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 Appropriations

BILL:	CS/SB 348
INTRODUCER:	Health Policy Committee and Senator Rodriguez
SUBJECT:	Medicaid
DATE:	March 10, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.	McKnight	Kidd	AHS	**Recommend: Favorable**
3.	McKnight	Sadberry	AP	**Favorable**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 348 requires Florida Medicaid to reimburse for Medicare crossover claims for non-emergency ambulance services. Currently, Medicaid pays for emergency transportation crossover claims but not for non-emergency transportation crossover claims.

The bill requires Florida Medicaid to pay all deductibles and coinsurance for Medicare-covered services provided to Medicare-eligible recipients by ambulances licensed pursuant to chapter 401, Florida Statutes, according to the corresponding procedure codes for such services. Currently, Medicaid must pay all deductibles and coinsurance for Medicare emergency transportation services provided by ambulances licensed pursuant to chapter 401, Florida Statutes.

The bill is estimated to have an indeterminate fiscal impact on the Florida Medicaid program. *See* Section V of this analysis.

The bill takes effect on July 1, 2021.

II. Present Situation:

Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[1] The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the Agency for Health Care Administration (AHCA) and financed through state and federal funds.[2]

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups).[3] States set individual eligibility criteria within federal minimum standards. The AHCA may seek an amendment to the state plan as necessary to comply with federal or state laws or to implement program changes. States send state plan amendments to the federal CMS for review and approval.[4]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan.

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[5] The SMMC program has two components, the Managed Medical Assistance (MMA) program and the Long-term Care program. Florida's SMMC offers a health care package covering both acute and long-term care.[6] The SMMC benefits are authorized by federal authority and are specifically required in ss. 409.973 and 409.98, F.S.

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[1] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Feb. 23, 2021).
[2] Section 20.42, F.S.
[3] Agency for Health Care Administration (AHCA), *Senate Bill 348 Fiscal Analysis* (Feb. 1, 2021) (on file with Senate Committee on Health Policy).
[4] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Feb. 23, 2021).
[5] *Id.*
[6] *Id.*

The AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014, and was re-procured for a period beginning December 2018 and ending in 2023.[7]

Florida Medicaid Dual-Eligible Recipients

Medicare is the federally administered and federally funded health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease.[8] Individuals who are enrolled in both Medicare and Medicaid are referred to as dual-eligible recipients.

For dual-eligible recipients, Medicare is the primary payer for medical services and Medicaid is the payer of last resort. Medicaid may cover medical costs that Medicare does not cover or only partially covers, such as nursing home care, personal care, and home and community-based services.

When Medicare does not pay the full amount billed for a service rendered to a dual-eligible recipient, the claim is transferred to the state Medicaid program to determine if Medicaid can pay the difference. This is often referred to as a crossover claim. This process also facilitates Medicaid programs in covering the costs of the recipient's Medicare Part A or Part B coinsurance or deductible amounts.

Various state statutes and rules govern whether or how much of a crossover Medicaid will pay. In the case of Medicare emergency ambulance services, s. 409.908(13), F.S., specifies that Medicaid must pay the entire crossover amount for dual-eligible recipients.

Regulation of Emergency Medical Transportation

Part III of ch. 401, F.S., governs the provision of medical transportation services in Florida and establishes the licensure and operational requirements for emergency medical services.[9]

Florida Medicaid currently covers emergency and non-emergency ambulance services as a mandatory state plan benefit.[10] This includes both ground and air ambulances. In the fee-for-service delivery system, the Medicaid reimbursement rate for ambulance transportation varies based on the mode of transportation (air or ground) and the needs of the recipient during transport (basic life support, advanced life support, or specialty care).

[7] *Id.*
[8] Medicare.gov, *What's Medicare*, *available at* https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare (last visited Feb. 2, 2021).
[9] Section 401.251, F.S.
[10] AHCA, *Senate Bill 348 Fiscal Analysis* (Feb. 1, 2021) (on file with Senate Committee on Health Policy).

Medicare Ambulance Services

Medicare covers emergency and non-emergency ambulance services under its Part B services category. Medicare enrollees who receive these services are responsible for a 20-percent coinsurance or deductible payment.[11]

Unlike Florida Medicaid, Medicare does not reimburse flat rates for ambulance transportation. Medicare pays providers a base rate plus an additional amount based on miles traveled. These rates are based on multiple factors, including geography and regional costs of living, and can range from as low as $400 to $1,500 depending on the level of care and miles traveled.[12]

III. Effect of Proposed Changes:

Section 1 amends s. 409.908(13)(c)4., F.S., to require Medicaid to pay deductibles and coinsurance for Medicare-covered services provided to Medicare-eligible recipients by ambulances licensed pursuant to ch. 401, F.S., according to the corresponding procedure codes for such services. This authorizes the reimbursement of those costs for non-emergency transportation.

Section 401.23, F.S., defines the term "ambulance," which is interchangeable with the term "emergency medical services vehicle," to mean any privately or publicly owned land or water vehicle that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, land or water transportation of sick or injured persons requiring or likely to require medical attention during transport. An ambulance or emergency medical services vehicle can be used for both emergency and non-emergency transportation.

Section 2 provides an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

[11] Medicare.gov, *Ambulance Services*, *available at* https://www.medicare.gov/coverage/ambulance-services (last visited Feb. 2, 2021).
[12] AHCA, *Senate Bill 348 Fiscal Analysis* (Feb. 1, 2021) (on file with Senate Committee on Health Policy).

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will increase reimbursements paid to ambulance providers that provide non-emergency transportation to dually-eligible individuals.

C. Government Sector Impact:

In the fee-for-service (FFS) delivery system, the deductibles and coinsurance for non-emergency medical transportation are already covered. For state fiscal year 2019-2020, Medicaid paid $1.1 million for coinsurance and deductibles for non-emergency transportation services provided to dually-eligible individuals through the FFS delivery system. In managed care, reasonable costs to comply with mandates must be built into the capitation rates paid to the health plans participating in the SMMC program, however, the proposed change would not have a material impact on the capitation rates. The bill is estimated to have an indeterminate fiscal impact on the Florida Medicaid program.[13]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 409.908 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on February 3, 2021:
The CS clarifies that the services required to be reimbursed must be services covered by Medicare and that they will be reimbursed according to their corresponding procedure

[13] AHCA, *Senate Bill 348 Fiscal Analysis* (Feb. 1, 2021) (on file with Senate Committee on Health Policy).

codes. The CS reinstates the requirement in current law that such reimbursed services be provided by ambulances licensed under ch. 401, F.S.

B. Amendments:

None.