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 348
INTRODUCER:	Senator Rodriguez
SUBJECT:	Medicaid
DATE:	February 3, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

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-eligible recipients receiving services provided by ambulances. Currently, Medicaid must pay all deductibles and coinsurance for Medicare emergency transportation services provided by ambulances licensed pursuant to ch. 401, F.S.

The bill is estimated to have a negative fiscal impact on state government that, at this time, is indeterminate. *See* Section V of this analysis.

The bill provides an effective date of July 1, 2021.

II. Present Situation:

Florida Medicaid Program

Florida Medicaid is the health care safety net for low-income Floridians. The national Medicaid program is a partnership of federal and state governments established to provide coverage for health services for eligible persons. Florida's program is administered by the Agency for Health Care Administration (AHCA) and financed through state and federal funds.[1]

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

[1] Section 20.42, F.S.

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).[2] 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.

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.[3] 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.[4] The SMMC benefits are authorized by federal authority and are specifically required in ss. 409.973 and 409.98, F.S.

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.[5]

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.[6] 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.

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[2] Agency for Health Care Administration, *Senate Bill 348 Fiscal Analysis* (Feb. 1, 2021) (on file with Senate Committee on Health Policy).
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] 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).

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.[7]

Florida Medicaid currently covers emergency and non-emergency ambulance services as a mandatory state plan benefit.[8] 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).

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.[9]

Unlike Florida Medicaid, Medicare does not reimburse flat rates for ambulance transportation. Medicare pays providers a base rate plus an additional amount based on mileage 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.[10]

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-eligible recipients receiving services provided by ambulances, as that term is defined in s. 401.23(5), F.S. This authorizes the reimbursement of non-emergency transportation and removes the statutory requirement for ambulances providing such reimbursed services to be licensed pursuant to ch. 401, F.S.

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.

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[7] Section 401.251, F.S.
[8] *Supra*, note 2.
[9] Medicare.gov, *Ambulance Services*, *available at* https://www.medicare.gov/coverage/ambulance-services (last visited Feb. 2, 2021).
[10] *Supra*, note 2.

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.

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:

According to the AHCA, the bill, at this time, has an indeterminate negative fiscal impact on the Medicaid program.[11]

VI. Technical Deficiencies:

Under the bill as written, Medicaid must pay all deductibles and coinsurance for Medicare-eligible recipients who receive services provided by ambulances. The bill does not require that those services be covered by Medicare or Medicaid. If the intent is to apply this requirement only to services covered by Medicare and Medicaid, the bill should be amended.

Additionally the bill removes the requirement that ambulances providing such services be licensed pursuant to ch. 401, F.S. If the intent is to require these ambulances to be licensed, the bill should be amended.

[11] *Supra*, note 2.

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

None.

B. Amendments:

None.