2015

Oklahoma Hospitals

Oklahoma Hospital Association

A Resource Guide for *Elected Officials*

Oklahoma Hospitals

A Resource Guide for Elected Officials

Purpose

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

The Oklahoma Hospital Association

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

Currently, the OHA represents more than 135 hospitals and health care entities across the state of Oklahoma. OHA's primary objective is to promote the welfare of the public by leading and assisting its members in the provision of better health care and services for all people.

OHA provides a variety of membership services including legislative advocacy and representation, communications, educational programs, information and data, quality initiatives and more. OHA also partners with a number of other organizations on a variety of initiatives to lower the number of uninsured and improve the health of Oklahomans.

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

The information in this document is current at publication date of February 2015.

Table of Contents

Oklahoma Hospitals 1
Types of Hospitals 2
Economic Impact 3

Health Care's Shifting Environment 3
Health Care Reform 3
Affordable Care Act 4
Increasing Public Transparency 4

Financial Information 5
Funding Sources 5
Hospital Payments 9
Billing & Collections 10
Uncompensated Care 11
Community Benefit 11

Quality and Patient Safety 12
Mandated Quality and Safety Programs 12
Voluntary Quality and Safety Programs 12
Pay for Performance 14
Clinical Initiatives 14
Infection Control and Prevention 15
Quality Public Reporting and Transparency 15

Rural Hospitals 16
Oklahoma is a rural state 16
Part of a rural health safety net 16
Economic impact of Critical Access Hospitals 16
The rest of the safety net 16

Health Care Workforce 17
Nursing and Allied Health Recruitment 17
Physician Recruitment 18
Medical Licensing and Credentialing 19

Health Information 19
Electronic Health Records 19
State Health Information Exchange 20
HIPAA 20

Telemedicine 20
Regulation of Telemedicine 20
Funding of Telemedicine 20
Telehealth 21

Trauma Care 21
Background 21
Trauma Legislation 21
Trauma Fund 22
Revenues and Distributions 22
EMTALA 22
Oklahoma Trauma Center Levels 22

Disaster Preparedness 23
Ebola and other infectious diseases 23

Improving Oklahoma's Health 23
Oklahoma Health Improvement Plan 23
Oklahoma's Tobacco Tax 24
Tobacco Settlement Endowment Trust (TSET) 24
OHA Health Improvement Initiatives 25

Appendix 1: Statutory References 27
Appendix 2: Snapshot of Oklahoma Hospitals 29
Glossary of Terms 33

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 33).

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

City and/or county-owned hospitals

These 42 hospitals fall under the non-profit or not-for-profit category. In many instances these hospitals are public trusts.

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

For a complete list of *Oklahoma hospitals* by size and type, see Appendix 2 on Page 29.

For-profit hospitals

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

Specialty hospitals

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

Critical access hospitals (CAH)

Established under the federal Balanced Budget Act of 1997, CAHs are limited service hospitals located in rural areas. CAH is a special Medicare designation for payment that is limited to hospitals with 25 beds or less and an average length of stay less than four days. There is a state and federal approval process required by the Oklahoma State Department of Health and the Centers for Medicare & Medicaid Services for this designation. Under Medicare, CAHs are paid at 101 percent of Medicare cost instead of a fixed diagnostic related group (DRG) payment (see glossary page 33) as other hospitals. Further, there are some differences in regulatory requirements. There are 34 CAHs in Oklahoma.

System hospitals

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

Government-owned hospitals

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

Indian Health Service/Tribal Hospitals

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

Teaching Hospitals

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

Economic Impact

The Health Care Industry in Oklahoma

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

- Employed more than 215,000 people in Oklahoma (November 2014).
- Directly contributed $11.15 billion to Oklahoma's Gross Domestic Product (GDP) in 2013 (real dollars).
- Has grown at an average annual rate of 2.2 percent per year over the last five years in Oklahoma, which is greater than the 1.8 percent growth rate in the national industry and greater than the 1.8 percent growth in the state's economy.

Economic Impact of Oklahoma Hospitals

According to the American Hospital Association's 2013 survey, Oklahoma's 157 hospitals:

- Employ 75,889 persons.
- Deliver 55,828 babies yearly.
- Provide for 481,420 inpatient admissions, 2,113,791 emergency room visits, and 8,395,867 other outpatient visits.
- Have an average daily inpatient census totaling 7,757.
- Generate $9,364,828,563 in net revenue (excluding tax revenue).
- Have annual expenses of $9,936,041,328.
- Pay salaries and wages of $3.818 billion.

Source: AHA Annual Survey 2013

Health Care's Shifting Environment

Health Care Reform

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

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

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

Affordable Care Act

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

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

Expanding Medicaid coverage would provide coverage mostly to childless adults whose income is below 138 percent of the federal poverty limit. For a family of two, this would be a family income that is below $21,187, or less than $410 per week[1]. It is estimated that approximately 233,334 individuals would enroll in coverage over 10 years, based on a medium take-up rate[2]. The new coverage would be paid for through 2016 with 100 percent federal funding, phasing down to 90 percent by 2020, and then remaining at 90 percent. The state's share would increase to the maximum of 10 percent in 2020.

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

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

1. Based on 2014 Federal Poverty Level Guidelines

2. Source: Kaiser State Health Facts; Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma."

Increasing Public Transparency

Pricing

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

In 2011, the Oklahoma State Department of Health began a public web service offering similar information, the Oklahoma Hospital Quality Reports, as part of their web-based query system, Oklahoma Statistics on Health Available for Everyone (OK2SHARE). This system allows users to query the state's public health dataset directly. Each hospital's median charge and length of stay for a diagnosis group or inpatient procedure is compared with state and U.S. medians.

This **Oklahoma hospital pricing information can be found at** www.health.state.ok.us/stats, under Hospital – Quality Reports, or under Hospital – Inpatient Discharge – Statistics. Because the state now provides this information for the public, OHA has discontinued its hospital pricing transparency site.

Quality

In addition, to monitor the quality of care in a hospital and to make information about the care that a hospital gives transparent to the public, Medicare and the state of Oklahoma (through the Oklahoma State Department of Health) require that hospitals report certain aspects of care. This includes whether or not the hospital has followed evidence-based standards of care for certain types of patients and the rate at which certain events occur. The number of indicators that a hospital must report grows yearly. In 2015, acute hospitals must report on 58 inpatient measures and 28 outpatient measures. In addition, acute long term care hospitals must report on 12 measures, psychiatric hospitals on 15 measures, rehabilitation hospitals on seven measures and cancer hospitals on 19 measures. Medicare uses these indicators to determine the level of payment a hospital receives. **To view this hospital quality data, go to www.hospitalcompare.hhs.gov.**

Financial Information

Funding Sources

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

Medicare

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

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

Medicare payments vary between geographic regions to reflect local wage rates. Hospitals in Oklahoma's cities receive higher payment rates from Medicare than rural facilities.

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

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

Medicare is overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS), and is administered through contractors known as Medicare Administrative Contractors (MACs). The MAC for hospitals in Oklahoma and 10 other states, effective Oct. 29, 2012, is Novitas Solutions, Inc. Formerly known as Highmark Medicare Services, Novitas is a wholly-owned subsidiary of Diversified Service Options, Inc., a subsidiary of Blue Cross Blue Shield of Florida, and has headquarters in Camp Hill, Penn.

Medicare consists of:

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

Medicaid

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

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

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

FMAP - The Federal Medical Assistance Percentage

(FMAP) determines the amount of federal payments to the state for medical services. The FMAP formula compares each state's average per capita income with the national average. This formula has not changed in 49 years. This calculation changes yearly and always impacts funds available for Medicaid. States with lower incomes receive more federal assistance. The minimum FMAP is 50 percent. Oklahoma's FMAP for 2015 is 62.30 percent, and for 2016 will be 60.99 percent. In times of relative prosperity for the state, Oklahoma's FMAP is decreased, reducing federal contributions to Oklahoma's Medicaid program. Oklahoma's FMAP is higher than average because of our lower than average per capita income.

Populations Eligible for Medicaid in Oklahoma

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

*Federal Poverty Level; **Supplemental Security Income

Source: Oklahoma Health Care Authority 2014

Medicaid does not provide coverage to all low income people. To qualify for Medicaid coverage persons must meet:

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

Even the extremely poor do not qualify for Medicaid if they do not fit into one of these categories. Therefore, non-disabled working age adults without children are not eligible for Medicaid in Oklahoma unless the state chooses to cover this population as allowed by the ACA (see page 4). See chart to the right for income guidelines.

2015 Poverty Level Guidelines

as published in the Federal Register on Jan. 22, 2015. All states except Alaska & Hawaii - annual income

Family Size	Federal Poverty Guideline	37% FPL (1)	133% FPL (2)	185% FPL (3)	200% FPL (4)
1	$11,770	$4,355	$15,654	$21,775	$23,540
2	15,930	5,894	21,187	29,471	31,860
3	20,090	7,433	26,720	37,167	40,180
4	24,250	8,973	32,253	44,863	48,500
5	28,410	10,512	37,785	52,559	56,820
6	32,570	12,051	43,318	60,255	65,140
7	36,730	13,590	48,851	67,951	73,460
8	40,890	15,129	54,384	75,647	81,780

FPL = Federal Poverty Level

(1) SoonerCare income limit for a parent of an eligible child (2) Potential Medicaid expansion (Obamacare) income limit

(3) SoonerCare income limit for children and pregnant women (4) Insure Oklahoma income limit – Employer Sponsored Insurance

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

SCHIP - The State Children's Health Insurance Program (SCHIP), now more commonly known as CHIP, 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. 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. This is about a three-to-one match, meaning for every $1 the state allocates, the state receives $3 from the federal government. For 2015, Oklahoma's enhanced FMAP for CHIP is 73.61 percent.

- On Feb. 4, 2009, President Obama signed into law the 2009 SCHIP Reauthorization Act through September 2013. The program is funded through a 62 cent increase in the federal tax on cigarettes.
- The Affordable Care Act split CHIP's authorization into two pieces.
  - Funding was extended two years, through September 2015.
  - Authorization continues through 2019.

Medicaid by the Numbers

Medicaid (SoonerCare) Eligibility

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

Medicaid Enrollment SFY2014

1,033,114 enrolled members consisting of:

446,647 Adults/average expenditure per year including nursing home care – $6,191

586,467 Children/average expenditure per year – $2,777

Medicaid: A State and Federal Partnership with Matching Funds

SoonerCare FMAP* for 2015 – 62.3% federal funds/37.7% state funds
*Federal Medical Assistance Percentage

Oklahoma Medicaid – 41,174 Providers of Care

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

Medicaid Budget Cuts in 2010, deepened in 2014

Across-the-board budget reductions of 3.25% to all providers in 2010 were followed by 7.75% reductions in July 2014. In addition to the rate cuts, OHCA has:

- Reduced co-insurance/deductible payments;
- Cut behavioral health payments for residential treatment for children;
- Reduced pharmacy coverage and rates;
- Reduced coverage and rates for dental services;
- Reduced rates for durable medical equipment; and
- Implemented prior authorization for some hospital services.

Supplemental Hospital Offset Payment Program (SHOPP)

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

In 2011, the Legislature passed HB1381, the Supplemental Hospital Offset Payment Program (SHOPP), to allow hospitals to provide additional money for the state to draw down federal matching funds to approximately the federal upper payment limit. (Federal upper payment limit refers to a federal limit to matching that is equivalent to what Medicare would pay for the same services. In 2011, Oklahoma hospitals were paid by Medicaid an average of 67 percent of Medicare payment rates.) Forty-six states have provider fee programs like SHOPP. The Oklahoma Legislature passed a provider fee for nursing homes in 2000 and amended it again in 2011.

For 2015, the Supplemental Hospital Offset Payment Program assesses hospitals 3.0 percent of annual net patient revenue to initially generate approximately $199 million annually for the state's share, to garner a $325 million in federal funding for a total of $524 million. Of the $524 million, $445 million is paid to hospitals as supplemental payments for care provided to cover the unreimbursed cost of Medicaid (SoonerCare) patients and $79 million is used to maintain current SoonerCare payment rates for physicians and other Medicaid providers to ensure access to care.

Seventy-eight hospitals participate in the assessment, while 71 hospitals are excluded, including critical access hospitals, 13 long-term care hospitals, 14 specialty hospitals, OU Medical Center, one Medicare certified children's hospital, and a hospital which provides the majority of its care under a state agency contract.

The SHOPP act provides for a sunset of Dec. 31, 2017. The program has worked as anticipated and has provided stability in the Medicaid program.

Insure Oklahoma -
Public/Private Health Insurance Partnership

Insure Oklahoma Employer Sponsored Insurance (ESI) is a health coverage subsidy to help small business owners provide health insurance to their low to moderate income employees and employees' spouses and dependents. ESI is available to businesses with up to 99 employees. The health coverage plans are commercial insurance plans available in the private market. In August 2010 the ESI expanded to offer coverage for dependent children of Insure Oklahoma members who are between 186 and 200 percent of the federal poverty level. The program was to terminate at the end of 2014, but the state was granted a one year extension through Dec. 31, 2015.

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

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

Enrollment as of January 2014 includes:
Businesses - 4,811;
ESI enrollees - 14,471;
IP enrollees - 4,966;
Total enrollees - 19,437.

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

Employees Group Insurance Division (EGID)

The Employees Group Insurance Division (EGID), formerly the Oklahoma State & Education Employees Group Insurance Board (OSEEGIB), provides group health, dental, life, and disability insurance plans for Oklahoma's public sector employees. These plans are known as HealthChoice.

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

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

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

Workers' Compensation

The Oklahoma Workers' Compensation Commission publishes a Schedule of Medical and Hospital Fees, which sets the rates every two years for hospital and physician payments. Inpatient payments depend on the patient's diagnosis and surgery, much like Medicare rates. Additional payment is made for implanted devices, based on the device's cost. For more information regarding medical fee schedules, see www.ok.gov/wcc/Resources/Medical_/index.html.

Indian Health/Tribal Services

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

The IHS has compacted with some tribes to operate health facilities for Indians, including hospitals. (See Appendix 2 on page 29.)

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

Hospital Payments

Oklahoma's 157 hospitals have total annual expenses of $9.9 billion according to the American Hospital Association's 2013 Annual Survey.

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

These two programs cover approximately one third of the population, but provide close to half of the typical hospital's revenue.

Oklahoma Hospital Patient Revenue (in $ millions)

	Gross Charges	Net Revenue	% of Net Revenue
Medicare	$ 12,868	$ 3,209	36.4%
Medicaid	4,569	1,243	14.1%
Other third-party payers	10,692	3,994	45.3%
Self-pay revenue	2,246	365	4.1%
Total	$ 30,375	$ 8,812	100%

Gross Charges and Net Collections

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

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

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

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

There are currently no penalties for violations of this provision under state law.

Billing & Collections

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

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

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

Hospital Pricing Transparency

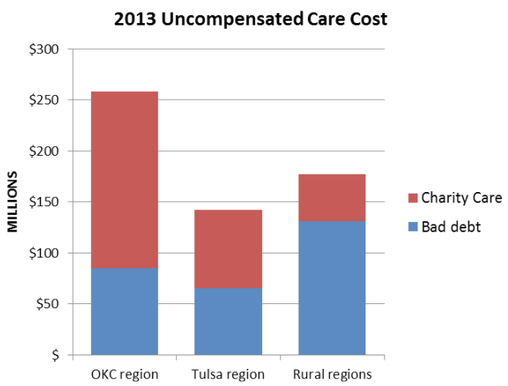
In 2007, the Oklahoma Hospital Association introduced a user-friendly website that allowed consumers to view inpatient prices for hospitals in their communities and across the state. The site enabled consumers to search a database of hospital prices for most inpatient hospital procedures or diagnoses, such as a C-section or a total knee replacement. Pricing information for these services was taken from inpatient discharge data reported by hospitals to the Oklahoma State Department of Health.

In 2011, the Oklahoma State Department of Health began a public web service offering similar information, the Oklahoma Hospital Quality Reports, as part of their web-based query system, Oklahoma Statistics on Health Available for Everyone (OK2SHARE). This system allows users to query the state's public health dataset directly. Each hospital's median charge and length of stay for a diagnosis group or inpatient procedure is compared with state and U.S. medians.

This Oklahoma hospital quality and pricing information can be found at: www.health.state.ok.us/stats/index.shtml. Because the state now provides this information for the public, OHA has taken down its hospital pricing transparency site.

Uncompensated Care

Oklahoma hospitals provide more than $577 million in uncompensated care annually, according to the American Hospital Association's annual hospital survey conducted in 2014. Uncompensated care includes the cost of charity care and bad debt. These shortfalls must be "cost shifted" to insurance companies, self-insured businesses, and others who pay for health care services.



The Uninsured in Oklahoma

- More than one in six (666,000) Oklahomans is uninsured, 17 percent of our citizens.[1]
- Oklahoma ranks 7th highest in the nation for its percent of uninsured citizens.[1]
- One in 10 Oklahoma children (98,000) is uninsured, 9.8 percent.[2]
- Oklahoman ranks 15th in the nation for percent of uninsured children.[2]

1. According to U.S. Census Bureau, 2013 American Community Survey, Table HI06. Percentages are rounded.

2. According to The Uninsured, A Primer, Kaiser Commission on Medicaid and the Uninsured, December 2014 (2013 data).

Community Benefit

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

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

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

- Providing free or low-cost health screenings, health education and wellness programs, counseling services, transportation and immunizations.
- Providing medical, nursing, and allied health education/ training.
- Offering medical treatment at or below the cost of providing care.
- Performing medical research.
- Donating funds or services to community organizations.
- Serving as community volunteers.
- Offering essential health services for citizens which generate a negative profit margin, such as burn centers and trauma centers.

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

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

Quality and Patient Safety

Ensuring quality and patient safety is a never-ending job in a hospital. Hospitals continually strive to raise their quality standards, keep patients safe and improve their efforts.

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

Quality in hospitals can be divided into three areas:
- Clinical quality
- Patient safety, including infection prevention
- Patient satisfaction

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

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

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

Mandated quality and safety programs

State

While hospitals spend many of their resources voluntarily participating in activities that ensure patient safety and quality care, regulatory entities provide oversight of the hospital industry (see Figure 1, page 13). At the state level, the Oklahoma State Department of Health licenses hospitals and continually monitors all aspects of delivering safe care. This includes requirements regarding the environment, medical records, education and training of physicians and staff, infection control, and monitoring the quality of care provided. For more information, visit www.ok.gov/health/Protective_Health/Medical_Facilities_Service/Facility_Services_Division/index.html.

Federal

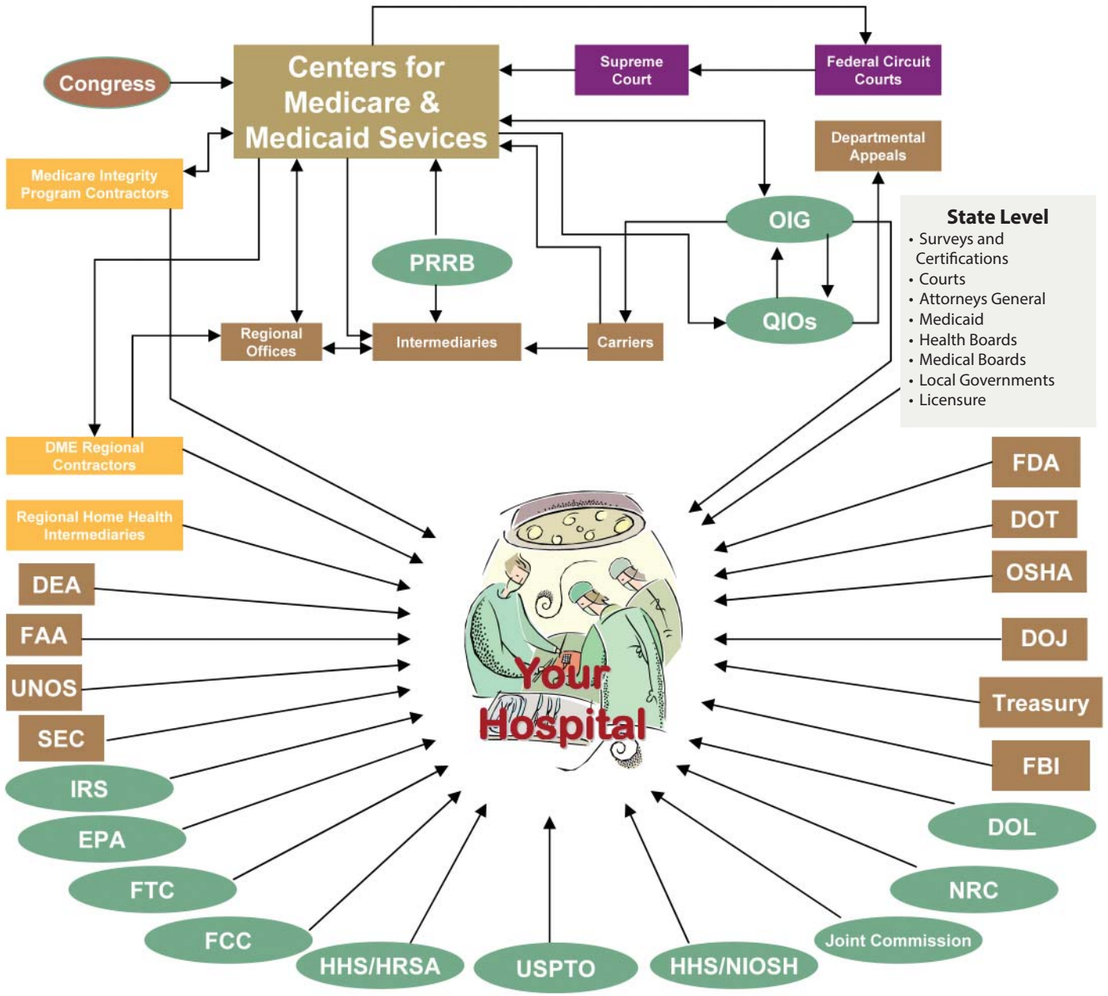
In order for hospitals to treat Medicare patients and receive Medicare funds, they must comply with "Medicare Conditions of Participation." These conditions include many aspects of hospital administration and requirements for care, just as the state licensure requirements.

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

Voluntary quality and safety programs

Accreditation - Hospitals utilize accreditation organizations to demonstrate that they have passed a rigorous external inspection and the care they provide meets the highest and most current standards. While some accreditation organizations survey the overall hospitals, many also specialize in a specific area such as the laboratory and radiology. Hospitals pay thousands of dollars, depending on their size, for this external review and/or educational opportunities (see page 5).

Quality, Patient Safety and Regulatory Oversight



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

Figure 1: Regulatory entities providing oversight of the hospital industry

Medicare Quality Improvement Organization - Hospitals also voluntarily participate in the Medicare Quality Improvement Program. The Medicare Quality Improvement Organizations (QIO) are private organizations that contract with Medicare to set goals and implement new quality improvement projects every three years. They also perform the statutory requirement to monitor the quality of care provided by performing chart review and investigating complaints. KeyPro is the organization that performs care review in Oklahoma. Texas Medical Foundation (TMF) is the QIO in Oklahoma that assists physician offices, hospitals and nursing homes in adopting and implementing systems, redesigning processes and developing organizational cultures to accelerate the rate of quality improvement.

Pay for Performance

Through the pay for performance program, also called the "Value Based Purchasing" program (VBP), hospitals are at risk to lose reimbursement in several different areas including:

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

By FFY 2017, hospitals could lose up to 6 percent of their reimbursement from Medicare, depending on how they perform compared to other hospitals in the U.S in the areas of condition specific quality, patient outcomes, hospital acquired conditions, readmissions and performance efficiency (cost per Medicare beneficiary). The number of conditions and measures that are included in the VBP program will increase each year. Many of these measures are available on www.hospitalcompare.hhs.gov.

Patient Satisfaction

Hospitals are required to report on 27 patient satisfaction indicators and are now being paid according to their level of rating. These rates are available for public viewing at www.hospitalcompare.gov. Many hospitals are meeting together to identify and share ways they can improve the customer experience.

Clinical Initiatives

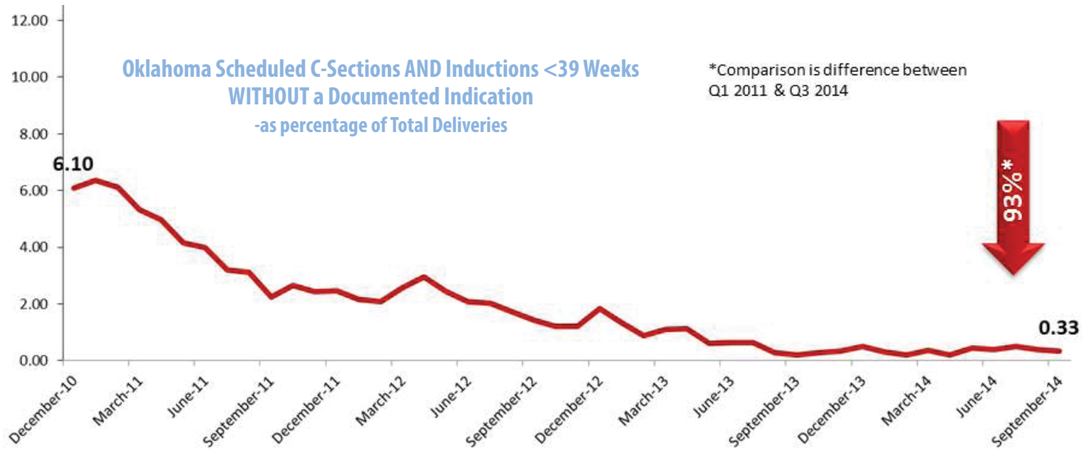
To assist and enhance their efforts to improve the quality of care and patient safety, hospitals participate in organized projects and initiatives. Through these initiatives they have access to subject matter experts and learn to implement best practices and collect and monitor data to track their progress. These initiatives include topics such as preventing hospital acquired infections, falls, pressure ulcers, readmissions, medication errors, and early unnecessary deliveries before 39 weeks of pregnancy.

Measure	% Improvement
Central Line Associated Blood Stream Infections	13%
Early Elective Deliveries	75%
OB Trauma	6%
Patient Falls	23%
Readmissions	13%
Surgical Site Infections	16%
Venous Thromboembolism	2%

2012-2014

Oklahoma Hospital Patient Safety Progress

The results of two recent OHA-led initiatives are above and below.



Infection Control and Prevention

Hospitals are continuously alert for patients with communicable diseases and infections. They are under federal and state regulations to identify, report, prevent and treat many types of infections. When they are identified, they are reported to the appropriate agencies.

Communicable diseases are reported to the Oklahoma State Department of Health (OSDH), which then uses the information for public health purposes. Examples of these are Ebola, Measles, Pertussis and Influenza. A complete list of reportable diseases can be found on the OSDH website at: www.ok.gov/health/Disease,_Prevention,_Preparedness/Acute_Disease_Service/Disease_Reporting/What_to_Report/index.html.

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 do 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.
2. Some of the reportable hospital acquired infections are included in the CMS value based purchasing program for hospitals.
3. Some of the infections are included in the payment penalty program of CMS called "Hospital Acquired Conditions."

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

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

Quality Public Reporting and Transparency

To monitor the quality of care in a hospital and to make information about the care that a hospital gives transparent to the public, Medicare and the state of Oklahoma (through the Oklahoma State Department of Health) require that hospitals report certain aspects of care. This includes whether or not the hospital has followed evidence-based standards of care for certain types of patients and the rate at which certain events occur. The number of indicators that a hospital must report grows yearly. In 2015, acute hospitals must report on 58 inpatient measures and 28 outpatient measures. All types of hospitals have reporting requirements. For example, acute long term care hospitals must report on 12 measures, psychiatric hospitals on 15 measures, rehabilitation hospitals on seven measures and cancer hospitals on 19 measures. Medicare uses these indicators to determine the level of payment a hospital receives.

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

Rural Hospitals

Oklahoma is a rural state

With a population of 3,850,000 (U.S. Census 2013 estimate), 1,898,000 Oklahoman's live in the five most populous counties of Oklahoma, Tulsa, Cleveland, Comanche, and Canadian. This leaves over half the state's population spread across the remaining 72 counties. Access to timely, appropriate and affordable care is just as important to the state's rural residents as it is to urban residents, especially when that access may mean a 20 to 50-mile trip over farm-to-market roads.

Part of a rural health safety net

Of the 157 hospitals in Oklahoma, 34 are designated as Critical Access. A Critical Access Hospital (CAH) is a hospital certified under a set of Medicare Conditions of Participation (CoP), which 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. When an outside entity looks to invest in a community, they look at workforce availability, infrastructure, and access to health care. If one of these is missing, that entity will bypass that community and possibly the state. Communities that are fortunate enough to have a CAH already enjoy a significant economic impact. The CAH is generally one of the largest employers in that community. An assessment done in 2013-14 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 CAH $3,829,235
- Secondary economic impact per CAH $689,262
- Total economic impact per CAH $4,518,498

Taking that average total economic impact, and multiplying it by the 34 CAHs in Oklahoma results in a total annual economic impact of $153,628,932 for the state.

The rest of the safety net

97 total "rural" hospitals (those located outside of the five most populated counties), 34 CAHs, 63 with other designations, provide local, affordable, quality care to 68 counties across the state. These hospitals, working in partnership with rural health clinics, community health centers, physicians in private practice, and local emergency medical services, are the backbone of the rural safety net.

Health Care Workforce

Nursing and Allied Health Recruitment

Of the nearly 300 individually identified allied health professions, very few can be found in adequate supply in Oklahoma, and the shortage is compounded for rural areas.

Addressing workforce shortages in Oklahoma

As part of the Oklahoma Health Improvement Plan's Healthcare Workforce Workgroup, and in conjunction with National Governors Association's Health Division, a health workforce summit was held in 2014. The four focus areas of the summit, and ultimately the implementation task of the Healthcare Workforce Workgroup are: coordination of state workforce efforts through a single, centralized entity; identification of the top 20 most critical health care occupations through the development of a comprehensive data set; putting strategies in place to increase the supply of the top 20 critical health occupations; and development of at least five policies/programs that address recruitment/training/retention of a health care workforce and keep it at the optimum level.

Oklahoma Health Care Workforce Center

Initially created through legislation (SB 1394) in 2006, the Oklahoma Health Care Workforce Center operates as a private nonprofit organization that acts as a clearinghouse of information and activities focused on health care workforce supply and demand issues. All state programs are to coordinate efforts and resources with the Center.

The Center is a member of the workforce committee of the Oklahoma Health Improvement Plan (OHIP) charged with helping develop and implement a health care workforce strategy for Oklahoma. The Center also serves as the co-lead organization of the Oklahoma Action Coalition that was formed to implement recommendations from the Institute of Medicine's report on the future of nursing. In addition, the Center works with health care employers to determine vacancy and turnover rates for key occupations on an annual basis and manages www.okhealthcareers.com, a website designed to give children, teens, and adults the information they need to choose a health care career.

The Center launched The Clinical Hub in 2011, an online tool to help hospitals and schools manage the placement of nursing and other health care students in clinical rotations. The Clinical Hub was developed in response to a shortage of health care professionals and the need to increase the education pipeline. The tool provides information regarding hospital capacity to handle rotations and helps schools increase and maximize rotations for their students. In addition, The Clinical Hub can provide information to state government to help with decision making regarding the allocation of education and workforce resources. For more information on The Clinical Hub, visit www.theclinicalhub.com.

The premiere program offered by the Center is an annual conference on the use of simulation in health care. The conference draws more than 100 health care professionals from academia and practice and brings in expert speakers from around the country to teach best practices on how to use simulation to enhance critical thinking and clinical skills to improve health outcomes for Oklahomans.

The Center currently receives no appropriation from the Legislature and must instead rely on cash and in-kind donations from the Oklahoma State Regents for Higher Education and the Oklahoma Department of Career and Technology Education, as well as funds from the provision of program services.

For more information about the Center, visit www.ohcwc.com.

Health care job seekers log on to OKHospitalJobs.com

Health care job seekers across Oklahoma have found a valuable tool in www.okhospitaljobs.com, an online health care job search tool hosted by the Oklahoma Hospital Association. Numerous hospitals and health clinics post jobs to the site, which launched in 2003. OKHospitalJobs.com has more than 20,000 unique visitors each year. More than 1,000 statewide health jobs are available for search on the site at any given time in a variety of medical professions, including registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist, speech pathologist, radiology technician, pharmacist and many others. Non-clinical and administrative positions are also posted to the site.

Physician Recruitment

Just as retaining an adequate, quality workforce of nursing, allied health professionals is vital, physician recruitment is a primary concern for OHA members. Retaining medical students and residents trained in Oklahoma is critical. University of Oklahoma College of Medicine and Oklahoma State University College of Osteopathic Medicine train physicians and provide residencies for some specialty certifications. OU School of Medicine may accept up to 165 new medical students each year and OSU College of Osteopathic Medicine may accept up to 115 new medical students each year. OU Tulsa has become accredited for a full four-year program and will begin with around 25 students in 2015.

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

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

Physician shortages in Oklahoma

- Oklahoma ranks 49th in the nation in primary care providers (United Health Foundation Health Care Rankings) with 80.2 physicians per 100,000 citizens.
- 63 of Oklahoma's 77 counties are designated as the primary care health professional shortage areas.
- According to the American Medical Association, Oklahoma ranks last in the nation in physician to patient ratio.
- Oklahoma ranks third lowest among rural states for maldistribution of physicians, with only 184 physicians per 100,000 people.
- Only 6 percent of residents nationally desire a rural practice.
- Oklahoma's 2010 Health Improvement Plan proposed by the State Board of Health listed training and recruitment of primary care physicians as one of the top five issues Oklahoma must address.

Medical Licensing and Credentialing

Licensure

Licensure of health care providers such as physicians, physician assistants and nurses, to name a few, is a function of each state. State boards such as the State Board of Medical Licensure and Supervision, which licenses medical doctors (MD), physician assistants (PA), physical therapists (PT) and others; the State Board of Osteopathic Examiners, which licenses osteopathic physicians (DO); and the Oklahoma Board of Nursing were created by the Legislature. Licensure boards are funded by fees paid by the licensee.

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

Credentialing

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

For more information...

- Oklahoma Board of Medical Licensure & Supervision
  www.okmedicalboard.org
- Oklahoma Board of Osteopathic Examiners
  www.docboard.org/ok/ok.htm
- Oklahoma Board of Nursing
  www.youroklahoma.com/nursing

Health Information

Electronic Health Records

The American Recovery and Reinvestment Act (ARRA) of 2009 established incentive payments for the use of Electronic Health Records (EHRs) by hospitals and physicians, through both the Medicare and Medicaid programs.

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

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

The last year that hospitals can begin receiving Medicare EHR incentive payments is 2015. Beginning in 2015, hospitals and physicians who are not meaningful users of certified EHRs will face reduced payments from Medicare.

The goal of the EHR incentive program is to allow for increased efficiency and less redundancy in patient care.

State Health Information Exchange

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

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

HIPAA

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

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

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

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

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

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

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, smart phones, wireless tools 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 consumer's homes and workplaces. Telemedicine is not a separate medical specialty.

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 State Department of Health**: Licenses the telemedicine network. Such licensure is necessary for obtaining Medicaid reimbursement.
- **Oklahoma Health Care Authority**: Provides for reimbursement of telemedicine services over a licensed network for certain conditions.
- **Oklahoma Board of Medical Licensure and Supervision** and **Oklahoma State Board of Osteopathic Examiners**: Provide for licensure and supervision of licensed physicians for purposes of providing telemedicine services in Oklahoma.

Funding of Telemedicine

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

Several funding sources are available in Oklahoma for reimbursement of hardware and operations that are the necessary infrastructure to operate telemedicine networks and sites.

- 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.

- 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 first before state funding. In 2012, telemedicine requests were expected to be approximately $26 million for OUSF for telemedicine infrastructure.
- The federal HealthCare Connect Fund was established in 2013 with a nationwide pool of $400 million for funding telemedicine services. In 2014, only $8 million was awarded to Oklahoma entities.
- Insurance, Medicare or Medicaid funding: Products and services related to telemedicine are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. In Oklahoma, most OHA member hospitals are origination or receiving sites for telemedicine. Reimbursement for telemedicine services can vary depending on the payer. Oklahoma has parity in telemedicine, which means if a service is provided face-to-face and reimbursed, then the service shall also be reimbursed by the insurance carrier. The Medicaid program in Oklahoma does reimburse for numerous telemedicine services.

In 2014, the enacted rules of the Oklahoma Board of Medical Licensure (OBML) allow 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 OBML 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.

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 can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services. www.healthit.gov/providers-professionals/faqs/what-telehealth-how-telehealth-different-telemedicine.

Trauma Care

Background

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

In November 2004, a state question was passed by the people to enact an increase in the tobacco tax for health care (see page 24). 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.

Trauma Legislation

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

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

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

Source: Oklahoma State Department of Health

Trauma Fund

The Trauma Fund is a continuing fund that is available to support uncompensated trauma care and is distributed to the following entities: hospitals, physicians, EMS 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
- Tobacco tax.

Revenues and Distributions

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

EMTALA

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

The emergency department must treat an individual with an emergency medical condition until the condition is resolved or stabilized. If the hospital does not have the capability to treat the condition, the hospital must make an appropriate transfer of the patient to another hospital with such capability. Hospitals with specialized capabilities must accept such transfers.

Oklahoma Trauma Center Levels

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

Level IV: A facility which 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. This is a primary referral facility, for rapid stabilization and transfer to definitive care.

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

Level II: A facility which 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. This is a tertiary referral facility, capable of managing all types of trauma.

Level I: This is the highest level, 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 is a trauma care teaching facility.

Disaster Preparedness

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

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

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

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

Ebola and other infectious diseases

The most recent example of statewide disaster preparedness occurred in late 2014 surrounding the national Ebola crisis. In January 2015, a specialized infectious disease unit opened at OU Medical Center, ready to activate if the need arises. The Oklahoma Biocontainment Care Unit is designed to care for pediatric and adult patients in the state who test positive for dangerous infectious diseases like Ebola. The nearly 4,000-square-feet specialized unit is isolated in a decommissioned hospital building on the Oklahoma Health Center campus and is self-sufficient relative to the air handling system, supply and distribution of medical gasses and the storage and removal of biomedical waste.

Improving Okla homa's Health

Oklahoma Health Improvement Plan

In 2008, the Oklahoma Legislature, in SJR-41, directed the State Board of Health to prepare a report outlining a plan for the "general improvement of the physical, social and mental well being of all people in Oklahoma through a high-functioning public health system." At the time Oklahoma's national health statistics rankings were 49th in the nation. According to the United Health Foundation, Oklahoma's 2014 national health rankings have improved and Oklahoma is currently ranked 46th.

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

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

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

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

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

For information on the Oklahoma Health Improvement Plan, visit www.health.ok.gov. For information on the 2014 state health rankings, visit www.americashealthrankings.org

Oklahoma's Tobacco Tax

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

The funds generated from the increase in the tobacco tax were dedicated to funding health care needs such as:

- Insure Oklahoma insurance program,
- Rural hospital relief,
- Emergency room physicians' rate increase,
- Ambulance rate increase,
- OU Comprehensive Cancer Center,
- OSU Telemedicine Project,
- Breast and cervical cancer treatment for low income women,
- Adolescent substance abuse services,
- Smoking cessation programs, and
- Trauma Care Assistance Fund.

Tobacco Settlement Endowment Trust (TSET)

Master Settlement Agreement

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

Endowment Trust Fund

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

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

Source: Oklahoma Tobacco Settlement Endowment Trust.

OHA Health Improvement Initiatives

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

"Supporting Oklahoma hospitals in leading a culture of health improvement in their communities through reducing illness, disability and death due to tobacco use."

OHA assists hospital leadership and clinical staff in moving toward a totally tobacco-free culture using evidence-based strategies in the following areas:

- Supporting hospitals and their affiliated outpatient clinics in moving toward tobacco free campus policy development and step-by-step implementation of 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 based on the U.S. Public Health Service clinical practice guideline, Treating Tobacco Use and Dependence, endorsed by the CDC, CMS, TJC and more than 60 other national and state health organizations. Through this strategy, providers refer patients directly to the Oklahoma Tobacco Helpline, via fax or electronic referrals, for patients to receive telephone or website counseling and guidance throughout 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 this initiative began in 2009, nearly 25 hospitals of all sizes, including one large health system, have implemented cessation services, through permanent system changes, for their patients and employees.
- In 2014, the first electronic referral was successfully established in Oklahoma when the Chickasaw Nation Medical Center revised their Electronic Medical Record to complete this process by sending the first electronic referred patient to the Helpline. They also developed a mechanism by which the Helpline was able to electronically return that patient outcome report to the hospital patient chart. All referral processes are encrypted and HIPAA compliant.
- Between October 2010 and December 2014, 8,841 hospital and clinic patients and employees have been referred to the Helpline. Of those, 38 percent have accepted services when contacted – higher than the national average.

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

HOSPITALS helping PATIENTS QUIT
Advancing Tobacco Treatment

Work Healthy Hospitals

Hospital workplace wellness

WorkHealthy Hospitals is an OHA board initiative, funded by the Oklahoma Tobacco Settlement Endowment Trust and aimed at assisting Oklahoma hospitals improve the health of their employees. Since July 2013, OHA has partnered with Prevention Partners of North Carolina through their WorkHealthy America initiative, to provide Oklahoma hospitals with sustainable, best practice heath improvement strategies that address each of the following four key areas:
OHA's role is to:

- Aid hospitals in the completion of the WorkHealthy America assessment that provides them with the current status of their organization's efforts in each 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.
- Link hospitals to a vast array of implementation tools and educational resources including webinars.
- Liaison hospitals with Prevention Partners for additional resources and support.
- Demonstrate and share innovative strategies with Prevention Partners to build new resources for wellness improvement and Implementation Science.
- Monitor and analyze implementation strategies and outcomes.

Once hospitals reach their goals in three of these areas, they receive a Gold award for each: Gold Star for tobacco cessation, Gold Medal for physical activity, and Gold Apple for nutrition and food environment. Hospitals displaying exemplary accomplishments are recognized as Best Practice Sites and Best Practice Systems and then participate with OHA in state and national webinars as well as other activities and recognitions. In just the initial 18 months of the initiative, nearly 40 Oklahoma hospitals participated in WorkHealthy Hospitals, touching nearly 26,000 employees, and have received numerous Gold awards. These hospitals and others joining the effort daily have expectations of continuing and expanding this health improvement success for years to come.

Oklahoma is the only state outside of the east coast that has committed to this initiative and has received national recognition for this innovative effort.

WorkHealthy HOSPITALS
Helping Hospitals Improve Employee Health.
A program of TSET. Better Lives Through Better Health.

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
Disaster Preparedness		See also page 23
Oklahoma Emergency Catastrophic Health Powers Act	Title 63, Section 6101 et. seq.	General Provisions
Emergency Management Act of 2003	Title 63, Section 683.1 et. seq.	
Emergency Response		
Oklahoma Emergency Response Systems Development Act	Tile 63, Section 1-2501 et. seq.	
Health Facilities		
Hospital Licensure Generally	Title 63, Section. 1-701 et seq.	
Ambulatory Surgical Center	Title 63, Section 2657	
Child Care Facilities Licensure Act	Title 10, Section 401 et. seq.	Child Placing Facilities such as Children's Inpatient & day care
City and County Owned Hospitals	Title 19, Chapter 17 County Hospitals, Section 781 et seq.	
Critical Access Hospitals	Title 63, Section 1-701	Definition
Children's Hospital of Oklahoma	Title 10, Section 175.12	
Diagnostic X-Ray Facility Act	Title 63, Section 1-1501.1 et. seq.	
Hospital Construction of Facilities	Title 6, Sec. 1-720b et. seq.	Construction Only
Nursing Homes	Title 63, Sec. 1-1900 et. seq	See also Long-Term Care Ombudsman Act Title 63, Section 1-2211 et. seq.
Psychiatric and Chemical Dependency Facility Certificate of Need Act	Title 63 Section 1-880.1.	
Specialty Hospitals	Not defined separately in statute different than hospitals	See also references in Title 63, Section 1-720b et seq.
Oklahoma State University Medical Authority Act	Title 63, Section 3271	
University Hospitals Authority Act	Title 63, Section 3201 et. seq.	OU Medical Center
Medicaid		
Oklahoma Health Care Authority Act	Title 63, Section 5004	
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 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.	

Appendix 1: Statutory References

Subject	Title and Section	Notes
Supplemental Hospital Offset Payment Program Act (SHOPP)	Title 63, Section 3241.1	Sunsets December 31, 2017
Workers Compensation	Title 85A, Section 1 et. seq.	
Medical Licensure		See also page 19
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
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	
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
Duty to report Child Abuse/Neglect	Title 10A, Section 1-2-101	Mandatory duty to Report Abuse or Neglect of Child Under Eighteen
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	
Designation of Caregiver	Title 63, Section 3112	
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	(2014) all inpatient health care entities and providers, board and CEO, GC must comply.
Nondiscrimination in Treatment Act	Title 63, Section 3090.1	
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.
Oklahoma Tobacco Use Prevention and Cessation Act	Title 63, Section 1-229.1 et. seq.	
Telemedicine		
Oklahoma Telemedicine Network	Title 63, Section 1-2702 et. seq.	
Oklahoma Telecommunications Act of 1997: Oklahoma Universal Service Fund	Title 17, Section 139.106	OUSF provides funding for some telemedicine, administered by OCC

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HIPAA
Health Insurance Portability and Accountability Act (see page 20)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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, smart phones, 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 Purchasing (see page 14)

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