. AMENDATORY 63 O.S. 2021, Section 1-701, is amended to read as follows:

Section 1-701. For the purposes of Section 1-701 et seq. of this title:

1. "Hospital" means any institution, place, building or agency, public or private, whether organized for profit or not, primarily engaged in the maintenance and operation of facilities for the diagnosis, treatment or care of patients admitted for overnight stay or longer in order to obtain medical care, surgical care, obstetrical care, or nursing care for illness, disease, injury,

infirmity, or deformity. Except as otherwise provided by ~~paragraph 5 of this subsection~~ paragraph 7 of this section, places where pregnant females are admitted and receive care incident to pregnancy, abortion or delivery shall be considered to be a "hospital" within the meaning of this article, regardless of the number of patients received or the duration of their stay. The term "hospital" includes general medical surgical hospitals, specialized hospitals, critical access ~~and emergency~~ hospitals, emergency hospitals, rural emergency hospitals, and birthing centers;

2. "General medical surgical hospital" means a hospital maintained for the purpose of providing hospital care in a broad category of illness and injury;

3. "Specialized hospital" means a hospital maintained for the purpose of providing hospital care in a certain category, or categories, of illness and injury;

4. "Critical access hospital" means a hospital determined by the State Department of Health to be a necessary provider of health care services to residents of a rural community;

5. "Emergency hospital" means a hospital that provides emergency treatment and stabilization services on a twenty-four-hour basis that has the ability to admit and treat patients for short periods of time;

6. "Rural emergency hospital" means a hospital that provides emergency treatment and stabilization services for an average length of stay of twenty-four hours or less;

7. "Birthing center" means any facility, place or institution, which is maintained or established primarily for the purpose of providing services of a certified midwife or licensed medical doctor to assist or attend a woman in delivery and birth, and where a woman is scheduled in advance to give birth following a normal, uncomplicated, low-risk pregnancy. Provided, however, licensure for a birthing center shall not be compulsory;

~~7.~~ 8. "Day treatment program" means nonresidential, partial hospitalization programs, day treatment programs, and day hospital programs as defined by subsection A of Section 175.20 of Title 10 of the Oklahoma Statutes; and

~~8.~~

9. a. "Primarily engaged" means a hospital shall be primarily engaged, defined by this section and as determined by the State Department of Health, in providing to inpatients the following care by or under the supervision of physicians:

(1) diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or

(2) rehabilitation services for the rehabilitation of injured, disabled or sick persons.

b. In reaching a determination as to whether an entity is primarily engaged in providing inpatient hospital services to inpatients of a hospital, the Department shall evaluate the total facility operations and consider multiple factors as provided in subparagraphs c and d of this subsection.

c. In evaluating the total facility operations, the Department shall review the actual provision of care and services to two or more inpatients, and the effects of that care, to assess whether the care provided meets the needs of individual patients by way of patient outcomes.

d. The factors that the Department shall consider for determination of whether an entity meets the definition of primarily engaged include, but are not limited to:

(1) a minimum of four inpatient beds,

(2) the entity's average daily census (ADC),

(3) the average length of stay (ALOS),

(4) the number of off-site campus outpatient locations,

(5) the number of provider-based emergency departments for the entity,

(6) the number of inpatient beds related to the size of the entity and the scope of the services offered,

(7) the volume of outpatient surgical procedures compared to the inpatient surgical procedures, if surgical services are provided,

(8) staffing patterns, and

(9) patterns of ADC by day of the week.

e. Notwithstanding any other provision of this section, an entity shall be considered primarily engaged in providing inpatient hospital services to inpatients if the hospital has had an ADC of at least two (2) and an ALOS of at least two (2) midnights over the past twelve (12) months. A critical access hospital shall be exempt from the ADC and ALOS determination. ADC shall be calculated by adding the midnight daily census for each day of the twelve-month period and then dividing the total number by days in the year. A facility that has been operating for less than (12) months at the time of the survey shall calculate its ADC based on the number of months the facility has been operational, but not less than three (3) months.

If a first survey finds noncompliance with the ADC and ALOS, a second survey may be required by the Department to demonstrate compliance with state licensure.

SECTION 2. AMENDATORY 63 O.S. 2021, Section 3241.3, as amended by Section 2, Chapter 398, O.S.L. 2022 (63 O.S. Supp. 2022, 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 or rural emergency 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 the supplemental hospital offset payment program fee shall be disbursed for the following purposes in the following priority order:

a. One Hundred Thirty Million Dollars ($130,000,000.00) to be transferred annually to the Medical Payments Cash Management Improvement Act Programs Disbursing Fund to fund the state Medicaid program,

b. the nonfederal share of:

(1) the upper payment limit gap,

(2) the managed care gap,

(3) the managed care provider incentive pool to support health care quality assurance and access improvement initiatives, with the pool amount determined by the representative sharing ratio of provider and hospital participation in Medicaid. Provider eligibility shall be determined by the Authority. For purposes of this division, eligible providers shall not include those employed by or contracted with, or otherwise a member of, the faculty practice plan of either:

(a) a public, accredited Oklahoma medical school, or

(b) a hospital or health care entity directly or indirectly owned or operated by the entities

created pursuant to Section 3224 or 3290 of this title,

(4) 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

(5) Thirty Million Dollars ($30,000,000.00) annually 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.

If the nonfederal share generated by the supplemental hospital offset payment program fee is not sufficient to fully fund the disbursements described in divisions 1 through 5 of this subparagraph, the funds directed toward such disbursements shall be reduced proportionally, and

c. any remaining funds shall be deposited into the Medicaid Health Improvement Revolving Fund created in Section 23 of Enrolled Senate Bill No. 1337 of the 2nd Session of the 58th Oklahoma Legislature.

2. The assessment rate 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 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 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 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 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 which hospitals are eligible to participate in the Supplemental Hospital Offset Payment Program provided for in this subsection and which hospitals are exempted 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. 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 an eligible hospital ceases to be an eligible hospital for any reason, 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 be an eligible hospital, the hospital shall pay the assessment for the year as adjusted, to the extent not previously paid.

2. In the case of 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 for one or more of the purposes identified in division 1, 2, or 3 of subparagraph b of paragraph 1 of subsection C of this section, the portion of the supplemental hospital offset payment program fee attributable to any such purpose for which matching expenditures are

unavailable 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 reports as required by this section in a timely manner.

I. The Oklahoma Health Care Authority Board shall have the power to promulgate emergency rules to implement the provisions of the Supplemental Hospital Offset Payment Program Act.

SECTION 3. AMENDATORY 63 O.S. 2021, Section 3241.4, as amended by Section 3, Chapter 398, O.S.L. 2022 (63 O.S. Supp. 2022, 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. The Oklahoma Health Care Authority is authorized to transfer each fiscal quarter 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 subsection C of Section 3241.3 of this title.

D. Notice of Assessment.

1. The Authority shall send an annual notice of assessment to each eligible hospital informing the hospital of the assessment rate, the net hospital patient revenue calculation, and the assessment amount owed by the eligible hospital for the applicable year.

2. 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. An eligible hospital shall have thirty (30) days from the date of its receipt of an annual notice of assessment to notify the Authority of any error in the notice.

5. An eligible hospital 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 subsections A and C of Section 3241.3 of this title shall be due and payable on a quarterly basis. However, the first quarterly payment of an annual assessment 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 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 first quarterly payment of an annual assessment has been paid under this section, each subsequent quarterly payment

shall be due and payable by the fifteenth day of the first month of the applicable quarter.

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

a. a penalty fee equal to five percent (5%) of the eligible hospital's unpaid quarterly payment, and

b. if the quarterly payment and penalty fee are not paid in full by the end of the quarter, an additional penalty fee of five percent (5%) of the eligible hospital's unpaid quarterly payment.

4. The quarterly payment including applicable penalty fees must be paid regardless of any administrative review requested by the eligible hospital. If an eligible hospital fails to pay the Authority the assessment within the time frames noted on the invoice to the eligible hospital, the assessment, applicable penalty fees, 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 inpatient and outpatient services, the Authority shall make hospital access payments to eligible hospitals ~~and~~, critical access hospitals, and rural emergency hospitals to supplement reimbursements for inpatient and outpatient services that are

provided through Medicaid on both a fee-for-service and managed care basis.

2. On an annual basis prior to the start of each calendar year, the Authority shall determine:

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

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

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

d. the 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 the eligible hospitals ~~and the~~, critical access hospitals, and rural emergency 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 a Medicaid fee-for-service basis and through directed payment arrangements for services provided on a Medicaid managed care basis,

as approved by the federal Centers for Medicare and Medicaid Services.

4. Hospital access 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 upper payment limit gap for inpatient services,

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

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

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

e. (1) A critical access hospital and rural emergency hospital payment pool established from funds transferred from each pool established in subparagraphs a through d of this paragraph.

(2) Prior to the start of each calendar year, the Authority shall determine an estimated amount that each critical access hospital and rural emergency hospital may be entitled to receive for

providing Medicaid services, not to exceed that critical access hospital's or rural emergency hospital's billed charges.

(3) The Authority shall fund the critical access hospital and rural emergency hospital payment pool in an amount equal to the total estimated amount that all critical access hospitals and rural emergency hospitals may be entitled to receive for providing Medicaid services, as calculated in division 2 of this subparagraph.

(4) The Authority shall consult with the Committee regarding the calculations in divisions 2 and 3 of this subparagraph.

(5) The Authority shall fully fund the critical access hospital and rural emergency hospital payment pool prior to issuing any payment from the pools established in subparagraphs a through d of this paragraph.

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

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 fee-for-service payment pool 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 calendar year, the Authority shall consult with the Committee to minimize potential payment disparities to protect access to rural and independent hospitals, and

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 calendar 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 contained in the data used to calculate the managed care gap. To assure timely

payment, the Authority may make the calculation in this subparagraph using good-faith reasonable estimates if complete data does not exist or is not available. Each quarterly payment from the hospital inpatient managed care payment pool shall be paid to the eligible hospital through a directed payment.

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

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 fee-for-service payment pool calculated as 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, 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 calendar 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. To assure timely payment, the Authority may make the calculation in this subparagraph using good-faith reasonable estimates if complete data does not exist or is not available. Each quarterly payment from the hospital outpatient managed care payment pool shall be paid to the eligible hospital through a directed payment.

7. In addition to any other funds paid to critical access hospitals or rural emergency hospitals for inpatient and outpatient hospital services to Medicaid patients, each critical access hospital and rural emergency hospital physically located in this state shall receive hospital access payments each quarter from the critical access hospital and rural emergency hospital payment pool as follows:

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

b. the quarterly hospital access payments made to each critical access hospital and rural emergency 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 and rural emergency hospital in accordance with subparagraph a of this paragraph, and

c. 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 one percent (101%) of Medicare's critical access hospitals' 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 on which each quarterly payment of an annual assessment is due as required in subsection E of this section.

9. In processing directed payments through contracted entities, the following requirements shall apply:

a. the Authority shall provide each contracted entity with a listing of the hospital access payments to be paid by each contracted entity to each eligible hospital ~~and~~, critical access hospital, and rural emergency hospital in accordance with this subsection,

b. a contracted entity shall pay hospital access payments to eligible hospitals ~~and~~, critical access hospitals, and rural emergency hospitals within five (5) business days of receiving a supplemental capitation payment from the Authority,

c. a contracted entity 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, and rural emergency hospital receives full payment of all hospital access payments to which it is entitled pursuant to this subsection.

10. A hospital access payment shall not be used to offset any other payment 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.

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 the portion of the assessment attributable to the nonfederal share of the upper payment limit gap and the nonfederal share of the managed care gap 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, and

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.

12. If the federal Centers for Medicare and Medicaid Services disallows any hospital access payments 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 an amount equal to that hospital's pro rata share of the recouped federal funds that is proportionate to the hospital's positive contribution to the disallowed payment. The refund shall be required 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 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 or rural emergency 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 in accordance with subsection C of Section 3241.3 of this title, 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.

2. The Authority shall pay from the Supplemental Hospital Offset Payment Program Fund quarterly installment payments to hospitals as set forth in this section.

3. 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 the Supplemental Hospital Offset Payment Program Act; and

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

SECTION 4. This act shall become effective October 1, 2023.

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