



The Florida Senate

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Committee on Health Regulation

AVAILABILITY OF PHYSICIANS AND PHYSICIAN SPECIALISTS FOR HOSPITAL EMERGENCY SERVICES AND CARE

SUMMARY

In Florida, and nationwide, hospitals are facing a shortage of physician specialists who are willing to provide on-call coverage in hospital emergency departments (EDs). The availability of physician specialists is determined by market forces. Physicians find an increasing demand for their services outside hospitals. They have the opportunity to balance their professional and nonprofessional pursuits without having to take call in EDs.

There are multiple reasons why physicians are unavailable for on-call coverage in hospital EDs and a single strategy will not solve the problem. The problem varies by locality, specialty, and hospital. However, in general, physicians are reluctant to provide emergency on-call coverage due to the negative impact on their lifestyle, the perceived hostile medical malpractice climate, and the inability to obtain adequate compensation for services rendered. All of these reasons are disincentives to assuming liability for treating emergency patients previously unknown to the physician. In some cases, however, the problem is simply an inadequate supply of a particular type of specialist in the market.

There are a number of potential market-based solutions. Some will require additional expenditures by hospitals to provide sufficient incentives for physician specialists to take call. Many hospitals in Florida and nationwide have already started paying physician specialists for taking call or are employing physician specialists. The Senate professional staff recommends that hospitals avail themselves of existing viable private-market solutions.

With regard to a governmental response to the problem, the professional staff recommends that the Legislature:

- More closely align the state's access to emergency services and care law with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) to provide greater flexibility to hospitals in providing on-call coverage;
- Establish a task force to develop standards, to be adopted by rule, for practitioners and hospitals to use in screening and stabilizing ED patients so that staffing pressures for physician specialty on-call services in EDs will be relieved; and
- Continue to support and encourage the funding of hospital residency slots and studies that monitor physician practice and supply in Florida.

BACKGROUND

State and Federal Regulations Relating to Hospital Emergency Services and Care

Florida hospital licensure requirements

Hospitals are licensed by the Agency for Health Care Administration (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 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,

¹ Section 395.002(12), Florida Statutes.

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 October 1, 2007, 220 out of 280 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 a 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.

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 participates 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

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.

² S. 395.002(25), F.S.

³ See:

<http://ahca.myflorida.com/MCHO/Health_Facility_Regulation/Hospital_Outpatient/forms/hosp_er_svcs_inventory_10_1_07.pdf> (Last visited on October 26, 2007).

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

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(2)(2) available at:<http://www.cms.hhs.gov/manuals/Downloads/som107_ap_v_emerg.pdf> (Last visited on October 25, 2007).

physician supply.⁷ 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.⁸ However, the demand for physicians is likely to grow even more rapidly over this period than the supply.

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.⁹ 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.¹⁰ 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.¹¹ Half of the Florida-licensed allopathic physicians voluntarily submitted workforce planning related information in conjunction with their January 2007 license renewal. Under 2007 legislation,¹² 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.

Reimbursement for Services/Uninsured

According to federal government estimates, approximately 46 million Americans were uninsured in 2004.¹³ There are about 2.6 to 2.9 million Floridians who are uninsured.¹⁴ Between 1999 and 2004, the number and proportion of Floridians without health insurance increased. Uninsured persons and insured persons who have high out-of-pocket costs are more likely to forgo needed medical care until an emergency arises.¹⁵

Physicians carry the financial risk of providing care to uninsured or underinsured patients they treat in EDs. Physicians are less likely to be reimbursed for services they provide in EDs. Physician willingness to take call is influenced by the level of reimbursement for their services. Between 1995 and 2003, the average physician net income from the practice of medicine had declined but medical specialists' real income was unchanged.¹⁶

Since physicians are no longer dependent on hospitals to obtain new patients to support their office-based practices and since many of the patients seen in hospital EDs are uninsured or underinsured, physicians are increasingly reluctant to provide services in hospital EDs without adequate compensation. As a result, many hospitals are paying stipends; the amounts vary depending on specialty and market, to physician specialists to provide emergency call coverage.¹⁷

⁷ 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 October 26, 2007).

⁸ *Id.*

⁹ 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 October 26, 2007).

¹⁰ *Id.*

¹¹ Source: The Florida Department of Health. Physician data is for fiscal year 2007-2008 as of October 17, 2007.

¹² See Chapter 2007-172, Laws of Florida.

¹³ See DeNavas-Walt, Carmen, Bernadette D. Proctor, and Cheryl Hill Lee. "Income, Poverty, and Health Insurance Coverage in the United States: 2004." Current Population Reports P60-229 (Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration, August 2005), <www.census.gov/prod/2005pubs/p60-229.pdf> (Last visited on October 26, 2007).

¹⁴ See Duncan, et al, "Comparative Findings from the 1999 and 2004 Florida Health Insurance Studies," Department of Health Services Research, Management and Policy, University of Florida (August 2005).

¹⁵ FHA "Florida Hospital Association Task Force on Addressing the Crisis in Emergency Care," December 2005.

¹⁶ See H.T. Tu and P.B. Ginsburg, "Losing Ground: Physician Income, 1995-2003," Tracking Report No. 15, June 2006, Center for Studying Health System Change at <<http://www.hschange.com/CONTENT/851/>> (Last visited on October 26, 2007).

¹⁷ See Henze, L. and Forster, K. P. "Call of the Riled: Addressing the Financial Impact of ED Call Coverage,"

Anti-kickback and Stark Self-Referral Laws

While the shortage of physicians for on-call coverage of EDs can be at least partially addressed through private sector compensation arrangements for physicians or cooperative arrangements between hospitals, hospitals and physicians must be careful not to violate certain federal and state laws limiting such arrangements. The federal anti-kickback statute prohibits the knowing and willful offer, payment, solicitation, or receipt of any remuneration, directly or indirectly, in return for referrals or to induce referrals for which payment may be made under the Medicare or Medicaid programs.¹⁸ Although many compensation arrangements are legitimate business arrangements, compensation arrangements may violate the anti-kickback statute if one purpose of the arrangement is to compensate physicians for past or future referrals.

The Office of the Inspector General within the U.S. Department of Health and Human Services (HHS) recently issued an advisory opinion, which provides some guidance to hospitals on how to structure a compensation agreement between physicians and the hospital for ED on-call coverage so as not to violate the federal anti-kickback statutes.¹⁹ The advisory opinion concludes that HHS would not impose civil monetary penalties, exclude from federal health care programs, or impose other administrative sanctions on a hospital for paying physicians to provide on-call coverage and uncompensated care services in its ED.²⁰

Medical Malpractice Liability

Nationally, rising medical malpractice liability insurance premiums, in combination with lower reimbursement rates, have rendered the practice of certain physician specialties less monetarily attractive.

Healthcare Financial Management Association, January 2007 at:

<http://findarticles.com/p/articles/mi_m3257/is_1_61/ai_n17114335> (Last visited on October 29, 2007).

¹⁸ See Section 1128B(b) of the Social Security Act. See also the Stark Act, which prohibits certain physician referrals where the physician has a financial relationship with the entity to which he is referring patients. See under Florida law, ss. 456.053 and 456.054, F.S., which prohibit health care providers from receiving kickbacks for patient referrals and prohibit certain patient referrals for health services to an entity in which the provider is an investor.

¹⁹ See Advisory Opinion No. 07-10 (September 27, 2007), Office of Inspector General, U.S. Dept of HHS at <<http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-10A.pdf>> (Last visited on October 26, 2007).

²⁰ *Id.*

However, according to a recent national survey of hospital leaders, only six percent cited physician liability concerns as a factor in the loss of physician specialty coverage.²¹ Florida has one of the largest medical malpractice insurance markets in the country. Before the 2003 tort reform legislation passed, Florida's medical malpractice insurance market experienced double-digit rate increases, an availability crisis, and one of the highest defense cost and containment expense ratios in the country.²²

In 2006, the total medical malpractice insurance premium, at \$847 million, decreased by 3 percent from the year before and has dropped for a third consecutive year.²³ Tort reform in Florida has reduced the severity (type of injury – minor, to death of insured) of claims. Florida medical malpractice insurance companies reported 900 closed claims in Florida compared to 3,753 claims reported in 2005. Seven new companies entered the Florida medical malpractice market during 2006. The Office of the Consumer Advocate has argued that medical malpractice losses and expenses have decreased by 43.6 percent in the two years subsequent to the passage of the 2003 tort reform but that decreases in malpractice insurance premiums have failed to be consistent with costs. According to representatives of a major medical malpractice insurer in Florida, a specialist who takes call and treats patients in an ED does not pay a higher premium than one who does not.

METHODOLOGY

Senate professional staff reviewed relevant case law, and laws relating to emergency services, tort reform, federal and state anti-fraud, sovereign immunity, health care joint ventures, and antitrust. Staff met with interested stakeholders, and the staff of relevant state and local agencies. Staff reviewed and researched relevant literature and reports regarding physician practice and supply, and federal and state requirements for hospitals to provide emergency services.

FINDINGS

Florida-licensed hospitals must maintain a roster of physician specialists to provide care and consultation in accordance with the federal EMTALA and

²¹ See American Hospital Association 2007 Survey of Hospital Leaders (July 2007).

²² See Florida Office of Insurance Regulation 2007 Annual Report – October 1, 2007, Medical Malpractice Financial Information, Closed Claim Database and Rate Filings.

²³ *Id.*

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.

Some areas within Florida, such as Palm Beach County, have experienced significant population growth and have had a shortage of physician specialists staffing EDs. The shortage in that county included a number of specialties. Palm Beach County has studied the issue of physician availability for on-call coverage and found that each hospital within the county must maintain an extensive infrastructure and complement of physician specialists to treat all clinical disorders.²⁴ Physicians have moved their practice out of hospitals, dropping clinical privileges in hospitals, so that hospitals have very little leverage to mandate on-call coverage.²⁵

²⁴ Taheri, P.A. and Butz, D.A., "Specialist On-Call Coverage of Palm Beach County Emergency Departments," December 13, 2004.

²⁵ *Id.*

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.²⁶ One third of the surveyed hospitals reported reducing or eliminating services in the past two 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.²⁷ Specialties with the most significant increased need compared to the current supply include: psychiatry, general surgery, neurosurgery, family practice, urology, dermatology, and orthopedic surgery.²⁸

Physician Workforce Information in Florida

Although it is commonly reported that there exists a lack of physicians in certain specialties, the state does not have sufficient data to substantiate those reports. It is also reported that physicians are leaving the state, reducing their practice, or retiring in response to the unfavorable practice environment in Florida. With the collection of physician workforce planning data from physicians as part of licensure renewal, the state will have the ability to determine the supply of physician specialists. Once all physicians have submitted the required information, it will be important for the DOH and others to analyze the data.

Employment/Compensation/Recruitment

In the past, physicians provided emergency room on-call coverage as a condition of hospital privileges and in exchange for the economic benefit derived in building their practice. Many physician specialists now get their income primarily from office-based practice. On-call duty competes with time that the physician could spend in his or her private office-based practice.²⁹ As a result, hospitals have been forced to negotiate on-call coverage payment to ensure adequate emergency room coverage. The provision of financial incentives, such as pay for on-call coverage and guaranteed compensation, is becoming a necessary business practice for hospitals.

²⁶ 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).

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Supra* at note 17.

Payment for on-call coverage is a partial, short-term solution although it is costly to hospitals. Payment for on-call coverage probably will need to be supplemented with long-term solutions to emergency room on-call coverage to reduce the burden of call duty on the limited number of physicians taking call. Increasingly, hospitals are employing physicians and many physicians are actively seeking hospital employment to relieve them of the stress of high malpractice rates, the struggle for reimbursement from third-party payers, administrative duties, and the general risks and hassles of private practice.³⁰

Sixty-seven out of sixty-nine hospitals responding to a recent survey noted that they are engaged in physician recruitment activities and some are considering adding residency slots. Less than one-third of the hospitals participating in the survey have a residency program. These hospitals reported having 1,874 residency slots and 1,252 of these slots were funded solely by the hospital. The specialties with the most residency slots in Florida are pediatrics, internal medicine, family practice, emergency medicine, and surgery. The Florida Hospital Association (FHA) notes that hospitals are faced with challenges in recruiting physicians to Florida due to the perceived negative malpractice climate, low reimbursement rates and emergency on-call requirements. Despite the challenges, hospitals have recruited 1,528 physicians within the last two years. The majority of hospitals surveyed anticipate employing more physicians during the next five years.

Regional Call Panels/ Group Purchasing Organizations

One solution that has been proposed is the establishment of regional call panels, which are a conceptual model that would allow hospitals on a regional basis to provide physician specialty coverage in EDs.³¹ A similar concept involves the use of a group

purchasing organization (GPO)³² where two or more hospitals in a geographic market create a GPO to bid out and contract for on-call physician specialty coverage. The benefits of a GPO include the possibility of more competitive contracting for physician specialty services for work in EDs.

The GPO would serve as a middleman between the *purchaser* of services, the hospital(s), and the *seller* of services, the physician specialist(s). If the purchasers and the sellers in a GPO conspire or agree to allocate market share they may be liable for antitrust enforcement. Federal antitrust laws prohibit monopolies and concerted actions that may be a restraint on trade or limit competition. Health care providers may not conspire to allocate market shares among competitors or set prices and terms of their work without running afoul of federal antitrust laws.

Various states have attempted to exempt physicians from federal antitrust laws through the state-action doctrine.³³ The state-action doctrine may be raised as a defense by a party who is subject to an antitrust action by the Federal Trade Commission or the Department of Justice. Under the test, active supervision requires not only that there be a structure for state involvement, but that the state act, in fact, and it must act as more than a rubber stamp for private anticompetitive conduct.

The GPO and any model for a regional call panel to provide physician specialty coverage must be structured carefully to also avoid any of the legal obstacles involving state and federal anti-kickback laws and physician self-referral laws.

The regional call concept is currently being explored by Palm Beach County to create a system for a county-wide electronic ED call schedule so that access could be granted to each county ED, pre-hospital providers, and the Palm Beach Health Care District. In addition to the regional call panel, a referral center is being

³⁰ See Merritt Hawkins & Associates, "2007 Review of Physician and CRNA Recruiting Incentives." at http://www.merrithawkins.com/pdf/2007_Review_of_Physician_and_CRNA_Recruiting_Incentives.pdf (Last visited on October 26, 2007).

³¹ California HealthCare Foundation Issue Brief "On-Call Physicians at California Emergency Departments: Problems and Potential Solutions" (January 2005) at <http://www.chcf.org/documents/hospitals/OnCallPhysiciansAtCAEmergencyDepts.pdf> (Last visited on October 26, 2006) and Hospital Association of Southern California Brief Focus by Jim Lott "On Call In Crisis Problems Pervasive, Solutions Unique" (September 22, 2006) at <http://www.hasc.org/download.cfm?ID=13604> (Last

visited on October 26, 2006).

³² Group purchasing organizations are input joint ventures that have been recognized to have procompetitive effects that benefit consumers, including the provision of services at a lower cost or the provision of a service that would not have been provided absent the joint venture. See Health Care & Antitrust Law § 13.7 (Thomson/West 2007) and Statements of Antitrust Enforcement Policy in Health Care, U.S. Dept of Justice and Federal Trade Commission (August 1996).

³³ See *Parker v. Brown*, 317 U.S. 341 (1943). Also see, *California Retail Liquor Dealers Assn. V. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

planned in Palm Beach County to provide referral for identified specialties with severe shortages. All hospitals within the county would be encouraged to participate in the electronic call schedule, but participation in the regional referral center would be voluntary. Although the system would not have any financial relationship with the hospitals or physician specialists, and is not intended to allocate any market share of physician specialty services, it could potentially run afoul of the antitrust laws.

The failure, so far, to implement the regional call panel and referral center is, in part, the result of a reluctance of the parties to risk potential liability under federal and state antitrust laws, anti-kickback laws, and physician self-referral laws. Also, the parties may find other alternatives more attractive, from a cost-benefit analysis, to recruit physician specialists for on-call coverage of EDs.

Federal and State Requirements

With respect to the availability of physician specialists in EDs, Florida's access to emergency services and care requirements are more stringent than the federal EMTALA requirements in two key areas as follows.

State Requirements	Federal Requirements (including interpretive guidelines)
Care, treatment, or surgery necessary to relieve or eliminate the emergency medical condition	Medical examination and treatment to stabilize the medical condition for transfer or discharge
Hospital must provide services within its services capability <i>at all times</i>	Hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond

Some stakeholders have suggested that Florida's requirements are contributing to the hospitals' difficulty in providing physician specialty coverage in EDs. They suggest that aligning the state's law more closely with the federal requirements will allow for expanded on-call coverage solutions and developing innovative models for patient care and services through the ED. One such option is to modify Florida's law to endorse a standard of practice that would allow emergency physicians to stabilize a patient with an emergency medical condition until specialists are available for scheduled treatment during normal business hours, except in those most serious cases where immediate specialty treatment is needed. Such

standards should be developed by experienced physicians and other parties to assure that patient safety remains in the forefront.

Satisfying Service Capabilities

Florida law authorizes a hospital to provide emergency services either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangements. A hospital may enter into an agreement with another hospital for purposes of meeting its service capability requirements, and appropriate compensation or other reasonable conditions may be negotiated for these backup services.³⁴ Currently some hospitals have transfer agreements with nearby hospitals for coverage of certain services. Similarly, EMTALA guidelines recognize opportunities for community-wide plans for certain hospitals to treat specified emergency medical conditions. In those cases, the individual would be screened and stabilized for transport at the presenting hospital then appropriately transferred to the community-plan hospital.³⁵ These types of arrangements necessitate a level of cooperation that competing hospitals have avoided. Hospitals pursuing these options must carefully negotiate any agreements to avoid antitrust pitfalls.

The AHCA has implemented rules³⁶ to exempt a hospital from ensuring services capability *at all times* based on the hospital demonstrating to the AHCA its lack of ability to ensure such capability and that it has exhausted all reasonable efforts to ensure such capability through backup arrangements. In reviewing exemption requests, the AHCA considers the following:

- Number and proximity of hospitals with the same service capability;
- Number, type, credentials, and privileges of specialists;
- Frequency of procedures; and
- Size of the hospital.

As of October 1, 2007, 14 hospitals have emergency service exemptions, all of which are partial exemptions for certain services from the requirement that the service be available 24 hours a day / 7 days a week.³⁷

³⁴ S. 395.1041(3)(d)1., F.S.

³⁵ *Supra* at Note 6. Tag number A407 (renumbered to A2407).

³⁶ Rule 59A-3.255, F.A.C.

³⁷ See: <http://ahca.myflorida.com/MCHQ/Health_Facility

Each exemption establishes a minimum number of days per month that the service will be available. The hospitals with exemptions are located in the following counties: Bay, Citrus, Miami-Dade, Lake, Leon, Martin (2 hospitals), Palm Beach, Pasco, Polk, St. Lucie (2 hospitals), and Volusia (2 hospitals). The most common exemption is for neurosurgery (8 hospitals have this exemption). The AHCA has 45 days from receipt of the request to approve or deny the request. Hospitals may have competitive and marketing disincentives to requesting emergency service exemptions.

Telemedicine

Stakeholders have suggested the use of telemedicine as a short-term strategy to address the shortage of physician specialists taking ED call. Telemedicine may be most effectively used in medical specialties where consultation is needed between an emergency room physician and a physician specialist. Telemedicine would not work well when the physician specialist must provide hands-on care and treatment. Barriers to the use of telemedicine include lack of access to needed technology and the fact that telemedicine is not currently a reimbursable service under many health plans.

Physician Licensure

Allopathic physicians are licensed under ch. 458, F.S., and osteopathic physicians are licensed under ch. 459, F.S. It has been suggested that Florida could require allopathic and osteopathic physicians to take on-call duty in hospital EDs as a condition of licensure. This potential solution could cause some physicians to leave the state or not come to the state. It may also weaken the ability of hospitals to negotiate other issues with physicians and could cause other undesired effects in a market-driven health system.

Sovereign Immunity

Some stakeholders argue that sovereign immunity may be used as an incentive to recruit physicians to take on-call duty in hospital EDs. Sovereign immunity is a legal doctrine that insulates the state and its officers or agents from a lawsuit. If immunity from liability is granted to physicians treating patients in EDs or to the owners of EDs, the state would be extending sovereign immunity to parties who are not state officers or agents. A likely constitutional challenge would be that the law violates an individual's right of access to court. To

impose a barrier on a litigant's right to file certain actions, the extension of the immunity from liability would have to meet the test announced by the Florida Supreme Court in *Kluger v. White*.³⁸ Under this test, the Legislature would have to: (1) provide a reasonable alternative remedy or commensurate benefit, or (2) make a legislative showing of overpowering public necessity for the abolishment of the right and no alternative method of meeting such public necessity exists.

Medical liability is important but is not the only factor that motivates a physician's choice not to take call. Other factors such as lifestyle, low reimbursement, or the lack of compensation for providing medical services on call in EDs also influence a physician's choice to take call.

RECOMMENDATIONS

There is no single solution to solve the problem that hospitals face in encouraging physician specialists to provide on-call coverage in hospital EDs. Many of the potential solutions that have been suggested may have unintended consequences in local health care markets.

Senate professional staff recommends that hospitals avail themselves of existing viable private-market solutions to address shortages and maximize the availability of physician specialists to take call.

The professional staff recommends that the Legislature:

- More closely align the state's access to emergency services and care law with the EMTALA to provide greater flexibility to hospitals in providing on-call coverage;
- Establish a task force to develop standards, to be adopted by rule, for practitioners and hospitals to use in screening and stabilizing ED patients so that staffing pressures for physician specialty on-call services in EDs will be relieved; and
- Continue to support and encourage the funding of hospital residency slots and studies that monitor physician practice and supply in Florida.

³⁸ See *Kluger v. White*, 281 So.2d 1 (Fla. 1973).