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DATE: February 19, 2002

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH & HUMAN SERVICES APPROPRIATIONS
ANALYSIS

BILL #: HB 589

RELATING TO: Emergency Services & Care/Health

SPONSOR(S): Representative(s) Berfield and others

TIED BILL(S): None

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH REGULATION YEAS 11 NAYS 0
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS YEAS 11 NAYS 2
(3) FISCAL POLICY & RESOURCES
(4) COUNCIL FOR HEALTHY COMMUNITIES
(5)

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I. SUMMARY:

This bill redefines emergency medical condition to include psychiatric disturbances, substance abuse, and court ordered evaluations that could reasonably result in serious jeopardy to the health of the patient or others.

This bill adds new definitions and amends definitions relating to emergency services and care provided by hospitals and other health care facilities. It also revises the provisions relating to services capability and access to emergency services and care provided by hospitals.

This bill establishes the uncompensated emergency services and care reimbursement program under the Agency for Health Care Administration (Agency) to reimburse health care facilities and practitioners for the cost of uncompensated emergency services and care provided.

This bill revises requirements for the provision of emergency services and care by Health Maintenance Organizations (HMO) and prepaid health clinics, under Medicaid managed care plans and MediPass. It provides requirements for health insurance policy coverage of hospital emergency services and care.

The Agency is directed to convene a workgroup regarding hospital emergency services capability requirements and to make recommendations to the Legislature on emergency services capability requirements. It provides treating physicians with greater authority in the treatment of emergency conditions, and restricts the ability of commercial and Medicaid HMOs to deny payment for services rendered.

The bill appropriates $50 million from the General Revenue Fund to the Agency for the Uncompensated Emergency Services and Care Reimbursement Program (See VI. Fiscal Impact).

This bill provides for the act to take effect on July 1, 2002.

On February 12, 2002, the Committee on Health Regulation adopted a "strike-all" amendment which is traveling with the bill and the bill was reported favorably. The "strike-all" amendment removed the $50 million appropriated in the original bill. See section VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES, below.

On February 19, 2002, the Committee on Health and Human Services Appropriations adopted two amendments to the "strike-all" amendment that is traveling with the bill and the bill was reported favorably. See section VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES, below.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

Less Government: Requires the State of Florida to create the uncompensated emergency care fund.

B. PRESENT SITUATION:

EMTALA / Federal Provisions:

The Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395, requires Medicare-participating hospital with an Emergency Department (ED) to provide medical screening examinations to all person who present at the emergency department and request service, regardless of that person's ability to pay for medical services. If the person is in an emergency medical condition, or if a pregnant woman is in active labor, the hospital must treat or stabilize the person, or provide for an appropriate transfer to another facility.

The EMTALA screening requirements apply to any Medicare-participating hospital with an Emergency Department (ED). First, a hospital is required to provide a medical screening exam to any person who comes to the emergency department and requests examination or treatment for a medical condition. Second, if a hospital determines that the individual has an emergency medical condition, the hospital must provide further medical examination and treatment to stabilize the medical condition. Third, if the hospital is unable to stabilize the patient, the hospital must provide for an appropriate transfer to another medical facility. The statute prohibits hospitals from delaying a medical screening exam and stabilizing treatment in order to inquire about the person's method of payment or insurance status. In addition, the statute allows individuals suffering personal harm and medical facilities suffering financial loss as a direct result of a hospital's EMTALA violation to bring a civil action against the offending hospital and obtain personal injury damages; all civil actions must commence within 2 years of the date of the violation. (42 U.S.C. Sec. 1395dd(d)(2)).[1]

The regional offices of the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) are responsible for investigating complaints of alleged EMTALA violations and forwarding confirmed violations to HHS Office of Inspector General (OIG) for possible imposition of civil monetary fines.

In November 1999, CMS and the OIG jointly issued Special Advisory Bulletins that focused on the application of EMTALA provisions for individuals insured by managed care plans and provided some "best practices" to help hospitals comply with EMTALA in a **managed care environment**.

[1] United States General Accounting Office, Report to Congressional Committees, *EMTALA Implementation and Enforcement Issues*, June 2001.

The bulletin states that it is **not appropriate for a hospital to seek, or direct a patient to seek, authorization to provide screening or stabilizing services from the individual's health plan or insurance company until after the hospital has provided a medical screening exam and initiated stabilizing treatment for an emergency medical condition.** It also advises against informing patients that they would be responsible for paying for their care if their insurer does not provide payment, or otherwise attempting to obtain patients' agreement to pay for services, before they are stabilized.

Although federal law mandates that emergency services be provided to every patient, regardless of the patient's ability to pay, the federal government does not provide any funding mechanism outside of the usual reimbursement though Medicare and Medicaid.

Emergency Care in Florida

Provisions for both access to and for providing emergency care and services are addressed throughout the Florida Statutes. The law requires providers to provide emergency care and transportation regardless of ability to pay.

Section 154.306, F.S., provides that a county where an indigent patient resides shall, in all instances, be liable for the cost of treatment provided to a qualified indigent patient at an out-of-county hospital for any emergency medical condition.

Section 381.026, F.S., specifies that a patient's rights to access to care includes the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment.

Section 391.0315, F.S., specifies that children eligible for services shall receive…initial health care screening or treatment of an emergency medical condition.

In addition, s. 394.462(h), F.S., directs law enforcement officers to transport a person to a hospital for emergency treatment if the officer believes that a person has an emergency medical condition.

Section 401.45, F.S., specifies "a person may not be denied needed prehospital treatment or transport from any licensee for an emergency medical condition. A person may not be denied treatment for any emergency medical condition that will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room."

Section 409.9128, F.S., sets forth the provision for providing emergency services and care as it relates to Florida's Medicaid and Medipass, and HMO programs.

Chapter 415, F.S., sets forth the provisions for adult protective services. Section 415.1051, F.S., protective services interventions when capacity to consent is lacking; nonemergencies; emergencies; orders; limitations; specifies that a medical facility is required to provide "treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient pending court determination of the department's petition authorizing emergency protective services." Any person may seek an expedited judicial intervention under rule 5.900 of the Florida Probate Rules concerning medical treatment procedures.

Chapter 456, F.S., governs the provisions for licensed health care practitioners. Section 456.056, F.S., specifies that if treatment is provided to a beneficiary [Medicare] for an emergency medical condition the physician must accept Medicare assignment provided that the requirement to accept

Medicare assignment for an emergency medical condition shall not apply to treatment rendered after the patient is stabilized, or the treatment is unrelated to the original emergency medical condition. For the purpose of this subsection, "stabilized" is defined to mean with respect to an emergency medical condition, that no material deterioration of the condition is likely within reasonable medical probability.

Chapter 641, F.S., sets forth the provisions for health insurance: Part I, governs Health Maintenance Organizations; Part II governs Prepaid Health Clinics; and Part III governs Health Care Services. Although there are provisions relating to emergency services the law is silent when treating a patient in an "emergency condition" whom may be experiencing psychiatric disturbances, symptoms of substance abuse, or whom may be taken into custody and delivered to a hospital under a court ex parte order.

"In a report titled *EMTALA: Survey of Hospital Emergency Departments,* the Office of Inspector General found the effects of managed care payment policies on hospital emergency departments were exacerbated by the federal Emergency Medical Treatment and Labor Act. It reported that EMTALA requires hospitals to provide medical screening exams and stabilizing treatment for all patients, but imposes no requirements on managed care plans to pay for these services. It stated that many private health plans are not paying for emergency services not authorized before they are rendered, leaving hospitals with the difficult choice of calling the health plan before the exam, and possibly violate EMTALA, or waiting until after the exam and risking non-payment"[2]

In Florida, the issue of uncompensated emergency care is exasperated by several key factors:

- Population growth,
- Aging population, and
- Increased number of uninsured.

Population growth. Florida is one of the fasting growing states in the nation. Over the last decade, Florida's population grew 24% to over 16 million residents. According to the Florida Hospital Association (FHA), the number of hospital beds per thousand populations fell from 4.0 beds to 2.9 beds and the number of community hospitals declined from 231 to 217. As the population grows, the number of people requiring emergency services grows.

Aging of the population. Florida leads the nation in the percentage of the population 65 years and older. As the population ages, their need for emergency services increases, according to FHA, persons 75 years and older had the highest ED visit rate and 41.5% of these persons arrived by ambulance.

Increased number of uninsured. The census bureau estimates that 3.0 million Floridians or 22% of the non-elderly population were uninsured in 2000. According to FHA, hospital in Florida absorbed 1.1 billion in costs treating the uninsured that came into emergency rooms.

A recent survey was conducted by the Associate Professor and Chair, Department of Health Policy and Management, College of Public Health, at the University of South Florida, of all emergency physician groups at Florida hospitals with emergency departments in an effort to identify the amount of uncompensated care provided by ED physicians during the 1998 year. The response rate was 47%, with 70 emergency physician groups at the 150 hospitals responding. Hospital ownership and size categories are representative of Florida hospitals. Respondents provided information on 1,414,341 ED visits.

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[2] American College of Emergency Physicians, *ACEP Praises OIG Report; Renews Call for Action to Preserve the Nation's Health Care Safety Net,* September 25, 2001.

The major findings from a preliminary analysis of data concluded:

- 21.4% of visits were self-pay patients;
- 26.0% of visits resulted in no compensation for emergency physician care. This suggests that although some patients have health insurance or coverage, the health plan and patient do not pay for any portion of the visit; and
- 31.2% of care was uncompensated (calculated by dividing uncompensated care charges by total charges).

As a succinct summary of findings:

- one in five ED patients are self-pay;
- one in four ED visits do not result in any payment for ED physician care; and
- nearly one-third of ED physician services are provided in the absence of reimbursement.

Chapter 395, F.S., does not contain a definition for "Medically unnecessary procedure", nor does "Emergency medical condition", as defined, include those patients presenting for emergency services or care with psychiatric or substance abuse symptoms.

In addition, currently there is no provision spelled out for interface between the Agency and the Department of Health in providing the Inventory of Hospital Emergency Services to assist in the location of appropriate emergency medical care to EMS providers and the public.

There is neither a reimbursement mechanism identified nor Agency funds to pay health care facilities and providers for uncompensated emergency services and care costs.

Presently, health insurers, HMOs, and prepaid health clinics have some discretion in denying or reducing requests for payment for emergency medical services, after they have reviewed the claim. Insurers are not required to pay for follow-up care provided by non-contracted providers, and psychiatric disturbances and symptoms of substance abuse are not listed as emergency care conditions.

The definition of basic life support in Chapter 401, F.S., provides for treatment of medical emergencies by a qualified person using enumerated techniques and those approved by rule of the Department of Health. The definition of advanced life support in Chapter 401, F.S., provides for the treatment of life threatening medical emergencies by a qualified person through the use of enumerated techniques as provided by rule of the Department of Health.

C. EFFECT OF PROPOSED CHANGES:

Florida law provides that emergency medical care, as mandated by the federal EMTALA law, will be provided to the residents of Florida regardless of their ability to pay. This bill reconciles the health insurance provisions as it relates to providing emergency care with the expanded definition of emergency condition with the federal law mandates of providing emergency care. Additionally, it provides for a funding mechanism when patients are not covered by either a federal, state, or private insurance benefits.

HB 589 amends the definition of emergency medical condition to include psychiatric disturbances, symptoms of substance abuse, as well as situations involving a court order.

The bill addresses the cooperation between the Agency and the Department of Health in providing and making available hospital emergency services offered by every hospital with an emergency

department to emergency medical services providers and others to assist locating appropriate emergency medical care.

The bill significantly affects the ability of health insurers, HMOs, prepaid health plans, and other group insurers to evaluate emergency treatment rendered and to deny or reduce the amount of payment requested. The bill gives the treating physicians discretion in the treatment of emergencies, and requires health insurers, HMOs and prepaid clinics to pay for follow-up care in non-contracted hospitals.

This bill establishes the Uncompensated Emergency Services and Care Reimbursement Program and appropriates $50 million from General Revenue Fund exclusively for the implementation of this program to the Agency.

HB 589 establishes a workgroup, to be convened by the Agency for Health Care Administration. The workgroup shall consisting of representatives from the Florida Hospital Association, Florida Medical Association, and Florida College of Emergency Physicians to make recommendations for changes to:

a) services performed on an infrequent basis that would not be considered to be within the service capability of the hospital,
b) situations when a hospital would be deemed exempt from providing services at all times that are within their service capability.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 383.50(4), F.S., conforming cross-reference to substantive change in statute.

Section 2. Amends s. 394.4787(7), F.S., conforming cross-reference to substantive change in statute.

Section 3. Amends s. 395.022, F.S., redefining the terms *emergency medical condition, service capability, stabilized* to include psychiatric disturbances and symptoms of substance abuse. Creates definitions for; e*mergency medical services provider, medically unnecessary procedure;* and renumbering subsections conforming statute to substantive changes.

Section 4. Amends s. 395.1041, F.S., limiting the legislative intent, as it relates to providing emergency services and the subsequent follow-up consultation and treatment. Provides that the Department of Health shall be included in the responsibility of providing a statewide inventory of hospitals that provide emergency services and that AHCA will maintain the inventory that will be available to others to assist in locating appropriate emergency services. Providing that a patient that has not been stabilized may be transferred to another hospital which as the requisite service capability. Clarifies that provider means emergency medical service provider. Deleting obsolete language, that reference the adoption of rules dated January 31, 1993 for exemptions. Providing that the Agency convene a workgroup of representatives from the Florida Hospital Association, the Florida Medical Association, and the Florida College of Emergency Physicians to make recommendations to the legislature regarding: services performed on an infrequent basis that would not be considered to be within the service capability of the hospital and situations which hospitals would be deemed exempt from providing services at all times that are within their service capability.

Section 5. Creates s. 395.1042, F.S., the Uncompensated Emergency Services and Care Reimbursement Program, for the purposes of reimbursing health care facilities and health care practitioners for the cost of uncompensated emergency services care, requiring that AHCA shall

reimburse providers for services at the Medicaid rate in an amount equal to the provider's pro rata share of uncompensated emergency services and care provided in the prior fiscal year. Directs that all funds from the general appropriations act that funds s. 395.1041, F.S., be used exclusively to compensate providers under the Uncompensated Emergency Services and Care Reimbursement Program.

Section 6. Amends s. 395.602, F.S., conforming cross-reference to substantive change in statute.

Section 7. Amends s. 395.701, F.S., conforming cross-reference to substantive change in statute.

Section 8. Amends s. 400.051, F.S., conforming cross-reference to substantive change in statute.

Section 9. Amends s. 401.23, F.S., redefining the term *advanced life support* to mean assessment, monitoring, or treatment of medical conditions, through use of techniques described in the Paramedic Basic Training Course Curriculum of the United States Department of Transportation, by a paramedic under the supervision of a medical director of a licensee, pursuant to rules of the department. The term "advance life support" also includes techniques provided to persons with psychiatric disturbances, symptoms of substance abuse, or emergency medical conditions, as defined in 42 U.S.C. 1395dd.*;* and redefining the term *basic life support* to mean assessment, monitoring, or treatment of medical conditions described in the Emergency Medical Technician Basic Training Course Curriculum of the United States Department of Transportation, by an emergency medical technician or paramedic under the supervision of a medical director, as required by the department. The term 'basic life support" also includes techniques provided to persons with persons with psychiatric disturbances, symptoms of substance abuse, or emergency medical conditions as defined in 42 U.S.C. 1395dd; and other techniques which have been approved and are preformed under conditions specified by rules of the department.

Section 10. Amends s. 409.901, F.S., redefining the term *emergency medical condition* including persons exhibiting acute psychiatric disturbances or substance abuse symptoms, or taken into custody and delivered to a hospital under a court ex prate order for examination or placed by an authorized party for involuntary examination in accordance with chapter 394 or chapter 397, that the absence of immediate medical attention could reasonably be expected to result in: serious jeopardy to the health of a patient or serious jeopardy to the health of others. Redefining the term *Emergency medical care*, replacing " relieve or eliminate" with "Stabilize".

Section 11. Amends s. 409.905, F.S., conforming cross-reference to substantive change in statute.

Section 12. Amends s. 409.9128, F.S.:

- Providing that emergency services and care is a covered service under a Managed care contract or Medipass;
- Providing that neither a Managed care plan or the Medipass program may limit the covered service from a health care provider who has a contract with Managed care plan or the Medipass program;
- Providing that payment may not be denied if enrollee obtains care from a health care provider that has a contract with a managed care plan;
- Specifying that pre-hospital, hospital-based trauma services, emergency services and care is a covered service to an enrollee of a managed care plan or the Medipass program as required in ss. 395.1041, 395.4045, and 401.45, F.S.;
- Providing that emergency services and treatment that is required by law to determine whether the patient's condition is an emergency medical condition exist, such services shall

not be denied payment. As well this section specifies that a physician that provides care, treatment, or surgery necessary to stabilize the emergency medical condition may, at his or her sole discretion, continue to care for the patient for the duration of the patient's hospital stay and for any medically necessary follow-up or may transfer care of the patient, in accordance with the state and federal laws, to a provider that has a contract with the managed care plan or Medipass provider; and

- Establishing that reimbursement amounts for services provided an enrollee of a managed care plan shall be governed by the terms of the provider contract, when it exists and specifies that when such contract does not exist the managed care plan will reimburse at a rate that is lesser or, for noninstitutional providers, the usual and customary rates or the charge mutually agreed to by the entity and the provider within 35 days after submittal of the claim, and specifies that this section of law may not be waived, voided, or nullified by contract.

Section 13. Amends s. 468.505, F.S., conforming cross-reference to substantive statutory change.

Section 14. Creates s. 627.6053, F.S.: This section requires all health insurance contracts to provide emergency services and care.

Section 15. Amends s. 641.19, F.S., specifying that psychiatric disturbances and symptoms of substance abuse are defined as an emergency medical condition as it relates to health maintenance organizations.

Section 16. Amends s. 641.47, F.S., specifying that psychiatric disturbances and symptoms of substance abuse are defined as an emergency medical condition as it relates to prepaid health clinics.

Section17. Amends s. 641.513, F.S.; providing that emergency services and care is a covered service as it relates to health care service programs when services are provided by a health care provider that has a contract with the health maintenance organization, and disallows the denial of payment if the provider does not have a contract. Providing that the health maintenance organization shall compensate providers for services that are required by law and provides that the treating physician may continue to treat patient for any follow-up care and that if it is found that no emergency medical condition exist, payment shall not be denied. Provides that reimbursement amounts for services shall be governed by contract with the provider or that reimbursable amounts for services shall be the lesser or amounts for non-institutional providers the usual and customary provider charges for similar services in the community where the services were provided. And when no contract exist, the charges shall be the lesser of, for non-institutional providers, the usual and customary charges for services within that community, or charges mutually agreed to by the entity and the provider within 35 days after submittal of the claim. In addition, stipulates that the provision of law may not be waived, voided, or nullified by contract.

Section18. Amends s. 812.014, F.S., conforming cross-reference to substantive change in statute.

Section19. Appropriates $50 million from General Revenue Fund to the Agency for Health Care Administration for the Uncompensated Emergency Services and Care Reimbursement Program.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

According to AHCA:

General Revenue

Salaries	$ 0	$ 0
OPS	$ 0	$ 0
Expense (or Medicaid Fiscal Contract)	$150,000	$ 0
OCO	$ 0	$ 0
Total Non-Recurring Expenditures	$150,000	$ 0

Salaries	$ 0	$ 0
OPS	$ 0	$ 0
Expense (or Medicaid Fiscal Contract)	$ 613,200	$ 613,200
OCO	$ 0	$ 0
Uncompensated Emergency Services and Care Reimbursement Program	$50,000,000	$50,000,000
Total Recurring Expenditures	$50,613,200	$50,613,200

Expenditures:

	Amount Year 1 (FY 02-03)	**Amount Year 2 (FY 03-04)**
Sub-Total Non-Recurring Expenditures	$ 150,000	$ 0
Sub-Total Recurring Expenditures	$50,613,200	$50,613,200
Total Expenditures	**$50,763,200**	**$50,613,200**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to the Department of Insurance, "this bill specifically defines and describes the emergency medical services and provider reimbursement provision that must apply to health insurance policies and HMO contracts. The bill specifically requires acute psychiatric, substance abuse or involuntary commitment ER services to be covered." If the law expands eligible ER services, increased claims costs to insurers and HMO could be passed through to policyholders or subscribers in the form of increased premium cost.

Statutory definitions may provide uniformity of coverage for emergency care services and provider reimbursement eligibility among insurers and HMOs.

D. FISCAL COMMENTS:

The Department of Health could incur additional expenses through the enforcement of the new definitions of advanced life support (ALS) and basic life support (BLS). There could be hidden costs associated with changes throughout the statutes and rules, which may require further legislative action and/or rule development. Since the definitions of advanced life support and basic life support form the foundation of everything in the emergency medical service transportation area, it is likely that there will be consequences, which cannot be anticipated. It is unclear whether the proposed changes to the definition of ALS and BLS will require a rule change, but if they do, the approximate cost to promulgate a new rule is $3,500.

According to AHCA, the bill does not specifically address how the data used to calculate the payments to health care providers for uncompensated emergency services and care will be collected by the Agency for use in calculating the reimbursement amounts to be paid prorata to the providers. One method would be to require providers to submit claims to the Agency's fiscal agent or some other contractor for the emergency services and care that is otherwise uncompensated. This would also allow the Agency to verify that the recipient is not Medicaid eligible. If the program is implemented in FY 2002-2003 and payment to providers is to be based on uncompensated claims in the prior year, all the claims for uncompensated care and services would have to be filed by a specific date in FY 2002-2003 to permit time to calculate the reimbursement to providers. Claims received after the specific date would be disallowed for the calculation. The bill also should provide for a specific deadline each year by which claims are due for uncompensated care and services for the prior fiscal year. The bill does not provide for refund of amounts paid to the provider from the program if a claim is paid by the recipient or a third party subsequent to the claim being fully or partially paid by the program. Because the bill provides that prior fiscal year data is used to calculate the reimbursement to providers, it may be appropriate to state that the payment will be made only once a year. This would reduce the administrative burden on the Agency.

Assuming that there are 3 million claims for uncompensated care filed with the Agency each year and the cost per claim for processing of the claim and calculating the payment is $0.2044, the estimated annual cost is $613,200. Non-recurring funding of $150,000 is estimated for system development and implementation.

There is appropriated $50 million from the General Revenue Fund for the Uncompensated Emergency Services and Care Reimbursement Program. It is not clear if the $50 million is intended for reimbursement to providers or a portion of the funding is intended for administrative costs. An alternative way to finance the administration of the program would be to authorize the Agency to prorate the cost of the program based on the reimbursement provided to the providers and deduct the cost from the reimbursement.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require a city or county to expend funds or to take any action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

This bill provides rulemaking authority to AHCA and DOH; however, DOI does not have specific authority to promulgate rules to implement the provisions of this bill.

C. OTHER COMMENTS:

As noted, the bill uses different definitions for emergency medical condition that could result in a denial of Medicaid, insurance and health maintenance benefits to emergency medical service transportation providers. The bill amends the definition of emergency medical condition to be the same in all statutes except the amendment to the emergency medical service transportation statute. This discrepancy would likely result in litigation and potential loss of reimbursement for services provided by ambulance services.

The Department of Health expressed concerns that funding the Uncompensated Emergency Care Reimbursement Program may diminish resources provided to DOH for furtherance of the public health mission. In addition, DOH purports the program notably excluded the services provided by licensed ambulance services in Florida.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On February 12, 2002, the Committee on Health Regulation considered HB 589 and passed the bill favorably with a “strike-all” amendment. The amendment differs from the original bill in that it:

- Adds provisions that eliminate the cap on the number of programs that may be supervised by a single risk manager in a hospital setting;

- Requires AHCA program compliance determinations to be made by a licensed risk manager in accordance with the prevailing professional standard of care. Requires AHCA to promulgate

rules governing the conduct of investigations and inspections to minimize, to the greatest extent possible, disruption of facility operations and facility cost;

- Provides that when emergency medical transportation provides an inter-facility transfer during the patient's emergency medical condition, this service shall be considered emergency service and care;

- Redefines the terms *advanced life support* and *basic life support* reflecting the most current definitions as provided by the United States Department of Transportation National Standard Paramedic Curriculum;

- Adds the Statutory Teaching Hospital Council as a member of the AHCA workgroup created in this bill;

- Provides for a definition of *emergency medical condition* under s. 401.23, F.S., consistent with the definition in s.395.002, F.S., as it applies to emergency transport;

- Includes "inpatient admission" as part of the continuum of service that may be required to stabilize a patient in providing for emergency services and care;

- Includes emergency services as a mandatory service to Medicaid recipients;

- Provides that medical screening and evaluation to be included in services authorized under s.409.9128, F.S., Medicaid HMO requirements for emergency services and care;

- Replaces the term "noninstitutional" with "non-hospital" for clarification as it relates to payment negations with HMO and Medipass;

- Deletes the provisions for health insurers as it pertains to requirements for providing emergency services and care;

- Amends the definition of emergency services and care under the HMO statute, reflecting the changes made in s. 395.002, F.S.;

- Provides for several technical and statutory cross reference changes; and

- Removes the $50 million appropriation funding for the Uncompensated Emergency Care Program.

On February 19, 2002, the Committee on Health and Human Services appropriations considered HB 589 with the "strike-all" amendment that is traveling with the bill. The Committee adopted two amendments to the "strike-all" amendment.

The first amendment made the section creating the Uncompensated Emergency Services and Care Reimbursement Program contingent upon specific appropriations in the General Appropriations Act.

The second amendment revises bill language as follows, with the amendment's language in bold:

"(c) The physician who provides the care, treatment, or surgery necessary to stabilize the emergency medical condition may, at his or her sole discretion, continue to provide care to the patient for the duration of the patient's hospital stay and for any medically necessary followup,

after stabilization for those services which would otherwise be covered in the HMO contract, or may transfer care of the patient, in accordance with state and federal law, to a provider that has a contract with the health maintenance organization."

VII. SIGNATURES:

COMMITTEE ON HEALTH REGULATION:

Prepared by:	Staff Director:
Lisa Rawlins Maurer, Legislative Analyst	Lucretia Shaw Collins

AS REVISED BY THE COMMITTEE ON HEALTH & HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Staff Director:
Bill Speir	Cynthia Kelly