Assembly Bill No. 1705

CHAPTER 544

An act to amend Sections 14105.94, 14129, and 14129.3, and to add Section 14105.945 to, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor October 7, 2019. Filed with Secretary of State October 7, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1705, Bonta. Medi-Cal: emergency medical transportation services.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Existing law authorizes a Medi-Cal provider of ground emergency medical transportation services, that is owned or operated by the state, a city, county, city and county, fire protection district, special district, community services district, health care district, or a federally recognized Indian tribe, to receive supplemental Medi-Cal reimbursement, in addition to the rate of payment the eligible provider would otherwise receive for those services. Existing law requires the department to develop a modified supplemental reimbursement program, with necessary federal approvals, that would seek to increase the reimbursement to the above-described eligible providers. Existing law requires the nonfederal share of any supplemental reimbursement provided under the modified program to be derived from voluntary intergovernmental transfers of local funds. Existing law states the Legislature's intent in enacting these provisions to provide the supplemental reimbursement without any expenditure from the General Fund.

The bill would instead require the department to implement, subject to any necessary federal approvals, and no sooner than July 1, 2021, the Public Provider Intergovernmental Transfer Program (program), for the duration of any Medi-Cal managed care rating period, and would authorize the department to continue conducting any administrative duties related to the above-specified supplemental Medi-Cal reimbursement. The bill would require an eligible provider, defined, in part, as a provider of emergency medical transport, to receive an add-on increase to the associated Medi-Cal fee-for-service payment schedule, and would require the department to develop the add-on increase pursuant to specified standards, including an eligible provider's average cost directly associated with providing a Medi-Cal emergency medical transport under the Medi-Cal program. The bill would require Medi-Cal managed care health plans and emergency medical

transport providers to comply with specified federal standards relating to the payment standards for emergency medical transport. The bill would limit the amount that a noncontract eligible provider may collect for emergency medical transport. The bill would require the department to assess a 10% fee on each transfer of public funds to the state to pay for health care coverage and to reimburse the department for its administrative costs relating to the program. The bill would limit the operation of the program on the condition that the program would be financially and programmatically supportive of the Medi-Cal program. The bill would authorize the department to implement these provisions by various means, including all-county letters or provider bulletins, without taking regulatory action.

Existing law, the Medi-Cal Emergency Medical Transportation Reimbursement Act, commencing July 1, 2018, and subject to federal approval and the availability of federal financial participation, imposes a quality assurance fee for each emergency medical transport provided by an emergency medical transport provider subject to the fee in accordance with a prescribed methodology. Existing law requires the Director of Health Care Services to deposit the collected quality assurance fee into the continuously appropriated Medi-Cal Emergency Medical Transport Fund, for exclusive use in a specified order of priority, including to enhance federal financial participation for ambulance services under the Medi-Cal program. Existing law requires each emergency medical transport provider to report to the department specified data and material, including the number of actual emergency medical transports by payer type. The act increases Medi-Cal reimbursement to emergency medical transport providers for emergency medical transports.

The bill would exempt an eligible provider from the quality assurance fee and add-on increase for the duration of any Medi-Cal managed care rating during which the Public Provider Intergovernmental Transfer Program is implemented.

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

SECTION 1. Section 14105.94 of the Welfare and Institutions Code is amended to read:

14105.94. (a) An eligible provider, as described in subdivision (b), may, in addition to the rate of payment that the provider would otherwise receive for Medi-Cal ground emergency medical transportation services, receive supplemental Medi-Cal reimbursement to the extent provided in this section.

(b) A provider shall be eligible for supplemental reimbursement if the provider has all of the following characteristics continuously during a state fiscal year:

(1) Provides ground emergency medical transportation services to Medi-Cal beneficiaries.

(2) Is a provider that is enrolled as a Medi-Cal provider for the period being claimed.

(3) Is owned or operated by the state, a city, county, city and county, fire protection district organized pursuant to Part 2.7 (commencing with Section 13800) of Division 12 of the Health and Safety Code, special district organized pursuant to Chapter 1 (commencing with Section 58000) of Division 1 of Title 6 of the Government Code, community services district organized pursuant to Part 1 (commencing with Section 61000) of Division 3 of Title 6 of the Government Code, health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code, or a federally recognized Indian tribe.

(c) An eligible provider's supplemental reimbursement pursuant to this section shall be calculated and paid as follows:

(1) The supplemental reimbursement to an eligible provider, as described in subdivision (b), shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (f).

(2) The amount certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, shall not exceed 100 percent of actual costs, as determined pursuant to the Medi-Cal State Plan, for ground emergency medical transportation services.

(3) The supplemental Medi-Cal reimbursement provided by this section shall be distributed exclusively to eligible providers under a payment methodology based on ground emergency medical transportation services provided to Medi-Cal beneficiaries by eligible providers on a per-transport basis or other federally permissible basis. The department shall obtain approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and may not make any payment pursuant to this section prior to obtaining that approval.

(d) (1) It is the Legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund. An eligible provider, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department for the costs of administering this section.

(2) The nonfederal share of the supplemental reimbursement submitted to the federal Centers for Medicare and Medicaid Services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities described in paragraph (3) of subdivision (b) and certified to the state as provided in subdivision (e).

(e) Participation in the program by an eligible provider described in this section is voluntary. If an applicable governmental entity elects to seek supplemental reimbursement pursuant to this section on behalf of an eligible provider owned or operated by the entity, as described in paragraph (3) of subdivision (b), the governmental entity shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for the ground emergency medical transportation services are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department.

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(4) Keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the eligible provider is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f) (1) The department shall promptly seek any necessary federal approvals for the implementation of this section. The department may limit the program to those costs that are allowable expenditures under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). If federal approval is not obtained for implementation of this section, this section shall not be implemented.

(2) The department shall submit claims for federal financial participation for the expenditures for the services described in subdivision (e) that are allowable expenditures under federal law.

(3) The department shall annually submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(g) (1) If a final judicial determination is made by any court of appellate jurisdiction or a final determination is made by the administrator of the federal Centers for Medicare and Medicaid Services that the supplemental reimbursement provided for in this section must be made to any provider not described in this section, the director shall execute a declaration stating that the determination has been made and on that date this section shall become inoperative.

(2) The declaration executed pursuant to this subdivision shall be retained by the director, provided to the fiscal and appropriate policy committees of the Legislature, the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and posted on the department's internet website.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins, or similar instructions, without taking regulatory action.

(i) Notwithstanding any other law, this section shall become inoperative during the entirety of any Medi-Cal managed care rating period in which Section 14105.945 is implemented, in whole or in part. The department may conduct any necessary and remaining administrative duties related to any time period during which this provision remained operative, even after this

section becomes inoperative, and may receive all compensation for those activities until paid in full.

(j) The department, in its sole discretion, may determine it has received all compensation for activities conducted pursuant to this section and completed all administrative duties related to time periods when this section was operative.

SEC. 2. Section 14105.945 is added to the Welfare and Institutions Code, to read:

14105.945. (a) For purposes of this section, the following definitions apply:

(1) "Eligible provider" means a provider who is eligible for reimbursement of Medi-Cal emergency medical transports pursuant to this section, and who continually meets all of the following requirements during the entirety of any Medi-Cal managed care rating period that this section is implemented:

(A) Provides emergency medical transports to Medi-Cal beneficiaries.

(B) Is enrolled as a Medi-Cal provider for the period being claimed.

(C) Is owned or operated by the state, a city, county, city and county, fire protection district organized pursuant to Part 2.7 (commencing with Section 13800) of Division 12 of the Health and Safety Code, special district organized pursuant to Chapter 1 (commencing with Section 58000) of Division 1 of Title 6 of the Government Code, community services district organized pursuant to Part 1 (commencing with Section 61000) of Division 3 of Title 6 of the Government Code, health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code, or a federally recognized Indian tribe.

(2) (A) "Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations that are billed with billing codes A0429 BLS Emergency, A0434 Specialty Care Transport, A0225 Neonatal Emergency Transport, A0427 ALS Emergency, and A0433 ALS2, and any equivalent, predecessor, or successor billing codes, as may be determined by the director.

(B) "Emergency medical transport" shall not include transportation of beneficiaries by passenger car, taxicab, litter van, wheelchair van, or other forms of public or private conveyances, nor shall it include transportation by an air ambulance provider. An "emergency medical transport" does not occur if a transport is not provided following evaluation of a patient.

(3) "Medi-Cal managed care rating period" means a period selected by the department for which the actuarially sound capitation rates are developed and documented in the rate certification that the department submits to the federal Centers for Medicare and Medicaid Services as required by Section 438.7(a) of Title 42 of the Code of Federal Regulations.

(b) (1) Commencing no sooner than July 1, 2021, the department shall implement the Public Provider Intergovernmental Transfer Program

(program) pursuant to this section for any Medi-Cal managed care rating period that the department has obtained necessary federal approvals.

(2) Notwithstanding any other law, during the entirety of any Medi-Cal managed care rating period for which the requirements of this section are implemented, in whole or in part, supplemental Medi-Cal reimbursements described in Section 14105.94 shall become inoperative.

(c) To the extent authorized under federal and state law, an eligible provider shall receive increased reimbursement by application of an add-on increase, as determined pursuant to subdivision (d), to the associated Medi-Cal fee-for-service payment schedule for emergency medical transports provided to applicable Medi-Cal beneficiaries.

(d) The department shall develop the statewide add-on increase to be provided under the program as follows:

(1) The department shall determine an initial statewide add-on increase that is based on the most recent audited cost reports of eligible providers available at the time the add-on increase is developed, as determined by the department. In determining the initial statewide add-on increase, the department may make adjustments to account for inflation, trend, or other material changes, as appropriate under federal law and actuarial standards.

(2) The initial statewide add-on increase shall represent the difference between both of the following:

(A) The average reimbursement paid pursuant to the applicable base Medi-Cal fee-for-service payment fee schedule for an emergency medical transport during the time period of the applicable cost-report to an eligible provider, and weighted according to those services provided by all eligible providers during the applicable time period.

(B) The average cost directly associated with providing a Medi-Cal emergency medical transport under the Medi-Cal program by an eligible provider during the time period of the applicable cost-report, as determined based on all eligible providers' audited cost reports pursuant to paragraph (1), and weighted according to those services provided by all eligible providers during the applicable time period.

(3) For subsequent Medi-Cal managed care rating periods, the department, in consultation with participating eligible providers, and as determined by the department, may adjust periodically the initial statewide add-on increase to account for inflation, trend adjustments, or other material changes, as appropriate under federal law and actuarial standards.

(4) To the extent that the department deems practicable, the department shall set a schedule for determining the statewide add-on increase before the department submits to the federal Centers for Medicare and Medicaid Services actuarially sound Medi-Cal managed care rates for an applicable Medi-Cal managed care rating period pursuant to subdivision (e).

(5) Once the department determines the add-on increase for a Medi-Cal managed care rating period, the add-on increase shall not be modified for that rating period unless the modification is required for purposes of receiving federal approval or claiming federal financial participation for the requirements of this section.

(e) (1) A Medi-Cal managed care health plan shall satisfy its obligation under Section 438.114(c) of Title 42 of the Code of Federal Regulations for emergency medical transport, and shall provide payment to applicable noncontract emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code.

(2) During the entirety of any Medi-Cal managed care rating period that this section is implemented, the amounts a noncontract eligible provider may collect if a Medi-Cal beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to Section 1396u-2(b)(2)(D) of Title 42 of the United States Code shall be the resulting Medi-Cal fee-for-service payment schedule amounts after the application of the add-on increase described in this section. During the Medi-Cal managed care rating period that the requirements of this section are implemented, any reimbursement to a noncontract emergency medical transport provider that is not an eligible provider shall be made in accordance with subdivision (b) of Section 14129.3.

(f) The Medi-Cal reimbursement provided by this section shall be distributed exclusively to eligible providers under a payment methodology based on emergency medical transport provided to Medi-Cal beneficiaries by eligible providers on a per-transport basis or other federally permissible basis.

(g) During the entirety of any Medi-Cal managed care rating period that this section is implemented, in whole or in part, the department shall provide appropriate funding to each applicable Medi-Cal managed care plan to account for the add-on increase obligations of these plans pursuant to this section in federally approved risk based capitation rates developed in accordance with Section 14301.1.

(h) (1) For any Medi-Cal managed care rating period that this section is implemented, the nonfederal share, which is associated with the add-on increase as it applies to the Medi-Cal fee-for-service payment schedule and the portion of the risk-based capitation rate to Medi-Cal managed care health plans, may consist of voluntary intergovernmental transfers of funds provided by eligible providers and their affiliated governmental entities or other public entities pursuant to Section 14164, as applicable. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify, in the form and manner specified by the department, that the transferred funds qualify for federal financial participation pursuant to applicable laws relating to the federal Medicaid program. Any intergovernmental transfer of funds made pursuant to this section shall be voluntary for purposes of federal law.

(2) The department shall assess a 10-percent fee on each transfer of public funds to the state pursuant to this subdivision to pay for health care coverage and to reimburse the department for its costs associated with administering the program. Excluding this fee, the department shall not assess a percentage fee in connection with any intergovernmental transfer of funds made pursuant to this subdivision.

(3) The department shall develop and maintain, in consultation with participating eligible providers, a protocol and schedule for funding the nonfederal share of expenditures during a Medi-Cal managed care rating period that this section is implemented using voluntary intergovernmental transfers.

(4) This section does not limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of expenditures in the Medi-Cal program.

(i) During the entirety of any Medi-Cal managed care rating period for which this section is implemented, in whole or in part, an eligible provider shall be exempt from the quality assurance fee and add-on increase pursuant to Article 3.91 (commencing with Section 14129).

(j) This section shall cease to be operative on the first day of the Medi-Cal managed care rating period beginning on or after the date the department determines, after consultation with participating eligible providers, that implementation of this section is no longer financially and programmatically supportive of the Medi-Cal program. The department shall make this determination if the projected amount of nonfederal share funds available for an applicable Medi-Cal managed care rating period is insufficient to support implementation of this section in the subject Medi-Cal managed care rating period. The department shall post notice of the determination on its internet website.

(k) The director may modify any process or methodology specified in this section to the extent necessary to comply with state or federal law or regulations, or to secure or maintain federal approval or federal financial participation. If the director determines, after consulting with participating eligible providers, that a modification to the process or methodology is necessary, the director shall execute a declaration stating that this determination has been made and describing the modification. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature. The director shall post the declaration on the department's internet website.

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of all-county letters, provider bulletins, plan letters, or other similar instructions without taking regulatory action.

(m) (1) The department shall implement this section only to the extent that federal financial participation is available and any necessary federal approvals are obtained.

(2) The department shall promptly seek any necessary federal approvals for the implementation of this section for an applicable Medi-Cal managed care rating period.

SEC. 3. Section 14129 of the Welfare and Institutions Code is amended to read:

14129. For purposes of this article, the following definitions apply:

(a) "Annual quality assurance fee rate" means the quality assurance fee assessed on each emergency medical transport during each applicable state fiscal year.

(b) "Aggregate fee schedule amount" means the product of the fee-for-service add-on increase described in Section 14129.3 and the Medi-Cal emergency medical transports, including both fee-for-service transports paid by the department and managed care transports paid by Medi-Cal managed care health plans, utilizing the billing codes for emergency medical transport for the state fiscal year.

(c) "Available fee amount" shall be calculated as the sum of the following:

(1) The amount deposited in the Medi-Cal Emergency Medical Transport Fund established under Section 14129.2 during the applicable state fiscal year, less the amounts described in subparagraphs (A) and (B) of paragraph (2) of subdivision (f) of Section 14129.2.

(2) Any federal financial participation obtained as a result of the deposit of the amount described in paragraph (1) in the Medi-Cal Emergency Medical Transport Fund, created pursuant to Section 14129.2, for the applicable state fiscal year.

(d) "Department" means the State Department of Health Care Services.

(e) "Director" means the Director of Health Care Services.

(f) "Effective state medical assistance percentage" means a ratio of the aggregate expenditures from state-only sources for the Medi-Cal program divided by the aggregate expenditures from state and federal sources for the Medi-Cal program for a state fiscal year.

(g) "Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an emergency medical transport provider by means of an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations that are billed with billing codes A0429 BLS Emergency, A0427 ALS Emergency, A0434 Specialty Care Transport, A0225 Neonatal Emergency Transport, and A0433 ALS2, and any equivalent, predecessor, or successor billing codes as may be determined by the director. "Emergency medical transport" excludes transportation of beneficiaries by passenger car, taxicabs, litter vans, wheelchair vans, other forms of public or private conveyances, and transportation by an air ambulance provider. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

(h) "Gross receipts" means gross payments received as patient care revenue for emergency medical transports, determined on a cash basis of accounting. "Gross receipts" includes all payments received as patient care revenue for emergency medical transports, including payments for billing codes A0429 BLS Emergency, A0427 ALS Emergency, and A0433 ALS2, and any equivalent, predecessor, or successor billing codes as may be determined by the director, and any other ancillary billing codes associated with emergency medical transport as may be determined by the director.

"Gross receipts" excludes supplemental amounts received pursuant to Sections 14105.94 or 14105.945.

(i) "Emergency medical transport provider" means any provider of emergency medical transports, except that during any Medi-Cal managed care rating period for which Section 14105.945 is implemented "emergency medical transport provider" shall exclude "eligible providers" as defined in paragraph (1) of subdivision (a) of Section 14105.945 for purposes of this article.

(j) "Emergency medical transport provider subject to the fee" means all emergency medical transport providers who bill and receive patient care revenue from the provision of emergency medical transports, except emergency medical transport providers that are exempt pursuant to subdivision (c) of Section 14129.6.

(k) "Medi-Cal managed care health plan" means a "managed health care plan" as that term is defined in subdivision (ab) of Section 14169.51.

SEC. 4. Section 14129.3 of the Welfare and Institutions Code is amended to read:

14129.3. (a) Except as provided in subdivision (i) of Section 14105.945, commencing July 1, 2018, and for each state fiscal year thereafter for which this article is operative, reimbursement to emergency medical transport providers for emergency medical transports shall be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. The add-on increase to the fee-for-service payment schedule under this section shall be calculated on or before June 15, 2018, and shall remain the same for later state fiscal years for which this article is operative, to the extent the department determines federal financial participation is available and is not otherwise jeopardized. The add-on increase to the fee-for-service payment schedule under this section shall apply only to those billing codes identified in, or any equivalent, predecessor, or successor billing codes as may be determined by the director pursuant to, subdivision (g) of Section 14129. The department shall calculate the projections required by this subdivision based on the data submitted pursuant to Section 14129.1. The fee-for-service add-on shall be equal to the quotient of the available fee amount projected by the department on or before June 15, 2018, for the 2018–19 state fiscal year, divided by the total Medi-Cal emergency medical transports, including both fee-for-service transports paid by the department and managed care transports paid by Medi-Cal managed care health plans, utilizing these billing codes projected by the department on or before June 15, 2018, for the 2018–19 state fiscal year. The resulting fee-for-service payment schedule amounts after the application of this section shall be equal to the sum of the Medi-Cal fee-for-service payment schedule amount for the 2015–16 state fiscal year and the add-on increase.

(b) (1) Each applicable Medi-Cal managed care health plan shall satisfy its obligation under Section 438.114(c) of Title 42 of the Code of Federal Regulations for emergency medical transports and shall provide payment to noncontract emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code. Effective July 1,

2018, and for each state fiscal year thereafter for which this article is operative, the amounts a noncontract emergency medical transport provider could collect if the beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to Section 1396u-2(b)(2)(D) of Title 42 of the United States Code shall be the resulting fee-for-service payment schedule amounts after the application of this section.

(2) This subdivision shall not apply to an eligible provider, as defined in paragraph (1) of subdivision (a) of Section 14105.945, who provides noncontract emergency medical transports to an enrollee of a Medi-Cal managed care plan during any Medi-Cal managed care rating period that Section 14105.945 is implemented.

(c) The increased payments required by this section shall be funded solely from the following:

(1) The quality assurance fee set forth in Section 14129.2, along with any interest or other investment income earned on those funds.

(2) Federal reimbursement and any other related federal funds.

(d) The proceeds of the quality assurance fee set forth in Section 14129.2, the matching amount provided by the federal government, and any interest earned on those proceeds shall be used to supplement existing funding for emergency medical transports provided by emergency medical transport providers and not to supplant this funding.

(e) Notwithstanding this article, the department may seek federal approval to implement any add-on increase to the fee-for-service payment schedule pursuant to this section for any state fiscal year or years, as applicable, on a time-limited basis for a fixed program period, as determined by the department.

(f) Notwithstanding this article, the add-on increase to the fee-for-service payment schedule pursuant to this section shall only be required and payable for state fiscal years that a quality assurance fee payment obligation exists for emergency medical transport providers.

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