# Oklahoma Hospitals

2023-2024

## 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 119 hospitals 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, sharrison@okoha.com, Scott Tohlen, stohlen@okoha.com, or Don Armes, darmes@okoha.com; call (405) 427-9537; or go to www.okoha.com.

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# Types of Hospitals

There are numerous terms that define hospitals, their ownership or control, or the services that they provide. Generally, Oklahoma law defines hospitals under Title 63:1-701. The term "hospital" includes general medical surgical hospitals, 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 43).

## 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 44) as other hospitals. Further, there are some differences in regulatory requirements. There are currently 40 CAHs in Oklahoma.

## 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.

## Free-Standing Emergency Rooms

There is no official designation for a "free-standing" emergency room. However, a licensed hospital can offer off-campus emergency services as long as it is within 35 miles of the licensed hospital. These facilities must comply with the same standards as in-hospital emergency services and have a transfer plan for patients that need a higher level of care. All emergency services must comply with EMTALA and must post publicly if they do not accept Medicare, Medicaid or other government insurances.

## 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 seven 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.

## Micro-Hospitals

Micro-hospitals are independently licensed acute care facilities with acuity comparable to a community hospital, but at a fraction of the size. Micro-hospitals typically have 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 value of the micro-hospital manifests when it is considered as part of an overall delivery system and continuum of care.

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

## Rural Emergency Hospitals

Rural Emergency Hospitals (REH) are a new provider type established by the 2021 federal Consolidated Appropriations Act to address the growing concern over closures of rural hospitals. The REH designation provides an opportunity for Critical Access Hospitals (CAHs) and small rural hospitals to avert potential closure and continue to provide essential services for the communities they serve. Conversion to an REH allows for the provision of emergency services, observation care, and outpatient services. They can keep a patient for

observation, but cannot exceed an annual per patient average of 24 hours. This new provider type, effective Jan. 1, 2023, will promote equity in health care for those living in rural communities by facilitating access to needed services.

### 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.

### 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.

### 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.

# Current Health Care Environment

## *Affordable Care Act*

The U.S. Congress passed the Patient Protection and Affordable Care Act (ACA) on March 23, 2010. The purpose of the ACA was to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health care costs.

In passage of the ACA, the hospital industry, including the American Hospital Association, agreed to ten years and $155 billion in cuts from the Medicare program to be offset by increased insurance coverage that would result in 94% of the nation's population having coverage. As a result, Oklahoma hospitals were 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. Until Medicaid expansion was enacted in Oklahoma, hospitals experienced these cuts without revenue effects.

Since the ACA's inception, numerous court cases have been heard challenging the validity of the ACA, either in its entirety or portions of it. In 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. On June 17, 2021, the U.S. Supreme Court threw out a 2018 challenge to the ACA by 18 Republican state attorneys general and the Trump administration, who sought to declare the ACA unconstitutional. The Court held that because there was no harm or injury traceable to the health insurance mandate, the ACA was constitutional.

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.

According to the Kaiser Family Foundation, as of Sept. 2021, 20 million people in the U.S. were enrolled in the ACA Medicaid expansion group and about 17 million of them were newly eligible under the ACA.

As of Jan. 11, 2023, more than 15.9 million Americans had selected ACA health insurance plans on the Health Care Marketplace.

## *Medicaid Expansion*

On June 30, 2020, Oklahoma voters approved SQ 802, Medicaid expansion. Oklahoma is the 37th state to pass Medicaid expansion under the 2010 Affordable Care Act. Medicaid expansion is now part of the Oklahoma Constitution and provides health care to more than 300,000 Oklahomans aged 19-64 who make less than $17,796 a year or a family of four making less than $36,588 a year. The income level cannot exceed 138% 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. The state's share of the cost is paid for through an increase in the state's hospital provider fee. The Medicaid expansion funding formula can only be changed by an Act of Congress. Native Americans are covered at 100% of the cost.

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.

In 2022, Oklahoma took an innovative approach to Medicaid managed care, with the passage of SB 1337 and SB 1396. Together, these bills ushered in a new payment program and quality incentive pool for hospitals and health care providers, respectively. In order to receive approval from the federal government, this new payment program is tied to performance and quality measures that hospitals and providers must meet. Medicaid managed care will not include the aged, blind, and disabled population, and is voluntary for Native American tribes. The anticipated date for implementation is February 2024.

**For more information on Medicaid, see pages 5-12 on Financial Information.**

# Mental Health and Substance Abuse

**Hospitals play a critical role in addressing both mental health and substance use conditions, offering both inpatient and outpatient services for Oklahomans, often in times of crisis. Establishing a nonstate psychiatric facility requires a demonstration of need in Oklahoma, known as certificate of need, or CON. These hospital facilities are regulated by the Oklahoma Department of Human Services (minors), the Oklahoma Department of Mental Health and Substance Abuse Services, and the Oklahoma Health Care Authority.**

**In 2021, there are 1,647 staffed beds for the treatment of mental health and substance use disorders spread across both standalone and system-based facilities.* Services provided include:**

- **Acute inpatient programs**
- **Residential treatment programs**
- **Outpatient programs**
- **Intensive outpatient programs**
- **Therapeutic foster care**
- **Substance use treatment**
- **Partial hospitalization programs**

*2021 American Hospital Association Survey

# 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.

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 37% of Medicare beneficiaries in Oklahoma (and 48% 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.)

### Economic Impact of Oklahoma Hospitals

**According to the American Hospital Association's 2021 survey, Oklahoma's 147 hospitals:**

- **Employ 78,361 persons.**
- **Deliver nearly 46,000 babies yearly.**
- **Provide for 431,557 inpatient admissions, 1,792,549 emergency room visits, and 9,728,796 other outpatient visits.**
- **Have an average daily inpatient census totaling 7,648.**
- **Generate $12,157,457,094 in net patient revenue (excluding tax revenue).**
- **Have annual expenses of $13,570,605,229.**
- **Pay salaries and wages of $4.784 billion.**

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 by an approved accreditation agency. If a hospital is accredited by an approved accreditation agency, it is not required to be surveyed by the health department for Medicare.

At this time, there are four Medicare approved accrediting agencies:

- Accreditation Commission for Health Care (ACHC)
- Center for Improvement in Healthcare Quality (CIHQ)
- DNV-Healthcare (DNV)
- The Joint Commission (TJC)

## 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 2022 was 68.31%, and for 2023 will be 67.36%.**

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

## Populations Eligible for Medicaid in Oklahoma

Oklahoma Medicaid Expansion became 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 $17,796 for an individual or $36,588 for a family of four.

| Population | Income Eligibility | Asset Limit |
|---|---|---|
| Adults aged 19-64 | 138% of FPL* | None |
| Children up to age 19 | 138% of FPL | None |
| Pregnant Women | 138% of FPL*** | None |
| Parent of dependent child | Approx. 37% of FPL | None |
| Single parent transitioning from welfare to work | 138% of FPL<br>(Eligible for up to 12 months) | None |
| Aged, Blind and Disabled (ABD) | 100% of FPL | $2,000 individual<br>$3,000 couple |
| Specified Low-income Medicare Beneficiaries | 120% of FPL; covers<br>Medicare Part B Premium | $4,000 individual<br>$6,000 couple |
| ABD in institution or Home-and-Community based waiver program | 300% of SSI** | $2,000 individual<br>$3,000 couple |

***Federal Poverty Level; **Supplemental Security Income; ***205% pending CMS approval.**

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; and
- state residency requirements.

**See chart to the right for income guidelines.**

### 2023 Poverty Level Guidelines

As posted by the Department of Health and Human Services, eff. January 2023.
All states except Alaska and Hawaii - annual income.

| Family Size | Federal Poverty Guideline (eff. 1/1/2023) | SoonerCare limit for Adult Caretaker/ Relative with Child (eff. 4/1/2022) | SoonerCare limit for Children Pregnant Women: Soon-To-Be-Sooners (eff. 4/1/12022) | SoonerCare limit for Expansion Adults (eff. 4/1/2022) |
|---|---|---|---|---|
| 1 | $14,580 | $4,884 | $28,560 | $18,768 |
| 2 | 19,720 | 6,252 | 38,460 | 25,272 |
| 3 | 24,860 | 8,016 | 48,384 | 31,800 |
| 4 | 30,000 | 9,840 | 58,296 | 38,304 |
| 5 | 35,140 | 11,496 | 68,196 | 44,820 |
| 6 | 40,280 | 13,176 | 78,120 | 51,336 |
| 7 | 45,420 | 14,832 | 88,032 | 57,852 |
| 8 | 50,560 | 16,368 | 97,932 | 64,356 |

FPL = Federal Poverty Level
Source: For FPL guideline, www.aspe.hhs.gov
Source: SoonerCare and Insure Oklahoma Income Guidelines, https://bit.ly/3iMdhic

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.

## Oklahoma Medicaid – 66,455 Providers of Care

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

## 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, Most Oklahoma hospitals in 2011 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.

Sixty-nine hospitals were required to pay the SHOPP assessment for 2022, while 79 hospitals were excluded from this requirement, including 40 critical access hospitals, certain specialty hospitals, and long-term care hospitals.

## Supplemental Payments Based on Upper Payment Limit

In 2011, the Oklahoma Legislature passed the Supplemental Hospital Offset Payment Program (SHOPP), also known as HB 1381, to allow hospitals to provide additional funding to the state that could be used to draw down federal matching funds up to the federal upper payment limit (UPL). This limit refers to the maximum amount that the federal government will match for the payment of certain services and is equivalent to what Medicare would pay for those services. At the time, Oklahoma hospitals were receiving an average of 67% of the Medicare payment rates through Medicaid. The SHOPP program is similar to provider fee programs that have been implemented in 49 other states. Oklahoma also passed a provider fee for nursing homes in 2000, which was amended in 2011.

In 2020 and 2021, the SHOPP assessment rate was set at 2.3% and 2.11%, respectively, of annual net patient revenue. However, these rates were reduced due to increased federal matching rates as a result of the public health emergency and the American Rescue Plan Act (ARPA), which provided additional funding to states that expanded Medicaid in 2021 or later. For 2022, the assessment rate was set at 3% by Senate Bill 1045, which also established a rate of 3.5% for 2023 and 4% for 2024 and beyond.

The SHOPP assessment for 2022 was projected to generate approximately $247 million in funding for the state, used to draw down $343 million in federal funding for a total of $590 million. Of this total, $500 million is paid to hospitals as supplemental payments for the care provided to Medicaid (SoonerCare) patients to cover the unreimbursed costs of their care. The remaining $90 million is used to maintain SoonerCare payment rates for physicians and other Medicaid providers to ensure access to care.

The SHOPP Act previously had a sunset date, but this date has now been removed. This means that the SHOPP program will continue indefinitely unless it is explicitly terminated or amended by the state Legislature.

## Directed Payments Based on Average Commercial Rate

In 2021, Senate Bill 1396 maintained the Supplemental Hospital Offset Payment Program (SHOPP) as a funding mechanism for the Aged, Blind, and Disabled populations that will not be included in the Medicaid managed care delivery model. SB 1396 also created a new funding mechanism, which will take the form of supplemental payments, to be implemented when Medicaid managed care is introduced for children, caregivers, and the Medicaid Expansion population. As of the date of publication, it is expected that these supplemental payments to hospitals will be based on 90% of the Average Commercial Rate (ACR) charged by commercial insurers in Oklahoma, and this change is scheduled to take effect on April 1, 2024.

SB 1396 also authorized the Oklahoma Health Care Authority (OHCA) to implement a managed care directed payment program, subject to approval by the Centers for Medicare & Medicaid Services (CMS), with a statutory implementation date of Oct. 1, 2023, for the population that will be transitioning to managed care. However, the agency has stated they will not meet the timeline. OHCA is required to calculate the maximum total dollar amount of the directed payment program based on 90% of an average commercial rate benchmark for hospitals, which will be determined using Oklahoma's average commercial rates rather than a national metric. Contracted entities will be required to pay directed payments to hospitals on a quarterly basis and must do so within five business days of receiving the calculation from OHCA.

SB 1396 also allocated the first $130 million collected through the directed payment program to be distributed to the Medical Payments Disbursing Fund. The purpose of this fund is to supplement the state Medicaid program, SHOPP, and the Rate Preservation Fund. If CMS does not approve the direct payment program based on ACR, the SHOPP program will remain in place, and Medicaid managed care will not be implemented. The provisions of SB 1396 are tied to those of SB 1337, so if the financial aspect of the legislation does not take effect, neither will the policy provisions.

## 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. Since Medicaid expansion began on July 1, 2021, to adults with incomes up to 138% of the federal poverty level, the ESI program has been revised to cover individuals with qualifying incomes from 138 to 200% of the federal poverty level.

Enrollment as of October 2022 includes:

- Businesses – 3,115
- ESI enrollees – 9,680
- Total enrollees – 12,795

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 www.ok.gov/wcc.

## 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 39.)

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

# *Hospital Payments*

Oklahoma's 152 hospitals have total annual expenses of $13.5 billion according to the American Hospital Association's 2021 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.

## 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

## Oklahoma Hospital Patient Revenue (in $ millions)

| | Gross Charges | Net Revenue | % of Net Revenue |
|---|---|---|---|
| Medicare | $ 24,347 | $ 4,649 | 39% |
| Medicaid | $8,243 | $1,882 | 16% |
| Other third-party payers | $17,698 | $4,997 | 42% |
| Self-pay revenue | $3,482 | $244 | 2% |
| **Total** | **$ 53,770** | **$ 11,772** | **100%** |

Source: 2021 American Hospital Association Survey

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.

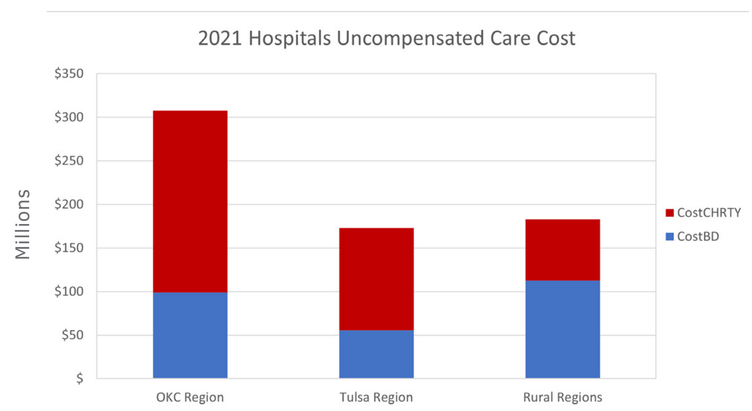
The Affordable Care Act requires hospitals to make public the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups. For this reason, the Centers for Medicare & Medicaid Services requires all hospitals to post a listing of all detailed charges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

# *Uncompensated Care*

Uncompensated care is care hospitals provide for which they are not reimbursed. Federal law requires medical screening and stabilization of any person who presents in an emergency room. (See EMTALA, page 29.) Oklahoma hospitals provided




Source: 2021 American Hospital Association Survey

## The Uninsured in Oklahoma

- **One in seven (537,825) Oklahomans is uninsured, 13.8% 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, 7.4%.[2]**
- **Oklahoman ranks eighth in the nation for percent of uninsured children.[2]**

[1] According to U.S. Census Bureau, 2021 American Community Survey, Table R2701.
[2] According to U.S. Census Bureau, 2021 American Community Survey, Table R2702.
* This ranking does not reflect a full year of Medicaid expansion and only captures six months of enrollment.

more than $663 million in uncompensated care annually, according to the American Hospital Association's annual hospital survey conducted in 2021. 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.

# *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 and 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 to CMS 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?

**Equity** – Equity means providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

## *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.

### Federal

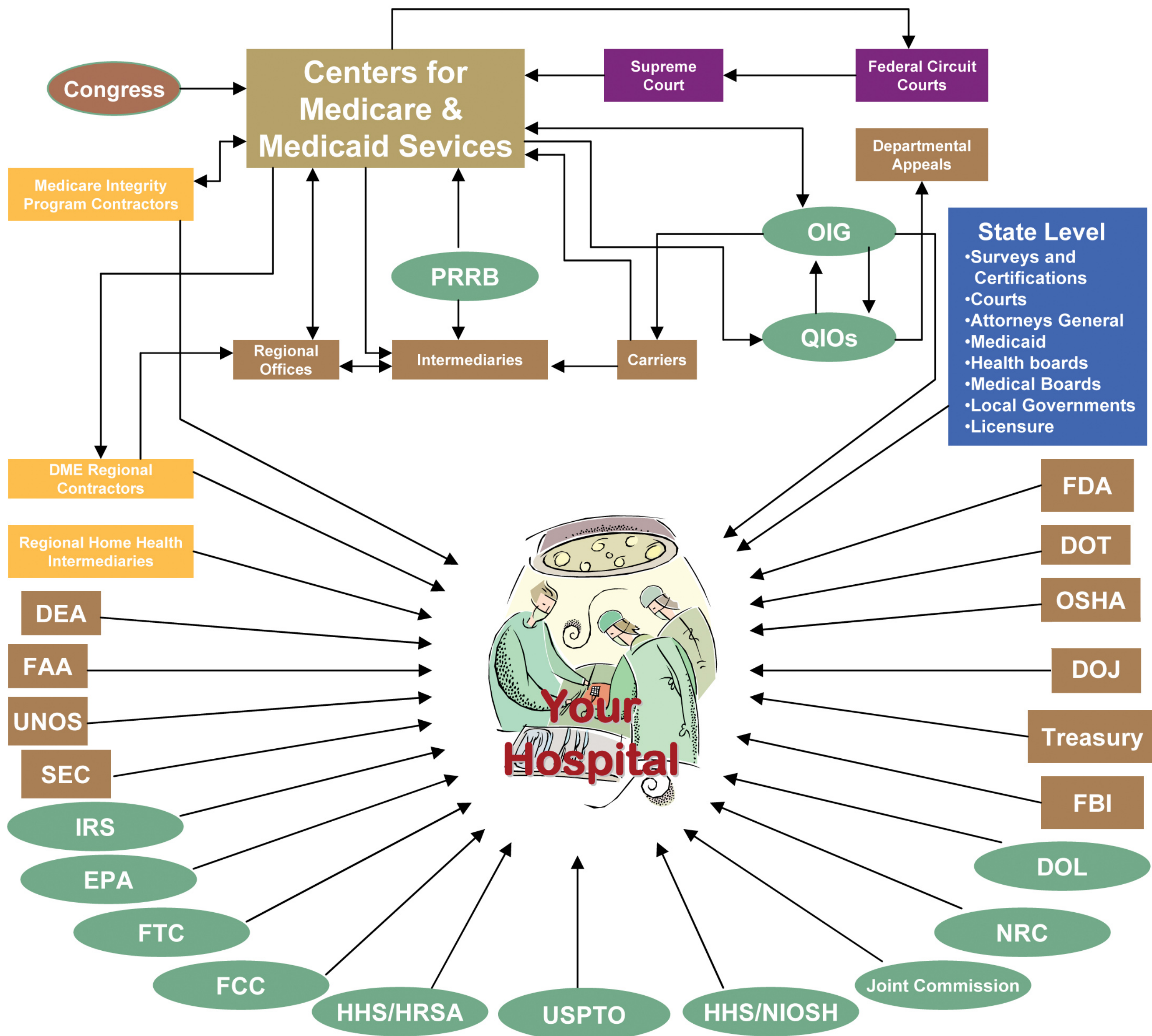
In order for hospitals to treat Medicare patients and receive Medicare funds, they must comply with "Medicare Conditions of Participation." These conditions include many aspects of hospital administration and requirements for care, just as the state licensure requirements.

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

# 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

thousands of dollars, depending on their size, for this external review and/or educational opportunities. (See page 6.)

### 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 this care review in Oklahoma for hospitals. 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 required by federal and state regulations to identify, report, prevent and treat many types of infections.

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

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

Federal and state governments both have specific guidelines hospitals are required to follow for infection control and prevention. These guidelines include the development of a hospital-wide infection control and prevention plan, specific resources allocated to these activities, and the internal and

external reporting requirements. 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 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 2023, 68 measures will be monitored related to inpatient and outpatient care. (See below for examples.) In addition, acute long-term care hospitals are monitored on 18 measures, psychiatric hospitals on 22 measures, rehabilitation hospitals on 18 measures, ambulatory surgery centers on 18 measures, and cancer hospitals on 16 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?**

# *Duty to Report*

In Oklahoma law, hospitals have many statutory responsibilities to report persons entering the hospital for various medical or social conditions. Those duties to report include, but are not limited to, infection control, human trafficking, child welfare observations, and death in restraints in the hospital.

## 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 COVID-19, Ebola, measles, pertussis and influenza. A complete list of reportable diseases can be found on the Oklahoma State Department of Health (OSDH) website at https://bit.ly/3jHubyF.

## Human Trafficking

Hospitals must report any observation of possible human trafficking victims who have been brought to or are seeking treatment at the hospital. Hospitals must report these observations by contacting the Oklahoma Bureau of Narcotics (OBN) Human Trafficking Hotline at (855) 617-2288.

## Child Welfare Observations

Any person who observes child abuse or neglect in Oklahoma is a mandatory reporter of such abuse or neglect to the Oklahoma Department of Human Services (OKDHS) Hotline. However, physicians and other health professionals must report injuries to children under 18 to the DHS Abuse and Neglect Hotline at (800) 522-3511. *(See 10A O.S. § 1-2-101.)*

## Infants Testing Positive for Controlled Substances

Every physician, surgeon, or other health care professional, including midwifes, involved in the prenatal care of expectant mothers or the delivery or care of infants must promptly report to OKDHS instances in which an infant tests positive for alcohol or a controlled dangerous substance. This shall include infants who are diagnosed with Neonatal Abstinence Syndrome or Fetal Alcohol Spectrum Disorder.

## Death in Restraints

Federal rules require that when a patient dies in the hospital while being restrained either physically or chemically, or while in seclusion, the quality or risk manager must be notified immediately. The case should be evaluated to determine if it meets the CMS definition of a reportable event. Deaths occurring within one week after a restraint episode must be reported to CMS.

# Controlled Dangerous Substances

## *The Opioid Epidemic*

Many public health experts believe the modern opioid epidemic began in the late 1990s when major drugmakers, distributors and pharmacy chains started selling pain pills aggressively.  Two decades later, local and state governments still face a devastating surge of drug overdoses and deaths. Communities say they desperately need resources to keep people alive.

Opioid abuse is largely driven by prescribing practices. In 2019, approximately 72,000 people in the U.S. died from drug overdoses, making it a leading cause of injury-related death. Of those overdose deaths, more than 70% involved a prescription or illicit opioid.

Formed in April 2017, the Oklahoma Commission on Opioid Abuse brought all stakeholders to the table to study the Oklahoma epidemic and formulate a response. Stakeholders included doctors, law enforcement officials, treatment and addiction specialists, local business leaders, and members of the state Legislature. During the 2018 legislative session, seven pieces of legislation recommended by the Commission were signed into law. The nine-member Commission was chaired by then Oklahoma Attorney General Mike Hunter. Since the resignation of Hunter, subsequent attorney generals have not placed as strong an emphasis on policy changes.

In April 2018, Senate Bill 1446 was passed to limit the prescribing in Oklahoma to one initial seven-day prescription of opioids. This law was intended to apply only to Schedule II controlled dangerous substances but ultimately applied to all opioids due to confusing language. Examples of Schedule II drugs are Dilaudid, Demerol, Oxycodone (OxyContin, Percocet), fentanyl, morphine, opium, and codeine.

The effective date on SB 1446 was Nov. 1, 2018. However, many retail pharmacies enforced the law much earlier. Due to some confusion about the law, in the summer of 2018, the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) promulgated an emergency rule that allowed for the prescribing of an opioid via a second seven-day prescription at the same time as the first, with an express "do not fill until" date, but only after a major surgical procedure or for a patient with a homebound ailment. Ultimately, SB 1446 caused a 19% decrease in the number of opioids prescribed in the first year.

In 2019, Senate Bill 848 was passed to modify SB 1446. SB 848 established the seven-day initial prescription limit for opioids. SB 848 applies only to patients who are filling prescriptions outside of a facility setting. It does not apply to inpatients

in hospitals, cancer patients, or patients in hospice. SB 848 codified the OBNDD emergency rule from summer 2018 and cleaned up other provisions. The bill also established the mandatory Opioid Continuing Education Requirement of two CME hours per year for all physicians and other providers who write for Schedule IIs.

In 2018 and 2019, state agencies and stakeholders such as OHA collaborated on a "Prescribing Practice Guideline" document, which outlines how physicians and other health care professionals should interpret the laws surrounding the prescribing of any opioid. View the document at https://bit.ly/3G9dS54. The physician licensure boards also published a "Sample Written Opioid Policy" because the law requires every hospital and physician to have an established policy.

## Prescription Monitoring Program (PMP)

On Jan. 1, 2020, it became mandatory for all prescribers to issue electronic prescriptions for controlled substances and to check the prescription monitoring program before prescribing such substances. All electronic prescriptions of controlled substances are subject to the requirements set forth in 21 CFR, Section 1311 et seq. The PMP mandate applies to all controlled dangerous substances in Schedules II, III, IV, and V. There are a few exemptions to electronic prescribing for controlled substances found in Title 63 Section 2-309 such as: (1) a person licensed to practice veterinary medicine; (2) a person experiencing a technological failure or other extenuating circumstances; (3) a practitioner, other than a pharmacist who dispenses directly to an end user; (4) or a practitioner who orders a controlled substance to be administered on site through an on-site pharmacy in the following: a hospital; a nursing facility; an inpatient hospice facility; an outpatient dialysis facility; a continuum of care facility; or a correctional facility. All physicians have been provided a limited number of paper prescription pads printed by OBNDD to be used only in case of technological failure.

## Opioid Litigation

During his tenure, Attorney General Mike Hunter sued a number of pharma companies on behalf of the state of Oklahoma. In March 2019, Perdue Pharma agreed to pay $270 million to the state. Oklahoma was the first state to win settlement of litigation stemming from the opioid epidemic. In 2019, there were more than 1,600 other cases pending across the U.S. against manufacturers, distributors and others. The basis of the litigation was the aggressive marketing to physicians used by pharma companies like Perdue.

On May 28, 2019, AG Hunter initiated a trial against pharmaceutical company Johnson & Johnson (J&J) in Cleveland County, marking the first case in the U.S. to go to trial on the grounds of the opioid epidemic constituting a public nuisance. In 2019, Judge Thad Balkman of the state District Court ruled in favor of the argument that Johnson & Johnson's marketing of prescription pain medication resulted in a "public nuisance." "Those actions compromised the health and safety of thousands of Oklahomans. Specifically, defendants caused an opioid crisis," Balkman said at the time. The judge also awarded the state a $572 million judgement. However, J&J appealed on Nov. 9, 2021, and the Oklahoma Supreme Court ruled that $465 million (of the $572 million award) be set aside and concluded the general public nuisance law was never intended to address a big public crisis like the opioid epidemic. Oklahoma did not receive any dollars from J&J but has received numerous settlements with other litigants on the opioid epidemic.

# Rural Hospitals

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.

## *Critical Access Hospitals*

Of the 147 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

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. The health care workforce in Oklahoma is served by two medical schools, 63 nursing education programs, and other allied health programs.

## *Recruitment Initiatives*

### Health Care Workforce Training Commission

The Health Care Workforce Training Commission was created by state statute and charged with increasing the number of practicing physicians, nurses and physician assistants in Oklahoma, particularly in rural and underserved areas of the state. Formerly known as the Physician Manpower Training Commission (PMTC), the commission was established by the state in 1975. The commission is made up of nine members who are appointed by the governor and confirmed by the Senate. The commissioners are three practicing allopathic physicians, three osteopathic physicians, two registered nurses, and one member of the public. For more information, go to oklahoma.gov/hwtc.html.

**Oklahoma Nursing Snapshot**

**Licensure Count by Type, FY 2021**

| Type | Count |
|---|---|
| RNs | 51,104 |
| LPNs | 16,233 |
| APRNs | 5,344 |
| Prescriptive Authority | 4,396 |
| AUAs | 410 |
| Nursing Education Programs | 63 |
| AUA Education Programs | 8 |

**Advanced Unlicensed Assistants*
*** Source: Oklahoma Board of Nursing FY 2021 Annual Report*

## *The American Rescue Plan Act and Health Care Workforce*

In 2021, Congress passed the federal American Rescue Plan Act (HR 1319). Its passage provided a unique opportunity for Oklahoma to make significant investments in the state's nursing shortage. In 2022, the state Legislature appropriated millions of dollars to career tech and higher education to expand capacity within existing nursing programs across the state. In total, $64 million has been earmarked for addressing the nursing shortage, which will create more than 2,500 additional health care workers within the next five years.

## *TSET Funds for Workforce Shortages*

TSET (Tobacco Settlement Endowment Trust) funds two grant programs that are critical to addressing the health care workforce shortage:

- The Oklahoma Medical Loan Repayment Program recruits primary care physicians to rural and medically underserved areas through a partnership between TSET and the Health Care Workforce Training Commission by paying off student loans under certain conditions.
- The Oklahoma State University Medical Authority Residency Program supports osteopathic physician residents in rural and medically underserved areas. In

# Oklahoma Physician Snapshot

- **Oklahoma ranks 42nd (down from 36th) in the nation in primary care providers with 231.7 primary care providers per 100,000 citizens. *(America's Health Rankings, 2022)***
- **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 842 allopathic physicians (MDs) practicing in rural areas. *(Oklahoma Board of Medical Licensure, December 2022)***
- **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, Feb. 13, 2019)***
- **Oklahoma has 11,955 allopathic physicians with active licenses, with 6,853 actively practicing in Oklahoma. *(Oklahoma Board of Medical Licensure, December 2022)***

**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.*

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.

# *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.

## 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 advanced 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)*

## 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.ok.gov/osboe

**Oklahoma Board of Nursing**
www.nursing.ok.gov

# 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.

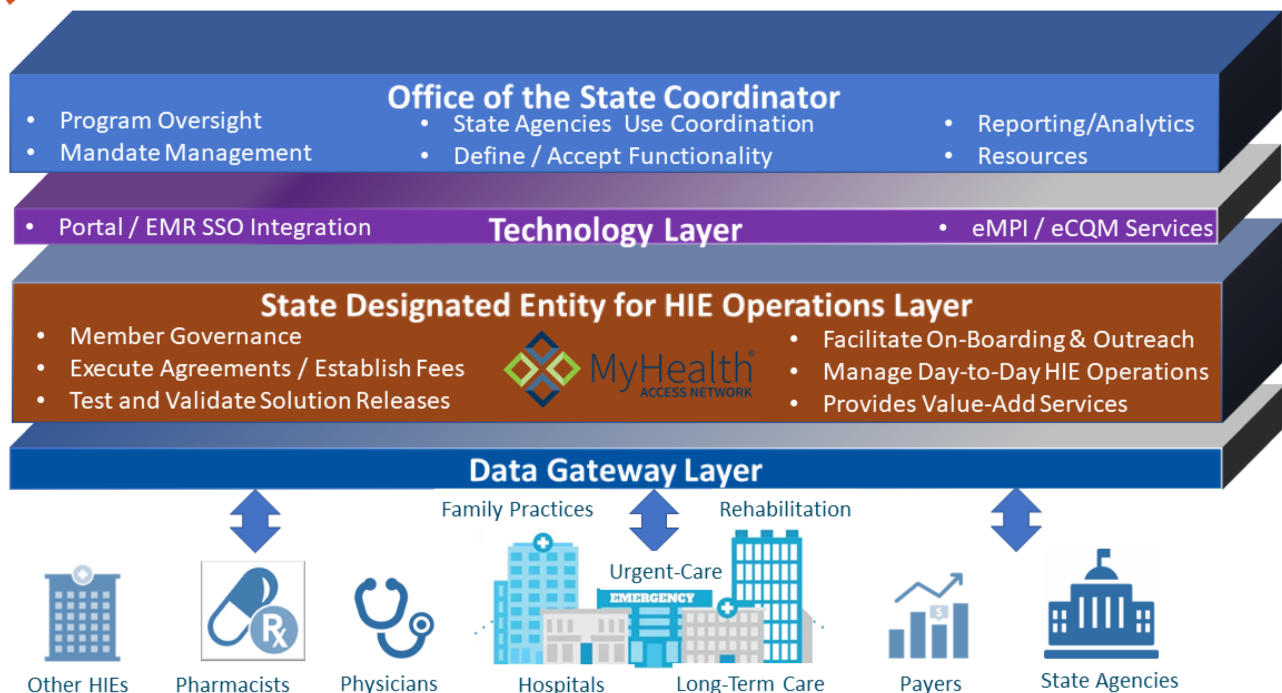
The last year that hospitals could have begun receiving Medicare EHR incentive payments was 2015. Since 2015, hospitals and physicians who are not meaningful users of certified EHRs face reduced payments from Medicare.

## State Health Information Exchange

The 2016 Oklahoma Legislature created the Health Information Technology Advisory Board (HITAB), 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). In the 2019 legislative session, HITAB was replaced with OKSHINE. OKSHINE created the Office of the State Coordinator, which has program oversight over the non-profit data gateways such as MyHealth. Most of the hospital industry is already contracted with and sending data to MyHealth.

Hospitals were uncomfortable with the state owning all of the data outright, so the nonprofit and governance framework was put into place.

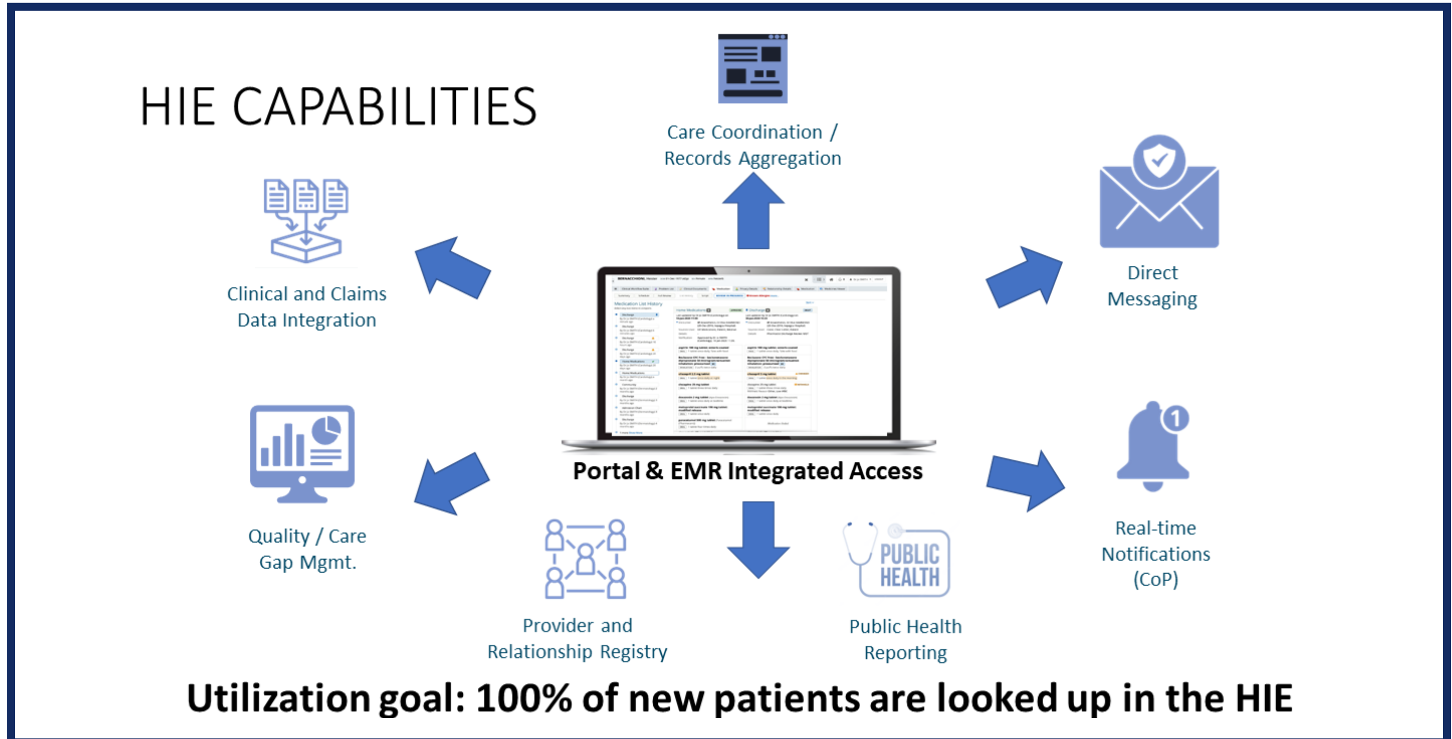
OKSHINE HIE FRAMEWORK



In 2022, Senate Bill 1369 created the Office of the State Coordinator for Health Information Exchange and the concept of a state designated entity for HIE operations overseen by the office. The bill also mandates that "all providers" participate in the statewide HIE by July 1, 2023. The HIE coordinator may grant exemptions for financial hardship or technological capability.

Why do we need a health information exchange? Seventy percent of Oklahomans have records in more than one health care delivery system. Health information exchanges help:

- Reduce health care costs associated with redundant testing, hospital readmissions, and emergency department visits.
- Improve care coordination during transitions between health care settings, reduce adverse drug events and missed preventive care.
- Improve patient experience and performance on quality measures.
- Comply with state and federal programs such as MIPS, ONC, and CMS interoperability rules.




# 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. To obtain "A Guide to Hospital & News Media Relations" for a more complete explanation, members of the Oklahoma media may 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 use 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 offered by some 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 – OU Health:** Physicians at OU Health in Oklahoma City and Tulsa are offering telehealth visits in 77 medical specialties for both adults and children, representing nearly every specialty available. Telehealth visits are available for both existing and new patients. More than 800 OU Health physicians and advanced practice providers are connecting with their patients across the state through telehealth. OU Health completed more than 60,000 virtual visits during the pandemic and is developing staffing models to integrate telehealth into clinic schedules.
- **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. ECHO uses video conferencing to help rural areas access experts in various fields in order to provide better patient care. 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 (OCC). *(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 2016, the OHA, as part of a consortium, worked on overhauling the OUSF from a litigation-based system to an administrative process. House Bill 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.
- The Federal Communications Commission program is a Universal Service Fund subsidy for broadband-facilitated diagnosis and treatment. In 2020, the FCC announced the Commission would carry forward up to $197.98 million in unused funds to provide $802.7 million to meet growing demand for telehealth in rural America. In several COVID relief packages, Congress appropriated an additional $449.95 million to the COVID-19 Telehealth Program at the FCC. The FCC COVID-19 Telehealth program supports the efforts of health care providers to continue serving their patients by providing reimbursement for telecommunications services, information services and connected devices necessary to enable telehealth during the pandemic. It is unknown if these programs will continue after the end of the public health emergency in 2023.
- The federal 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)

## 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 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 | | ✓ | |
| Payment parity mandated in law | | | ✓ |

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

** Except for during PHE

Source: Heartland Telehealth.

program and the Telecommunications (Telecom) program.

- On Nov. 10, 2022, the FCC released a Notice of Funding Opportunity (NOFO) for the Affordable Connectivity Program (ACP) Outreach Grant Program. The ACP is a $14.2 billion FCC program that helps ensure that qualifying low-income households can afford the broadband they need for work, school, health care and more.
- 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. 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)*

## Payment Parity in Telemedicine

Oklahoma has had consumer parity, also known as service parity, in telemedicine since 1997 in state law. Consumer parity requires insurance companies to provide the same services covered via telemedicine as would be covered if delivered in-person. This type of parity does not guarantee the same rate of payment. In 2021, OHA and several other providers formed a coalition to pass payment parity for health care and mental health services. Telemedicine payment parity requires insurers to reimburse the same payment rate for telemedicine services as in-person care. OHA had advocated for payment parity in prior legislative sessions, but until the pandemic, other stakeholders were not supportive. Senate Bill 674 passed and was implemented Jan. 1, 2022, which provided for true payment parity for telehealth across specialties. The bill also allowed for payment of remote patient monitoring for the first time by commercial insurance.

## Physician Patient Relationship in Telemedicine

In 2017, Senate Bill 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 that 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. 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.

| 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 |
| Nurse Monitoring | NICU | School-Based |

# Trauma Care

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 33). 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.

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

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

The Trauma and Emergency Response Advisory Council, under the Commissioner of Health, is the entity that assumes the duties of the Oklahoma Emergency Response Systems Development Advisory Committee, the Medical

## Oklahoma Trauma Center Levels

**All hospitals 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.**

Audit Committee and the Trauma Systems Improvement and Development Advisory Committee. These entities were consolidated by an act of the state Legislature in 2013.

## 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, and 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 medical 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 $119,942 fine per violation for large hospitals and $119,942 per violation by physicians. Under EMTALA, the federal government may also exclude physicians from participation in Medicare and state health care programs. CMS may penalize a hospital by terminating its provider agreement. Additionally, private citizens who are harmed by a physician's or hospital's failure to provide stabilizing treatment may file a civil suit against the hospital to obtain damages available under the personal injury laws of that state in which the hospital is located, in addition to recouping any equitable relief as is appropriate. *(See 42 U.S.C. § 1395dd(d)(2)(A))*

If the hospital does not have the capability to treat the condition, the hospital must first stabilize the patient then make an appropriate transfer 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 will be asked for payment for emergency treatment after they are stabilized.

# Crisis Pregnancy and Hospitals

With the impending U.S. Supreme Court decision in *Dobbs V. Jackson* Women's Health Organization, the Legislature passed several bills in the 2022 legislative session concerning abortion. Following the U.S. Supreme Court's decision, numerous pieces of legislation, commonly referred to as "trigger" laws, went into effect in Oklahoma upon certification by the state attorney general on June 24, 2022, that Roe and Casey were overruled.

## Recently Enacted Statutes

A "Texas-style" abortion ban, House Bill 4327, prohibits an abortion except to save the life of the mother, or when the pregnancy is the result of rape, sexual assault, or incest that has been reported to law enforcement. This statute allows for the members of the public to bring a private civil action against abortion providers or those who aid or abet in the performance or inducement of an abortion within six years of the abortion occurring. Violating the law could result in statutory damages of up to $10,000. (Effective May 6, 2022)

Senate Bill 612 prohibits an abortion with an exception to save the life of the pregnant woman due to a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself. The performance of an abortion is punishable by a fine up to $100,000 and a prison term not to exceed 10 years. The law does not prohibit the prescription or administration of contraceptives if administered before the time a pregnancy could be determined and if the contraceptive is used according to manufacturer instructions. (Effective Aug. 25, 2022)

Senate Bill 1503 prohibits an abortion once a fetal heartbeat is detected. Fetal heartbeat is defined as cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac. Like HB 4327, the bill creates a private right of action by a member of the public against abortion providers or those who aid or abet in the performance or inducement of an abortion within six years of the abortion occurring. Violating the law could result in statutory damages of up to $10,000.

Senate Bill 1555 updated statutory language from Senate Bill 918 (2021) on the Oklahoma Trigger Language law. SB 1555 clarifies the state may enforce O.S. 21 § 861, or enact similar laws prohibiting an abortion, upon certification by the Oklahoma attorney general that Roe v. Wade has been overruled in whole or in part by the U.S. Supreme Court. This statute makes the procurement of an abortion a felony with a prison term of no less than two years and no more than five years, applicable to the provider only.

## Practice Guidelines and Oklahoma Attorney General Memo

Because several of the abortion laws conflict, OHA supported the activities of the physician licensing boards and associations in seeking clarification to the Oklahoma laws. The physician licensure boards worked with the Oklahoma attorney general to clarify questions they received from physicians. As a result, both physician licensure boards adopted Practice Guidelines on Sept. 15, 2022. View the Practice Guidelines at https://bit.ly/3vqYxrF. It should be noted that the practice guidelines are just guidelines and there is a disclaimer on the document that any district attorney may choose to interpret the law differently.

On Aug. 31, 2022, Oklahoma Attorney General John O'Conner issued a memo titled "Guidance for Oklahoma Law Enforcement following Dobbs v. Jackson Women's Health Organization. Information that is relevant to health professionals was contained in the AG guidance, available at https://bit.ly/3WCzbmL.

For example, the AG guidance stated "contrary to disinformation spread by those with a political agenda, there are clear instances where prosecutions should not be initiated:

- Oklahoma laws prohibiting abortion do not allow for the prosecution or punishment of any mother for seeking or obtaining an abortion.
- Nor do Oklahoma abortion prohibitions apply to

> unintentional miscarriages and miscarriage management (such as the removal of a dead child), ectopic pregnancies and treatments, in vitro fertilization (IVF) and other fertility treatments, or uses of prescription of contraception, including Plan B."

The AG guidance is a memo and does not have the same legal weight as an official published AG opinion, which is the rule of law in Oklahoma until a court rules otherwise. A memo issued by the AG does not have the force of law.

# *Gov. Stitt HELP Committee*

On July 11, 2022, Gov. Kevin Stitt issued Executive Order 2022-14 creating the Helping Every Life and Parent (HELP) Task Force, https://bit.ly/3hZtn7Q. The HELP Task Force has 11 appointees and is tasked with making recommendations on the following: support of crisis pregnancy centers in Oklahoma; eliminating unnecessary barriers to adoption; encouraging and providing resources to our communities to support mothers faced with an unplanned pregnancy; finding ways to "do justice, love kindness, and walk humbly" in support of Oklahoma mothers and families; educating Oklahomans on the reality of life in the womb; and empowering nonprofit organizations and local faith communities to efficiently support families and mothers before, during and after childbirth.

On Oct. 28, 2022, the HELP Task Force issued recommendations that included additional medical coverage by the Medicaid agency. Among the final recommendations, which were unanimously approved by the task force in September, was for the Oklahoma Health Care Authority to expand coverage for SoonerCare members receiving pregnancy and postpartum services. Specifically, two major policy changes were proposed. First, to increase Oklahoma's income threshold for full-scope pregnancy-related benefits from 138% to 205% of the federal poverty level (FPL). Secondly, to provide new mothers in Oklahoma with up to 12 months of continuous postpartum coverage.

These policy changes, which will require approval from the Centers for Medicare & Medicaid Services, are fully supported by Gov. Stitt, his office said in a press release. For a full copy of the Task Force report go to https://bit.ly/3Vvh0Oh.

# 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 manmade 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, Senate Bill 178 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 tornadoes in central Oklahoma.

## *Pandemic Planning*

All hospitals are required by federal law to have an emergency preparedness plan that incorporates 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 progressed, hospitals adjusted 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.

# 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

HB 1010xx, passed during a 2018 special legislative session, 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.

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

- The Oklahoma Medical Loan Repayment Program recruits primary care physicians to rural and medically underserved areas through a partnership between TSET and the Health Care Workforce Training Commission by paying off student loans under certain conditions. To date, more than 465,000 patient visits have been conducted through physicians participating in the program.
- The Oklahoma State University Medical Authority Residency Program supports osteopathic physician residents 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 70 hospitals of all sizes, including large health systems, have implemented these treatment services through permanent system changes.
- Between October 2010 and July 2022, 54,244 hospital and clinic patients and employees have been referred by their health care providers to the Oklahoma Tobacco Helpline. Of those 54,244 people, about 29% have accepted services when contacted by the Helpline.
- Those referrals have accounted for an estimated 35,084 years of life saved and $19.2 million in health care cost savings.

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 Oklahoma.

# WorkHealthy Hospitals

## Hospital Workplace Wellness

Work*Healthy* 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.

# Notes

# 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 | 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 32.) |
| Oklahoma Emergency Catastrophic Health Powers Act | Title 63, Section 6101 et. seq. | General Provisions<br>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. | |
| Free Standing Emergency Hospitals | Title 63, Section 1-706 | Creation of state EMTALA and signage requirements. |
| 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. | Known as "CON." |
| 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 |
| **Health Information Exchange** | | |
| Oklahoma Health Information Exchange Act | Title 63, Section 7100.1 et. seq. | Establishes standards for health information exchange and establishes regulatory structure. |
| **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. |
| Medicaid Managed Care | Title 56, Section 4002.1 et. seq. | Also called the Ensuring Access to Medicaid Act and the "Guardrail Bill". |
| **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 10.) |
| 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 et. seq. | |
| Transparency in Health Care Prices Act | Title 63, Section 1-725.1 | Oklahoma statutory pricing transparency law |
| 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<br>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 |
| Mandatory Insurance Coverage of Mammography screenings | Title 36, Section 6060 | Diagnostic mammograms, breast magnetic resonance imaging and breast ultrasounds are now covered by commercial insurance. |
| 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. |
| No Patient Left Alone | Title 63, Section 1-706a | |
| 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 on telemedicine. |
| Oklahoma Telecommunications Act of 1997: Oklahoma Universal Service Fund | Title 17, Section 139.106 | OUSF provides funding for some telecommunication service lines to operate telemedicine, administered by the Oklahoma Corporation Commission. |
| Oklahoma Telemedicine Parity | Title 36, Section 6803 | Payment parity achieved in 2021 in SB 674. |
| Physician Patient Relationship for Purposes of Telemedicine Encounter | Title 59, Section 478.1 | |

# 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.

### Average Commercial Rate (ACR)
A Medicaid finance program where hospitals will be paid a supplemental payment based on claims and reimbursement. It is based on the average amount of payment allowed by the top commercial payers, including copays and deductibles, for each service (by CPT billing code) provided by the hospital. ACR was created in statute in Oklahoma in 2022 in SB 1337 and SB 1396 as part of implementation of Medicaid managed care.

### 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 24).

## 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. (See page 4.)

## 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 Emergency Hospital (REH)

Established by the Consolidated Appropriations Act of 2021 (CAA), Rural Emergency Hospital (REH) became a new designation for hospital licensure in the Medicare program. The designation is meant for facilities that convert from either a critical access hospital (CAH) or a rural hospital with less than 50 beds and that do not provide acute care inpatient services. The REH designation was meant to help financially struggling rural hospitals by offering such hospitals financial incentives for conversion.

## 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

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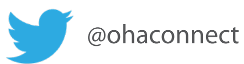
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