Oklahoma Hospitals

A Resource Guide for Elected Officials
The Oklahoma Hospital Association

The Oklahoma Hospital Association has prepared this document to assist elected officials in better understanding various health care terminology and practices as they relate to the government’s impact on hospitals.

Established in 1919, the Oklahoma Hospital Association (OHA) is the voice of Oklahoma’s hospital industry. The Association is a private, non-profit trade association funded by organizations and individuals who purchase memberships in exchange for services. In addition to hospitals, the Association offers memberships to businesses, agencies and individuals who are interested in networking with those in Oklahoma’s health care industry.

Currently, the OHA represents 137 hospitals and health care entities across the state of Oklahoma. OHA’s primary objective is to promote the welfare of the public by leading and assisting its members in the provision of better health care and services for all people. OHA provides a variety of membership services including legislative advocacy and representation, communications, educational programs, information and data, quality initiatives and more. OHA also partners with a number of other organizations on a variety of initiatives to lower the number of uninsured and improve the health of Oklahomans.

No other industry is changing so quickly and dramatically. In order to keep up with these changes and the challenges that lie ahead, hospitals must continue to adapt. The OHA’s objective is to assist hospitals and health care professionals as they look ahead to the challenges of the future. For more information about the Oklahoma Hospital Association, contact Lynne White or Sandra Harrison (405) 427-9537, lwhite@okoha.com, sharrison@okoha.com, or go to www.okoha.com.

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The information in this document is current at publication date of January 2019.
Types of Hospitals

There are numerous terms that define hospitals, their ownership or control, or the services that they provide. Generally, Oklahoma law defines hospitals under Title 63:1-701. The term “hospital” includes general medical surgical hospitals, specialty hospitals, critical access hospitals, and birthing centers. However, the following definitions provide additional clarification. Oklahoma does not have a hospital Certificate of Need requirement (see glossary page 41).

Non-Profit or Not-for-Profit Hospitals
A non-profit hospital is recognized under the IRS code as a 501(c)(3) organization. The term non-profit does not imply that the hospital does not make a profit, rather that profits of the hospital are returned to the control of the hospital for operations rather than to shareholders. Typically, these hospitals are owned by a religious organization or charitable foundation.

City and/or County-Owned Hospitals
These hospitals fall under the non-profit or not-for-profit category. In many instances these hospitals are public trusts.

Both not-for-profit and city/county-owned hospitals are generally exempt from ad valorem taxes. In return, there is a clear expectation that the hospital will provide community benefit services in programs for uncompensated care.

For-Profit Hospitals
In a for-profit hospital, the profit or loss of the hospital is a direct profit or loss of the shareholders (owners) of the hospital. These facilities in Oklahoma may be publicly traded or privately owned; others are owned by physicians and/or smaller companies. These hospitals pay ad valorem taxes on hospital property.

Specialty Hospitals
Specialty hospitals are hospitals that provide a limited service such as orthopedics, heart care, children's medical care, psychiatric care and other single services. In Oklahoma, some specialty hospitals are owned by full-service acute care hospitals and since the 1990s, many new facilities built in Oklahoma are owned by physician investors.

Critical Access Hospitals (CAH)
Established under the federal Balanced Budget Act of 1997, CAHs are limited service hospitals located in rural areas. CAH is a special Medicare designation for payment that is limited to hospitals with 25 beds or less and an average length of stay less than four days. There is a state and federal approval process required by the Oklahoma State Department of Health and the Centers for Medicare & Medicaid Services for this designation. Under Medicare, CAHs are paid at 101 percent of Medicare cost instead of a fixed diagnostic related group (DRG) payment (see glossary page 41) as other hospitals. Further, there are some differences in regulatory requirements. There are currently 40 CAHs in Oklahoma.

System Hospitals
System hospitals may be managed or owned by a corporate entity, either for-profit or not-for-profit. A hospital system may have a collection of any of the hospitals previously described such as acute medical surgical, specialty or critical access.

Government-Owned Hospitals
Some hospitals are owned by the state of Oklahoma. Likewise, federal hospitals such as veteran's hospitals are owned by the federal government. Oklahoma has six state hospitals and two Veteran's Administration hospitals.

Indian Health Service/Tribal Hospitals
The federal government operates the U.S. Public Health Service hospitals for care for American Indians. Several Oklahoma tribes compact with the Indian Health Service to provide medical care for their tribes. There are currently two Indian Health Service hospitals and six tribally operated hospitals in Oklahoma.

Teaching Hospitals
Teaching hospitals are facilities that have been approved to participate in residency training by the Accreditation Council for Graduate Medical Education and/or have a residency or internship program(s) approved by the American Osteopathic Association and/or are members of the Council of Teaching Hospitals.

Micro-Hospitals
Micro-hospitals are independently licensed facilities with acuity comparable to a community hospital, but at a fraction of the size. Micro-hospitals typically only have about eight to 15 beds. The buildings range in size from about 30,000 to 60,000 square feet because they often function as a “healthplex” and include ancillary service lines and physician offices. The micro-hospital serves a significantly different patient population than an urgent care center. The value of the micro-hospital manifests when it is considered as part of an overall delivery system and continuum of care.

Free-Standing Emergency Rooms
Free-standing emergency rooms are open 24/7, are integrated within the hospital system, and are based on hospital licensure. Free-standing emergency rooms in Oklahoma must meet the same level of quality and licensure as a hospital would for operations for the safety of Oklahomans. Free-standing ERs typically take all patients, but will transfer acute patients to a more intensive level of care in a hospital setting.
Health Care Reform

The past few years we have witnessed, as at no other time in our history, the multitude of interconnecting environmental forces that are now driving transformational change within the health care system. These transforming trends of health care reform include:

- An increased aging population living with multiple chronic illnesses that together produce a growing demand on health care services.
- Pressures from employers, government and the public at large to stem the tide of unsustainable increases in their costs of health care.
- Continued advances in medical technology, pharmaceuticals and newly developed treatments based upon genetic analysis.
- Greater demands for transparency and accountability placed on providers for patient safety and the quality of their health care services.
- A shift away from paying providers based on a fee-for-service that rewards volume to a more desired payment system that rewards value received from outcomes and efficiency.
- Demand for capital to address information system, medical technology and building replacement needs.

These and other driving forces are producing a dramatic paradigm shift in how health care services will be delivered and paid for, for decades to come. Their implications will continue to shape the priority of, and means for, addressing the annual agendas of government at both the state and federal level well into the future.

Affordable Care Act

The hospital industry, including the American Hospital Association, agreed to $155 billion in cuts from the Medicare program (2013-2022) to be offset by an increased insurance coverage that would result in 94 percent of the nation’s population having coverage. Oklahoma hospitals are expected to experience $2.4 billion in cuts over this 10-year period. These reductions will occur through Medicare payment rate cuts, quality-based payment changes, and reductions in the disproportionate share hospital (DSH) payments made in the Medicare and Medicaid programs.

On Dec. 14, 2018, Judge Reed O’Connor, Texas Federal District Court, issued an initial ruling in the case Texas v. United States that the entire Affordable Care Act is unconstitutional because Congress repealed the tax penalty enforcing the law’s individual mandate. The decision will be appealed to the U.S. Court of Appeals for the Fifth Circuit, and the ruling has no immediate impact on any ACA program and does not give the Administration clear authority to alter any ACA program.

Public Transparency

Pricing

There is considerable public and policymaker focus on the issue of health care price transparency. While public focus on this issue is not new, disruption in the health care marketplace is heightening its importance. Price transparency has been a longstanding issue for uninsured patients, but growing enrollment in plans with higher levels of deductibles and coinsurance is creating a greater demand for meaningful price information for insured patients as well.

Sharing meaningful information, however, is challenging because hospital care is specifically tailored to the needs of each patient. For example, a gall bladder operation for one patient may be relatively simple, but for another patient, it could be fraught with unforeseen complications, making meaningful “up front” pricing difficult and, perhaps, confusing for patients. Moreover, hospital prices do not include physician costs, other professionals’ costs, laboratory costs, or, most importantly, how much of the cost a patient’s insurance company may cover.
Economic Impact

The Health Care Industry in Oklahoma

The health care industry is the second largest employing industry in Oklahoma. It is a major economic engine for Oklahoma and considered key to the state's efforts to recruit and retain new and expanding businesses. The health care industry:

- Employed 215,000 people in Oklahoma (October 2016).
- Directly contributed $11.8 billion to Oklahoma's Gross Domestic Product (GDP) in 2015 (real dollars).
- Over the last five years, the earnings in Oklahoma's health care sector increased by 12 percent, while the nation's increased by 7 percent.

Economic Impact of Oklahoma Hospitals

According to the American Hospital Association's 2017 survey, Oklahoma's 153 hospitals:

- Employ 76,829 persons.
- Deliver 50,459 babies yearly.
- Provide for 460,936 inpatient admissions, 2,116,069 emergency room visits, and 8,109,925 other outpatient visits.
- Have an average daily inpatient census totaling 7,596.
- Generate $11,031,275,157 in net revenue (excluding tax revenue).
- Have annual expenses of $11,579,629,793.
- Pay salaries and wages of $4.189 billion.

Source: AHA Annual Survey 2017

Currently, 42 states including Oklahoma already report information on charges or payment rates, and make that information available to the public. In 2011, the Oklahoma State Department of Health began a public web service as part of their web-based query system, Oklahoma Statistics on Health Available for Everyone (OK2SHARE). This system allows users to query the state's public health dataset directly. Each hospital's median charge and length of stay for a diagnosis group or inpatient procedure is compared with state and U.S. medians. This Oklahoma hospital pricing information can be found at www.health.state.ok.us/stats, under Hospital – Quality Reports, or under Hospital – Inpatient Discharge – Statistics.

The Affordable Care Act requires hospitals to make public the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups. For this reason, the Centers for Medicare & Medicaid Services, as of Jan. 1, 2019, requires all hospitals to post a listing of all detailed charges on the internet.

Quality

In addition, to monitor the quality of care in a hospital and to make information about the care that a hospital gives transparent to the public, Medicare and the state of Oklahoma (through the Oklahoma State Department of Health) monitor and publicly report certain aspects of care. This includes whether or not the hospital has followed evidence-based standards of care for certain types of patients and the rate at which certain events occur. The number of indicators that are monitored and/or reported grows yearly. In 2019, 86 measures will be monitored related to inpatient and outpatient care. (See page 16 for examples.) In addition, acute long-term care hospitals are monitored on 19 measures, psychiatric hospitals on 24 measures, rehabilitation hospitals on 18 measures, ambulatory surgery centers on 18 measures, and cancer hospitals on 23 measures. Medicare uses these indicators to determine the level of payment a hospital receives. To view this hospital quality data, go to www.medicare.gov/hospitalcompare.
Financial Information

Funding Sources

Government health programs, such as Medicare, Medicaid, and many government employee benefit plans, set hospital payment amounts through the regulatory process. These payment amounts are non-negotiable.

Medicare

Established in 1965 by federal law, Medicare is available to most people beginning at age 65 and to those with end stage renal (kidney) disease or total disability.

Medicare is overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS), and is administered through contractors known as Medicare Administrative Contractors (MACs). The MAC for hospitals in Oklahoma and 10 other states since 2012 is Novitas Solutions, Inc. Formerly known as Highmark Medicare Services, Novitas is a wholly-owned subsidiary of Diversified Service Options, Inc., a subsidiary of Blue Cross Blue Shield of Florida, and has headquarters in Mechanicsburg, Penn.

Medicare consists of:

- Part A, which covers hospital benefits;
- Part B, which covers outpatient and physician services;
- Part C, an option to receive Part A and Part B benefits through private insurance plans known as “Medicare Advantage” plans; and
- Part D, Medicare’s prescription drug plan.

Medicare Part A and Part B have cost-sharing requirements and significant gaps in coverage. Medicare supplemental insurance, also known as “Medigap” policies, cover some of these costs, including deductibles and cost-sharing.

About 18 percent of Medicare beneficiaries in Oklahoma (and 33 percent nationally) have enrolled in private Part C plans. These Medicare Advantage plans have different cost sharing provisions than traditional Medicare, and Medigap policies cannot be used with Medicare Advantage.

Medicare pays hospitals predetermined, non-negotiable fixed amounts based on the patient’s diagnosis and treatment. For inpatient services, this is known as a DRG, which means a diagnosis related group. For outpatient services, Medicare uses Ambulatory Payment Classifications (APCs). Services in each APC are similar clinically and require the use of similar resources. A payment rate is established for each APC. This Medicare payment methodology for inpatient and outpatient services is referred to by Medicare as a Prospective Payment System (PPS).

Except for critical access hospitals (see page 2), Medicare payments vary between geographic regions to reflect local wage rates. Hospitals in Oklahoma’s cities receive higher payment rates from Medicare than rural facilities.

Medicare inpatient payments are also adjusted for differences between hospitals in quality measurements. Poor scores can reduce Medicare payments by up to 6 percent. For further information, see “Pay for Performance,” (page 15).

At left:
Overall, Medicare pays less than cost to most hospitals. In FY 2015, Medicare paid 96 percent of cost on average to PPS hospitals. As shown in the chart, Medicare payments have been less than Medicare costs since 2011.

Source: OHA Analysis of Medicare Cost Reports
Medicare is entirely a federal program. The Oklahoma State Department of Health surveys hospitals for compliance with Medicare’s conditions of participation, or hospitals can be certified for Medicare through accreditation by The Joint Commission, DNV, or other accreditation program. If a hospital is accredited by an approved accreditation program, it is not required to be surveyed by the Health Department.

- The Joint Commission (TJC) is a voluntary and costly accreditation agency that surveys enrolled hospitals regarding many aspects of quality. Nearly half of Oklahoma hospitals are Joint Commission accredited.
- DNV GL (Det Norske Veritas - Germanischer Lloyd), a worldwide quality assurance and risk management company, is another accreditation agency approved for deeming authority by the CMS. It is used by a growing number of Oklahoma hospitals.
- The Healthcare Facilities Accreditation Program (HFAP) is an accreditation program of the American Osteopathic Association, a medical association representing osteopathic physicians (DOs). HFAP has deeming authority from CMS.

Medicaid

Also established by federal law in 1965, Medicaid is jointly funded by the federal and state governments. The program is operated by the states and overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS).

Oklahoma’s Medicaid program is known as SoonerCare. The Oklahoma Health Care Authority is the regulatory agency that pays providers for services to enrollees.

FMAP - The Federal Medical Assistance Percentage

FMAP determines the amount of federal payments to the state for medical services. The FMAP formula compares each state’s average per capita income (over a three-year period) with the national average. This formula has not changed in more than 50 years, and is designed to give relatively poor states a higher share of federal dollars than wealthier states. The calculation changes yearly, and changes the amount of funds available for Medicaid. In times of relative prosperity for the state, FMAP is decreased, reducing federal contributions to Oklahoma’s Medicaid program.

The minimum FMAP is 50 percent. On average, this formula has resulted in the federal government paying for about 57 percent of spending on Medicaid benefits nationally and states paying 43 percent. Oklahoma’s FMAP for 2019 is 62.38 percent, and for 2020 will be 66.02 percent.

Medicaid is available to the following populations in Oklahoma as seen in the chart below.

<table>
<thead>
<tr>
<th>Population</th>
<th>Income Eligibility</th>
<th>Asset Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children up to age 19</td>
<td>185% of FPL*</td>
<td>None</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>185% of FPL</td>
<td>None</td>
</tr>
<tr>
<td>Parent of dependent child</td>
<td>Approx. 37% of FPL</td>
<td>None</td>
</tr>
<tr>
<td>Single parent transitioning from welfare to work</td>
<td>185% of FPL (eligible for up to 12 months)</td>
<td>None</td>
</tr>
<tr>
<td>Aged, Blind and Disabled (ABD)</td>
<td>100% of FPL</td>
<td>$2,000 individual; $3,000 couple</td>
</tr>
<tr>
<td>Specified Low-income Medicare Beneficiaries</td>
<td>120% of FPL; covers Medicare Part B Premium</td>
<td>$4,000 individual; $6,000 couple</td>
</tr>
<tr>
<td>ABD in institution or Home-and-Community based waiver program</td>
<td>300% of SSI**</td>
<td>$2,000 individual; $3,000 couple</td>
</tr>
</tbody>
</table>

*Federal Poverty Level; **Supplemental Security Income
Source: Oklahoma Health Care Authority
Medicaid does not provide coverage to all low-income people. To qualify for Medicaid coverage, persons must meet:

- income eligibility criteria;
- certain categorical criteria such as being aged, blind, and disabled (ABD);
- resource eligibility limits; and
- state residency requirements.

Even the extremely poor do not qualify for Medicaid if they do not fit into one of these categories. Therefore, non-disabled working age adults without children are not eligible for Medicaid in Oklahoma unless the state chooses to cover this population as allowed by the ACA (see page 3). See chart to the right for income guidelines.

The federal government sets minimum standards, but states can choose to cover people at higher income levels and in defining eligible populations. The last major expansion in Oklahoma occurred in 1997 when children and pregnant women up to 185 percent of the federal poverty level were included. Shortly thereafter, the federal government began offering states an enhanced federal Medicaid matching rate to cover these children through the Children’s Health Insurance Program (CHIP). Later expansions have targeted small populations such as low-income women with breast or cervical cancer and low-income women and men in need of family planning services.

CHIP - The Children’s Health Insurance Program (CHIP), formerly known as the State Children’s Health Insurance Program (SCHIP), is a 1997 expansion of the federal Medicaid program. If authorized by an act of a state Legislature, CHIP allows states to cover additional children in families with incomes that are modest but too high to qualify for Medicaid. Oklahoma does cover children under CHIP. CHIP funding uses an FMAP formula that assigns a higher share of the program’s cost to the federal government than the Medicaid program does. CHIP was reauthorized in 2018 to run through 2027. The reauthorization included a reduction in future years’ CHIP matching rate, beginning in 2020.

The 2019 Poverty Level Guidelines:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Federal Poverty Guideline</th>
<th>37% FPL (1)</th>
<th>133% FPL (2)</th>
<th>185% FPL (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,490</td>
<td>$4,621</td>
<td>$16,612</td>
<td>$23,107</td>
</tr>
<tr>
<td>2</td>
<td>$16,910</td>
<td>6,257</td>
<td>22,490</td>
<td>31,284</td>
</tr>
<tr>
<td>3</td>
<td>$21,330</td>
<td>7,892</td>
<td>28,369</td>
<td>39,461</td>
</tr>
<tr>
<td>4</td>
<td>$25,750</td>
<td>9,528</td>
<td>34,248</td>
<td>47,638</td>
</tr>
<tr>
<td>5</td>
<td>$30,170</td>
<td>11,163</td>
<td>40,126</td>
<td>55,815</td>
</tr>
<tr>
<td>6</td>
<td>$34,590</td>
<td>12,798</td>
<td>46,005</td>
<td>63,992</td>
</tr>
<tr>
<td>7</td>
<td>$39,010</td>
<td>14,434</td>
<td>51,883</td>
<td>72,169</td>
</tr>
<tr>
<td>8</td>
<td>$43,430</td>
<td>16,069</td>
<td>57,762</td>
<td>80,346</td>
</tr>
</tbody>
</table>

FPL = Federal Poverty Level
(1) SoonerCare income limit for a parent of an eligible child
(2) Potential Medicaid expansion (Obamacare) income limit
(3) SoonerCare income limit for children and pregnant women

The federal government sets minimum standards, but states can choose to cover people at higher income levels and in defining eligible populations. The last major expansion in Oklahoma occurred in 1997 when children and pregnant women up to 185 percent of the federal poverty level were included. Shortly thereafter, the federal government began offering states an enhanced federal Medicaid matching rate to cover these children through the Children’s Health Insurance Program (CHIP). Later expansions have targeted small populations such as low-income women with breast or cervical cancer and low-income women and men in need of family planning services.

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For 2019, the Supplemental Hospital Offset Payment Program

Supplemental Hospital Offset Payment Program (SHOPP) Hospital Provider Fee

Hospital payments for Medicaid (SoonerCare) patients are limited by appropriations made to the Oklahoma Health Care Authority. The state does not pay for the full cost of care provided by hospitals to Medicaid patients. Because payment rates for hospitals are tied to swings in the state budget, Oklahoma hospitals agreed to a public/private partnership through an assessment to provide the state’s share of Medicaid matching funds to garner federal funds to supplement the existing Medicaid program.

In 2011, the Legislature passed HB1381, the Supplemental Hospital Offset Payment Program (SHOPP), to allow hospitals to provide additional private dollars for the state to draw down federal matching funds to approximately the federal upper payment limit. (Federal upper payment limit refers to a federal limit to matching that is equivalent to what Medicare would pay for the same services. In 2011, Oklahoma hospitals were paid by Medicaid an average of 67 percent of Medicare payment rates.) Forty-nine states have provider fee programs like SHOPP. The Oklahoma Legislature passed a provider fee for nursing homes in 2000 and amended it again in 2011.
assesses hospitals 2.8 percent of annual net patient revenue to initially generate approximately $204 million annually for the state's share, to garner $352 million in federal funding for a total of $556 million. Of the $556 million, $474 million is paid to hospitals as supplemental payments for care provided to cover the unreimbursed cost of Medicaid (SoonerCare) patients and $82 million is used to maintain current SoonerCare payment rates for physicians and other Medicaid providers to ensure access to care.

Sixty-six hospitals are required to pay the assessment, while 64 hospitals are excluded, including 40 critical access hospitals, eight long-term care hospitals, 13 specialty hospitals, OU Medical Center, one Medicare certified children's hospital, and a hospital which provides the majority of its care under a state agency contract.


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**Medicaid by the Numbers**

**Medicaid (SoonerCare) Eligibility**

Poor elderly, disabled, pregnant women, and children based upon a percentage of federal poverty limit guidelines. These guidelines are outlined on the Oklahoma Health Care Authority's website at www.okhca.org/soonercare.

**Medicaid Enrollment – November 2018**

797,028 enrolled members consisting of:
- 265,767 Adults
- 531,261 Children

**Medicaid: A State and Federal Partnership with Matching Funds**

SoonerCare FMAP* for 2019 – 62.38 percent federal funds/37.62 percent state funds

*Federal Medical Assistance Percentage

**Oklahoma Medicaid – 50,033 Providers of Care**

Hospitals
Doctors
Nursing Homes
Pharmacies
Behavioral Health Specialists
Durable Medical Suppliers
And a host of others

**Medicaid Budget Cuts**

Across-the-board budget reductions of 3.25 percent to all providers in 2010 were followed by 7.75 percent reductions in July 2014 and 3 percent reductions in January 2016, for total cuts of 14 percent. In addition to the rate cuts, OHCA has:

- Reduced co-insurance/deductible payments;
- Reduced pharmacy coverage and rates;
- Reduced coverage and rates for dental services;
- Reduced rates for durable medical equipment;
- Implemented prior authorization for some hospital services; and
- Changed hospital DRG payment policies, reducing hospital payments an average of 4 percent.

SoonerCare payment rates for free-standing psychiatric hospitals were cut 3 percent on May 1, 2016, and residential psychiatric service per diem rates were cut 15 percent.

The state Legislature directed OHCA to increase provider payment rates in SB 1605 (2018). Payment rates were increased 4 percent for long-term care facilities and 3 percent for most other provider types, including hospitals, effective Oct. 1, 2018.

Source: “Fast Facts” - Oklahoma Health Care Authority
**Insure Oklahoma - Public/Private Health Insurance Partnership**

Insure Oklahoma, created by the Oklahoma Legislature in 2004, authorized the Oklahoma Health Care Authority to develop a premium assistance program for low-income working adults. In November 2004, SQ 713 passed by a vote of the people of Oklahoma, increasing the sales tax on tobacco products. A portion of these tax revenues were designated to fund Insure Oklahoma.

Insure Oklahoma Employer Sponsored Insurance (ESI) is a health coverage subsidy to help small business owners provide health insurance to their low to moderate income employees and employees’ spouses and dependents. ESI is available to businesses with up to 250 employees. Premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent). The health coverage plans are commercial insurance plans available in the private market. In August 2010 the ESI expanded to offer coverage for dependent children of Insure Oklahoma members who are between 186 and 200 percent of the federal poverty level.

The Individual Plan (IP) is also available for Oklahoma residents between the ages of 19 and 64 who are self-employed, temporarily unemployed or working disabled, as well as those employed by a small business that does not offer a commercial plan. In January 2014, the qualifying income was decreased from 200 to 100 percent of the federal poverty level.

Individuals are responsible for minimal premiums and any applicable deductibles and co-payments. In September 2010, the Individual Plan was expanded to offer coverage for dependent children of Insure Oklahoma’s members who are between 186 and 200 percent of the federal poverty level.

Enrollment as of September 2018 includes:
- Businesses - 4,543
- ESI enrollees – 13,711
- IP enrollees – 5,285
- Total enrollees – 18,996

In 2018, CMS reauthorized the Insure Oklahoma plan for five years, through the end of 2023. Funding for the program comes from Oklahoma’s tobacco tax, which provides the state’s share, and is matched approximately $1.66 (by the federal government) for every $1 from the state. For more information regarding Insure Oklahoma, see [www.insureoklahoma.org](http://www.insureoklahoma.org).

**Employees Group Insurance Division (EGID)**

The Employees Group Insurance Division (EGID), formerly the Oklahoma State & Education Employees Group Insurance Board (OSEEGIB), advises the Office of Management and Enterprise Services (OMES) on group health, dental, life, and disability insurance plans for Oklahoma’s public sector employees. These plans are known as HealthChoice.

EGID also manages health provider networks for the Department of Rehabilitative Services (DRS) and the Department of Corrections (DOC).

The Oklahoma Employee Benefits Department (EBD) of OMES provides state employees with a choice of health insurance plans. In addition to EGID’s HealthChoice, state employees have a choice of Health Maintenance Organization (HMO) plans.

**Workers’ Compensation**

When a worker is injured on the job, they may seek medical services for their injury through the workers’ compensation system. The Oklahoma Workers’ Compensation Commission publishes a Schedule of Medical and Hospital Fees, which sets the rates for hospital and physician payments. Inpatient payments depend on the patient’s diagnosis and surgery, much like Medicare rates. Additional payment is made for implanted devices, based on the device’s cost. For more information regarding medical fee schedules, see [https://bit.ly/2SIFPaa](https://bit.ly/2SIFPaa).

**Indian Health/Tribal Services**

The Indian Health Service (IHS) provides health care services to American Indians in federal hospitals. Some individual tribes also operate their own health care facilities. Services Indians cannot receive in Indian hospitals, such as specialty services, are sometimes authorized in other hospitals by the IHS.

The IHS has compacted with some tribes to operate health facilities for Indians, including hospitals. (See Appendix 2 on page 37.)

As federal or tribal facilities, Indian Health Service hospitals are not subject to regulation by the Oklahoma State Department of Health.
Hospital Payments

Oklahoma’s 152 hospitals have total annual expenses of $11.6 billion according to the American Hospital Association’s 2017 Annual Survey.

Most Oklahoma hospitals depend heavily on reimbursement from services provided to Medicare and Medicaid patients.

<table>
<thead>
<tr>
<th>Oklahoma Hospital Patient Revenue (in $ millions)</th>
<th>Gross Charges</th>
<th>Net Revenue</th>
<th>% of Net Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$18,400</td>
<td>$3,822</td>
<td>37%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$6,071</td>
<td>$1,410</td>
<td>14%</td>
</tr>
<tr>
<td>Other third-party payers</td>
<td>$14,889</td>
<td>$4,918</td>
<td>47%</td>
</tr>
<tr>
<td>Self-pay revenue</td>
<td>$2,970</td>
<td>$308</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>$42,330</td>
<td>$10,458</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: 2017 American Hospital Association Survey

Gross Charges and Net Collections

Hospitals charge the same prices to all patients as a requirement of federal law. However, different payers pay different amounts to hospitals.

- Government payers, such as Medicare and Medicaid, usually pay the lowest rates to providers.
- Private (commercial) health plans pay rates that are negotiated between the payer and the hospital through contracts, creating a network of providers that offer health services to patients who are insured by a particular health plan, such as:
  - PPOs (Preferred Provider Organizations) negotiate payment rates with hospitals and refer patients to their contracted hospitals as a network. PPO members receive the highest level of benefit from their plan by using a network hospital, and typically have higher out-of-pocket costs when using an out-of-network hospital.
  - HMOs (Health Maintenance Organizations) use primary care physicians (PCPs) as “gatekeepers” to control members’ access to medical services. Members select a PCP who acts as their main doctor. Except for emergencies, HMO members can only get their care from in-network health care providers, and as approved by their PCP.

Oklahoma’s Health Care Freedom of Choice Act (Title 36, Section 6055) provides for the application of deductibles and co-payments for covered services. The Act also specifies:

- that a practitioner, hospital or ambulatory surgical center that is not a preferred provider shall disclose to the insured, in writing, that the insured may be responsible for additional charges, and;
- when a referral is made to a nonparticipating hospital or ambulatory surgical center, the referring practitioner must disclose in writing to the insured any ownership interest in the out-of-network hospital or ambulatory surgical center.

There are currently no penalties for violations of this provision under state law.
Oklahoma law requires hospitals to have a discount program for patients with household incomes up to 300 percent of the federal poverty limit guidelines. The patient is responsible for proving income eligibility and cannot be enrolled in any health insurance plan with hospital coverage. If the patient can prove these criteria, the hospital is required to limit collection action to no greater than either (1) the Medicare payment for the cost of services, or (2) the hospital's whole cost-to-charge ratio times billed charges. This limitation applies only to medically necessary procedures as determined by the treating physician. State law applies only to hospital charges and does not apply to physician charges for patient care.

The federal Affordable Care Act sets additional requirements for Section 501(c)(3) (non-profit) hospitals to maintain their tax-exempt status. These hospitals are required to adopt, implement, and widely publicize a written financial assistance policy. This policy is to include eligibility criteria for financial assistance, including free or discounted care, and describes the basis for calculating the amounts charged to patients and the method for applying for financial assistance.

Further, hospitals must have a policy on collection efforts and a policy on the emergency treatment of people who don't qualify for financial assistance. The ACA also limits amounts charged for emergency or other medically necessary care to no more than the lowest amount charged to patients who have insurance.

**Hospital Pricing Transparency**

There is considerable public and policymaker focus on the issue of health care price transparency. While public focus on this issue is not new, trends in the health care marketplace are heightening its importance. Price transparency has been a longstanding issue for uninsured patients, but growing enrollment in plans with higher levels of deductibles and coinsurance is creating a greater demand for meaningful price information for insured patients as well.

Sharing meaningful information, however, is challenging because hospital care is specifically tailored to the needs of each patient. For example, a gall bladder operation for one patient may be relatively simple, but for another patient, it could be fraught with unforeseen complications, making meaningful

“up front” pricing difficult and, perhaps, confusing for patients. Moreover, hospital prices do not include physician costs, other professionals’ costs, laboratory costs, or, most importantly, how much of the cost a patient’s insurance company may cover.

Currently, 42 states including Oklahoma already report information on charges or payment rates, and make that information available to the public. In 2011, the Oklahoma State Department of Health began a public web service as part of their web-based query system, Oklahoma Statistics on Health Available for Everyone (OK2SHARE). This system allows users to query the state’s public health dataset directly. Each hospital’s median charge and length of stay for a diagnosis group or inpatient procedure is compared with state and U.S. medians. This Oklahoma hospital pricing information can be found at [www.health.state.ok.us/stats](http://www.health.state.ok.us/stats), under Hospital – Quality Reports, or under Hospital – Inpatient Discharge – Statistics.

The Affordable Care Act requires hospitals to make public the hospital’s standard charges for items and services provided by the hospital, including for diagnosis-related groups. For this reason, the Centers for Medicare & Medicaid Services requires all hospitals to post a listing of all detailed charges on the internet.
Uncompensated Care

Uncompensated care is care hospitals provide for which they are not reimbursed. Federal law requires stabilization of any person who presents in an emergency room. Oklahoma hospitals provide more than $570 million in uncompensated care annually, according to the American Hospital Association’s annual hospital survey conducted in 2018. Uncompensated care includes the cost of charity care and bad debt. These shortfalls must be “cost shifted” to insurance companies, self-insured businesses, and others who pay for health care services.

The Uninsured in Oklahoma

- One in seven (545,000) Oklahomans is uninsured, 14.2 percent of our citizens.¹
- Oklahoma ranks second highest in the nation for its percent of uninsured citizens.¹
- One in 12 Oklahoma children (below 200 percent of poverty) is uninsured, 8.1 percent.²
- Oklahoman ranks fourth in the nation for percent of uninsured children.²

¹ According to U.S. Census Bureau, 2017 American Community Survey, Table HI-05.
² According to U.S. Census Bureau, 2017 American Community Survey, Table HI-10.

Source: 2017 American Hospital Association Survey

Community Benefit

Contributions made by Oklahoma hospitals to their communities go well beyond providing patient care.

Community benefit is described as programs or services that address community health needs—particularly those of the poor and other underserved groups—and provide measurable improvement in health access, health status and use of health care resources.

As community partners, hospitals possess a social and moral obligation to improve the lives of individuals, thereby enhancing the quality of life for the entire community, 24 hours a day, seven days a week. Hospitals are committed to improving the well-being of their communities beyond patient care by:

- Offering medical treatment at or below the cost of providing care.
- Performing medical research.
- Donating funds or services to community organizations.
- Serving as community volunteers.
- Offering essential health services for citizens that generate a negative profit margin, such as burn centers and trauma centers.

Under the Affordable Care Act, non-profit hospitals are required to assess community health needs every three years.

Hospitals must then report how they are addressing the community health needs identified in the assessment and describe any needs that are not being addressed, along with the reasons why the needs are not being addressed.
Quality and Patient Safety

Ensuring quality and patient safety is a never-ending job in a hospital. Hospitals continually strive to provide quality care and keep patients safe.

Hospitals spend significant resources on identifying, implementing and monitoring the quality and safety of care provided to patients. While quality and safety programs are mandated by both state and federal entities, many hospitals also seek accreditation from entities recognized in the health care industry as having developed exceptional standards to which a hospital can be compared.

Quality in hospitals can be divided into these areas:
- Clinical quality and outcomes
- Patient safety, including infection prevention
- Patient satisfaction
- Cost efficiency

Clinical Quality - Clinical quality is the actual medical care that a patient receives. Process measures are one way to measure this type of quality. Measures are founded on proven evidence-based medicine and assess the process of care a patient receives based on a disease-specific category. For example, did a sepsis patient receive certain care within the accepted timeframe? Clinical quality also considers outcome measures such as readmissions and mortality.

Patient Safety and Infection Prevention - Patient safety in a hospital is defined as keeping the patient safe from harmful events such as errors, complications and infections. Hospitals have extensive programs in place to prevent these potential complications.

Patient Satisfaction - Patient satisfaction is the perception of care that the patient received while in the hospital. Patient satisfaction is measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The survey includes 27 questions in seven areas. Some examples include: doctor communication, cleanliness of the hospital and pain management.

Cost Efficiency – Cost efficiency is a measure of resources used in an episode of care related to a specific condition. These resources can be Medicare program costs and beneficiary payments. For example, how much did Medicare pay a hospital for care provided to a hip replacement patient while in the hospital and for any care provided within 30 days of the surgery?

Mandated Quality and Safety Programs

State

While hospitals spend many of their resources voluntarily participating in activities that ensure patient safety and quality care, regulatory entities provide oversight of the hospital industry (see Figure 1, page 14). At the state level, the Oklahoma State Department of Health licenses hospitals and continually monitors all aspects of delivering safe care. This includes requirements regarding the environment, medical records, education and training of physicians and staff, infection control, and monitoring the quality of care provided. For more information, visit https://bit.ly/2DUycd2.

Federal

In order for hospitals to treat Medicare patients and receive Medicare funds, they must comply with “Medicare Conditions of Participation.” These conditions include many aspects of hospital administration and requirements for care, just as the state licensure requirements.

Medicare continually monitors and reviews certain aspects of care and manages patient complaints. It is required that hospitals participate in the Medicare Care Review programs and processes related to these activities.

Voluntary Quality and Safety Programs

Accreditation - Hospitals utilize accreditation organizations to demonstrate that they have passed a rigorous external inspection and the care they provide meets the highest and most current standards. While some accreditation organizations survey the overall hospitals, many also specialize in a specific area such as the laboratory and radiology. Hospitals pay thousands of dollars, depending on their size, for this external review and/or educational opportunities.
Figure 1: Regulatory entities providing oversight of the hospital industry

**DEA**: Drug Enforcement Administration  
**FAA**: Federal Aviation Administration  
**UNOS**: Organ Procurement Organizations  
**SEC**: Securities and Exchange Commission  
**IRS**: Internal Revenue Service  
**EPA**: Environmental Protection Agency  
**FTC**: Federal Trade Commission  
**FCC**: Federal Commerce Commission  
**HHS**: Health and Human Services  
**HRSA**: Health Resources and Services Administration  
**NIOSH**: National Institute for Occupational Safety and Health  
**Joint Commission**: Joint Commission on Accreditation of Healthcare Organizations  
**DOJ**: Department of Justice  
**OSHA**: Occupational Safety and Health Administration  
**DOT**: Department of Transportation  
**FDA**: Food and Drug Administration  
**OIG**: Office of Inspector General  
**QIOs**: Quality Improvement Organizations  
**PRRB**: Provider Reimbursement Review Board
Medicare Quality Improvement Organization (QIO) - Medicare contracts with organizations to perform the statutory requirement to monitor the quality of care provided through chart review, investigating complaints, and managing discharge grievances. KeyPro is the organization that performs care review in Oklahoma. Texas Medical Foundation (TMF) is the QIO in Oklahoma that assists physician offices, home health agencies and nursing homes in adopting and implementing systems, redesigning processes and developing organizational cultures to accelerate the rate of quality improvement.

Pay for Performance

Through Medicare’s payment incentive program, hospitals are at risk to lose reimbursement in several different areas including:

- Clinical outcomes
- Customer satisfaction
- Mortality (death rate in certain conditions)
- Efficiency indicator (cost per Medicare beneficiary)
- Hospital readmissions
- Hospital adverse safety events (i.e. hospital acquired infections)

Hospitals can lose up to 6 percent of their reimbursement from Medicare depending on how they perform compared to other hospitals in the U.S. in the areas listed above. The number of conditions and measures that are included in the payment incentive program changes each year. Many of these measures are available at www.medicare.gov/hospitalcompare.

Patient Satisfaction

Hospitals are required to report on 27 patient satisfaction indicators and are now being paid according to their level of rating. These rates are available for public viewing at www.medicare.gov/hospitalcompare.

Clinical Initiatives

To assist and enhance their efforts to improve the quality of care and patient safety, hospitals participate in organized projects and initiatives. Through these initiatives they have access to subject matter experts and learn to implement best practices and collect and monitor data to track their progress. These initiatives include topics such as preventing hospital acquired infections, falls, pressure ulcers, readmissions, and medication errors.

Since 2010, OHA has partnered with other organizations, state agencies and private providers to improve infant and maternal mortality in Oklahoma. Through a project called “Every Week Counts,” the unnecessary early delivery rate decreased by 93 percent from 2010 - 2014. Birthing hospitals have continued to keep the early unnecessary delivery rate to a very low percentage.

OHA is currently working with medical providers to prevent maternal death and complications through a project called “Every Mother Counts.” “Every Baby Counts” is an initiative to improve the accuracy and timeliness of newborn screenings, thereby quickly getting valuable and potentially life-saving information back to providers and families of newborns.

OHA continues to assist hospitals to improve quality and prevent harm by leading them in national patient safety projects.

- During recent projects, OHA achieved all eight “Milestones” (deliverables based upon data submission completeness and improvement) by OHA HIIN (Hospital Improvement Innovation Network) hospitals.
- Participating hospitals made significant improvement in avoiding harm from hypoglycemia and opioid reversal events, surgical site infections (hips, knees, abdominal hysterectomies) and post-op sepsis.
- Areas of continued improvement include hospital-onset sepsis, pressure ulcer prevention, ventilator-associated conditions and worker safety/workplace violence.
- Through funded projects, OHA awarded scholarships totaling $145,000 for professional development to individuals in hospitals, which will increase knowledge and ability to lead quality efforts.
**Infection Control and Prevention**

Hospitals are continuously alert for patients who enter the hospital with communicable diseases and infections. They are under federal and state regulations to identify, report, prevent and treat many types of infections.

Communicable diseases are reported to the Oklahoma State Department of Health (OSDH), which then uses the information for public health purposes. This includes the notification of others who may have been exposed and the prevention of further disease in the community. Examples of these are Ebola, Measles, Pertussis and Influenza. A complete list of reportable diseases can be found on the OSDH website at: https://bit.ly/2DOIU0L.

Infections (beyond the above reportable list) discovered or acquired in the hospital are reportable to the CDC. Medicare requires the reporting of these infections and they affect hospital reimbursement in several ways:

1. If a Medicare patient acquires an infection while in the hospital, the hospital will not be reimbursed for the resources required to treat the infection. Some of the reportable hospital acquired infections are included in the CMS value based purchasing program for hospitals.
2. Some of the reportable hospital acquired infections are included in two of the CMS payment incentive programs for hospitals.

Federal and state governments both have specific guidelines hospitals are required to follow for infection control and prevention. These guidelines include the development of a hospital-wide infection control and prevention plan, specific resources allocated to these activities and the internal and external reporting methods. Hospitals are surveyed by the OSDH and other accrediting bodies to monitor compliance.

A significant aspect of the prevention, management and treatment of infections includes the physical environment and resources. Many hospitals have patient rooms that are designed specifically to isolate and manage infections. All hospitals maintain a supply of personal protective equipment for the staff to use as a barrier precaution or protection. Because of the tremendous resources required to care for an Ebola patient, a specialized infectious disease unit opened in January 2015 at OU Medical Center, ready to activate if the need arises. The Oklahoma Biocontainment Care Unit is designed to care for pediatric and adult patients in the state who test positive for dangerous infectious diseases like Ebola. The nearly 4,000-square-foot specialized unit is isolated in a de commissioned hospital building on the Oklahoma Health Center campus and is self-sufficient relative to the air handling system, supply and distribution of medical gases and the storage and removal of biomedical waste.

**Quality Public Reporting and Transparency**

To monitor the quality of care in a hospital and to make information about the care that a hospital gives transparent to the public, Medicare and the state of Oklahoma (through the Oklahoma State Department of Health) monitor and publicly report certain aspects of care. This includes whether or not the hospital has followed evidence-based standards of care for certain types of patients and the rate at which certain events occur. The number of indicators that are monitored and/or reported grows yearly. In 2019, 86 measures will be monitored related to inpatient and outpatient care. (See below for examples.) In addition, acute long-term care hospitals are monitored on 19 measures, psychiatric hospitals on 24 measures, rehabilitation hospitals on 18 measures, ambulatory surgery centers on 18 measures, and cancer hospitals on 23 measures. Medicare uses these indicators to determine the level of payment a hospital receives. To view this hospital quality data, go to www.medicare.gov/hospitalcompare.

**Examples of Quality Measures**

- Do patients receive preventive care for blood clots while in the hospital?
- Do stroke patients receive the appropriate medication and education upon discharge from the hospital?
- Do patients develop certain infections while in the hospital?
- How many heart attack patients unexpectedly return to the hospital within 30 days after discharge?
Economic Impact of Critical Access Hospitals

Access to health care is one of the main factors of economic development in a community. When a company looks to invest and locate in a community, they look at workforce availability, infrastructure, and access to health care. If one of these is missing, that company will likely bypass that community and possibly the state. Communities that are fortunate to have a CAH already enjoy a significant economic impact. The hospital is generally one of the largest employers in that community. An assessment of individual hospital data from Fiscal Year 2014 Oklahoma Medicare Cost Reports by OSU Extension and the Oklahoma Office of Rural Health of nine CAHs representing seven counties provided the following average data:

- Direct economic impact per critical access hospital: $3,855,761
- Secondary economic impact per critical access hospital: $732,595
- Total economic impact per critical access hospital: $4,588,355

Taking that average total economic impact, and multiplying it by the 40 CAHs in Oklahoma results in a total annual economic impact of $183,534,224 for the state.

The Backbone of the Rural Safety Net

A total of 90 “rural” hospitals in Oklahoma (those located outside of the five most populated counties), which include 40 CAHs, provide local, affordable, quality care to 66 counties across the state. These hospitals are the backbone of the rural safety net, working in partnership with rural health clinics, community health centers, physicians in private practice, and local emergency medical services.
Oklahoma Rural Hospitals at Risk of Closure

Since 2010, 90 rural hospitals across the U.S. have closed their doors. An independent company, iVantage Analytics, studied the financial profiles and other benchmarks of the hospitals that closed and compared that information to all other rural hospitals. The result is called the Vulnerability Index™:

- As of their January 2016 report, 673 rural hospitals in the U.S. identified by iVantage Analytics fall into this Vulnerability Index™ and have a profile of being at risk of closure.
- Of those, 42 are in Oklahoma (only Texas has more with 75).

Due to a variety of causes including changing demographics, urbanization of medicine, and a long series of budget cuts, rural hospitals are at risk of being able to sustain traditional operations, resulting in possible closure.

- “Death by a thousand cuts” is how Maggie Elehwany of the National Rural Health Association describes the many payment cuts over the last seven years to rural hospitals. A half percent here, a half percent there, up to the two percent of sequestration – when added together the cuts can create a negative profit margin, forcing the hospital to operate on reserve funds if available or become insolvent.

At left:
On average, Oklahoma’s rural hospitals struggle to remain solvent, due to a variety of reasons. The blue line is the operating margin average for all hospitals in Oklahoma, the red line is the average operating margin of only rural Oklahoma hospitals.

Currently 55 of Oklahoma’s rural hospitals are operating at a loss. (2018, Eide Bailly)

Rural patients tend to be older, sicker, and poorer than their urban neighbors, and rural hospitals deal with a lower volume of patients with a higher proportion of Medicaid, Medicare and uncompensated care of the uninsured. (2017, The Commonwealth Fund)

Many rural hospitals are based in aging buildings that are costly to operate, repair, and maintain to current licensure standards.

Source: OHA Analysis of Medicare Cost Reports
Health Care Workforce

Nursing and Allied Health Recruitment

Of the nearly 300 individually identified allied health professions, critical shortages can be found among almost all of them in Oklahoma. These shortages are compounded for rural areas.

Addressing Workforce Shortages in Oklahoma

Oklahoma faces the significant challenges of an aging physician workforce and an alarming shortage of primary care providers for those in the greatest need. In December 2016, the National Governors Association (NGA) chose Oklahoma as one of two states to receive technical assistance on using existing Medicaid funds to meet state workforce requirements in underserved areas of the state. The technical assistance program, “Connecting Medicaid to Health Workforce,” will provide expert consultation to assist Oklahoma agency leaders in developing a plan to use Medicaid funds to address state health workforce needs, particularly in rural and medically underserved areas.

This opportunity with the NGA for technical assistance builds on prior collaborative health workforce efforts that resulted in the development of the Oklahoma Governor’s Health Workforce Action Plan and the establishment of the Health Workforce Subcommittee of the Governor’s Council for Workforce and Economic Development. One of the primary goals of the project will be to develop strategies that ensure transparency and accountability for state GME funding, while aligning Medicaid GME with state-specific health workforce needs. The team will specifically address the need for increasing both training of primary care physicians and support for community-based, inter-professional education. This includes teaching health center programs in federally qualified health centers, rural health clinics, and tribally operated health systems.

The Health Workforce Subcommittee of the Governor’s Council for Workforce and Economic Development was a result of SB 612 passed in the 2015 legislative session. CEOs of two rural hospitals are co-chairing the Health Workforce Subcommittee. The subcommittee’s purpose is to inform, coordinate, and facilitate statewide efforts to ensure that a well-trained, adequately distributed, and flexible health workforce is available to meet the needs of an efficient and effective health care system in Oklahoma. Goals identified for 2017-2022 by the Health Workforce Subcommittee include:

- Increase the number of primary care professionals in areas currently designated as primary health professional shortage areas;
- Increase the availability and accessibility of health profession training programs in rural and underserved areas;
- Establish health profession career pathways from pre-baccalaureate health professions to a more skilled health care labor force.

In an effort to ease the nursing shortage in Oklahoma, the OHA assisted in 2016 with passage of the Nurse Licensure Compact Bill, HB 2482. The bill provides that nurses with domicile in Oklahoma can uniformly obtain a multistate license. This will assist those facilities that are in border cities of Oklahoma to be able to access quality licensed nurses from surrounding states. Multistate licensure for nurses went into effect in 2018 after the required 26 states adopted the compact. Oklahoma was the seventh state to adopt the compact.

Nursing Population in Oklahoma

- Oklahoma has 700 RNs per 100,000 citizens, well below the national average of 1,150 per 100,000.\(^1\)
- Oklahoma has 56,490 licensed RNs. Of those, 44,363 reside in Oklahoma with 12,127 residing outside the state.\(^2\)
- Only 12 percent of RNs in Oklahoma are age 29 and under; 48 percent are between the ages of 30 and 49, and 40 percent age 50 and over.\(^2\)
- In 2017, there were 11.3 percent fewer new RNs licensed in Oklahoma than in 2012. The number of new RNs licensed in 2017 is the lowest number of this classification since 2012.\(^3\)
- In 2015, the number of newly licensed LPNs declined 8.3 percent from 2014. Some rebound in new LPN licensure was noted in 2017, with the decline being only 1.9 percent from its highest point in 2014.\(^3\)

2. Oklahoma Board of Nursing, 2018 Annual Report
3. Oklahoma Board of Nursing, 2017 Annual Education Reports
Physician Shortages in Oklahoma

- Oklahoma ranks 36th in the nation in primary care providers (United Health Foundation Health Care Rankings) with 129.4 physicians per 100,000 citizens.
- 72 of Oklahoma’s 77 counties are designated as primary care health professional shortage areas. These designated areas demonstrate a critical shortage of primary care physicians, in accordance with the federal guidelines.*
- 58.6 percent of Oklahomans live in a primary care shortage area. (United Health Foundation Health Care Rankings)
- Oklahoma ranks 43rd among rural states for maldistribution of physicians, with only 182.2 physicians per 100,000 people. (Merritt Hawkins Physician Access Index)
- Only 6 percent of medical residents nationally desire a rural practice setting after graduation.
- Oklahoma ranks 11th in the U.S. for the percentage of practicing physicians who are over the age of 60 years old, according to the American Association of Medical Colleges.
- 55 percent of rural Oklahoma primary care doctors are older than 55. (United Health Foundation Health Care Rankings)

*Primary care physicians are MDs and DOs who practice in one of the following specialties: family practice, general practice, internal medicine, pediatrics, OB/GYN and general geriatrics.

Health Care Job Seekers Log on to OKHospitalJobs.com

Health care job seekers across Oklahoma have found a valuable tool in [www.okhospitaljobs.com](http://www.okhospitaljobs.com), an online health care job search tool sponsored by the Oklahoma Hospital Association. Numerous hospitals and health clinics post jobs to the site, which launched in 2003. OKHospitalJobs.com is one of 19 state hospital association job sites that make up HospitalCareers.com, which has more than 88,000 unique visitors each month. More than 1,500 statewide health jobs are available for search on the site at any given time in a variety of medical professions, including registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist, speech pathologist, radiology technician, pharmacist and many others. Non-clinical and administrative positions are also posted to the site.

Physician Recruitment

Just as retaining an adequate, quality workforce of nursing and allied health professionals is vital, physician recruitment is a primary concern for OHA members. Retaining medical students and residents trained in Oklahoma is critical. University of Oklahoma College of Medicine and Oklahoma State University College of Osteopathic Medicine train physicians and provide residencies for some specialty certifications. OU School of Medicine may accept up to 165 new medical students each year and OSU College of Osteopathic Medicine may accept up to 120 new medical students each year. OU Tulsa became accredited for a full four-year program in 2015 and may accept up to 25 students each year. Announced in November of 2018, OSU-Center for Health Sciences and the Cherokee Nation announced the creation of a new joint venture, osteopathic medical school campus, to be located in Tahlequah. The first incoming class of 50 medical students will enroll in the fall of 2020.

Ensuring an adequate supply and distribution of trained physicians across the state has the dual benefit of supporting economic prosperity, as well as supporting improved health. Health care plays a locally-driven, integral role for the state’s economy, contributing nearly 10 percent of the state’s gross state product (GSP) in 2015. Subsectors which depend on recruitment and retention of physicians, such as ambulatory health care services and hospitals, supported nearly 140,000 jobs, or over 6 percent of estimated total employment in Oklahoma in 2015. (Bureau of Economic Analysis 2017)

Local wages and income generated by physicians support consumer spending, investment and other commercial activity in a manner that has a “multiplier effect.” (U.S. Bureau of Economic Analysis, Regional Input-Output Modeling System) The private sector firm IMS Health quantified approximately $1.5 to 2 million in new local revenues, including approximately $50,000 annual state tax revenues as a result of the recruitment of a new physician to an Oklahoma community. (IMS Health. The National Economic Impact of Physicians: National Report, prepared for the American Medical Association. March 2014.)

The Oklahoma State Chamber of Commerce identifies rising costs of health care and challenges in overall wellness as factors that may inhibit Oklahoma business growth and profitability. (State Chamber of Oklahoma Research Foundation ACE Book 2016: Accountability for a Competitive Economy.)

In 2012, the Oklahoma Hospital Residency Training Program Act established new primary care residency training programs
focused on meeting the health care needs of medically underserved and rural areas. The Act appropriated $3.08 million to the OSU Medical Authority to disburse to qualified applicants and provides for “startup” costs associated with establishing a hospital-based Medicare supported graduate medical education residency program. The authorization allows for funding primary care residencies at an average of $50,000 per resident annually in hospital locations that meet the residency accreditation requirements. The Act has created 127 accredited residency slots to serve rural Oklahoma's primary care needs. Funds from the initial appropriation will be expended prior to the end of the fiscal year, leaving more than half of the newly accredited residency slots unfunded.

**Physician Manpower Training Commission**

The Physician Manpower Training Commission (PMTC), established by the state in 1975, is a seven-member commission whose members are appointed by the governor and confirmed by the Senate. The commissioners are three practicing allopathic physicians, two osteopathic physicians, and two governor’s appointees. Broadly, the commission is charged with increasing the number of practicing physicians, nurses and physician assistants in Oklahoma, particularly in rural and underserved areas of the state. For more information, see www.pmtc.state.ok.us.

A 25-year study of PMTC’s physician retention conducted by the OSU Center for Rural Health in 2001 noted 82 percent of physicians participating in a PMTC practice obligation remained in Oklahoma practice, with a rate of 67 percent of those in a rural area. *(Lapolla, Michael. Twenty-Five Years; Oklahoma Physician Manpower Training Commission – A Health Policy Report. OSU Center for Health Sciences, October 2001.)*

In 2016, OHA worked with others in modernizing PMTC with the passage of SB 1179. The bill expands definitions used in the Oklahoma Medical Loan Repayment Program to include health center and teaching health center. The bill permits the Physician Manpower Training Commission to accept donations of public or private funding. HB 2987, which took effect Nov. 1, 2018, allows physician assistants practicing in rural areas to also participate in the Oklahoma Medical Loan Repayment program.

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**Oklahoma Tobacco Settlement Endowment Trust (TSET) Funds for Workforce Shortages**

Created by voters in 2000, TSET is an endowment trust established with payments from the 1998 Master Settlement Agreement (MSA) between 46 state attorneys general and the tobacco industry. Payments are invested by a board of investors and only the earnings from those investments are used by the board of directors to support efforts to improve the health of Oklahomans. TSET has focused funding on reducing Oklahoma’s leading causes of preventable death – tobacco use and obesity – in order to reduce cancer and cardiovascular disease. As a state grant-making trust, TSET funds prevention, research and emerging opportunities to improve the health of every Oklahoman.

Two grant programs that TSET funds critical to the Oklahoma health care workforce shortage are:

- **Oklahoma Medical Loan Repayment Program** to recruit primary care physicians to medically underserved areas through a partnership between TSET and the Physician Manpower Training Commission. The Oklahoma Medical Loan Repayment Program pays off student loans for primary care physicians who establish practices in medically underserved areas. Physicians must agree to establish a practice in a medically underserved area of the state for a minimum of two years. The physician then becomes eligible for student loan repayments that last up to four years, so long as the physician maintains his or her practice in the community. To date, more than 56,000 patient visits have been conducted through physicians participating in the program.

- **Oklahoma State University Medical Authority Residency Program** to support physician training in rural and medically underserved areas. In 2015, the TSET board of directors awarded a six-year, $3.8 million grant to the OSU Center for Health Sciences and the OSU Medical Authority. TSET’s grant will fund up to 118 osteopathic physician residents in six hospitals across the state, through a combination of TSET and matching federal funds.
Licensing & Credentialing of Health Care Professionals

Licensure

Licensure of health care providers such as physicians, physician assistants and nurses, to name a few, is a function of each state. State boards such as the State Board of Medical Licensure and Supervision, which licenses medical doctors (MD), physician assistants (PA), physical therapists (PT) and others; the State Board of Osteopathic Examiners, which licenses osteopathic physicians (DO); and the Oklahoma Board of Nursing; were created by the state Legislature. Licensure boards are funded by fees paid by the licensee not state appropriated funds.

In addition to licensure and the investigation of complaints, each board makes rules and policies in conformity with the stated purpose of the Board and the mission mandated by state law.

In an effort to ease the nursing shortage in Oklahoma, the OHA assisted in 2016 with passage of the Enhanced Nurse Licensure Compact Bill, HB 2482. The bill provides that nurses with domicile in Oklahoma can uniformly obtain a multistate license. This will assist those facilities that are in border cities of Oklahoma to be able to access quality licensed nurses from surrounding states. Oklahoma was the seventh state to adopt the compact. Implementation of the enhanced Nurse Licensure Compact (eNLC) began on Jan. 19, 2018. The eNLC introduced 11 uniform requirements for a multistate license to ensure that nurses from eNLC states have comparable qualifications. New nurses getting their first license in an eNLC state will be able to practice in all the eNLC states. Each eNLC state is responsible to notify nurses by mail of the changes to the license and the process to obtain an enhanced compact license.

Due to the complex nature of health care professions and workforce shortages, the sweeping reforms of occupational licensure that began in 2018 in the Oklahoma Legislature are an important issue to monitor. After the U.S. Supreme Court case of North Carolina Dental vs. Federal Trade Commission, the Oklahoma attorney general conducted a review to make sure all the professional boards were in compliance on their policies regarding convictions. The majority holding in the case was when a controlling number of the decision makers on a state licensing board are active participants in the occupation the board regulates, the board can invoke state-action immunity only if it is subject to active supervision by the state. In July of 2015, Gov. Mary Fallin issued Executive Order 2015-39, which directed the Oklahoma attorney general to supervise the actions of the boards and commissions in Oklahoma. The boards and commissions of Oklahoma are in compliance with EO 2015-39 as they submit policy and rules for review by the attorney general. Effective July 1, 2018, the Occupational Licensing Review Commission began its work as instructed by SB 1475. The bill creates the Occupational Licensing Review Commission to review current occupational and professional licensure requirements, which includes the health care professions. Any recommendations on potential changes to current requirements must be submitted to the Legislature.

Credentialing

Credentialing is the process used by a hospital to analyze the qualifications of a licensed physician or other practitioner’s education, training, experience, competence and judgment as well as their scope of practice. Credentialing is the basis for appointing health care professionals to the staff of a hospital or other health care organizations. A credentialed staff member is permitted to perform certain clinical duties within the organization. Clinical duties are defined by the medical staff of the hospital. The state does not credential health care providers for the purpose of working in hospitals or other health care facilities.

For more information...

- Oklahoma Board of Medical Licensure & Supervision
  www.okmedicalboard.org
- Oklahoma Board of Osteopathic Examiners
  www.osboe.ok.gov
- Oklahoma Board of Nursing
  www.youroklahoma.com/nursing
Electronic Health Records

The American Recovery and Reinvestment Act (ARRA) of 2009 established incentive payments for the use of Electronic Health Records (EHRs) by hospitals and physicians, through both the Medicare and Medicaid programs. The goal of the EHR incentive program was to allow for increased efficiency and less redundancy in patient care.

To qualify, hospitals must achieve a number of specific capabilities known collectively as “meaningful use.” Examples include charting patients’ vital signs electronically and maintaining medication allergy lists. The EHR software used by the hospital must also be approved through a certification process.

The last year that hospitals could have begun receiving Medicare EHR incentive payments was 2015. Since 2015, hospitals and physicians who are not meaningful users of certified EHRs face reduced payments from Medicare.

State Health Information Exchange

The American Recovery and Reinvestment Act also provided money for the State Health Information Exchange Cooperative Agreement Program. The purpose of this program was to rapidly build capacity for exchanging health information across the health care system both within and across states.

The 2016 Legislature created the Health Information Technology Advisory Board, which is intended to advise in the development of a long-range plan for health information technology to the state chief information officer. The board is made up of nine members appointed by the governor and Legislature, each serving a three-year term. One member represents a statewide organization representing urban and rural hospitals (OHA).

HIPAA

The Health Insurance Portability and Accountability Act, enacted by the U.S. Congress in 1996, has two main provisions.

**Title I** protects health insurance coverage for workers and their families when they change or lose their jobs.

**Title II**, known as the Administrative Simplification provisions, requires the establishment of national standards for electronic health care transactions, and national identifiers for health care providers and plans.

The Administrative Simplification provisions of HIPAA also address the privacy and security of health care data. Covered entities may disclose medical record contents to facilitate treatment, payment, or health care operations, or if the entity has received authorization from the patient. Providers must also establish administrative, physical, and technical safeguards against unauthorized access to protected data.

Medical records in any form, including electronic health records, are included in this provision.

Under HIPAA, a hospital may release certain information about the patient only under certain conditions. As long as the patient is informed in advance and does not object, a hospital may disclose certain limited information only to persons who inquire about the patient by name. Members of the Oklahoma media may obtain “A Guide to Hospital & News Media Relations” for a more complete explanation. Go to www.okoha.com/mediaguide or contact OHA at (405) 427-9537, oha@okoha.com.

Telemedicine

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smartphones, wireless tools, apps and other forms of telecommunications technology. The use of telemedicine is becoming integrated into the ongoing operations of hospitals, specialty departments, home health agencies, and private physician offices, as well as consumers’ homes and workplaces. All 77 counties in Oklahoma have telehealth. There are more than 400 facilities in Oklahoma that send and/or receive telehealth services. Telemedicine is not a separate medical specialty, but is a tool for providing health care.
Virtual visits direct to consumer are also now being offered by Oklahoma hospitals. A virtual visit is an internet-based episode of physician-patient interaction. Virtual visits can provide health services online and help in the management of chronic diseases, including diabetes, asthma, hypertension, heart failure, HIV, and high-risk pregnancies.

**Regulation of Telemedicine**

Although telemedicine is not a separate medical specialty, telemedicine in Oklahoma is regulated specifically by the following state agencies:

- **Oklahoma Corporation Commission**: provides funding to certain not-for-profit providers for telemedicine infrastructure upon successful completion of the application process.
- **Oklahoma Health Care Authority**: provides for Medicaid reimbursement of telemedicine services work for certain conditions or specific services for SoonerCare members.
- **Oklahoma Board of Medical Licensure and Supervision (OBMLS) and Oklahoma State Board of Osteopathic Examiners**: provide for licensure and supervision of licensed physicians for purposes of providing telemedicine services in Oklahoma. OBMLS also provides for licensure and supervision of physician assistants and physical therapists for purposes of providing telemedicine services in Oklahoma. OBMLS allows for the practice of telemedicine without a face-to-face consultation. To practice allopathic medicine in Oklahoma and do so only in telemedicine format, the physician must still obtain a license from the OBMLS prior to serving Oklahomans. The Oklahoma State Board of Osteopathic Examiners provides for a conditional license for practice of telemedicine in Oklahoma for Osteopathic physicians.

Other licensure boards that are either licensing or have recently enacted legislation to license their practitioners specifically for telemedicine or telehealth include Oklahoma Board of Nursing and Oklahoma Board of Optometric Physicians.

**Agency Partnerships:**

- **The Oklahoma State Department of Health**: created the Office of Telehealth within the Center for Health Innovation and Effectiveness to advance the use of telehealth services throughout the state of Oklahoma. The Office seeks to engage partners statewide, to achieve improved health outcomes and a more effective, accessible health care system for Oklahoma.

**Academic Partners:**

- **Oklahoma State University TeleHealth**: provides telemedicine and distance learning resources and services to physicians, students, residents and faculty of Oklahoma State University and health care professionals involved in serving rural and underserved patients in Oklahoma. OSU has one of the state's largest telemedicine networks connecting health care providers to rural and underserved patients. This medical lifeline provides patients in non-metropolitan areas with access to specialty health care.

- **The University of Oklahoma Health Sciences Center - Center for Telemedicine**: exists to enhance access to care to underserved areas of Oklahoma and to provide educational opportunities for health care providers. This network provides 45 rural hospitals with telemedicine workstations, connectivity to the internet, access to medical libraries at OUHSC and around the country, and the potential to access clinical specialists around the state.

**Funding of Telemedicine**

Several funding sources are available in Oklahoma for reimbursement of hardware and operations that are the necessary infrastructure to operate telemedicine networks and sites. Further, reimbursement for telemedicine services is available in Oklahoma in the private and public sector.

- **The Oklahoma Telecommunications Act of 1997 established the Oklahoma Universal Service Fund (OUSF). Fees are paid by phone users into a fund that is disbursed primarily to telephone companies. Secondly, funds are**
disbursed to several entities, including health care, for purposes of providing telemedicine. The OUSF is administered by the Oklahoma Corporation Commission. (See Title 17 O.S., Section 139.106.)

The secondary entities that receive OUSF are referred to in statute and rules as “Special Universal Services.” The health care applicant must be a not-for-profit hospital, not-for-profit mental health and substance abuse facility, or federally qualified health center. Also, the OUSF application requires the applicant to have applied for federal funding before state funding. In 2015, telemedicine requests were expected to be approximately $51 million for OUSF for telemedicine infrastructure, as budgeted by the program. In 2016, the OHA, as part of a consortium, worked on overhauling the OUSF from a litigation-based system to an administrative process. The bill, HB 2616, also established deadlines for OCC action once an application for funding is received and established a requirement for competitive bidding of telecommunication carrier services.

In June 2018, the Federal Communications Commission announced it will boost spending on its telehealth program by $171 million (43 percent) to $571 million, lifting the cap on the program. The program is a Universal Service Fund subsidy for broadband-facilitated diagnosis and treatment. In 2017, $8 million was awarded to Oklahoma entities.

The Rural Health Care (RHC) Program supports health care facilities in bringing world class medical care to rural areas through increased connectivity. It supports reduced rates for broadband and telecom services. There are two subprograms in the RHC Program: The Healthcare Connect Fund (HCF) program and the Telecommunications (Telecom) program.

Commercial Insurance, Medicare or Medicaid funding: In Oklahoma, most OHA members are origination or receiving sites for telemedicine. Some Oklahoma hospitals also offer direct-to-consumer visits though an app on a smartphone and are termed virtual care. Reimbursement for telemedicine services can vary depending on the payer. Oklahoma has consumer parity in telemedicine, which means if a service is provided face-to-face and reimbursed, then the telemedicine service must also be reimbursed by the insurance carrier. The Medicaid program in Oklahoma does reimburse for numerous telemedicine services.

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### Oklahoma Reimbursement Comparison

<table>
<thead>
<tr>
<th>Telemedicine/Telehealth</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Private Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays for telehealth</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Requires a modifier</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
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<tr>
<td>Patient must be at a rural site*</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Providers specified</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>✔️</td>
<td>Only IHS/Tribal</td>
<td>✔️</td>
</tr>
<tr>
<td>Only reimburses for specific CPT codes</td>
<td>✔️</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interactive telecommunication network preapproved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telemedicine visits counted toward the applicable benefit limits for these services</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Store and forward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-covered services: telephone conversation, E-mail, FAX</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Patient must be in Oklahoma at time of teleconsult</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
</tbody>
</table>

*Medicare defines “rural” as a non-MSA or rural HPSA. Medicaid defines “rural” as a county with a population of less than 50,000 people. Source: Heartland Telehealth, May 2015.
Physician Patient Relationship in Telemedicine

In 2017, SB 726 was enacted, which allows the physician patient relationship to be established through telemedicine, but not only by telephone (audio-only). The bill put into statute many of the regulations formerly imposed by the rules of the Oklahoma Board of Medical Licensure. Restrictions include: telemedicine cannot be used to establish a valid physician-patient relationship for purposes of prescribing opiates, synthetic opiates, semisynthetic opiates, benzodiazepine, or carisprodal, but may be used to prescribe opioid antagonists or partial agonists. Instead, such prescribing must occur through a face-to-face visit for the initial encounter of the patient. The duties and obligations created by a physician-patient relationship shall not apply until the physician affirmatively undertakes to diagnose and treat the patient or participates in the treatment of the patient.

Telehealth

When telemedicine is discussed, the term telehealth is often used interchangeably. Telehealth is different from telemedicine because it refers to a broader scope of remote health care services than telemedicine. While telemedicine refers specifically to remote clinical services, telehealth is a broader term and can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

Trauma Care

Background

In 1999, the state established the Trauma Care Assistance Revolving Fund. The legislation provided for partial reimbursement of uncompensated costs associated with trauma care provided by recognized trauma facilities and emergency medical providers.

In November 2004, Oklahoma voters approved State Question 713 to enact an increase in the tobacco tax for health care (see page 29). Funding from the tax enabled the state to greatly assist in the development of a statewide trauma system.

Prior to the enactment of the 2004 tobacco tax increase and other legislative funding initiatives, the state’s only Level 1 Trauma Center, OU MEDICAL CENTER, announced a potential downgrade if adequate funding was not appropriated. If funding had not been provided, Oklahoma would not have had any Level I hospital and severely injured Oklahomans would have died.

Trauma Legislation

Senate Bill 290 established the Trauma Care Assistance Revolving Fund (Trauma Fund) in 1999. This Bill provided for reimbursement of uncompensated costs associated with trauma care provided by recognized trauma facilities and emergency medical providers. In 2004, House Bill 1554 added physicians to the list of providers eligible for reimbursement from the Trauma Fund. Administrative rules by the Oklahoma State Department of Health to implement the law became effective on July 11, 2005.

<table>
<thead>
<tr>
<th>Examples of Telehealth Services Provided in Oklahoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn</td>
</tr>
<tr>
<td>Dermatology</td>
</tr>
<tr>
<td>Geriatrics</td>
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<tr>
<td>Infectious Disease</td>
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<tr>
<td>Neonatology</td>
</tr>
<tr>
<td>Pulmonology</td>
</tr>
<tr>
<td>Telestroke</td>
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</tbody>
</table>
Oklahoma Trauma Center Levels

All levels of a recognized trauma center must identify the level of trauma services provided, participate in and submit data to the statewide trauma registry, and operate quality assurance processes.

**Level IV:** A facility that staffs a 24-hour emergency service with at least a licensed physician’s assistant, a nurse practitioner, or a registered nurse, licensed practice nurse, or intermediate or paramedic emergency medical technician. No surgical or diagnostic services are required. Level IV is a primary referral facility, for rapid stabilization and transfer to definitive care.

**Level III:** A facility that staffs a 24-hour emergency service with at least a physician, and which has general surgical services on-site or on an on-call basis. X-ray, laboratory services, recovery room and intensive care beds are required. Level III is an intermediate facility, capable of handling minor and some major trauma patients.

**Level II:** A facility that staffs a 24-hour trauma service with at least an emergency department physician, with a surgeon designated as trauma director, and 24-hour on-site general surgery, anesthesia and neurosurgical services. Extensive clinical specialty services are available, including cardiology, internal medicine, orthopedics, and obstetrical/gynecology services. Level II is a tertiary referral facility, capable of managing all types of trauma.

**Level I:** This is the highest level of trauma center designation, with all the requirements of Level II, and extensive clinical specialty services including the following surgical specialties: hand, microvascular, oral/maxillofacial, thoracic, plastic, urological, and also a trauma research program. Level I is a trauma care teaching facility.

The Oklahoma Trauma System Improvement and Development Act was passed during the 2004 legislative session. The Act:

- Created the Oklahoma Trauma Systems Improvement and Development Advisory Council;
- Created Regional Trauma Advisory Boards with representation from regional hospital and ambulance services;
- Called for development of a statewide trauma system plan;
- Called for the development, regulation and improvement of a trauma system on a statewide basis; and
- Requires the development of regional trauma quality improvement activities and a state Medical Audit Committee to review these activities.

The Trauma and Emergency Response Advisory Council, under the Board of Health, is the entity that assumes the duties of the Oklahoma Emergency Response Systems Development Advisory Committee, the Medical Audit Committee and the Trauma Systems Improvement and Development Advisory Committee. These entities were consolidated by an act of the state Legislature in 2013.

Source: Oklahoma State Department of Health

**Trauma Fund**

The Trauma Fund, established in 1999 in Title 63, is a continuing fund that is available to support the public health safety net required to provide appropriate emergency medical care to the severely injured patient and uncompensated trauma care. The Trauma Fund is distributed by the Oklahoma State Department of Health to the following entities: hospitals, physicians, emergency responder agencies. Revenues for the fund come from:

- Renewal and reinstatement of driver’s license fees,
- Fines for second/subsequent convictions for driving without a license,
- Convictions for driving under the influence,
- Failure to maintain mandatory motor vehicle insurance,
- Violating the open container law,
- Speeding,
- Drug related convictions, and
- 2004 Tobacco tax.
Revenues and Distributions

Ninety percent of the money received by the Trauma Fund is distributed by the Oklahoma State Department of Health to reimburse trauma facilities, ambulance service providers, and physicians for uncompensated trauma care expenditures. Of this amount, up to 30 percent of each distribution is earmarked for physicians. The fund does not fully reimburse the cost of uncompensated trauma care to providers.

EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a 1986 federal law requiring acute care hospitals to provide care to anyone needing emergency treatment, regardless of citizenship, legal status, or ability to pay. Individuals requesting emergency care must be given a screening examination to determine whether an emergency medical condition exists.

The emergency department must treat an individual with an emergency medical condition until the condition is resolved or stabilized, before asking about insurance coverage or payment. If a hospital does ask about insurance coverage before stabilization, the hospital is subject to a $50,000 financial penalty per violation of federal EMTALA. If the hospital does not have the capability to treat the condition, the hospital must first stabilize the patient then make an appropriate transfer of the patient to another hospital with such capability. Hospitals with specialized capabilities must accept transfers of patients under federal law.

Disaster Preparedness

Following the terrorist attacks on Sept. 11, 2001, the president issued a number of executive orders to advance the nation’s preparedness and capacity. These orders led to the development of an all-hazard planning approach to address manmade and natural disasters.

In 2002, the Oklahoma State Department of Health formed the Bioterrorism Preparedness Division, which has evolved into the Emergency Preparedness and Response Service, to address implications of a large-scale disaster.


State and federal agencies, along with the provider community, work closely on a continuous basis to plan, drill and evaluate actions required to manage health care emergencies on both large and small scales. A great deal of information was shared and incorporated from hospitals, health care providers, state agencies and other organizations impacted by or involved with the May 2013 tornados in central Oklahoma.

Infectious Outbreak Preparedness

In January 2015, a specialized infectious disease unit opened at OU Medical Center, ready to activate if the need arises. The Oklahoma Biocontainment Care Unit is designed to care for pediatric and adult patients in the state who test positive for dangerous infectious diseases like Ebola. The nearly 4,000-square-feet specialized unit is isolated in a decommissioned hospital building on the Oklahoma Health Center campus and is self-sufficient relative to the air handling system, supply and distribution of medical gasses and the storage and removal of biomedical waste.
Improving Oklahoma’s Health

Oklahoma Health Improvement Plan

In 2008, the Oklahoma Legislature, in SJR-41, directed the State Board of Health to prepare a report outlining a plan for the “general improvement of the physical, social and mental well-being of all people in Oklahoma through a high-functioning public health system.”

The latest plan, Healthy Oklahoma 2020, updates Oklahoma’s existing health improvement plan. The new plan seeks to build on the Oklahoma Health Improvement Plan’s (OHIP’s) successes while addressing areas where Oklahoma continues to fall short, in physical, social and mental health of all Oklahomans, by reducing tobacco use, reducing obesity, improving the health of children and improving behavioral health.

According to the United Health Foundation, Oklahoma’s 2017 national health rankings have worsened and Oklahoma is currently ranked 47th, down from 43rd in 2016. For more, go to https://bit.ly/2C0px3m.

Since the initial report issued in 2010, while much remains to be improved, there have been gains, including:
- Reduction in the percent of public high school students who are obese.
- Reduction in the infant mortality rate.
- Increase in the number of school districts working to create a healthy environment that incorporates nutritious food and time for physical activity.
- Reduction in tobacco use among adults and adolescents.
- Increase in the number of schools that are tobacco free 24 hours a day, 7 days a week.

There is still room for improvement. Many Oklahomans continue to be obese. A large percentage of pregnant women do not receive prenatal care and many babies are born with low birth weight, especially among African-American people. Too many youth begin smoking or using tobacco products every year. Some Oklahomans don’t have the same access to quality health care services as others. Oklahoma must create and assure conditions where the healthy choice is the easy choice to address the health challenges we face in our state and meet the goals of Healthy Oklahoma 2020.

For more information, visit www.OHIP2020.com.

Oklahoma’s Tobacco Tax

On Nov. 2, 2004, State Question 713 passed a statewide vote of the people. The people approved an additional excise tax on cigarettes by 80 cents per 20-cigarette pack. It also levied an additional tax on other tobacco products.

The funds generated from the increase in the tobacco tax were dedicated to funding health care needs such as:
- Insure Oklahoma insurance program,
- Rural hospital relief,
- Emergency room physicians’ rate increase,
- Ambulance rate increase,
- OU Comprehensive Cancer Center,
- OSU Telemedicine Project,
- Breast and cervical cancer treatment for low income women,
- Adolescent substance abuse services,
- Smoking cessation programs, and
- Trauma Care Assistance Fund.

2018 Cigarette Tax Increase

The state budget for SFY 2019, beginning July 1, 2018, comprises $507.6 million in new tax revenue, including HB 1010xx, which increased the cigarette tax by $1 per pack, the fuel tax on gas by 3 cents per gallon and on diesel by 6 cents per gallon, and the initial gross production tax rate from 2 to 5 percent.

According to the Campaign for Tobacco-Free Kids, the evidence is clear that raising the price of cigarettes is one of the most ef-
effective ways to reduce smoking, especially among kids. The $1 cigarette tax increase is projected to:

- Prevent 17,300 Oklahoma kids from becoming smokers.
- Spur 18,700 current adults to quit.
- Save 10,200 Oklahomans from premature, smoking-caused deaths.
- Save $767 million in future health care costs.

**Tobacco Settlement Endowment Trust (TSET)**

**Master Settlement Agreement**

In 1996, Oklahoma became the 14th state to file suit against the tobacco industry to recover tax dollars lost from treating tobacco related diseases. Within two years, 46 state attorneys general had joined together to negotiate a settlement with the tobacco companies. These states negotiated a Master Settlement Agreement from which Oklahoma is projected to receive approximately $2 billion over the 25 years of the settlement.

**Endowment Trust Fund**

In 2000, Oklahoma’s constitution was amended by a vote of the people to place a portion of each payment from the Master Settlement Agreement into an endowment trust fund, to create a five-member board of investors to oversee the investment of the trust fund and to create a seven-member board of directors to direct the earnings from the trust to fund programs in the following five areas:

- Clinical and basic research and treatment efforts in Oklahoma for the purpose of enhancing efforts to prevent and combat cancer and other tobacco-related diseases;
- Cost-effective tobacco prevention and cessation programs;
- Programs designed to maintain or improve the health of Oklahomans or to enhance the provision of health care services to Oklahomans, with particular emphasis on such programs for children;
- Programs and services for the benefit of the children of Oklahoma, with particular emphasis on common and higher education, before- and after-school programs, substance abuse prevention and treatment programs and services designed to improve the health and quality of life of children; and
- Programs designed to enhance the health and well-being of senior adults.

Two grant programs that TSET funds critical to the health care workforce shortage are:

- Oklahoma Medical Loan Repayment Program to recruit primary care physicians to medically underserved areas through a partnership between TSET and the Physician Manpower Training Commission. The Oklahoma Medical Loan Repayment Program pays off student loans for primary care physicians who establish practices in medically underserved areas. Physicians must agree to establish a practice in a medically underserved area of the state for a minimum of two years. The physician then becomes eligible for student loan repayments that last up to four years, so long as the physician maintains his or her practice in the community. To date, more than 56,000 patient visits have been conducted through physicians participating in the program.
- Oklahoma State University Medical Authority Residency Program to support physician training in rural and medically underserved areas. In 2015, the TSET Board of Directors awarded a six-year, $3.8 million grant to the Oklahoma State University Center for Health Sciences and the OSU Medical Authority. TSET’s grant will fund up to 118 osteopathic physician residents in six hospitals across the state, through a combination of TSET and matching federal funds.

Source: Oklahoma Tobacco Settlement Endowment Trust.

**OHA Health Improvement Initiatives**

OHA Health Improvement Initiatives have been established to address the poor health of Oklahomans in our state, related to tobacco use and obesity, through the development of hospital leadership in health improvement.

**Hospitals Helping Patients Quit**

**Tobacco Cessation Initiative**

With grant funding from the Tobacco Settlement Endowment Trust, OHA provides individualized support to hospitals and health care systems to address tobacco cessation with their patients and employees. The OHA is committed to the project mission of:

“Supporting Oklahoma hospitals in leading a culture of health improvement in their communities through reducing illness, disability and death due to tobacco use.”
OHA assists hospital leadership and clinical staff in moving towards a totally tobacco-free/smoke-free culture using evidence-based strategies in the following areas:

- Supporting hospitals and their affiliated outpatient clinics in moving toward implementing tobacco free/smoke-free campus policies and step-by-step implementation of best practice, cost-effective procedures that assist employees, visitors and patients.
- Implementing a sustainable, brief, effective intervention with all tobacco-using inpatients and outpatients. This treatment protocol is the U.S. Public Health Service clinical practice guideline, Treating Tobacco Use and Dependence, endorsed by the CDC, CMS, TJC and 60+ other national and state health organizations. Through this strategy, individuals ready to quit are referred directly to the Oklahoma Tobacco Helpline, via fax or electronic referral, to receive telephone or website counseling and guidance through the quitting process.
- Assisting hospitals to develop supportive policies and health benefits to assist employees with this same evidence-based tobacco cessation service.
- Strengthening partnerships with hospital leaders, utilizing specific knowledge of hospital culture, processes and systems to integrate and tailor intervention strategies into the existing hospital system and structure.

Results:

- Since OHA’s health improvement initiatives began in 2009, approximately 50 hospitals of all sizes, including large health systems, have implemented these treatment services through permanent system changes.
- Between October 2010 and August 2018, 28,793 hospital and clinic patients and employees have been referred by their health care providers to the Oklahoma Tobacco Helpline. Of those 28,793 people, about 29 percent have accepted services when contacted by the Helpline.

Of all fax and e-referrals made since November 2014, 81 percent are electronic.

This initiative has led Oklahoma to be recognized nationally in tobacco treatment system changes and has contributed to the decline in adult smoking prevalence in our state in the past several years.

Estimated years of life saved: 22,093

Estimated health care costs avoided due to enhanced cessation rates: $11,117,672

WorkHealthy Hospitals

Hospital Workplace Wellness

WorkHealthy Hospitals is an OHA board initiative, funded by the Oklahoma Tobacco Settlement Endowment Trust and aimed at assisting Oklahoma hospitals to improve the health of their employees. Dedicated OHA staff work to provide Oklahoma hospitals with sustainable, best practice health improvement strategies that address key areas of well-being, including tobacco cessation, nutrition and food environment, physical activity, culture, behavioral and financial health.

OHA’s role is to:

- Aid hospitals in the completion of an assessment that provides them with the current status of their organization’s efforts in each wellness area.
Approximately one in eight visits to emergency departments (EDs) in the U.S. involves mental and substance use disorders (M/SUDs). ED visits involving M/SUDs are considered potentially avoidable – if these conditions are adequately managed through appropriate outpatient care, then ED visits should be rare. Such potentially preventable M/SUD-related ED visits are more than twice as likely to result in hospital admissions compared with ED visits that do not involve M/SUDs. (AHRQ, Healthcare Cost and Utilization Project, statistical brief 216, 2016)

Compounding the problem is a shortage of mental health professionals. For psychiatrists alone, a 2017 report published by the National Council for Behavioral Health estimates the shortage in the U.S. will be between 6,100 and 15,600 practitioners by 2025. That same report points out that lack of access to psychiatric services in hospital emergency departments is especially problematic. (STAT News, Boston Globe Media, Oct. 18, 2018)

Oklahoma has the second highest prevalence of adults with mental illness in the U.S. at 21.88 percent and the second highest prevalence of adults with severe mental illness at 5.24 percent.

Oklahoma has the seventh worst overall mental health system in the U.S. based on prevalence and access to care.

Oklahoma ranks as the 17th worst state in terms of suicide rate.

In Oklahoma, 111,000 adults with a mental illness are uninsured. (The Curbside Chronicle, 2018)

Although Oklahoma has nine stand-alone behavioral health hospitals and a few medical hospitals with behavioral health units, there is a shortage of both inpatient and outpatient services as seen by the high volumes of patients who seek mental health care in an emergency department. Some patients that require inpatient care are kept in EDs for many hours and sometimes days waiting for placement.

- Assist wellness committees in prioritizing improvement recommendations to develop and implement tailored wellness work plans with system improvements.
- Provide consultation, technical assistance and evidence-based/promising practice resources for employee well-being.
- Link hospitals to a vast array of implementation tools and educational resources.
- Demonstrate and share innovative strategies to build new resources for wellness improvement and implementation science.
- Monitor and analyze implementation strategies and outcomes.

Behavioral Health
Current Issues Impacting Hospitals

Below are some of the important issues currently impacting hospitals (as of January 2019).

Medical Marijuana and Hospital Employees

Oklahoma voters approved State Question 788 in June 2018, which provided for medical marijuana to be legally sold in Oklahoma with licensing for patients, lay caregivers and commercial interests. SQ 788, although titled medical marijuana, does not describe restrictive medical conditions to obtain a license. This new law affects hospitals in several ways:

- As employers, Oklahoma hospitals have concerns regarding employees and patient safety. Currently under SQ 788, both pre-employment and random drug testing are prohibited if the employee holds a medical marijuana license. Most employment attorneys believe the law creates a protected class of employees. If an employee holds a medical marijuana license, he or she cannot be tested for marijuana usage unless there is causation. The law is clear that if an employee is a medical marijuana license holder, they may not use marijuana on the job.
- Some hospitals have determined that they must comply with the federal Drug-Free Workplace Act of 1988, which would require them to pre-screen job applicants and include those who hold medical marijuana licenses. The Federal Act requires some federal contractors and all federal grantees to agree that they will provide drug-free workplaces as a condition of receiving a contract or grant from a federal agency. Oklahoma employers who wish to drug test employees in Oklahoma can only do so in accordance with the Workplace Drug and Alcohol Testing Act. (Title 40 Okla. Stat. Section 554.)
- Because marijuana is a Schedule I drug and is illegal to prescribe or use federally, hospitals must seriously consider if they will allow patients who have a license to use marijuana while admitted as an inpatient. Marijuana cannot be allowed in the pharmacy, and hospital employees cannot administer the drug to a patient.

Opioids – Addressing the Epidemic of Addiction in Oklahoma

Hospitals see firsthand the effect of opioid abuse, addiction and overdoses in the communities we serve in Oklahoma. In 2015, Oklahoma providers wrote 101.7 opioid prescriptions per 100 persons (3.97 million prescriptions).

Emergency department (ED) visits for opioid overdoses rose 30 percent in all parts of the U.S. from July 2016 through September 2017. People who have had an overdose are more likely to have another, so being seen in the ED is an opportunity for action. EDs can provide naloxone, link patients to treatment and referral services, and provide health departments with critical data on overdoses. ED data provide an early warning system for health departments to identify increases in opioid overdoses more quickly and coordinate response efforts. (CDC, Vital Signs, March 2018)

The 2018 legislative session saw the passage of several pieces of legislation to address the opioid epidemic in Oklahoma:

Mandatory Electronic Prescribing for Scheduled Drugs, HB 2931 will become effective Jan. 1, 2020. The bill requires the use of electronic prescribing for all scheduled II, III, and IV drugs. The bill requires all practitioners to register with the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) by Jan. 1, 2020. All prescriptions are to be issued on official prescription forms from OBNDD.

Opioid Pain Management, Pill Counts and Disciplinary Actions passed in SB 1446, which requires the board of medical licensure to require a licensee to receive not less than one hour of education in pain management or opioid use and addiction each year preceding an application for renewal of a license with a few exceptions. The bill restricts initial prescriptions for opioids limited to a seven-day supply. SB 1446 requires a review of the course of treatment for any patient who is continuously
prescribed any opioid or other Schedule II controlled substance for three months. This bill applies only to MDs and perhaps DOs but does not apply to any other prescribers. Please note the exemptions from SB 1446 include patients who are receiving active treatment of cancer, in hospice, receiving palliative care, or residents of a long-term care facility. There are two sections of SB 1446 impacting minors – informed consent and Patient-Provider Agreements for pain management.

A document titled “Oklahoma Senate Bill 1446 – Best Practice for an Act Regulating of Opioid Drugs” issued in late October 2018 was the result of collaboration by the Oklahoma Hospital Association working with Oklahoma State Medical Association (OSMA); Oklahoma Osteopathic Association (OOA); the executive staff of the Oklahoma State Medical Licensure Board; the executive staff of the Oklahoma State Board of Osteopathic Examiners; and many others. This document found on www.okoha.com is an attempt to alleviate the confusion surrounding the passage of SB 1446, which limited the writing of not only Schedule II opioids but all opioids by physicians. OHA has interpreted SB 1466 to apply to all settings where a prescription is being filled at a retail pharmacy. If the patient is admitted and is only inpatient, SB 1466 does not apply under the language in the bill. Once the patient is discharged from acute care and is discharged as an outpatient, SB 1446 applies.

Workplace Violence

Violent behavior is always a risk in a medical center, particularly in the emergency department (ED), the bustling point of intake. In general, EDs throughout metro areas in Oklahoma have experienced an increase in violent incidents involving patient-to-patient and patient-to-staff assaults. Increased volumes in the ED present a challenge to manage patient acuity safely. Workplace violence experiences in the hospital have a negative impact on staff, including increased levels of stress, heightened emotions, absenteeism and anxiety. These have become major drivers of job dissatisfaction, resignation and staff turnover in hospital staff.

Workers in hospitals, nursing homes, and other health care settings face significant risks of workplace violence. From 2002 to 2013, the rate of serious workplace violence incidents (those requiring days off for an injured worker to recuperate) was more than four times greater in health care than in private industry on average. In fact, health care accounts for nearly as many serious violent injuries as all other industries combined. Many more assaults or threats go unreported. (U.S. Department of Labor, Occupational Safety and Health Administration, “Worker Safety in Hospitals,” 2015)

In 2013, the broad “health care and social assistance” sector had 7.8 cases of serious workplace violence per 10,000 full-time employees. Other large sectors such as construction, manufacturing, and retail all had fewer than two cases per 10,000 full-time employees. Patients are the largest source of violence in health care settings, but they are not the only source. In 2013, 80 percent of serious violent incidents reported in health care settings were caused by interactions with patients. Other incidents were caused by visitors, coworkers, or other people. (USDA, “Workplace Violence in Healthcare,” 2015)
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Glossary of Terms

Accreditation
Certification by a recognized organization that an individual, a service or a facility has met a set of standardized criteria, typically determined by a process set by the certifying organization.

Acute Care Hospital
A facility that provides services designed to meet the needs of patients who require short-term care for a period of less than 30 days.

Allied Health Professional
Persons who are not nurses or physicians and who have special training and are licensed when necessary, who work under the supervision of a health professional and provide direct patient care. These include, but are not limited to, respiratory, physical and occupational therapists; radiology technologists and technicians; medical laboratory technologists and technicians; and surgical technologists.

Ambulatory Care
Health care services provided on an outpatient basis, where no overnight stay in a health care facility is required.

Ambulatory Surgical Center
A facility equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services available on call, and registered professional nursing services available on site while patients are in the facility. Provides services for patients to recover for a period not to exceed 23 hours following surgery.

American Hospital Association
The nation’s principal trade association for hospitals with offices in Washington, D.C., and Chicago.

Ancillary Care Services
Diagnostic or therapeutic services, such as laboratory, radiology, pharmacy and physical therapy, performed by non-nursing departments.

Any Willing Provider
Terminology relating to legislation that would require managed care plans to allow any individual physician or other provider to participate on the provider panels they do business with.

Bad Debt
The costs absorbed by hospitals or physicians for care provided to patients from whom payment was expected but no payment was received. Differs from charity care.

Certificate of Need
A method of controlling the expansion of health care facilities, services and technology in which the approval of a government agency or other empowered entity is required for a health care organization to engage in a construction or remodeling project, make a significant capital expenditure or provide a new service. Oklahoma does not currently have a Certificate of Need requirement for hospitals.

Charge
The dollar amount that a health care provider assigns to a specific unit of service to a patient. A “charge” may not be totally reflective of the actual cost involved in providing that service.

Charity Care
The unreimbursed cost to a hospital or health system for providing free or discounted care to persons who cannot pay and who are not eligible for public programs.

CMS
Centers for Medicare & Medicaid Services (see page 5).

Community Benefit
Programs or services that address community health needs, particularly those of the poor, minorities, and other underserved groups, and provide measurable improvement in health access, health status and use of health care resources.

Cost Shifting
A phenomenon occurring in the U.S. health care system in which providers are inadequately reimbursed for their costs by some payers and subsequently raise their prices to other payers in an effort to recoup costs.

Credentialing
Generally used as the basis for appointing health care professionals to an organization’s staff, it is the process used to analyze the qualifications of a licensed practitioner’s education, training, experience, competence and judgment. A credentialed staff member is permitted to perform clinical duties within the organization.

Critical Access Hospital (CAH)
Established under the Balanced Budget Act of 1997, CAHs are limited-service hospitals located in rural areas with no more than 25 acute-care beds. They receive cost-based reimbursement for Medicare patients and are relieved from some Medicare regulations.

Diagnosis Related Group (DRG)
A method of classifying inpatients into groupings based on common characteristics, each of which can be expected to require similar services. Used as the basis of the Medicare inpatient prospective payment system (PPS).

Disproportionate Share Hospital
A hospital with a disproportionately large share of low-income patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

HIPAA
Health Insurance Portability and Accountability Act (see page 23).
**HCAHPS**
Hospital Consumer Assessment of Healthcare Providers and Systems (See page 13).

**Hospital Acquired Condition**
A condition that develops while a patient is in the hospital, such as an infection, a pressure ulcer or some type of injury.

**Licensed Beds**
The maximum number of beds authorized by a government agency for a health care organization to admit patients.

**Long-Term Acute Care Hospital (LTAC)**
A hospital providing specialized care to medically complex patients who usually require an extended hospital stay.

**Long-Term Care Facility (LTCF)**
Any residential health care facility that administers health, rehabilitative or personal services for a prolonged period of time.

**MRSA**
An acronym for methicillin resistant staphylococcus aureus. This is a microscopic organism that causes infections in many places in and on the body. While “staph” is a common organism, it has evolved so that many MRSA strains are currently resistant to several different antibiotics. S. aureus is sometimes termed a “superbug” because of its ability to become resistant to several antibiotics. MRSA is found worldwide.

**Outpatient Prospective Payment System (OPPS)**
A determined payment rate for a Medicaid outpatient procedure regardless of services rendered or the intensity of the services.

**Payer**
An organization (such as the federal government for Medicare or a commercial insurance company) or person who directly reimburses health care providers for their services.

**Present Upon Admission (POA)**
Whether or not a patient has a certain condition upon the time of being admitted to a hospital. These conditions include different types of infections and pressure ulcers.

**Prospective Payment System (PPS)**
A system in which payment for services is determined before the services are actually provided and that amount is reimbursed to the provider regardless of the actual cost of services.

**Hospital Provider Fee**
The hospital provider fee is the informal name of the Supplemental Hospital Offset Provider Program (SHOPP). SHOPP was passed in 2011 by the state Legislature as a public-private partnership to allow hospitals to pay a fee as the state share to draw down additional federal dollars for the state Medicaid program. (See page 7.)

**Quality Measure**
Also called a quality indicator, this is a specific process or outcome that can be measured.

**Serious Adverse Event**
An unexpected event that happens during a hospital admission that results in harm or injury to a patient.

**Specialty Hospital**
A limited-service hospital designed to provide one medical specialty such as orthopedic or cardiac care. Also called a niche or boutique hospital.

**Swing Beds**
Acute care hospital beds that can also be used for long-term care, depending on the needs of the patient and the community. Only those hospitals with fewer than 100 beds and located in a rural community, where long-term care may be inaccessible, are eligible to have swing beds.

**Telemedicine**
The use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status. Includes a growing variety of applications and services using two-way video, email, smartphones, wireless tools and other forms of telecommunications technology. Telemedicine is not a separate medical specialty.

**Telehealth**
The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Telehealth is different from telemedicine because it refers to a broader scope of remote health care services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

**Trauma**
An injury or injuries caused by external force or violence. Trauma injuries may range from minor to severe, from obvious to non-apparent and may include single or multiple injuries.

**Trauma System**
An organized approach to facilitating and coordinating a multidisciplinary system response to severely injured patients.

**Uncompensated Care**
Care given for which payment is not received, or for which only a portion of the cost is reimbursed. Includes charity care, Medicaid underpayments, legislated care underpayments and bad debt.

**VBP**
Value Based Pricing. A key element of the Affordable Care Act was a push for “value-based pricing,” using the authority of the Centers for Medicare & Medicaid Services (CMS) to experiment with pricing incentives to reduce overuse in clinical care. In essence, the plan consisted of CMS and private insurers trying to transfer the actuarial risk of patient care to providers, counting on the new financial incentive to change behavior.