

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 Committee on Health Policy

BILL: SB 768

INTRODUCER: Senator Gaetz

SUBJECT: Patient Observation Status Notification

DATE: March 9, 2015

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	Pre-meeting
2.			CF	
3.			FP	

I. Summary:

SB 768 requires a hospital, ambulatory surgical center, or mobile surgical facility to provide a patient with oral and written notification immediately upon placing the patient in an observation status rather than an admission status.

II. Present Situation:

Observation Status

Observation services are services that are given in a hospital in order to help the treating physician decide whether the patient needs to be admitted to the hospital or if the patient can be discharged. These services can occur in the hospital's emergency department or in another area of the hospital.¹

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Although generally a physician should order a patient admitted who is expected to spend 24 hours or more in the hospital, such a decision is a complex medical judgment which the physician should only make after considering a number of factors including:

- The severity of signs and symptoms exhibited by the patient;
- The medical probability of something adverse happening to the patient;
- The need for diagnostic studies to assist in the admitting decision; and

¹ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Product No. 11435, *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* (May 2014) <https://www.medicare.gov/Pubs/pdf/11435.pdf> (Last visited Feb. 23, 2015).

- The availability of diagnostic procedures at the time when the patient presents.²

Observation services are considered outpatient services even if the patient spends one or more nights in the hospital. Outpatient services are covered under Medicare Part B, rather than Part A, so some patients with Medicare can see increased out of pocket costs for observation services versus being admitted to the hospital.³ For example, hospital inpatient services are covered under Medicare Part A which requires the patient to pay a one-time deductible (\$1,260) for all hospital services for the first 60 days of his or her stay. However, hospital outpatient services, including observation services, are covered under Medicare Part B and the patient must pay the Part B deductible (\$147) as well as 20 percent of the Medicare-approved amount for doctor services.⁴ Also, a patient may be responsible for the costs of a skilled nursing facility stay once discharged from the hospital and any prescription drug costs which typically are not covered under Medicare Part B.⁵

According to a study published in 2014, between 2001 and 2009, the rate of hospitals' use of observation services for Medicare patients has approximately doubled. Additionally, the number of Medicare patients who were placed on observation status and then released without being admitted to the hospital has increased by 131 percent over the same time period.⁶ The federal Centers for Medicare and Medicaid Services (CMS) has also noted an increase in the percentage of hospital patients receiving observation services for longer than 48 hours from approximately 3 percent in 2006 to approximately 8 percent in 2011.⁷ This trend concerns CMS since "beneficiaries who are treated for extended periods of time as hospital outpatients receiving observation services may incur greater financial liability...[from] Medicare Part B copayments, the cost of self-administered drugs that are not covered under Part B, and the cost of post hospital skilled nursing facility care."⁸

Part of the cause of the upward trend in longer periods on observation status may be due to hospitals' wariness of the denial of their Medicare Part A inpatient claims due to a Medicare review contractor determining that the inpatient admission was not reasonable and necessary. To combat this, CMS, enacted the 48 hour benchmark which is guidance that states that "the decision to admit a beneficiary should be made within 24 to 48 hours of observation care [and that] only in rare and exceptional cases do reasonable and necessary outpatient observation

² Medicare Benefit Policy Manual, Chapter 1 at 10, available at <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf> (last visited March 6, 2015).

³ AARP Public Policy Institute, *Rapid Growth in Medicare Hospital Observation Services: What's Going On?*, p. 1 (September 2013) http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf (Last visited Feb. 23, 2015.)

⁴ See supra note, at 1, and Medicaid.gov., *Medicare 2015 costs at a glance* <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html> (Last visited Feb. 23, 2015).

⁵ Note: *Some Medicare beneficiaries purchase separate Medicare Part D coverage for prescription drugs.*

⁶ Supra note 3, at 6.

⁷ Fed. Reg., Vol. 78, No. 160, pp. 50495-50907 (August 19, 2013) <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf> (last visited Feb. 25, 2015).

⁸ Id. Note: *For skilled nursing facility care to be covered under Medicare Part A the patient must have a prior 3-day stay in the hospital as an inpatient.*

services in the hospital span more than 48 hours.”⁹ In addition, starting April 1, 2015,¹⁰ Medicare’s review contractors are required to presume as reasonable and necessary admissions for patients that are expected to require more than one Medicare utilization day (defined as spanning two midnights).¹¹

III. Effect of Proposed Changes:

SB 768 amends s. 395.301, F.S., to require a hospital, ambulatory surgical center, or mobile surgical facility to provide written and oral notification immediately to a patient that is placed on observation status. The patient, his or her legal guardian, conservator, or other authorized representative must sign and date the written notice which must be placed in the patient’s record at the time of the oral notification. Such notification must include:

- A statement that the patient is not admitted to the facility but has been placed on observation status;
- A statement that being placed on observation status may affect the patient’s Medicare, Medicaid, or private insurance coverage for hospital services and for home or community-based care or skilled nursing facility services upon discharge; and
- A statement recommending that the patient contact his or her health insurance provider to determine the implications of being placed on observation status and his or her right to appeal the placement by the facility.

These provisions take effect on July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

⁹ Id.

¹⁰ See Amanda Cassidy, *The Two-Midnight Rule*, Health Affairs, Health Policy Briefs (Jan. 22, 2015) available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=133, (last visited Feb. 25, 2015).

¹¹ Supra note 10, at 50908

B. Private Sector Impact:

SB 768 may provide a positive fiscal impact for some patients who are placed on observation status in a hospital if such placement would require that they pay high out of pocket costs for outpatient services not covered by their insurance and if through receiving the notification the patient can avoid such costs.

The bill may cause a negative fiscal impact for facilities that fail to provide the required notice since failing to provide the required notice would constitute a licensure violation for that facility.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

SB 768 allows a patient's conservator to sign the notification of observation status in place of the patient. Under s. 747.035, F.S., a conservator has only the rights, powers, and duties of a guardian of the property of the person for whom he or she is acting. Typically a conservator is acting only on behalf of the person's property, and not on behalf of the person for health care decisions. A surrogate or health care surrogate as authorized under ch. 765, F.S., is typically the person designated to make health care decisions for an incapacitated patient. Additionally, a conservator, without more specific authorization, may not be able to receive the notice as it would be protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

VIII. Statutes Affected:

This bill substantially amends section 395.301 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

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

None.

B. Amendments:

None.