Oklahoma Hospitals

2021-2022

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 more than 135 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 Sandra Harrison or Scott Tohlen at (405) 427-9537, sharrison@okoha.com, stohlen@okoha.com, or go to www.okoha.com.

Copyright © 2021
Oklahoma Hospital Association

The information in this document is current at publication date of January 2021.

Table of Contents

Types of Hospitals 2

Current Health Care Environment 3

Affordable Care Act 3
Medicaid Expansion 3
Medicaid Managed Care 4

Financial Information 5

Funding Sources 5
Hospital Payments 10
Billing , Collections & Charity Care 11
Uncompensated Care 12
Community Benefit 12

Quality and Patient Safety 13

Mandated Quality and Safety Programs 13
Voluntary Quality and Safety Programs 13
Pay for Performance 15
Clinical Initiatives 15
Infection Control and Prevention 15
Quality Public Reporting and Transparency 16

Rural Hospitals 17

Oklahoma Is a Rural State 17
Part of a Rural Health Safety Net 17
Economic Impact of Critical Access Hospitals 17
The Backbone of the Safety Net 17

Health Care Workforce 18

Nursing and Allied Health Recruitment 18
Physician Recruitment 19
TSET Funds for Workforce Shortages 21
Licensing and Credentialing of Health Care Professionals 21

Health Information 23

Electronic Health Records 23
State Health Information Exchange 23
HIPAA 23

Telemedicine 24

Regulation of Telemedicine 24
Funding of Telemedicine 25
Physician Patent Relationship in Telemedicine 25
Telehealth 25

Trauma Care 27

Background 27
Trauma Legislation 27
Trauma Fund 28
Revenues and Distributions 28

EMTALA 28

Emergency Preparedness 29

COVID-19 29
Specialized Infectious Unit 30

Improving Oklahoma's Health 30

Oklahoma's Tobacco Tax 30
2018 Cigarette Tax Increase 30
Tobacco Settlement Endowment Trust (TSET) 31
OHA Health Improvement Initiatives 31

Appendix 1: Statutory References 33
Appendix 2: Snapshot of Oklahoma Hospitals 35
Glossary of Terms 39

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 39).

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 and 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% of Medicare cost instead of a fixed diagnostic related group (DRG) payment (see glossary page 40) 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.

For a complete list of *Oklahoma hospitals* by size and type, see Appendix 2 on page 35.

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 usually 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. These facilities typically take all patients, but will transfer acute patients to a more intensive level of care in a hospital setting. Free-standing emergency rooms must also comply with EMTALA and must post publicly if they do not accept as payment Medicare, Medicaid or other government payments.

Current Health Care Environment

Affordable Care Act

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

In passage of the ACA, the hospital industry, including the American Hospital Association, agreed to $155 billion in cuts from the Medicare program (2013-2023) to be offset by an increased insurance coverage that would result in 94% of the nation's population having coverage. Oklahoma hospitals are expected to experience $2.4 billion in cuts from 2013-2023. These reductions 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 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.

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 was appealed to the U.S. Court of Appeals for the Fifth Circuit. In a 2-1 decision, the Fifth Circuit partially affirmed the district court decision and remanded it to the district court on the issue of severability. Seventeen states, led by California, were permitted by the trial court to intervene in the case and defend the ACA. They appealed the Fifth Circuit's decision to the U.S. Supreme Court.

The U.S. Supreme Court heard oral arguments in the case of California v. Texas (known as Texas v. U.S. in lower courts) on Nov. 10, 2020. The court considered whether the repealed individual mandate provision was constitutional and whether, if unconstitutional, that provision was severable from the rest of the law. A decision on the ACA is expected in the summer of 2021 by the U.S. Supreme Court. The Texas lower court ruling has no immediate impact on any ACA program and does not give the administration clear authority to alter any ACA program. The decision of the U.S. Supreme Court is of extreme importance to the 39 states that have expanded Medicaid. According to the Kaiser Family Foundation, as of June 2019, 15 million people were enrolled in the ACA Medicaid expansion group and about 12 million of them were newly eligible under the ACA.

Medicaid Expansion

On June 30, 2020, Oklahoma voters approved SQ 802, Medicaid expansion. Medicaid expansion is now part of the Oklahoma Constitution and, when fully implemented, will offer health care to around 200,000 Oklahomans age 19-64 who make less than $17,000 a year or a family of three making less than $29,000 a year. The income level cannot exceed 133% of the federal poverty level.

The SQ 802 ballot title stated:

"The Medicaid program is funded jointly by the federal government and the State. This measure would require the Oklahoma Health Care Authority (OHCA) to try to maximize federal funding for Medicaid expansion in Oklahoma. If the measure is approved, OHCA has 90 days to submit all documents necessary to obtain federal approval for implementing Medicaid expansion by July 1, 2021."

The federal government pays 90% of the cost of expansion for newly eligible adults. The state pays 10% of the cost. This formula can only be changed by an Act of Congress. Native Americans are covered at 100% of the cost.

Oklahoma is the 37th state to pass Medicaid expansion under the 2010 Affordable Care Act. According to Families USA (June 2020), "Medicaid expansion would provide a huge infusion of federal dollars to support Oklahoma's struggling economy. With expansion, many more federal dollars would buy health

care within the state. The resulting increased economic activity would not only ensure that thousands of uninsured Oklahomans would have access to coverage, it would also create jobs and add revenue to state and local budgets."

The next step will be the enactment and implementation of funding the 10% state share by the Oklahoma Legislature with approval from the governor. Once fully implemented, it is projected that during the first five years, Medicaid expansion will create 27,280 jobs; generate $15.5 billion in new economic activity and more than $6.7 billion in labor income; and increase state and local tax revenues by $488.7 million (National Center for Rural Health Works, May 2020).

Medicaid Managed Care

Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. It is intended to reduce the cost of providing health care and providing health insurance while improving the quality of that care. However, it has attracted controversy because state governments that have outsourced Medicaid managed care to commercial organizations have had mixed results in its overall goal of controlling medical costs. Proponents and critics are also sharply divided on managed care's overall impact on U.S. health care delivery.

The Oklahoma Health Care Authority (OHCA) has utilized managed care techniques and care coordination contractors since the state's last failed attempt at managed care in the early 2000s. OHCA has a low administrative cost in administering the Medicaid program at 3.7%, whereas outsourcing the program to commercial managed care will increase administrative costs to 15% as allowed under federal law. Hospitals in Oklahoma participate in managed care programs such as Medicare Advantage and have much experience chasing payment for clean claims and dealing with denials of services and claims.

For more information on Medicaid, see pages 6-10 on Financial Information.

Economic Impact of Oklahoma Hospitals

According to the American Hospital Association's 2019 survey, Oklahoma's 146 hospitals:

- Employ 81,223 persons.
- Deliver 52,455 babies yearly.
- Provide for 462,194 inpatient admissions, 2,108,265 emergency room visits, and 8,783,245 other outpatient visits.
- Have an average daily inpatient census totaling 7,593.
- Generate $11,944,898,696 in net revenue (excluding tax revenue).
- Have annual expenses of $13,032,353,125.
- Pay salaries and wages of $4.664 billion.

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.

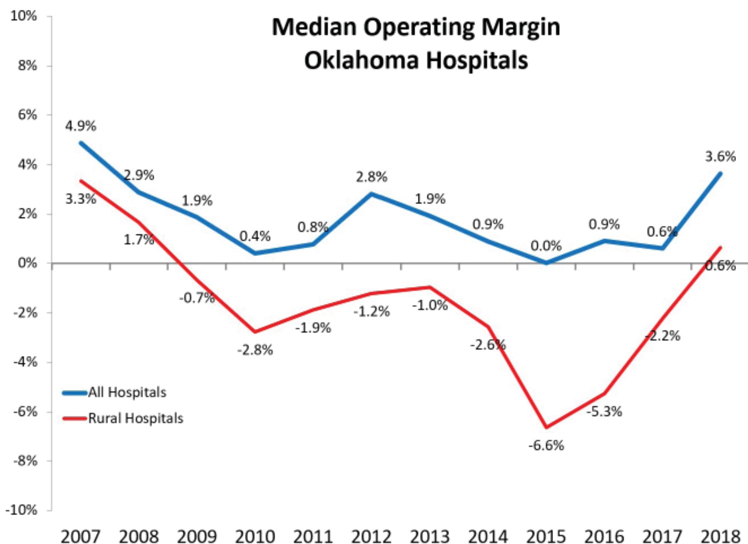
Medicare Part A and Part B have cost-sharing requirements and significant gaps in coverage. Medicare supplemental insurance, also known as "Medigap" policies, cover some of these costs, including deductibles and cost-sharing.

About 26% of Medicare beneficiaries in Oklahoma (and 40% 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%. For further information, see "Pay for Performance," (page 15).



Source: OHA Analysis of Medicare Cost Reports

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.

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%. On average, this formula has resulted in the federal government paying for about 57% of spending on Medicaid benefits nationally and states paying 43%. Oklahoma's FMAP for 2021 is 67.99%, and for 2022 will be 68.31%.

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

Populations Eligible for Medicaid in Oklahoma

Oklahoma Medicaid Expansion becomes effective July 1, 2021. State Question 802, passed by a majority vote to expand Medicaid eligibility to adults ages 19-64 whose income is 138% (133% with a 5% disregard) of the federal poverty level or lower. This equates to an estimated annual income of $16,970 for an individual or $34,846 for a family of four. More information can be found at https://bit.ly/3nkWY87.

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

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.

When Medicaid expansion begins July 1, 2021, there will no longer be categorical eligibility, only income eligibility in Oklahoma.

Even the extremely poor do not qualify for Medicaid if they do not fit into one of these categories until July 1, 2021 when expansion begins. **See chart to the right for income guidelines.**

2021 Poverty Level Guidelines

As posted by the Dept of Health & Human Services, eff. Jan. 17, 2021
All states except Alaska & Hawaii - annual income

Family Size	Federal Poverty Guideline	37% FPL (1)	133% FPL (2)	185% FPL (3)
1	$12,760	$4,721	$16,971	$23,606
2	17,240	6,379	22,929	31,894
3	21,720	8,036	28,888	40,182
4	26,200	9,694	34,846	48,470
5	30,680	11,352	40,804	56,758
6	35,160	13,009	46,763	65,046
7	39,640	14,667	52,721	73,334
8	44,120	16,324	58,680	81,622

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% 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. Oklahoma voters approved State Question 802 on June 30, 2020, expanding Medicaid coverage to adults ages 19-64 with incomes of 138% or less of the Federal Poverty Level.

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.

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 HB 1381, 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% 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.

For 2020, the Supplemental Hospital Offset Payment Program assessed hospitals 2.3% of annual net patient revenue to initially generate approximately $182 million annually for the state's share, to garner $361 million in federal funding for a total of $543 million. Of the $543 million, $453 million is paid to hospitals as supplemental payments for care provided to cover the unreimbursed cost of Medicaid (SoonerCare) patients and $90 million is used to maintain SoonerCare payment rates for physicians and other Medicaid providers to ensure access to care.

Sixty-five hospitals are required to pay the assessment for 2021, while 83 hospitals are excluded, including 40 critical access hospitals, certain specialty hospitals, and long-term care hospitals.

SHOPP is expected to grow due to Oklahoma's Medicaid expansion, which becomes effective July 1, 2021. Therefore, the SHOPP assessment rate increased from 2.3% to 2.5% as of Jan. 1, 2021.

The SHOPP Act provides for a sunset of Dec. 31, 2025.

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 2020

929,017 enrolled members consisting of:

- 325,465 Adults
- 603,552 Children

SoonerCare enrollment has increased substantially since March 2020 because of COVID-19 economic impact and relief measures (continuity of care by postponing recertifications).

Medicaid: A State and Federal Partnership with Matching Funds

SoonerCare FMAP* for 2021 – 67.99% federal funds/32.01% state funds.

Oklahoma Medicaid – 69,346 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% to all providers in 2010 were followed by 7.75% reductions in July 2014 and 3% reductions in January 2016, for total cuts of 14%. 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%.

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

The state Legislature directed OHCA to increase provider payment rates in SB 1605 (2018). Payment rates were increased 4% for long-term care facilities and 3% for most other provider types, including hospitals, effective Oct. 1, 2018. Payment rates were increased by another 5% effective Oct. 1, 2019.

**Federal Medical Assistance Percentage*
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%), the employer (25%) and the employee (15%). 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% of the federal poverty level. When Oklahoma expands Medicaid on July 1, 2021, to adults with incomes up to 138% of the federal poverty level, the ESI program will be revised to cover individuals with qualifying incomes from 138 to 200% of the federal poverty level.

The Individual Plan (IP) has also been 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. Individuals are responsible for minimal premiums and any applicable deductibles and co-payments. In January 2014, the qualifying income was decreased from 200 to 100% of the federal poverty level. When Oklahoma expands Medicaid July 1, 2021, to adults with incomes up to 138% of the federal poverty level, the Individual Plan members will gain this coverage and the Insure Oklahoma Individual Plan will end. However, the ESI coverage will continue through a waiver.

Enrollment as of November 2020 includes:

- Businesses – 3,605
- ESI enrollees – 14,819
- IP enrollees – 18,495
- Total enrollees – 33,314

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 $2.12 (by the federal government) for every $1 from the state. 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), 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, the worker 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.

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 35.)

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 146 hospitals have total annual expenses of $13 billion according to the American Hospital Association's 2019 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	$ 21,880	$ 4,352	38%
Medicaid	$6,846	$1,535	13%
Other third-party payers	$17,610	$5,289	46%
Self-pay revenue	$3,456	$319	3%
Total	**$ 49,792**	**$ 11,495**	**100%**

Source: 2019 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. For example:
  - 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.
  - Medicaid Managed Care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

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.

Signed into law on Dec. 27, 2020, the federal "No Surprises Act," Title XXVII of the Public 8 Health Service Act (42 U.S.C. 300gg–11 et seq.) was amended by adding SEC.2799A-, Preventing Surprise Medical Bills. This Amendment prohibits providers from balance billing patients for emergency services or medical care the patient reasonably could have expected to be in-network and does not allow patients to be charged more than the in-network cost-sharing amount. The proposal does not rely on a benchmark payment rate to determine out-of-network reimbursement, but instead includes a period for health plans

and providers to negotiate reimbursement, to be followed by a mediated dispute resolution process should it be necessary. The bill also includes several other provisions to help patients access certain types of care and better understand their provider networks and costs.

Billing, Collections and Charity Care

Oklahoma law requires hospitals to have a discount program for patients with household incomes up to 300% 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, 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.

The Hospital Price Transparency Final Rule, which went into effect on Jan. 1, 2021, requires hospitals to provide patients with easily accessible information about standard charges for items and services offered by hospitals. In the final rule, CMS establishes the following policies:

1. Definitions of "hospital", "standard charges", and "items and services."
2. Requirements for making public a machine-readable file online that includes all standard charges (including gross charges, discounted cash prices, payer-specific negotiated rates [but defined as charges in the final rule], and de-identified minimum and maximum negotiated rates) for all hospital items and services.
3. Requirements for making public discounted cash prices, payer-specific negotiated rates, and de-identified minimum and maximum negotiated rates for at least 300 "shoppable" services (70 CMS-specified and 230 hospital-selected) that are displayed and packaged in a consumer-friendly manner.

4. Monitoring for hospital noncompliance and actions to address hospital noncompliance-including issuing a warning notice, requesting a corrective action plan, and imposing civil monetary penalties – and a process for hospitals to appeal these penalties.

The Uninsured in Oklahoma

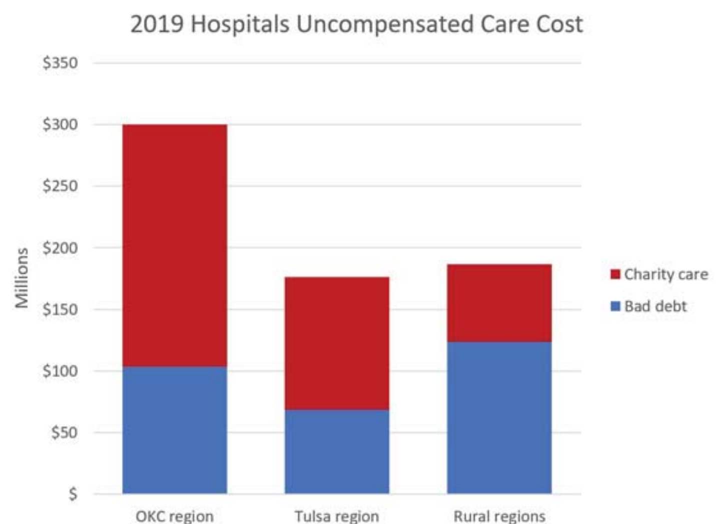
- One in seven (552,835) Oklahomans is uninsured, 14.3% of our citizens.[1]
- Oklahoma ranks second highest in the nation for its percent of uninsured citizens.[1]
- One in 12 Oklahoma children is uninsured, 8.6%.[2]
- Oklahoman ranks fifth in the nation for percent of uninsured children.[2]

[1] According to U.S. Census Bureau, 2019 American Community Survey, Table R2701.

[2] According to U.S. Census Bureau, 2019 American Community Survey, Table R2702.

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 $663 million in uncompensated care annually, according to the American Hospital Association's annual hospital survey conducted in 2020. 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.



Source: 2019 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:

- 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 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.

Quality, Patient Safety and Regulatory Oversight

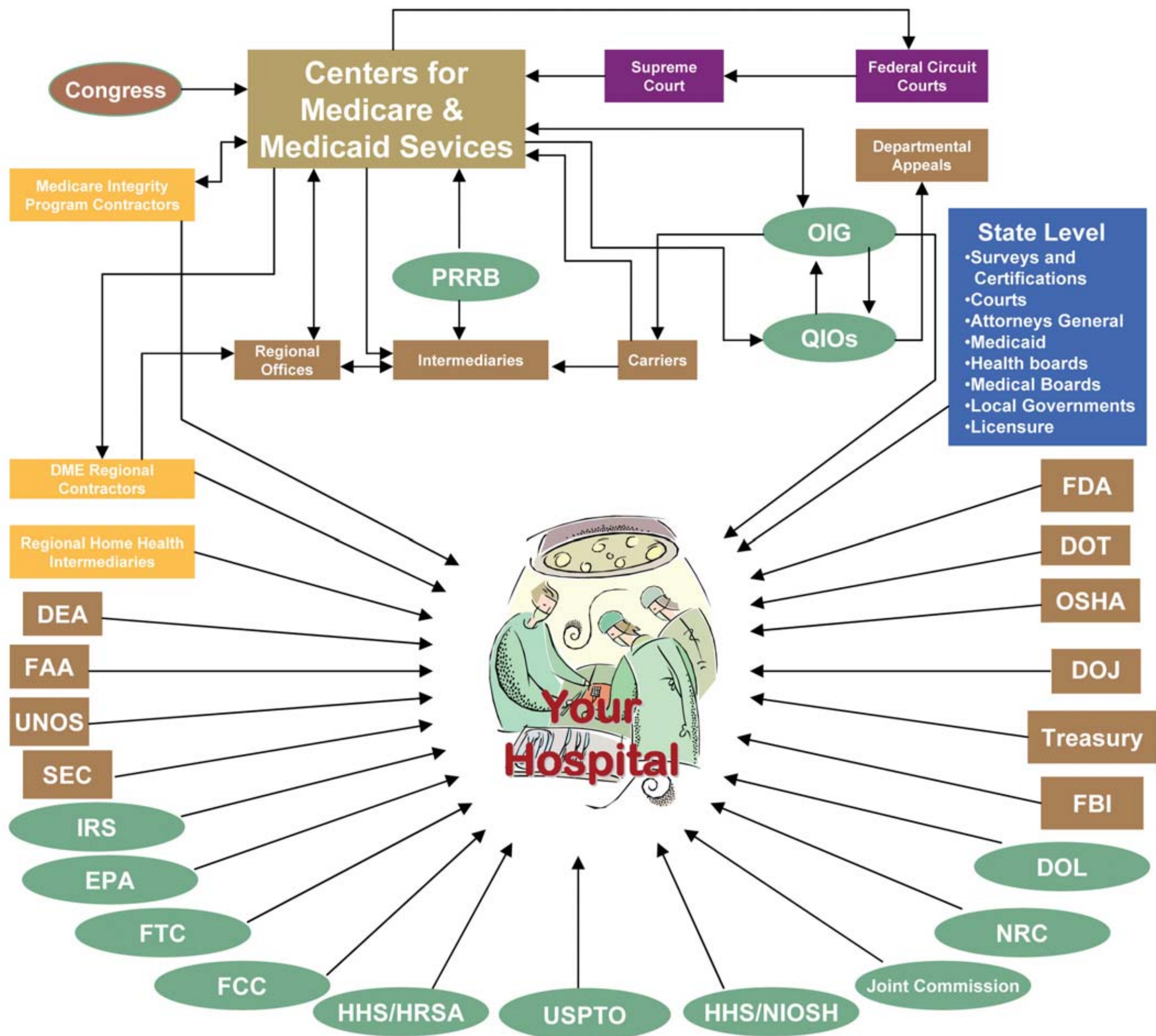


Figure 1: Regulatory entities providing oversight of the hospital industry

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

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. Telligen 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% 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. These measures and how hospitals have performed 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. All of Oklahoma's birthing hospitals participate in several initiatives including: "Every Week Counts," keeping the rate of medically unnecessary inductions of birth at a minimum; "Every Baby Counts," to improve the accuracy and timeliness of infant blood specimens sent to the state lab for testing; "Every Mother Counts," the American College of OB/GYN's program to improve maternal mortality; and Oklahoma Mothers and Newborns Affected by Opioids (OMNO).

OHA continues to assist hospitals to improve quality and prevent harm by leading them in national patient safety projects and offering them opportunities for professional education.

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/2WQjGuh.

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 report-

ing 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, staff education 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.

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 monitors and publicly reports 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 2021, 61 measures will be monitored related to inpatient and outpatient care. (See right for examples.) In addition, acute long-term care hospitals are monitored on 18 measures, psychiatric hospitals on 20 measures, rehabilitation hospitals on 17 measures, ambulatory surgery centers on 14 measures, and cancer hospitals on 21 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?

Rural Hospitals

Oklahoma Is a Rural State

With a population of 3,980,783 *(Population and Housing Unit Estimates, U.S. Census Bureau July 1, 2020)*, approximately 1,331,558 Oklahomans live in a rural area of the state *(ERS-USDA State Data)*. Access to timely, appropriate and affordable care is critical to the future of rural Oklahoma, especially when that access may mean a 20 to 50-mile trip over farm-to-market roads.

Part of a Rural Health Safety Net

Of the 152 hospitals in Oklahoma, 40 are federally designated as Critical Access. A Critical Access Hospital (CAH) is a hospital certified under a set of Medicare Conditions of Participation (CoP) that are structured differently than non CAH acute care hospital CoP. Some of the requirements for CAH certification include having no more than 25 inpatient beds; maintaining an annual average length of stay of no more than 96 hours for acute inpatient care; offering 24-hour, seven-day-a-week emergency care; and being located in a rural area, at least 35 miles drive away from any other hospital or CAH (fewer miles in some specific circumstances). The limited size and short stay length allowed to CAHs encourage a focus on providing care for common conditions and outpatient care, while referring other conditions to larger hospitals.

Certification allows CAHs to receive cost-based reimbursement from Medicare instead of standard fixed reimbursement rates. This enhanced reimbursement is due to typically lower volumes of patients and the types of services provided by the CAH. Enhanced reimbursement allows the CAH to remain viable as a source of emergency and ordinary care for the residents of that rural area, who tend to be poorer than their urban counterparts.

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.

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," provides 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.

The NGA Health Workforce Policy Academy team seeks to expand on the work that began in 2014 with Oklahoma's focus on health care workforce, part of which included the creation of the Healthcare Workforce Subcommittee. The four goals of the academy are: improve data collection availability and analysis, systematic evaluation to improve recruitment and retention, demonstrate return on investment for data capacity, and identify data to develop policies that support a more robust behavioral health workforce. The NGA facilitated an in-state visit for Oklahoma in February 2020 to discuss challenges and opportunities with health care workforce stakeholders and share a case study example from Indiana. Work was interrupted in 2020 due to the COVID-19 pandemic.

The Health Workforce Subcommittee of the Governor's Council for Workforce and Economic Development is co-chaired by two rural hospital CEOs. 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:

- Conduct data analysis and prepare reports on health workforce supply and demand;
- Research and analyze state health professional education and training capacity;
- Recommend recruitment and retention strategies for areas of high need; and
- Assess health workforce policy, evaluate impact on Oklahoma's health system and health outcomes, and develop health workforce policy recommendations.

Nursing Population in Oklahoma

- Oklahoma has 51,590 licensed RNs. Of those, 46,749 reside in Oklahoma with 4,831 residing outside the state. *(Oklahoma Board of Nursing, 2020 Annual Report)*
- The average age of an RN in Oklahoma is 46 and the average age of an LPN is 44. *(Oklahoma Board of Nursing, 2020 Annual Report)*
- In FY 2020, of the 5,127 advance practice nurses licensed in Oklahoma, 4,110 of those (roughly 80%) also hold prescriptive authority. *(Oklahoma Board of Nursing, 2020 Annual Report)*
- General medical and surgical hospitals employ the largest number of RNs in the U.S., 30.9%, followed by outpatient clinics at 17.9%. *(U.S. Bureau of Labor Statistics)*
- Demand for nurse practitioners (NPs) and physician assistants (PAs) is increasing. For the first time, NPs placed second on lists of most requested search engagements. The number of searches conducted for NPs and PAs increased by 54% year-over-year, with their role likely to increase post-COVID-19. *(Merritt Hawkins Incentive Review 2020)*

Multistate Registered Nursing Licenses Issued

The enhanced Nurse Licensure Compact (eNLC) was enacted by the state of Oklahoma in April 2016 for registered nurses. (This does not include advance practice nurses.)The legislation that enabled Oklahoma to join the compact provides that nurses with domicile in Oklahoma can uniformly obtain a multistate license (MSL). This will assist those facilities that are in border cities of Oklahoma to access quality licensed nurses from surrounding states. Multistate licensure was implemented nationwide on Jan. 19, 2018, in accordance with the date set by the Interstate Commission of Nurse Licensure Compact Administrators, the governing body of the eNLC. The eNLC is an updated version of the original Nurse Licensure Compact, allowing registered nurses and licensed practical nurses to have one multistate license (MSL), with the ability to practice in person or via telehealth in both their home state (primary state of residence) and other eNLC party states. An MSL is not automatically granted to all nurses licensed in Oklahoma; individuals interested in an MSL must apply. All applicants for an MSL are required to meet the same licensing requirements, which include federal and state background checks. *(Oklahoma Board of Nursing, 2020 Annual Report)*

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 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 30 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. There are 11 residency programs and nine fellowship programs at OSU Medical Center that train more than 150 residents in primary care and subspecialties on an annual basis. OU Tulsa is an accredited full four-year program and may accept up to 25 students each year.

In November 2018, the OSU Center for Health Sciences and the Cherokee Nation announced the creation of the first tribal nation medical school and osteopathic medical school campus, to be located in Tahlequah. The first incoming class of 50 medical students began in the fall of 2020 at the OSU campus in Tahlequah.

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, with physicians contributing nearly 7.1% of the state's gross state product (GSP) in 2020.

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)* Each physician generates an average economic impact of $1.9 million in local revenues. According to a study by Physicians Impact, 6,915 physicians in Oklahoma created 80,751 total jobs, with 47,336 being indirect jobs. *(American Medical Association Economic Impact Study, 2018)* Prior studies have shown that $1.9 million economic impact includes approximately $50,000 annual state tax revenues as a result of the recruitment of a new physician to an Oklahoma community. *(IMS Health, 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. Since 2013, there have been more than 324,000 patient visits with this program. *(Tobacco Settlement Endowment Fund, December 2020)*

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. Physicians that participate in the program for up to four years can receive up to $200,000 in student loan assistance. PMTC loan repayment participants most often present loan amounts in the $300,000 range. The burden of medical school debt can sometimes prevent physicians from practicing general medicine or working in rural or underserved areas.

A 25-year study of PMTC's physician retention conducted by the OSU Center for Rural Health in 2001 noted 82% of physicians participating in a PMTC practice obligation remained in Oklahoma practice, with a rate of 67% 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.)*

Physician Shortages in Oklahoma

- Oklahoma ranks 42nd (down from 36th) in the nation in primary care providers with 212.4 primary care providers per 100,000 citizens. *(America's Health Rankings, 2019)*
- 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.*
- Oklahoma has only 865 allopathic physicians (MDs) practicing in rural areas.
- As of 2019, 3,153 osteopathic physicians and surgeons are licensed by the Oklahoma State Board of Osteopathic Examiners. Of that number, 2,543 live in Oklahoma or treat patients from Oklahoma. The remaining 610 live out of state but keep their Oklahoma licensure current. *(Oklahoma Board of Osteopathic Examiners)*
- Oklahoma has 12,409 allopathic physicians with active licenses, with 6,921 actively practicing in Oklahoma. *(Oklahoma Board of Medical Licensure, December 2020)*
- More doctors are choosing to work part time. Nearly 10% of physicians reported working 30 hours or less per week, including clinical and nonclinical tasks, in 2018, according to a joint survey of about 700,000 doctors by Merritt Hawkins and the Physicians Foundation. That's a 16% increase from the number of physicians working 30 hours or less weekly in 2012.
- The COVID-19 pandemic has caused early retirements of physicians. A survey of more than 3,000 U.S. physicians released in 2020 by Physicians Foundation, a non-profit group, reported 4% said they wouldn't return to work, fearing for their personal health, while more than a quarter (28%) admitted having "serious concerns" about catching COVID-19. Nearly half (47%) described their anxiety as "moderate," while about a fifth (21%) said they weren't too worried about it.
- For the 14th consecutive year, family physicians topped the list of the 20 most requested recruiting engagements, underscoring continued demand for primary care. *(Merritt Hawkins Incentive Review 2020)*

**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.*

TSET Funds for Workforce Shortages

Two grant programs funded by the Tobacco Settlement Endowment Trust (TSET) critical to the Oklahoma health care workforce shortage are (see page 31 for more info on TSET):

- 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.
  - Since the start of the program in 2013, doctors have conducted more than 324,600 patient visits. In addition, doctors participating in the program see patients enrolled in SoonerCare.
  - To date, physicians participating in the loan repayment program have conducted more than 97,000 SoonerCare patient visits. During that time, physicians in the program have referred more than 11,000 patients to free cessation coaching and services through the Oklahoma Tobacco Helpline, a program also funded by TSET.
  - In May 2019, the TSET Board of Directors voted to extend the contract with the Physician Manpower Training Commission for another five years to recruit and retain physicians in rural Oklahoma. This will allow an additional 42 physicians to be placed in rural and medically underserved areas in Oklahoma.
- Oklahoma State University Medical Authority Residency Program supports physician training in rural and medically underserved areas with a six-year $3.8 million grant. Oklahoma has consistently ranked poorly in access to health care, and 64 of the state's 77 counties have a shortage of primary medical care providers, according to U.S. Department of Health and Human Services. 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 and 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. The Oklahoma Nursing Practice Act requires licenses and certificates to be renewed every two years according to a schedule published by the Oklahoma Board of Nursing. The number of registered nurse and licensed practical nurse licenses issued fluctuates yearly in relation to the total number of applications received and the Pass Rate.

COVID-19 Pandemic Licensure

In 2020, licensure during the COVID-19 pandemic became a critical issue. On March 15, 2020, Gov. Kevin Stitt issued Executive Order 2020-07 (which was last amended by Executive Order 202-13 dated April 8, 2020) declaring an emergency caused by the impending threat of COVID-19 to the health and safety of Oklahomans. Further, on April 2, 2020, the governor declared a health emergency in the state of Oklahoma as defined in 63 O.S. § 6104. Pursuant to the Executive Order 2020-07, the following were accomplished by the Board of Nursing:

- Nurses holding a license issued by any state that is party to the Emergency Management Compact were allowed to apply for a temporary, single state nursing license to practice in Oklahoma at no cost to the applicant;
- License expiration dates occurring during the emergency were extended during the Order, and expiration dates were set to expire 14 days following withdrawal or termination of the Order;
- Oklahoma licensed RNs and LPNs whose licenses had not been in an active status for less than five years were allowed to reinstate to a single state temporary licensure, at

no cost, waiving continuing education qualifications; and,

- The requirement for Oklahoma Tax Commission compliance for nursing licensure was waived for renewal or reinstatement of a lapsed or inactive license or certificate.

From the first Executive Order issued through the Third Amended Executive Order 2020-20 issued on July 30, 2020, all occupational licenses that were to expire during the health emergency were to be extended 14 days beyond the withdrawal or termination of the Executive Order. Through June 30, 2020, a total of 2,182 nursing licenses had expiration dates extended. *(Oklahoma Board of Nursing, 2020 Annual Report)*

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.

APRN Licensure

Four roles of advanced practice registered nurses (APRNs) are licensed in Oklahoma: 1) Certified Nurse Practitioner (APRN-CNP); 2) Certified Nurse Midwife (APRN-CNM); 3) Clinical Nurse Specialist (APRN-CNS); and 4) Certified Registered Nurse Anesthetist (APRN-CRNA). The number of Advanced Practice Registered Nurses with prescriptive authority continues to rise, reflective of the increased numbers of advanced practice registered nurses. Currently, 80.2% of advanced practice registered nurses hold prescriptive authority recognition. *(Oklahoma Board of Nursing, 2020 Annual Report)*

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. Credentialing of health care providers is the responsibility of the facilities hiring the individual.

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

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. 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.
- **The OSU Center for Health Sciences:** launched Project ECHO (Extension for Community Healthcare Outcomes) in Oklahoma, an innovative care model to bring specialty medicine to rural areas of Oklahoma. Created in 2003 by the University of New Mexico, Project ECHO operates more than 90 hubs worldwide covering more than 45 diseases and conditions. According to OSU's website, ECHO uses video conferencing to help rural areas access experts in various fields in order to provide better patient care. Two reasons for Oklahoma's poor health status in rural areas are the shortage of primary care physicians and the lack of specialists, many who prefer to practice medicine in urban areas. Many tribal communities and small towns do not even have a primary care physician. Unlike telemedicine where a single provider can see a patient, ECHO is a tool for multiple providers to collaborate and make recommendations regardless of where they're based.

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. Secondarily, 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%) 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, 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.

(See further Title 17 O.S. 139.101 definitions and 139.109 Special OUSF)

Physician Patient Relationship in Telemedicine

In 2017, SB 726 was enacted, which allows the physician patient relationship to be established through telemedicine, but not 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.

Oklahoma Reimbursement Comparison

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

*Medicare defines "rural" as a non-MSA or rural HPSA. Medicaid defines "rural" as a county with a populatuion of less than 50,000 people.

Source: Heartland Telehealth, May 2015.

Examples of Telehealth Services Provided in Oklahoma

Burn	Cardiology	Child Abuse Exams & Forensic Interviews
Dermatology	Emergency	Endocrinology
Geriatrics	Hospitalist	Intensive Care Unit
Infectious Disease	Internal Medicine	Mental Health/Substance Abuse
Neonatology	Neurology	Perinatology
Pulmonology	Second Opinions	Speech Language Pathology
Stroke	Corrections	Radiology

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, physicians 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 30). 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, Oklahomans would not have had access to a Level I Trauma Center.

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.

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.

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 maintain 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 and is accredited by the American College of Surgeons, 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. This level is a trauma care teaching facility.

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 on a quarterly basis. Of this amount, up to 30% 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. In 2020, the Oklahoma Legislature passed the Patient Protection Act (SB 1748), which contains a provision creating a state EMTALA for hospitals that are state licensed. All patients in Oklahoma, regardless of the licensure of the hospital where they are treated, will be asked for payment for emergency treatment after they are stabilized.

Emergency 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 man-made and natural disasters.

As of Nov. 15, 2017, hospitals were to become compliant with emergency preparedness rules developed by CMS. The purpose, according to CMS, was to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems. This affected all provider and supplier types. Every provider and supplier must have emergency preparedness regulations incorporated into its set of conditions or requirements for certification. And they must be in compliance with emergency preparedness regulations to participate in the Medicare or Medicaid program. Hospitals are surveyed by the Oklahoma State Department of Health under contract with CMS to demonstrate compliance with these regulations. The regulations are organized into four areas for which hospitals (and all health facilities) must develop a plan:

1. Risk Assessment and Planning
2. Policies and Procedures
3. Communication
4. Training and Testing

Through federal funding, the Oklahoma State Department of Health manages the Regional Medical Response System (RMRS) made up of eight regions that act as a coordinating agency for the providers in the eight regions. All health care facilities are required to have a representative on the Health Care Coalition managed by the RMRS in the respective region. The Health Care Coalition works together during disasters and emergencies. 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.

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.

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.

COVID-19

All hospitals are required by federal law to have an emergency preparedness plan that includes plans for infectious outbreaks, including pandemics. When the COVID-19 pandemic began in March 2020, hospitals implemented their plans.

Surge Planning

As the COVID-19 pandemic progresses in 2021, hospitals are adjusting to managing more and more patients, which is called a surge. To manage an infectious outbreak, patients with an infection must be segregated from those who are not. This causes difficultly in managing all types of patients, because certain units must be set aside to care for the infected patients. Hospital staff must take every precaution to wear protective equipment to keep themselves and patients safe.

Strategies to manage a hospital surge include:

- decreasing other services to be able to use the staff and physical space;
- determining ways to "stretch" staff who care for patients, such as assigning more patients per nursing staff;
- hiring and utilizing non-licensed staff for tasks that do not require a professional;
- decreasing elective surgeries; moving patients to hospitals that have capacity; and
- working with the rehabilitation or nursing home community to efficiently discharge patients no longer needing acute care.

Reporting Requirements

Under an Executive Order by Gov. Stitt, hospitals are required to report information regarding hospital capacity and supplies to the state health department. This is done through a program

called EMResource, which historically has been used for the trauma program. This reporting is required daily. As the federal government also requires reporting, the state has coordinated the two programs to try to reduce the reporting burden on hospitals. However, the two programs have different requirements. Hospitals that have laboratories that perform COVID-19 testing also have to do daily reporting to the state and federal governments.

OHA and Surge Planning

In March of 2020, the Oklahoma secretary of health asked OHA to develop a statewide hospital surge plan for the Governor's COVID-19 Solutions Task Force. At that time, all hospitals were surveyed regarding the number of staffed medical/surgical and ICU beds and available ventilators. OHA also asked the hospitals what it would take to increase their capacity by 40%. All of this information was given to the COVID-19 Task Force leadership.

Since March 2020, OHA has been asked to update the hospital surge plan two more times as the environment and strategies change and as more is learned about this virus and the pandemic.

Specialized Infectious Disease Unit

In health care, Oklahoma hospitals meet changing needs and disease states. 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-foot 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's Tobacco Tax

According to the Campaign for Tobacco-Free Kids, the evidence is clear that raising the price of cigarettes is one of the most effective ways to reduce smoking, especially among kids.

Oklahomans approved State Question 713 on Nov. 2, 2004, which eliminated the sales tax on cigarettes and other tobacco products while increasing the excise tax on a pack of cigarettes by 80 cents. It also levied an additional tax on other tobacco products.

The funds generated from the increase 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 comprised $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%. 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. This resulted in the Master Settlement Agreement, from which Oklahoma will receive annual payments in perpetuity from participating manufacturers that are party to 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 (TSET). This included the creation of a five-member board of investors to oversee the investment of the trust fund and 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 toward 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 60 hospitals of all sizes, including large health systems, have implemented these treatment services through permanent system changes.
- Between October 2010 and August 2020, 46,044 hospital and clinic patients and employees have been referred by their health care providers to the Oklahoma Tobacco Helpline. Of those 46,044 people, about 29% have accepted services when contacted by the Helpline.
- Those referrals have accounted for an estimated 32,308 years of life saved and $16,257,829 in health care cost savings.
- Of all fax and e-referrals made since November 2014, 81% 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.

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 heath improvement strategies that encompass a holistic approach to wellbeing, from physical activity and nutrition to professional fulfillment 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.
- 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.

Appendix 1: Statutory References

Subject	Title and Section	Notes
Controlled Substances		
Uniform Controlled Dangerous Substances Act	Title 63, Section 2-101 et. seq.	Article 1 - General Provisions
Uniform Controlled Dangerous Substances Act	Title 63, Section 2-201 et. seq.	Article 2 - Standards and Schedules of Controlled Substances
Medical Marijuana Legalization	Title 63, Section 420A	
Opioid Prescription Writing limited to 7 days	Title 63, Section Title 63, Section 2-309(I)	Outpatient prescribing limits, not inpatient
Electronic Prescribing of Controlled Dangerous Substances	Title 63, Section 2-309	
Disaster Preparedness		(See also page 29.)
Oklahoma Emergency Catastrophic Health Powers Act	Title 63, Section 6101 et. seq.	General Provisions Utilized during COVID with legislative approval
Emergency Management Act of 2003	Title 63, Section 683.1 et. seq.	
Emergency Response		
Community Paramedic	Title 63, Section 1-2503 etc. seq	
Oklahoma Emergency Response Systems Development Act	Tile 63, Section 1-2501 et. seq.	
Health Facilities		
Hospital Licensure Generally	Title 63, Section. 1-701 et seq.	
Ambulatory Surgical Center	Title 63, Section 2657	
Child Care Facilities Licensure Act	Title 10, Section 401 et. seq.	Child Placing Facilities such as Children's Inpatient & day care
City and County Owned Hospitals	Title 19, Chapter 17 County Hospitals, Section 781 et seq.	
Critical Access Hospitals	Title 63, Section 1-701	Definition
Children's Hospital of Oklahoma	Title 10, Section 175.12	
Diagnostic X-Ray Facility Act	Title 63, Section 1-1501.1 et. seq.	
Hospital Construction of Facilities	Title 63, Sec. 1-707 et. seq.	Construction only
Nursing Homes	Title 63, Sec. 1-1900 et. seq	See also Long-Term Care Ombudsman Act Title 63, Section 1-2211 et. seq.
Psychiatric and Chemical Dependency Facility Certificate of Need Act	Title 63 Section 1-880.1.	
Specialty Hospitals	Not defined separately in statute different than hospitals	See also references in Title 63, Section 720
Oklahoma State University Medical Authority Act	Title 63, Section 3271	
University Hospitals Authority Act	Title 63, Section 3201 et. seq.	OU Medical Center
Medicaid		
Oklahoma Health Care Authority Act	Title 63, Section 5004	
Medicaid Expansion	Oklahoma Constitution Article 25-A section 1 et. Seq	Constitutional amendment passed June 2020
Billing and Collection		
Affordable Care Act: Navigator Registration Act	Title 36, Section 1415.2	State licensure requirements broader than the ACA
Discount program	Title 63, Section 1-723.2	(See also page 11.)
Employees Group Insurance Division	Title 74, Section 1304.1 et. seq.	(formerly known as OSEEGIB)
Insure Oklahoma	Title 56, Section 1010.1 et. seq.	
Medical Liens – Itemized statements eliminated	Title 42, Section 44	
Supplemental Hospital Offset Payment Program Act (SHOPP)	Title 63, Section 3241.1	Sunsets December 31, 2025
Workers' Compensation	Title 85A, Section 1 et. seq.	

To view the Oklahoma Statutes Citationized Index, visit https://bit.ly/3bEUcIM.

Appendix 1: Statutory References

Subject	Title and Section	Notes
Medical Licensure		
State Board of Medical Licensure	Title 59, Section 480 et. seq.	Oklahoma Allopathic Medical and Surgical Licensure Supervision Act
State Board of Osteopathic Physicians	Title 59, Section 620 et. seq.	Oklahoma Osteopathic Medicine Act
Maintenance of Certification (MOC)	Title 59, Section 492 for MDs Title 59, Section 622 for DOs	
Oklahoma Board of Nursing	Title 59, Section 567.1. et. seq.	Oklahoma Nursing Practice Act
Medical Treatment		
Abortions	Title 63, Section 1-730 et. seq.	Definitions
Adult Day Care Act	Title 63, Section 1-870 et. seq.	
Oklahoma Advance Directive Act	Title 63, Section 3101.1	
Child Abuse Prevention Act	Title 63, Section 1-227 et. seq	See also Title 10A, Section 1-1-105 Definitions of child abuse or neglect
Designation of Caregiver	Title 63, Section 3112	
Duty to report cancer conditions	Title 63, Section 1-551.1	
Duty to report Child Abuse/Neglect	Title 10A, Section 1-2-101	Mandatory duty to Report Abuse or Neglect of Child Under 18
Duty to report Human Trafficking	Title 21, Section 870	Mandatory reporting of trafficking in children to Oklahoma Bureau of Narcotics and Dangerous Drugs
Duty to provide human trafficking victims with medical care	Title 21, Section 748.2 (A)(4)	
Duty to report drug endangered children	Title 10A, Section 1-2-101	
Lay Caregivers and discharge	Title 63 O.S. Section 3112 et. seq.	Discharge planning with lay caregivers
Mammography	Title 63, Section 1-553.1	Breast density notifications
Medical care of children in DHS custody	Title 10A, Section 1-3-102	Authorization to Consent to Emergency Medical Care
Uniform Determination of Death Act	Title 63, Section 3121	
Organ Donation	Title 63, Section 2200.14A	Hospitals can adopt guidelines
Hydration and Nutrition for Incompetent Patients Act	Title 63, Section 3080.1	
Oklahoma Do-Not-Resuscitate Act	Title 63, Section 3131.1	
Medical Treatment Laws Information Act	Title 63, Section 3160	All inpatient health care entities and providers, board and CEO, GC must comply.
Nondiscrimination in Treatment Act	Title 63, Section 3090.1	
Physician Orders for Life Sustaining Treatment (POLST)	Title 63, Section 3105.1 et seq.	
Recruitment		
Oklahoma Medical Loan Repayment	Title 63, O.S. 1-2720	Loans to Physicians, PAs & Nurses for rural areas
Trauma		
Trauma Care Assistance Revolving Fund	Title 63, Section 330.97	
Oklahoma Trauma System Improvement and Development Act	Title 63, Section 1-2530 et. seq.	
Tobacco		
Tobacco Settlement Endowment Trust	Oklahoma Constitution Section Article 10 section 40 - Tobacco Settlement Endowment Trust Fund	Added by State Question No. 692 in 2000. See also 62 O.S.§ 2301-2310.
Oklahoma Tobacco Use Prevention and Cessation Act	Title 63, Section 1-229.1 et. seq.	
Health Care Enhancement Fund – 2018 Cigarette Tax	Title 68, Section 302-7a of Title 68	
Telemedicine		
Oklahoma Telemedicine Network	Title 63, Section 1-2702 et. seq.	Establishes OSDH duties
Oklahoma Telecommunications Act of 1997: Oklahoma Universal Service Fund	Title 17, Section 139.106	OUSF provides funding for some telemedicine, administered by OCC
Oklahoma Telemedicine Parity	Title 36, Section 6803	
Physician Patient Relationship for Purposes of Telemedicine Encounter	Title 59, Section 478.1	

Appendix 2: Snapshot of Oklahoma Hospitals

Company	Licensed Beds	City	Non-Profit: Religious/ Charitably Owned	Non-Profit: City/County or Public Trust	For-Profit	*State, Federal & Tribal	Critical Access Hospital	Teaching Hospital	Member of Hospital System	Specialty Hospitals	Trauma Level	US Congress	State House	State Senate
Chickasaw Nation Medical Center	72	Ada				3						4	25	13
Mercy Hospital Ada	144	Ada	X						MERCY		III	4	25	13
Rolling Hills Hospital	60	Ada			X					PSYCH		4	25	13
Jackson County Memorial Hospital	49	Altus		X							III	3	52	38
Share Medical Center	25	Alva		X			X				IV	3	58	27
Physicians Hospital in Anadarko	25	Anadarko			X		X				IV	3	56	26
Pushmataha Hospital	23	Antlers		X							IV	2	19	5
Mercy Hospital Ardmore	190	Ardmore	X						MERCY		III	4	48	14
Atoka County Medical Center	25	Atoka		X			X				IV	2	22	6
Ascension St. John Jane Phillips	133	Bartlesville	X						ASJ		III	1	10	29
Beaver County Memorial Hospital	24	Beaver		X			X				IV	3	61	27
The Children's Center Rehabilitation Hospital	160	Bethany	X							CHILDREN		5	84	30
Stillwater Medical Blackwell	25	Blackwell		X					SMC		IV	3	38	19
Cimarron Memorial Hospital	25	Boise City		X			X				IV	3	61	27
Bristow Medical Center	49	Bristow			X						IV	3	29	12
Ascension St. John Broken Arrow	44	Broken Arrow	X						ASJ		IV	1	75	36
St. John Rehabilitation Hospital/Encompass Health	60	Broken Arrow			X					REHAB		1	76	33
Harper County Community Hospital	25	Buffalo		X			X				IV	3	61	27
Carnegie Tri-County Municipal Hospital	17	Carnegie		X			X				IV	3	60	26
Roger Mills Memorial Hospital	15	Cheyenne		X			X				IV	3	55	26
Grady Memorial Hospital	57	Chickasha		X							III	4	56	23
Claremore Indian Hospital	44	Claremore				2						2	9	2
Hillcrest Hospital Claremore	49	Claremore			X				AHS		IV	2	9	2
Cleveland Area Hospital	14	Cleveland		X			X				IV	3	35	20
AllianceHealth Clinton	56	Clinton			X				CHS		IV	3	57	38
Coal County General Hospital	20	Coalgate		X			X				IV	2	18	6
Cordell Memorial Hospital	14	Cordell		X			X				IV	3	55	38
Hillcrest Hospital Cushing	99	Cushing			X				AHS		IV	3	33	21
Drumright Regional Hospital	15	Drumright		X			X				IV	3	35	12
Duncan Regional Hospital	110	Duncan	X						DRHH		III	4	50	31
AllianceHealth Durant	138	Durant			X				CHS		III	2	21	6
INTEGRIS Health Edmond	60	Edmond	X						IH		III	5	96	41
Oklahoma ER & Hospital	4	Edmond			X					MICRO		5	83	47
Summit Medical Center	9	Edmond			X					SURG		5	83	47
Great Plains Regional Medical Center	62	Elk City	X								IV	3	57	26
INTEGRIS Bass Baptist Health Center	183	Enid	X						IH		III	3	40	19

***These hospitals are as follows: State = 1, Federal = 2, and Tribal = 3**

System Affiliation Codes:
AHS=Ardent Health Svcs/Hillcrest Healthcare System
ASJ=Ascension St. John
CHG=Cornerstone Healthcare Group
CHS=Community Health Systems
DRHH=DRH Health
HPI=Healthcare Partners Investments
IH=INTEGRIS Health
MCNO=Muscogee (Creek) Nation of Oklahoma
MERCY=Mercy
SFHS=Saint Francis Health System
SM=Select Medical
SSMHO=SSM Health Oklahoma
SMC=Stillwater Medical Center
UHI=Universal Health Services, Inc.

Types of Specialty Hospitals:
CANCER=Cancer Facility
CHILDREN=Children's Facility
DMHSAS=Department of Mental Health & Substance Abuse Facility
HEART=Specializes in Cardiac Treatment
LTAC=Long Term Acute Care Facility
ORTHO=Orthopedic Facility
PSYCH=Psychiatric Facility
REHAB=Rehabilitation Facility
SURG=Surgery Center
WOMENS=Specializes in Women's Services

St. Mary's Regional Medical Center	229	Enid			X				UHI		III	3	40	19
Fairfax Community Hospital	15	Fairfax		X			X				IV	3	36	10
Fairview Regional Medical Center	25	Fairview		X			X				IV	3	58	27
INTEGRIS Grove Hospital	58	Grove	X						IH		IV	2	5	3
Mercy Hospital Logan County	25	Guthrie	X				X		MERCY		IV	3	31	20
Memorial Hospital of Texas County Authority	33	Guymon		X			X				IV	3	61	27
Mercy Hospital Healdton	22	Healdton	X				X		MERCY		IV	4	48	14
Hillcrest Hospital Henryetta	30	Henryetta			X				AHS		IV	2	16	8
Elkview General Hospital	38	Hobart		X							IV	3	55	38
Holdenville General Hospital	25	Holdenville		X			X				IV	2	24	13
Harmon Memorial Hospital	22	Hollis		X			X				IV	3	52	38
Choctaw Memorial Hospital	34	Hugo		X							IV	2	19	5
McCurtain Memorial Hospital	25	Idabel	X				X				IV	2	1	5
Mercy Hospital Kingfisher	25	Kingfisher	X				X		MERCY		IV	3	59	26
Comanche County Memorial Hospital	265	Lawton		X							III	4	64	32
Jim Taliaferro Community Mental Health Center	30	Lawton				1				DMHSAS		4	64	32
Lawton Indian Hospital	26	Lawton				2						4	64	31
Southwestern Medical Center	199	Lawton			X						III	4	62	31
Lindsay Municipal Hospital	26	Lindsay		X							IV	4	42	43
AllianceHealth Madill	25	Madill			X		X		CHS		IV	2	49	6
Mangum Regional Medical Center	18	Mangum		X			X				IV	3	52	38
Mercy Health Love County	25	Marietta		X			X		MERCY		IV	4	49	14
Carl Albert Community Mental Health Center	15	McAlester				1				DMHSAS		2	17	7
McAlester Regional Health Center	149	McAlester		X							III	2	17	7
INTEGRIS Miami Hospital	117	Miami	X						IH		IV	2	7	1
Willow Crest Hospital	50	Miami			X					PSYCH		2	7	1
AllianceHealth Midwest	255	Midwest City			X				CHS		III	4	95	42
Inspire Specialty Hospital	31	Midwest City			X					LTAC		4	95	42
Cornerstone Specialty Hospitals Muskogee	64	Muskogee			X				CHG	LTAC		2	13	9
Jack C. Montgomery VA Medical Center	112	Muskogee				2						2	13	9
Saint Francis Hospital Muskogee	320	Muskogee	X						SFHS		III	2	13	9
Griffin Memorial Hospital	182	Norman				1				DMHSAS		4	44	16
JD McCarty Center for Children	36	Norman				1				CHILDREN		4	45	16
Norman Regional Health System	387	Norman		X							III	4	44	16
Ascension St. John Nowata	25	Nowata	X				X		ASJ		IV	2	10	29
Okeene Municipal Hospital	17	Okeene		X			X				IV	3	59	26
Creek Nation Community Hospital	24	Okemah				3	X		MCNO		IV	2	24	8
AMG Specialty Hospital At Mercy	18	Oklahoma City			X				AMG	LTAC		5	82	47
Cedar Ridge	116	Oklahoma City			X				UHI	PSYCH		5	97	48
Community Hospital	45	Oklahoma City			X				HPI	SURG	IV	4	91	45

Appendix 2: Snapshot of Oklahoma Hospitals

			Non-Profit											
Company	Licensed Beds	City	Religious/ Charitably Owned	City/County or Public Trust	For-Profit	*State, Federal & Tribal	Critical Access Hospital	Teaching Hospital	Member of Hospital System	Specialty Hospitals	Trauma Level	US Congress	State House	State Senate
Curahealth Hospital Oklahoma City	59	Oklahoma City			X					LTAC		5	88	46
INTEGRIS Baptist Medical Center	892	Oklahoma City	X						IH		III	5	87	40
INTEGRIS Community Hospital At Council Crossing	32	Oklahoma City			X				IH			5	100	47
INTEGRIS Southwest Medical Center	334	Oklahoma City	X						IH		III	5	89	46
Lakeside Women's Hospital	23	Oklahoma City			X				IH	WOMENS		5	85	30
McBride Orthopedic Hospital	68	Oklahoma City			X					ORTHO		5	97	48
Mercy Hospital Oklahoma City	385	Oklahoma City	X						MERCY		III	5	82	47
Mercy Rehabilitation Hospital Oklahoma City	50	Oklahoma City			X				MERCY	REHAB		5	82	47
Northwest Surgical Hospital	9	Oklahoma City			X				HPI	SURG		5	85	40
Oakwood Springs	72	Oklahoma City			X					PSYCH		5	99	48
Oklahoma Center for Orthopaedic & Multi-Specialty Hospital	9	Oklahoma City			X					SURG		5	54	44
Oklahoma Heart Hospital	97	Oklahoma City			X				MERCY	HEART		5	82	47
Oklahoma Heart Hospital South	44	Oklahoma City			X				MERCY	HEART		5	94	15
Oklahoma Spine Hospital	25	Oklahoma City			X					ORTHO		5	82	47
OneCore Health	8	Oklahoma City			X					ORTHO		5	93	46
OU Health University of Oklahoma Medical Center	804	Oklahoma City	X					X			I	5	99	48
Select Specialty Hospital Oklahoma City	72	Oklahoma City			X				SM	LTAC		5	87	40
SSM Health St Anthony Hospital - Oklahoma City	773	Oklahoma City	X						SSMHO		III	5	88	46
Surgical Hospital of Oklahoma	12	Oklahoma City			X					SURG		5	92	44
Valir Rehabilitation Hospital	50	Oklahoma City			X					REHAB		5	92	46
Veterans Affairs Medical Center	222	Oklahoma City				2						5	99	48
Muscogee (Creek) Nation Medical Center	66	Okmulgee				3			MCNO		IV	2	16	8
Muscogee (Creek) Nation Physical Rehabilitation	4	Okmulgee				3			MCNO	LTAC		2	16	8
Ascension St. John Owasso	36	Owasso	X						ASJ			1	74	34
Bailey Medical Center	73	Owasso			X				AHS		IV	1	74	34
Pawhuska Hospital	25	Pawhuska		X			X				IV	3	36	10
Stillwater Medical Perry	26	Perry		X					SMC		IV	3	38	20
AllianceHealth Ponca City	140	Ponca City			X				CHS		IV	3	37	10
Eastern Oklahoma Medical Center	33	Poteau		X			X				IV	2	3	4
Prague Community Hospital	25	Prague			X		X				IV	3	32	28
Hillcrest Hospital Pryor	48	Pryor			X				AHS		IV	2	8	2
Purcell Municipal Hospital	39	Purcell		X							IV	4	42	43
Northeastern Health System Sequoyah	41	Sallisaw		X							IV	2	2	4
Ascension St. John Sapulpa	25	Sapulpa	X				X		ASJ		IV	3	30	12
Seiling Municipal Hospital	18	Seiling		X			X				IV	3	59	27
AllianceHealth Seminole	32	Seminole			X				CHS		IV	5	28	28

***These hospitals are as follows: State = 1, Federal = 2, and Tribal = 3**

System Affiliation Codes:
AHS=Ardent Health Svcs/Hillcrest Healthcare System
ASJ=Ascension St. John
CHG=Cornerstone Healthcare Group
CHS=Community Health Systems
DRHH=DRH Health
HPI=Healthcare Partners Investments
IH=INTEGRIS Health
MCNO=Muscogee (Creek) Nation of Oklahoma
MERCY=Mercy
SFHS=Saint Francis Health System
SM=Select Medical
SSMHO=SSM Health Oklahoma
SMC=Stillwater Medical Center
UHI=Universal Health Services, Inc.

Types of Specialty Hospitals:
CANCER=Cancer Facility
CHILDREN=Children's Facility
DMHSAS=Department of Mental Health & Substance Abuse Facility
HEART=Specializes in Cardiac Treatment
LTAC=Long Term Acute Care Facility
ORTHO=Orthopedic Facility
PSYCH=Psychiatric Facility
REHAB=Rehabilitation Facility
SURG=Surgery Center
WOMENS=Specializes in Women's Services

Newman Memorial Hospital	25	Shattuck	X				X				IV	3	61	27
Cornerstone Specialty Hospitals Shawnee	34	Shawnee			X				CHG	LTAC		5	26	28
SSM Health St Anthony Hospital - Shawnee	96	Shawnee	X						SSMHO		IV	5	26	17
Haskell Regional Hospital	25	Stigler			X		X				IV	2	15	7
Stillwater Medical Center	117	Stillwater		X					SMC		IV	3	34	21
Memorial Hospital of Stilwell	67	Stilwell	X								IV	2	86	3
Stroud Regional Medical Center	25	Stroud			X		X				IV	3	32	28
Arbuckle Memorial Hospital	25	Sulphur		X			X				IV	4	22	14
Northeastern Health System	98	Tahlequah		X								2	4	9
WW Hastings Indian Hospital	60	Tahlequah				3						2	4	9
Choctaw Nation Health Care Center	44	Talihina				3						2	17	7
Mercy Hospital Tishomingo	25	Tishomingo	X				X		MERCY		IV	2	22	14
Ascension St. John Medical Center	677	Tulsa	X						ASJ		II	1	78	35
Brookhaven Hospital	64	Tulsa			X					PSYCH		1	77	34
Hillcrest Hospital South	180	Tulsa			X				AHS		III	1	67	25
Hillcrest Medical Center	626	Tulsa			X				AHS		III	1	72	11
Laureate Psychiatric Clinic and Hospital	90	Tulsa	X						SFHS	PSYCH		1	79	39
Oklahoma State University Medical Center	235	Tulsa		X				X			III	1	73	11
Oklahoma Surgical Hospital	75	Tulsa			X					SURG		1	69	35
PAM Rehabilitation Hospital of Tulsa	55	Tulsa			X					REHAB		1	67	25
PAM Specialty Hospital of Tulsa	60	Tulsa			X					LTAC		1	78	25
Parkside Psychiatric Hospital and Clinic	120	Tulsa	X							PSYCH		1	72	11
Saint Francis Hospital	1088	Tulsa	X						SFHS		II	1	79	39
Saint Francis Hospital South	104	Tulsa	X						SFHS		III	1	67	25
Select Specialty Hospital Tulsa	56	Tulsa			X				SM	LTAC		1	72	11
Southwestern Regional Medical Center	40	Tulsa			X					CANCER		1	79	33
Tulsa Center for Behavioral Health	56	Tulsa				1				DMHSAS		1	70	39
Tulsa ER & Hospital	8	Tulsa			X					MICRO		1	68	37
Tulsa Spine & Specialty Hospital	38	Tulsa			X				AHS	SURG		1	68	37
Oklahoma Forensic Center	200	Vinita				1				PSYCH		2	6	1
Saint Francis Hospital Vinita	50	Vinita	X								IV	2	6	1
Wagoner Community Hospital	100	Wagoner		X							IV	1	12	18
Mercy Hospital Watonga	25	Watonga	X				X		MERCY		IV	3	59	26
Jefferson County Hospital	18	Waurika		X			X		DRHH		IV	4	50	31
Weatherford Regional Hospital	25	Weatherford		X			X				IV	3	57	38
AllianceHealth Woodward	87	Woodward			X				CHS		IV	3	58	27
Northwest Center for Behavioral Health	28	Woodward				1				DMHSAS		3	58	27
INTEGRIS Canadian Valley Hospital	75	Yukon	X						IH		IV	3	60	45
Total Number of Hospitals - 150														
Totals			**36**	**42**	**55**	**17**	**40**	**2**						

Glossary of Terms

340B
Section 340B of the federal Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations, including certain hospitals that care for many uninsured and low-income patients. For more than 25 years, the 340B Drug Pricing Program has provided financial help to hospitals serving vulnerable communities to manage rising prescription drug costs.

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 low income, 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.

HCAHPS

Hospital Consumer Assessment of Healthcare Providers and Systems (see page 13).

HIPAA

Health Insurance Portability and Accountability Act (see page 23).

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.

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.)

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.

Managed Care

A system of health care in which patients are able to visit only certain doctors and hospitals, and in which the cost of treatment is monitored by a managing company.

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.

Rural Health Clinics

The Rural Health Clinic Service Act of 1977 addressed an inadequate supply of physicians serving Medicare beneficiaries in rural areas and increased the use of nurse practitioners (NPs), physician assistants (PAs), and certified nurse-midwives (CNMs) in these areas. Medicare pays RHCs an all-inclusive rate (AIR) for medically necessary, face-to-face primary health services and qualified preventive health services furnished by an RHC practitioner. There are hospital-based rural health clinics in Oklahoma that provide primary care and preventive health services in underserved rural areas.

Serious Adverse Event

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

SoonerCare

Name for Oklahoma's Medicaid program administered by the Oklahoma Health Care Authority (OHCA).

Specialty Hospital

A limited-service hospital designed to provide one medical specialty such as orthopedic or cardiac care.

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.

Notes

4000 Lincoln Blvd. • Oklahoma City, OK 73105
(405) 427-9537 • Fax: (405) 424-4507
E-mail: oha@okoha.com
www.okoha.com