

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL: SPB 7014

INTRODUCER: For consideration by the Health Regulation Committee

SUBJECT: Access to emergency services and care

DATE: January 14, 2008 REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe / Stovall	Wilson		Pre-meeting
2.				
3.				
4.				
5.				
6.				

I. Summary:

This bill revises provisions of the access to emergency services and care law to ease staffing pressures for physician specialty on-call services in hospital emergency departments and to facilitate a hospital's compliance with its requirement to provide emergency services and care by:

- Statutorily recognizing that a patient may be stabilized to await subsequent emergency services and care,
- Authorizing staff in an emergency department to transmit certain medical records of a patient in that emergency department to another hospital's emergency department prior to the physical transfer of the patient to the other hospital's emergency department in order to expedite care and treatment of that patient,
- Authorizing the Agency for Health Care Administration (AHCA) to adopt rules related to on-call coverage and telemedicine, and
- Requiring the Boards of Medicine and Osteopathic Medicine, in consultation with the AHCA, to adopt rules establishing standards for physicians to use in determining whether a specialist must be called in prior to, or immediately following, a patient's stabilization for emergency department patients requiring orthopedic specialty services.

The bill also deletes obsolete provisions that were applicable to the initial implementation in 1992 of the access to emergency services and care law.

This bill amends the following sections of the Florida Statutes: 395.002 and 395.1041, and creates one undesignated section of law.

II. Present Situation:

State and Federal Regulations Relating to Hospital Emergency Services and Care

Florida hospital licensure requirements

Hospitals are licensed by the AHCA under ch. 395, F.S., and the general licensure provisions of part II, ch. 408, F.S. A hospital offers more intensive services than those required for room, board, personal services, and general nursing care. A range of health care services is offered with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care. Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent.¹ Hospitals are not required to provide emergency services.

State access to emergency services and care provisions

Section 395.1041, F.S., requires every hospital that has an emergency department (ED) to provide emergency services and care to any person upon request, or when emergency services and care are requested on behalf of a person, without regard to the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. Emergency services and care means appropriate screening, examination, and evaluation to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

The hospital must provide services within its service capability *at all times*. Service capability means all services offered by the facility as evidenced by the appearance of the service in a patient's medical record or itemized bill.² Each hospital providing emergency services must report to the AHCA the services within its service capability. A hospital reaffirms its service capability when its license is renewed or prior to the addition or termination of a service.

The AHCA maintains an inventory of hospitals with an ED and all services within the service capability of these hospitals. This inventory is used to assist emergency medical services providers and others in locating appropriate emergency medical care. According to the AHCA's inventory, as of January 7, 2008, 221 out of 282 hospitals in the state have an ED and provide at least one emergency service, while most of these hospitals provide almost all of the 38 services identified by the AHCA's rule.³ Hospitals are required to maintain a list of "on-call" critical care physicians (specialists) available to the hospital.⁴

Section 395.1041, F.S., governs transferring an ED patient to another hospital and is designed to prevent transfers for inappropriate reasons. It also contains civil and criminal penalties for the violation of the access to emergency services and care provisions.

¹ Section 395.002(12), Florida Statutes.

² S. 395.002(25), F.S.

³ See:

<http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/forms/HospitalERServicesInventory.pdf> (Last visited on January 14, 2008).

⁴ Rule 59A-3.255(6), Florida Administrative Code.

Federal Emergency Medical Treatment and Active Labor Act (EMTALA)

The EMTALA⁵ was signed into law on April 7, 1986, and was amended in 1989 and 1990. The EMTALA was enacted to ensure public access to emergency services regardless of ability to pay and applies to hospitals with an ED that participate in the Medicare program. Most Florida hospitals participate in Medicare. Similar to Florida's access to emergency services and care law, EMTALA specifies that a hospital with an ED must provide for an appropriate medical screening examination to determine whether an emergency medical condition exists for any individual who comes to an ED and requests examination or treatment of a medical condition. If an emergency medical condition exists, the hospital must provide, within the staff and facilities available at the hospital, further medical examination and treatment as may be required to stabilize the medical condition for transfer of the patient to another medical facility or discharge. In this context, to stabilize means that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the facility or that a pregnant woman has delivered the child and the placenta. In certain situations, a patient who is not stabilized may be transferred to another hospital.

Hospitals with an ED are required to maintain an on-call list. Similar to Florida's law, if a hospital offers a service to the public, the service should be available through on-call coverage of the ED. The EMTALA interpretive guidelines provide that physicians, including specialists and subspecialists, are not required to be on call at all times. The hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control. Furthermore, each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients.⁶ A determination as to whether the on-call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician. His or her ability and medical knowledge of managing that particular medical condition will determine whether the on-call physician must come to the emergency department.⁷

Civil monetary penalties are provided for violations of the EMTALA for both hospitals and physicians. The EMTALA does not preempt any state or local law requirement, except to the extent that the requirement directly conflicts with a requirement of the EMTALA.

Physician Practice and Supply

There has been ongoing debate about the adequacy of the supply of physicians in the U.S. The Council on Graduate Medical Education (COGME) was authorized by Congress in 1986 to make policy recommendations regarding the adequacy of the U.S. physician supply.⁸ A 2005 COGME report found that under current production and practice patterns, the number of full-time practicing physicians is expected to rise from 781,200 in 2000 to 971,800 in 2020, a 24 percent increase.⁹ However, the demand for physicians is likely to grow even more rapidly over this period than the supply.

⁵ Section 1867 of the Social Security Act, 42 U.S.C. s 1395dd.

⁶ Tag number A404 (renumbered to A2404) Interpretive Guidelines: §489.20(r)(2) available at: <http://www.cms.hhs.gov/manuals/Downloads/som107ap_v_emerg.pdf> (Last visited on January 14, 2008).

⁷ *Ibid.* Interpretive Guidelines: §489.24(j)(1)

⁸ Council on Graduate Medical Education, Sixteenth Report, "Physician Workforce Policy Guidelines for the United States 2000-2020, January 2005," found at: <<http://www.cogme.gov/16.pdf>> (Last visited on January 14, 2008).

⁹ *Id.*

The projected shortage in the physician workforce could profoundly affect specialty care available to an aging population that has a greater need for physician specialists. The specialty mix of the existing physician workforce may not be proportionate to medical needs.¹⁰ The supply of physicians is not keeping pace with the need for primary care physicians in areas with rapid population growth or low-income residents.¹¹ Recent studies suggest that medical students are choosing a medical specialty based upon lifestyle choices to control the total number of weekly hours spent on professional responsibilities and to have sufficient personal time free of practice requirements.

In Florida, it has been difficult to accurately identify and track trends in the physician workforce supply because of the lack of data. According to the Department of Health (DOH), there are about 52,984 active licensed allopathic physicians and 4,719 active licensed osteopathic physicians.¹² Half of the Florida-licensed allopathic physicians voluntarily submitted workforce planning related information in conjunction with their January 2007 license renewal. Under 2007 legislation,¹³ allopathic and osteopathic physicians are required to submit specified information in conjunction with their license renewal. The 2007 legislation requires the DOH to analyze the results of the required physician survey each year for specified information.

Florida-licensed hospitals must maintain a roster of physician specialists to provide care and consultation in accordance with the federal EMTALA and s. 395.1041, F.S. Although emergency physicians are available to stabilize patients in EDs, other medical physician specialists, such as neurosurgeons and orthopedic surgeons, provide on-call coverage, which means they are called in to provide specialized medical treatment when needed. Fewer physicians than in the past are willing to take call. There are a number of complex reasons, which include physician decisions about their income, type of practice, lifestyle, and legal concerns. Stakeholders have argued that physicians are reluctant to provide emergency on-call coverage due to the perceived medical malpractice climate in Florida and the inability to obtain adequate compensation for services rendered, both of which, are disincentives to assuming liability for treating emergency patients previously unknown to the physician.

Emergency on-call duties can have a significant impact on a physician's private practice obligations. Many physician specialists have organized their own office-based practices enabling them to screen patients for the severity of their condition, to ensure payment is provided for services rendered, and to establish a physician-patient relationship that may mitigate any litigation in the event of a bad clinical outcome. The large number of uninsured in Florida, in addition to the downward spiral of physician income has had some impact on physicians' willingness to accept pro bono work, such as treatment rendered to ED patients who are unable to pay for emergency care. In many instances, a specialist who has moved his or her practice to outpatient facilities and who no longer maintains hospital privileges is a direct competitor with hospitals for the same specialty service.

¹⁰ See Blumenthal, David, "New Steam From an Old Cauldron — The Physician Supply Debate," *New England Journal of Medicine*, Vol. 350, No. 17(April 22, 2004) as referenced in Ha, T. and O'Malley, A. "Exodus of Male Physicians from Primary Care Drives Shift to Specialty Practice" Tracking Report No. 17, June 2007, Center for Studying Health System Change at <http://www.hschange.com/CONTENT/934/> (Last visited on January 14, 2008).

¹¹ *Id.*

¹² Source: The Florida Department of Health. Physician data is for fiscal year 2007-2008 as of October 17, 2007.

¹³ See Chapter 2007-172, Laws of Florida.

An analysis of a recent survey of Florida hospitals found that the lack of available physicians is cited as a common reason why hospitals are having difficulties in getting physicians to take ED call.¹⁴ One third of the surveyed hospitals reported reducing or eliminating services in the past 2 years due to a physician shortage. Twelve hospitals reported eliminating services. The specialties cited with the greatest need include: family practice, internal medicine, pediatrics, general surgery, obstetrics/gynecology, orthopedic surgery, and psychiatry.¹⁵ Specialties with the most significant increased need compared to the current supply include: psychiatry, general surgery, neurosurgery, family practice, urology, dermatology, and orthopedic surgery.¹⁶

Senate Interim Project 2008-138

During the 2007-2008 interim, professional staff of the Senate Committee on Health Regulation reviewed the availability of physicians specialists for providing hospital emergency services and care. This proposed committee bill addresses recommendations in the Interim Project Report 2008-138, *Availability of Physicians and Physician Specialists for Hospital Emergency Services and Care*.¹⁷

III. Effect of Proposed Changes:

Section 1. Amends s. 395.002, F.S., which provides definitions for licensure of hospitals and certain health care facilities, to redefine the term “stabilized” to apply to patients awaiting further emergency services and care. In effect, a patient with an emergency medical condition would be considered stabilized if no material deterioration of the condition is likely to result while the patient is awaiting further emergency services and care.

Section 2. Amends s. 395.1041, F.S., which relates to access to emergency services and care, to revise legislative intent regarding the followup consultation and treatment a patient may need in order to effectively care for an emergency medical condition. The proposed committee bill clarifies that the consultation and treatment need not occur immediately after a patient is stabilized. Obsolete dates and requirements for the AHCA relating to it obtaining information from hospitals regarding the hospitals’ service capability and the inventory of hospital emergency services are deleted. The proposed committee bill authorizes a hospital to transmit a patient’s medical records to another emergency department when seeking to transfer the patient to another hospital, before the transfer, to expedite the patient’s care and treatment or for assistance in the determination of whether the receiving hospital has the requisite service capability and service capacity to provide additional emergency care and treatment to the patient. The AHCA is authorized to adopt rules that provide for physician on-call coverage and other standards to help facilitate a hospital’s compliance with access to emergency services and care requirements relating to:

¹⁴ Source: FHA Hospital Survey October 2007 (Sixty-nine hospitals and health systems responded, representing 93 acute hospitals and 22,244 beds, with a response rate of 43.7 percent of acute hospitals and 41.3 percent of the beds).

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ Interim Project Report 2008-138, *Availability of Physicians and Physician Specialists for Hospital Emergency Services and Care* is available at: <http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-138hr.pdf> along with the addendum to the report which is available at: <http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-138ahr.pdf> (Last visited on January 14, 2008).

- Conditions under which a physician may be on call at multiple hospitals concurrently,
- Conditions under which a physician may perform elective surgeries while on call, and
- The use of telemedicine to provide consultation or care for a patient receiving services in a hospital emergency department.

Section 3. Creates an undesignated section of law which requires the Board of Medicine and the Board of Osteopathic Medicine, in consultation with the AHCA, to adopt rules establishing standards for physicians to use in the emergency department to determine whether an orthopedic physician specialist must be called in prior to or immediately following stabilization of a patient who requires medical care and treatment by a specialist who is an orthopedic physician.

Section 4. Provides an effective date of July 1, 2008.

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 Article VII, Section 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 Article I, Section 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 Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Passage of this bill, along with authorized rulemaking, should ease some of the pressure facing hospital emergency departments as they fulfill their statutory obligation to provide emergency services and care and avoid civil, administrative, and perhaps criminal sanctions for non-compliance. The bill should also reduce the frequency in which orthopedic physician specialists are needed while in on-call status.

C. Government Sector Impact:

The bill authorizes the AHCA to adopt rules and requires rulemaking by the Boards of Medicine and Osteopathic Medicine in consultation with the AHCA. The fiscal impact on the Boards is unknown at this time.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.
