Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: June 24, 2021

Reference: APA WF 21-09 Emergency Rule

SUMMARY:

Supplemental Hospital Offset Payment Program (SHOPP)— The proposed changes will amend the Supplemental Hospital Offset Payment Program (SHOPP) policy to be in compliance with Senate Bill 1045.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; 42 Code of Federal Regulations (C.F.R.) §§ 447.272 and 447.321

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 21-09

A. Brief description of the purpose of the rule:

The proposed changes will amend the Supplemental Hospital Offset Payment Program (SHOPP) policy to be in compliance with Senate Bill 1045.

The proposed changes will define "directed payments" as specific payments made by managed care plans to providers under certain circumstances that assist states in furthering the goals and priorities of their Medicaid programs. The measure provides that funds from SHOPP may be used to fund supplemental or directed payments. Additionally, the changes will modify the assessment calculation methodology from a rate needed to generate an amount up to the sum of certain expenses to a fixed

rate. Additionally, the proposed changes renders the portion of the SHOPP fee attributable to certain expenses null and void if federal matching funds for the program become unavailable. The measure also eliminates the termination date of the program and removes a cap on quarterly transfers of funds. Finally, other changes are for grammar and language cleanup and to align the SHOPP rule with current business practice and needed changes for the funding of expansion adults and services through managed care.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

SoonerCare contracted hospitals will be affected by the proposed rule changes.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes will benefit those individuals who fall into the new adult eligibility catergory by creating a mechanism to help fund their health care coverage.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There are no fee changes associated with the rule change.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no cost impact. However, the agency estimates that for SFY2022 there will be an increase in state share of $37,209,936, for SFY2023 there will be an increase in state share of $89,574,388, and for SFY2024 there will be an increase in state share of $135, 766,567.

SB1045 directs OHCA to use the collected state share to fund Medicaid expansion and other programs, if needed

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule changes will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule changes.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The agency does not anticipate that the proposed rule changes will have an adverse effect on small businesses.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there are no other legal methods to achieve the purpose of the proposed rule. Measures included a formal public comment period and tribal consultation.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes are not designed to reduce any significant risks to the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency anticipates that in the absence of these rule changes, there would not be any detrimental effect on the public health, safety, and environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: June 8, 2021

RULE TEXT:

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-58. Supplemental Hospital Offset Payment Program

(a) **Purpose.** The Supplemental Hospital Offset Payment Program (SHOPP) is a hospital assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3241.1 of Title 63 of the Oklahoma Statutes (O.S.).

(b) **Definitions.** The following words and terms, when used in this Section have the following meaning, unless the context clearly indicates otherwise:

(1) **"Base Year"** means a hospital's fiscal year ending in 2009, as reported in the Medicare Cost Report or as determined by the Oklahoma Health Care Authority (OHCA) if the hospital's data is not included in a Medicare Cost Report.

(2) "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.

~~(2)~~(3) **"Fee"** means supplemental hospital offset assessment pursuant to Section (§) 3241.1 of Title 63 of the ~~Oklahoma Statutes~~O.S.

~~(3)~~(4)**"Hospital"** means an institution licensed by the State Department of Health as a hospital pursuant to ~~Section~~§ 1-701.1 of Title 63 of the ~~Oklahoma Statutes~~O.S. maintained primarily for the diagnosis, treatment, or care of patients.

~~(4)~~(5)**"Hospital Advisory Committee"** means the Committee established for the purposes of advising the OHCA and recommending provisions within and approval of any state plan amendment or waiver affecting the Supplemental Hospital Offset Payment Program.

(5) **"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", "Outpatient services") of the Medicare ~~Cost Report~~cost report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)"Net patient revenues"~~)~~ and Worksheet G-2 (Part I, Column 3, Line "Total patient revenues").

(6) **"Medicare ~~Cost Report~~cost report"** means the ~~Hospital Cost Report~~hospital cost report, Form CMS-2552-96 or subsequent versions.

(7) **"Upper payment limit"(UPL)"** means the maximum ceiling imposed by ~~42 C F R §§~~42 Code of Federal Regulations (C.F.R.) §§ 447.272 and 447.321 on hospital Medicaid reimbursement for inpatient and outpatient services, other than to hospitals owned or operated by state government.

(8) **"Upper payment limit gap"** means the difference between the upper payment limit and SoonerCare payments not financed using hospital assessments.

(c) **Supplemental Hospital Offset Payment Program.**

(1) Pursuant to 63 ~~Okla. Stat.~~O.S. §§ 3241.1 through 3241.6 the ~~Oklahoma Health Care Authority (OHCA)~~OHCA is mandated to assess hospitals licensed in Oklahoma, unless exempted under (c) (2) of this Section, a supplemental hospital offset payment fee.

(2) The following hospitals are exempt from the SHOPP fee:

(A) ~~a~~A hospital that is owned or operated by the state or a state agency, or the federal government, as determined by OHCA, using most recent Medicare cost report worksheet S-2, column 1, line 18 or other line that indicates ownership, or by a federally recognized Indian tribe or Indian Health Services, as determined by OHCA, using the most recent IHS/Tribal facility list for Oklahoma as updated by the Indian Health Service Office of Resource Access and Partnerships in Partnership with the Centers for Medicare and Medicaid Services and ~~State~~state operations.

(B) ~~a~~A hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA, as determined by OHCA, using data provided by the hospital;

(C)~~a~~A hospital for which the majority of its inpatient days are for any one of the following services, as determined by OHCA, 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:

(i) ~~treatment~~Treatment of a neurological injury;

(ii) ~~treatment~~Treatment of cancer;

(iii) ~~treatment~~Treatment of cardiovascular disease;
(iv) ~~obstetrical~~Obstetrical or childbirth services; or
(v) ~~surgical~~Surgical care except that this exemption will 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.

(D) ~~a~~A hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long term acute hospital, according to the most recent list of LTCH's published on the CMS http://www.cms.gov/LongTermCareHospitalPPS/08download.asp or as a children's hospital; and

(E) ~~a~~A hospital that is certified by CMS as a critical access hospital, according to the most recent list published by Flex Monitoring Team for Critical Access Hospital (CAH) Information at http://www.flexmonitoring.org/cahlistRA.cgi, which is based on CMS quarterly reports, augmented by information provided by state Flex Coordinators.

(d) **The Supplemental Hospital Offset Payment Program Assessment.**

(1) The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, for each calendar year in an amount calculated as a percentage of each hospital's net hospital patient revenue. ~~The assessment rate until December 31, 2012, is two and one-half percent (2.5%). At no time in subsequent years will the assessment rate exceed four percent (4%).~~The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, in an amount calculated as a percentage of each hospital's net hospital patient revenue. At no time will the assessment rate exceed four percent (4%). 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%).

~~(2) OHCA will review and determine the amount of annual assessment in December of each year.~~

~~(3)~~(2) A hospital may not charge any patient for any portion of the SHOPP assessment.

~~(4)~~(3) The ~~Method~~method of collection is as follows:

(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.

(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the hospital's net patient revenue calculation, and the assessment amount.
(C) New hospitals will only be added at the beginning of each calendar year.
(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the applicable quarter (i.e. January 15th, April 15th, etc.)
(E) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th ~~will~~may result in a debt to the State of Oklahoma and is subject to penalties of ~~5%~~five percent (5%) of the amount ~~and interest of 1.25%~~one ~~and a quarter percent (1.25%) per month~~.
(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA ~~will~~may add to the assessment:

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

(ii) ~~on~~On the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(iii) ~~the~~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 OHCA the assessment within the time frames noted on the invoice to the provider, the assessment~~,~~ and applicable penalty~~, and interest~~ will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in future payments in accordance with ~~OAC~~Oklahoma Administrative Code (OAC) 317:2-1-15 SHOPP appeals.

(iv) If additional allocation or recoupment resulting from an appeal is for the current calendar year and another SHOPP payment is scheduled for the calendar year, an adjustment to the next payment will be calculated. If additional allocation or recoupment is for a prior calendar year, a separate payment/account receivable (AR) will be issued.

(G) The SHOPP assessments excluding penalties and interest are an allowable cost for cost reporting purposes.

(e) **Supplemental Hospital Offset Payment Program Cost Reports.**

(1) The report referenced in paragraph (b)(6) must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 ~~U.S.C.~~United States Code (U.S.C.) Section 1320a-7b which states, in part, "Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefits or payment...shall (i) in the case of such statement, representation, failure, or conversion by any person in connection with furnishing (by the person) of items or services for which payment is or may be under this title (42 U.S.C. § 1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than ~~$25,000~~twenty-five thousand dollars ($25,000) or imprisoned for not more than five (5) years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than ~~$10,000~~ten thousand dollars ($10,000) or imprisoned for not more than one year, or both."

(4) Net hospital patient revenue is determined using the data from each hospital's applicable Medicare ~~Cost Report~~cost report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System (HCRIS) file. The base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g. calendar year 2022 will use 2020 fiscal year cost reports), as contained in the HCRIS file dated June 30 of each year.

~~(A) Through 2013, the base year for assessment shall be the hospital's fiscal year that ended in 2009, as contained in the HCRIS file dated December 31, 2010;~~

~~(B) For years 2014 and 2015, the base year for assessment shall be the hospital's fiscal year that ended in 2012, as contained in the HCRIS file dated June 30, 2013; and~~

~~(C) For subsequent two-year periods the base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g.,2016 & 2017 - 2014 fiscal year; 2018 & 2019 - 2016 fiscal year), as contained in the HCRIS file dated June 30 of the following year.~~

(5) If a hospital's applicable Medicare ~~Cost Report~~cost report

is not contained in the Centers for Medicare and Medicaid Services' HCRIS file, the hospital will submit a copy of the hospital's applicable Medicare ~~Cost Report~~cost report to the ~~Oklahoma Health Care Authority (OHCA)~~OHCA in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(6) If a hospital commenced operations after the due date for a Medicare ~~Cost Report~~cost report, the hospital will submit its initial Medicare ~~Cost Report~~cost report to ~~Oklahoma Health Care Authority (OHCA)~~OHCA in order to allow the OHCA to determine the hospital's net patient revenue for the base year.

(7) Partial year reports may be prorated for an annual basis. Hospitals whose assessments were based on partial year cost reports will be reassessed the following year using a cost report that contains a full year of operational data.

(8) In the event that a hospital does not file a uniform cost report under 42 U.S.C., Section 1396a(a)(40), the OHCA will provide a data collection sheet for such facility.

(f) **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, the assessment for the year in which the cessation occurs is 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 denominator of which is 365. Within 30 days of ceasing to operate as a hospital, or otherwise ceasing to be subject to the assessment, the hospital will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment calculation must be submitted to OHCA by September 30 of each year.

(g) **Disbursement of payment to hospitals.**

(1) All in-state inpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments 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.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to SoonerCare members, each eligible hospital will receive inpatient hospital access payments each year equal to the hospital's pro rata share of

the inpatient supplemental payment pool as reduced by payments distributed in paragraph (1) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for inpatient services divided by the total SoonerCare payments for inpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(C) Directed payments paid through a managed care organization (MCO) as approved in the CMS-approved 438.6(c) directed payment pre-prints.

(2) All in-state outpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to outpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments 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.

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by payments distributed in paragraph (2) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(C) Directed payments paid through a managed care organization (MCO) as approved in the CMS-approved 438.6(c) directed payment pre-prints.

(3) Medicaid payments to a group of facilities within approved categories may not exceed the upper payment limit in accordance with 42 ~~CFR~~C.F.R. 447.272 (b) (2) and 42 ~~CFR~~C.F.R 447.321 (b) (2). If any audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed based on the following methods:

(A) If it is determined prior to issuance of hospital access payments that the pool of hospitals would exceed the upper payment limit estimate of that pool, the amount above the UPL estimate will be allocated to another pool of hospitals that does not exceed the upper payment limit estimate of that pool. The reallocation can be applied to multiple pools

if necessary.

(B) If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

(4) ~~In order to ensure sufficient funds to make payments effective July 1, 2013 OHCA shall reduce the next quarterly payment by 1.4% (OHCA will pay out 23.6% of the assessment rather than 25%). This reduction will be distributed in the fourth (4th) quarter of the year as soon as all assessments are received. This payment will also be increased by penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate.~~

(5) Effective for all subsequent calendar years the OHCA will distribute payments in the following quarterly percentages: 23.6%, 25%, 25%, 25%. A 5th fifth (5th) payment of 1.4% in the fourth (4th) quarter of each calendar year will also be made as soon as all assessments are received. ~~This payment will also be increased by any penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate. If all assessments are r~~eceived prior to the 4th fourth (4th) quarterly payment being processed the 4th fourth (4th) quarter payment may be adjusted to pay out 26.4% plus accrued penalties.