AMENDED IN ASSEMBLY APRIL 14, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 1223

Introduced by Assembly Member O'Donnell

February 27, 2015

An act to amend ~~Section~~ *Sections 1797.98a, 1797.98e, and* 1797.220 ~~of~~ *of, and to add Section 1797.120 to,* the Health and Safety Code, relating to emergency medical services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1223, as amended, O'Donnell. Emergency medical services: noncritical cases.

Existing law establishes the Maddy Emergency Medical Services (EMS) Fund, and authorizes each county to establish an emergency medical services fund for reimbursement of costs related to emergency medical services. Existing law limits payments made from the fund to claims for care rendered by physicians to patients who are initially medically screened, evaluated, treated, or stabilized in specified facilities, including a site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.

This bill would expand those specified facilities to include any licensed clinic or mental health facility, and any site approved by a county as a paramedic receiving station for the treatment of emergency patients. This bill would make conforming changes.

Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, authorizes each county to develop an emergency medical services program. The act further authorizes a local emergency medical services (EMS) agency

to develop and submit a plan to the Emergency Medical Services Authority for an emergency medical services system, and requires the local EMS agency, using state minimum standards, to establish policies and procedures *to assure medical control of the emergency medical services system* that may require basic life support emergency medical transportation services to meet any medical control ~~requirements~~ *requirements,* including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements.

This bill would ~~authorize the policies and procedures to allow for the transportation of a noncritical case that cannot be immediately admitted to a hospital emergency room to another appropriate medical treatment facility, including, but not limited to, a clinic, as defined, or a doctors' office.~~ *require a local EMS agency to include in those policies and procedures specified policies, including the establishment and enforcement of criteria relating to ambulance patient offload time, as defined, and for the transport of a patient to an alternate emergency department or facility under specified circumstances. The bill would require the authority to develop a statewide standard methodology for the calculation and reporting by a local EMS agency of ambulance patient offload time.*

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1797.98a of the Health and Safety Code is amended to read:

1797.98a. (a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) (1) Each county may establish an emergency medical services fund, upon the adoption of a resolution by the board of supervisors. The moneys in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state.

(2) Costs of administering the fund shall be reimbursed by the fund in an amount that does not exceed the actual administrative

costs or 10 percent of the amount of the fund, whichever amount is lower.

(3) All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(4) Each administering agency may maintain a reserve of up to 15 percent of the amount in the portions of the fund reimbursable to physicians and surgeons, pursuant to subparagraph (A) of, and to hospitals, pursuant to subparagraph (B) of, paragraph (5). Each administering agency may maintain a reserve of any amount in the portion of the fund that is distributed for other emergency medical services purposes as determined by each county, pursuant to subparagraph (C) of paragraph (5).

(5) The amount in the fund, reduced by the amount for administration and the reserve, shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county according to the following schedule:

(A) Fifty-eight percent of the balance of the fund shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic, comprehensive, or standby emergency services pursuant to paragraph ~~(3)~~ *(4)* or ~~(5)~~ *(6)* of subdivision (f) of Section 1797.98e up to the time the patient is stabilized.

(B) Twenty-five percent of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services.

(C) Seventeen percent of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers. Funding may be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of emergency services and are consistent with the intent of this chapter.

(c) The source of the moneys in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.

(d) Any physician and surgeon may be reimbursed for up to 50 percent of the amount claimed pursuant to subdivision (a) of

Section 1797.98c for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to Section 1797.98e. All funds remaining at the end of the fiscal year in excess of any reserve held and rolled over to the next year pursuant to paragraph (4) of subdivision (b) shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year.

(e) Of the money deposited into the fund pursuant to Section 76000.5 of the Government Code, 15 percent shall be utilized to provide funding for all pediatric trauma centers throughout the county, both publicly and privately owned and operated. The expenditure of money shall be limited to reimbursement to physicians and surgeons, and to hospitals for patients who do not make payment for emergency care services in hospitals up to the point of stabilization, or to hospitals for expanding the services provided to pediatric trauma patients at trauma centers and other hospitals providing care to pediatric trauma patients, or at pediatric trauma centers, including the purchase of equipment. Local emergency medical services (EMS) agencies may conduct a needs assessment of pediatric trauma services in the county to allocate these expenditures. Counties that do not maintain a pediatric trauma center shall utilize the money deposited into the fund pursuant to Section 76000.5 of the Government Code to improve access to, and coordination of, pediatric trauma and emergency services in the county, with preference for funding given to hospitals that specialize in services to children, and physicians and surgeons who provide emergency care for children. Funds spent for the purposes of this section, shall be known as Richie's Fund. This subdivision shall remain in effect until January 1, 2017, and shall have no force or effect on or after that date, unless a later enacted statute, that is chaptered before January 1, 2017, deletes or extends that date.

(f) Costs of administering money deposited into the fund pursuant to Section 76000.5 of the Government Code shall be reimbursed from the money collected in an amount that does not exceed the actual administrative costs or 10 percent of the money collected, whichever amount is lower. This subdivision shall remain in effect until January 1, 2017, and shall have no force or effect

on or after that date, unless a later enacted statute, that is chaptered before January 1, 2017, deletes or extends that date.

SEC. 2. Section 1797.98e of the Health and Safety Code is amended to read:

1797.98e. (a) It is the intent of the Legislature that a simplified, cost-efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of proposed reimbursement requests submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency Medical Services Fund on at least a quarterly basis to applicants who have submitted accurate and complete data for payment. When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment, the administering agency shall fairly prorate, without preference, payments to each claimant at a level less than the maximum payment level. Each administering agency may encumber sufficient funds during one fiscal year to reimburse claimants for losses incurred during that fiscal year for which claims will not be received until after the fiscal year. The administering agency may, as necessary, request records and documentation to support the amounts of reimbursement requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Reimbursements requested and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement. The administering officer shall not give preferential treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of

January 1, 1991, or a person under the direct supervision of that person, shall not be the administering officer. The board of supervisors of a county or any other county agency may serve as the administering officer. The administering officer shall solicit input from physicians and surgeons and hospitals to review payment distribution methodologies to ensure fair and timely payments. This requirement may be fulfilled through the establishment of an advisory committee with representatives comprised of local physicians and surgeons and hospital administrators. In order to reduce the county's administrative burden, the administering officer may instead request an existing board, commission, or local medical society, or physicians and surgeons and hospital administrators, representative of the local community, to provide input and make recommendations on payment distribution methodologies.

(b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the administering agency may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the emergency medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.

(c) During normal working hours, the administering agency may make any inspection and examination of a hospital's or physician and surgeon's books and records needed to carry out this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.

(d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.

(e) All payments from the fund pursuant to Section 1797.98c to physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical

setting, including, but not limited to, radiology and pathology settings.

(f) All payments from the fund shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:

(1) A basic or comprehensive emergency department of a licensed general acute care hospital.

(2) A licensed clinic or mental health facility.

~~(2)~~

(3) A site that ~~was~~ *is* approved by a county ~~prior to January 1, 1990,~~ as a paramedic receiving station for the treatment of emergency patients.

~~(3)~~

(4) A standby emergency department that was in existence on January 1, 1989, in a hospital specified in Section 124840.

~~(4)~~

(5) For the 1991–92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.

~~(5)~~

(6) A standby emergency room in existence on January 1, 2007, in a hospital located in Los Angeles County that meets all of the following requirements:

(A) The requirements of subdivision (m) of Section 70413 and Sections 70415 and 70417 of Title 22 of the California Code of Regulations.

(B) Reported at least 18,000 emergency department patient encounters to the Office of Statewide Health Planning and Development in 2007 and continues to report at least 18,000 emergency department patient encounters to the Office of Statewide Health Planning and Development in each year thereafter.

(C) A hospital with a standby emergency department meeting the requirements of this paragraph shall do both of the following:

(i) Annually provide the State Department of Public Health and the local emergency medical services agency with certification that it meets the requirements of subparagraph (A). The department shall confirm the hospital's compliance with subparagraph (A).

(ii) Annually provide to the State Department of Public Health and the local emergency medical services agency the emergency

department patient encounters it reports to the Office of Statewide Health Planning and Development to establish that it meets the requirement of subparagraph (B).

(g) Payments shall be made only for emergency medical services provided on the calendar day on which emergency medical services are first provided and on the immediately following two calendar days.

(h) Notwithstanding subdivision (g), if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

(i) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (f).

(j) The administering agency shall compile a quarterly and yearend summary of reimbursements paid to facilities and physicians and surgeons. The summary shall include, but shall not be limited to, the total number of claims submitted by physicians and surgeons in aggregate from each facility and the amount paid to each physician and surgeon. The administering agency shall provide copies of the summary and forms and instructions relating to making claims for reimbursement to the public, and may charge a fee not to exceed the reasonable costs of duplication.

(k) Each county shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the fund. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Part 3 of Title 9 of the Code of Civil Procedure, or to a local medical society for resolution by neutral parties.

(*l*) Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

SEC. 3. Section 1797.120 is added to the Health and Safety Code, to read:

1797.120. The authority shall develop a statewide standard methodology for the calculation and reporting by a local EMS agency of ambulance patient offload time.

~~SECTION 1.~~

SEC. 4. Section 1797.220 of the Health and Safety Code is amended to read:

1797.220. (a) The local EMS agency, using state minimum standards, shall establish policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system. The policies and procedures approved by the medical director may require basic life support emergency medical transportation services to meet any medical control ~~requirements~~ *requirements,* including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements.

(b) The policies and procedures adopted pursuant to subdivision (a) ~~may allow for the transportation of a noncritical case that cannot be immediately admitted to a hospital emergency room to another appropriate medical treatment facility, including, but not limited to, a clinic as defined in Section 1200 or an establishment owned or leased and operated as a clinic or office by one or more licensed health care practitioners and used as an office for the practice of their profession.~~ *shall include the following:*

(1) A policy that uses the authority's standard methodology for calculating ambulance patient offload time to establish and enforce compliance with criteria for the offloading of a patient transported by ambulance.

(2) Criteria for the reporting of and quality assurance followup for a "never event," as defined in subdivision (c).

(3) A policy that allows a patient the right to request transport to another emergency department if the patient is subject to extended ambulance patient offload time.

(4) A policy that allows a patient with a minor medical injury or illness to be transported, as approved by a licensed physician under direct medical control of the patient, to a county-approved or state-approved receiving facility, including a clinic, stand-alone emergency department, mental health facility, or sobering center.

(c) For the purposes of this section, a "never event" occurs when the ambulance patient offload time for a patient exceeds one hour.

(d) For the purposes of this section, "ambulance patient offload time" is defined as the interval between the arrival of an ambulance patient transported by the local EMS agency at an emergency department and the time that the emergency department assumes responsibility for care of the patient following the transfer of the patient to a stretcher utilized by the emergency department.

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