2013

Oklahoma Hospitals

Resource Guide for *Elected Officials*

Oklahoma Hospital Association

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A Resource Guide for Elected Officials

Purpose

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.

The Oklahoma Hospital Association

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 more than 130 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 Patti Davis or Lynne White (405) 427-9537, davis@okoha.com, lwhite@okoha.com or go to www.okoha.com.*

The information in this document is current at publication date of February 2013.

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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, speciality 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 27).

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 39 hospitals are owned by a religious organization or charitable foundation.

City and/or county-owned hospitals

These 42 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 a complete list of *Oklahoma hospitals* by size and type, see Appendix I on Page 23.

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. Sixty Oklahoma hospitals are for profit. 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 in the past decade, 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 and 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 27) as other hospitals. Further, there are some differences in regulatory requirements. There are 34 CAHs in Oklahoma.

System hospitals

System hospitals may be managed or owned by a corporate entity. A hospital system may have a collection of any of the hospitals previously described such as for profit, not-for profit, 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 four 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.

Economic Impact

The Health Care Industry in Oklahoma

The health care industry is the second largest employing sector 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:

- Provided 198,636 jobs with approximately 141,032 additional jobs created indirectly in other industry sectors according to 2004 data.
- Directly contributed $6.5 billion to Oklahoma's Gross State Product (GSP) in 2003.
- Directly and indirectly contributed $11.7 billion to the state's Gross State Product (GSP) in 2003.

Economic Impact of Oklahoma Hospitals

According to the American Hospital Association's 2011 survey, Oklahoma's 158 hospitals:

- Employ 75,369 persons.
- Deliver 50,058 babies yearly.
- Provide for 495,023 inpatient admissions, 2,097,888 emergency room visits, and 6,749,328 other outpatient visits.
- Have an average daily inpatient census totaling 7,857.
- Generate $9,287,039,645 in net revenue (excluding tax revenue).
- Have annual expenses of $9,579,046,429.
- Pay salaries and wages of $3.426 billion.

Source: AHA Annual Survey 2011

Health Care's Shifting Environment

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 upon 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

On June 28, 2012, the U.S. Supreme Court ruled that the Affordable Care Act (ACA) was constitutional as passed by the U.S. Congress on March 23, 2010. The only change in the ACA ruling was the Court's decision that states cannot be required to expand Medicaid coverage beyond existing current Medicaid programs.

The hospital industry, including American Hospital Association, agreed to $155 billion in cuts from the Medicare program (2013-2022) to be offset by an insurance uptake rate of 94 percent of the nation's population. Oklahoma hospitals are expected to experience $2.4 billion in cuts. 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. The Congressional Budget Office affirms that the ACA will reduce the deficit by trimming the growth of the cost of health care.

Expanding Medicaid coverage would provide coverage mostly to childless adults whose income is below 133 percent of the federal poverty limit. For a family of two, this would be a family income that is below $20,123. It is anticipated that approximately 200,000 more Oklahomans could qualify for Medicaid, if expanded. The first three years would be paid for with 100 percent federal funding with a sliding scale after that to a 90 percent/10 percent participation rate with federal/state match in 2020.

OHA has prepared fact sheets on various topics of the Accountable Care Act that are of interest to hospitals. Fact sheets can be found at www.okoha.com/aca and include:

- Disproportionate Share Hospital Payment Reductions
- Employer Provisions to Provide Health Care
- Financing the ACA
- Health Insurance Exchanges
- Impact on Oklahomans
- And more

Increasing Public Transparency

Pricing

In 2007, the Oklahoma Hospital Association introduced a user-friendly website that allowed consumers to view inpatient prices for hospitals in their communities and across the state. The site, www.OKHospitalPricing.org, enabled consumers to search a database of hospital prices for most inpatient hospital procedures or diagnoses, such as a C-section or a total knee replacement. Pricing information for these services was taken from inpatient discharge data reported by hospitals to the Oklahoma State Department of Health. At the time, this information on hospital prices was not generally available to the public.

In 2011, the Oklahoma State Department of Health began a public web service offering similar information, the Oklahoma Hospital Quality Reports, 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 under the quality reports at: https://www.phin.state.ok.us/ahrq/MONAHRQ%202010/index.html. Because the state now provides this information for the public, OHA plans to take down its hospital pricing transparency site.

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) require that hospitals 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 a hospital must report grows yearly. In 2013, acute hospitals must report on 65 inpatient measures and 12 outpatient measures. In addition, acute long term care hospitals must report on four measures, psychiatric hospitals on six measures and rehabilitation hospitals on two measures. Medicare uses these indicators to determine the level of payment a hospital receives.

To view this hospital quality data, go to www.hospitalcompare.hhs.gov.

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

Medicare pays predetermined fixed amounts for services based on the patient's diagnosis and treatment. This is known as a DRG, which means a diagnosis related group.

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 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 The Joint Commission 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. Half of Oklahoma hospitals are Joint Commission accredited.
- DNV (Det Norske Veritas), a worldwide health care accreditation program, 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 (D.O.). HFAP has deeming authority from CMS.

Medicare is overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS), and is administered through contractors known as Medicare Administrative Contractors (MACs). The MAC for hospitals in Oklahoma and 10 other states, effective Oct. 29, 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 Camp Hill, Penn.

Medicare consists of:

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

Medicaid

Also established 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 and Medicaid Services (CMS).

Oklahoma's Medicaid program is known as SoonerCare. The Oklahoma Health Care Authority is the regulatory agency.

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 with the national average. **This formula has not changed in 47 years.** This calculation changes yearly and always impacts funds available for Medicaid. States with lower incomes receive more federal assistance. The minimum FMAP is 50 percent. Oklahoma's FMAP for 2013 is 64.00 percent. In times of relative prosperity for the state, Oklahoma's FMAP is decreased, reducing federal contributions to Oklahoma's Medicaid program. Oklahoma's FMAP is higher than average because of our lower than average per capita income.

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

Populations Eligible for Medicaid in Oklahoma

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

*Federal Poverty Level; **Supplemental Security Income

Source: Oklahoma Health Care Authority 2012

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 4).

See chart below 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 State Children's Health Insurance Program (SCHIP). 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.

SCHIP - 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, SCHIP allows states to cover additional children in families with incomes that are modest but too high to qualify for Medicaid. SCHIP funding uses an FMAP formula that assigns a higher share of the program's cost to the federal government than the Medicaid program does. This is about a three-to-one match, meaning for every $1 the state allocates, the state receives $3 from the federal government. For 2013, Oklahoma's enhanced FMAP for SCHIP is 74.80 percent.

- On Feb. 4, 2009, President Obama signed into law the 2009 SCHIP Reauthorization Act through September 2013. The program is funded through a 62 cent increase in the federal tax on cigarettes.

2013 Poverty Level Guidelines
as published in the Federal Register on January 24, 2013
All states except Alaska & Hawaii - annual income

Family Size	Federal Poverty Guideline	37% FPL (1)	133% FPL (2)	185% FPL (3)	200% FPL (4)
1	$11,490	$4,251	$15,282	$21,257	$22,980
2	15,510	5,739	20,628	28,694	31,020
3	19,530	7,226	25,975	36,131	39,060
4	23,550	8,714	31,322	43,568	47,100
5	27,570	10,201	36,668	51,005	55,140
6	31,590	11,688	42,015	58,442	63,180
7	35,610	13,176	47,361	65,879	71,220
8	39,630	14,663	52,708	73,316	79,260

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
(4) Insure Oklahoma income limit

Medicaid by the Numbers

Medicaid (SoonerCare) Eligibility

Poor elderly, disabled, pregnant women 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 SFY2012

1,007,356 enrolled members consisting of:
396,860 Adults/average expenditure per year including nursing home care – $6418
610,496 Children/average expenditure per year – $2553

Medicaid: A State and Federal Partnership with Matching Funds

SoonerCare FMAP* – 64% federal funds/36% state funds
*Federal Medical Assistance Percentage

Oklahoma Medicaid – 38,968 Providers of Care

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

Optional Benefits Covered By Medicaid

Impacts 200,000 Oklahomans at a cost of $332 million (total) ($119.5 million state, applying 36%) covering:

Prescription drugs	188,946 adults	$197,618,120
Behavioral health services	23,160 adults	$55,443,616
Dialysis	2,161 adults	$6,842,586
Durable medical equipment *(such as wheelchairs, diabetic supplies, etc.)*	57,639 adults	$49,281,653
Podiatry	12,099 adults	$2,055,309
Dental	36,048 adults	$19,471,250
Eye-care & Exams	18,224 adults	$1,468,302

2010 Medicaid Budget Cuts Impacting Providers are Still in Effect

Across-the-board budget reductions of 3.25% to all providers include:

- Reduction in co-insurance/deductible payments
- Behavioral health payment cuts for residential treatment for children
- Reduced pharmacy coverage and rates
- Reduced rates for dental services
- Reduced rates for durable medical equipment
- Additional auditing on claims

Supplemental Hospital Offset Payment Program (SHOPP)

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 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 money 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 six 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.

The Supplemental Hospital Offset Payment Program assesses hospitals 2.5 percent of annual net patient revenue to initially generate approximately $152 million annually for the state's share, to garner a $269 million in federal funding for a total of $421 million. Of the $421 million, $338 million is paid to hospitals as supplemental payments for care provided to cover the unreimbursed cost of Medicaid (SoonerCare) patients and $83 million is used to maintain current SoonerCare payment rates for all providers to ensure access to care.

Seventy-seven hospitals participate in the assessment, while 71 hospitals are excluded, including critical access hospitals, 14 long-term care hospitals, 14 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.

The SHOPP act provides for a sunset of Dec. 31, 2014. The program has worked as anticipated and has provided stability in the Medicaid program. The Oklahoma Hospital Association intends to pursue legislation to extend this sunset provision.

Insure Oklahoma - *Public/Private Health Insurance Partnership*

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. ESI is available to businesses with 50 to 99 employees. 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.

Individuals are responsible for minimal premiums and any applicable deductibles and co-payments. In September 2010, the IP 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 2012 includes: businesses – 4,811; ESI enrollees – 16,525; and IP enrollees – 13,694 Total enrollees: 30,219.

Funding for the program comes from Oklahoma's tobacco tax which is the state's share and is matched about $2 (by the federal government) for every $1. For more information regarding Insure Oklahoma, see www.insureoklahoma.org.

Employees Group Insurance Division (EGID)

The Employees Group Insurance Division (EGID), formerly the Oklahoma State & Education Employees Group Insurance Board (OSEEGIB), provides 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 Council (EBC) 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.

The EBC, along with EGID, became part of the state's Office of Management and Enterprise Services (formerly the Office of State Finance) in 2012.

Workers' Compensation

The Oklahoma Workers' Compensation Court publishes a Schedule of Medical and Hospital Fees, which sets the rates every two years 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 www.owcc.state.ok.us.

Indian Health/Tribal Services

The Indian Health Service 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 1 on page 23.)

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

Hospital Payments

Oklahoma's 158 hospitals have total annual expenses of $9.6 billion according to the American Hospital Association's 2011 Annual Survey.

Most Oklahoma hospitals depend heavily on reimbursement from services provided to Medicare and Medicaid patients. These two programs cover approximately one third of the population, but provide close to half of the typical hospital's revenue.

Oklahoma Hospital Patient Revenue (in $ millions)

	Gross Charges	Net Revenue	% of Net Revenue
Medicare	$ 11,081	$ 3,043	34.5%
Medicaid	4,127	1,074	12.2%
Other third-party payers	9,112	3,986	45.2%
Self-pay revenue	1,986	717	8.1%
Total	$ 26,306	$ 8,820	100%

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 usually pay the lowest rates.
- Private (commercial) health plans pay rates that are negotiated between the payer and the hospital through contracts thus 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.

Billing & Collections

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 the Medicare payment for the cost of services or the hospital's whole cost-to-charge ratio times billed charges. This 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 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, these 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 law 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

In 2007, the Oklahoma Hospital Association introduced a user-friendly website that allowed consumers to view inpatient prices for hospitals in their communities and across the state. The site, www.OKHospitalPricing.org, enabled consumers to search a database of hospital prices for most inpatient hospital procedures or diagnoses, such as a C-section or a total knee replacement. Pricing information for these services was taken from inpatient discharge data reported by hospitals to the Oklahoma State Department of Health. At the time, this information on hospital prices was not generally available to the public.

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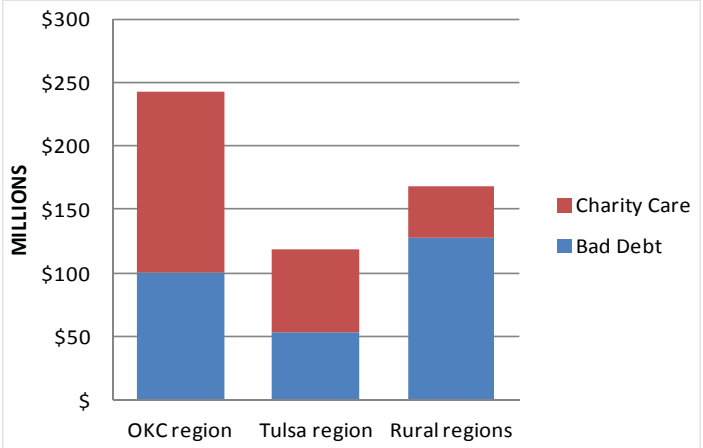
This Oklahoma hospital quality and pricing information can be found at: https://www.phin.state.ok.us/ahrq/MONAH-RQ%202010/index.html. Because the state now provides this information for the public, OHA plans to take down its hospital pricing transparency site.

To view this hospital quality data, go to www.hospitalcompare.hhs.gov.

Uncompensated Care

Oklahoma hospitals provide more than $500 million in uncompensated care annually, according to the American Hospital Association's annual hospital survey conducted in 2012. 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.

2011 Uncompensated Care Cost



The Uninsured in Oklahoma

- Nearly 1 in 6 (636,415) Oklahomans is uninsured, 17 percent of our citizens.[1]
- Oklahoma ranks 15th highest in the nation for its percent of uninsured citizens.[2]
- 1 in 14 Oklahoma children (67,332) is uninsured, 7 percent.[1]
- Oklahoman ranks 15th in the nation for percent of uninsured children.[2]
- Oklahoma's uninsured population costs Oklahomans $954 million annually in cost shifting. This figure amounts to the 3rd highest "hidden tax" burden in the nation.[2]

1. According to US Census Bureau, Current Oklahoma Population Survey, Annual Social and Economic Supplement, Table Creator, 2011 data collected in 2012. Percentages are rounded.

2. According the Kaiser Commission on Medicaid and the Uninsured, October 2012 (2010-2011 data).

3. Kenneth Thorpe, PhD, "Paying a Premium: The Added Cost of Care for the Uninsured," Families USA 2009.

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:

- Providing free or low-cost health screenings, health education and wellness programs, counseling services, transportation and immunizations.
- Providing medical, nursing, and allied health education/ training.
- 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 which generate a negative profit margin, such as burn centers and trauma centers.

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

These 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 raise their quality standards, keep patients safe and improve their efforts.

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 three areas:

1. Clinical quality
2. Patient safety
3. Patient satisfaction

Clinical quality - Clinical quality is the actual medical care that a patient receives. Process measures are one way to measure this type of quality. They are founded on proven evidence-based medicine. These measures assess the process of care a patient receives based on a disease-specific category. For example, did a heart attack patient receive an aspirin upon arrival in the emergency room? Clinical quality also considers outcome measures such as readmissions and mortality.

Patient Safety - Patient safety in a hospital is defined as keeping the patient safe from harmful events such as errors and complications. These events include infections, injuries and medication errors. Hospitals have extensive programs in place to prevent and monitor 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.

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 chart page 13). 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 www.ok.gov/health/Protective_Health/Medical_Facilities_Service/Facility_Services_Division/index.html.

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.

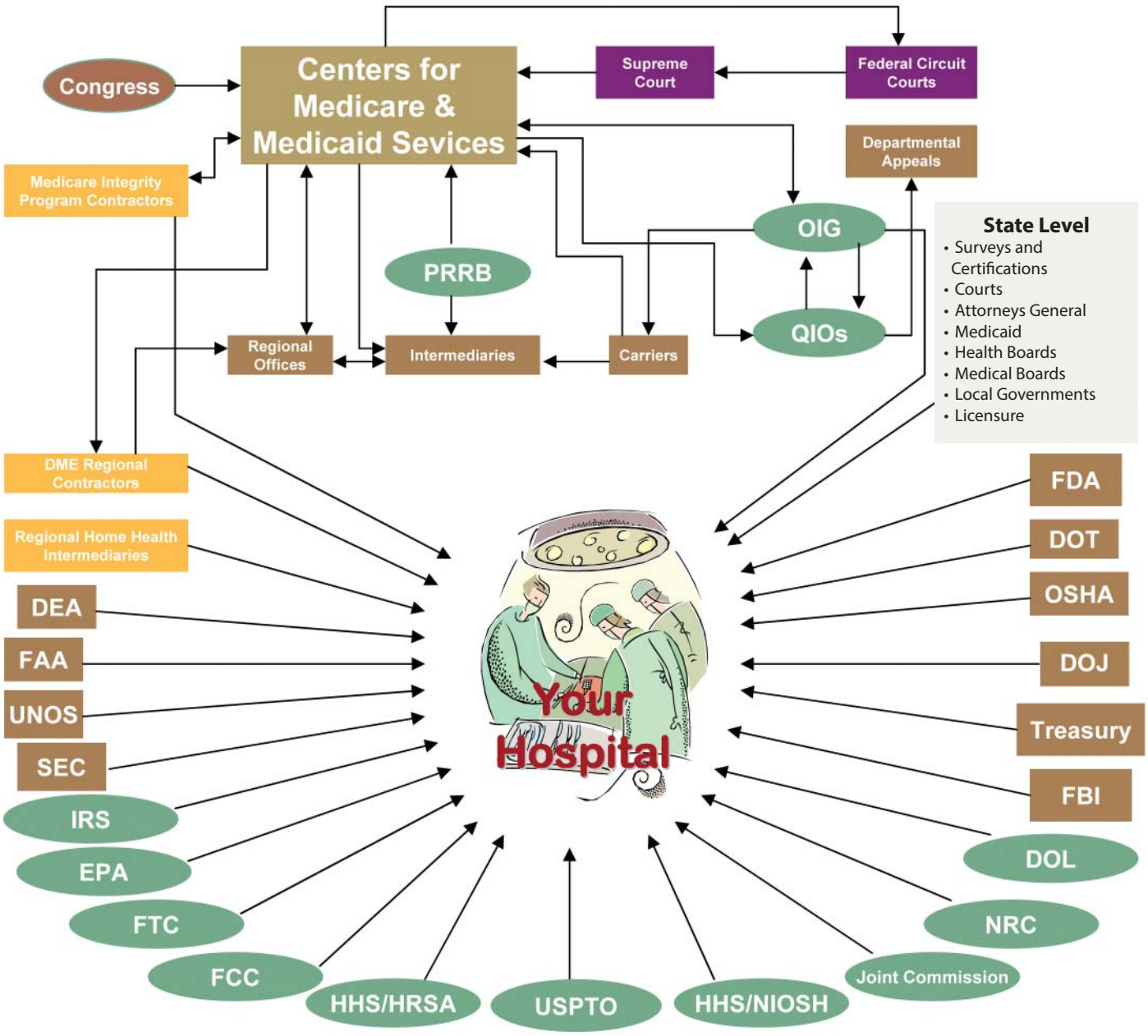
Medicare continually monitors and reviews certain aspects of care and manages patient complaints. It is required that hospitals participate in the Medicare Care Review programs and processes related to these activities.

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 (see page 5).

Medicare Quality Improvement Organization - Hospitals also voluntarily participate in the Medicare Quality Improvement Program. The Medicare Quality Improvement Organizations (QIO) are private organizations that contract with Medicare to set goals and implement new quality improvement projects every three years. They also perform the statutory requirement to monitor the quality of care provided by performing chart review and investigating complaints.

Quality, Patient Safety and Regulatory Oversight



Key to Chart

DEA: Drug Enforcement Administration
FAA: Federal Aviation Administration
OPOs: 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
NRC: Nuclear Regulatory Commission
DOL: Department of Labor
FBI: Federal Bureau of Investigation
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

The Oklahoma Foundation for Medical Quality (OFMQ) is the Oklahoma QIO. OFMQ assists physician offices, hospitals 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 the pay for performance program, also called the "Value Based Purchasing" program (VBP), hospitals are at risk to lose reimbursement in several different areas including:

- Clinical processes
- 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)

In FFY 2013, hospitals could lose up to 6 percent of their reimbursement from Medicare, depending on how they perform compared to other hospitals in the U.S. This amount of loss will continue to escalate. The number of conditions and measures that are included in the VBP program will increase each year. Many of these measures are available on www.hospitalcompare.hhs.gov.

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.hospitalcompare.gov. Many hospitals are meeting together to identify and share ways they can improve the customer experience.

Current OHA Initiatives

Every Week Counts

To address Oklahoma's higher than national average infant mortality rate and high prematurity rates, Oklahoma birthing hospitals have implemented policies and processes to eliminate early elective deliveries of babies who have not yet reached 39 weeks of pregnancy. Babies born earlier than 39 weeks have more difficulty in areas of breathing, temperature control and managing bilirubin. Because of this, they are admitted to a higher level of nursery care more often than babies born at 39 or 40 weeks.

Since April 2011, the rate of early elective deliveries has been decreased by 77 percent to a rate of .89 percent. At the beginning of the initiative, eight babies were born too early every day in Oklahoma. By Sept. 30, 2012, that number was decreased to 2 babies.

Hospital Engagement Network

Through the Partnership for Patients initiative, 81 Oklahoma hospitals are working to reduce potentially avoidable readmissions and patient harm in these nine areas:

- Patient falls
- Pressure ulcers
- Adverse drug events
- OB harm
- Central line blood infections
- Urinary catheter infections
- Surgical site infections
- Ventilator associated pneumonia
- Venous Thrombus Embolism (blood clots)

Hospitals form teams dedicated to each of these topics to develop individualized interventions. They also take the time to meet together to learn and share with each other. Data on most of these topics are reported to Medicare and will be transparent to consumers in 2013.

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) require that hospitals 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 a hospital must report grows yearly. In 2013, acute hospitals must report on 65 inpatient measures and 12 outpatient measures. In addition, acute long term care hospitals must report on four measures, psychiatric hospitals on six measures and rehabilitation hospitals on two measures. Medicare uses these indicators to determine the level of payment a hospital receives.

To view this hospital quality data, go to www.hospitalcompare.hhs.gov.

Health Care Workforce

Nursing and Allied Health Recruitment

Oklahoma Health Care Workforce Center

Initially created through legislation (SB 1394) in 2006, the Oklahoma Health Care Workforce Center operates as a private nonprofit organization that acts as a clearinghouse of information and activities focused on health care workforce supply and demand issues. All state programs are to coordinate efforts and resources with the Center. The Center currently receives no appropriation from the Legislature and must instead rely on cash and in-kind donations from the Oklahoma State Regents for Higher Education and the Oklahoma Department of Career and Technology Education, as well as funds from the provision of program services.

The premiere program offered by the Center is The Clinical Hub, an online tool to help hospitals and schools manage the placement of nursing and other health care students in clinical rotations. The Clinical Hub was developed in response to a shortage of health care professionals and the need to increase the education pipeline. The tool provides information regarding hospital capacity to handle rotations and helps schools increase and maximize rotations for their students. In addition, The Clinical Hub can provide information to state government to help with decision making regarding the allocation of education and workforce resources.

Other programs provided by the Center include an annual conference focused on the use of simulators in health care and www.okhealthcareers.com, a website designed to give children, teens, and adults the information they need to choose a health care career. For more information about the Center and its programs, go to www.ohcwc.com.

Health care job seekers log on to OKHospitalJobs.com

Health care job seekers across Oklahoma have found a valuable tool in www.okhospitaljobs.com, an online health care job search tool hosted by the Oklahoma Hospital Association. Numerous hospitals and health clinics post jobs to the site, which launched in 2003. OKHospitalJobs.com has more than 20,000 unique visitors each year. More than 1,000 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, 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 115 new medical students each year.

In 2012, the Oklahoma Hospital Residency Training Program Act established new primary care residency training programs, focused upon 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 appli-

cants and provides for "startup" costs associated with establishing a hospital-based Medicare supported graduate medical education residency program. The funding will allow for eight primary care residencies funded at $75,000 each in up to five hospital locations that meet criteria for residency requirements. It is anticipated that this seven-year funding plan will create 160 new physicians per year once implemented to serve Oklahoma's primary care needs.

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 members are three practicing medical doctors and two osteopathic physicians. 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.

Physician shortages in Oklahoma

- 66 of Oklahoma's 77 counties fail to meet the national standard of one physician for every 3,500 people.
- According to the American Medical Association, Oklahoma ranks last in the nation in physician to patient ratio.
- Oklahoma ranks third lowest among rural states for maldistribution of physicians, with only 184 physicians per 100,000 people.
- Only 6 percent of primary care residents desire a rural practice.
- Oklahoma's 2010 Health Improvement Plan proposed by the State Board of Health listed training and recruitment of primary care physicians as one of the top five issues Oklahoma must address.

Medical Licensing and Credentialing

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 Legislature. Licensure boards are funded by fees paid by the licensee.

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.

For more information...

Oklahoma Board of Medical Licensure & Supervision
www.okmedicalboard.org

Oklahoma Board of Osteopathic Examiners
www.docboard.org/ok/ok.htm

Oklahoma Board of Nursing
www.youroklahoma.com/nursing

Credentialing

Credentialing is the process used 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 institution's medical staff. The state does not credential health care providers for the purpose of working in hospitals or other health care facilities.

Health Information

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.

To qualify, hospitals must achieve a number of specific capabilities known 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.

Critical Access Hospitals receive an enhanced cost reimbursement for their EHR as their Medicare incentive, and other hospitals get payments based on inpatient volume. The Medicare incentives available to hospitals other than Critical Access Hospitals are typically several million dollars.The Medicaid program's EHR incentives require similar achievements, and are available to hospitals with at least 10 percent Medicaid patient volume. Unlike most Medicaid expenditures, the EHR incentives are fully paid by the federal government without state participation. The federal government also pays 90 percent of the state's cost of administering the incentive program.

Beginning in 2015, hospitals and physicians who are not meaningful users of certified EHRs will face reduced payments from Medicare.

EHRs will allow for increased efficiency and less redundancy in patient care.

State Health Information Exchange

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

The 2010 Legislature created the Oklahoma Health Information Exchange Trust (OHIET) as the state-designated entity responsible for this project. OHIET and its partners provide information, education, funding, training, policy development and other support on health information technology (HIT) and health information exchange (HIE) within the State and region.

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, require 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.

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, a state question was passed by the people to initiate a tobacco tax. Funding from the tax enabled the state to greatly assist in the development of a statewide trauma system.

Prior to the enactment of the tobacco tax and other legislative funding initiatives, also enacted in 2004, the state's only Level 1 Trauma Center, OU MEDICAL CENTER, announced a potential downgrade if adequate funding was not appropriated.

Stroke Protocols - The trauma system requires that all hospitals be designated as one of four levels according to their ability to care for sick and injured patients. Hospitals are also given a primary or secondary designation according to their ability to aggressively treat stroke patients. With these two designations, the emergency medical system (ambulances) is informed of the most appropriate hospital to which to transport patients.

Trauma Legislation

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.
- Requires the development of regional trauma quality improvement activities and a state Medical Audit Committee to review these activities.

Source: Oklahoma State Department of Health

Trauma Fund

The Trauma Fund is a continuing fund that is available from year-to-year to support the state trauma system. 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
- Tobacco tax

Revenues and Distributions

Ninety percent of the money received by the Trauma Fund is distributed 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 medical care.

Oklahoma Trauma Center Levels

All levels of a recognized trauma center must maintain a trauma registry and operate quality assurance processes informed by it.

Level IV: A facility which staffs a 24-hour emergency service with at least a "physician extender" such as a licensed physician's assistant, a nurse practitioner, a registered nurse or a paramedic, with special trauma training as defined by that facility. No surgical or diagnostic services are required. This is a primary referral facility, for rapid stabilization and transfer to definitive care.

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

Level II: A facility which staffs a 24-hour trauma service with at least an emergency department physician, and which maintains a surgeon-led trauma team with rigorous response standards, capable of immediate surgical intervention when necessary. 24-hour neurosurgical capacity is required. Extensive specialty services are available, including cardiac, thoracic and orthopedic surgery. This is a tertiary referral facility, capable of managing all types of trauma.

Level I: This is the highest level, with all the features of level II, plus physician anesthesia and a trauma research program. This is a trauma care teaching facility.

EMTALA

The Emergency Medical Treatment and Active Labor Act 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. If the hospital does not have the capability to treat the condition, the hospital must make an appropriate transfer of the patient to another hospital with such capability. Hospitals with specialized capabilities must accept such transfers.

Disaster Preparedness

Following the terrorist attacks on Sept. 11, 2011, 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 in to the Emergency Preparedness and Response Service, to address implications of a large scale disaster.

There are at least three comprehensive sections of Oklahoma law that encompass disasters: The Catastrophic Health Emergency Powers Act, passed in 2003; Emergency Management Act of 2003; and the Emergency Response and Notification Act. In 2012, SB178 amended the Emergency Response and Notification Act to allow for adaptive standards of care where an extreme emergency exists.

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." At the time Oklahoma's national health statistics rankings were 49th in the nation. According to the United Health Foundation, Oklahoma's 2012 national health rankings have improved and Oklahoma is currently ranked 43rd.

To implement the 2008 legislative directive, the Board of Health invited leaders in health care, lawmakers, and representatives of all segments of Oklahoma including business, labor, tribes, academia, state and local governments, professional organizations and private citizens to develop the health improvement plan. Prior to the 2009 launch of the plan, the group conducted "listening sessions" in 10 communities to seek input from Oklahomans about their most crucial health needs.

The Oklahoma Health Improvement Plan was launched in December 2009 and "addresses improving health outcomes through targeted 'flagship initiatives' of children's health improvement, tobacco use prevention, and obesity reduction. The plan also looks at the complex issue of increasing the public health infrastructure's effectiveness and accountability. Finally, the plan discusses approaches to addressing the social determinants of health – those factors such as poverty, education, access to health services, housing and transportation – that help determine whether individuals stay healthy or become ill. The plan confirms that Oklahoma ranks near the bottom in multiple key health status indicators measured at the state and national levels, including Oklahoma's infant mortality rate."

According to State Commissioner of Health Dr. Terry Cline in 2009, "The transformation of Oklahoma to a healthy state will not be possible until we have major reductions in tobacco use, increase our physical activity, and make better food choices."

Health indicators scoring strongly for Oklahoma were improvements in the infant mortality rate because of initiatives from the Oklahoma Health Care Authority and the Oklahoma Hospital Association, up-to-date immunization coverage for children 19 months to 35 months, a low incidence of infectious disease cases, an improvement in the percent of persons without health insurance (even though one in six Oklahomans are currently uninsured), and an improvement in the percent of children under age 18 living in poverty.

On the downside, a high prevalence of smoking, sedentary lifestyle, obesity, diabetes, limited availability of primary care physicians, and a high rate of cardiovascular disease deaths continue to be health challenges for the state.

For information on the Oklahoma Health Improvement Plan, visit www.health.ok.gov. For information on the 2012 state health rankings, visit www.americashealthrankings.org.

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
- Trauma Care Assistance Fund

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.

Source: Oklahoma Tobacco Settlement Endowment Trust

OHA Health Improvement Initiatives

Tobacco Cessation Initiative

With funding from the Tobacco Settlement Endowment Trust, OHA works with hospitals and their health care systems to address tobacco cessation with their employees and patients. 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."

- Implementing a brief, effective, evidence-based cessation intervention with all tobacco using inpatients and outpatients using the clinical practice guideline, Treating Tobacco Use and Dependence, endorsed by the U.S. Public Health Service and the CDC. This includes patient referrals to the Oklahoma Tobacco Helpline for multiple-call counseling and guidance through the quitting process.
- Supporting hospitals in moving toward tobacco free campus policy development and step-by-step implementation of cost-effective procedures that assist employees, visitors and patients.
- Assisting hospitals to develop supportive policies and health benefits to assist employees in tobacco cessation.
- 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.

This initiative has led Oklahoma to be recognized nationally in system cessation efforts.

Hospital workplace wellness

Oklahoma hospitals are working to lead the way to a healthier state through new initiatives aimed at not only empowering greater health and wellness among their employees, but also serving as the example for their communities. Hospitals are working hand-in-hand with individuals and organizations in their communities for better health for all Oklahomans. The Oklahoma Hospital Association has challenged hospitals to apply for the state's Certified Healthy Business program, and as a result, 55 hospitals are now certified.

In addition, the OHA board of trustees developed a program challenging hospital leaders to improve the health of their employees and communities by taking the first steps to better health. The "Your 1 2 3: Oklahoma Hospitals Advancing Wellness" initiative, challenges each hospital employee to take three steps now to improve their health, and challenges each hospital to look at three steps they can take in the community to improve health statistics in their area.

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.

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 which 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

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 17)

HCAHPS
Hospital Consumer Assessment of Health Plans Survey
(see page 12)

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.

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.

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 Purchasing (see page 14)

Notes

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