

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

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

9 AUTHOR: Add the following House Coauthor: Randleman

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

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

1 contingency effective date; and declaring an  
2 emergency.

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

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

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

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

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

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

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

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

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

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

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

24

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 E. Closure, merger and new hospitals.

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

24

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 D. Notice of Assessment.

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

23

24

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

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

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

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

24       E. Quarterly Notice and Collection.



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

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

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

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

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

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

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

24 F. Medicaid Hospital Access Payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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





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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

12 SECTION 5. It being immediately necessary for the preservation  
13 of the public peace, health or safety, an emergency is hereby  
14 declared to exist, by reason whereof this act shall take effect and  
15 be in full force from and after its passage and approval."  
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24

1 Passed the House of Representatives the 28th day of April, 2022.

2  
3  
4 Presiding Officer of the House of  
5 Representatives

6 Passed the Senate the \_\_\_\_ day of \_\_\_\_\_, 2022.

7  
8  
9 Presiding Officer of the Senate