SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/SB 1490

SPONSOR: Appropriations Subcommittee on Health and Human Services, Health, Aging and Long-Term Care Committee and Senator Campbell

SUBJECT: Emergency Services and Care/Health

DATE: March 11, 2002 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Favorable/CS
2.	Peters	Belcher	AHS	Favorable/CS
3.			AP	
4.				
5.				
6.				

I. Summary:

This bill redefines *emergency medical condition* to include psychiatric disturbances and substance abuse, as that term is used in ch. 395, F.S., relating to hospitals; ch. 409, F.S., relating to the Medicaid program; ch. 627, F.S., relating to health insurance; and ch. 641, F.S., relating to health maintenance organizations. The bill establishes coverage requirements for providing emergency services and care under group, blanket, or franchise health insurance policies, preferred provider organizations, and exclusive provider organizations. The bill gives the physician who stabilizes a patient's emergency medical condition sole discretion to continue to care for the patient in the hospital for any medically necessary followup, after stabilization for those services that would otherwise be covered, or to transfer care of the patient to a provider that has a contract with the insurer (Medicaid, health insurer, health maintenance organization, preferred provider organization, or exclusive provider organization).

The bill defines *medically unnecessary procedure* for purposes of hospital regulation and hospital adverse incident reporting requirements. The Agency for Health Care Administration (AHCA) is required to adopt rules governing the conduct of specified inspections or investigations to protect the due process rights of licensed facilities and personnel and to minimize disruption of facility operations and the cost to facilities resulting from the investigations.

The bill modifies the requirements for internal risk management programs in hospitals and ambulatory surgical centers to: allow facilities to use the services of a risk manager, rather than being required to employ a risk manager; remove a limitation on the number of facilities that a risk manager may supervise; and to require that certain criteria used to determine compliance

with statutory requirements is recognized as acceptable and appropriate by similar licensed risk managers.

The bill creates a workgroup to recommend statutory changes regarding requirements for hospitals to provide services within their service capability to address situations in which services are performed infrequently and situations where hospitals would be deemed exempt from providing a service.

The bill changes the definitions of *advanced life support* and *basic life support* to conform to the definitions of the United States Department of Transportation paramedic and emergency medical technician training curricula.

This bill amends ss. 383.50, 394.4787, 395.002, 395.0161, 395.0197, 395.1041, 395.602, 395.701, 400.051, 401.23, 409.901, 409.905, 409.9128, 468.505, 641.19, 641.47, 641.513, and 812.014, F.S., and creates s. 627.6053, F.S.

II. Present Situation:

Hospital Emergency Services and Care

Under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals are required to screen or appropriately transfer patients who come to the hospital's emergency department requesting examination or treatment for a medical condition. If a hospital determines that a person has a medical emergency, it must stabilize the condition or provide for an appropriate transfer.

Chapter 395, F.S., governs hospital licensure and regulation and includes requirements for emergency medical services. The definition of *emergency medical condition* in s. 395.002, F.S., is a condition "manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or a fetus.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part."

With respect to pregnant women, the following situations meet the definition of emergency medical condition:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

This definition is very similar to the definition provided in EMTALA. Neither the federal nor the state definition of *emergency medical condition* includes patients suffering from psychiatric disturbance or symptoms of substance abuse. Under the Medicaid program, emergency medical service does not include acute psychiatric disturbances and substance abuse.

Under s. 395.0197, F.S., hospitals are required to report adverse incidents to the Agency for Health Care Administration (AHCA). Within 15 days after the occurrence, a hospital must report: the death of a patient; brain or spinal damage of a patient; the performance of a surgical procedure on the wrong patient; the performance of a wrong-site surgical procedure; the performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition; the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient; or the performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.

Section 395.0197, F.S., also establishes requirements for risk management programs in hospitals and ambulatory surgical centers. Each facility must hire a licensed risk manager who may not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals. AHCA is given access to all licensed facility records to carry out its responsibilities for ensuring that risk management programs meet statutory requirements.

Emergency Medical Services

Part III of ch. 401, F.S., provides for the regulation of medical transportation services, paramedics, and emergency medical technicians. This part defines advanced life support services and basic life support services in s. 401.23, F.S. Any person or business that provides pre-hospital or inter-facility advanced life support services or basic life support services must be licensed by the Department of Health.

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid program. Under s. 409.902, F.S., the Agency for Health Care Administration is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S. Section 409.901, F.S., provides definitions relating to the Medicaid program, including definitions of emergency medical condition and emergency services and care. Section 409.9128, F.S., establishes requirements for providing emergency services and care under the Medicaid program.

Health Insurance

Part VI of chapter 627, F.S., governs rates and contracts for health insurers delivering or issuing individual health insurance policies. This part does not govern group or blanket policies, which are governed under part VII, except for exclusive provider organizations (EPOs) under s. 627.6472, F.S., which limit coverage to service from network providers, and preferred provider organizations (PPOs) under s. 627.6471, F.S., which provide greater benefits if an insured obtains services from a network provider, and lesser benefits (greater deductibles and coinsurance) if the insured obtains services from a non-network provider. Section 627.6699, F.S.,

is the "Employee Health Care Access Act." The section provides for the regulation by the Department of Insurance of group health insurance coverage provided to small employers (businesses with at least 1 but not more than 50 eligible employees).

Health Maintenance Organizations

Health maintenance organizations (HMOs) are governed under Parts I and III of chapter 641, F.S. HMOs manage the delivery of health care services as a way of controlling health care costs by modifying the behavior of physicians and other health care providers. Techniques that HMOs use to manage health care costs include reviewing the medical necessity or appropriateness or the site of services; contracting with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites, and controlled access to services by a case manager. Section 641.513, F.S., establishes requirements for providing emergency services and care.

III. Effect of Proposed Changes:

This bill amends s. 395.002, F.S., which provides definitions for the regulation of hospitals, ambulatory surgical centers, and trauma centers, to redefine *emergency medical condition* to include acute psychiatric disturbances and substance abuse when the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient or jeopardy to the health of others. This definition includes a person taken into custody and delivered to a hospital under a court ex parte order for examination or placed by an authorized party for involuntary examination in accordance with chapter 394 or 397, F.S.

The bill defines *medically unnecessary procedure* to mean a surgical or other invasive procedure that no reasonable physician, in light of the patient's history and available diagnostic information, would deem to be indicated in order to treat, cure, or palliate the patient's condition or disease. This new definition would be used to determine whether a surgical procedure is medically unnecessary and therefore reportable to AHCA as an adverse incident. *Service capability* is redefined to mean the physical space, equipment, supplies, and services that the hospital provides and the level of care that the medical staff can provide within the training and scope of their professional licenses and hospital privileges. The definition of *stabilized* is amended to include stability not just for transfer of a patient, but also for discharge.

The bill amends s. 395.0161, F.S., to require AHCA to adopt rules governing hospital licensure inspections or investigations regarding:

- Reports filed under s. 395.0197, F.S., the internal risk management program;
- Complaints alleging violations of state or federal emergency access laws; or
- Complaints made by the public alleging violations of law by licensed facilities or personnel.

The rules must state procedures to be used in the investigations or inspections that would protect the due process rights of facilities and personnel and to minimize the disruption of facility operations and cost to facilities.

The bill amends s. 395.0197, F.S., the internal risk management program, to permit a facility to use the services of a risk manager, rather than being required to hire a risk manager, and to delete the requirement that a risk manager must not be responsible for more than four risk management programs in separate licensed facilities. The bill specifies that a determination must be based on specified criteria and must be recognized as acceptable and appropriate by similar licensed risk managers.

The bill amends s. 395.1041, F.S., relating to access to emergency services and care, to require AHCA to cooperate with the Department of Health to provide the inventory of available hospital services to emergency medical services providers. Emergency medical transportation – provided under this section is considered to be emergency services and care as defined in s. 395.002, F.S. The bill creates a workgroup to recommend statutory changes regarding services performed infrequently that would not be considered within the service capability of a hospital and situations where hospitals would be exempt at all times from providing services that are within their service capability. Representatives from the Florida Hospital Association, the Florida Statutory Teaching Hospital Council, the Florida Medical Association, the Florida Osteopathic Association and the Florida College of Emergency Physicians will comprise the workgroup.

The bill amends s. 401.23, F.S., to change the definition of *advanced life support* to mean the use of skills and techniques described in the most recent U.S. Department of Transportation (DOT) National Standard Paramedic Curriculum A paramedic under the supervision of a medical director must perform these services. The definition of advanced life support includes other techniques that have been approved under conditions specified by rules of the department.

The definition of *basic life support* is similarly modified. The skills and techniques for basic life support are those in the most recent U.S. DOT National Standard EMT-Basic Curriculum. The bill adds a definition of *emergency medical condition* to s. 401.23, F.S.

The bill requires the Medicaid program's coverage of emergency medical services to include medical conditions of psychiatric disturbances and symptoms of substance abuse by amending the definition of emergency medical condition in s. 409.901, F.S., and by specifying that emergency services and care, including an inpatient admission, is a covered service in s. 409.9128, F.S. This section does not prevent the Agency from implementing an emergency care review or hospital inpatient prior-authorization process consistent with federal, state and maximum payment limits for hospital inpatient and outpatient nonemergency care. The bill prohibits denial of payment if an emergency condition is found not to exist. If an emergency medical condition is found to exist, the Medicaid program must pay for all emergency services and follow-up care.

Section 409.9128, F.S., is further amended to give the physician who stabilizes a patient's emergency medical condition sole discretion to continue to care for the patient in the hospital for any medically necessary followup after stabilization for those services that would otherwise be covered in the managed care plan contract, Medicaid program, or MediPass, or to transfer care of the patient to a provider that has a contract with the Medicaid managed care plan or MediPass provider. The provisions of s. 409.9128, F.S., may not be waived, voided, or nullified by contract.

The bill creates s. 627.6053, F.S., to require group, blanket, or franchise health insurance policies (including policies for small employers), preferred provider organizations, and exclusive provider organizations to cover hospital emergency medical services and care. The section defines *emergency medical condition*, *emergency services and care*, and *provider*. A health insurer may not require prior authorization for prehospital transportation and treatment or indicate that emergencies must be life threatening in order to be covered. A health insurer could not limit emergency service to that provided by a health care provider with whom it has a contract. Health insurers must cover pre-hospital and hospital-based trauma services and emergency services and care. The bill requires a hospital that provides emergency services to notify the patient's insurer as soon as possible prior to discharge of the patient from the emergency care area. The physician who stabilizes a patient's emergency medical condition is given sole discretion to continue to care for the patient in the hospital for any medically necessary followup after stabilization for those services that would otherwise be covered in the insurance policy, or to transfer care of the patient to a provider that has a contract with the health insurer. Reimbursement amounts for emergency services and care are specified. The provisions of this section may not be waived, voided, or nullified by contract.

The bill amends ss. 641.19, 641.47, and 641.513, F.S., to require health maintenance organizations to include care for medical conditions of psychiatric disturbances and symptoms of substance abuse in their coverage for emergency medical services and care, which could include an inpatient admission, and to provide necessary follow-up care. A health maintenance organization would have to cover examination for an emergency in situations where an emergency was found not to exist. The physician who stabilizes a patient's emergency medical condition is given sole discretion to continue to care for the patient in the hospital for any medically necessary followup after stabilization for those services that would otherwise be covered in the health maintenance contracts, or to transfer care of the patient to a provider that has a contract with the health maintenance organization. The provisions of s. 641.513, F.S., may not be waived, voided, or nullified by contract.

The bill amends ss. 383.50, 394.4787, 395.602, 395.701, 400.051, 409.905, 468.505, and 812.014, F.S., to conform cross-references.

The bill takes effect July 1, 2002.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, s. 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private insurers would incur the cost of emergency medical services for individuals suffering from psychiatric disturbances or symptoms of substance abuse.

C. Government Sector Impact:

There is no fiscal impact. Medicaid currently covers emergency services and care including emergency medical services for individuals suffering from psychiatric disturbances or symptoms of substance abuse. Specific language was included in the bill to clarify that nothing in the bill prevented the Agency from implementing an emergency care review or hospital inpatient prior-authorization process consistent with federal, state and maximum payment limits for hospital inpatient and outpatient nonemergency care.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.