STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL 1045

By: Thompson and Hall of the Senate

and

Wallace and Hilbert of the House

COMMITTEE SUBSTITUTE

An Act relating to the Supplemental Hospital Offset Payment Program; amending 63 O.S. 2011, Section 3241.2, as last amended by Section 1, Chapter 56, O.S.L. 2019 (63 O.S. Supp. 2020, Section 3241.2), which relates to definitions; modifying and adding definitions; amending 63 O.S. 2011, Section 3241.3, as last amended by Section 2, Chapter 56, O.S.L. 2019 (63 O.S. Supp. 2020, Section 3241.3), which relates to supplemental hospital offset payment program fee; modifying assessment methodology; stating allowed expenses; fixing certain rates for specified time periods; requiring annual determination of base year; clarifying rulemaking entity; rendering portion of fee null and void under certain condition; removing termination date of fee; amending 63 O.S. 2011, Section 3241.4, as last amended by Section 3, Chapter 345, O.S.L. 2016 (63 O.S. Supp. 2020, Section 3241.4), which relates to Supplemental Hospital Offset Payment Program Fund; removing limitation on certain transfers; extending time period for certain payments; allowing access payments through directed payments; allowing certain transfers of directed payments; clarifying rulemaking entity; updating statutory reference; providing an effective date; and declaring an emergency.

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

SECTION 1. AMENDATORY 63 O.S. 2011, Section 3241.2, as last amended by Section 1, Chapter 56, O.S.L. 2019 (63 O.S. Supp. 2020, Section 3241.2), is amended to read as follows:

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

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

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

3. ~~"Net hospital patient revenue" means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines "Total inpatient routine care services", "Ancillary services", and "Outpatient services") of the Medicare Cost Report, multiplied by the hospital's ratio of total net to gross revenue, as reported on Worksheet G-3 (Column 1, Line "Net patient revenues") and Worksheet G-2 (Part I, Column 3, Line "Total patient revenues")~~ "Directed payments" means payment arrangements allowed under 42 C.F.R. Section 438.6(c) that permit states to direct specific payments made by managed care plans to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs;

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

5. "Hospital Advisory Committee" means the Committee established for the purposes of advising the Oklahoma Health Care Authority and recommending provisions within and approval of any state plan amendment or waiver affecting hospital reimbursement made necessary or advisable by the Supplemental Hospital Offset Payment Program Act. In order to expedite the submission of the state plan amendment required by Section 3241.6 of this title, the Committee shall initially be appointed by the Executive Director of the Authority from recommendations submitted by a statewide association representing rural and urban hospitals. The permanent Committee shall be appointed no later than thirty (30) days after November 1, 2011, and shall be composed of five (5) members ~~to serve until December 31, 2025,~~ from lists of names submitted by a statewide association representing rural and urban hospitals, as follows:

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

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

~~Membership shall be extended until December 31, 2025, for those members who are serving as of December 31, 2019~~ Members shall serve at the pleasure of the appointing authority;

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

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

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

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

~~9.~~ 10. "Upper payment limit gap" means the difference between the upper payment limit and Medicaid payments not financed using hospital assessments made to all hospitals other than hospitals owned or operated by state government.

SECTION 2. AMENDATORY 63 O.S. 2011, Section 3241.3, as last amended by Section 2, Chapter 56, O.S.L. 2019 (63 O.S. Supp. 2020, 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 ~~Oklahoma~~ 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,

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 ~~Medicaid and~~ 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 ~~Medicaid and~~ Medicare and Medicaid Services as a critical access hospital.

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

1. ~~The assessment rate shall be determined annually based upon the percentage of net hospital patient revenue needed to generate an amount up to the sum of~~ Funds generated by the supplemental hospital offset payment program fee shall be disbursed for the following purposes in the following priority order:

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

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

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

2. The assessment rate until December 31, 2012, shall be fixed at two and one-half percent (2.5%). ~~At no time in~~ 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 ~~shall~~, the assessment rate ~~exceed~~ shall be fixed at four percent (4%).

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

a. Through 2013, the base year for assessment shall be the hospital's fiscal year that ended in 2009, as

contained in the Healthcare Cost Report Information System file dated December 31, 2010.

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

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

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

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

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

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

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

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

E. Closure, merger and new hospitals.

1. If a hospital ceases to operate as a hospital or for any reason ceases to be subject to the fee imposed under the Supplemental Hospital Offset Payment Program Act, the assessment for the year in which the cessation occurs shall be adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the hospital is subject to the assessment and the denominator of which is 365. Immediately upon ceasing to operate as a hospital, or otherwise ceasing to be subject to the supplemental hospital offset payment

program fee, the hospital shall pay the assessment for the year as so adjusted, to the extent not previously paid.

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

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

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

3. In the event that the supplemental hospital offset payment program fee is determined to be null and void for any of the reasons

enumerated in this subsection, any supplemental hospital offset payment program fee assessed and collected for any period after such invalidation shall be returned in full within twenty (20) days by the Authority to the 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;

2. Submit the fee in a timely manner;

3. Submit reports as required by this section; or

4. Submit reports timely.

I. ~~The supplemental hospital offset payment program fee shall terminate effective December 31, 2025.~~

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

SECTION 3. AMENDATORY 63 O.S. 2011, Section 3241.4, as last amended by Section 3, Chapter 345, O.S.L. 2016 (63 O.S. Supp. 2020, 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 hospitals pursuant to the Supplemental Hospital Offset Payment Program Act and otherwise specified or authorized by law;

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

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

C. Notwithstanding any other provisions of law, the Oklahoma Health Care Authority is authorized to transfer ~~Seven Million Five Hundred Thousand Dollars ($7,500,000.00)~~ 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 a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.

2. Annual notices of assessment shall be sent 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 Centers for Medicare and Medicaid Services that the assessments and payments required under the Supplemental Hospital Offset Payment Program Act and, if necessary, the waiver granted under 42 C.F.R., Section 433.68 have been approved.

4. The hospital shall have thirty (30) days from the date of its receipt of a notice of assessment to review and verify the assessment rate, the hospital's net patient revenue calculation, and the assessment amount.

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

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

E. Quarterly Notice and Collection.

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

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

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

3. If a hospital fails to timely pay the full amount of a quarterly assessment, the Authority shall add to the assessment:

a. a penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date, and

b. on the last day of each quarter after the due date until the assessed amount and the penalty imposed under subparagraph a of this paragraph are paid in full, an additional five-percent penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

4. The quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the Authority the assessment within the time frames noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments.

F. Medicaid Hospital Access Payments.

1. To preserve the quality and improve access to hospital services for hospital inpatient and outpatient services rendered on or after ~~the effective date of this act~~ August 26, 2011, the

Authority shall make hospital access payments as set forth in this section.

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

3. The Authority shall calculate the hospital access payment amount up to but not to exceed the upper payment limit gap for inpatient and outpatient services.

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

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

a. In addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible hospital shall receive inpatient hospital access payments each year:

i. equal to the hospital's pro rata share of the inpatient hospital access payment pool based upon the hospital's Medicaid payments for inpatient

services divided by the total Medicaid payments for inpatient services of all eligible, or

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

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

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

a. In addition to any other funds paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital shall receive outpatient hospital access payments each year:

i. equal to the hospital's pro rata share of the outpatient hospital access payment pool based upon the hospital's Medicaid payments for outpatient services divided by the total Medicaid payments for outpatient services of all eligible, or

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

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

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

a. In addition to any other funds paid to critical access hospitals for inpatient and outpatient hospital services to Medicaid patients, each critical access hospital shall receive hospital access payments:

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

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

b. The Authority shall calculate hospital access payments for critical access hospitals and deduct these payments from the inpatient hospital access payment

pool and the outpatient hospital access payment pool before allocating the remaining balance in each pool as provided in subparagraph a of paragraph 5 and subparagraph a of paragraph 6 of this subsection.

c. Critical access hospital payments shall be made on a quarterly basis.

8. A hospital access payment shall not be used to offset any other payment by Medicaid for hospital inpatient or outpatient services to Medicaid beneficiaries, including without limitation any fee-for-service, per diem, private hospital inpatient adjustment, or cost-settlement payment.

9. If the Centers for Medicare and Medicaid Services finds that the Authority has made payments to hospitals that exceed the upper payment limits determined in accordance with 42 C.F.R. 447.272 and 42 C.F.R. 447.321, hospitals shall refund to the Authority a share of the recouped federal funds that is proportionate to the hospitals' positive contribution to the upper payment limit.

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

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

a. transfers to the Medical Payments Cash Management Improvement Act Programs Disbursing Fund ~~(Fund 340)~~ 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 ~~(Fund 340)~~ for the state share of supplemental or directed payments or both for ~~Critical Access Hospitals~~ critical access hospitals,

c. transfers to the Administrative Revolving Fund ~~(Fund 200)~~ 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 ~~(Fund 340) in an amount not to exceed Seven Million Five Hundred Thousand Dollars ($7,500,000.00)~~ 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.

2. The Authority shall pay from the Supplemental Hospital Offset Payment Program Fund quarterly installment payments to hospitals of amounts available for supplemental inpatient and outpatient payments or directed inpatient and outpatient payments or both, and supplemental payments for ~~Critical Access Hospitals~~ critical access hospitals or directed payments for critical access hospitals or both.

3. Except for the transfers described in subsection C of this section, 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 ~~regulations~~ rules that:

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

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

SECTION 4. This act shall become effective July 1, 2021.

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

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