HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 461 Medicare Transportation Services
SPONSOR(S): Finance & Facilities Subcommittee, Trabulsy and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 348

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Finance & Facilities Subcommittee	16 Y, 0 N, As CS	Grabowski	Lloyd
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

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

Medicare is a federal health insurance program for people 65 or older, people under 65 with certain disabilities, and people of any age with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). The program is administered by the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services.

Individuals who are eligible for both Medicaid and Medicare are known as “dual eligibles.” Medicaid wraps around Medicare’s coverage by providing financial assistance to dual-eligible recipients. In cases where Medicare does not pay the full amount billed for a service rendered to a dual-eligible recipient, the claim is transferred to AHCA for a determination on whether Medicaid can cover the remaining balance.

Florida Medicaid currently covers emergency and non-emergency ambulance services as a mandatory state plan benefit, meaning that they are available to all Medicaid recipients. This includes both ground and air ambulances. Florida law also requires Medicaid to pay all Medicare deductibles and coinsurance for emergency transportation services provided to dual eligibles by licensed ambulances.

The bill requires Medicaid to pay all deductibles and coinsurance costs for Medicare-covered services provided by a licensed ambulance. This change requires the reimbursement of costs for *non-emergency* transportation services provided by Medicaid to dual eligibles, in addition to the current law requirement for the reimbursement of emergency transportation services.

The bill has an indeterminate, but likely insignificant, fiscal impact on AHCA, and no fiscal impact on local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid Program

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, which makes eligibility determinations.

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, ambulatory surgical center services, and dialysis.[3]

The Florida Medicaid program covers approximately 4.5 million low-income individuals.[4] Medicaid is the second largest single program in the state, behind public education, representing approximately one-third of the total FY 2020-2021 state budget.[5]

Medicaid Managed Care

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. Many states have elected to provide Medicaid benefits through a managed care model. Traditionally, Medicaid services are paid for under a fee-for-service (FFS) reimbursement model. Under the FFS model, the state pays providers directly for each covered service received by a Medicaid beneficiary. Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan. In turn, the plan pays providers for all of the Medicaid services a beneficiary may require that are included in the plan's contract with the state.[6]

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[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, December 2020, https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed February 18, 2021).
[5] Ch. 2020-111, L.O.F. See also *Fiscal Analysis in Brief: 2020 Legislative Session*, p. 3, https://flsenate.gov/UserContent/Committees/Publications/FiscalAnalysisInBrief/2020_Fiscal_Analysis_In_Brief.pdf (last accessed February 18, 2021).
[6] Medicaid and CHIP Payment and Access Commission (MACPAC), *Provider payment and delivery systems*, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/ (last accessed March 1, 2021).

For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[7] The MMA program was enacted in 2011 and fully implemented in 2014.

MMA Program

The MMA program provides acute health care services through managed care plans contracted with AHCA in the 11 regions across the state.[8] Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease may also select from specialized plans. Roughly 80% of Florida's Medicaid population is served through the MMA program, with the remainder of participants served by traditional FFS Medicaid.[9]

Most Medicaid recipients must be enrolled in the MMA program. Those individuals who are not required to enroll, but may choose to do so, are:

- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home- and community-based waiver or those waiting for waiver services; and
- Children in a prescribed pediatric extended care center.[10]

Other Medicaid enrollees are exempt from the MMA program and receive Medicaid services on a fee-for-service basis. Exempt enrollees are:

- Women who are eligible for family planning services only;
- Women who are eligible only for breast and cervical cancer services; and
- Persons eligible for emergency Medicaid for aliens.

Participating health plans receive capitated payments for services provided. Under this approach, providers receive a fixed per person (or "capitated") payment that covers all health care services over a defined time period, adjusted for each patient's expected needs, and are also held accountable for high-quality outcomes.[11]

Medicaid Transportation Services

Florida Medicaid currently covers emergency and non-emergency ambulance services[12] as a mandatory state plan benefit, meaning that they are available to all Medicaid recipients.[13] This includes

[7] S. 409.964, F.S.
[8] Agency for Health Care Administration, *SMMC Region Map*, https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/SMMC_Region_map.pdf (last accessed March 9, 2021).
[9] Agency for Health Care Administration, presentation by Beth Kidder, Deputy Secretary for Medicaid, to the House Health and Human Services Committee, February 17, 2021, https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3085&Session=2021&DocumentType=Meeting%20Packets&FileName=hhs%202-17-21.pdf (last accessed March 5, 2021).
[10] S. 409.972, F.S.
[11] Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid program has been using capitated payment systems since the early 1990s.
[12] Ambulance services are otherwise regulated by ch. 401, F.S.
[13] S. 409.905(12), F.S.

both ground and air ambulances. In the FFS delivery system, the Medicaid reimbursement rate for ambulance transportation varies based on the mode (air or ground) and the needs of the recipient during transport (i.e., basic life support, advanced life support, or specialty care).[14] In the MMA program, reimbursement for ambulance transportation is built into the capitation rates paid to participating managed care plans.[15]

Medicare-Medicaid Dual Eligibles

Medicare is a federal health insurance program for people 65 or older, people under 65 with certain disabilities, and people of any age with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).[16] The program is administered by the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services.

Individuals who are eligible for both Medicaid and Medicare are known as "dual eligibles." These individuals may be served by either FFS Medicaid or the MMA program. In either case, Medicaid wraps around Medicare's coverage by providing financial assistance to dual-eligible recipients. Medicare covers their acute care services, while Medicaid covers Medicare premiums and cost sharing, and - for those below certain income and asset thresholds - long-term care services. The term "dual eligible" encompasses all Medicare beneficiaries who receive Medicaid assistance, including those who receive the full range of Medicaid benefits and those who receive assistance only with Medicare premiums or cost sharing.[17]

In cases where Medicare does not pay the full amount billed for a service rendered to a dual-eligible recipient, the claim is transferred to AHCA for a determination on whether Medicaid can cover the remaining balance. This is referred to as a crossover claim. The process facilitates Medicaid programs in covering the costs of the recipient's deductible and coinsurance amounts.[18] Section 409.908(13), F.S., sets parameters on Medicaid's financial obligation for deductibles and coinsurance incurred by dual-eligibles.

Transportation Services for Dual-Eligibles

Florida law currently specifies that Medicaid shall pay all deductibles and coinsurance for Medicare emergency transportation services provided by licensed ambulances.[19]

Unlike Florida Medicaid, Medicare does not reimburse flat rates for ambulance transportation and 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 $400.00 to $1,500.00 depending on the level of care and miles traveled.[20]

Effect of Proposed Changes

The bill requires Medicaid to pay all deductibles and coinsurance costs for Medicare-covered services provided by a licensed ambulance vehicle according to appropriate medical procedure codes for those services. This change requires the reimbursement of costs for *non-emergency* transportation services

[14] Agency for Health Care Administration, *Agency Bill Analysis for HB 461 of 2021*, February 24, 2021 (on file with staff of the Finance & Facilities Subcommittee).
[15] Id.
[16] Medicare.gov, *What's Medicare*, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare (last accessed March 3, 2021).
[17] Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, January 2018, https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/ (last accessed March 3, 2021).
[18] Supra note 14.
[19] S. 409.908(13)(c)4., F.S.
[20] Supra note 14.

provided by Medicaid to dual eligibles, in addition to the current law requirement for the reimbursement of emergency transportation services.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 409.908, F.S.; relating to reimbursement of Medicaid providers.
Section 2: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill may have a negative, but likely insignificant, fiscal impact on AHCA. In FFS Medicaid, Medicare deductibles and coinsurance for non-emergency transportation are already paid through Medicaid. In the MMA program, reasonable costs to comply with program requirements must be built into the capitation rates paid to participating health plans. The bill may lead to a small increase in the capitation rates by requiring plans to cover non-emergency transportation costs that would otherwise accrue to patients dually eligible for Medicare and Medicaid.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may lead to an increase in reimbursements to ambulance providers who serve individuals dually-eligible for Medicare and Medicaid.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have

to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 10, 2021, the Finance & Facilities Subcommittee adopted an amendment to the bill. The amendment clarifies that reimbursement for Medicare transportation services are made:

- For Medicare-covered services, rather than Medicare services;
- To Medicare-eligible recipients, which is implied, but not specified, by current law; and,
- Consistent with appropriate procedure codes, which is not specified by current law.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Finance & Facilities Subcommittee.