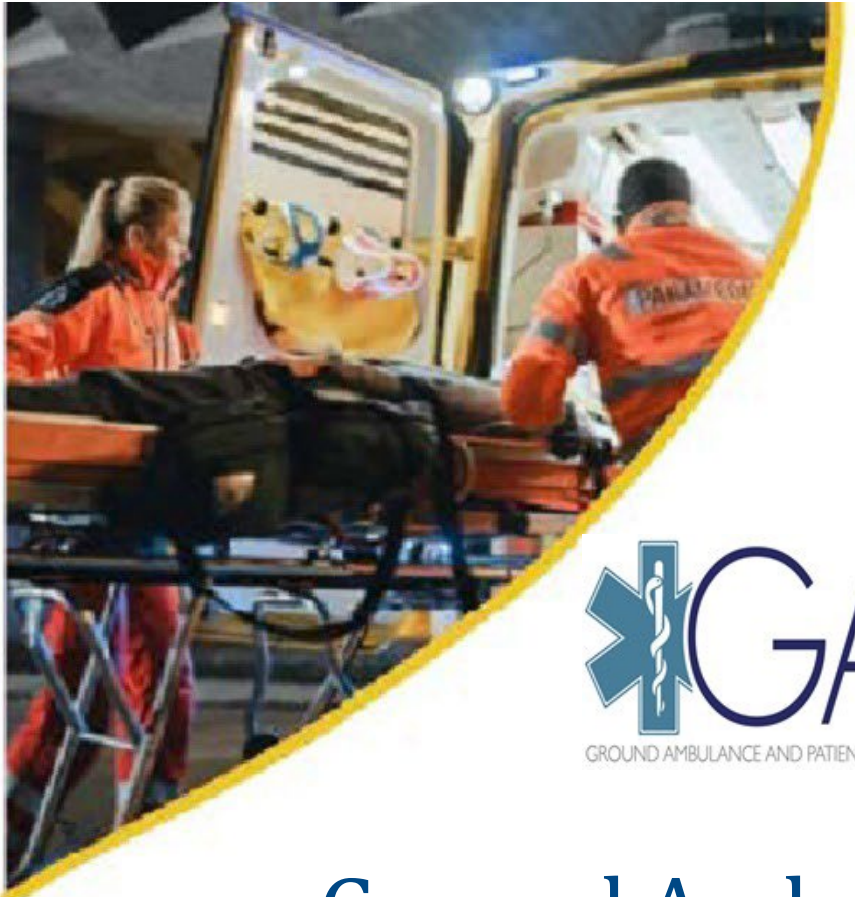

GAPB

GROUND AMBULANCE AND PATIENT BILLING ADVISORY COMMITTEE

Ground Ambulance & Patient Billing Advisory Committee

Report on Prevention of Out-Of-Network Ground Ambulance Emergency Service Balance Billing

March 29, 2024

Report of the Advisory Committee on Ground Ambulance and Patient Billing: Prevention of Out-Of-Network Ground Ambulance Emergency Service Balance Billing

Contents

Executive Summary

The Ground Ambulance and Patient Billing (GAPB) Advisory Committee convened between May and November, 2023 and developed the recommendations in this report to prevent out-of-network ground ambulance service balance billing to consumers. The Committee unanimously agreed that unique features of ground ambulance emergency medical services would require substantial modifications to current law to both protect consumers from balance billing and protect their access to emergency services.

Consumer Protections

The Committee was unanimous on the need to take consumers who have health coverage for emergency services (covered individuals) out of the middle of ground ambulance emergency service billing disputes between ground ambulance providers/suppliers and insurance companies and group health plans (payors). There was broad consensus among Committee members to recommend mandatory coverage of, and prohibition of balance billing for, ground ambulance emergency medical services when plans or issuers cover any emergency services. Most supported mandatory coverage and inclusion in Essential Health Benefits definitions, not only for ground ambulance services that result in transport to a hospital, but also for emergency interfacility transports and emergency medical services that do not result in transport. They reasoned this approach would best protect consumers by embracing the breadth of ground ambulance emergency response scenarios and by preventing unnecessary emergency department visits. They also agreed on related recommendations to reduce barriers encountered by providers/suppliers in obtaining consumer health coverage billing information and to require certain standard consumer-friendly content in provider/supplier bills.

A large majority of the Committee supported establishing a fixed dollar cap on cost sharing that would apply before the requirement of a covered individual to meet their annual deductible. They believed this policy would best protect consumers who may fail to call 911 when care is needed for fear of unknown out-of-pocket costs. A small minority of the Committee differed primarily on the details of how best to set maximum cost sharing amounts, instead supporting limiting cost sharing at the amount that would apply to in-network ground ambulance services.

All voting (present and non-abstaining) members of the Committee supported the recommendation to establish a federal advisory committee to advise the Secretaries on ground ambulance coverage and reimbursement policy across regulated health programs. A majority of the Committee also felt strongly about extending balance billing protections and cost-sharing limitations to non-emergency ground ambulance services. While patients in these situations may be medically stable and out of crisis, they may still not be fully capable of considering the implications of health coverage rules when their treating or discharging clinicians recommend ambulance transports. However, because the complete set of interrelated recommendations on non-emergency services was not adopted, no recommendations on non-emergency ground ambulance services were finalized for this report.

Plan and Issuer Out-of-Network Payment

Voting members of the Committee were unanimous on the need to prohibit consumer balance billing coupled with a guarantee of reasonable payment for out-of-network ground ambulance

emergency medical services. They believe that only by connecting requirements for coverage, cost-sharing limits, and reasonable direct payment to ground ambulance providers and suppliers can consumer protections (including continued access to timely emergency response) be achieved. The most significant matters on which Committee members did not reach consensus were on whether to mandate a minimum payment, how best to set the upper limit of a reasonable minimum payment for out-of-network services, and how those payment requirements would apply to employers' self-funded group health plans.

A majority of the Committee supported establishing a minimum required out-of-network payment amount to ground ambulance providers/suppliers determined by a hierarchy starting with the amount specified in State balance billing law, if one exists, and, if not, to locally set regulated rates. The recommendation did not include any limit on such state or locally set rates. However, the Committee recommended that in order for such state or locally set rates to qualify as the minimum required payment, the rate-setting process would have to meet certain guardrails specified by Congress. The Committee recommended a number of such guardrails, including rate-setting through a public process and public reporting of rates in one central place that the public and regulators can easily find. If neither state nor local rates applies, and no amount is agreed to between the payor and the out-of-network provider/supplier (single-case rate), then the minimum required payment would default to a Congressionally determined multiple of Medicare rates, or other amount for non-Medicare-covered services. The Committee did not recommend a specific multiple or percentage increase over Medicare rates, but noted that several States have or are planning to adopt such a standard.

A majority supported this out-of-network payment methodology for all group health plans and health insurance issuers, whether regulated under State law or ERISA.[1] They supported this approach because it respects state authority and rate regulation processes which are entwined with local Emergency Medical Services (EMS) response requirements. They believed this approach best reimburses the costs of ground ambulance providers and suppliers, especially those serving many rural communities, for which payments based on average rates may not be adequate to maintain viable local service levels needed by the residents of those communities. These community needs do not differ by whether residents' health coverage is provided by self-funded group health plans or health insurance issuers.

A minority of the Committee supported a minimum required out-of-network payment amount that would be established differently depending on whether a covered individual's health coverage is provided by a state-regulated health insurance issuer or a self-funded group health plan regulated under ERISA.

- For state-regulated health insurance plans, they supported a hierarchy of methods starting with the amount specified in State balance billing law. If no such law exists, then the determination would default to a Congressionally determined multiple of Medicare rates, or other amount for non-Medicare-covered services.
- For self-funded group health plans, they supported a minimum required out-of-network payment amount that would always be the Congressionally determined multiple of Medicare rates, or other amount for non-Medicare-covered services. They supported this

[1] The Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, *et seq.*

approach because they believe it is less likely to blunt incentives for cost control at the local level and, thus, would better constrain growth in health care costs and premiums. A minority also held that this approach was more consistent with longstanding ERISA preemption of state requirements for self-funded employer group health plans.

A minority of the Committee also supported access to a form of independent dispute resolution process, especially in cases in which small providers or suppliers serving more remote communities do not have access to adequate reasonable minimum payments. They reasoned this might occur under either of the minimum required out-of-network payment approaches, due to the absence of qualifying locally set rates and/or the insufficiency of Congressionally set amounts. However, a majority of the Committee did not support recommending access to an independent dispute resolution process, in part due to the expectation of excessive administrative cost and burden.

Overview of Detail Discussions in the Report

Discussion and recommendations regarding options, best practices, and identified standards to address balance billing considered by the Committee are presented in Chapters 2-5, which address the applicability of the No Surprises Act's (NSA's) framework, definitions relevant to the recommendations, consumer protections, and plan and issuer payments.

A list of adopted recommendations addressing steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, is presented in Chapter 6.

A list of adopted recommendations for Congressional action to prevent balance billing is presented in Chapter 7.

A list of significant findings relevant to the Committee that were outside the scope of the GAPB Advisory Committee's charter and related supplemental material are presented in Chapter 8.

Chapter 1 – Overview of the GAPB Advisory Committee

Consolidated Appropriations Act, 2021

Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021 (CAA), establish new protections for covered individuals related to surprise billing and transparency in health care. The legislation contains new requirements for group health plans, health insurance issuers in the group and individual markets, providers, facilities, and air ambulance providers. The Department of Health and Human Services (HHS), in coordination with the Department of Labor (DOL) and the Department of the Treasury (Treasury) (and to a lesser degree the Department of Transportation (DOT), National Highway Traffic Safety Administration (NHTSA) and other federal and external components), is responsible for implementation and, along with state regulatory entities, enforcement of these new requirements.

Section 117 of the NSA, enacted as part of the Consolidated Appropriations Act, 2021, requires the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury (the Secretaries) to establish and convene an advisory committee for the purpose of reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing [*Appendix A*]. The Advisory Committee must submit a report that includes recommendations with respect to disclosure of charges and fees for ground ambulance services and health coverage, consumer protection and enforcement authorities of the Departments of Labor, Health and Human Services, and the Treasury and State authorities, and the prevention of balance billing to consumers.

GAPB Committee Process

Formation

On November 16, 2021, the Departments received approval of the charter for this committee [*Appendix B*] and established the committee. The Department of Health and Human Services published a notice announcing the establishment of the Committee, and solicited nominations for membership. During 2022, nominations were reviewed against the representation requirements required by the enabling legislation and the Federal Advisory Committee Act. The roster of 17 Committee members [*Appendix C*] was announced in a notice published in December of 2022. The Committee convened during 2023 in accordance with adopted Bylaws [*Appendix D*].

Meetings, subcommittees and adoption of recommendations

The Committee's first public meeting held on May 2 and May 3, 2023 included presentations that provided an overview of ground ambulance provider and suppliers and issues pertaining to balance billing. (Public meeting summaries [*Appendix F*] and all Committee materials are located at **CMS GAPB.**) Two subcommittees were established at the end of the first

public meeting to conduct research and draft potential recommendations on specific topic areas for further deliberation by the Committee. On August 16, 2023, the Committee convened a second public meeting to review the preliminary findings from the subcommittees and to provide transparency on the workings of the committee, the subcommittee, and the research that had been compiled to date. During that meeting, the Committee also solicited public comment on 14 key issues [*Appendix G*] to be received during a public comment period that ended September the 5th. The public comments received were reviewed by the Committee and informed the subcommittees' drafting of key findings and recommendations on which the Committee deliberated and voted during its third public meeting. During the third public meeting held on October 31, and November 1, 2023, the Committee deliberated on key findings and draft recommendations presented on both days. A total of 30 recommendations were presented to the Committee during the two-day public meeting, 19 of which were adopted by the Committee (12 recommendations and 7 definitions). Several recommendations were considered jointly, and it is important to note that the adopted recommendations are not intended to be considered individually but are instead intended to be accepted as a complete policy.

Chapter 2 – Recommendation on the NSA Framework

The Committee understood that addressing the issue of "surprise medical billing" (or "balance billing" as it is referenced throughout this report) in the context of ground ambulance services is complex. It involves not only questions about the coverage and reimbursement for these services, but also:

- Issues of state and local government oversight;
- The ongoing viability of and access to the network of ground ambulance service providers/suppliers that comprise the nation's EMS response system;
- The advent of technologies and medical protocols that have advanced pre-hospital emergency medical care available to patients;
- The requirement that ground ambulances respond to emergency/emergent requests for services and transport without the ability to refuse to treat or turn away an individual based upon insurance status;
- The critical role of ground ambulance services in care coordination among different health care facilities; and
- The use of ground ambulance services to support issuer's/plan's provider networks.

The Committee heard from numerous subject matter experts and explored potential recommendations to protect covered individuals[2] from receiving balance bills for ground ambulance services. It became clear that the complexities of the task at hand would require the Committee to provide comments on areas that interact with balance billing but are outside the scope of the Committee's statutory charge. In that regard, the Committee offers a separate set of findings that point to challenges faced by patients, payors and ground ambulance providers and suppliers. We encourage federal, state, and local policy makers to consider the issues raised in the findings, in addition to the formal recommendations related to eliminating balance billing for ground ambulance services.

In terms of the formal recommendations, the Committee emphasizes that while all members agree that consumers whose health coverage includes emergency ground ambulance services should not receive a bill for more than their in-network deductible or other cost-sharing amounts, a simple ban on balance billing by providers/suppliers will not work. Such a prohibition must be tied to requirements on payors to provide appropriate reimbursement, and to adhere to prompt and direct pay requirements for providers/suppliers, as well as to prohibitions on limitations on coverage (such as prior authorization for emergency services, higher coinsurance amounts, and other practices that can erode the coverage the consumer believed they had).

The Committee noted the unique role of state and local governments in the oversight and regulation of ground ambulance services. Consistent with the NSA framework, the Committee recommends that any legislation on eliminating balance billing for ground ambulance services also respects the work that several states have already undertaken, as well as future work by additional states to address balance billing. As listed in Table 1, the states of Arkansas,

[2] The terms *covered individual, consumer* and *patient* are generally used interchangeably in this report, although some references to *consumer* and *patient* would also apply more broadly in practice.

California, Colorado, Delaware, Florida, Illinois, Louisiana, Maine, Maryland, New York, Ohio, Texas, Vermont, and West Virginia have passed balance billing laws that specifically address ground ambulance services.[3,4] The Ohio and Vermont balance billing laws apply only to emergency services rather than to ground ambulance services generally.

Table 1. State GAPB Protections as of March 2024 (Source: Center on Health Insurance Reforms | Georgetown University)

State	State Citation	Balance Billing Protections	Rate Reimbursement
Arkansas	Act 578 (HB 1312) Act 597 (HB 1776)	X	X
California	Ch. 454 (AB 716)	X	X
Colorado	CO 10-16-704; 3 CCR 702-4, New Regulation 4-2-66, 4-2-67 and Amended 4-2-67	X	X
Delaware	Del Code. Tit 18 § 3348 et seq; §3571H (ambulance)	X	
Florida	Fla Code § 641.19 & .513	X	X
Illinois	215 IL Compiled Statutes 5/356z.3a, 215 ILCS 5/370o, 215 ILCS 134/10, bills to amend code HB 2391, SB 1925	X	
Indiana	HB 1385	X	X
Louisiana	Act 453	X	X
Maine	24-A M.R.S. § 4303-C, 24-A M.R.S. § 4303-F	X	X
Maryland	MD Ins Code Annotated § 15-138, 14-205.2, Health Code Ann. § 19-701, 19-710	X	
New York	NY Ins Law §§ 3216(i)(24), 3221(l)(15), 4303(aa)(2), NY CLS Fin Serv § 603	X	X
Ohio	OH Ann. 3902.50(A), 3902.51(A)(1)(c), 3902.51(B)(1)(a), Ohio Revised Code Ann. 3902.54	X	X
Texas	SB2476, Tex. Ins. Code 1301.0053, §843.002, § 1271.155, § 1301.155	X	X
Vermont	Code of Vermont Rules 21-040-010, HB 263	X	
Washington	SB 5986. Chapter 218, 2024 Laws.	X	X
West Virginia	W. Va. CSR § 114-50-1, Code § 16-4C-3, 114-50-2, 114-50-4	X	X

While this report identifies specific recommendations, the Committee strongly advises that

[3] O'Brien, M., Hoadley, J., Kona, M. (2021, November 15). Protecting Consumers from Surprise Ambulance Bills. The Commonwealth Fund Blog. https://www.commonwealthfund.org/blog/2021/protecting-consumers-surprise-ambulance-bills.

[4] PIRG. (2022, December 13; updated 2023, October 26). *EMERGENCY: The high cost of ambulance surprise bills*. https://pirg.org/resources/emergency-the-high-cost-of-ambulance-surprise-bills/.

Congress not pick and choose among these recommendations as if they were an *a la carte* menu; rather, Congress should interpret the recommendations as a complete set. For example, the Committee's consensus would be broken if its recommended ban on balance billing were to move forward, but a proposal other than the one recommended within this report for determining the appropriate minimum required payment rate were abandoned or substantially modified. This is because the Committee strongly believes that if balance billing is eliminated, equitable access to vital EMS services can be maintained only with fair, reasonable, and consistent funding, without added arbitration costs.

Consistent with this principle, Committee members agreed that balance billing prohibitions for out-of-network emergency and non-emergency ground ambulance services must each be accompanied by a set of coverage, maximum cost-sharing, and minimum required out-of-network payment amount requirements. For example, maximum cost sharing requirements would be meaningless without a prohibition of balance billing. A $1,000 out-of-network ambulance charge would be equivalent from the payor and consumer perspective whether it sets an allowed amount at $800 with cost-sharing of $200 (and a potential balance bill of $200) or sets an allowed amount at $700 with cost-sharing of $100 (and a potential $300 balance bill). The payor would still be paying $600 in either case and the consumer would still be liable for $400 in either case.

Similarly, balance billing prohibitions alone would not protect consumers from high cost sharing or protect providers and suppliers from inadequate payor reimbursements. Continuing the previous example, neither a $700 nor $800 allowable amount would be sufficient to protect ongoing access to ground ambulance services without balance billing of consumers if provider/supplier costs were $1,000 per response. Addressing each of these aspects of the issue in a comprehensive solution is necessary to ensure consumers both affordability of and adequate access to ground ambulance services. Consequently, Committee members agreed that if all recommendations related to either emergency or non-emergency ground ambulance services were not adopted to establish a comprehensive solution, then any Committee recommendations related to that type of service would not move forward to the final report. Chapters 4 and 5 address the Committee's consideration and voting on these and other recommendations for protecting consumers from balance billing.

Subcommittee Recommendation on the NSA Framework presented to the Committee:

The Committee recommends that while the framework of the No Surprises Act should be a base for specific ground ambulance legislation, Congress should not add "ground ambulance emergency medical services" into the current No Surprises Act without substantial modifications, as outlined in the subsequent Recommendations.

The Committee recommends that the following provisions could be maintained without significant change around consumer protections: directory information, price comparison tool, continuity of care, and state/federal enforcement authority within the current provisions of the No Surprises Act.

Advisory Committee Discussion and Recommendations

With the exception of a grammatical correction, there was no further discussion and Recommendation (1) was adopted by the Committee with 13 votes in favor, none opposed, the designees of Treasury, HHS and DOT abstaining, and the designee of DOL not present.

> **Committee Recommendation 1**
>
> **The Committee recommends that while the framework of the No Surprises Act should be a base for specific ground ambulance legislation, Congress should not add ground ambulance emergency medical services into the current No Surprises Act without substantial modifications, as outlined in the subsequent Recommendations.**
>
> **The Committee recommends that the following provisions could be maintained without significant change around consumer protections: directory information, price comparison tool, continuity of care, and state/federal enforcement authority within the current provisions of the No Surprises Act.**

Relation to Current NSA Balance Billing Regulations

The Committee discussed at length how the provision of ground ambulance services differs from the provision of other health care services, especially those provided in a brick-and-mortar setting. As a result, the Committee concluded that several structural aspects of the current NSA would not be appropriate to apply to ground ambulance services. Some of the principal differences and related Committee presentations[5] are highlighted below. These and other differences will be discussed in more detail in succeeding chapters of the report.

Differences in market structure and dynamics. Differences include: the establishment, oversight, and regulation of ground ambulance emergency medical services by state and local officials;[6] the requirement that ground ambulance emergency medical service providers/suppliers respond to emergency/emergent requests for services and transport in many different settings without the ability to refuse to treat or turn away an individual based on health coverage status;[7] and the high proportion of providers that are not contracted with payor networks.[8]

Too few in-network ground ambulance negotiated rates to adequately design a *qualifying*

[5] All Committee presentation materials are located on the Committee website at: https://www.cms.gov/medicare/regulations-guidance/advisory-committees/advisory-committee-ground-ambulance-and-patient-billing-gapb.

[6] Dia Gainor, National Association of State Emergency Medical System Officials (NASEMSO). May 2023 Presentation; Maria Bianchi, American Ambulance Association, May 2023 Presentation.

[7] Shawn Baird, Metro West Ambulance, May 2023 Presentation.

[8] Loren Adler, The Brookings Institution, May 2023 Presentation; Kathy Lester, Lester Health Law PLLC, May 2023 Presentation.

payment amount (QPA). The NSA generally establishes an initial payment for out-of-network services by defining a qualifying payment amount based on the median in-network rate for items and services in that geographic region. This model would be problematic for out-of-network ground ambulance payments because as many as 85 percent of ground ambulance emergency claims are out-of-network.[9] In addition, there is substantial variation in in-network rates.[10] Thus, it would be problematic to rely on limited and highly variable payor in-network rates to establish a market-based benchmark for the NSA.

Concerns about the cost and burden of the NSA Independent Dispute Resolution system to settle payment disputes between payors and ground ambulance providers and suppliers. Committee members expressed varying concerns about the NSA's Independent Dispute Resolution (IDR) process. The Committee heard that the majority of ground ambulance services are small[11] and locally owned, i.e., privately held, volunteer, or established by a local governing authority. Approximately 75 percent of these services bill fewer than three transports a day.[12] Some presenters and Committee members expressed concern that IDR fees may exceed the cost of the ambulance charges in dispute and that smaller providers would not have the resources needed to engage in a formal dispute process. There was also concern expressed that the administrative cost of an arbitration system would add to the overall cost of ground ambulance services, health coverage, and HHS programs. Because of these significant concerns about the impact of the NSA IDR process, the committee explored non-dispute alternatives for establishing out-of-network payments.

Emergency services response and ambulance billing differing significantly from most hospital-based care and billing covered under the NSA. Pre-service disclosures and notice and consent to waive balance billing protections as defined in the NSA would be unwieldy and impractical in ground ambulance emergency medical services settings. Because of the nature of 911 ambulance responses, transports, and interfacility transfers, patients would rarely be in a position to read a notice or make a decision to waive their balance billing protections.[13] Additionally, because of the difficulty in obtaining a patient's health coverage information in emergency circumstances, ground ambulance providers and suppliers often send patients an ambulance bill directly—before

[9] Adler, L., Bich L., Duffy E., Hannick K., Hall M., & Trish, E. (2023). Ground Ambulance Billing And Prices Differ By Ownership Structure. *Health Affairs*, 42(2), 227-236. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00738

[10] Zach Gaumer, Health Management Associates (HMA), May 2023 Presentation.

[11] *Nearly 75% provide < 800 transports each year.* (Zach Gaumer, HMA. Presentation to the GAPBAC) "Findings from MedPAC and GAO Analyses (2023), 13. (May 2023); see also Centers for Medicare & Medicaid Services. "Medicare's Ground Ambulance Data Collection System: Sampling and Instrument Considerations and Recommendations,"5-9. (July 30, 2019) *(MITRE reported that 70 percent of suppliers and providers provide fewer than 800 Medicare transports in 2016);* Centers for Medicare & Medicaid Services. "Ground Ambulance Industry Trends, 2017–2020: Analysis of Medicare Fee-for-Service Claims," 25 (Nov. 2022*)(RAND reported that 73 percent of suppliers and providers provided fewer than 800 Medicare transports in 2020). According to CMS, 47 percent of ground ambulance services are classified as rural or super rural.*

[12] HMA Analysis of 2020 CMS 100% file; RAND analysis of merged 2016 Medicare enrollment and claims data; Shawn Baird. Metro West, May 2023 Presentation.

[13] Ritu Sahni, MD, May 2023 Presentation.

determining the patient's health coverage. Patients may be confused as to whether that bill has been submitted to the payor and whether the bill reflects their cost share or the full amount. To eliminate balance billing, this difference between ground ambulance provider/suppliers and other health care providers in pre-service patient contact must be addressed. The Committee, therefore, looked for ways to redirect patient information transparency protections from pre-service disclosures to post-service billing requirements.

These were only some of the concerns raised by Committee members when considering whether to issue a simple recommendation to add ground ambulance emergency medical service providers and suppliers to the existing NSA. In response to these concerns, the Committee crafted a comprehensive set of recommendations tailored to protect this unique set of patients and the ground ambulance emergency medical service providers/suppliers who serve them.

Chapter 3 – New Definitions For Terms Used in Recommendations

Background

The Committee found that key terms in its recommendations have not been codified in the NSA or its regulations. The Committee believes statutory definitions are needed to promote consistent understanding. This is particularly true because ground ambulance services have typically been covered and reimbursed primarily as transport services, rather than as providers of both medical treatment and highly skilled medical transportation. The Committee started with a review of other statutory and regulatory definitions to determine whether these could apply to this issue area. In developing new definitions, the Committee relied on the knowledge of its members, state and local officials, ground ambulance providers and suppliers, emergency medical technicians, emergency physicians, consumer advocates, and health insurance industry experts, as well as on input on definitions provided by stakeholders and industry groups. Discussion of some of the reasons for these definitions appears in this section, and additional background will be discussed in the context of related recommendations.

Need for a Distinct Prudent Person Standard

The Committee discussed that an important part of its work to stop balance billing is to help eliminate consumers' uncertainty about whether their health coverage will cover ground ambulance emergency medical services. Because most people don't have medical training, sometimes people call an ambulance when they don't actually need one. But to support public health goals and to ensure that payors will cover emergency transport services for people who need these services and make a reasonable decision to request them, 48 states[14] and the federal government have defined a "prudent layperson standard" to evaluate that decision. These standards in effect establish a prospective patient-determined basis assessing for medical necessity in lieu of a retrospective payor-determined medical necessity assessment. The Committee wants to avoid individuals feeling that they cannot call an ambulance when they truly need one out of fear of high out-of-pocket costs if coverage were to be subsequently denied for lack of medical necessity. Because of the need to protect consumers, the Committee recommends a definition of "*ground ambulance emergency medical service*" that incorporates a prudent person standard informed in part by standards put in place in the 1990s in California.

While many states and the federal government have adopted prudent layperson standards, the prudent person standard being recommended in this report takes into consideration different educational levels and cultural differences of consumers, including patients, people caring for them, and bystanders. It places the emphasis on the particular individual's decision to call 911 rather than creating a "prudent layperson" standard that could lead to more denials, resulting in higher out-of-pocket costs for patients. The recommended standard is based on the individual's "reasonable belief". "Reasonable belief" differs both from requiring the person to have an

[14] *48 states (all but Mississippi and Wyoming) have enacted various versions of the PLP standard.* Parker, T., Gaines, E., Boessler, E., (2023, October 26) *VACEP Legal Victory Illustrates Why the Prudent Layperson Standard Still Matters*. ACEP Now. https://www.acepnow.com/article/vacep-legal-victory-illustrates-why-the-prudent-layperson-standard-still-matters/#:~:text=In%20addition%2C%2048%20states%20(all,versions%20of%20the%20PLP%20standard.

average knowledge of health and medicine and from the condition that a "prudent layperson" is holding a reasonable belief. These distinctions are intended to avoid excluding situations in which the actual decisionmaker may not be a prudent layperson as defined under typical prudent layperson standards. The Committee heard from Health Access California, a statewide health care consumer advocacy coalition, in support of a similar idea. They recommended replacement of the federal prudent layperson standard for emergency care for the standard in California's law that offers greater consumer protection with adjustments appropriate for behavioral health crises and protections for post-stabilization care. For further discussion of the prudent person standard in contrast with the standard applied in the NSA regulations, please see the "Relation to Current NSA Balance Billing Regulation Definitions" section at the end of this chapter.

Need to Address Components of Ground Ambulance Services

The Committee discussed the need to define certain components of ground ambulance services, such as "emergency interfacility transports" and "community paramedicine (or mobile integrated healthcare)" that are not commonly defined under healthcare programs. For instance, regarding emergency interfacility transports, the Committee discussed the challenges that consumers and patients may have in understanding the difference between their emergency hospital visit and their subsequent ambulance transfer to another facility. Such transfers may constitute an emergency, but are distinguishable from the initial visit. For example, a patient may arrive at a hospital that cannot provide the emergency treatment they need – whether they got themselves to the hospital or were taken by ambulance. After the initial stabilization services, health care professionals may decide that the patient must be transferred by ambulance to another health care facility that can provide the needed emergency treatment and care. When a ground ambulance service is required for the transfer of such a patient, it is referred to as an interfacility transport (from one health care facility to another). Interfacility transports are becoming more common because of health system consolidation and reorganizations of capacity that may transfer specialty care to just one hospital in the service area.

For a more detailed example: a patient may be taken by a ground ambulance responding to a 911 call to the closest hospital for treatment (as required by law). The health care providers at that hospital determine that the patient requires a level of services not available at their hospital. As a result, a second ambulance is needed to transfer the patient to a higher acuity facility—for instance, going from a Level 3 trauma center to a Level 1 trauma center for specialty care, such as neurosurgery or trauma orthopedics. An emergency interfacility transfer may also be needed for a patient to get access to critical technology, such as an MRI, that is not available at their current facility. The recommended definition for the term *emergency interfacility transport* seeks to include these types of transfers. The Committee agreed that balance billing protections should be provided for these types of transports based on evidence presented that out-of-network ambulances are often used for interfacility transports, and that balance bills are then sent to patients.[15] Additionally, under current law, patients often find coverage for interfacility transports denied because the transports did not technically involve emergency services. They are then responsible for the entire cost of the transport—whether it was in- or out-of-network.

The Committee discussed that costs incurred by ground ambulance services include costs that

[15] Loren Adler, Brookings Institution, May 2023 presentation.

other providers incur, such as labor, facility, insurance, maintenance, utilities, taxes, medical equipment and supplies, drugs and biologicals, and similar expenditures. However, such costs also include vehicle purchase, fuel, maintenance, licensure, and other expenditures related to providing mobile health care. These specialized costs are driven by local, state, and national protocols that define the scope of ground ambulance emergency medical services. They are also driven by the particular service area and the availability of other health care providers, such as hospitals and physicians, in the service area. The ground ambulance emergency service provider's mandated emergency response time and its cost of readiness also play a significant role in their costs. Some Committee members discussed the challenges of assessing volunteer labor, the role of state/local subsidies for non-medical services, and similar programs that are unique to this intersection of health care and public safety. Moreover, because most payors—including federal programs—reimburse ground ambulance emergency medical services only when a transport occurs, the costs for providers' responses and treatments when no transport occurs must be allocated over the claims for which a transport does occur.

The recommended definition of *cost* includes a sentence related to medical oversight because many stakeholders believe that the CMS Ground Ambulance Data Collection System[16] process will not fully account for the cost of medical oversight in the system. The importance of medical oversight is only magnified in terms of better patient outcomes and better patient safety when the context of ground ambulance emergency medical services is expanded to include providers' non-transport services, such as treatment in place. "Medical oversight" or what is often called "medical direction" in this context is the medical supervision of the emergency services organization, including prospectively creating treatment and education protocols, concurrently providing online medical control to crews or providing standby online medical oversight readiness for crews to address unique situations, and retrospectively providing quality improvement and quality review. From the second a patient calls 911, health care is being provided in some way or manner, and it is the medical oversight of the system that really is the key component that works to ensure that the care provided is appropriate, guided by medical principle and medical guidelines where applicable, and focused on patient outcomes.

The Committee discussed the importance of ending some payors' practice of sending checks to enrollees instead of directly to the ground ambulance provider or supplier, which can delay payment. It also heard from members that some payors hold claims an unnecessarily long time. Therefore, the Committee agreed it was important to define terms for *prompt payment* and *bill triggering the duty to make a minimum required payment or issue a notice of denial of payment*.

Subcommittee Recommendations on Definitions presented to the Committee

(Recommendation 2): The Committee recommends that Congress or the Secretaries adopt the following definitions to align with the recommendations and findings found in the final report.

2A—Community paramedicine

[16] https://www.cms.gov/medicare/payment/fee-schedules/ambulance/medicare-ground-ambulance-data-collection-system.

2B—Cost
2C—Emergency interfacility transport
2D—Ground ambulance emergency medical service (prudent person standard)
2E—Ground ambulance provider or supplier
2F—Prompt payment
2G—Bill triggering the duty to make a minimum required payment or issue a notice of denial of payment

Advisory Committee Discussion and Recommendations

Following the discussion of Recommendation 2 and the associated proposed definitions:

- The Committee unanimously agreed to adopt Recommendation 2, as well as to adopt the definitions of all terms with the exception of that for *prompt payment*.
- The Committee vote on the definition for *prompt payment* was 14 in favor, 1 opposed, 1 abstaining (Treasury), and 1 not present (DOL). For the record, the member in opposition explained that the 'no' vote was not with an issue around prompt payment itself, which is generally also required within 30 days under most state laws. Rather, the member opposed the adoption of the recommendation because of the tie to the "minimum required payment" in Recommendation 12 based on the belief that a minimum required payment is not the appropriate policy solution to Recommendation 12.

As the result of the vote, the Committee adopted the following Recommendation:

Committee Recommendation 2

The Committee recommends Congress or the Secretaries adopt the following definitions to align with the recommendations and findings found in the final report.

Community paramedicine **(or mobile integrated health care) means the practice of providing person-centered care in a diverse range of settings that address the needs of a community. This practice may include the provision of primary health care, emergency or acute care, health promotion, disease management, clinical assessment, and needs based interventions. Professionals who practice community paramedicine are often integrated with interdisciplinary health care teams that aim to improve patient outcomes through education, advocacy, and health system navigation.**

Cost **means those costs defined in the Medicare Ground Ambulance Data Collection System's (GADCS) Medicare Ground Ambulance Data Collection Instrument, including labor costs; facilities costs; vehicle costs; equipment, consumable, and supply costs; other costs directly related to supporting an organization's ground ambulance services that are not covered by other categories. In addition, the term also includes medical oversight costs.**

Emergency interfacility transport **means the transport by a ground ambulance**

emergency medical service provider or supplier of a patient with an emergency medical condition from one healthcare facility to another location or facility to receive services not available at the originating facility, as ordered by a licensed treating healthcare provider.

Ground ambulance emergency medical service (Prudent Person Standard) **means ground ambulance medical or transport services furnished to an individual for whom an immediate response was required to assess and/or treat a medical or behavioral condition that the individual reasonably believed (or a prudent layperson would reasonably have believed) that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance services. Such services include the ground transportation of the patient to a hospital or other medically appropriate destination as defined by federal, state, or local law. The determination as to whether an individual believed or would reasonably believe the absence of immediate medical attention would result in serious jeopardy or harm shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.**

Ground ambulance provider or supplier **means an entity that is authorized and licensed by the appropriate governmental entity to respond to a request for ground ambulance medical services.**

Prompt payment **means, with respect to the payment required under Recommendation 12, that either the payment or the notice of payment denial is issued within 30 days of receiving a bill triggering the duty to make a minimum required payment or to issue a notice of denial of payment.**

Bill triggering the duty to make a minimum required payment or issue a notice of denial of payment **means a claim that includes the following elements: Coverage provider; insured's I.D. number; patient's name; patient's birth date; insured's name; patient's address; insured's policy group or FECA number; date of current illness, injury, or pregnancy; name of referring provider or other source; ICD indicator; date(s) of service; place of service; procedures, services, or supplies, including CPT/HCPCS code(s) and modifier(s); diagnosis pointer; charges; days or units; federal tax I.D. number; acceptance of assignment (Y/N); total charge; signature of physician or supplier; service facility location information, including NPI; billing provider information, including NPI.**

Relation to Current NSA Balance Billing Regulation Definitions

Ground ambulance emergency medical services are generally engaged through EMS systems as the result of calls to 911 call centers. A distinct prudent person standard is recommended to prevent a consumer from not making that call and avoiding necessary emergency medical care based on uncertainty over whether their health coverage will cover the services. In addition,

current NSA emergency services balance billing protections are tied to definitions that do not work well for ground ambulance emergency medical services.

The function of the ”prudent layperson standard” in federal law incorporated in the NSA is generally to define ”emergency medical conditions” to which certain statutory requirements on health plans or healthcare providers apply.[17] This includes the *emergency medical condition* and *emergency medical services* definitions in the NSA regulations at 45 CFR 149.110(c). These definitions incorporate requirements applicable to Medicare hospitals under Section 1867 of the Social Security Act, known as the EMTALA provisions.[18]

Even though ground ambulance emergency medical services may include transport of a consumer to an emergency medical facility where the EMTALA provisions are triggered, the federal prudent layperson standard incorporated in the NSA regulations does not apply to ground ambulance emergency medical services.[19] Since the function of the federal layperson standard applicable to the NSA is to clarify when specific Medicare hospital requirements must be met, a separate and distinct prudent person standard is needed for clarifying the medical necessity standard applicable to ground ambulance emergency medical services. The Committee recommendation seeks to accomplish this by incorporating a separate and distinct prudent person standard into the definition of *ground ambulance emergency medical services*.

This definition differs from the definition of *emergency medical services* in the NSA regulations. First, the NSA protections require an *emergency medical condition* tied to a prudent layperson standard that is not broad enough to encompass the range of individuals calling 911. Second, the NSA protections require the provision of *emergency services* tied to the screening and treatment services required by a hospital emergency department under §1862 of the Social Security Act, as required by EMTALA. Third, the NSA protections are tied to services provided in connection with the delivery of services by hospital emergency departments or freestanding emergency departments. These ties to Medicare hospital requirements align with the items and services currently protected by the NSA. However, the NSA definition of emergency medical services is not broad enough to encompass all ground ambulance emergency medical services, including treatment in place (*i.e.*, Treatment and No Transport) and emergency interfacility transports (to non-emergency-department admissions). As a result, now, when a patient receives an emergency

[17] For example: *Our rationale for the prudent layperson standard is to determine whether an EMTALA obligation has been triggered toward a particular individual. It is a legal standard that would be used to determine whether EMTALA was triggered*…[68 FR 53241]; *EMTALA is triggered when there has been a request for medical care inside the dedicated emergency department or for emergency care on hospital property outside the dedicated emergency department*. [68 FE 53242]; *We agree with the commenters that the prudent layperson standard is to be relied upon only in circumstances where the individual is unable to make the request for examination or treatment of himself or herself*. [68 FR53241].

[18] The Emergency Medical Treatment and Labor Act (EMTALA) was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). The law is codified in Section 1867 of the Social Security Act and implementing regulations are codified at 42 CFR 489.24 *Special responsibilities of Medicare hospitals in emergency cases*. [59 FR 32120].

[19] Other federal regulations, such as the Medicare Advantage regulations at 42 CFR 422.113(b)(i), and some state laws apply a similar prudent layperson standard to ambulance services. In addition, some Committee members noted that Medicare, the Veterans Health Administration and other states have applied the prudent layperson standard in practice to support individuals seeking ground ambulance services when they believe such services are necessary.

interfacility transport, but is not admitted to a second emergency department, the criteria for emergency services' coverage (and NSA protections) are often not satisfied, claims may be denied, and balance billing is not prohibited.

Therefore, a distinct definition of ground ambulance emergency medical services is needed in addition to the emergency services' definitions in the NSA. The Committee recommends this be a standard in which the emergency medical condition is based on a broader prudent person standard—one that is more closely aligned with a consumer's, caregiver's, or bystander's decision to call 911.

In addition, the current NSA regulations, as issued at the time this report was written, tie balance billing protections for "items or services" provided by a "physician or other health care provider" to services provided in connection with visits to certain types of facilities. Ground ambulance emergency medical services are provided in more settings and broader contexts than the items and services subject to the NSA. Furthermore, based on data presented by Fair Health and Health Management Associates, there is substantial variability in the commercially contracted rates for ground ambulance emergency medical services. Subject matter experts provided specific examples of some plans refusing to negotiate with ground ambulance providers/suppliers, while other plans did engage in negotiations. Therefore, the Committee recommends a different approach that does not rely upon contracted rates for determining payments for out-of-network ground ambulance emergency medical services. As a result, the Committee has identified the need for new definitions for *Ground ambulance provider or supplier, Ground ambulance emergency medical service, Emergency interfacility transport, Community paramedicine (or mobile integrated healthcare), Cost, Prompt payment,* and *Bill triggering the duty to make a minimum required payment or issue a notice of denial of payment.*

Chapter 4 – Consumer Protections for Ground Ambulance Services

Background

Balance bills for ground ambulance emergency medical services for covered individuals occur for three main reasons:

1) Unavoidable use of out-of-network provider and supplier services resulting in bills that are not limited by contractual fee arrangements.
2) Higher than expected cost sharing, such as coinsurance rates without caps, combined with no protection against out-of-network provider balance billing.
3) Health coverage benefits that do not cover the full scope of services provided by ground ambulance providers/suppliers in responding to EMS calls and other medically necessary transports.

Other contributing factors to balance billing include unavailability of consumer health coverage information at the point of emergency response and inefficiencies in acquiring this information after the provision of care. Recommendations to address the first issue are discussed in the following chapter. Recommendations presented in this chapter address cost sharing and coverage solutions, as well as certain disclosures and protections to enable consumers to understand and advocate for their rights.

Extensive Out-of-Network Provider Status

Available data on ground ambulance transport claims supports the experience of Committee members that most ground ambulance emergency medical service transports are provided by out-of-network ground ambulance providers and suppliers. The Committee heard from Zach Gaumer, Health Management Associates, during its May 2023 meeting, that Fair Health data show substantial variability in the commercially contracted in-network rates and that a significant number of plans and issuers do not include ground ambulance providers and suppliers in their networks, resulting in a high percentage of out-of-network claims. A 2023 study[20] looking at claims data from three large national health insurance companies for the period 2014-2017 found that 85 percent of emergency ground ambulance transports were delivered out of network. Approximately two-thirds of claims for these emergency transports were paid in full, while 28 percent were paid at less than billed charges, putting the consumer at risk of a balance bill. The study limitations note that these results may not be generalizable to other commercial payers, so the extent of consumer exposure to balance bills may be greater. In fact, many towns or counties across the U.S. contract with a single company to provide emergency services in their community. Covered individuals with a plan or issuer that does not contract with that locale's contracted company will be at risk of incurring a balance bill *every time* they need an ambulance. Under these circumstances, consumers cannot avoid an out-of-network ambulance and it is beyond their control to change that situation. The extent of out-of-network provider/supplier status means that most covered individuals cannot anticipate the costs of ground ambulance emergency medical services and that many could be exposed to potential balance bills.

[20] Adler, L., Bich L., Duffy E., Hannick K., Hall M., & Trish, E. (2023). Ground Ambulance Billing And Prices Differ By Ownership Structure. *Health Affairs*, 42(2), 227-236. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00738.

Consumers may also receive a bill for the full amount of the ground ambulance service when they are directly billed by ground ambulance providers/suppliers for services that have not yet been submitted to their plan or issuer. This could happen because insurance information was not available to be exchanged in the course of the emergency or trauma incident response or transport. Many times, as the result of their acute medical condition, patients do not have the ability to tell the ground ambulance provider/supplier what type of health coverage they have. In such circumstances, these providers/suppliers frequently must rely upon other sources to obtain that information. Ideally, providers can ask the admitting hospital or emergency department for the patient's health coverage information or use public health information exchanges. Alternatively, providers may attempt to communicate with patients after a transport has been completed through phone numbers and sending written or electronic communications (e-mails). Billing companies have processes in place to find patient health coverage information and work with plans and issuers to get the data necessary to submit claims. However, these processes are not always successful, and sometimes providers/suppliers bill the consumer directly to determine the responsible party.

The Committee discussed what this issue looks like from the consumer's point of view. Medical bills can be very confusing to consumers. Between explanations of benefits, account statements and bills, and bills that are received before a provider/supplier submits the reimbursement request to a consumer's payor, it can be very hard for many consumers to know whether they actually owe the account balance that is in front of them. When health coverage information is not shared with the ambulance provider or supplier, sometimes the bill is sent directly to the patient first. This situation leads to confusion, as it is difficult for the patient to determine whether the bill reflects their out-of-pocket obligation, or whether the bill is simply an attempt to get the patient to submit it to their health coverage on the provider's or supplier's behalf. The Committee discussed the need to prevent consumers from receiving a bill before their responsibility has been determined by their plans or issuers. One step that the Committee discussed at length was the need for a patient's treating physician or facility to share the patient's health coverage information directly with the ground ambulance providers/suppliers. The Committee heard from technical experts and members of the Committee itself that oftentimes other facilities and healthcare providers do not respond to ground ambulance providers'/suppliers' requests for such information. Since such exchange of health coverage information is a permitted disclosure under federal law, there should not be barriers to properly protected sharing of this information.

Consumer confusion could also be mitigated by the adoption of requirements for consumer billing communications so the consumer can clearly understand such facts as: whether or not a health coverage determination has been made on the claim, whether the consumer needs to provide their health coverage information directly to the ground ambulance provider/supplier, and whether the billing communication is a final bill or not. Consumers should also be notified of their protection from balance billing and how to assert those rights if they end up receiving a balance bill. Through discussions with billing offices, other presenters and through public comment, the Committee learned that important communications to help a patient understand a billing statement are not always included with bills. Although the initial subcommittee recommendation submitted for discussion outlined "a standardized bill", other members objected, explaining that this would be a very burdensome requirement for ground ambulance

providers/suppliers to meet. The final recommendation put forth for a vote was a compromise meeting both the consumer's need for information and the provider's flexibility in communicating with patients. Thus, the result was a recommendation identifying some standardized content elements, and not standardized billing statements per se. The Committee also believes that standardized elements will make it easier for help desks and consumer advocates/advisors to assist patients in finding the important information on the communication from the ambulance provider or supplier and begin the education process, so patients know what is expected of them.

No Limits on Cost Sharing

Although balance billing bans are helpful to protect consumers, the impact on consumer cost sharing when service is provided by an out-of-network provider is also an important consumer protection consideration the Committee discussed at length. Coinsurance and copayments[21] are two types of out-of-pocket expenses that patients typically must pay, in addition to premium and any annual deductible. Because coinsurance is applied to the allowable amount the payor calculates, in addition to the coinsurance percentage itself, it is important to clarify to what amount the coinsurance percentage will be applied. While coinsurance percentages are clearly stated in consumer benefit summaries, the allowable amounts to which the percentages will be applied are not foreseeable.

Consumer cost-sharing protections in the NSA and most state laws generally require cost sharing to be no higher than it would be for an in-network service. In the case of items and services subject to the current NSA rules (with the exception of air ambulance services), the in-network cost-sharing amount is the out-of-pocket expense that most patients pay (as the large majority of such care is delivered in-network). However, this is often not the case for ground ambulance services where, according to the research cited above, 85% of transports are considered out-of-network. That is, a payor's in-network cost-sharing rules for ground ambulance services hold no bearing for most patients today and, thus, may have limited salience on consumer health coverage enrollment decisions. In addition, the number of contracted rates is insufficient to determine a market rate by region. Out-of-network ground ambulance emergency medical service providers and suppliers, by definition, do not have negotiated contractual rates with payors. Therefore, in-network coinsurance percentages applied to potentially higher billed charges/out-of-network rates may result in unexpectedly higher cost-sharing amounts for consumers than they would generally incur for in-network services.

The Committee also discussed the potential for a ground ambulance balance billing solution that established a minimum payment to out-of-network providers/suppliers to result in increased payments by payors to out-of-network providers, i.e., higher amounts than currently paid without a contract. In response, payors could pass through the higher required ambulance service rates by raising in-network cost-sharing levels, for instance from 20% to 50%. Payors requiring patients to pay higher cost sharing amounts would undermine the value of patient out-of-pocket-cost protections these recommendations aim to achieve. Taking this into consideration, some members of the Committee wondered whether some state ambulance balance billing laws might

[21] Coinsurance: A percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible. Copayment [or copay]: A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible. From: https://www.healthcare.gov/glossary/.

actually increase out-of-pocket costs if payors were to decide to pass on any increase in costs to patients through higher cost-sharing percentages or copays. While several Committee members disagreed with this assessment, Committee members overwhelmingly agreed it was important to consider other options than in-network cost-sharing levels for determining appropriate consumer cost sharing on out-of-network ground ambulance services.

To address the cost-shifting possibility, the Committee worked to identify a solution that would designate a minimum payment standard [see Chapter 5] in combination with a maximum cost-sharing rate and fixed dollar cap on consumer cost sharing that applies before the in-network deductible. The Committee believes it is only when there is that sort of guardrail on payment and benefits that the consumer can be protected not only from a balance bill, but also from pass-throughs of additional costs the payor might incur. This combined payment/cost cap solution goes above and beyond the cost-sharing protections in place under the NSA for other forms of even very important medical care, which defer to payor-determined in-network benefit terms. Although setting a consistent out-of-pocket amount for patients is unusual as a policy proposal, patients requiring ground ambulance emergency medical services are in an unusual situation. It would benefit consumers to know a flat amount that would be the most they will owe for an ambulance call, wherever they are. That would likely make it easier for them to make the decision to call for emergency services when the situation requires it.

Emergency services have previously received particular treatment under Federal health care programs with respect to limited or zero cost sharing. In a final rule published in 2016 [81 FR 88368], the Office of Inspector General (OIG), HHS amended safe harbors (exceptions) to the anti-kickback statute at 42 CFR 1001.952(k)(4) to include waivers of cost sharing for emergency ambulance services furnished by state- or municipality-owned ambulance services.[22] There are some localities, such as Baltimore, Washington, D.C., and Baton Rouge that do waive cost sharing for these services, recognizing the public health benefit of doing so. In addition, the Committee believes the out-of-pocket expense protection should stand whether or not the patient's deductible has been met, considering that families who need an emergency response at the beginning of a plan year may end up facing the full bill to meet their deductible amount. In 2022, the average deductible for an individual employer plan is almost $2000, and for a family

[22] 42 CFR 1001.952(k)(4) If the cost-sharing amounts are owed to an ambulance provider or supplier for emergency ambulance services for which a Federal health care program pays under a fee-for-service payment system and all the following conditions are met:

(i) The ambulance provider or supplier is owned and operated by a State, a political subdivision of a State, or a tribal health care program, as that term is defined in section 4 of the Indian Health Care Improvement Act;

(ii) The ambulance provider or supplier engaged in an emergency response, as defined in 42 CFR 414.605;

(iii) The ambulance provider or supplier offers the reduction or waiver on a uniform basis to all of its residents or (if applicable) tribal members, or to all individuals transported; and

(iv) The ambulance provider or supplier must not later claim the amount reduced or waived as a bad debt for payment purposes under a Federal health care program or otherwise shift the burden of the reduction or waiver onto a Federal health care program, other payers, or individuals.

plan is more than $3800.[23] That amount could be a huge disincentive for that family to call 911. Setting a capped amount also solves the operational disclosure challenge of helping patients understand their financial obligation for ambulance payments. It avoids patient confusion as to the expected cost sharing by not basing the cost-sharing obligation on amounts that vary by the plan's or issuers' benefits or by out-of-network provider/supplier charges.

Non-Covered Services

Under the Affordable Care Act (ACA), Congress specified *essential health benefits* that have to be covered by certain health insurance plans in the individual and small group markets. Once an item or service is deemed an essential health benefit, there can be no lifetime or annual limits and it must be covered under every ACA-compliant plan. "Emergency services" are already within the scope of the essential health benefits; however, Congress deferred to the Secretaries and the states to further define what constitutes emergency services. As a result, different plans and issuers provide different levels of coverage for ground ambulance emergency medical services. The industry, the public, and consumers would benefit from clarity under federal law that *ground ambulance emergency medical services* (as defined in this report), including emergency interfacility transports and such services when an ambulance has responded, but no transport has occurred, are within the definition of emergency services under the Essential Health Benefits provisions.

The Committee heard that ground ambulance providers and suppliers provide many services that are not always covered by commercial or governmental payors. These include Advance Life Support (ALS) first response, treatment in place (aka Treatment and No Transport), alternative destinations other than the hospital emergency department in an emergency response request (such as to a substance abuse center or behavioral health center), and community paramedicine or mobile integrated healthcare. The Committee reviewed data presented by the National EMS Information System (NEMSIS).[24] (Eric Chaney, NHTSA Office of EMS, August 2023 Presentation) indicating roughly 30 percent of emergency (i.e., 911 or equivalent) calls result in a response that does not require the patient being transported anywhere. When ground ambulance services providers or suppliers do not transport a patient, there generally is no reimbursement for the medical services provided. When these services are not covered, this will result in the patient receiving a bill for the uncovered services. The Committee heard from providers that some ambulances are charging "assessment fees" even when no treatment or transportation is provided. It appears that many covered individuals don't have coverage for these assessment fees and are, therefore, stuck with paying the entire assessment fee. Consumers may be surprised to learn the emergency medical services they received under such circumstances are not covered by their plan.

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[23] KFF State Health Facts. (2022) Average Annual Deductible per Enrolled Employee in Employer-Based Health Insurance for Single and Family Coverage. Accessed 2/28/2024: https://www.kff.org/other/state-indicator/average-annual-deductible-per-enrolled-employee-in-employer-based-health-insurance-for-single-and-family-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[24] NEMSIS (the National EMS Information System) is a database maintained by National Association of State EMS Officials (NASEMSO) that contains near real-time standardized data reported by local EMS agencies from 54 states and territories and approximately 14,000 EMS agencies. NEMSIS was originally funded by the National Highway Traffic Safety Administration NHTSA, the Health Resources and Services Administration HRSA, and the Centers for Disease Control and Prevention CDC. Public release of data has been available since 2006. (nemsis.org).

The Committee is recommending that plans and issuers be required to cover and reimburse ground ambulance emergency medical services provided even when the patient is not transported. Such services are known as "Treatment and No Transport" coverage. Coverage is directly linked to the issue of balance bills because consumers need and expect that their health coverage is going to protect them in these situations. Consumers get stuck in the middle, receive the bill and are impacted financially when plans and issuers do not pay for some components of emergency response care. This situation most frequently occurs in connection with non-transport services after ground ambulance providers or suppliers respond to a call, assess the patient, provide treatment, medications, or apply devices, but the patient declines to go to the hospital or is able to travel to a treatment facility of their choosing on their own. Coverage for interfacility transfers (from one hospital to another) is another situation in which consumers face coverage gaps. When a consumer is brought to an emergency department that cannot meet the consumer's clinical needs and they must be transferred to another facility *(emergency interfacility transport*), if that consumer does not have coverage for interfacility transports, then they will get the whole bill.

Committee members noted that when health plans limit coverage and payment for emergency ground ambulance services to only services that result in transportation to a hospital, this does not recognize the value of today's treatment options allowing effective care to be offered outside of the hospital walls. Furthermore, coverage limitations to only those responses that result in transport to a hospital are not consistent with current medical standards or the principle of treating patients in the most appropriate and cost-effective manner. It also creates a perverse incentive for the ambulance to transport a patient to a hospital, not because the patient needs emergency department care, but simply in order to be reimbursed by health coverage. The better public health policy would be to provide health coverage for ground ambulance emergency medical services even if there is no need for transport, or the patient declines transport. Emergency medicine has evolved substantially since the benefit was defined in terms of transportation, and medical oversight plays a significant role in ensuring that Treatment and No Transport is done in a safe and effective manner. This issue relates in another way to the balance billing scope of the Committee because the transportation requirement potentially subjects consumers to additional and potentially unnecessary medical treatments resulting in more medical costs than they may have actually needed to incur. The better public health and consumer protection policy would reimburse ground ambulance services provided, even when transportation to a hospital is not medically necessary or is declined. However, Committee members acknowledged that some guardrails may be needed to protect against the potential for abuse. For example, medical necessity determinations can and should still play a role in determining the application of coverage for some of these particular emergency services, including the emergency interfacility transports.

Scheduled Non-Emergency Ground Ambulance Services

Non-emergency ground ambulance services consist of transports requiring medical support, such as discharges from the hospital to the patient's residence (home or non-acute care facility), discharges from a hospital to a rehabilitation center, or an interfacility transfer for a higher level of care from an out-of-network to an in-network facility. Such transports still require the same skill sets as ground ambulance emergency medical services for clinical monitoring, such as for

EKGs, IVs, ventilator management, providing oxygen, or fracture management, in order to provide continuity of care in transferring the patient safely and without any deterioration. The primary distinction is that non-emergency transport is more likely able to be planned and scheduled in advance.

In small, rural communities, these services may be provided by the same public, private or volunteer providers and suppliers as emergency services. In larger communities, non-emergency transports are not typically handled by community fire departments. Instead, many of them are performed by privately owned and operated ground ambulance providers/suppliers. Some of these are hospital-owned companies, and a few are very large private equity-owned companies. The Committee saw data from 2014-2017 claims[25] indicating that about 90% of non-emergency transports were provided by private sector providers/suppliers. According to this same data, about half (57%) of all non-emergency ground ambulance transports were delivered out-of-network. Oftentimes, the only non-emergency ground ambulance service available at a given time may be from an out-of-network provider. So out-of-network balance billing is also an important concern for non-emergency ground ambulance services because, even if these transports do not have to happen immediately, they are still medically necessary and a type of service that patients may not be choosing for themselves.

The NSA permits balance billing in certain non-emergent circumstances where a patient has access to in-network providers but prefers to use an out-of-network provider. Differences between the emergency and non-emergency ground ambulance medical provider and supplier markets may allow for multiple entities to serve a community. Because non-emergency transports may be scheduled in advance, notice and consent provisions could potentially support similar out-of-network balance billing in circumstances if there is in-network provider choice available and upon appropriate timing, disclosures, pricing estimates, and informed patient consent.

Some Committee members argued that from the consumer's perspective, in many cases there is still no meaningful choice of ground ambulance provider or supplier. While the distinctions between emergency and non-emergency care are meaningful to the ground ambulance providers or suppliers and to treating clinicians, patients are less apt to understand the difference between the ambulance to the nursing home versus the ambulance to another hospital, for instance. Patients involved in post-hospital-discharge transfers may not be in a condition to understand the distinction between coverage for the hospital or post-acute care services and coverage of the interfacility or discharge-to-home transfers ordered by treating clinicians. That is, while patients in these situations may be medically stable and out of crisis, they may generally still not be fully capable of considering the implications of health coverage rules when treating or discharging clinicians recommend ambulance transports. Patients may not fully appreciate or understand that they have a choice of providers when it comes to such services, even if they do have a choice. Therefore, additional guardrails protecting consumers may be warranted, such as limitations on cost-sharing obligations.

[25] Adler, L., Bich L., Duffy E., Hannick K., Hall M., & Trish, E. (2023). Ground Ambulance Billing And Prices Differ By Ownership Structure. *Health Affairs*, 42(2), 227-236. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00738.

Since some patients are not in an emergency situation and there is time to schedule ambulance transportation, some Committee members believe it may be appropriate for health plans to require preauthorization in certain situations. If non-emergency ground ambulance medical services can be scheduled and preauthorized in advance, health coverage medical necessity criteria for covered services could still apply. Some Committee members raised concerns that providing the same strong protections for cost sharing to non-emergency ground ambulance medical services (as recommended for emergency services) might generate overutilization that would not meet coverage criteria, resulting in the consumer owing the entire bill. If so, they reasoned, overutilization could also increase payor incentives to deny more claims as non-covered benefits due to lack of medical necessity.

Subcommittee Recommendations on Prevention of Consumer Balance Billing presented to the Committee

(Recommendation 12): Prohibit balance billing and guarantee reasonable payment for ground ambulance emergency medical services – **SEE CHAPTER 5**

(Recommendation 6): Congress should place a limitation on billing patients for ground ambulance emergency and non-emergency medical services before seeking insurance information.

- A ground ambulance organization may not bill a patient until after it has been submitted to the patient's insurance company and a determination of payment has been made, unless the ground ambulance emergency or non-emergency provider or supplier first made a reasonable attempt to obtain the patient's insurance information but was unable to do so within 3 to 7 days.

(Recommendation 9): Congress requires the Secretary of HHS to amend the relevant conditions of participation to require health care providers to share patient insurance information with an emergency ground ambulance services provider or supplier that treated a mutual patient, upon request by the emergency ground ambulance services provider or supplier

Subcommittee Recommendations on Coverage for Emergency Ground Ambulance Services presented to the Committee

(Recommendation 3): Congress should require coverage of ground ambulance emergency medical services.

- Option A: If a group health plan or health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to emergency services then the plan or issuer must cover ground ambulance emergency medical services. In addition, the group health plan and issuers must cover such services;
    a. Without the need for any prior authorization determination;
    b. Whether the ground ambulance provider or supplier furnishing such services is a

participating provider or supplier with respect to such services;
c. Without imposing any requirements or limitations on coverage that is more restrictive than the requirements or limitations that apply to such services if they were received from a participating emergency ground ambulance services provider or supplier; and
d. Without regard to any other term or condition of such coverage

- Option B: If a group health plan or health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to emergency services then the plan or issuer must cover ground ambulance emergency medical services (including emergency interfacility transports and such services when an ambulance has responded, but no transport has occurred). In addition, the group health plan and issuers must cover such services;
    a. Without the need for any prior authorization determination
    b. Whether the ground ambulance provider or supplier furnishing such services is a participating provider or supplier with respect to such services
    c. Without imposing any requirements or limitations on coverage that is more restrictive than the requirements or limitations that apply to such services if they were received from a participating emergency ground ambulance services provider or supplier; and
    d. Without regard to any other term or condition of such coverage

(Recommendation 5): Ground Ambulance Emergency Medical Services should be incorporated in the definition of emergency services under the Essential Health Benefit (EHB) requirements.

(Recommendation 4): Congress should establish a statutory federal advisory committee to advise the Secretaries of Health and Human Services, the Department of Labor, and the Department of the Treasury on ground ambulance reimbursement policy to evaluate how expanding coverage and reimbursement of ground ambulance services beyond transports to hospitals, skilled nursing facilities, and critical access hospitals could improve patient outcomes, reduce overall health care costs, and support the continuum of care.

Among the topics the Committee recommends that such an advisory committee consider are community paramedicine/mobile integrated healthcare, Advanced Life Support first response, treatment in place, and alternative destination. The advisory committee could also provide guidance on how to address the rising costs of ancillary supplies, oxygen, high-cost drugs, and medical equipment in the context of pre-hospital emergency services.

(Recommendation 8): Establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for ground ambulance emergency medical services.

Any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to ground ambulance emergency medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner if the services were provided by an in-network provider or supplier.

- Option A: The patient cost-sharing requirement is 10% of the rate established under

Recommendation 12, subject to out-of-pocket limits with a fixed dollar maximum.

- Option B: The patient cost-sharing requirement may be the lesser of $100 (adjusted by the CPI-U annually) or 10% of the rate established under Recommendation12, regardless of whether the health plan includes a deductible.
- Option C: The patient cost-sharing requirement for ground ambulance emergency medical services may be no higher than the amount that would apply if such services were provided by a participating ground ambulance provider or supplier.

Subcommittee Recommendations on Disclosure Requirements presented to the Committee

(Recommendation 10): Ground ambulance emergency medical services should provide a bill to consumers with minimum elements for a standardized bill.

I. All bills must include the following elements:
   a. Clarify whether or not the bill reflects a final determination by the patient's insurance
   b. Provide information about how a patient can dispute the charges and the coverage determination
   c. Provide information that they should not receive a balance bill and if they do, how they can report that illegal bill to be sure it does not appear as an amount owed or be sent to collections

II. Communications from ground ambulance emergency medical services to the patient before obtaining the patient's insurance information or completing a reasonable attempt to obtain said information must make clear that it is not a bill.
   a. Required language could be: "THIS IS NOT A BILL. We are attempting to determine your insurance information."

(Recommendation 7): Congress should direct patients with concerns, disputes, and questions about ground ambulance emergency and non-emergency medical services billing to the No Surprises Help Desk. The No Surprises Help Desk triages patient calls and connects them with the right resources (back to their insurers, providers, or to local regulators or federal regulators at CMS or DOL).

Subcommittee Recommendations on Coverage for Non-Emergency Ground Ambulance Services presented to the Committee

(Recommendation 13): Establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for non-emergency ground ambulance medical services.

Any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to non-emergency ground ambulance medical services must be counted toward any in-network

deductible and out-of-pocket maximum in the same manner if the services were provided by an in-network non-emergency ground ambulance services provider or supplier.

- Option A: The patient cost-sharing requirement is 10% of the rate established under Recommendation 14, subject to out-of-pocket limits with a fixed dollar maximum.
- Option B: The patient cost-sharing requirement may be the lesser of $100 (adjusted by the CPI-U annually) or 10% of the rate established under Recommendation 14, regardless of whether the health plan includes a deductible.
- Option C: The patient cost-sharing requirement for non-emergency ground ambulance medical services may be no higher than the amount that would apply if such services were provided by a participating non-emergency ground ambulance services provider or supplier.

Advisory Committee Discussion and Recommendations

The Committee deliberated on key findings and draft recommendations related to consumer protections for ground ambulance services, and then held the following votes. A record of voting by each Committee member is presented in Table 2 in Appendix E.

The primary recommendation—***to prohibit balance billing***—is tied to a guarantee of reasonable payment and so is described in the next chapter on Plan and Issuer Payment for Ground Ambulance Services (and addressed in Recommendation 12).

Following discussion on Recommendation (6) on limiting the billing of patients before seeking insurance information. the Committee vote was 13 in favor, none opposed, 3 abstaining (Godette-Crawford, HHS, Treasury), and 1 not present (DOL), and the Committee adopted the recommendation as follows:

> **Committee Recommendation 6**
>
> **The Committee recommends Congress place a limitation on billing patients for ground ambulance emergency and non-emergency medical services before seeking insurance information. Specifically, a ground ambulance organization may not bill a patient until the claim for the services has been submitted to the patient's insurance company and a determination of payment has been made, unless the ground ambulance emergency or non-emergency provider or supplier first made a reasonable attempt to obtain the patient's insurance information, but was unable to do so within 3 to 7 days**.

Following discussion on Recommendation (9) on amending conditions of participation to require sharing of patient insurance information, the Committee vote was 14 in favor, none opposed, 2 abstaining (HHS, Treasury), and 1 not present (DOL), and the Committee adopted the recommendation as follows:

> **Committee Recommendation 9**

The Committee recommends Congress require the Secretary of HHS to amend the relevant conditions of participation to require health care providers to share patient insurance information with an emergency ground ambulance services provider or supplier that treated a mutual patient, upon request by the emergency ground ambulance services provider or supplier.

Following discussion on Recommendation 3 on coverage requirements for ground ambulance emergency services:

- The Committee vote on Option 3A was 12 in favor, 3 opposed, 1 abstaining (Treasury), and 1 not present (DOL).
- With respect to the 'No' votes, members explained:
  - that coverage for services delivered when ground ambulance providers/suppliers treat and do not transport is critical because it is a substantial expense; for example, someone who is in cardiac arrest and subsequently dies and ends up being transported by a coroner, rather than by an ambulance service, has received an intense amount of care and treatment in the attempt to save their life;
  - that the concept of applying a medical necessity standard is not appropriate when a consumer calls 911 and the provider/supplier must respond and treat the patient; and
  - that non-transport services must be covered to avoid the patient experiencing a negative impact.
- As the result of the vote, the Committee adopted Option 3A.
- Following the Committee vote on Option 3A, members identified unclear language and possibly missing words in the initial sentence of the recommendations concerning applicability to insurance benefits and this was subsequently corrected in the public meeting materials to align more closely with existing NSA emergency services coverage applicability regulatory text.
- Following further discussion on Option 3B, the Committee voted to also adopt Recommendation 3B. The Committee vote on Option 3B was 14 in favor, none opposed, 2 abstaining (HHS, Treasury), and 1 not present (DOL).

Subsequent to the vote, all members present agreed that the primary recommendation of the Committee would be presented as Option 3B in the final report, as follows:

Committee Recommendation 3

The Committee recommends Congress require coverage of ground ambulance emergency medical services. Specifically, if a group health plan or health insurance issuer offering group or individual health insurance coverage provides or covers any benefits with respect to emergency services, then the plan or issuer must cover ground ambulance emergency medical services (including emergency interfacility transports and such services when an ambulance has responded, but no transport has occurred). In addition, the plan or issuer must cover such services:

a. Without the need for any prior authorization determination;
b. Whether the ground ambulance provider or supplier furnishing such services is a participating provider or supplier with respect to such services;
c. Without imposing any requirements or limitations on coverage that are more restrictive than the requirements or limitations that apply to such services if

they were received from a participating emergency ground ambulance services provider or supplier; and

d. **Without regard to any other term or condition of such coverage**

Following discussion on Recommendation 5 on specifically incorporating ground ambulance emergency services (as defined in this report) into the EHB requirements, the Committee vote was 14 in favor, none opposed, 2 abstaining (HHS, Treasury), and 1 not present (DOL). The Committee adopted the recommendation as follows:

Committee Recommendation 5

The Committee recommends Congress incorporate Ground Ambulance Emergency Medical Services under the definition of emergency services under the Essential Health Benefit (EHB) requirements.

Following the discussion on Recommendation 4 on establishment of a federal advisory committee, the Committee vote was 13 in favor, none opposed, 3 abstaining (Beck, HHS, Treasury), and 1 not present (DOL), and the Committee adopted the recommendation as follows:

Committee Recommendation 4

The Committee recommends Congress establish a statutory federal advisory committee to advise the Secretaries of Health and Human Services, the Department of Labor, and the Department of the Treasury on ground ambulance reimbursement policy to evaluate how expanding coverage and reimbursement of ground ambulance services beyond transports to hospitals, skilled nursing facilities, and critical access hospitals could improve patient outcomes, reduce overall health care costs, and support the continuum of care.

Among the scope of topics to be addressed the Committee recommends that such an advisory committee consider are community paramedicine/mobile integrated healthcare, Advanced Life Support first response, treatment in place, and alternative destination. The advisory committee could also provide guidance on how to address the rising costs of ancillary supplies, oxygen, high-cost drugs, and medical equipment in the context of pre-hospital emergency services.

Following the discussion on Recommendation 8 concerning maximum cost sharing amounts for ground ambulance emergency medical services:

- The Committee vote on Option 8A was 11 in favor, 3 opposed, 2 abstaining (HHS, Treasury), and 1 not present (DOL).
- For the record, members voting "no" explained they did so because a fixed percentage would be an insufficient cap on cost sharing for expensive calls, it would be preferable for consumers to have a very clear idea in their head of how much an ambulance service and/or transport is going to cost them before they call 911, and that another option was the superior approach.
- The Committee vote on Option 8B was 13 in favor, 1 opposed, 2 abstaining (HHS,

Treasury), and 1 not present (DOL).

- The member in opposition noted for the record that the 'no' vote was because another option was preferred.
- The Committee vote on Option 8C was 1 in favor, 13 opposed, 2 abstaining (HHS, Treasury), and 1 not present (DOL).
- For the record, some of the members voting "no" explained why they did so. The reasons included: a desire for greater consumer certainty in advance on the amount of cost-sharing which could deter some people from calling 911 for help, the absence of comprehensive data for the committee to determine the amount that a patient would owe based on this proposed calculation, the low number of ground ambulance providers/suppliers in networks, and that in-network negotiated rates may be too low to sustain the ability of providers to respond and cost sharing too high for consumers to afford.
- On the basis of the voting, the Committee adopted both Recommendations 8A and 8B.
- However, a motion was made to revisit the two adopted options to consolidate those down to one recommendation. The Chairperson seconded this motion and those Committee members who voted in the affirmative on both Option 8A and 8B subsequently agreed unanimously to having their preferred vote be registered as Option 8B.

Therefore, the Committee adopted the primary recommendation as follows:

Committee Recommendation 8

The Committee recommends Congress establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for ground ambulance emergency medical services. Specifically, the patient cost-sharing requirement shall be the lesser of $100 (adjusted by the CPI-U annually) or 10% of the rate established under Recommendation 12, regardless of whether the health plan includes a deductible. In addition, any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to ground ambulance emergency medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner as if the services were provided by an in-network provider or supplier.

Following the discussion on Recommendation 10 concerning disclosure requirements in consumer billing communications, the Committee vote was 14 in favor, none opposed, 2 abstaining (HHS, Treasury), and 1 not present (DOL). The Committee adopted the recommendation as follows:

Committee Recommendation 10

The Committee recommends Congress require ground ambulance emergency medical services providers and suppliers provide a bill to consumers with minimum elements for a standardized bill.

I. All bills must include the following elements:

a. Clarify whether or not the bill reflects a final determination by the patient's insurance
b. Provide information about how a patient can dispute the charges and the coverage determination
c. Provide information that they should not receive a balance bill and if they do, how they can report that illegal bill to be sure it does not appear as an amount owed or be sent to collections

II. Communications from ground ambulance emergency medical services to the patient before obtaining the patient's insurance information or completing a reasonable attempt to obtain said information must make clear that it is not a bill. Required language could be: "THIS IS NOT A BILL. We are attempting to determine your insurance information."

Following the discussion on Recommendation 7 concerning consumer access to the NSA Help Desk, the Committee vote was 14 in favor, none opposed, 2 abstaining (HHS, Treasury), and 1 not present (DOL), and the Committee adopted the recommendation as follows:

Recommendation 7

The Committee recommends Congress direct patients with concerns, disputes, and questions about ground ambulance emergency and non-emergency medical services billing to the No Surprises Help Desk. The No Surprises Help Desk triages patient calls and connects them with the right resources (back to their insurers, providers, or to local regulators or federal regulators at CMS or DOL).

Following the discussion on Recommendation 13 concerning maximum cost sharing amounts for scheduled non-emergency medical services:

- A motion was made and seconded to revisit the first two options to consolidate these into the second option and eliminate the first Option A. There was no objection and the Chairperson directed that there would be no vote on Option A.
- The Committee vote on Option 13B was 11 in favor, 2 opposed, 1 abstaining (Treasury), and 3 not present (DOL, HHS, DOT).
- For the record, members voting "no" explained why they did so, including because of concerns about requiring stronger cost-sharing protections for non-emergency transports than for other scheduled health care, such as for surgery or hospital services, and concerns about providing stronger protections on out-of-network than on in-network care.
- The Committee vote on Option 13C was 3 in favor, 10 opposed, 2 abstaining (HHS, Treasury), and 2 not present (DOL, DOT).
- For the record, some of the members voting "no" explained why they did so, including because there is not enough information to understand what in-network cost sharing levels would be, concerns that many communities would have no in-network providers, and the desire for greater consumer protections for services that consumers frequently are not really in a position to select.

Therefore, the Committee adopted the following recommendation:

Recommendation 13

Establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for non-emergency ground ambulance medical services.

Any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to non-emergency ground ambulance medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner if the services were provided by an in-network non-emergency ground ambulance services provider or supplier.

- Option A: The patient cost-sharing requirement is 10% of the rate established under Recommendation 14, subject to out-of-pocket limits with a fixed dollar maximum.
- Option B: The patient cost-sharing requirement may be the lesser of $100 (adjusted by the CPI-U annually) or 10% of the rate established under Recommendation 14, regardless of whether the health plan includes a deductible.
- Option C: The patient cost-sharing requirement for non-emergency ground ambulance medical services may be no higher than the amount that would apply if such services were provided by a participating non-emergency ground ambulance services provider or supplier.

Note: As described in Chapter 2, Committee members agreed that balance billing prohibitions for emergency and non-emergency ground ambulance services must each be accompanied by a set of coverage, maximum cost-sharing, and required reasonable payment rate requirements. Addressing each of these aspects of the issue in a comprehensive solution is necessary to protect consumers for both affordability of and adequate access to ground ambulance services. Consequently, Committee members agreed that if all recommendations in a set were not adopted for a comprehensive solution, then the Committee recommendations related to that type of service would not move forward to the final report. Therefore, following the completion of all voting, and the failure of related recommendations on non-emergency ground ambulance service protections, the adoption of Recommendation 13 was subsequently nullified and is not put forward as adopted in the final report.

Summary

The Committee was unanimous on the need to get the consumers who are covered individuals out of the middle of ground ambulance emergency service billing disputes between providers and payors. There was broad consensus among Committee members to recommend mandatory coverage of, and prohibition of balance billing for, ground ambulance emergency medical services when group health plans or health insurance issuers cover any emergency services. They supported mandatory coverage and Essential Health Benefits status not only for services that end up with transport to a hospital, but also for emergency interfacility transports and medical services for emergency response when no transport occurs. They reasoned this approach would best support consumers by embracing the breadth of ground ambulance emergency response scenarios and preventing unnecessary emergency department visits. The Committee members also agreed on recommendations to address other reasons for balance bills, including reducing

barriers experienced by ground ambulance providers and suppliers obtaining consumer health coverage billing information and requiring certain standard consumer-friendly content in bills.

A vast majority of the Committee supported a fixed dollar cap on cost sharing that would apply before the requirement of a covered individual to meet their annual deductible to best prevent consumers avoiding calling 911 when needed out of fear of unknown out-of-pocket costs. They also supported the recommendation to establish a federal advisory committee to advise the Secretaries on ground ambulance coverage and reimbursement policy across regulated health programs. A small minority of the Committee differed primarily on the details of how best to set maximum cost sharing amounts. This minority supported limiting cost sharing at the in-network ground ambulance services rates.

During the consideration of the scope of the recommendations, the Committee considered ground ambulance services both in the context of emergency and non-emergency services. The Committee voted in favor of establishing some consumer protections for non-emergency services, such as maximum cost-sharing requirements. However, the Committee later determined [see Chapter 5] that applying some of the other related recommendations, such as setting a minimum required payment rate for out-of-network non-emergency ground ambulance services, would require additional background and considerations that the Committee did not have adequate time or resources to address. As a result, the recommendations related to non-emergency ground ambulance services did not move forward as final recommendations in the report, even though the Committee did vote to adopt maximum cost sharing protections.

In fact, a majority of the Committee members felt strongly about extending balance billing protections and cost-sharing limitations to out-of-network non-emergency ground ambulance services. While the distinctions between emergency and non-emergency care are meaningful to the ground ambulance providers or suppliers and to treating clinicians, patients may not always understand the differences. While patients in these situations may be medically stable and out of crisis, they may generally still not be fully capable of considering the implications of health coverage rules when their treating or discharging clinicians recommend ambulance transports. However, because the complete set of interrelated recommendations regarding non-emergency services were not adopted, no recommendations on non-emergency ground ambulance services were finalized for this report.

Relation to Current NSA Balance Billing Consumer Protections

Consumer Disclosures

Committee members believe that the consumer disclosure protections in the NSA would generally not be appropriate for ground ambulance emergency services. This is primarily due to the unplanned, emergent timing of EMS incidents. It is also because of the impracticality of emergency response personnel having discussions about administrative matters with consumers in acute distress. However, certain other types of consumer disclosures related to billing are necessary, as are protections for assisting consumers to exercise their rights.

The NSA does not directly address provider billing communication content. The NSA regulations do require providers to publicly post and provide copies of standardized disclosure

notices to insured consumers on patient protections against balance billing. These individual notices must be one-page notices delivered no later than the date and time on which the provider or facility requests payment from the individual (or with respect to an individual from whom the provider or facility does not request payment, no later than the date on which the provider or facility submits a claim to the group health plan or health insurance issuer) and be provided in-person or through mail or email, as selected by the individual. The regulations do not directly address communications through web-based electronic medical records or other portals.

In the case of ground ambulance emergency medical service billing, Committee members believe all oral, printed, and electronic communications from ground ambulance emergency medical service providers and suppliers to the patient (before obtaining the patient's health coverage information after completing a reasonable attempt to obtain such information) should make it clear to the consumer that these are not a bill. The Committee agreed that all printed and electronic bills must clarify whether the bill reflects a final determination by the consumer's group health plan or health insurance issuer, as well as specify how the consumer can dispute either charges or the coverage determination and how to report illegal bills to the No Surprises Help Desk.

Consumer Cost Sharing

The NSA currently requires that out-of-network cost sharing for services protected under the NSA be no greater than the plan's or issuer's in-network benefit terms applied to an amount called the *recognized amount.* This amount is generally based on state balance billing laws or the *qualifying payment mount*, which is generally the median of the plan's in-network contracted rates for the billed item or service in that geographic region. The in-network benefit terms differ among plans and policies and may be changed annually. For reasons that are elaborated upon in the next chapter, this approach does not work well for ground ambulance emergency services.

The recommended requirement for the maximum cost-sharing amount to be counted toward any in-network deductible and out-of-pocket maximum in the same manner as if the services were provided by an in-network ground ambulance emergency medical service provider or supplier mirrors current NSA protections.

Coverage

Current NSA regulatory emergency services balance billing protections apply to out-of-network provider services delivered in connection with services provided by hospital or freestanding emergency departments. Therefore, protections do not extend to out-of-network services that do not involve an emergency department setting or to post-hospital-discharge services. Ensuring coverage of emergency medical services provided by ground ambulance providers and suppliers under both Essential Health Benefits and the NSA framework requires addressing additional settings and services which are not routinely covered by plans and issuers today.

Coverage Information Exchange

Reliable and timely access to consumer health coverage information is not a matter addressed by the current NSA statutory provisions and regulations on balance billing. The statutory scheme appears to presume that this information will be available to providers and facilities but is silent

on any requirements on how this information exchange takes place. In the good faith estimate provisions, convening providers and facilities are expected to obtain this information from a consumer at the time of direct communication and the scheduling of items and services. The statute and rules are silent on expectations for insurance information transfers in circumstances when this exchange of information does not invariably occur. The Committee recommends that the relevant Medicare Conditions of Participation be amended to require this exchange when requested by a ground ambulance provider or supplier. Specifically, the recommendation is that the Secretary of HHS be directed to amend the Medicare Hospital Conditions of Participation, the Medicare Skilled Nursing Facility Conditions of Participation, and the Critical Access Hospital Conditions of Participation to require health care organizations to share, upon request by the ground ambulance provider or supplier, patient health coverage information with a ground ambulance emergency services provider or supplier that treated a mutual patient.

Consumer Assistance

One of the most difficult things to do when new consumer protections are passed is to help people know and understand their new rights. Because billing is complex, the NSA included a one-stop shop for consumers to be able to call an 800-number or communicate by e-mail for help in understanding their medical billing protections. Understanding that different levels of state enforcement or federal enforcement would be involved, and that it would be impossible for a consumer to understand which agency or department could help, the NSA Help Desk was established as a one-stop resource for consumers. The NSA Help Desk assists consumers by helping to identify the problem and then connect them to the right information or government agency that can best help. Since consumers will think about medical billing as a whole, and won't necessarily think about whatever new protections they have around ambulance billing, the consumer-friendly solution would be to handle ground ambulance balance billing consumer concerns in the same manner as for other medical services. Thus, the Committee recommends that Congress extend the current NSA complaint process to include access to the NSA Help Desk for consumers with ground ambulance emergency medical services concerns and disputes.

Chapter 5 – Plan and Issuer Payment for Ground Ambulance Services

Background

State and local governments establish and oversee America's EMS system. There is enormous variability in how these EMS systems are designed that take into account local needs, geography, and the distribution of other health care providers in the area, among other things. (IOM, Emergency Medical Services At The Crossroads, 2007.) Yet, there are a set of consensus-based national protocols, overseen by the National Association of State Emergency Medical System Officials (NASEMSO) and others,[26] that create continuity in care. Together these factors drive the cost of providing ground ambulance services. Many towns or counties across the United States contract with ambulance companies to provide emergency services in their community. In these situations, the local governing body may set specific rates that those contracted ambulances can charge patients for emergency services. Rates can be set for different levels of service, including Basic Life Support (BLS) or Advanced Life Support (ALS), and for operating cost components, including mileage and sometimes ancillary services, such as oxygen. These local rates are set in different ways.

The Committee heard from several local officials from various jurisdictions across the United States about how they use this delegated rate-setting and oversight authority to ensure a cost-effective delivery of EMS in their communities. The state and local officials presented Committee members with examples of several different models for rate regulation. Each model included public and transparent processes. The officials described public meetings and hearings in which local elected officials debate and evaluate proposed ambulance rates with active public engagement. One Committee member expressed the opinion that the public has little power or information to object to ambulance rates when participating in the public process; that ground ambulance providers/suppliers simply present their business plans; and that the most power the consumer has is to object. Some Committee members asked about the substantial variation in rates, including significant differences in mileage rates. The state and local officials explained these variations exist in part due to distinctions between communities in service-level standards, local availability and access to primary care, the number of ambulances available in a region, geographic distances covered, and population density. They also discussed the inverse relationship between volume and cost – the fewer transports, the higher the per-trip costs – which is a correlation seen throughout the health care system.

While states and localities often have a public process and strive to make rates public, there is variation in transparency among jurisdictions. In addition, the results are not generally reported to or conveniently accessible in centralized state or national public databases. In some cases, it is difficult to find information about local ambulance rates. For instance, they might exist in town hall meeting minutes, but may not be easily accessible unless one knows where they are listed. Some states, such as Arizona, require disclosure of rates via a state website. Some jurisdictions, such as Austin-Travis County EMS, even codify ambulance rates in ordinances and post these via their website. Some governmental ambulance services do not bill insured residents and conduct "insurance only billing". The Committee heard that no national standard reporting

[26] Dia Gainor. NASEMSO, May 2023 Presentation.

format for rate reporting has been identified. Accordingly, in the absence of a centralized and up-to-date national public database, some Committee members believed it would be very challenging for group health plans or health insurance issuers to operationalize provider reimbursement and consumer cost sharing based on state and local rates.

The Committee heard that a large part of America is rural, super rural, or frontier by geography, with scarce and diminishing access to healthcare resources.[27] Local governments are responsible for understanding what it takes to provide emergency services in those rural, less populated areas. Some urban areas also face related challenges with a dearth of healthcare services that must be addressed locally. The Committee heard from members and experts during the May 2023 Public Meeting about ambulance services closing because their costs exceed their revenues. As a result, individuals in these communities have lost some degree of, if not all, access to ground ambulance emergency medical services. The Committee heard from members that news reports are following the rising number of ambulance services closing, especially in rural and medically underserved areas.[28]

The issue of defining reasonable rates for ground ambulance services to be paid by group health plans and health insurance issuers is one component of the larger policy issue of funding EMS systems nationally. Group health plans and health insurance issuer enrollees are not the only, or even the predominant, users of EMS services. The Committee heard from two presenters that private plans and issuers accounted for 13% and 15%, respectively, of payor mix in their 2022 claim samples (Kim Stanley, EMS Management and Consultants, May 2023 Presentation; Shawn Baird, Metro West Ambulance, May 2023 Presentation). These presentations indicated that Medicare covers about 50% of ground ambulance claims, with Medicaid programs responsible for 15–25%, and uninsured individuals and other payors accounting for the remainder. Therefore, the group health plans and health insurance issuers of concern to this Committee are responsible for an estimated 15% of billed ground ambulance services.

Because Medicare covers half of all ground ambulance claims, the impact of Medicare reimbursement policies is immense and may affect rates that private payors are billed. The findings of two earlier GAO reports suggested that Medicare rates across rural counties likely do not fully reflect differences in providers' cost per trip due to variation in trip volume.[29] Notably, the vast majority of in-network rates available through Fair Health data are substantially above current Medicare rates.[30] However, Medicare ground ambulance coverage and payment policy is not within the scope of this Committee's charge and recommendations. For this reason, the Committee has not made recommendations on Medicare policy, but has included a section on

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[27] *77% of rural counties are Health Professional Shortage Areas; 9% percent have no physicians; and rural hospitals have been closing* (Kathy Lester, Lester Health Law PLLC, May 2023 Presentation).

[28] For instance: Hassanein, N. (2023, June 26). What if the ambulance doesn't come? Rural America faces a broken emergency medical system. USA Today, https://www.usatoday.com/story/news/health/2023/06/26/no-ambulances-closing-hospitals-the-crisis-facing-rural-america/70342027007/.

[29] GAO. Ambulance Providers: Costs and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased (2012); GAO. Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly (2007); Zach Gaumer, HMA, May 2023 Presentation.

[30] Zach Gaumer, HMA, May 2023 Presentation.

significant findings related to this concern in Chapter 8.

The Committee heard that the majority of this estimated 15% of claims paid by group health plans and health insurance issuers have been reimbursed as transport services, with some plans and issuers using reimbursement methodologies tied to Medicare rates. Congress and CMS have recognized Medicare rates need to be updated, and the methodology has not been revised since 2002.[31] The Committee heard about the initial work to collect current ambulance costs that will be presented to MedPAC in 2024 and eventually inform recommendations to Congress (Maria Durham, CMS and A. Mulcahy, The RAND Corporation, May 2023 Presentation). Committee members familiar with the Medicare fee schedule development process and methodology stated that the base rates were not constructed using provider/supplier costs, but rather were the result of a negotiated rulemaking that took a set amount of total Medicare spending and divided it across a set utilization. This process never reflected the average costs of all the labor, equipment, supplies, pharmaceuticals and medical management needed for current EMS response standards. In contrast, some municipalities or counties, such as Santa Clara, San Bernadino, Los Angeles, and Contra Costa counties in California, allow billing rates for additional charges, such as oxygen, EKGs and other services and medications. In addition, the Committee heard that while a few payors have been reimbursing claims at full billed charges, most payors do not. Most payors also have not routinely reimbursed for medical response services when an ambulance has responded but no transport has occurred—which are essential components of EMS response that the Committee recommends be covered (in Recommendation 3). (The extent to which this lack of plan and issuer coverage has been driven by lack of Medicare coverage is unknown but some Committee members believe this may be an important factor.) Other presentations to the Committee also outlined how ambulance services in rural and super-rural areas have very low volume while covering massive geographies. When payors propose urban rate payments to these rural providers, some providers/suppliers can only meet their costs by operating with volunteer emergency personnel. When payors do not pay the full amount of a billed charge, many patients may then be balance billed to make up the discounted and disallowed amounts.

Some members argued that tying payment to the Medicare rates could result in underpayment for ambulance services. They quoted studies by the Government Accountability Office (GAO)[32] and the Medicare Payment Advisory Commission (MedPAC) that conclude the current Medicare Ambulance Fee Schedule (AFS) needs revision to appropriately reimburse costs for some services, particularly in geographically isolated, low volume areas. Others argued that any recommendation to tie rates to Medicare would only use Medicare rates as a starting point and the expected payment would be some percentage (greater than 100%, or a multiple) of Medicare rates. They pointed to state ambulance laws, such as in Colorado and Maine, that have used this approach.[33] The Committee heard about the CMS Ground Ambulance Data Collection System process that is currently collecting ambulance cost data from around the country, which will be

[31] Ambulance Fee Schedule (AFS) Final Rule -Federal Register, February 27, 2002 (67 FR 9 100).

[32] (GAO. Ambulance Providers: Costs and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased (2012); GAO. Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly (2007); Zach Gaumer, HMA, May 2023 Presentation).

[33] Kelmar, P., (2022). *Emergency: The High Cost of Ambulance Surprise Bills* [White paper]. U.S. PIRG Education Fund. https://publicinterestnetwork.org/wp-content/uploads/2022/12/EMERGENCY-The-high-cost-of-ambulance-surprise-bills-USPIRG-Education-Fund-December-2022-Final.pdf.

presented to MedPAC in 2024. These data are expected to inform the question of the extent to which current Medicare rates cover the costs of ambulance services based on current services and costs. These data would have been useful to the GAPB Advisory Committee, but were not yet available. The Committee noted that an ongoing advisory committee process could tackle a deeper dive into the actual cost data once collected, as well as look into other data, such as local ambulance rates being collected by states under state ambulance laws.

The Committee believes increasing the components of service for which costs are reimbursed, as well as the rates paid for these items and services, would be expected to improve the financial viability of ground ambulance providers/suppliers and help preserve consumer access. Some Committee members raised concerns that increasing reimbursement rates would also increase health coverage costs to employers and premiums for consumers. They noted employer health coverage premiums have consistently risen commensurately with health care claims spending.[34] They also noted the Congressional Budget Office explained that the estimated effects of the No Surprises Act on health coverage premiums were primarily a byproduct of the level of payments newly mandated by the law in relation to existing prices for affected health care items and services.[35] Other members reported analysis from the legislature of the State of Louisiana, which issued a fiscal note summarizing their cost estimate findings, which did not project their recent ground ambulance balance billing law would affect premiums ("The LA Department of Insurance reports the proposed legislation is not anticipated to have an impact on health insurance policies issued under the health insurance exchanges/marketplace"[36]).

The Committee heard from some members that improved coverage of ground ambulance emergency medical services could eliminate some unnecessary hospital emergency department visits and associated downstream costs. One member also noted that that if ground ambulance providers and suppliers could be reimbursed for all the non-transport services provided, there would be an offset to transport costs in jurisdictions like California. This is because public ground ambulance providers and suppliers there are not permitted to make a profit, so transport charges would be reduced because of no longer having to recover the cost of the no-transport as part of the cost of a transport. In other words, the total costs of operating ground ambulance services would no longer be spread across only transports, thus reducing the overall cost of the claims for transports because the cost of services provided when no transport is made would also be reimbursed. However, no evidence was presented to the Committee to indicate the magnitude of these offsetting effects or how representative they might be nationally. Aside from discussing the lack of Medicare coverage precedent, the Committee did not receive information on or discuss why private payors do not routinely elect to cover such services today. This question, as well as to what degree any resulting downstream savings would be expected to offset the increased payor payments for ground ambulance emergency medical services could also be topics for an ongoing advisory committee process.

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[34] https://www.kff.org/private-insurance/issue-brief/medical-loss-ratio-rebates/ (See Figure 2).

[35] https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf. See, e.g., "*smaller payments to some providers would reduce premiums by between 0.5 percent and 1 percent*" .

[36] State of Louisiana Fiscal Office. (June 8, 2023) *Fiscal Note on SB 109*. accessed 2/5/2024 at: https://fastdemocracy.com/bill-search/la/2023/bills/LAB00020614/.

The Committee discussed concerns about requiring plans to make payments in the amount defined by state and local rates. There was no disagreement that state and local rate-setting processes are currently incentivized to look very closely at actual costs. However, there was disagreement on the downstream impact of requiring plans and issuers to pay state and local rates on health coverage costs and premiums. Some members expressed concern that there were not sufficient guardrails to control costs in all jurisdictions, while others stated that state and local governments successfully guard against rate inflation. For some, there remains a concern that if plans or issuers were to be required to reimburse the full locally set rate, the motivation for cost-control would be lessened. They believed that when combined with limitations on patient cost sharing, the requirement to reimburse at levels set by states and localities raises health economics concerns of dynamic incentives to increase rates beyond the level otherwise needed to help fund other governmental expenditures. To address this concern, some members of the Committee suggested setting a cap on the state and local rates that would be the basis for the amounts reimbursed by group health plans and health insurance issuers. Other members of the Committee suggested requiring adherence to only those state or local rates that are established using one or more of a set of "guardrail" process mechanisms that would serve as a public, transparent check on the appropriateness of the rates. A tool that would be essential to monitoring state and local rates is establishing a central repository for ambulance rates by state or at the national level, to track rates and identify outliers.

As examples of such guardrails, the Committee heard from state and local government officials, technical experts who oversee local rate-setting, and members of the Committee about existing guardrails protecting against excessive state and local rate-setting that are in place. The Committee heard from a sample of local regulators who oversee ground ambulance regulated rates in their communities. These regulators described how they have enacted policies and practices to control the cost and guard against overpaying for ground ambulance services. These have informed the Committee's Recommendation 11 on guardrails. In California, for example, public ground ambulance providers and suppliers cannot recover more than the cost of providing the service, every fee charged to the public has to be reviewed by the governing body of the agency providing the service, and providers have to be able to validate that they are not collecting more than the cost of providing the service. During the Committee's third public meeting, a Health Access California representative explained their state's approach to combining prohibition of ground ambulance balance billing with payments tied to local rates set subject to guardrails, as follows:

> "Under California's new law, AB 716, if a consumer is transported in an out-of-network ambulance, consumers will be prohibited from receiving a bill beyond their in-network cost-sharing amount. In this situation, the insurer health plan will be required to pay the ambulance provider, both public and private, the remainder of the locally set ambulance rates. We chose to require payment at the locally set rate because this rate is set through an existing public process approved by elected officials responsible to their constituents, and these rates are set by cities or counties. These processes will also allow interested stakeholders to engage in that public process, including consumer advocates and health plans. Importantly, under California law, local governments cannot charge more than the cost of ambulance services. If adopted nationally, there should be similar guardrails for other states

> and local governments to prevent increases in rates to backfill other budget needs on the backs of consumers' health care. To monitor the local ambulance rates, our new law requires an annual state report on trending local rates by county and requires that report to be submitted to the regulators for rate review and our new Office of Healthcare Affordability. This law applies to both emergency and non-emergency ambulance transport, including interfacility transfers."

In considering the recommendation relating to guaranteeing a reasonable payment, there was consensus among Committee members that if a state had passed a law defining payment for out-of-network ambulance services, or a local rate-setting process existed, that the state or local law should prevail over any other payment calculation for fully insured state-regulated plans. There was also consensus that payors should be able to negotiate single case rates for specific patients.

There was considerable discussion on how rates should be determined in the absence of state balance billing laws or locally set rates. Those supporting a reliance on a percentage (multiple) of Medicare rates expressed the belief that those rates avoided the potential of inflated rates set at a local level. They expressed that if the state felt the nationally set rate was insufficient, the state still had the ability to rely on local and municipal rates by passing its own state ambulance balance billing law which would carry precedence over the nationally set rate. Those in favor of a nationally set rate also argued for the simplicity of the payment mechanism for payors.

There was also considerable discussion about whether state and locally set rates should apply to self-insured employer plans that are typically exempt from ERISA mandates and what should happen in areas without any state or locally set rates. Those supporting the application of state and local rates to both state-regulated and self-insured plans expressed a belief that state and local governments can best determine appropriate payment amounts for their geography. Supporters emphasized the oversight and public health responsibilities that these governments have with regard to emergency medical services and their understanding of the cost challenges that may be unique to providing such services in their area. Supporters believe these jurisdictions have significant incentives to keep rates reasonable since their citizens and public assistance programs must also abide by these rates. Those opposed to applying state and locally set rates to self-insured group health plans cited precedent under ERISA and a belief that disregarding that precedent and applying state and local payment mandates to self-insured plans could lead to higher costs for those employers. In areas without relevant state or local laws regulating payment rates for ground ambulance services, there was general consensus to mandate payment based on a Congressionally determined percentage increase in (multiple above) Medicare rates (for Medicare-covered services) or some other Congressionally determined amount for services not covered by Medicare. The Committee did not recommend a specific percentage increase in or multiple of Medicare rates but noted that several States were adopting such a standard.

<u>Dispute Resolution</u>

Due to the high fixed costs of equipping, staffing and maintaining readiness of ground ambulance services combined with substantial differences among communities in the number of medical transports over which to recover those costs, there is a large variance in regulated and/or billed rates. Some Committee members raised concerns that any fixed rate or benchmark established by Congress might not support financial viability for providers and suppliers serving

outlier communities with higher costs per service, such as those with broader geographic areas and lower population density, as well as those already reliant on volunteers. Some presenters and Committee members expressed concern that arbitration fees may exceed the cost of the ambulance charges in dispute and that smaller providers would not have the resources needed to engage in a formal dispute process. They were also concerned that the administrative cost of an arbitration system would add to the overall cost of ground ambulance services, health coverage, and HHS programs.

The NSA established an independent dispute resolution (IDR) process to support access to reasonable reimbursement in atypical cases when qualifying payment amounts derived from health coverage claims data are deemed insufficient by out-of-network providers and facilities. The current IDR process has been legally and operationally challenged.[37] Some Committee members expressed the belief that the IDR process has been overused, and that the process increases costs for providers, payors, and consumers. They expressed the expectation that an IDR process for ground ambulance emergency medical services might generate similarly high overutilization of the dispute resolution process in certain market areas—particularly to the extent that ground ambulance organizations are associated with the same entities as the most frequent users of the No Surprises Act IDR process.[38]

Subcommittee Recommendations on Minimum Required Payment for Emergency Ground Ambulance Services presented to the Committee

(Recommendation 11): Establish minimum guardrails for State and Local Regulated Rates for ground ambulance emergency medical services and non-emergency ground ambulance medical services to ensure reasonable regulated rates under Recommendations 12B and 14.

- Option A— A state or local regulated rate for ground ambulance emergency and non-emergency ambulance medical services that are established outside of a state balance or surprise billing statute will meet the guardrail requirement under Recommendation 12B or Recommendation 14, if it:
    I. Meets one or more of the following requirements:
        i. Takes into account emergency ground ambulance services provider or supplier's Operational Model and Cost
        ii. Takes into account emergency ground ambulance services provider or supplier's Payer Mix Revenue
        iii. Is adopted through a public process (e.g., city council meeting, public notice)
        iv. Includes a public process for the annual evaluation of ground ambulance emergency medical services rate if the process includes procedures that take into account public input, such as rulemaking. (E.g., tie an annual update to a cost evaluation by a specific local entity.)
        v. The establishment of a reimbursement rate for rulemaking through a state

[37] GAO. (2023). PRIVATE HEALTH INSURANCE: Roll Out of Independent Dispute Resolution Process for Out-of-Network Claims Has Been Challenging (GAO-24-106335, Report to Congressional Committees). United States Government Accounting Office. https://www.gao.gov/assets/d24106335.pdf.

[38] GAO. (2023).

legislative/regulatory process or via local community public process.
vi. Is adopted following a public hearing where rates are evaluated and discussed.
vii. Is linked to another rate that is determined with public input at the State or local level, AND

II. There is full transparency with the rate subject to public disclosure and reported to a state governing entity for accessible public viewing.
III. The tri-departments should maintain a publicly available database of state- and locally set rates that are binding for any minimum required payment, broken out by service and locality. States and localities should report the information required for such a database to the federal government.

- Option B— A state or local regulated rate for ground ambulance emergency and non-emergency ambulance medical services that are established outside of a state balance or surprise billing statute will meet the guardrail requirement under Recommendation 12B or Recommendation 14, if:
  I. Locally set rates cannot be higher than the Payment Reimbursement Options referenced in Recommendation 12A, AND
  II. There is full transparency with the rate subject to public disclosure and reported to a state governing entity for accessible public viewing.
  III. The tri-departments should maintain a publicly available database of state- and locally set rates that are binding for any minimum required payment, broken out by service and locality. States and localities should report the information required for such a database to the federal government.

(Recommendation 12): Prohibit balance billing and guarantee reasonable payment for ground ambulance emergency medical services.

- Option A: Ground Ambulance Out-of-Network Rate is a National Set Rate by the Congress and Secretaries. The group health plan or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for ground ambulance emergency medical services provided to a participant, beneficiary, or enrollee.
  A. Payment Reimbursement Options
     1. For fully insured plans and other plans regulated by state law, the rate is the amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
     2. If there is no state balance billing law or the group or individual health insurance coverage is not regulated by state law, then the amount is
        a. If Medicare covers the service, a Congressionally set percentage of Medicare
        b. If Medicare does not cover the service, either
           i. A fixed amount set by the Congress or
           ii. A percentage of a benchmark determined by the Congress.
  B. Timing of Payment
     1. Within 30 days of receipt of a bill as currently defined in the NSA

2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
4. If it is determined that a plan or issuer has failed to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

C. Maximum patient cost-sharing as indicated in Recommendation 8

- Option B: Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries. The group health plan, or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for ground ambulance emergency medical services provided to a participant, beneficiary, or enrollee.
    A. Minimum Required Payment
        1. The amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
        2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
        3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the emergency ground ambulance services provider or supplier
        4. If none of the above exist, then the amount is:
            a. If Medicare covers the service, a Congressionally set percentage of Medicare
            b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.
    B. Timing of Payment
        1. Within 30 days of receipt of a bill as currently defined in the NSA
        2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
        3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
        4. If it is determined that a plan or issuer has failed to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.
    C. Maximum patient cost-sharing as indicated in Recommendation 8

D. Minimum Guardrails for State and Local Regulated Rates for ground ambulance emergency medical services as indicated in Recommendation 11.

Subcommittee Recommendations for Minimum Required Payment for Non-Emergency Ground Ambulance Services presented to the Committee

(Recommendation 14): Prohibit balance billing and guarantee reasonable payment for covered non-emergency ground ambulance medical services.

- Option A: Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries. The group health plan, or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.
    A. Minimum Required Payment
        1. The amount specified in a State balance billing law (or, in a state with an All-Payor Model agreement, the amount defined in that Agreement)
        2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
        3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the emergency ground ambulance services provider or supplier
        4. If none of the above exist, then the amount is:
            a. If Medicare covers the service, a Congressionally set percentage of Medicare
            b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.

    B. Timing of Payment
        1. Within 30 days of receipt of a bill as currently defined in the NSA
        2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
        3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
        4. If it is determined that a plan or issuer has failed to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

    C. Maximum patient cost-sharing as indicated in Recommendation 13

D. Minimum Guardrails for State and Local Regulated Rates for ground ambulance emergency medical services as indicated in Recommendation 11.

- Option B: Same as Option A, but with an additional provision (E):

E. Notice and Consent for Certain Non-Emergency Ground Ambulance Medical Services. The non-emergency ground ambulance services provider or supplier may not bill or hold liable the patient for more than the cost-sharing amounts consistent in Recommendation 13 unless it has provided notice with the information required by the current NSA within 72 hours prior to the date of the service and the patient has signed a written consent consistent with the information requirements in the current NSA.

- Option C: Ground Ambulance Out-of-Network Rate is a National Set Rate by the Congress and Secretaries. The group health plan or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for ground ambulance non-emergency medical services provided to a participant, beneficiary, or enrollee.

A. Payment Reimbursement Options
   1. For fully insured plans and other plans regulated by state law, the rate is the amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
   2. If there is no state balance billing law or the group or individual health insurance coverage is not regulated by state law, then the amount is
      a. If Medicare covers the service, a Congressionally set percentage of Medicare
      b. If Medicare does not cover the service, either
         i. A fixed amount set by the Congress or
         ii. A percentage of a benchmark determined by the Congress.

B. Timing of Payment
   1. Within 30 days of receipt of a bill as currently defined in the NSA
   2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
   3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
   4. If it is determined that a plan or issuer has failed to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

C. Maximum patient cost-sharing as indicated in Recommendation 13

Subcommittee Recommendations on Ground Ambulance Payment Dispute Resolution presented to the Committee

(Recommendation 15):

I. Emergency and non-emergency ground ambulance providers or suppliers and group health plans or health insurance issuers may access the Independent Dispute Resolution (IDR) process only when the Out-of-Network Rate (see Recommendations 12 and 14) is:
   1. a set percentage of Medicare if Medicare covers the service or
   2. if Medicare does not cover the service, either
      a. a fixed amount set by the Congress or
      b. a percentage of a benchmark determined by the Congress and the process will be modified to be tailored to ground ambulance emergency medical services and non-emergency ground ambulance medical services.

II. The Committee recommends that the IDR process set forth in the NSA be adopted for ground ambulance emergency medical services and non-emergency ground ambulance medical services, with the following modifications:

   A. Both parties would have the ability to request an IDR process, but only when the Out-of-Network Rate (see Recommendations 12 and 14) is a set percentage of Medicare if Medicare covers the service or if Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.
   B. The IDR entity should be required to consider the following ground ambulance emergency medical services and non-emergency ground ambulance medical services specific factors when determining the payment amount:
      1. The ground ambulance specific Out-of-Network Rate;
      2. The level of services being provided;
      3. The acuity of the individual receiving the services or the complexity of furnishing the services to the individual;
      4. The ambulance vehicle type, including the clinical capability of the level of the vehicle;
      5. Population density of the location where the patient was met;
      6. The time on task, including but not limited to wait-times and hospital wait-times;
      7. Distance from the destination, including but not limited to lack of access to providers within a reasonable distance (such as being in a medically underserved area); and
      8. State/local protocols and requirements
   C. The prohibition on the IDR entity considering other rates would be amended to remove Medicare rates from the list of prohibited factors.
   D. The mileage and base rate elements of a single claim should be required to be batched (addressed) together. The process should also allow f or batching of multiple claims that involve the same ground ambulance provider or supplier,

insurer, level of service, and geographic area.

E. The cost of the IDR process should recognize the unique nature of ground ambulance service claims and their substantially smaller size when compared to claims of other providers. For the administration fee to be limited $50 updated annually (e.g., such as by the CPI-U). For the IDR entity charge, the amount could be to be a percentage of the value of the claim(s) in dispute.
F. The other IDR-related provisions of the NSA would apply without modification. The Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.
G. The other IDR-related provisions of the NSA would apply without modification.

Advisory Committee Discussion and Recommendations

The Committee deliberated on key findings and draft recommendations related to health insurance payment for ground ambulance services, and then held the following votes. A record of voting by Committee member is presented in Appendix E.

During discussion of Recommendation (11) on establishing guardrails for locally set rates in order to serve as required minimum payment rates:

- A motion was made and seconded to include an element in both options of the recommendation that Congress appropriate the funds for implementation of the public reporting aspects. There was no opposition and the Committee adopted this recommended element for inclusion in the final recommendation in the final report.
- The Committee vote on Option 11A was 10 in favor, 3 opposed, 3 abstaining (HHS, Treasury, DOT), and 1 not present (DOL).
- For the record, the members voting "no" explained why they did so, including because of the lack of any upper limit on the amount of state or locally established rates, the application of state or locally mandated rates to ERISA group health plans, and concerns for the impact on premiums of extreme variations in rates. The majority having voted in the affirmative, Option 11A was adopted.
- The Committee vote on Option 11B was 3 in favor, 10 opposed, 3 abstaining (HHS, Treasury, DOT), and 1 not present (DOL).
- For the record, some of the members voting "no" explained why they did so, including because a default federal rate would become the *de facto* rate, which would undercut the ability of some citizens through representative government to implement appropriate community EMS response standards and provide necessary medical care. The majority having voted in opposition, Option 11B was not adopted.
- Following the completion of all voting and the failure of Recommendation 14 on non-emergency ground ambulance service protections, reference to that recommendation in Recommendation 11 was removed in the final report.

Therefore, the final recommendation was adopted as follows:

Committee Recommendation 11

The Committee recommends that Congress establish minimum guardrails for State and Local regulated rates for ground ambulance emergency medical service services and non-emergency ground ambulance medical services in the absence of negotiated network contractual agreements in order for such rates to be the basis for reasonable regulated rates under Recommendation 12B. Specifically, a **state or local regulated rate for ground ambulance emergency medical services that is established outside of a state balance or surprise billing statute will meet the guardrail requirement and apply under Recommendation 12 if it meets one or more of the following requirements:**

- **Takes into account emergency ground ambulance services provider or supplier's Operational Model and Cost**
- **Takes into account emergency ground ambulance services provider or supplier's Payer Mix Revenue**
- **Is adopted through a public process (e.g., city council meeting, public notice)**
- **Includes a public process for the annual evaluation of ground ambulance emergency medical services rate if the process includes procedures that take into account public input, such as rulemaking. (E.g., tie an annual update to a cost evaluation by a specific local entity.)**
- **The establishment of a reimbursement rate for rulemaking through a state legislative/regulatory process or via local community public process.**
- **Is adopted following a public hearing where rates are evaluated and discussed.**
- **Is linked to another rate that is determined with public input at the State or local level**

In addition, the Committee recommends Congress require and appropriate necessary funds for implementation of the following transparency requirements:

- **Full transparency of the State and Local Rates with mandatory reporting by State and local rate-setting authorities, initially and at any time rates are changed, to and public posting by a state governing entity, and**
- **A publicly available federal database of state- and locally set rates that are binding for any minimum required payment, broken out by service and locality, to be maintained by the tri-departments and regularly updated when necessitated by changes in regulated rates by the state governing entities.**

Following discussion of Recommendation 12 on prohibiting balance billing with the guarantee of reasonable payment for ground ambulance emergency medical services:

- The Committee vote on Option 12A was 3 in favor, 10 opposed, 3 abstaining (HHS, Treasury, DOT), and 1 not present (DOL).
- For the record, some of the members voting "no" explained why they did so, including because of the tie-in to coverage and payment for non-Medicare covered services and the belief that this option does not preserve local authority and autonomy to fund services needed in the communities with different costs. The majority having voted in opposition, Option 12A was not adopted.
- The Committee vote on Option 12B was 9 in favor, 4 opposed, 3 abstaining (HHS,

Treasury, DOT), and 1 not present (DOL).

- For the record, some of the members voting "no" explained why they did so, including because of the tie-in to coverage and payment for non-Medicare covered services, the belief that it would subject self-funded (non-state-regulated) ERISA plans to being governed by a state or local process, greater complexity, and the potential blunting of incentives for cost control at the local level and the potential for higher health care costs and premiums. The majority having voted in the affirmative, Option 12B was adopted.

Therefore, the final recommendation was adopted as follows:

Committee Recommendation 12

The Committee recommends that Congress prohibit balance billing and guarantee reasonable payment for ground ambulance emergency medical services. The reasonable payment is a Ground Ambulance Out-of-Network Rate that is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries. Specifically, the group health plan, or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for ground ambulance emergency medical services provided to a participant, beneficiary, or enrollee.

A. Minimum Required Payment
   1. **The amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)**
   2. **If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails**
   3. **If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the ground ambulance emergency services provider or supplier**
   4. **If none of the above exist, then the amount is:**
      a. **If Medicare covers the service, a Congressionally set percentage of Medicare**
      b. **If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.**

B. Timing of Payment
   1. **Within 30 days of receipt of a bill as currently defined in the NSA**
   2. **Patient share can be billed after group health plan or health insurance issuer pays or denies the claim**
   3. **Group health plan or health insurance issuer makes prompt payment directly to the ground ambulance emergency services provider or supplier**
   4. **If it is determined that a plan or issuer has failed to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum**

simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

C. Maximum patient cost-sharing as indicated in Recommendation 8

D. Minimum Guardrails for State and Local Regulated Rates for ground ambulance emergency medical services as indicated in Recommendation 11.

Following discussion of Recommendation (14) on prohibiting balance billing with a guarantee of reasonable minimum payment for covered non-emergency ground ambulance services:

- The Committee vote on Option 14A was 1 in favor, 12 opposed, 2 abstaining (HHS, Treasury), and 2 not present (DOL, DOT).
- For the record, members voting "no" explained why they did so, including because of concerns about requiring self-funded ERISA plans to pay state and local regulated rates, concerns that implications of coverage determination processes and other aspects of non-emergency service had not been fully fleshed out, and preference for another option.
- The Committee vote on Option 14B was none in favor, 13 opposed, 2 abstaining (HHS, Treasury), and 2 not present (DOL, DOT).
- For the record, members voting "no" explained why they did so, including because of concerns that in many cases, patients do not have any other options, so there could not be legitimate consent, and concerns that all implications for non-emergency services had not been thoroughly fleshed out.
- The Committee vote on Option 14C was 3 in favor, 10 opposed, 2 abstaining (HHS, Treasury), and 2 not present (DOL, DOT). For the record, members voting "no" explained why they did so, including because of concerns about overriding state and local government rate-setting processes, and concerns that all implications for non-emergency services had not been fleshed out.

Despite expressing a strong consensus around wanting to prohibit balance billing and taking the patient out of the middle of payment disputes for non-emergency scheduled ground ambulance medical services, the Committee did not reach consensus on how to move forward, and no recommendation was adopted. As the result of this outcome, related Recommendation 13 on maximum cost-sharing limits for covered non-emergency ground ambulance services was nullified.

Following discussion of Recommendation (15) on availability of the NSA independent dispute resolution process for ground ambulance services:

- The Committee vote was 6 in favor, 7 opposed, 2 abstaining (HHS, Treasury), and 3 not present (DOL, DOT).
- For the record, members voting "no" explained why they did so, including the expectation that the recommended approach of a federally required minimum payment should eliminate the need for any subsequent independent dispute resolution backstop, concerns about adding administrative costs and burden into the system (especially for small providers), and concerns that an IDR-process approach might be chosen in lieu of a minimum-required-payment approach based on regulated rates that community providers need.

A majority of Committee members being opposed, the recommendation was not adopted.

Summary

Voting members of the Committee were unanimous on the need to prohibit balance billing coupled with a guarantee of reasonable payment for out-of-network ground ambulance emergency medical services. They believe that only by connecting requirements for coverage, cost-sharing limits, and reasonable direct payment to ground ambulance providers and suppliers can consumer protections, including continued access to timely emergency response be achieved. The most significant matters on which Committee members did not reach consensus were on whether to mandate a minimum payment, how best to set the upper limit of a reasonable minimum payment for out-of-network services, and how those payment requirements would apply to self-funded group health plans.

A majority of the Committee supported establishing a minimum required out-of-network payment amount determined by a hierarchy starting with the amount specified in State balance billing law, if one exists, and, if not, to locally set regulated rates. The recommendation did not include any limit on such state or locally set rates. However, in order for such state or locally set rates to qualify as the minimum required out-of-network amount, the rate-setting process would have to meet certain guardrails specified by Congress. The Committee recommended a number of such guardrails, including rate-setting through a public process and public reporting of rates in one central place that the public and regulators can easily find. If neither state nor local rates applies, and no amount is agreed to between the payor and the out-of-network provider/supplier (single-case rate), then the minimum required payment would default to a Congressionally determined multiple of Medicare rates, or other amount for non-Medicare-covered services. The Committee did not recommend a specific multiple or percentage increase over Medicare rates, but noted that several States were adopting such a standard.

A majority supported this out-of-network payment methodology for all group health plans and health insurance issuers, whether regulated under State law or ERISA. They supported this approach because it respects state authority and rate regulation processes which are entwined with local EMS response requirements. They believed this approach best reimburses the costs of ground ambulance providers/suppliers, especially those serving rural and other atypical communities, for which payments based on average rates may not be adequate to maintain viable local service levels needed by the residents of those communities. These community needs do not differ by whether residents' health coverage is provided by self-funded group health plans or health insurance issuers.

A minority of the Committee supported a minimum required out-of-network payment amount that would be established differently depending on whether a covered individual's health coverage is provided by a state-regulated health insurance issuer plan or a self-funded group health plan regulated under ERISA. For state-regulated plans, the minority supported a hierarchy of methods starting with the amount specified in State balance billing law. If no such law exists, then the determination would default to a Congressionally determined multiple of Medicare rates, or other amount for non-Medicare-covered services. For self-funded group health plans, the minimum required out-of-network payment amount would always be the Congressionally

determined multiple of Medicare rates, or other amount for non-Medicare-covered services. They supported this approach because they believe it is less likely to blunt incentives for cost control at the local level and, thus, would better constrain growth in health care costs and premiums. A minority also held that this approach was more consistent with the longstanding ERISA preemption of state requirements for self-funded employer group plans.

A minority of the Committee also supported access to a form of independent dispute resolution process, especially in cases in which small providers or suppliers serving more remote communities do not have access to adequate reasonable minimum payments. They reasoned this might occur under either of the minimum required out-of-network payment approaches, due to the absence of qualifying locally set rates and/or the insufficiency of Congressionally set amounts. However, a majority of the Committee did not support recommending access to an independent dispute resolution process, in part due to the expectation of excessive administrative cost and burden.

Relation to Current NSA Plan and Issuer Payment Requirements

For bills for claims submitted to health insurance coverage or governmental plans regulated by a state (state plan, coverage or policy), the NSA currently defers to State balance billing laws, where they exist, in the state plan, coverage or policy's computation of the *recognized amount*, the *out-of-network rate,* and the *total amount payable*.

Under ERISA, self-funded group health plans are not subject to state insurance laws. In general, those laws are preempted by ERISA. However, self-insured plans may elect to opt into state balance billing laws if the state permits this. Accordingly, under the No Surprises Act, unless an ERISA-regulated self-funded plan has opted into a State's balance billing laws, the *recognized amount* for that plan is the lesser of the billed charge or the *qualifying payment amount*, which generally is the median of the plan's contracted rates for the billed item or service in that geographic region.

It may make sense to use plan contracted rates (or rates generated by certain identified claims databases based on in-network rates where a plan does not have sufficient information to calculate a median contracted rate) for determining reasonable payments in the context of the provider-billed items and services subject to current NSA balance billing protections. These rates are for items and services subject to the NSA, which include physician and ancillary services provided directly in connection with visits to hospitals, critical access hospitals, hospital outpatient departments, ambulatory surgery centers, and hospital or freestanding emergency departments. Group health plans and health insurance issuers have historically provided extensive coverage of and negotiated in-network contracts for these items and services. The AMA and Medicare have developed extensive detail on the costs of these services, developed coding (e.g., CPT and HCPCS), and collected associated geographic and resource use cost data to develop Medicare rates—which are then frequently utilized as the basis for many commercial

insurance payment methodologies.[39] In addition, commercial claims aggregators can provide access to very large datasets (*eligible databases*) comprised of such claims. So it is arguably reasonable to use this data to estimate reasonable payments for non-contracted providers.

The same conditions do not exist with regard to commercial payor rates for ground ambulance emergency (or non-emergency) medical services. These services occur in the many different settings in which emergency medical conditions arise and must be delivered in response to a 911 dispatch by law. Although data collection on updated ambulance costs is now underway through the CMS Ground Ambulance Data Collection System, there is currently no systematic source of costs of providing these services. NEMSIS, which collects a lot of information on EMS calls and responses, was not designed to collect either cost or billing data. In addition, the Committee heard from some members that both the underlying costs of ground ambulance emergency medical services and the allowable rates paid by commercial payors to ground ambulance provider and suppliers are highly variable. Operating costs are driven by state and local authorities in public governmental processes that determine local EMS system requirements. Some of these state and local processes also establish reimbursement rates. Substantial variation in rates exists due to distinctions between communities in EMS-service-level standards that vary based upon the availability and access to primary care, the number of ambulances available in a region, and geographic distance and population density differences. The fewer the billable 911 service calls in a locality, the greater the per service rates must be to cover fixed, as well as variable costs, leading to large variations even among adjacent localities.

With the exception of Medicare and Medicaid, any individual health care payor may have fewer contracted rates with a particular ground ambulance provider or supplier. Most ground ambulance claims are for out-of-network services. Therefore, group health plans and health insurance issuers may not have robust datasets of negotiated rates for ground ambulance services. Furthermore, out-of-network claim reimbursements are reportedly highly variable and rarely based on mutually negotiated payment rates. Consequently, claims payment data available to plans or in eligible databases are not representative of mutually negotiated rates or rates developed based upon resource use and geographic variations in costs. As a result, the methodology for determining and reimbursing reasonable payments for ground ambulance services to prevent balance billing would be better ascertained through other sources. A majority of the Committee favored sourcing rates for out-of-network payments to ground ambulance emergency medical services providers/suppliers from state or local authorities that establish the service-level requirements and concomitant reimbursement rates for EMS response in their respective communities. Every U.S. State and Territory has an EMS system, although there is a lot of variation and not all localities have established billing rates.

Historically, self-funded ERISA group health plans are not subject to state insurance law because of ERISA's preemption clause. Potentially differing state-mandated benefit laws are preempted in favor of allowing employers to create unified employee benefit packages for employees and retirees in many jurisdictions. However, this same sort of reasoning applies less well to EMS

[39] Anderson, C., Mills, C, Zhou D., & McBeth, A. (2023) *Commercial reimbursement benchmarking: Commercial payment rates for medical services as percentage of Medicare fee-for-service rates* [White Paper]. Milliman. https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-payment-rates-medicare-fee-for-service .

services. There are tens of thousands of EMS billing rates set by state and local government entities to support local EMS requirements needed to serve their residents. A majority of the Committee supported the federal government requiring self-funded group health plans to pay out-of-network ground ambulance emergency medical services providers/suppliers based on locally set rates instead of maintaining the longstanding ERISA preemption. While self-funded employer group health plans are not subject to state insurance laws, Congress could establish a federal requirement that if such plans cover emergency services, they must reimburse ground ambulance providers/suppliers for ground ambulance emergency medical services at state- and locally set rates.

Chapter 6 – Implications of Recommendations for States

The GAPB Committee's Recommendation 12 ties out-of-network payments for ground ambulance emergency medical services to state- or locally set regulated rates, where these exist. However, in order for such state or locally set rates to qualify as the minimum required out-of-network payment, the rate-setting process would have to (1) meet certain guardrails specified by Congress, and (2) the rates would have to be publicly posted and updated by a state governing entity, as described in Recommendation 11.

[Recommendation 11] The Committee recommends that Congress establish minimum guardrails for State and Local regulated rates for ground ambulance emergency medical service services and non-emergency ground ambulance medical services in the absence of negotiated network contractual agreements in order for such rates to be the basis for reasonable regulated rates under Recommendation 12B. Specifically, a state or local regulated rate for ground ambulance emergency medical services that is established outside of a state balance or surprise billing statute will meet the guardrail requirement and apply under Recommendation 12 if it meets one or more of the following requirements:

- Takes into account emergency ground ambulance services provider or supplier's Operational Model and Cost
- Takes into account emergency ground ambulance services provider or supplier's Payer Mix Revenue
- Is adopted through a public process (e.g., city council meeting, public notice)
- Includes a public process for the annual evaluation of ground ambulance emergency medical services rate if the process includes procedures that take into account public input, such as rulemaking. (E.g., tie an annual update to a cost evaluation by a specific local entity.)
- The establishment of a reimbursement rate for rulemaking through a state legislative/regulatory process or via local community public process.
- Is adopted following a public hearing where rates are evaluated and discussed.
- Is linked to another rate that is determined with public input at the State or local level

In addition, the Committee recommends Congress require and appropriate necessary funds for implementation of the following transparency requirements:

- Full transparency of the State and Local Rates with mandatory reporting by State and local rate-setting authorities, initially and at any time rates are changed, to and public posting by a state governing entity, and
- A publicly available federal database of state and locally set rates that are binding for any minimum required payment, broken out by service and locality, to be maintained by the tri-departments and regularly updated when necessitated by changes in regulated rates by the state governing entities.

Chapter 7 – Recommendations for Congressional Action[40]

The list of adopted recommendations for Congressional action to prevent out-of-network ground ambulance provider/supplier balance billing to consumers for ground ambulance emergency medical services is presented here. (Bracketed numbers reflect the Committee Recommendation number.)

[1] The Committee recommends that while the framework of the No Surprises Act should be a base for specific ground ambulance legislation, Congress should not add ground ambulance emergency medical services into the current No Surprises Act without substantial modifications, as outlined in the subsequent Recommendations.

The Committee recommends that the following provisions could be maintained without significant change around consumer protections: directory information, price comparison tool, continuity of care, and state/federal enforcement authority within the current provisions of the No Surprises Act.

[2] The Committee recommends Congress or the Secretaries adopt the following definitions to align with the recommendations and findings found in the final report.

> *Community paramedicine* (or mobile integrated health care) means the practice of providing person-centered care in a diverse range of settings that address the needs of a community. This practice may include the provision of primary health care, emergency or acute care, health promotion, disease management, clinical assessment, and needs based interventions. Professionals who practice community paramedicine are often integrated with interdisciplinary health care teams that aim to improve patient outcomes through education, advocacy, and health system navigation.
>
> *Cost* means those costs defined in the Medicare Ground Ambulance Data Collection System's (GADCS) Medicare Ground Ambulance Data Collection Instrument, including labor costs; facilities costs; vehicle costs; equipment, consumable, and supply costs; other costs directly related to supporting an organization's ground ambulance services that are not covered by other categories. In addition, the term also includes medical oversight costs.
>
> *Emergency interfacility transport* means the transport by a ground ambulance emergency medical service provider or supplier of a patient with an emergency medical condition from one healthcare facility to another location or facility to receive services not available at the originating facility, as ordered by a licensed treating healthcare provider.
>
> *Ground ambulance emergency medical service (Prudent Person Standard)* means ground ambulance medical or transport services furnished to an individual for whom an immediate response was required to assess and/or treat a medical or behavioral condition

[40] Per *Loper Bright Enterprises v. Raimondo (603 U. S. ____ (2024))*, Congress should consider expressly granting discretionary interpretive authority to the responsible administrative agency(ies).

that the individual reasonably believed (or a prudent layperson would reasonably have believed) that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance services. Such services include the ground transportation of the patient to a hospital or other medically appropriate destination as defined by federal, state, or local law. The determination as to whether an individual believed or would reasonably believe the absence of immediate medical attention would result in serious jeopardy or harm shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.

Ground ambulance provider or supplier means an entity that is authorized and licensed by the appropriate governmental entity to respond to a request for ground ambulance medical services.

Prompt payment means, with respect to the payment required under Recommendation 12, that either the payment or the notice of payment denial is issued within 30 days of receiving a bill triggering the duty to make a minimum required payment or to issue a notice of denial of payment.

Bill triggering the duty to make a minimum required payment or issue a notice of denial of payment means a claim that includes the following elements: Coverage provider; insured's I.D. number; patient's name; patient's birth date; insured's name; patient's address; insured's policy group or FECA number; date of current illness, injury, or pregnancy; name of referring provider or other source; ICD indicator; date(s) of service; place of service; procedures, services, or supplies, including CPT/HCPCS code(s) and modifier(s); diagnosis pointer; charges; days or units; federal tax I.D. number; acceptance of assignment (Y/N); total charge; signature of physician or supplier; service facility location information, including NPI; billing provider information, including NPI.

[3] The Committee recommends Congress require coverage of ground ambulance emergency medical services. Specifically, if a group health plan or health insurance issuer offering group or individual health insurance coverage provides or covers any benefits with respect to emergency services, then the plan or issuer must cover ground ambulance emergency medical services (including emergency interfacility transports and such services when an ambulance has responded, but no transport has occurred). In addition, the plan or issuer must cover such services:

a. Without the need for any prior authorization determination;
b. Whether the ground ambulance provider or supplier furnishing such services is a participating provider or supplier with respect to such services;
c. Without imposing any requirements or limitations on coverage that are more restrictive than the requirements or limitations that apply to such services if they were received from a participating emergency ground ambulance services provider or supplier; and
d. Without regard to any other term or condition of such coverage

[4] The Committee recommends Congress establish a statutory federal advisory committee to advise the Secretaries of Health and Human Services, the Department of Labor, and the

Department of the Treasury on ground ambulance reimbursement policy to evaluate how expanding coverage and reimbursement of ground ambulance services beyond transports to hospitals, skilled nursing facilities, and critical access hospitals could improve patient outcomes, reduce overall health care costs, and support the continuum of care.

Among the scope of topics to be addressed the Committee recommends that such an advisory committee consider are community paramedicine/mobile integrated healthcare, Advanced Life Support first response, treatment in place, and alternative destination. The advisory committee could also provide guidance on how to address the rising costs of ancillary supplies, oxygen, high-cost drugs, and medical equipment in the context of pre-hospital emergency services.

[5] The Committee recommends Congress incorporate Ground Ambulance Emergency Medical Services under the definition of emergency services under the Essential Health Benefit (EHB) requirements.

[6] The Committee recommends Congress place a limitation on billing patients for ground ambulance emergency and non-emergency medical services before seeking insurance information. Specifically, a ground ambulance organization may not bill a patient until the claim for the services has been submitted to the patient's insurance company and a determination of payment has been made, unless the ground ambulance emergency or non-emergency provider or supplier first made a reasonable attempt to obtain the patient's insurance information, but was unable to do so within 3 to 7 days.

[7] The Committee recommends Congress direct patients with concerns, disputes, and questions about ground ambulance emergency and non-emergency medical services billing to the No Surprises Help Desk. The No Surprises Help Desk triages patient calls and connects them with the right resources (back to their insurers, providers, or to local regulators or federal regulators at CMS or DOL).

[8] The Committee recommends Congress establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for ground ambulance emergency medical services. Specifically, the patient cost-sharing requirement shall be the lesser of $100 (adjusted by the CPI-U annually) or 10% of the rate established under Recommendation 12, regardless of whether the health plan includes a deductible. In addition, any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to ground ambulance emergency medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner as if the services were provided by an in-network provider or supplier.

[9] The Committee recommends Congress require the Secretary of HHS to amend the relevant conditions of participation to require health care organizations to share patient insurance information with an emergency ground ambulance services provider or supplier that treated a mutual patient, upon request by the emergency ground ambulance services provider or supplier.

[10] The Committee recommends Congress require ground ambulance emergency medical services providers and suppliers provide a bill to consumers with minimum elements for a

standardized bill.

I. All bills must include the following elements:
   a. Clarify whether or not the bill reflects a final determination by the patient's insurance
   b. Provide information about how a patient can dispute the charges and the coverage determination
   c. Provide information that they should not receive a balance bill and if they do, how they can report that illegal bill to be sure it does not appear as an amount owed or be sent to collections

II. Communications from ground ambulance emergency medical services to the patient before obtaining the patient's insurance information or completing a reasonable attempt to obtain said information must make clear that it is not a bill. Required language could be: "THIS IS NOT A BILL. We are attempting to determine your insurance information

[11] The Committee recommends that Congress establish minimum guardrails for State and Local regulated rates for ground ambulance emergency medical service services and non-emergency ground ambulance medical services in the absence of negotiated network contractual agreements in order for such rates to be the basis for reasonable regulated rates under Recommendation 12B. Specifically, a state or local regulated rate for ground ambulance emergency medical services that is established outside of a state balance or surprise billing statute will meet the guardrail requirement and apply under Recommendation 12 if it meets one or more of the following requirements:

- Takes into account emergency ground ambulance services provider or supplier's Operational Model and Cost
- Takes into account emergency ground ambulance services provider or supplier's Payer Mix Revenue
- Is adopted through a public process (e.g., city council meeting, public notice)
- Includes a public process for the annual evaluation of ground ambulance emergency medical services rate if the process includes procedures that take into account public input, such as rulemaking. (E.g., tie an annual update to a cost evaluation by a specific local entity.)
- The establishment of a reimbursement rate for rulemaking through a state legislative/regulatory process or via local community public process.
- Is adopted following a public hearing where rates are evaluated and discussed.
- Is linked to another rate that is determined with public input at the State or local level

In addition, the Committee recommends Congress require and appropriate necessary funds for implementation of the following transparency requirements:

- Full transparency of the State and Local Rates with mandatory reporting by State and local rate-setting authorities, initially and at any time rates are changed, to and public posting by a state governing entity, and
- A publicly available federal database of state and locally set rates that are binding for any minimum required payment, broken out by service and locality, to be maintained by the tri-departments and regularly updated when necessitated by changes in regulated rates by

the state governing entities.

[12] The Committee recommends that Congress prohibit balance billing and guarantee reasonable payment for ground ambulance emergency medical services. The reasonable payment is a Ground Ambulance Out-of-Network Rate that is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries. Specifically, the group health plan, or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for ground ambulance emergency medical services provided to a participant, beneficiary, or enrollee.

A. Minimum Required Payment
    1. The amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
    2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
    3. If there is neither a State balance billing law n or a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the ground ambulance emergency services provider or supplier
    4. If none of the above exist, then the amount is:
        a. If Medicare covers the service, a Congressionally set percentage of Medicare
        b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.

B. Timing of Payment
    1. Within 30 days of receipt of a bill as currently defined in the NSA
    2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
    3. Group health plan or health insurance issuer makes prompt payment directly to the ground ambulance emergency services provider or supplier
    4. If it is determined that a plan or issuer has failed to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

C. Maximum patient cost-sharing as indicated in Recommendation 8

D. Minimum Guardrails for State and Local Regulated Rates for ground ambulance emergency medical services as indicated in Recommendation 11.

Chapter 8 – Other Subcommittee Findings

During the course of the GAPB Advisory Committee's six months of work, members raised several issues of concern to be studied and addressed, but that were considered outside the scope of the GAPB's charter. In order to capture those issues for further consideration, the Committee decided to include an Other Findings section in the report. The Committee unanimously agreed that the following issues should be considered as additional work to pursue. Following this list of findings are some supplemental materials submitted by committee members to help inform some of the findings. It should be noted that these materials were not studied or reviewed by the Committee as a whole and are offered as a starting point for further research and discussion.

1. Congress should work with stakeholders once the data from the Ground Ambulance Data Collection System and Medicare Payment Advisory Commission (MedPAC) reports are available to modernize the Medicare ground ambulance benefit.

2. Congress should establish a standing advisory committee to evaluate expanding coverage and reimbursement of ground ambulance services beyond transports under the Social Security Act to include:
    - Community Paramedicine (or Mobile Integrated Healthcare)
    - Advanced Life Support First Response
    - Treatment in place/no transport
    - Transport to alternative (non-hospital) destinations
    - High-cost drugs and medical equipment
    - Oxygen and other ancillary supplies

3. Congress and the Secretary of Health and Human Services should evaluate and limit the Medicare beneficiary out-of-pocket obligations for ground ambulance emergency and non-emergency services under Medicare Advantage plans.

    The committee received numerous public comments related to this consumer protection that a maximum out-of-pocket (e.g., $50-$100) should be established for ground ambulance emergency and non-emergency medical services.

4. Congress and the Secretary of Health and Human Services should consider evaluating the cost and reimbursement of services under the Social Security Act for those ground ambulance service providers and suppliers in rural, super-rural, and medical-underserved areas.

    Numerous presentations and public comments were received related to this topic. Congress should also consider the MedPAC June 2016 Report to the Congress that suggested incentivizing continued operations in rural and underserved areas by having Medicare pay prospective rates for primary care visits and ambulance services, as well as provide an annual grant or fixed payment to support the capital and standby costs of the ambulance service, as well as uncompensated care costs.

GAPB Findings

Supplemental Resource

Note: These materials were not studied or reviewed by the Committee as a whole and are offered as a starting point for further research and discussion.

Supplemental Resource: Rural Ambulance Services: Challenges and Need for Private Insurer and Medicare Payment Reform

Rural ambulance services are essential for providing prompt emergency medical care in areas with limited access to such facilities. Yet, these vital services frequently struggle with financial issues that threaten their continued operation. We examined the financial struggles faced by rural ambulance services and find need for a remedy by Congress. Congress should establish a cost-plus payment model for private insurers and Medicare, akin to the existing system for Critical Access Hospitals (CAHs), to support the financial sustainability of these crucial services.

Introduction

Rural communities, often characterized by their remote locations and dispersed populations, rely heavily on ambulance services to provide essential emergency medical care. In such areas, these services are not just a convenience but a critical lifeline for residents who may be located far from hospitals and medical facilities. However, these indispensable services frequently grapple with severe underfunding, which hampers their ability to function effectively. The lack of adequate funding results in a host of problems, including outdated equipment, insufficient staffing, and limited training opportunities for emergency medical personnel. This scenario poses a significant risk to the quality of emergency care available to rural residents. Moreover, the financial strain can lead to increased response times in emergencies, potentially impacting patient outcomes. The challenges are compounded by the fact that many rural residents may be uninsured or underinsured, further straining the financial viability of these crucial services.

These findings highlight the acute financial challenges faced by rural ambulance services, underlining a pressing need for a sustainable funding model. One proposed solution to address this funding crisis is the implementation of a cost-plus payment system. This system would ensure that ambulance services are reimbursed for the actual costs incurred in delivering emergency medical services, plus a reasonable profit margin. Currently, payments to ambulance services are often based on fixed rates that do not adequately cover the costs of operation, especially in rural areas where the cost of providing services can be higher due to longer travel distances and lower call volumes. A cost-plus model would provide a more equitable and realistic reimbursement, reflecting the true cost of providing these essential services. This change could significantly improve the financial health of rural ambulance services, ensuring they can maintain their operations, invest in necessary equipment and training, and continue to provide high-quality emergency care.

Implementing a cost-plus payment system requires not just policy change but also a broader recognition of the unique challenges faced by rural ambulance services. By ensuring that rural ambulance services receive adequate funding, the overall healthcare system becomes more resilient and capable of serving all populations, regardless of their geographical location.

Furthermore, securing the financial viability of these services is not just a matter of healthcare policy but also a critical component of ensuring equitable access to healthcare across the country. In conclusion, adopting a cost-plus payment system could be a significant step towards addressing the longstanding financial challenges of rural ambulance services and ensuring that rural communities have reliable access to essential emergency medical care.

Challenges Faced by Rural Ambulance Services

Geographic Disparities

Rural ambulance services face numerous challenges, with geographic disparities being a significant concern. In many rural regions, the sparse population density hinders the establishment and maintenance of an adequate number of ambulance providers. This scarcity of services often results in longer response times during emergencies and a general reduction in the availability of emergency medical coverage. The low population density in these areas means that the demand for ambulance services is sporadic, which makes it financially challenging for these services to operate continuously and efficiently.

Furthermore, in several parts of the country, especially in remote or isolated regions, rural ambulance services are not just a means of emergency transportation; they often represent the only accessible healthcare provider. This puts an immense responsibility on these services, as they are tasked with providing a broad range of healthcare needs, from emergency medical care to basic healthcare services. The responsibility of being the sole healthcare provider in these areas adds to the operational and financial strain on these services. It requires them to be equipped not only for emergency response but also for a variety of healthcare scenarios, which can be challenging given the limited resources available to them.

The situation is compounded by the unique geographical challenges of rural areas. Terrain and distance play critical roles in how effectively ambulance services can operate. In mountainous or rugged terrains, for instance, reaching patients and transporting them to the nearest healthcare facility can be significantly more time-consuming and resource-intensive compared to more urban settings. Additionally, the distance from hospitals or medical centers often means that rural ambulance services have to cover vast areas, further stretching their limited resources. These geographical factors, coupled with the role of being the primary healthcare provider in many rural communities, underline the critical need for specialized support and resources to ensure these essential services can continue to operate effectively.

Financial Strain

Rural ambulance services function within the constraints of very tight budgets, navigating the challenges of limited funding sources. They typically rely on a mix of Medicare reimbursements, payments from private health coverage, and local subsidies to sustain their operations. However, these revenue streams frequently fall short of meeting the actual costs involved in running these essential services. The financial model for rural ambulance services is often precarious, as the reimbursements they receive are not always reflective of the true costs they incur. This discrepancy is particularly acute in rural and super-rural areas where operational expenses, such as equipment maintenance, fuel, and medical supplies, are comparable to those in suburban and urban areas. However, the significantly lower call volume in these sparsely populated regions means the cost per emergency call is much higher, creating a financial imbalance that is difficult

to reconcile under the current reimbursement system.

This situation is further exacerbated by the existing reimbursement framework, which does not adequately account for the unique financial challenges faced by rural ambulance services. Unlike urban areas, where the high volume of calls can help distribute operational costs more evenly, rural services find it challenging to offset the high cost per call due to their lower service demand. This financial strain is evident in the disparity between the costs incurred and the reimbursements received, leading to a substantial funding gap. As a result, many rural ambulance services are unable to afford full-time paid staff, thereby relying heavily on volunteer personnel to provide emergency medical services. While volunteers are invaluable to the community, this reliance often leads to challenges in maintaining consistent staffing levels and ensuring that all personnel have the latest training and qualifications, which are crucial for delivering high-quality emergency care.

The reliance on volunteer personnel, while commendable, is not a sustainable long-term solution for the provision of emergency medical services in rural areas. Volunteers often have other primary occupations and commitments, which can lead to unpredictable availability and potential gaps in service coverage. Moreover, the requirement for continuous training and certification can be a significant demand on volunteers who already donate their time and skills. This model places an enormous burden on the individuals who serve and can lead to burnout and high turnover rates. The situation underscores the urgent need for a revised funding and reimbursement model that recognizes and addresses the unique operational realities of rural ambulance services. Without adequate financial support and a sustainable staffing model, these critical services risk being unable to meet the emergency medical needs of rural communities, potentially leading to adverse outcomes in situations where timely medical response is crucial.

Workforce Shortages

Recruiting and retaining qualified personnel in rural ambulance services presents a significant challenge, one that stems largely from the limited financial resources typical of these areas. Rural ambulance services often struggle to offer competitive salaries, especially when compared to the wages offered in urban areas. This disparity makes it difficult to attract skilled professionals, who may prefer to work in more financially rewarding environments. The result is a chronic understaffing in these critical services, which places an enormous strain on the existing workforce. The few paramedics and emergency medical technicians (EMTs) who do choose to work in these rural settings often find themselves overworked, leading to increased stress and burnout. This not only affects their well-being but also the quality of care they can provide to patients.

The consequences of this staffing shortage are far-reaching and can significantly impact the quality of emergency medical services in rural communities. With fewer personnel available, response times to emergencies can be longer, which is particularly critical in life-threatening situations where every minute counts. Moreover, the overworked staff may have less time for continuous training and skill development, essential aspects of their profession given the rapid advancements in medical technology and procedures. This situation can lead to a decline in the overall standard of care provided to patients. Additionally, the high turnover rate, as staff leaves for better opportunities or due to burnout, exacerbates the problem, leading to a cycle of

continuous recruitment and training of new personnel, which is both time-consuming and costly for these services.

Aging Infrastructure

Rural ambulance services are often hampered by aging infrastructure and outdated equipment, posing significant challenges to their operational effectiveness. The vehicles used for emergency response, crucial for patient transport and care, often suffer from wear and tear due to constant use in often challenging rural terrains. These vehicles, alongside the facilities from which the services operate, require regular maintenance and upgrades to ensure they are reliable and equipped with the latest medical technologies. However, securing the funds necessary for these upgrades is a major hurdle. The cost of not only purchasing new vehicles but also equipping them with essential medical equipment and technology is substantial. Additionally, the facilities that house these services need regular maintenance to ensure they are safe and conducive to the staff's work. This need for continual investment in infrastructure and equipment places a significant financial burden on rural ambulance services, which already operate under tight budgets.

The impact of using aging equipment and facilities extends beyond financial concerns; it directly affects patient care and staff safety. Outdated or malfunctioning equipment can lead to delays in emergency response and treatment, potentially compromising patient outcomes in critical situations. For instance, an ambulance breakdown en route to a hospital can have dire consequences. Moreover, the lack of modern medical equipment in these ambulances can limit the level of care that paramedics and emergency medical technicians can provide to patients during transport. For the staff, working with old or unreliable equipment not only increases the stress and difficulty of their jobs but also poses significant safety risks. Emergency medical responders need to operate in a safe environment with dependable equipment to perform their duties effectively, which is often compromised by outdated infrastructure.

Proposal: Cost-Plus Payment System

To effectively address the financial challenges faced by rural ambulance services and ensure the continued provision of emergency care in rural areas, there should be a significant overhaul of the current payment system. Drawing inspiration from the payment structure for Critical Access Hospitals (CAHs), this proposal involves implementing a cost-plus payment system for Medicare and private insurers specifically tailored to rural ambulance services. This new system would fundamentally change how these services are reimbursed, ensuring they receive fair compensation that reflects their actual operating costs and the unique challenges they face in rural settings.

The cornerstone of our findings is the need for cost-plus rural and super-rural reimbursement. Under this system, rural ambulance services would be compensated based on their actual operating expenses. This approach stands in contrast to the current fixed-rate reimbursement system, which often fails to cover the total costs incurred by these services, especially in low-call-volume rural areas. By shifting to a cost-plus model, rural ambulance services would receive payments that more accurately reflect their operational realities, including expenses for equipment, maintenance, staff training, and other necessary operational costs. This change would provide a more sustainable financial model, ensuring these vital services can continue to operate

effectively in rural communities.

In addition to cost-plus reimbursement, there should be further measures to support rural ambulance services comprehensively. Similar to the support provided to CAHs, we find the need to facilitate additional funding for capital improvements and infrastructure upgrades, recognizing the significant challenges these services face with aging equipment and facilities. This aspect is critical in ensuring that rural ambulance services can maintain and upgrade their infrastructure to provide high-quality patient care and ensure staff safety. Furthermore, the payment system would encompass workforce incentives, offering provisions for competitive wages to attract and retain qualified staff. This is particularly important in rural areas, where staffing challenges are compounded by lower population densities and the high costs of living. Finally, to ensure that the increased funding is accompanied by high-quality care, rural ambulance services would be required to meet specific quality standards to qualify for the cost-plus reimbursement. These standards would ensure that the increased financial support translates into improved patient care and more efficient and effective emergency medical services in rural communities.

Benefits of the Cost-plus Payment System

The implementation of a cost-plus payment system for rural ambulance services would bring about transformative benefits, addressing the core challenges that these essential services currently face. This new payment model would have far-reaching implications for the quality and sustainability of emergency medical care in rural areas.

Firstly, the most immediate and significant benefit would be financial stability for rural ambulance services. Currently, many of these services operate on the brink of financial viability, with some facing the constant threat of closure due to insufficient funds. By ensuring reimbursement aligns with actual operating costs, rural ambulance services would be able to cover their expenses adequately. This stability would reduce the risk of closures and interruptions in services, ensuring that rural communities have consistent access to emergency medical care. The assurance of financial stability would also allow these services to plan and budget more effectively, investing in long-term improvements rather than merely surviving from one crisis to the next.

Secondly, the cost-plus payment model would lead to improved response times and the ability to closeup “ambulance deserts.” With a more secure financial footing, rural ambulance services would have the resources to invest in additional vehicles and staff. This expansion of resources would directly impact their ability to respond more swiftly to emergency calls. Faster response times are critical in emergency medicine, where every minute can be the difference between life and death. The ability to deploy more ambulances and staff more shifts would mean a broader coverage area and quicker on-scene arrival times, which could significantly improve patient outcomes in rural communities.

Thirdly, the payment system would have a positive impact on the workforce of these rural ambulance services. By providing funding that allows for competitive salaries and incentives, it would become easier to attract and retain skilled personnel. This is crucial in rural areas, where it is often challenging to find and keep qualified emergency medical technicians and paramedics. A more stable and well-compensated workforce would lead to higher-quality care for patients, as

experienced professionals are more likely to stay in their roles, reducing turnover and ensuring a consistently high level of expertise and service.

Lastly, the provision for infrastructure upgrades would significantly enhance patient care and staff safety. The additional funding could be used to modernize and maintain facilities and equipment, which is essential for both the effective treatment of patients and the safety of the medical staff. Up-to-date equipment and well-maintained vehicles are crucial for the provision of high-quality emergency medical services. Improved infrastructure would also mean a better working environment for staff, which can contribute to job satisfaction and retention.

Conclusion

In conclusion, rural ambulance services play a crucial role in providing timely and lifesaving care to communities that often face geographic and socioeconomic challenges. However, these services are confronted with a myriad of financial and operational difficulties that threaten their sustainability. This report has outlined the significant challenges faced by rural ambulance services, including workforce shortages, geographic disparities, regulatory burdens, uncompensated care, and limited revenue streams.

Drawing from the success of Critical Access Hospitals (CAHs), Congress should establish a cost-plus payment system that ensures rural ambulance services receive reimbursement based on their actual costs. This approach aligns to improve healthcare access in rural areas and sustain essential emergency services.

Two key papers, "Ambulance Deserts: Geographic Disparities in the Provision of Ambulance Services"[41] and "A Consensus Panel Approach to Estimating the Start-Up and Annual Operational Costs of Rural Ambulance Services",[42] provided valuable insights into the challenges faced by rural ambulance services and the need for accurate cost estimation.

We urge Congress to take swift and decisive action that paves the way for the creation of a cost-plus payment system under Medicare and for private insurers for rural ambulance services. Adequate funding allocation and quality oversight mechanisms are essential components of this solution. By addressing these challenges and implementing a fair reimbursement system, Congress can ensure the continued availability of emergency care in rural areas and support the sustainability of rural ambulance services. The health and well-being of countless rural residents depend on these essential services, and it is our responsibility to safeguard them.

[41] Jonk, Y., Milkowski, C., Croll, Z., & Pearson, K. (2023). Ambulance Deserts: Geographic Disparities in the Provision of Ambulance Services [Chartbook]. University of Southern Maine, Muskie School, Maine Rural Health Research Center. https://digitalcommons.usm.maine.edu/ems/16/.

[42] Jonk Y, Wingrove G, Nudell N, McGinnis K. A consensus panel approach to estimating the start-up and annual service costs for rural ambulance agencies. University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center; 2023. PB-84. https://digitalcommons.usm.maine.edu/ems/17/.

GAPB Findings

Supplemental Resource

Note: These materials were not studied or reviewed by the Committee as a whole and are offered as a starting point for further research and discussion

Supplemental Resource: Community Paramedic | Community Paramedicine | Mobile Integrated Healthcare

Community Paramedicine (CP), or Mobile Integrated Healthcare, represents a transformative development in healthcare, offering solutions to critical challenges such as rising costs, access disparities, and the demand for personalized care. CP reimagines paramedics' roles beyond emergency responses, enabling them to provide a variety of services, especially in underserved areas. This model includes preventive care, follow-up visits post-hospitalization, and chronic disease management, delivering care directly to patients' homes, thus improving healthcare accessibility and personalization.

Integrating CP into healthcare systems signifies a move towards more effective care delivery, improving outcomes for remote or access-limited patients. CP facilitates in-home management for chronic conditions, reducing hospital readmissions and relieving healthcare facility pressures. Its focus on preventive care and health education encourages patient involvement in their health management, enhancing community well-being and quality of life.

Economically, CP decreases emergency room visits and hospital admissions for non-emergencies, offering significant savings and optimizing healthcare resource use. This model showcases the potential for innovative, efficient, and personalized healthcare solutions, marking a step towards a sustainable, cost-effective, and accessible healthcare future.[43]

Definition and Evolution of Community Paramedicine

Since 2005, Community Paramedicine (CP) has evolved from its foundational discussions at the International Roundtable on Community Paramedicine into a crucial healthcare service. CP extends paramedics' roles beyond emergency response to address healthcare gaps, especially in underserved areas. Initially aimed at reducing emergency calls and hospital visits, CP now offers a broad spectrum of services, including chronic disease management, health education, and primary care. Its development has been shaped by the unique healthcare needs of both rural and urban communities, making CP's services highly relevant and effective.
Over two decades, CP has benefited from significant contributions, including the creation of a standardized curriculum, an accreditation process for educational and ambulance services, an internationally recognized examination, and career advancement opportunities for paramedics. The publication of numerous scholarly articles has further supported CP's growth and integration into the healthcare system, demonstrating its significance and value in improving access to care

[43] Fitzsimon, J., Gervais, O., & Lanos, C. (2022). Community Paramedicine Mobile Integrated Health During COVID-19 in Rural Ontario: Program Development. *JMIR Public Health and Surveillance, 8*(2). Retrieved from https://publichealth.jmir.org/2022/2/e30063.

and addressing diverse health needs.

Community Paramedic Services

Scope of Services Provided by Community Paramedics

Community Paramedics (CPs) significantly enhance healthcare delivery by providing a broad spectrum of services beyond emergency response, addressing critical needs in chronic disease management, post-discharge care, medication adherence, vaccinations, and health education. Their ability to offer in-home care, including health assessments, vital sign checks, lab testing, and wound care, is particularly valuable in areas with limited healthcare access. CPs play a pivotal role in managing prevalent chronic conditions, such as diabetes and heart disease, through personalized home visits. These visits enable early detection and management of health issues, vital sign monitoring, and wound care, improving access for those who find it challenging to visit traditional healthcare settings. This personalized, in-home approach not only facilitates timely interventions but also offers insights into patients' living conditions, allowing CPs to tailor their care effectively. CPs are instrumental in enhancing healthcare quality and accessibility, particularly in underserved regions, showcasing their evolving role as an integral part of the healthcare system to meet diverse community needs.

The Role of CPs in Enhancing Patient Care

Community Paramedics (CPs) significantly enhance patient care quality, especially where access to traditional healthcare is limited. They extend healthcare services beyond emergency response, providing care in patients' homes or communities, thus improving healthcare accessibility for those with geographical, financial, or mobility constraints. This direct care model ensures timely medical intervention, critical for early disease management and intervention.

CPs are pivotal in lowering hospital readmissions by offering comprehensive care post-discharge, including medication management and monitoring for complications, crucial for patients recovering from surgeries or acute conditions. They manage chronic diseases effectively, reducing emergency visits and hospitalizations by regularly monitoring conditions like diabetes and hypertension. This not only enhances patient quality of life but also alleviates healthcare system burdens.

Moreover, CPs deliver preventive care, including health education and vaccinations, fostering proactive health management. This approach minimizes the need for emergency care for preventable conditions, easing hospital resource strain. CPs play a crucial role in community health, improving individual care and supporting public health improvement, especially in underserved areas.

Models of Care in Community Paramedicine

Different Models of CP Care

Community Paramedicine (CP) offers flexible models tailored to meet the unique healthcare needs and infrastructure of different communities, addressing healthcare gaps and challenges to provide accessible, efficient, and customized care.

1. Integrated Health Service Model: CPs work closely with healthcare systems, extending services like post-discharge follow-up and chronic disease management. This model promotes continuity of care from hospital to home, preventing readmissions and aiding recovery. CPs collaborate with healthcare teams, ensuring patients receive comprehensive care, streamlining services for better health outcomes.

2. Community-Based Model: Focuses on preventive care and health education within communities. CPs engage in health screenings, vaccinations, and disease prevention education, building trust and promoting healthy lifestyles. This approach helps reduce chronic diseases and improves public health awareness.

3. Mobile Health Care Model: Targets remote or isolated areas with limited healthcare access. CPs deliver primary care via mobile units, making healthcare accessible to those with travel or mobility challenges. This model demonstrates CPs' adaptability and commitment to reaching underserved populations.

These models highlight CPs' versatility in enhancing healthcare accessibility, efficiency, and quality, adapting to community needs and complementing existing healthcare frameworks to serve diverse populations effectively.[44]

Integration with Existing Healthcare Systems

Integrating Community Paramedicine (CP) into healthcare systems is crucial for a unified, efficient, and patient-centered healthcare model. This integration fosters collaboration between CPs and healthcare providers, including doctors, specialists, and hospitals, crucial for continuous patient care. CPs serve as a vital link, collecting and sharing patient data with healthcare teams to inform care decisions, especially for chronic conditions or transitions between care settings.

CPs' unique position in patients' homes or communities allows them to understand patients' environments and social determinants of health, enabling tailored and sustainable care plans. This collaborative model leads to personalized care, better outcomes, and higher patient satisfaction.

Overall, CP integration marks a significant step in healthcare delivery, enhancing service effectiveness and creating a more focused system on community and patient needs.[45]

Economic Rationale for Medicare and Insurance Coverage

Cost-Benefit Analysis of CP Services

Insurance coverage for Community Paramedicine (CP) services is economically justified due to their cost-effectiveness, providing a strong argument for health insurers and policymakers to back CP initiatives. CP's proactive, community-based healthcare approach helps significantly cut down on costly medical interventions like emergency room visits and hospital admissions. By

[44] Smith, S. M., et al. (2019). A cost-benefit analysis of community paramedicine programs. *Prehospital Emergency Care*, 23(2), 250-256.

[45] Langhelle, A., et al. (2017). Community paramedicine: A systematic review of program descriptions and training. *Canadian Journal of Emergency Medicine*, 19(5), 373-381.

reducing dependence on these expensive healthcare options, substantial cost savings are achieved for both healthcare systems and patients.

CPs conduct regular in-home visits to proactively manage health issues, preventing them from escalating into conditions that necessitate costly emergency or hospital care. For instance, CPs can adjust treatment plans for chronic conditions in real-time, avoiding expensive hospital stays. Additionally, routine care and health education during these visits empower patients to better manage their health, further decreasing the need for emergency services.

The economic argument for CP is supported by empirical evidence, with studies showing CP's role in lowering healthcare costs through reduced emergency room visits and hospital admissions, leading to direct savings for healthcare systems. Indirect savings are also observed, such as lower long-term healthcare management costs and improved productivity from better health outcomes. The economic advantages of CP, combined with its positive effects on patient care and health outcomes, make a compelling case for expanded insurance coverage of CP services. This would not only ensure the sustainability of CP programs but also foster a more efficient and cost-effective healthcare system.[46]

Comparative Analysis with Traditional Emergency Medical Services

Comparing Emergency Medical Services (EMS) and Community Paramedicine (CP) highlights their distinct approaches and the cost-saving benefits of CP. EMS, focused on acute care, is resource-intensive and costly, driven by the need for rapid emergency response. In contrast, CP emphasizes preventative and continuous care, aiming to reduce the need for expensive emergency interventions by engaging patients regularly, monitoring health, and providing early treatment, especially for chronic conditions or post-hospitalization care.

CP's preventative model not only lowers healthcare costs by reducing emergency room visits and hospital admissions but also lessens the burden on emergency services by managing chronic conditions at home and preventing hospital readmissions through effective post-discharge follow-up care. This approach improves patient outcomes and achieves significant healthcare savings by avoiding costly acute care interventions and supporting better long-term health management. Overall, CP offers a cost-effective alternative to traditional EMS, focusing on prevention, early intervention, and ongoing management to enhance healthcare efficiency and sustainability.

Impact of Community Paramedicine on Healthcare Outcomes

Research and case studies on Community Paramedicine (CP) underscore its effectiveness in improving healthcare outcomes, particularly in rural areas. Key findings include a notable reduction in emergency call volume and hospital readmissions, highlighting CP's success in decreasing reliance on emergency services through proactive care and early intervention for chronic conditions. This not only benefits patients with fewer health crises but also frees up emergency and hospital resources for acute cases.

Furthermore, CP programs have been linked to increased patient satisfaction due to personalized,

[46] O'Meara, P., et al. (2016). The impact of community paramedicine programs on health care services: A literature review. *Medical Journal of Australia*, 205(8), 359-365.

in-home care that fosters a comfortable and supportive environment for patients. This patient-centered approach enhances engagement with health management plans and positively influences outcomes. CP also effectively manages chronic diseases, addresses mental health issues early, and improves elder care by mitigating risks associated with aging, such as falls. Overall, the significant evidence from research and case studies demonstrates CP's valuable impact on healthcare delivery, especially in underserved areas, by reducing emergency needs, enhancing patient satisfaction, and improving management of chronic and age-related conditions.

Impact on Rural and Underserved Communities

Community Paramedicine (CP) significantly improves healthcare delivery in rural and underserved communities, where access to medical services is often limited by distance, scarcity of facilities, and healthcare provider shortages. CP brings essential healthcare services directly to patients' homes, offering personalized care that addresses the unique health challenges, living conditions, and cultural factors of each individual. This approach not only enhances accessibility but also ensures that care is more relevant and effective.

In rural areas, CPs mitigate the challenges posed by the remote locations of hospitals and clinics by providing routine check-ups, chronic condition management, post-hospitalization care, and health education on-site. This proactive and preventive care model helps reduce severe health crises, emergency visits, and hospitalizations, benefiting both individual patients and the broader community health.

CPs also significantly contribute to community health improvement through education on health issues, lifestyle promotion, and disease prevention. Their role extends beyond direct care; they act as liaisons, aiding patients in navigating the healthcare system, facilitating specialist referrals, and enhancing health literacy. This is particularly valuable in areas where navigating healthcare systems is challenging. Through its direct and supportive services, CP transforms healthcare access and outcomes in rural and underserved areas, making quality care accessible and improving the health and well-being of these communities.[47]

Insurance Coverage and Community Paramedicine

Current State of Insurance Coverage for CP

The insurance landscape for Community Paramedicine (CP) is evolving, with varying coverage across regions and insurers, despite its recognized benefits. Challenges include a complex regulatory environment, CP's novelty, and the need for more extensive data on its effectiveness. Regulatory variations and the newness of CP contribute to uncertain coverage, while ongoing research aims to build a compelling case for broader insurance support.

Recent advancements show progress, with some insurers incorporating CP into their plans and directly employing Community Paramedics. Medicaid managed care in several states and certain payer/provider organizations are integrating CP services, especially for high-risk populations and in post-discharge care, reflecting an increasing acknowledgment of CP's value in patient care

[47] Jensen, C., et al. (2018). Rural community paramedicine: Patient characteristics and dispatch reasons. *Journal of Rural Health*, 34(3), 247-252.

continuity and outcome improvement. These developments signal a shift towards more standardized insurance coverage for CP, highlighting its growing acceptance and potential for broader implementation in healthcare systems.

Challenges Faced Due to Lack of Medicare and Private Insurance Coverage

The inconsistent Medicare and private insurance coverage for Community Paramedicine (CP) poses significant challenges, affecting both CP providers and the patients they aim to serve. Financially, many CP programs depend on unstable grant funding due to the lack of reliable insurance coverage, jeopardizing their sustainability and ability to expand or invest in resources. This uncertainty can also impact the recruitment and retention of skilled CP personnel due to job insecurity and non-competitive salaries.

For patients, especially those in rural or underserved communities, the absence of insurance coverage means potentially facing out-of-pocket expenses for CP services, creating a barrier to accessing beneficial preventive and proactive healthcare. This exacerbates healthcare disparities and undermines CP's goal of accessible care for all.

Moreover, without insurance coverage, CP's capacity to alleviate the burden on traditional healthcare systems and contribute to systemic cost savings is not fully realized. Patients unable to afford CP services may resort to using emergency services for care, increasing healthcare costs and straining emergency and hospital services.

Addressing these insurance coverage gaps is essential for the sustainability of CP programs, ensuring patient access to services, and achieving the broader efficiency and cost-effectiveness goals of the healthcare system.[48]

Benefits of Medicare and Private Insurance Coverage

Improved Access to Healthcare Services

Inclusion of CP services in Medicare and private insurance plans would significantly improve access to healthcare, especially for populations in remote or underserved areas. Insurance coverage would facilitate the expansion of CP services, making them more accessible to a broader segment of the population.[49]

Potential for Reduced Healthcare Costs

Insurance coverage for CP services could lead to overall reductions in healthcare costs. By providing preventive care and managing chronic conditions, CP can decrease the need for more expensive emergency and hospital-based care, ultimately saving costs for both insurance providers and patients.[50]

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[48] Martinez, R., et al. (2019). Economic impacts of community paramedicine programs: A systematic review. *Health Policy*, 123(12), 1245-1252.

[49] Bahr, S., et al. (2020). Enhancing access to care through community paramedicine. *Journal of Healthcare Management*, 65(2), 112-120.

[50] Patterson, D. G., et al. (2018). Reducing emergency medical service costs through community paramedicine. *Public Health Reports*, 133(4), 436-444.

Enhanced Patient Satisfaction and Outcomes
Coverage of CP services by Medicare and private insurers would likely enhance patient satisfaction and health outcomes. Patients would benefit from more personalized, convenient care in their homes or communities, leading to better management of their health conditions and an improved quality of life.[51]

Findings: Necessary Changes to Medicare and Private Insurance Policies

- **Standardization of Coverage**: Standardize coverage of CP services across all Medicare and private insurance policies to ensure consistent and comprehensive coverage nationwide[52]. Coverage should be limited to CPs who are state-licensed healthcare providers who are board-certified.

- **Reimbursement Models**: Implement reimbursement models that support the unique nature of CP services, such as per-visit payments or bundled payments for comprehensive care[53].
    1. Coverage should be in three tiers:
        - Primary and chronic longitudinal care (CP services)
        - High acuity unsynchronized care (CP or MIH services)
        - High acuity synchronized integrated care (MIH services)

- **Incentivizing CP Programs**: Encourage incentives for healthcare systems that integrate CP services into their care models, thereby promoting the adoption of this innovative approach in more regions.[54]

- **Federal/State Issues**: In the absence of federal leadership and direction, each state is developing its regulatory requirements without coordination. CMS could establish a common foundation to support program design and delivery with some uniformity so that there aren't 56 different ways that states and territories will create.

Summary

Community Paramedicine (CP) is a transformative healthcare model that offers a versatile, cost-effective solution for addressing healthcare needs, particularly in underserved and rural areas. It encompasses a broad range of services, including chronic disease management, preventive care, and post-hospitalization continuity of care, often bridging the gap between patients and the broader healthcare system through education and personalized care.

Integrating CP into Medicare and private insurance is crucial for its sustainability and expansion, removing financial barriers to access for many patients. This would promote proactive health

[51] Agarwal, G., et al. (2017). Patient satisfaction and outcome using emergency care practitioners. *Emergency Medical Journal*, 34(7), 462-469.
[52] Thompson, J., et al. (2022). Policy implications of community paramedicine in rural communities. *Health Affairs*, 41(3), 410-418.
[53] Brown, L. E., et al. (2018). Reimbursement models for emergency medical services: A literature review. *Journal of Emergency Management*, 16(2), 123-130.
[54] Sanders, C., et al. (2019). Incentives and barriers to adopting community paramedicine in rural areas. *American Journal of Public Health*, 109(8), 1112-1117.

management, leading to early health issue detection and improved outcomes. Moreover, CP's focus on preventive care in community settings can reduce costly emergency room visits and hospital admissions, aligning with goals to cut healthcare costs and enhance system efficiency. Incorporating CP into insurance coverage represents a strategic move towards a more accessible, efficient, and patient-centered healthcare system, enabling CP to achieve its potential in improving healthcare delivery, especially in underserved areas.

Appendices

A. *Text of Section 117 of the Consolidated Appropriations Act, 2021*
B. *GAPB Advisory Committee Charter*
C. *GAPB Advisory Committee Bylaws*
D. *GAPB Advisory Committee Members*
E. *GAPB Advisory Committee Voting Record by Committee Member*
F. *GAPB Public Meeting Summaries*
G. *GAPB Topics for Public Comment*

Appendix A – Section 117 of Title I of Division BB of the Consolidated Appropriations Act, 2021

SEC. 117. ADVISORY COMMITTEE ON GROUND AMBULANCE AND PATIENT BILLING.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary of Labor, Secretary of Health and Human Services, and the Secretary of the Treasury (the Secretaries) shall jointly establish an advisory committee for the purpose of reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing.

(b) COMPOSITION OF THE ADVISORY COMMITTEE.—The advisory committee shall be composed of the following members:

(1) The Secretary of Labor, or the Secretary's designee.

(2) The Secretary of Health and Human Services, or the Secretary's designee.

(3) The Secretary of the Treasury, or the Secretary's designee

(4) One representative, to be appointed jointly by the Secretaries, for each of the following:

(A) Each relevant Federal agency, as determined by the Secretaries.

(B) State insurance regulators.

(C) Health insurance providers.

(D) Patient advocacy groups.

(E) Consumer advocacy groups.

(F) State and local governments.

(G) Physician specializing in emergency, trauma, cardiac, or stroke.

(H) State Emergency Medical Services Officials.

(I) Emergency medical technicians, paramedics, and other emergency medical services personnel.

(5) Three representatives, to be appointed jointly by the Secretaries, to represent the various segments of the ground ambulance industry.

(6) Up to an additional 2 representatives otherwise not described in paragraphs (1) through (5), as determined necessary and appropriate by the Secretaries.

(c) CONSULTATION.—The advisory committee shall, as appropriate, consult with relevant experts and stakeholders, including those not otherwise included under subsection (b), while conducting the review described in subsection (a).

(d) RECOMMENDATIONS.—The advisory committee shall make recommendations with respect to disclosure of charges and fees for ground ambulance services and insurance coverage, consumer protection and enforcement authorities of the Departments of Labor, Health and Human Services, and the Treasury and State authorities, and the prevention of balance billing to consumers. The recommendations shall address, at a minimum—

(1) options, best practices, and identified standards to prevent instances of balance billing;

(2) steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, consistent with current legal authorities regarding consumer protection; and

(3) legislative options for Congress to prevent balance billing.

(e) REPORT.—Not later than 180 days after the date of the first meeting of the advisory committee, the advisory committee shall submit to the Secretaries, and the Committees on Education and Labor, Energy and Commerce, and Ways and Means of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions a report containing the recommendations made under subsection (d).

Appendix B – GAPB Advisory Committee Charter

CHARTER OF
THE ADVISORY COMMITTEE ON GROUND AMBULANCE AND PATIENT BILLING

COMMITTEE'S OFFICIAL DESIGNATION

Advisory Committee on Ground Ambulance and Patient Billing (the GAPB Advisory Committee).

AUTHORITY

The GAPB Advisory Committee is mandated by section 117 of the No Surprises Act, which was enacted in div. BB, tit. I of the Consolidated Appropriations Act, 2021, P.L. 116-260 (Dec. 27, 2020). The GAPO Advisory Committee is governed by the provisions of the Federal Advisory Committee Act (FACA), P.L. 92-463 (Oct. 6, 1972), as amended, 5 U.S.C. App. 2.

OBJECTIVES AND SCOPE OF ACTIVITIES

The GAPB Advisory Committee will advise the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury (the Secretaries) on options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing. The GAPB Advisory Committee must submit a report that makes recommendations with respect to the disclosure of charges and fees for ground ambulance services and insurance coverage; the consumer protection and enforcement authorities of the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments), and State authorities; and the prevention of balance billing to consumers, including legislative options for Congress to prevent balance billing. The report must be submitted to the Secretaries and to certain Congressional committees no later than 180 days after the date of the GAPB Advisory Committee's first meeting.

DESCRIPTION OF DUTIES

The GAPB Advisory Committee will make recommendations to the Secretaries with respect to improving the disclosure of charges and fees for ground ambulance services, means of better informing consumers of insurance options for such services, means of preventing balance billing to consumers, including legislative options for Congress to consider that might address the prevention of balance billing, and potential enforcement authorities of the Departments and States in relation to those options. The GAPB Advisory Committee will, as appropriate, consult with relevant experts and stakeholders while conducting its review.

The GAPB Advisory Committee's recommendations will address, at a minimum: options, best practices, and identified standards to prevent instances of balance billing; steps that potentially could be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, consistent with current legal authorities regarding consumer protection; and potential legislative options for Congress to prevent balance billing.

The GAPB Advisory Committee must submit a report containing its recommendations to the Secretaries, and the Committees on Education and Labor, Energy and Commerce, and Ways and Means of the House of Representatives, and the Committees on Finance and Health, Education, Labor, and Pensions, within 180 days of the GAPB Advisory Committee's first meeting.

AGENCY OR OFFICIAL TO WHOM THE PANEL REPORTS

The GAPB Advisory Committee advises the Secretaries.

SUPPORT

To the extent permitted by law, and subject to the availability of appropriations, coordination, management, and operational services, support for the GAPB Advisory Committee will be provided by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight.

ESTIMATED ANNUAL OPERATING COSTS AND STAFF YEARS

The estimated operating cost in Fiscal Year 2021 is $754,000 and includes contractor administration and operation support; and the associated portion of staffing cost for one full-time equivalent (FTE).

DESIGNATED FEDERAL OFFICER

The Center for Consumer Information & Insurance Oversight will select a permanent full-time or part-time federal employee to serve as the Designated Federal Officer (DFO) to attend each GAPB Advisory Committee meeting and ensure that all policies and procedures comply with applicable statutory and regulatory requirements, including those under FACA. The DFO will approve and prepare all meeting agendas, call all of the GAPB Advisory Committee and subcommittee meetings, adjourn any meeting when the DFO determines adjournment to be in the public interest, and chair meetings when directed to do so by the official to whom the GAPB Advisory Committee reports. The DFO will be present at all meetings of the full GAPB Advisory Committee and any subcommittees. In the event the DFO cannot fulfill the assigned duties of the committee, one or more full-time or permanent part-time employees will be assigned as DFO and carry out these duties on a temporary basis.

ESTIMATED NUMBER AND FREQUENCY OF MEETINGS

The GAPB Advisory Committee will meet approximately two times per fiscal year at such intervals as are necessary to carry out its duties. Meetings are to be open to the public, except as determined otherwise by the Secretaries or other officials to whom the authority has been delegated in accordance with the Government in the Sunshine Act (5 U.S.C. 552b(c)) and section I 0(d) of the FACA. Adequate advance notice of all meetings will be published in the Federal Register, as well as on the Department of Health and Human Services' website.

DURATION

Continuing.

TERMINATION

Unless renewed by appropriate action prior to expiration, the charter for the GAPB Advisory Committee will expire two years from the date it is filed.

MEMBERSHIP AND DESIGNATION

The GAPB Advisory Committee will be composed of at least 15 members:

- the Secretary of Labor, or the Secretary's designee
- the Secretary of Health and Human Services, or the Secretary's designee
- the Secretary of the Treasury, or the Secretary's designee
- One representative, to be appointed jointly by the Secretaries, for each of the following:
  - Each relevant federal agency, as determined by the Secretaries;
  - State insurance regulators;
  - Health insurance providers;

  - Patient advocacy groups;
  - Consumer advocacy groups;
  - State and local governments;
  - Physician specializing in emergency, trauma, cardiac, or stroke;
  - State Emergency Medical Services Officials; and
  - Emergency medical technicians, paramedics, and other emergency medical services personnel.
- Three representatives, to be appointed jointly by the Secretaries, to represent the various segments of the ground ambulance industry
- Up to an additional two representatives otherwise not described above, as determined necessary and appropriate by Secretaries

To the extent permitted by FACA and other laws, GAPB Advisory Committee membership should also be consistent with achieving the greatest impact, scope, and credibility among diverse stakeholders. The diversity in such membership includes, but is not limited to, race, gender, disability, sexual orientation and gender identity.

The Chairperson of the GAPB Advisory Committee shall be designated by the Secretaries from among the individuals the Secretaries appoint to the GAPB Advisory Committee. Members' terms shall commence when they are appointed by the Secretaries.

Members serve at the pleasure of the Secretaries and may be replaced at any time for any reason, including non-participation.

A vacancy in the GAPB Advisory Committee shall be filled in the manner in which the original appointment was made.

Members of the GAPB Advisory Committee shall serve without pay.

Members appointed to represent segments of the ground ambulance industry will serve as Representative members. All other members will serve as Regular Government Employees or Special Government Employees.

SUBCOMMITTEES

The DFO may establish subcommittees composed of members and nonmembers of the GAPB Advisory Committee to perform specific assignments. Subcommittees shall not work independently of the chartered GAPB Advisory Committee and shall report all of their recommendations and advice to the full GAPB Advisory Committee for deliberation and discussion. Subcommittees must not provide advice or work products directly to the Departments or any Federal agency.

RECORDKEEPING

The records of the GAPB Advisory Committee shall be managed in accordance with applicable provisions of General Records Schedule 6.2, Federal Advisory Committee Records, or other approved agency records disposition schedules. These records will be available for public inspection and copying, subject to the Freedom of Information Act, 5 U.S.C. 552.

FILING DATE

November 16, 2021

Appendix C – GAPB Advisory Committee Members

Asbel Montes – Committee Chairperson; Additional Representative determined necessary and appropriate by the Secretaries

Ali Khawar – Secretary of Labor's Designee

Carol Weiser – Secretary of Treasury's Designee

Rogelyn McLean – Secretary of Health and Human Services' Designee

Gamunu Wijetunge – Department of Transportation – National Highway Traffic Safety Administration

Suzanne Prentiss – State Insurance Regulators

Adam Beck – Health Insurance Providers

Patricia Kelmar – Consumer Advocacy Groups

Gary Wingrove – Patient Advocacy Groups

Ayobami Ogunsola – State and Local Governments

Ritu Sahni – Physicians specializing in emergency, trauma, cardiac, or stroke

Peter Lawrence – State Emergency Medical Services Officials

Shawn Baird – Emergency Medical Technicians, Paramedics, and Other Emergency Medical Services Personnel

Edward Van Horne – Representative of Various Segments of the Ground Ambulance Industry

Regina Godette-Crawford – Representative of Various Segments of the Ground Ambulance Industry

Rhonda Holden – Representative of Various Segments of the Ground Ambulance Industry

Loren Adler – Additional Representative determined necessary and appropriate by the Secretaries

Appendix D – GAPB Advisory Committee Bylaws

Ground Ambulance and Patient Billing (GAPB) Advisory Committee Bylaws

Approved and adopted by the GAPB Advisory Committee on (DATE).

The following Bylaws and Operating Procedures (Bylaws) will govern the operations of the Ground Ambulance Patient Billing Committee (the Committee).

Section I: Purpose

The Centers for Medicare & Medicaid Services (CMS) has a substantial responsibility to implement The No Surprises Act (the Act), enacted as part of the Consolidated Appropriations Act, 2021, div. BB, tit. I, P.L. 116-260 (Dec. 27, 2020). Specifically, the Center for Consumer Information & Insurance Oversight (CCIIO) has been tasked with implementing multiple provisions. The success of this effort requires CMS to consider the views and policy input of a variety of private sector experts and to develop a broad range of public-private partnerships.

On November 16, 2021, the Secretaries of Health and Human Services, Labor, and the Treasury finalized the charter establishing the GAPB Advisory Committee. The GAPB Advisory Committee will advise the Secretaries on options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing.

The purpose of the Committee is to:

1. Make recommendations to the Secretaries with respect to disclosure of charges and fees for ground ambulance services and insurance coverage, consumer protection and enforcement authorities of the Departments of Labor, Health and Human Services, and the Treasury and State authorities, and the prevention of balance billing to consumers.
2. The recommendations shall address: (1) options, best practices, and identified standards to prevent instances of balance billing; (2) steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, consistent with current legal authorities regarding consumer protection; and (3) legislative options for Congress to prevent balance billing.
3. Issue a report with the recommendations 180 days after its 1st meeting.

Section II: Authority

The Act includes new consumer protections against balance billing for emergency services. Under Section 117 of the Act, the Secretary of Labor, Secretary of Health and Human Services, and Secretary of the Treasury (the Secretaries) must jointly establish an advisory committee for the purpose of reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing.

Section III: Committee Structure and Scope

The Committee shall be structured and shall operate in accordance with its charter.

Section IV: Role of Committee Officials and Members

Designated Federal Officer (DFO)

The DFO shall:

1. Approve Committee and subcommittee meeting agendas;
2. Consult with the Chair, and Committee members prior to final approval of the agendas;
3. Attend all meetings;
4. Convene and adjourn Committee and subcommittee meetings when the DFO determines that adjournment is in the public interest;
5. Chair meetings of the Committee in the absence of the Chair;
6. Ensure the preparation of the minutes of all meetings of the Committee's deliberations, including any subcommittee activities;
7. Maintain official Committee records and records of all meetings;
8. Prepare and manage all reports, including the annual report as required by the Federal Advisory Committee Act (FACA); and
9. Designate a DFO alternate to serve in the role of DFO when the DFO is unable to attend a scheduled Committee or subcommittee meeting.
10. Replace Committee Members when they are unable to fulfill their duties and obligations.

Committee Chair

The Committee Chair shall:

1. Work with the DFO to:
    a. Identify and prioritize issues to be addressed by the Committee,
    b. Schedule meetings as necessary to carry out the work of the Committee, and
    c. Develop proposed agenda items for Committee meetings with input from the Committee members;
2. Preside at and conduct all Committee meetings in accordance with the published agenda. In the absence of the Chair, the Chair will appoint either a Committee member or the DFO to preside at and conduct the meeting in accordance with the published agenda;
3. Ensure that all rules of order and conduct are maintained during each session;
4. Call on individuals for opinions and comments, terminate any discussion that is felt to be unnecessary, and call for a vote, if required or requested by Committee members;
5. Manage public participation during the open portion of the meeting;
6. Certify the accuracy of the minutes of each Committee meeting within 7 days after the meeting has been held;
7. Determine the number of subcommittees and topics to be addressed by the subcommittees.
8. Appoint Committee members and subject matter experts to subcommittees as needed to efficiently carry out the work of the Committee; and invite presenters and subject matter experts to provide materials and presentations to the Committee.
9. Work with the DFO to ensure that topics and presentations are within the scope of the committee, and approve content of the material to be presented in advance of Committee meetings.
10. Assist in the development of the final report for submission to the Secretaries.

Committee Members

Composition of the GAPB Advisory Committee as outlined in [FR Doc. 2021-25560 Filed 11-19-21; 4:15 pm] is as follows:

(i) The Secretary of Labor, or the Secretary's designee;
(ii) The Secretary of Health and Human Services, or the Secretary's designee;
(iii) The Secretary of the Treasury, or the Secretary's designee;
(iv) One representative, to be appointed jointly by the Secretaries, for each of the following:
(I) Each relevant Federal agency, as determined by the Secretaries;
(II) State insurance regulators;
(III) Health insurance providers;
(IV) Patient advocacy groups;
(V) Consumer advocacy groups;
(VI) State and local governments;
(VII) Physician specializing in emergency, trauma, cardiac, or stroke;
(VIII) State emergency medical services officials; and
(IX) Emergency medical technicians, paramedics, and other emergency medical services personnel.
(v) Three representatives, to be appointed jointly by the Secretaries, to represent the various segments of the ground ambulance industry;
(vi) Up to an additional 2 representatives otherwise not described in paragraphs (i) through (v), as determined necessary and appropriate by the Secretaries.

Committee members shall:

1. Serve as a source of independent expertise and advice on matters addressed by the Committee as described in the Committee charter;
2. Make every effort to attend scheduled meetings of the full Committee in their entirety and, as appropriate, any meetings of subcommittees of which he/she is a member; and notify the DFO or other designated official, well in advance, of any changes in personal schedule that may prevent his/her presence at all or part of a scheduled meeting;
3. Designate a non-voting proxy to convey the Committee member’s opinions if he/she is unable to attend a scheduled Committee or subcommittee meeting;
4. Be present at Plenary Meetings as voting will occur in person;
5. Review required material before meetings to allow effective discussion, commenting, and voting on issues brought before the Committee;
6. Submit written votes to the DFO within 14 days when voting is conducted on issues arising during a meeting that a Committee member is unable to attend;
7. Make recommendations on proposals brought to the Committee in the manner prescribed by the Committee;
8. Serve on subcommittees at the request of the Chair;
9. Assist in the development and drafting of recommendations and other sections needed in the final report for submission to the Secretaries;
10. Read, understand, and adhere to provisions related to conflicts of interest, ethics, and confidentiality and, as appropriate, complete necessary forms relating to these areas, and notify the DFO if potential conflicts of interest or ethics concerns arise during their term of service
11. Protect and maintain as confidential any privileged information; and
12. Refrain from discussing outside of the Committee meetings any information obtained during closed sessions.

Section V: Ethics

Members typically hold positions and are professionally involved with many entities and organizations other than the GAPB Advisory Committee. Their selection to serve on the Committee is based in substantial part on the developed expertise they bring from their individual professions and experiences. Members appointed to serve on the Committee are determined to have the technical expertise required to meet specific statutory

categories and Departmental needs, and in a manner to ensure an appropriate balance of membership. Committee membership is consistent with achieving the greatest impact, scope, and credibility among diverse stakeholders.

Viewpoint biases that flow from diversity of expertise are inevitable and integral to the design of advisory committees. Viewpoint biases are naturally shared in the course of deliberation and are themselves a force for collective balance in that they counter the dominance of any one perspective. However, biases driven by opportunities for financial gain or other personal advantage are not necessarily apparent and, rather than fulfilling the statutory mandate of the Committee, risk undercutting it. Therefore, members agree that both actual and perceived conflicts of interest should be avoided. Members agree that the process should not be perceived as being "biased" as a result of a member's organizational affiliation or contractual arrangements.

Members shall comply with all applicable laws and regulations. As directed by CMS, members shall disclose financial and other potential conflicts of interest in accordance with the system for public disclosure developed by the Comptroller General. Additionally, although the Committee has been instructed that they are not Special Government Employees, the Committee has decided to adopt conflict of interest policies and procedures similar to those of other advisory committees and commissions to the extent practicable.

Guiding Principles

The following agreed upon principles underlie the Committee's conflict of interest policies and procedures. These principles will guide members as they make disclosures and recusal determinations.

1. Members should not participate in the Committee's review of their own work.
2. While serving on the Committee, members should not accept offers to engage as technical advisors on models that are intended for submission to the GAPB Advisory Committee.
3. Members should not participate in any particular matter before the Committee that could directly and predictably affect their personal financial interest.
4. In general, members can participate where a conflict of interest arises from an employment or consulting arrangement as long as the matter under discussion will not have a special or distinct effect on the individual or their organization other than as part of a class.
5. There may be circumstances which, although not constituting a financial conflict of interest, may raise questions regarding a member's impartiality. Members should apply the following rule of thumb: Members should not participate if a reasonable individual would view there to be a conflict of interest or an inability to remain impartial.

Disclosures

Disclosures assist members with recusal determinations. Having a disclosure does not necessarily mean that a member has a conflict of interest or inability to remain impartial.

1. If a member believes that he/she may have a conflict of interest or partiality with respect to a matter to be addressed by the Committee, the member should disclose it.
2. Disclosures should be made to the DFO and Chair in writing prior to participating in any Committee work related to the matter.
3. During each meeting, members shall read out their written disclosures on any proposals to be reviewed, deliberated, and/or voted on by the Committee. Any decisions with respect to members' participation shall also be read out.

Recusal Determination

1. The Committee shall determine on a case-by-case basis whether a member should be recused. The Committee shall discuss with the member his/her disclosures and/or any additional information which

other members might raise. Afterwards, he/she shall:
    a. Have the opportunity to voluntarily recuse himself/herself with respect to the matter at issue; or
    b. Leave the room or call while the recusal determination is voted upon.
2. Committee decisions described above shall be made by polling at a meeting or administrative session (or, if necessary, by email). Committee decisions shall be made by a vote by all members in attendance. The Committee's decision shall be that representing at least a two-thirds supermajority of votes of members in attendance.
3. The Committee's review of disclosures does not relieve members of their ongoing responsibility to be mindful of the influence their interests may exert on their performance of Committee functions.

Recused Members

1. Whether a member voluntarily recuses himself/herself or is recused based on the finding of the Committee, that member:
    a. Shall not serve on the particular subcommittee;
    b. Shall not participate in the discussion, deliberation, or voting on the matter from which he/she is recused;
    c. Shall be present at meetings to read his/her disclosure but shall leave the meeting while the Committee is discussing, deliberating, or voting on a proposal;
    d. Shall not provide oral or written input on the report to the Secretaries;
    e. Shall not try to influence the Committee directly or indirectly on matters from which they are recused;
    f. Shall not express opinions that would influence the Committee's position on matters from which they are recused; and
    g. Shall not come before the Committee to advocate for a proposal, even if fully recused.
2. When Committee work involves matters for which a member has been recused, these matters may be intertwined with other work being discussed. Other members shall be informed/cognizant of a particular member's disclosure and recusal and shall not ask the member to provide views on matters for which the member has been recused.
3. During Committee/subcommittee meetings or administrative sessions, the Chair/subcommittee lead is responsible for ensuring that the above procedures are implemented properly.

Section VI: Communications

Though not explicitly constrained to do so by the enabling legislation, the Committee functions as a collegial body, focusing the members' disparate views into a common position. For this reason, it is inappropriate for an individual member to attempt to interpret Committee positions or actions, except as authorized by the Committee and specifically with regard to recommendations reviewed by the Committee.

Except as noted below, individual members are always free, as individuals, to interact and communicate with other parties. However, it should always be clear that the member is not representing the Committee and is functioning as an independent expert/entity. It is inappropriate for a member to use the latitude provided in this paragraph to undermine a declared Committee position.

Where requests for interpretation of GAPB Advisory Committee positions are received, appropriate judgment should be used. Requests from Congress should be referred to the Chair and DFO. If an individual member is asked for an opinion, the member may respond, but should emphasize the fact that the individual members do not speak for the Committee. Requests from the media require more circumspection. The guiding principle is that a member should not undermine or reinterpret a Committee position, but is under no obligation to profess agreement with the Committee majority. The right to disagree does not imply the right to reinterpret.

To the extent that individual members engage in activities and communications outside of but related to the

work of the Committee, and which could be inadvertently mistaken for representing the work or opinion of the Committee, the Committee adopts the following expectations:

1. Members who have prepared papers, presentations, and other media that reference the Committee or recommendations submitted to the Committee should share them with the full Committee sufficiently in advance of their release such that revisions could be made in response to comments from the Committee if the member chooses to make such revisions.
2. Committee members should be given at least 48 hours to respond with suggestions or express concerns on content related to the GAPB Advisory Committee. Such content shall include a disclaimer that the member is not representing the Committee.

Except for discussions taking place as part of the Committee's or subcommittee's review of recommendations, members shall refrain from discussing with a submitter:

1. The submitter's recommendations (or related information) that are pending submission or have been submitted to the Committee, unless the member has announced to the submitter and the Committee his/her recusal from Committee and subcommittee work on the proposal; and
2. The Committee's processes surrounding the Committee's receipt, review, deliberation, and voting on the submitter's recommendations that are pending submission to the Committee or have been submitted to the Committee.

Section VII: Committee Meetings

The Committee will meet as often as necessary to complete its work timely. Meetings will be called by the DFO in consultation with the Committee Chair and will operate as follows:

Quorum

No meeting shall be held in the absence of a quorum. A quorum is a majority of the Committee's appointed membership. (The quorum is 9 members if all 17 members have been appointed.)

DFO Attendance

The DFO or the alternate DFO designated by the DFO must be present at each Committee meeting.

Agenda

Each meeting of the Committee shall be conducted in accordance with an agenda approved by the DFO. The DFO or those acting on behalf of the DFO will distribute the agenda to the members prior to each meeting and will publish an outline of the agenda with the notice of the meeting in the Federal Register. Items for the agenda may be submitted to the DFO and/or the Chair by any member of the Committee.

Minutes and Records

The DFO or those acting on behalf of the DFO will prepare minutes of each meeting and will distribute copies to each Committee member. Minutes of open meetings will be available to the public upon request. Minutes of closed meetings will also be available to the public upon request, subject to the withholding of matters about which public disclosure would be harmful to the interests of the Government, industry, or others, and which are exempt from disclosure under the Freedom of Information Act (FOIA). The minutes will include a record of the persons present (including the names of Committee members, staff, and members of the public from whom written or oral presentations were made) and a complete and accurate description of the matters discussed, conclusions reached, and copies of all reports received, issued, or approved by the Committee. All documents, recordings, reports, or other materials prepared by, or for, the Committee constitute official

government records and must be maintained according to United States General Services Administration (GSA) policies and procedures governing FACA committees.

Committee Deliberations

Committee deliberations on evidence, comments and recommendations shall be open to the public, except where a closed or partially closed meeting has been determined proper and consistent with the exemption(s) of the Government in the Sunshine Act (GISA), 5 U.S.C. 552b(c), as the basis for closure.

Committee Decision-Making

Committee decision-making (other than that described above in Section V, Ethics) will include both decisions on recommendations submitted to the Secretaries and other decisions that will be considered procedural decisions.

1. Committee decisions on recommendations to be made to the Secretaries shall be made in accordance with the procedures established by the Committee regarding recommendation review.
2. Other procedural decisions will be made by the Chair, first seeking to determine if consensus exists on the question under discussion. If consensus does not exist, the Chair will request a motion for a vote. Any member, including the Chair, may make a motion for a vote. No second after a proper motion will be required to bring any issue to a vote. If a quorum exists, a majority vote of the members present will be sufficient to approve a motion.

Subcommittees

Subcommittees may be established by the Committee Chair with the approval of the Secretaries or their designees to address specific issues. Subcommittee members will be composed of Committee members. A majority of the appointed subcommittee members shall constitute a quorum and no subcommittee shall meet unless a quorum of the subcommittee is present. The work of the subcommittees will be directed by the Chair. Subcommittees may convene or communicate via any combination of teleconference, videoconference, or email. Subcommittees will make their recommendations to the full Committee for deliberation; no action by a subcommittee will be considered an action by the Committee unless it has been approved by the full Committee. The DFO or the alternate DFO designated by the DFO must be present at each subcommittee meeting. If simultaneous subcommittee meetings are to be held, each subcommittee shall have a DFO or alternate DFO in attendance.

Openness

In compliance with the provisions of FACA, unless otherwise determined in advance, all meetings of the Committee will be open to the public and will follow relevant policies and procedures of FACA as specified in the Code of Federal Regulations at 41 CFR Parts 101-6. All materials brought before, or presented to, the Committee during the conduct of an open meeting, including the minutes of the proceedings of an open meeting, will be available to the public for review no later than 7 days after the meeting.

Members of the public may attend any meeting or portion of a meeting that is not closed to the public and may, at the determination of the Chair or acting Chair, offer oral comment at such meeting. Members of the public may be asked to pre-register for the meeting, and reasonable accommodations will be provided to those members of the public needing such accommodations. If the number of meeting registrants exceeds the capacity of the webinar platform, a wait list will be created. The Chair or DFO may decide in advance to exclude oral public comment during a meeting, in which case the meeting announcement published in the Federal Register will note that oral comment from the public is excluded and will invite written comment as an alternative. Members of the public may submit written statements to the DFO at any time.

Closed Meetings

Meetings of the Committee will be closed only in limited circumstances and in accordance with applicable law. In addition, requests for closed meetings must be approved by GSA's Office of General Counsel (OGC) 30 days in advance of the session. Where the DFO has determined in advance that discussions during a Committee meeting will involve matters about which public disclosure would be harmful to the interests of the Government, industry, or others, an advance notice of a closed meeting, citing the applicable exemptions of the Government in the Sunshine Act (GISA), will be published in the Federal Register. The notice may announce the closing of all or just part of a meeting. If, during the course of an open meeting, matters inappropriate for public disclosure arise during discussions, the Chair or DFO will order such discussion to cease and will schedule it for a closed session. Notices of closed meetings will be published in the Federal Register at least 15 calendar days in advance.

Section VIII: Staff Support

CMS and CCIIO are responsible for providing technical and operational support for the Committee, which may occur through the use of a contractor.

Section IX: Amendments

These Bylaws may be amended as needed by a vote of the members of the Committee. A simple majority vote in favor of amending the Bylaws shall constitute an approval of the amendment.

Appendix E – GAPB Advisory Committee Voting Record by Committee Member

Table 2. Voting Record by Committee Member by Recommendation

Member	1	2A	2B	2C	2D	2E	2F	2G	3A	3B	4	5	6	7	8A	8B	8C	9	10	11 A	11 B	12 A	12 B	13 A	13 B	13 C	14 A	14 B	14 C	15
Montes	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	N	Y	Y	Y	N	N	Y	—	Y	N	N	N	N	Y
Khawar	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	—	NP	NP	NP	NP	NP	NP
Weiser	A	Y	Y	Y	Y	Y	A	Y	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	—	A	A	A	A	A	A
McLean	A	Y	Y	Y	Y	Y	Y	Y	Y	A	A	A	A	A	A	A	A	A	A	A	A	A	A	—	NP	A	A	A	A	A
Wijetunge	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	A	A	A	A	—	NP	NP	NP	NP	NP	NP
Prentiss	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	—	Y	N	N	N	N	Y
Beck	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	Y	N	N	—	N	Y	N	N	N	N
Kelmar	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	N	Y	Y	N	—	Y	N	N	N	Y	N
Wingrove	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	N	N	Y	—	Y	N	N	N	N	N
Ogunsola	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	N	Y	N	—	Y	N	N	N	Y	N
Sahni	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	—	Y	N	N	N	N	N
Lawrence	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	—	Y	N	N	N	N	N
Baird	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	—	Y	N	N	N	N	Y
Van Horne	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	—	Y	N	N	N	N	Y
Crawford	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	N	Y	Y	Y	N	N	Y	—	Y	Y	N	N	N	Y
Holden	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	—	Y	N	Y	N	N	Y
Adler	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	N	—	N	Y	N	N	Y	N

Key: Y (in favor), N (opposed), A (abstaining), NP (not present), — (no vote)

Appendix F – GAPB Public Meeting Summaries

Ground Ambulance and Patient Billing (GAPB) Advisory Committee Public Meeting #1 – Meeting Summary May 2 - 3, 2023

The Ground Ambulance and Patient Billing (GAPB) Advisory Committee met virtually via Zoom.gov on May 2 and 3, 2023.The attached appendix identifies the Committee members, agency employees, and others who attended the meeting. In accordance with the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2, the meeting was open to the public. The webcast of the meeting is available at: CMS GAPB

Several topics were discussed at the meeting: (1) an overview of the ground ambulance industry; (2) insurance and ground ambulance payment systems; (3) ground ambulance billing practices; (4) disclosure of charges to consumers, separation of charges and cost shifting; (5) impact of balance billing on consumers and current consumer protections and (6) balance billing prevention, including potential legislative and regulatory options. The meeting consisted of a morning and afternoon session each day which included presentations and opportunity for discussion. The presentation materials that were provided at the meeting are available for public review and comment at CMS GAPB. The agenda for the meeting is attached as an appendix.

Day One May 2, 2023

Welcome

The first day of the GAPB Advisory Committee (Committee) meeting began at 9:30 AM on May 2, 2023. Terra Sanderson, moderator with Provider Resources gave welcoming remarks and provided meeting logistics. Ms. Sanderson stated the meeting would be live cast and a recording would be available on the CMS GAPB website following the meeting.

Presentations and Committee Discussion

Following the welcome and meeting logistics, the morning session of day one began. The Committee heard from speakers who presented overviews of the ground ambulance industry and No Surprises Act. After each session, the Committee was invited to ask questions and make comments.

Session 1: Introduction and Background

Introduction to the Ground Ambulance & Patient Billing Advisory Committee
Shaheen Halim, CCIO

The committee first heard from Shaheen Halim, Designated Federal Official for the Advisory Committee on Ground Ambulance and Patient Billing (GAPB) with Centers for Medicare & Medicaid Service. Ms. Halim welcomed the committee members to the inaugural meeting for the GAPB advisory committee. Ms. Halim reviewed the tasks assigned to the Committee by the Committee Charter and the No Surprises Act. Ms. Halim stated the intent of the meeting is to provide valuable background information to the committee and to the public to ensure that there is a full and robust understanding of issues pertaining to ground ambulance patient billing as it affects consumers and other stakeholders. Ms. Halim noted the GAPB committee is authorized by the No Surprises Act and the scope of topics for the committee is set my legislation, Section 117. Ms. Halim stated the GAPB committee is tasked with delivering a report to the Secretaries of Health and Human Services, Department of Labor, and Department of Treasury. This report will contain options for the secretaries to consider in implementing programs for disclosure of charges and fees for the ground ambulance services and insurance coverage. Finally, Ms. Halim introduced the 17 committee members and allowed them to give a brief introduction.

Overview of the No Surprises Act
Colin Goldfinch, CCIO

The committee then heard from Colin Goldfinch with the Center for Consumer Information and Insurance Oversight (CCIIO) at Centers for Medicare & Medicaid Services (CMS). Mr. Goldfinch provided an overview of the No Surprises Act as it relates to ground ambulance billing. Mr.
Goldfinch discussed the policies prohibiting surprise medical billing protections, and the key transparency policies related to providing consumers with either good faith estimates of their costs or advanced explanations of benefit.

Congress Recognized Need to Create Tailored Solution Specific to Ground Ambulance Services
Kathy Lester, Lester Health Law

Next the Committee heard from Kathy Lester with Lester Health Law. Ms. Lester discussed with the Committee Ground Ambulance services and the No Surprises Act. Ms. Lester provides an overview of the problem Congress sought to solve in the "No Surprises Act" and the complexities of understanding the issue of balancing billing in the context of ground ambulance services. Ms. Lester noted that Congress established two goals when establishing the Advisory Committee; to ensure that when Americans need an ambulance one is available and to protect patients and access to ground ambulance services. Ms. Lester discussed the concerns Congress expressed during the drafting of the legislation and the challenges the NSA definitions and structure presented if applied to the ground ambulance services without additional data and consideration by ambulance services, emergency services, and related experts. Next Ms. Lester discussed the costs of ground ambulance services and the current workforce crisis. Ms. Lester stated that more than one-third of ground ambulances providing EMS services in rural America are also in danger of closing. Ms. Lester noted that Congress established the advisory committee to provide a pathway for a solution to protect patients from balance billing and protect access to ground ambulance services and recommendations are needed on how to establish consumer protections to address certain insurance practices and to end the need for balance billing.

Session 2: Overview of the Ground Ambulance Industry

Introduction
Asbel Montes, GAPB Chairperson

Next the Committee heard from Asbel Montes chairperson for the Ground Ambulance and Patient Billing Advisory Committee. Mr. Montes gave welcoming remarks and thanked those present for attending. Mr. Montes stated as the chairperson, he is committed to ensuring that the committee operates with transparency, integrity and steadfast dedication to excellence. Mr. Montes noted that the Committee has been tasked with a vital responsibility of reviewing the options to improve disclosure of charges and fees for ground ambulance services to better inform the consumers that we serve of insurance options for such services and more importantly, protect the consumer from balance billing. Mr. Montes encouraged the Committee members to foster open communication and an inclusive environment where every single member's ideas and perspectives are valued, considered, and most importantly, heard

Overview of Fire-Based EMS Operations Career/Volunteer
Rob McClintock, International Association of Fire Fighters (IAFF)

Next the Committee heard from Robert McClintock Director of Fire and EMS Operations with the International Association of Fire Fighters (IAFF). Mr. McClintock provided a brief overview on the history and operations of career and volunteer fire-based EMS. Mr. McClintock stated that fire service is the predominant provider of EMS in the United States. Mr. McClintock discussed common trends in the EMS community and advantages of Fire-Based EMS.

Public and Private Partnerships
Mark Postma, AimHI

The Committee next heard from Mark Postma, Senior Vice President of Patient Care EMS (PCEMS) with AimHI. Mr. Postma described the characteristics and components of EMS Public/Private Partnerships commonly referred to as Public Utility Models (PUM). During the session, Mr. Posta pointed out important components of the PUM and fail safe protections for communities. Mr. Postma closed his presentation with a discussion of the financial differences in these Public Utility Models.

Overview of Non-Governmental Ambulance Services
Maria Bianchi, American Ambulance Association (AAA)

The committee then heard from Ms. Maria Bianchi, CEO of the American Ambulance Association. Ms. Bianchi provided an overview of private Emergency Medical Services (EMS) in the United States, the types and features, as well as the data related to private EMS's roles in providing mobile healthcare and its economic impact to communities as businesses and employers. Objectives include: a brief history and overview of private providers, various demographics (size, services provided, patients and communities served), their economic impact as employers and small business owners, and case studies of specific ways private ambulance services provide mobile healthcare in the United States.

Large Government Systems
Robert Luckritz, Austin-Travis County EMS

Rob Luckritz, chief of Austin-Travis County EMS in Austin, Texas presented on large government systems. Mr. Luckritz discussed the various governance models, to include, municipal, county, independent taxing district and the delivery models including fire-based or independent third services. Mr. Luckritz reviewed the unique mission profile of Austin Travis County EMS. He stated as a public service all of the funding is specifically to support the public good and all of our services are provided regardless of the ability to pay. Next Mr. Lukritz discussed how as a large governmental service the services provided are focused on equity and being a safety net to the providers and to the patients in the community. Mr. Luckritz noted that from a utilization standpoint as the community grows the goal is to identify ways to reduce the utilization of the EMS system. Finally, Mr. Lukritz discussed the funding models and cost drivers for large governmental systems.

State EMS Officials
Dia Gainor, National Association of State Emergency Medical Services Officials (NASEMSO)

Next the committee heard from Dia Gainor, Executive Director for the National Association of State Emergency Medical Services Officials (NASEMSO). Ms. Gainor discussed with the committee the roles and responsibilities of State EMS officials. Ms. Gainor provided the committee with examples of how state EMS officials have a direct impact on all local ground ambulance services in their state. Ms. Gainor then discussed the National EMS Information System and how the Committee can use data provided to quantify scenarios and practices.

Community-based Paramedicine
Gary Wingrove, The Paramedic Foundation

The committee then heard from Gary Wingrove, President of The Paramedic Foundation. Mr. Wingrove provided the committee with an overview of community paramedicine that included its beginnings, progress over nearly 20 years, and the landscape of current situation.

ET3 Model Test
Alexis Lilly and Chanelle Boone, CMMI

The Committee then heard from Alexis Lilly and Chanelle Boone of the Center for Medicare and Medicaid Innovation (CMMI).

Ms. Boone provided the committee with an overview of the Emergency Triage, Treat, and Transport (ET3) Model, a voluntary, five-year payment model that provides greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service (FFS) beneficiaries following a 911 call. Ms. Boone discussed how under this model, CMS pays participating ambulance providers and suppliers to transport to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health center (CMHC), or initiate and facilitate treatment in place with a qualified health care partner, either at the scene of the 911 emergency response or via telehealth. Ms. Boone noted the ET3 Model aims to reduce expenditures and preserve or enhance the quality of care by providing person- centered care, encouraging appropriate utilization of services, and increasing efficiency in the EMS system to more readily respond to and focus on high-acuity cases.

Following these presentations, the Committee adjourned for lunch.

Session 3: Insurance and Ground Ambulance Payment Systems Government Rate Setting Methodologies

Medicaid
Asher Mikow and Andrew Badaracco, CMS

Next the committee heard from Asher Mikow. Asher Mikow is a Technical Director with the Centers for Medicaid and Chip Services who has specialized in working with states to develop Medicaid value-based and innovative payment models in the Medicaid state plan fee-for-service delivery system. Mr. Miskow provided a high-level overview of how states may pay for ground ambulance services through Medicaid state plan authority. Mr. Miskow also described for the committee, permissible sources of funding of the state share of Medicaid payments and applicable regulatory citations and policies.

Medicare Ambulance Fee Schedule
Maria Durham, CMS

The committee then heard from Maria Durham, Division Director for Center for Medicare (CM), Technology, Coding, And Pricing Group (TCPG), Division of Data Analysis and Market Based Pricing (DDAMBP). Ms. Durham provided the committee with an overview of the ambulance transport benefit. Ms. Durham then discussed the COVID-19 Health Equity Task Force that was established by Executive Order 13995,Ensuring an Equitable Pandemic Response and Recovery to address the disproportionate and severe impact of coronavirus disease 2019 (COVID-19) on communities of color and other underserved populations. Finally, Ms. Durham provided information on the Medicare Ground Ambulance Data Collection System (GADCS) and the GADCS process.

Health Plan Coverage and Payment Requirements

Overview of Health Plan Coverage of Ground Ambulance Transportation
Adam Beck, AHIP

Next the Committee heard from Adam Beck, Senior Vice President for Commercial Employer and Product Policy at AHIP, the national trade association for health insurance providers, and many integrated healthcare systems. Mr. Beck provided an overview of how health plans determine coverage for ground ambulance transportation, including both emergency and inter- facility transportation. Mr. Beck discussed the levels of coverage that many commercial health plans provide for ground ambulance services, the destinations that commercial health plans will pay for ambulance transportation, the requirements that are typically associated with the plan's obligation to pay, and an provided an example of common plan contract terms and limitations

and exclusions.

Health Plan Coverage and Payment Requirements

Coverage and Payment Requirements for Health Plans *Asbel Montes, GAPB Chairperson*
Next, Asbel Montes, GAPB Chairperson provided examples of coverage and payment requirements for health plans from a payer perspective. Mr. Montes discussed the general coverage guidelines within the No Surprises Act around emergency ambulance services. Mr. Montes reviewed with the Committee the top 10 largest health insurance companies in the United States and their emergency ambulance services coverage.

Anatomy of an EMS Call
Ritu Sahni, MD, Clackamas County EMD and Washington County EMS

Next the Committee heard a pre-recorded presentation from Ritu Sahi on understanding EMS as healthcare. Mr. Sahni discussed the EMS response as a model, the components of the system and provided an overview of the infrastructure and training required to operate the system.

Level of Service and Care
Ed Marasco, Quick Med Claims

The Committee next heard from Ed Marasco of Quick Med Claims who presented on level of service and care aspect of the ambulance payment paradigm. Mr. Marasco discussed key aspects of the history of air ambulance payment system or the ambulance payment system as it relates to level of service. Mr. Marasco reviewed the level of service used in the current ambulance payment paradigm. He discussed the clinical view of these levels of care and service and the payment lens of that care or the payment algorithm which has been used over time. Mr. Marasco described some challenges that are a part of the current ambulance payment paradigm.

Independent Studies of Cost/Payment

Findings from MedPAC and GAO Analyses
Zach Gaumer, Health Management Associates (HMA)

Next the Committee heard from Zach Gaumer, Health Care Policy Consultant with Health Management Associates who presented findings from MedPAC and GAO analyses on ground ambulance services. Mr. Gaumer discussed findings related to costs for providing ambulance transports for various ambulance organization types. Mr. Gaumer noted that independent studies have shown, that higher costs per transport are associated with lower volume ambulance entities, entities with higher shares of emergency transports, geographically isolated areas, as well as entities that have high levels of government subsidy. Mr. Gaumer discussed recommendations from MedPAC and GAO for aligning Medicare payment with costs.

Ground Ambulance Payment and Billing for the Commercially Insured
Loren Adler, USC-Brookings Schaeffer Initiative for Health Policy

The last presentation of the day was Loren Adler, Health Economist at the Brookings Institution in Washington, D.C. Mr. Adler presented discussed with the Committee new data published in Health Affairs on ground ambulance payment and billing for commercially insured individuals, including breakdowns based on the ownership structure of ground ambulance organizations. Mr. Adler noted this data will detail prices nationally and by state, patient cost-sharing and balance bill magnitudes, and the prevalence of potential surprise bills. Mr. Adler also discussed how this data differs between ambulances owned by public sector entities, private equity or publicly traded companies, and other private sector companies.

Session 4: Wrap Up Day 1

The meeting was adjourned for the day by Ms. Sanderson around 5:30 PM. The meeting will reconvene at 9:00 AM on Wednesday, May 3, 2023

Day Two May 3, 2023

Welcome

The second day of the GAPB Advisory Committee (Committee) meeting began at 9:30 AM on May 3, 2023. Terra Sanderson, moderator with Provider Resources gave welcoming remarks and provided meeting logistics. Ms. Sanderson stated the meeting would be live cast and a recording would be available on the CMS GAPB website following the meeting.

Presentations

The morning session of day two consisted of presentations on ground ambulance billing. The Committee heard from speakers who presented on ground ambulance billing practices and disclosure of charges to consumers, separation of charges and cost shifting. After each session, the Committee was invited to ask questions and make comments

Session 1: Ground Ambulance Billing Practices

Overview of Billing Practices Among Ground Ambulance Provider Types
Kim Stanley, EMS Management and Consults (EMSMC)

The Committee first heard from Kim Stanley, Chief Compliance Officer with EMS Management and Consultants who provided an overview of the billing practices amongst the ground ambulance providers. Ms. Stanley provided the Committee the statistical make-up of the client base for a large billing agency, including the number of claims that are affected by potential surprise billing legislation. Ms. Stanley discussed how the charges are determined and explained the process in which a patient is billed for a ground ambulance service.

Overview of EMS Billing for the Oceanside (CA) Fire Department
Peter Lawrence, Oceanside Fire Division

Next the Committee heard from Peter Lawrence with Oceanside Fire Department in Southern California. Mr. Lawrence provided a high level overview of how the Oceanside Fire Department bills for EMS responses and transports. Mr. Lawrence provided information on how Oceanside Fire Department determines ground ambulance base rates, as well as their billing processes. Mr. Lawrence discussed some issues that help determine how Oceanside Fire Department bills for a service to include, time on task, mileage and medications, supplies needed, and the assessment required.

Private Ambulance Service Suppliers' Billing Practices Profile
Shawn Baird, American Ambulance Association

Next the Committee heard from Shawn Baird, licensed paramedic and past president of the American Ambulance Association. Mr. Baird discussed the role of private entities that provide ground ambulance services, particularly in rural and underserved areas, emphasizing the impact of how these challenges impact billing practice.

Session 2: Disclosure of Charges to Consumers

Overview of the Medicare Ground Ambulance Data Collection System
Andrew Mulcahy, The RAND Corporation

Next the Committee heard form Andrew Mulcahy, Health Policy Researcher and Health economist at the RAND Corporation who provided an overview of the Medicare Ground Ambulance Data Collection System (GADCS). Mr. Mulcahy discussed the GADCS process and how CMS selects organizations to collect information. He provided a high level overview of the GACDS general instructions and the 13 GACDS sections.

Disclosure of Charges to Consumers and Role of Essential Health Benefits
Adam Beck, AHIP

The Committee then heard from Adam Beck on the role of essential health benefits and disclosure of charges to consumers. Mr. Beck reviewed the 10 essential health benefit (EHB) categories that were established by the Affordable Care Act. Mr. Beck discussed how health plans cover EHB's and provided an example of costing.

Ambulance/EMS Responsibilities for Disclosure
Steve Wirth and Doug Wolfberg, Page, Wolfberg & Wirth, LLC

The final morning session presentation was given by Steve Wirth and Doug Wolfberg who provided overview of the challenges in EMS that make it difficult to provide informed disclosures to patients about the cost and coverage of ambulance services, especially at the time-of-service delivery or scheduling. They provided a summary of federal and state disclosure requirements and an overview of the current state of the law with respect to rate regulation of ambulance services. They described local rate regulation and disclosure requirements and the ordinance and contract rate regulation models. Finally, they described why point of service rate and coverage disclosures are such a challenge for both emergency and non-emergency ambulance services and the patients they serve.

Following these presentations, the Committee adjourned for lunch.

During the afternoon session, the Committee heard presentations on the impact of balance billing on consumers and current consumer protections and balance billing prevention, including potential legislative and regulatory options. As in the morning, after each presentation the Committee was invited to ask questions and make comments at the end of each session.

Session 3: Balance Billing – Impact on Consumers & Current Consumer Protections

Impact of Surprise Billing Laws
Jack Hoadley, Georgetown Center on Health Insurance Reforms

The Committee first heard from Jack Hoadley from the Georgetown Center on Health Insurance Reforms. Mr. Hoadley was asked to present to the Committee about the impact of surprise billing laws and state action to address ground ambulance billing. Mr. Hoadley discussed why ground ambulance billing protection is important and the ten states that protect patients from surprise ambulance billing. .Mr. Hoadley reviewed factors related to consumer and rate reimbursement and the partnership between state and federal in the No Surprises Act.

Consumer Access and Equity Issues
Justin Giovanelli, Georgetown

Next the Committee heard from Justin Giovanelli from Georgetown Center on Health Insurance Reforms. Mr. Giovanelli discussed consumer access and equity issues related to ground ambulance billing. Mr. Giovanelli reviewed how consumers are affected by the regulatory landscape for ground ambulance billing and how the gaps in the ground ambulance billing affects consumers as a practical matter. Mr. Giovanelli provided background information on regulatory mechanisms and network adequacy that is available for regulating and improving consumer access to providers.

Rural and Volunteer Ambulance Service Gary Wingrove, The Paramedic Foundation

Next the Committee heard from Gary Wingrove with the Paramedic Foundation. Mr. Wingrove provided and overview of rural and volunteer ambulance services. Mr. Wingrove described the uniqueness of providing EMS in rural, super-rural and volunteer models. Mr. Wingrove discussed the costs of ground ambulance services and provided policy suggestions.

Consumer Advocacy

Balance Billing – Impact on Consumers & Current Consumers Protections
Patricia Kelmar, PIRG

The Committee then heard from Patricia Kelmar, Senior Director for healthcare campaigns for U.S. PIRG, the Public Interest Research Group. Ms. Kelmar discussed the role of PIRG and the GAPB Committee. Ms. Kelmar noted her goal on this Committee is to help create solutions that maintain a robust emergency transportation system in all communities, but also accomplish two things for patients and insured Americans. Ms. Kelmar provided a real-life scenario of a patient impacted by ground ambulance billing. She then discussed the cost of surprise ambulance bills and provided suggestions on how to protect consumers.

Session 4: Potential Legislative and Regulatory Options to Prevent Balance Billing

Solutions/Objectives – Legislative and Regulatory Options – How to Prevent Balance Billing

Commissioner Jon Godfread, National Association of Insurance Commissioners (NAIC)

To begin session 4 the Committee heard from North Dakota Insurance Commissioner Jon Godfread. Mr. Godfread serves as Vice President for the National Association of Insurance Commissioners (NAIC). Mr. Godfread discussed approaches regulators can take while maintaining state and local control. Mr. Godfread shared recommendations for the Committee to consider based on the varying structures of ground ambulance billing while focusing on fairness for the consumer.

Matt Zavadsky, National Association of Emergency Medical Technicians (NAEMT)

Next the Committee heard from Matt Zavadsky, Director-at-Large for the National Association of Emergency Medical Technicians. Mr. Zavadsky provided an overview of the gap between the cost of service delivery, the reimbursement provided by governmental and commercial payers and how legislative action could mitigate the impact of balance billing on the patient, and local taxpayers, due to below cost reimbursement from commercial and governmental payers. Mr.
Zavadsky discussed three legislative changes that can be made to help reduce the impact of balance billing to patients due to under-reimbursement for ambulance services.

Evan Davis, IAFF

Next the Committee heard from Ethan Davis with IAFF. Mr. Davis discussed the different payer types for the EMS industry and a number of the challenges faced. Mr. Davis reviewed limitations to EMS reimbursement and provided suggestions on solutions to prevent balance billing.

Adam Beck, AHIP

Next the Committee heard from Adam Beck with AHIP. Mr. Beck discussed the challenges of ground

ambulance billing and potential solutions. Mr. Beck provided the Committee with three potential solutions at the federal legislative and regulatory levels. Mr. Beck then discussed potential solutions at the state level. He noted that currently ten states have some legal protections from consumers from ground ambulance billing and discussed these protections.

Kathy Lester, American Ambulance Association (AAA)

Next the Committee heard from Kathy Lester, Principle and Founder of Lester Health Law in Washington DC. Ms. Lester reviewed the goals for the advisory committee established by Congress. Ms. Lester then discussed recommendations for the advisory committee.

Consumer Advocacy

Potential Legislative and Regulatory Options
Patricia Kelmar, Public Interest Research Group (PIRG)

Next the committee heard from Patricia Kelmar with the Public Interest Research Group (PIRG). Ms. Kelmar discussed the need for ground ambulance services and the No Surprises Act protections for consumers. Ms. Kelmar provided recommendations for legislative and regulatory options for the Committee. She discussed the successes of the No Surprises Act and noted the law prevented one million out-of-network bills every month. Ms. Kelmar provided the Committee with real life examples of patients affected by ground ambulance billing.

Policy Options to Prevent Balance Billing
Loren Adler, USC-Brookings Schaeffer Initiative for Health Policy

For the final presentation of the Day, the Committee heard from Loren Adler Health Economist at the Brookings Institution in DC. Mr. Adler provided an overview of the federal and state options believed to be available for protecting consumers from balance bills from ground ambulance providers. Mr. Adler discussed the range of federal legislative approaches, limits with federal regulatory options, and how states that have regulated balance bills for ambulances have taken different approaches.

Session 5: Wrap Up Day 2

Next Shaheen Halim discussed the requirements of the GAPB Advisory Committee Ms. Halim noted that the Committee has two subcommittees. One of those subcommittees will be responsible for material related to network adequacy and cost and payment structures. Ms. Halim stated that this subcommittee will be co-led by Rogelyn McLean, who is the Secretary of HHS's designee for this FACA committee and Mr. Lee Resnick, who is a CMS employee that works in CCIIO, the Center for Consumer Information and Insurance Oversight. The second committee will be responsible for recommendations and findings pertaining to public and consumer disclosure and protection. Ms. Halim stated co-leading this committee will be Loren Adler and Patricia Kelmar. Both of these subcommittees will be responsible for addressing options for legislative and regulatory oversight to prevent balance billing of consumers and to enforce requirements.

The meeting concluded with the opportunity for final comments from the Committee and the public in attendance. The first meeting of the GAPB Advisory Committee was adjourned by Ms. Shaheen Halim around 4:00 PM.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

Shaheen Halim, Ph.D., J.D.
Designated Federal Official

Ground Ambulance and Patient Billing Advisory Committee
Centers for Medicare & Medicaid Services

Asbel Montes
Committee Chairperson
Ground Ambulance and Patient Billing Advisory Committee

Ground Ambulance and Patient Billing (GAPB) Advisory Committee Public Meeting #2 – Meeting Summary
August 16, 2023

The Ground Ambulance and Patient Billing (GAPB) Advisory Committee met virtually via Zoom.gov on August 16, 2023.The attached appendix identifies the Committee members, agency employees, and others who presented during the meeting. In accordance with the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2, the meeting was open to the public. The webcast of the meeting is available at: CMS GAPB

During the meeting, the Committee reviewed and discussed preliminary findings and recommendations from its two subcommittees. The meeting consisted of morning and afternoon sessions which included presentations and opportunity for discussion. The presentation materials that were provided at the meeting are available for public review and comment at CMS GAPB. The agenda for the meeting is attached as an appendix.

Welcome & Introduction to the GAPB Subcommittees

The second public meeting of the GAPB Advisory Committee meeting began at 9:30 AM on August 16, 2023. Terra Sanderson, moderator with Provider Resources gave welcoming remarks and provided meeting logistics. Ms. Sanderson stated the meeting would be live cast and a recording would be available on the CMS GAPB website following the meeting.

Shaheen Halim, CCIO, Designated Federal Officer Asbel Montes, GAPB Chairperson

The Committee first heard from Shaheen Halim, Designated Federal Official for the Advisory Committee on Ground Ambulance and Patient Billing (GAPB) with Centers for Medicare & Medicaid Service. Ms. Halim began her presentation with a brief background of the GAPB Committee. The GAPB Committee is authorized by the No Surprises Act and the scope of topics for the Committee is set my legislation, Section 117. Ms. Halim stated the Federal Advisory Committee Act (FACA) governs the formation and operation of the Committee and membership was formally announce in December 2022. Ms. Halim then reviewed the statutorily mandated scope of the GAPB Committee. The GAPB Committee is tasked with delivering a report that includes recommendations to the Departments of Health & Human Services, Labor and Treasury. This report will contain options for the secretaries to consider in implementing programs for disclosure of charges, consumer protections and fees for the ground ambulance services and insurance coverage. Ms. Halim noted the report is due 180 days after the date of the 1st Committee Meeting which was held May2-3, 2023. Ms. Halim stated today's meeting will focus on the preliminary findings and recommendations of the Network Adequacy & Cost/Payment Structure and Public/Consumer Disclosure & Coverages subcommittees. Ms. Halim then reviewed the process for submitting public comments to the GAPB Advisory Committee. Comments can be submitted via the chat feature during the meeting or emailed to gapbadvisorycommittee@cms.hhs.gov.

Next, the Committee heard from Asbel Montes, chairperson for the GAPB Committee. Mr. Montes gave welcoming remarks and thanked those present for attending and special guests. Mr. Montes provided the Committee with a brief overview of the subcommittee tasks. The two subcommittees meet weekly on Wednesdays to discuss findings. Mr. Montes stated that the Committee will be provided with an update today on the subcommittee's preliminary findings. Mr. Montes encouraged attendees to submit any questions and public comments via chat or to the GAPB mailbox.

Morning Sessions

Session 1: GAPB Subcommittee on Network Adequacy & Cost/Payment Structures

Rogelyn McLean, HHS Lee Resnick, HHS

The Committee first heard from Rogelyn McLean, co-lead for the Network Adequacy, cost and Payment Structures subcommittee regarding terms and definitions. Ms. McLean noted the statutory mandate of this subcommittee is to provide recommendations on potential federal, state and local regulatory and enforcement options for preventing ground ambulance balance billing and protecting consumers. Ms. McLean stated the subcommittee is tasked to provide recommended definitions of terms that should be adopted by the Department in rulemaking related to ground ambulance operations and balance bills for ground ambulance services. Ms. McLean then hosted a working session with the Committee to review the list of terms and the definition and welcomed feedback on the definitions.

Session 2: NHTSA & NEMSIS Presentation

Eric Chaney, MS, MBA, NREMT, NTSHA Office of EMS

Next the Committee heard from Eric Chaney, Program Manager, with the National EMS Information System (NEMSIS). Mr. Chaney began his presentation with a brief overview of NEMSIS. NEMSIS is a data standard that was established for all ambulance services in the United States. Mr. Chaney stated that today's presentation will focus on 2022 ground ambulance transport data. The 2022 NEMSIS data contains 51,379, 493 EMS activations submitted by 13,946 EMS agencies serving 54 states and territories. Mr. Chaney noted that ground transport represents 86.62% of this data. Mr. Chaney discussed with the Committee the percentage of calls where patients were treated with no transport. Mr. Chaney stated that 4.65% of patients treated without transport was due to patient refusal. Mr. Chaney then provided the Committee with the percentage of non-transport calls where patients received treatment in place. Next, Mr. Chaney discussed the most common reasons for non-transport for ground ambulance services. Mr. Chaney then provided the Committee with a breakdown of the transport destination for patients that required transport. Mr. Chaney stated that fire departments represent the largest percentage of agencies that submit data to NEMSIS. Mr. Chaney then provided the Committee with a breakdown of the variation of submissions by the USDA Urbanicity Codes. Mr. Chaney noted that NEMSIS uses urban, rural, suburban and frontier to categorize data. Mr. Chaney stated that only seven states require agencies to submit billing information. Mr. Chaney then welcomed any questions from the Committee and public.

Following these presentations, the Committee adjourned for lunch.

During the afternoon sessions, the Committee heard presentations on public/consumer disclosures and coverages, HIPPA regulations and cost and payment structures. As in the morning, after each presentation the Committee was invited to ask questions and make comments.

Afternoon Sessions

Session 1: GAPB Subcommittee on Public/Consumer Disclosures & Coverages

Patricia Kelmar, PIRG
Loren Adler, USC-Brookings Schaeffer Initiative for Health Policy

For the first afternoon session, the Committee heard from the Public/Consumer Disclosures & Coverages subcommittee co-leads Patricia Kelmar and Loren Adler. Mr. Adler reviewed with the Committee the goals of the subcommittee. Mr. Adler stated the focus of this subcommittee is to address how consumers can be best protected from costly ground ambulance bills, what are the consumer protections and are disclosures needed. Mr. Adler discussed with the Committee the policy issues/questions that were addressed during the subcommittee meetings. Mr. Adler noted that the subcommittee heard from multiple Subject Matter Experts (SME) to include the Center for Medicare and Medicaid Innovation (CMMI) officials: ET3 Model, EMS billing companies, insurance claims data organizations and state officials. Ms. Kelmar provided the Committee with an overview of the feedback the subcommittee received from the SMEs. Ms. Kelmar stated that

emergency services encompass more than just transport and treatment in place is not always covered by payers. The subcommittee also found that there are challenges in classifying emergency versus nonemergency for interfacility transports and this can lead to coverage disputes. Ms. Kelmar noted that due to the cost-sharing for ground ambulance transports being higher for Medicare Advantage than for a traditional Medicare plan, consumers on a traditional plan have higher costs. Ms. Kelmar then provided the Committee with feedback received from the State representatives. Ms. Kelmar noted that the consensus for all the state regulators was that consumers should be taken out of the middle of network disputes and emergency situations. Ms. Kelmar stated that there are now thirteen states that have surprise billing laws to protect consumers. Ms. Kelmar then discussed with the team the subcommittee's findings and welcomed public comment on the consumer protections and disclosures topics listed on the agenda. Ms. Kelmar noted public comments should be submitted to the GAPB mailbox by September 5, 2023.

Session 2: HHS OCR Presentation

Timothy Noonan, Office for Civil Rights (OCR)

Next the Committee heard from Timothy Noonan. Mr. Noonan is the Deputy Director for Health Information Privacy, Data, and Cybersecurity, at the Office for Civil Rights (OCR), United States Department of Health and Human Services. OCR administers and enforces the HIPAA Privacy, Security, and Breach Notification Rules and the Patient Safety and Quality Improvement Act and Rule through investigations, rulemaking, guidance, and outreach. Previously, Mr. Noonan served in OCR headquarters as the Acting Associate Deputy Director for Operations and the Acting Director for Centralized Case Management Operations. Mr. Noonan joined OCR as the Southeast Regional Manager in November 2013. Prior to joining OCR, Tim worked for the U.S. Department of Education, Office for Civil Rights, and was a shareholder in a Michigan law firm. Mr. Noonan is a graduate of Michigan State University and Wayne State University Law School.

Mr. Noonan began with a short overview of the HIPAA rules. Mr. Noonan stated that the HIPPA statue required the adoption of federal privacy protections for individually identifiable health information. This is accomplished through three rules; the HIPPA privacy rule, the HIPPA security rule and the HIPPA breach notification rule. Mr. Noonan provided the Committee with a description and examples of each rule. Next, Mr. Noonan discussed with the Committee who must comply with HIPAA and what is Protected Health Information (PHI). Mr. Noonan noted that HIPPA rules apply to covered entities and certain provisions, the security rule and primarily the impermissible disclosure provisions apply to business associates. A covered entity is defined as healthcare providers who transmit health information electronically in connection with the transaction for which the is a HIPPA standard. Mr. Noonan stated that PHI is identifiable health information held or transmitted by a covered entity or its business associate, this can be in any form to include electronic, paper or oral. Mr. Noonan then focused on areas of interest for ambulance providers covered by HIPAA and what protected health information hospitals can share with ambulance providers.

Session 3: GAPB Subcommittee on Network Adequacy & Cost Payment Structures

Rogelyn McLean, HHS Lee Resnick, HHS

For the last presentation of the day, Rogelyn McLean provided an update from the GAPB Subcommittee on Network Adequacy and Cost Payment Structures. This subcommittee is lead by Rogelyn McLean and Lee Resnick. Ms. McLean noted the stator mandate of this subcommittee is to provide recommendations on potential federal, state and local regulatory and enforcement options for preventing ground ambulance balance billing and protecting consumers. Ms. McLean then announced the members of the subcommittee and reviewed the four major areas of focus for the subcommittee. Ms. Mclean stated the first area of focus is terms and definitions. The subcommittee is tasked to recommend definitions of terms that should be adopted by the Department in rulemaking related to ground ambulance operations and balance bills for ground ambulance services. Ms. McLean stated the next area of focus for the subcommittee is to address state and federal authorities that can be leveraged to protect consumers and prevent balance bills. This third area of focus for the

subcommittee is the methodology for compensating out-of-network for ground ambulance services. The last area of focus for the subcommittee is to review the differences in costs between ground ambulance suppliers. Ms. McLean stated that the subcommittee has heard from several SMEs to include NEMSIS, CMMI and State Regulators. Ms. Mclean then reviewed the Committee feedback received during the subcommittee meetings and welcomed public comment on the topics.

Session 4: Next Steps & Public Comment

Shaheen Halim, Ph.D., J.D., Designated Federal Officer Asbel Montes, GAPB Chairperson

Next Shaheen Halim thanked all the presenters and members of the public for feedback during today's meeting. Ms. Halim stated all public comments should be submitted via email to the gabadvisorycommittee@cms.hhs.gov mailbox to ensure timely consideration.

Asbel Montes then discussed with the Committee the next steps for the subcommittee members. Mr. Montes stated that immediately following this meeting the two subcommittees will consolidate into one subcommittee. This subcommittee will be led by Asbel Montes and Rogelyn McLean and will meet weekly. provided the Committee with the next steps. Mr. Montes noted that during the final public Committee meeting in November the full committee will vote on recommendations to be included in the final report to CMS. The meeting concluded with the opportunity for final comments from the Committee and the public in attendance.

Materials for this meeting will be available for download on the CMS.gov ***GAPB*** website. Presentations will be available within 7 days after the meeting. A recording of the virtual meeting will be made available within 30 days after the meeting. As we continue this webinar series, we look to you as industry experts to provide feedback and recommend information that would be beneficial in future webinars. Public comments on the specific topics listed in the agenda should be submitted by September 5th for consideration by the Advisory Committee.

The second public meeting of the GAPB Advisory Committee was adjourned by Ms. Terra Sanderson around 4:00 PM.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

Shaheen Halim, Ph.D., J.D.
Designated Federal Official
Ground Ambulance and Patient Billing Advisory Committee
Centers for Medicare & Medicaid Services

Asbel Montes Committee
Chairperson
Ground Ambulance and Patient Billing Advisory Committee

Ground Ambulance and Patient Billing (GAPB) Advisory Committee Public Meeting #3– Meeting Summary
October 31, 2023 – November 1, 2023

The Ground Ambulance and Patient Billing (GAPB) Advisory Committee met virtually via Zoom.gov on October 31 – November 1, 2023. During the two-day meeting, the Committee reviewed and discussed findings and recommendations from its two subcommittees. The meetings consisted of morning and afternoon sessions which included presentations and opportunities for discussion.

In accordance with the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2, the meeting was open to the public. Information about the meeting, including the agenda and webcast, is available at https://www.cms.gov/medicare/regulations-guidance/advisory-committees/advisory- committee-ground-ambulance-and-patient-billing-gapb%20. Appendix A is the meeting agenda. Appendix B identifies the GAPB Advisory Committee members. Appendix B is the meeting agenda.

Day One October 31, 2023

Welcome & Introduction

The third public meeting of the GAPB Advisory Committee meeting began at 9:30 AM on October 31, 2023. Terra Sanderson, moderator with Provider Resources gave welcoming remarks and provided meeting logistics. Ms. Sanderson stated the meeting would be live cast and a recording would be available on the CMS GAPB website following the meeting.

Shaheen Halim, CMS, Designated Federal Officer

The Committee first heard from Shaheen Halim, Designated Federal Official for the Advisory Committee on Ground Ambulance and Patient Billing (GAPB) with Centers for Medicare & Medicaid Service. Ms. Halim began with a brief overview of the work the GAPB Committee has completed over the past five to six months to develop the recommendations and findings that will be discussed during the meeting. The GAPB Committee is authorized by the No Surprises Act and the scope of topics for the Committee is set by legislation, Section 117. Ms. Halim stated the Federal Advisory Committee Act (FACA) governs the formation and operation of the Committee and membership was formally announced in December 2022. The committee convened throughout 2023. The first public meeting was in May of 2023, during which the Committee provided an overview of the ground ambulance industry and issues pertaining to surprise billing. Ms. Halim noted at the end of the first public meeting subcommittees were established to begin researching potential recommendations. The second GAPB Advisory Committee public meeting was held in August. During this meeting the preliminary findings from the subcommittees were discussed. The public was allowed the opportunity to provide comments on 14 key issues during a public comment period that ended September 5, 2023. The public comments received during that period and during the year earlier were reviewed by the Committee in drafting the key findings and the recommendations.

Ms. Halim then reviewed the agenda items and the process the Committee will follow to vote on the recommendations. Ms. Halim noted the public will be given the opportunity to provide public comments during the afternoon session. Additionally, written comments can be submitted to the GAPB Advisory Committee by email or via the survey link that will be distributed at the conclusion of the meeting.

Ms. Halim noted the meeting artifacts will be posted on the GAPB Advisory Committee website. Additionally, the committee will be compiling a report that will be issued to the Secretaries in early 2024. This report will contain options for the Secretaries to consider in implementing programs for disclosure of charges, consumer protections and fees for the ground ambulance services and insurance coverage.

Morning Sessions

Session 1: GAPB Overview

Asbel Montes, Committee Chairperson Rogelyn McLean, HHS

The Committee first heard from Rogelyn McLean and Asbel Montes who provided a brief overview of GAPB Committee. Over the past six months, the Committee has been working on recommendations for consumer protections, disclosures, and preventing surprise billing over the last six months. The committee will vote on these recommendations later this afternoon, culminating in a final report to Congress and the Secretaries. The final report will explain the rationale for the recommendations and is expected to be issued in early 2024. Ms. Mclean then discussed the statutory charge of the Committee. Next, Ms. McLean discussed what is balance billing and the subject matter experts the Committee has met with to develop the recommendations. Ms. Mclean noted the Committee will review fifteen recommendations during the meeting. Finally, she thanked the Committee members and public for their participation.

Session 2: Key Findings Discussion

Asbel Montes, Committee Chairperson

Next the Committee heard from Asbel Montes, who provided an update on the Committee's Key Findings. Mr. Montes provided a brief overview of the Medicare Ambulance Fee Schedule and the evolution of the ambulance payment system. The current Medicare ambulance fee schedule is based on a base payment that covers labor and administrative components, based on the physician fee schedule. The formulary was negotiated through rulemaking, with 70% of adjustments related to labor and 30% to non-labor-related portions. The RVU system is similar to the position fee structure, with a conversion factor for ambulances. Mr. Montes noted the ambulance industry faces challenges in determining cost, and experts have discussed various cost models and reporting methods at the state level. In 2018, Congress extended the Bipartisan Budget Act, which required a five-year extender for ground ambulance cost data collection. The MedPAC report was stalled due to COVID-19, but the Consolidated Appropriations Act extended it for two years. The report was due to Congress after reviewing the initial data set. The report was to provide recommendations on the Medicare ambulance fee schedule and its impact on communities, whether urban or rural. The first public committee heard presentations on Medicare program data related to this issue. Mr. Montes then discussed with the Committee the four key findings. Mr. Montes stated the first key finding the Committee is recommending that Congress continue to work with stakeholders relative to the data that comes out of here in this MedPAC report as they modernize the Medicare ground ambulance benefit. Mr. Montes stated the second key finding the Committee is recommending that Congress establish a standing advisory committee. This committee would evaluate coverage and reimbursement of ground ambulance services under the Social Security Act. Mr. Montes then asked Gary Wingrove to provide an overview of Community Paramedicine. Next Peter Lawrence discussed Advance Life Support and First Response. Mr. Montes then discussed the remaining key findings and Gary Wingrove discussed ground ambulance service providers in rural, super-rural and underserved areas.

Following these presentations, the Committee adjourned for lunch.

Afternoon Sessions

Session 1: Public Comment

For the first afternoon session, the public was allowed the opportunity to provide public comments. PRI provided logistics on how to participate in the public comment session and facilitated the comments. Participants were given three minutes to provide public comments and asked to provide their name and organization.

Scott Moore, Moore EMS Consulting

"My name is Scott Moore. I am with Moore EMS Consulting in Moore Healthcare, LLC. I have been an EMT for over 33 years and a call firefighter -- or served as a call fighter in my hometown community of Topsfield, Massachusetts, for over 18. I have also been an EMS attorney for over 20 years. My firm assists EMS and public safety clients with various issues impacting EMS organizations, but primarily we focused on the Human Resources and workforce challenges that are facing EMS organizations today. I first just want to thank the Committee and its members for all of their hard work and efforts over the last few months. I know it has been incredibly challenging. I appreciate how complex and dynamic the factors are that impact balance billing with regards to the provision of ground ambulance services in this country. We're all anxious to take the patient out of the middle.

However, given the vast differences of EMS needs across the United States in the different urban, rural, and super rural communities the EMS agencies serve, I think it's going to be very difficult to develop one regulatory standard. So, I simply just ask the Committee to keep in mind the importance of local control of EMS in the regulatory arena. Then I ask the Committee to also keep in mind the Supreme Court's sort of position that Congress cannot commandeer states' regulatory process by ordering states to enact or administer a federal regulatory program that restricts the state actors' control. With that, I thank you."

Randall Strozyk, American Ambulance Association

"I am the President of American Ambulance Association, as well as I am a member of the Leadership Team at Global Medical Response. I want to also pass on, on behalf of the AAA, our appreciation to every member of this Committee and to the staff who have spent months working on our process that we know is complex but incredibly important for the continuation and stability of health care across the country. I also support, and we want to reiterate Scott's comments, that avoiding and cannot have ground ambulance fall into the NSA criteria. We are a different entity, and we are very much the stopgap for health care across the country. But equally important to us, or additionally important to us, is we need meaningful access to coverage. Many patients told us how they thought they had comprehensive coverage with their various health care plans, only to find out in the small print -- that nobody can read nor necessarily understand that coverage for ambulance service is either not covered or it's very limited. We need it to require -- the process to this community to require plans to cover ground ambulance service is an important part of consumer protection.

By that, people know that they are protected and that they are not going to be surprised to find out that their insurance coverage isn't there. It's difficult for providers to know what each plan is covering, so important to have a consistent pathway for patient responsibility. We need to be transparent so that people know what is covered and that they are protected. And I appreciate again everyone's time and commitment to this. We look forward to seeing the process continue today and into tomorrow. Thank you."

Katie Van Deynze, Health Access California

"Good afternoon, Committee members. I'm Katie Van Deynze with Health Access California, our statewide health care consumer advocacy coalition. We sponsored our new California law, signed earlier this month, which bans surprise medical bills for ground ambulance services and caps what the uninsured can be charged for ambulance services. We are here to share about California's new law, what we learned and offered and as an approach for your consideration, as well as recommendations to replace the federal prudent layperson standard for emergency care with California's law that offers greater consumer protection. Under California's new law, AB 716, if a consumer is transported in an out-of-network ambulance, consumers will be prohibited from receiving a bill beyond their in-network cost-sharing amount. In this situation, the insurer health plan will be required to pay the ambulance provider, both public and private, the remainder of the locally set ambulance rates. We chose to require payment at the locally set rate because this rate is set through an existing public process approved by elected officials responsible to their constituents, and these rates are set by cities or

counties. These processes will also allow interested stakeholders to engage in that public process, including consumer advocates and health plans. Importantly, under California law local governments cannot charge more than the cost of ambulance services.

If adopted nationally, there should be similar guardrails for other states and local governments to prevent increases in rates to backfill other budget needs on the backs of consumers' health care. To monitor the local ambulance rates, our new law requires an annual state report on trending local rates by county and requires that report to be submitted to the regulators for rate review and our new Office of Healthcare Affordability. This law applies to both emergency and nonemergency ambulance transport, including inner facility transfers. We offer California's new law as an approach for your consideration and are here as a resource. We were also asked to provide recommendations on the standard for health insurance payment claims for hospital emergency care, and we recommend replacing the prudent layperson standard with the reasonable lease standard in California law with adjustments appropriate for behavioral health crises and protections for post-stabilization care. You can find more details about all of these recommendations in our memo that we submitted to the Committee. Thank you for your time and consideration and all your work, thank you."

Doson Nguyen, National Rural Health Association

"My name is Doson Nguyen. I am the Legislative Affairs Manager at the National Rural Health Association and the newest member of the Government Affairs Team. Before that, I spent some time advising Congress on veterans' health and rural health policy issues. Before that, I spent some time in the courts; and I also spent eight years as an Army National Guard combat medic. So just to go over high-level policy positions from the National Rural Health Association, we have several issues that we'd like to raise including we support increasing ambulance payment to adequately cover reasonable standby and fixed costs. We support considering EMS as an essential service, the same as firefighting and law enforcement. And we support collecting rural ambulance agency workforce data to better understand workforce needs. Along that line, there is the Siren Act, which is federal legislation that would provide mechanisms to support education, particularly asynchronous and distance learning for rural EMS licensure and continuing education and programs. There's also legislation in Congress called the Protecting Access to Ground Ambulance Medical Services Act. This is a piece of legislation sponsored by Senator Cortez Masto from Nevada and co-sponsored by Senators Collins, Stabenow, and a ranking member of the Senate Health Committee, Senator Bill Cassidy. The legislation would ensure that all communities, particularly those in rural and underserved areas, have access to quality emergency ambulance services no matter where they live and would extend and increase Medicare payments for emergency ambulances. There's also some legislation coming down the line which would ease the transition from military medics to civilian EMTs that you can look for to be introduced here hopefully in the next month or so. That's all I have, so thank you very much."

Wayne Jurecki, Bell Ambulance

"My name is Wayne Jurecki. I am with Bell Ambulance in Milwaukee, Wisconsin. I have been part of Bell Ambulance and involved in EMS since 1984. Much of my experience is on the reimbursement side and regulatory rates. My experience and that of several of my colleagues that I've discussed with in other states is that the state and local rate regulation is a very thorough process. For example, here in the Milwaukee market when we were setting our rates with the City 911 system, the City comptroller actually did review of our financial statements to be able to make sure that the rates set would be sustaining for us as an organization but cost- effective for the residents in the city of Milwaukee. This type of process has occurred in many jurisdictions around the nation, and we just want to make sure that the Committee recognizes the effort, or the level of effort, that has been put in by the state or local jurisdictions in setting the rates for their ambulance services. This is something that certainly can be utilized when setting what a fair payment rate structure looks like in the advice of this Committee. Would also like to thank the Committee members for all their time and effort over the past many months, some, year on this process. So, thank you for your attention. Just looking to make sure that we get good, reasonable rates used for our payments going forward. Thank you. "

Jack Hoadley, Georgetown University

"This is Jack Hoadley. I'm a Research Professor Emeritus at Georgetown University. Appreciate the opportunity earlier this year to provide information to the Committee, and I appreciate all of the valuable work this Committee has done. I think we've all learned a lot. I just wanted to focus on what I think are the three chief goals of some of the recommendations that you're going to be talking about today. One is to protect consumers from balance bills. Another is to make sure we have fair payment to providers when they're treating patients, transporting patients out of network. Finally, containing costs for the health care system overall including consumer premiums. As you think about those things, I think some of the approaches that are important from the consumers are to ban balance bills, both in emergency and nonemergency transport situations by keeping in mind some of those key findings that you've just talked about earlier this morning. But also limit cost sharing to use some kind of a standard comparable to a lesser of a fixed amount, like a $50 to $100, a percentage coinsurance. But importantly, the plans in network cost sharing so that consumer costs are never above that in-network cost sharing level. Then as you think about setting a payment standard for providers, I think it's critical to balance the need to pay providers fairly with the need to make sure that we focus on overall costs and critical to keep total costs in mind as we do that. Considering some ability to establish guardrails on the use of either Medicare rates to the extent that that's part of your recommendations, but also the local rates to make sure that the end result does not raise costs to the system as a whole and raise premiums. Again, thank you for all your hard work on this process. We're always happy to provide more information if that's helpful as you go through finalizing your report. Thank you."

Jamie Pafford, Pafford Medical Services

"I'm Jamie Pafford with Pafford Medical Services in Polk, Arkansas. We're part of a 57-year-old family-owned and operated ambulance service. I've also had the pleasure of being the chairperson for the American Ambulance Association GAPBAC Committee. Just like so many others on this phone, so much time has been devoted to this topic; and we all found it very near and dear to our hearts. So, I can't thank the group enough for taking the time and your expertise and putting it to good use for our industry. The real point I want to make today is just to reiterate the importance of not just adding ground ambulance services to the current NSA. As an ambulance industry, we worked diligently for ground ambulance providers not to be included in that beginning document and later on the actual bill because we realize that we are very different from hospitals and physicians and other health care providers. Because at a moment's notice, as you all have heard throughout this nine-month deal that we respond immediately when an ambulance is called regardless of someone's ability to pay; and that has to be taken into consideration as we move forward.

Some examples of the provisions that do not work for our consumers for ground ambulance services are the consumer protections related to the disclosures and the access to services, as well as the methodology for setting the initial payment amounts and rates. And I appreciate you all taking all of that into consideration as you move forward. But it's so important that you make specific recommendations with specific policy modifications to ensure that we're addressing the problem of surprise billing and that it does not jeopardize our access to care and, in some cases possibly, even eliminate the ability of ambulance providers, especially in rural service areas, to respond to the needs of our local communities. So, we realize that there's a cost factor. We realize people don't want rates to go up. But at the same moment, they want to make sure an ambulance is there when their family members need it; and that's what we strive to do as our industry as well. Thank you for your hard work."

Adam Fox, Colorado Consumer Health Initiative

"Good afternoon, members of the Committee. My name is Adam Fox. I'm the Deputy Director at the Colorado Consumer Health Initiative. I think we would echo some of the comments that you've already heard, and we've already provided written commentary to the Advisory Committee and want to thank you for your time and work on this issue. I think we just want to reiterate that our end goal is to prohibit and ban the practice of balance billing consumers in emergency and nonemergency ground ambulance scenarios. We see through our

consumer assistance program that where we help folks navigate medical billing and insurance claim issues in particular a significant increase in the number of balance bills resulting from interfacility ground ambulance transfers. As you know, Colorado has at least partially addressed surprise out-of-network bills for ground ambulances in emergency scenarios. However, we still continue to see some of those as well. And it's important to ensure that consumers do not continue to receive balance bills in these cases because they are incredibly difficult to resolve. We also want to emphasize the need to limit the out-of-pocket costs for consumers, preferably to a set amount that is reasonable, though we acknowledge that operating with the in-network cost sharing structure may be an option but would encourage the Committee to consider a set cost amount for the in-network cost sharing, whichever is lower for the consumer.

Then also want to reiterate some of the commentary that you've heard that there needs to be a balance in reimbursement for sustainability for ground ambulance services and cost containment. We would also encourage the Committee to consider reasonable limitations on the level of variation allowed for reimbursement rates, as that may be important to ensure that consumers are protected in a similar way across the country. Lastly, I want to note that any sort of disclosure notification to consumers should really focus on their rights and protections under the rules and regulations and laws that exist. As we noted in our comments, disclosure and notification in ground ambulance cases cannot be applied in a similar way to scheduled services. In many cases, consumers do not have an option as to the ground ambulance that they are taking, whether they called 911 or transferred between facilities or receive other services. I will leave it at that and want to thank the Committee for your work. If there is more information we can provide, we are certainly happy to do so. Thank you."

Kim Godden, Superior Air-Ground Ambulance

"Hi, my name's Kim Godden. I'm with the Superior Air-Ground Ambulance Service of Indiana. I also chair government relations and am on the board for the Indiana EMS Association. We've been working really hard in the state of Indiana, our Association has, because in 2018 the largest health care provider in our state sent a letter out to all providers and said, 'Whether you're in-network or out-of-network, this is the rate we're paying you; and there is no negotiation.' That was in 2018. So, in essence when that occurred, that's when larger balance bills arrived to the consumers. We're in the business, me and my colleagues in the state, we're in the business of saving lives and not billing patients and don't want patients to be in the middle. With respect to cost containment, costs have increased significantly since 2018. That was prior to the pandemic. Since the pandemic, we've got paramedics and EMTs that are leaving the industry working in hospitals or leaving health care altogether or going to Amazon or other non-filled jobs because those jobs can pay more. Primarily that's because when reimbursement is fixed, we as an industry can't provide those competitive wages.

Our State General Assembly has tried to assist the industry and put regulations put a law in place in 2022 requiring commercial providers within the state of Indiana to negotiate reimbursement rates to make sure that all ambulance providers were in-network. That legislation created nine criteria that commercial providers would look at when they negotiate; and unfortunately to date, we have yet to see any commercial provider use those criteria to negotiate rates. Instead, any negotiation is a take-it-or-leave-it. We're going to increase up 1% or 2% over X rate and not taking a look at what the actual costs are within the geographic region that we operate in. So just appreciate the Committee looking at this issue. I know there's discussion about failure for there to be true negotiations, and that's really what puts patients in the middle. We really want there to be -- as Mr. Fox pointed out, there needs to be adequate reimbursement in order to maintain the system. We realize that there needs to be cost containment to the consumer; but when the insurance company is not able to fully have those negotiations or is not willing to pay a fair reimbursement rate, that's what puts the consumer at risk. Thank you."

Angela Johnson, Oklahoma Ambulance Association

"Good afternoon. I'm Angie Johnson. I serve as the Board Director for the Oklahoma Ambulance Association. First, I want to express my sincere gratitude to the Committee for the time and effort invested in addressing the

crucial aspects in this area. I'd like to emphasize a few key points for the Committee's consideration. In sharing cost and clear pay requirements, I cannot stress enough the significance of ensuring cost and transparent pay requirements. It has come to my attention that numerous plans tend to compensate patients rather than providers or prolong the reimbursement process, thereby exposing individuals to the risk of the surprise bill. It's imperative to establish measures that prevent such surprises, given that patients may not always be aware that the check received from the insurer needs to be forwarded to the provider. I would like to also underscore the importance of preventing insurers from imposing documentation demands that undermine the intended protection. While we acknowledge that the potential necessity for additional documentation is crucial to address, this appropriately removes an audit process preserving the established procedures. Supporting plans that prioritize fair payment to providers is essential, and these definitions play a pivotal role in establishing a consistent federal standard. I extend my appreciation for the coverage recommendations set forth by this Committee.

Through my experience, I've encountered numerous instances where patients believe they've had comprehensive coverage only to discover its limitations or exclusions in the fine print. Mandating plans to cover ground ambulance services is crucial to consumer protection measures that align with the best interests of the public. I am grateful for this opportunity to provide input on these vital matters. Your dedication to this cause is commendable. Thank you."

Tony Garr, Tennessee Health Care Campaign

"First of all, I'd like to make sure that public comments can be given following this meeting today and make sure that we have who to send that public comment to. The other comment that I'd like to make is that it's my understanding that there is still some debate in regard to whether or not ground ambulance services should be incorporated into the No Surprises Act. As a consumer advocate with the Tennessee Health Care Campaign, I fully support making sure that ground ambulance services is included in the No Surprise Act. The No Surprise Act -- I assume it would have to be amended so that this can be incorporated. Health insurance in general is complicated. Too many things fall through the cracks, and it's very important that we don't create a separate system for ground ambulance services that's not connected to the No Surprise Act. They need to be incorporated.

I know how difficult it may be, well, it is. I've been through the health insurance reform for 30 years trying to figure out how best to do things, and we don't need to separate entities and make this a separate thing that's not connected to the No Surprise Act. So, I just want to make sure that we continue along that direction. Thank you."

Kathy Lester, Lester Health Law

"I'm Kathy Lester. I actually was one of the presenters in that May meeting, and I am the founder of Lester Health Law in Washington D.C. and work with the American Ambulance Association. My background is in the General Counsel's Office of the Department of Health and Human Services, so I do want to thank all of the government representatives on this call and on the Committee for the hard work I know you have undertaken, as well as our Chair Asbel Montes, and very much appreciate the introductions this morning to really encapsulate how different ground ambulance services are from the hospitals and the physicians that the No Surprises Act currently regulates. So, I just wanted to applaud the Committee for its work and offer a statement in support of really taking the time and making sure that as we take the consumer out of the middle that we also do not end up obliterating the ground ambulance emergency services and the interfacility transports which enable care coordination that the country has been able to rely on for the last several decades.

So to that end, I would just say that as you look at the No Surprises Act, Congress understood that some of the one-size-fits-all approaches around brick-and-mortar providers do not make sense in a ground ambulance situation and encourage you all as you think about the recommendations to make sure that we take into account the unique needs of communities and their different geographic locations; their availability of other health care

providers in the area or lack of; and what it means to provide mobile integrated health care even at the emergency and interfacility level. So, to that, I just encourage you as you look at the recommendations to perhaps think about the framework of the NSA but to make sure it is tailored so that we don't endanger consumer access, patient access, to ground ambulance services. Thank you again for all your time and effort and look forward to the rest of the conversations this afternoon. Thank you."

PRI facilitator, Terra Sanderson thanked the public for their participation during the public comment session and opened the floor to the GAPB Advisory Committee members for comment. The Committee members had no additional public comments.

Session 2: Definitions

Asbel Montes, GAPB Chairperson
For the second session of the afternoon session, the Committee began the review of the recommendations for Congress and the voting process. Asbel Montes reviewed with the Committee the voting process and noted the Committee will have open discussion for each recommendation prior to the vote. Mr. Montes then asked that each Committee member introduce themselves and who they represent on the Committee.

Rhonda Holden represents various segments of the ground ambulance business -- most importantly in Washington State, The Association of Washington Public Hospital Districts and The Washington State Hospital Association. Ms. Holden works with the hospital-based ambulance service and has served nine years on the EMS and Trauma Council for Washington State.

Adam Beck is the representative of the health insurance provider industry. Edward Van Horne represents various segments of the ground ambulance industry as a paramedic for 20 years in multiple states across the U.S.

Patricia Kelmar is the representative for consumers. Ms. Kelmar is a nonprofit advocate that works for U.S. PIRG, the Public Interest Research Group. Ms. Kelmar worked on the No Surprises Act and served on the Federal Advisory Committee on Air Ambulances a few years ago.

Ritu Sahni represents physicians who take care of emergency/trauma/cardiac/stroke. Mr. Sanhi is an emergency physician and an EMS physician who serves as a Medical Director for two suburban counties in the Portland, Oregon area. Mr. Sanhi is also a past president of the National Association of EMS Physicians.

Suzanne Prentiss is an elected official at the State level and represents those who regulate insurance at the State level.

Gary Wingrove is the President of the Paramedics Foundation and uncompensated when serving on this Committee. Wingrove represents patient advocacy groups as a member of the Advisory Committee.

Carol Weiser is a Benefits Tax Counsel in the Office of Tax Policy at Treasury. Ms. Weiser works with the Department of Health and Human Services and the Department of Labor on regulations regarding group health plans and individual health insurance, including No Surprises.

Rogelyn McLean works in the Center for Consumer Information and Insurance Oversight within CMS at HHS. Ms. McLean is the Secretary's Designee for this Committee. Ms. McLean works with Ms. Weiser and colleagues at the Department of Labor implementing the No Surprises Act. She also served on the Air Ambulance Patient Billing Committee with Ms. Kelmar and Mr.
Montes.

Gamunu Wijetunge is the Director of the Office of Mercy Medical Services at National Highway Traffic Safety Administration representing the U.S. Department of Transportation. Dr. Ayobami works with the state of New Jersey as Program Manager and Alternate Grant Award Administrator.

Loren Adler is a Health Economist at the Brookings Institution in Washington D.C. Mr. Adler represents the non-stakeholder and non-government for this Committee.

Pete Lawrence is Deputy Fire Chief, of Oceanside Fire Department. Mr. Lawrence represents state and local EMS officials. Mr. Lawrence has been in the fire service industry for 43 years and ambulance reimbursement issues at the state and federal level for 35 years.

Mr. Montes then noted that no proxy is allowed for the Committee members during the voting process. Mr. Montes reviewed with the Committee that after discussion each recommendation is final. PRI will take the vote by calling each Committee member alphabetically. Committee members will vote, yes, no or abstain. Committee members that vote no will be given three minutes to discuss the reason for the vote. Mr. Montes then began the review of the recommendations.

Recommendation 1:
The Committee recommends that while the framework of the 'No Surprises Act' should be a base for specific ground ambulance legislation, Congress should not add 'ground ambulance emergency medical services' into the current 'No Surprises Act' without substantial modifications, as outlined in the subsequent Recommendations.

The Committee recommends that the following provisions that could be maintained without significant change around consumer protections, directory information, price comparison tools, continuity of care, and state and federal enforcement authority within the current provisions of the No Surprises Act.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Ms. Rogelyn McLean recommended modifying the recommendation to edit the first line of the second paragraph to remove the word “that”. The modified recommendation would state: “The Committee recommends that while the framework of the “No Surprises Act” should be a base for specific ground ambulance legislation, Congress should not add “ground ambulance emergency medical services” into the current “No Surprises Act” without substantial modifications, as outlined in the subsequent Recommendations.

The Committee recommends that the following provisions could be maintained without significant change around consumer protections, directory information, price comparison tool, continuity of care, and state/federal enforcement authority within the current provisions of the No Surprises Act.”

The Committee members agreed with this recommendation and voted on the modified recommendation.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes

Weiser, Carol - Abstain
Wijetunge, Gamunu - Abstain
Wingrove, Gary - Yes

Next, Mr. Montes discussed Recommendation 2 with the Committee. Mr. Montes noted the Committee will first vote to adopt the definitions then vote on each definition.

Recommendation 2:
The Committee recommends that Congress adopt the following definitions to align with the recommendations and findings found in the final report.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Mr. Wingrove suggested modifying the recommendation to state "Congress or the Secretaries". The Committee agreed with this modification and voted on the modified recommendation stating, "The committee recommends that Congress or the Secretaries adopt the following definitions to align with the recommendations and findings found in the final report."

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Yes
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu – Yes
Van Horne, Edward - Yes
Weiser, Carol - Yes
Wijetunge, Gamunu - Yes
Wingrove, Gary -Yes

Recommendation 2A:
Community paramedicine means the practice of providing person-centered care in a diverse range of settings that address the needs of a community. This practice may include the provision of primary health care, emergency or acute care, health promotion, disease management, clinical assessment, and needs based interventions. Professionals who practice community paramedicine are often integrated with interdisciplinary health care teams that aim to improve patient outcomes through education, advocacy, and health system navigation.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Rhonda Holden suggested that the definition be modified to note "also known as mobile integrated health care" because community paramedicine is often referred to as mobile integrated health care. The Committee members agreed with this modification.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes

Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Yes
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Yes
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Recommendation 2B:
Cost means those costs defined in the Medicare Ground Ambulance Data Collection System's Medicare Ground Ambulance Data Collection Instrument, including labor costs; facilities costs; vehicle costs; equipment, consumable, and supply costs; other costs directly related to supporting an organization's ground ambulance services that are not covered by other categories. The term also includes medical oversight costs.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Ritu Sahni noted that the sentence around medical oversight was added to this definition because several Committee members agreed that the Ground Ambulance Data Collection System process will not fully account for the cost of medical oversight in the system such as treatment in place or non- transport and paying for that and guaranteeing those payments. Mr. Sanhi stated, “the importance of medical oversight is only magnified in terms of better patient outcomes and better patient safety.” Ritu Sahni then discussed with the Committee “medical oversight” or what is often called “medical direction.

Carol Weiser suggested that the statement regarding medical oversight costs be reworded as, “In addition, the term includes medical oversight costs.” So that's it's clear that it's not already captured. The Committee agreed with this modification.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Yes
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Yes
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Recommendation 2C:
Emergency interfacility transport means the transport by a ground ambulance emergency medical service provider or supplier of a patient with an emergency medical condition from one healthcare facility to another location or facility to receive services not available at the originating facility, as ordered by a licensed treating healthcare provider.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Patricia Kelmar noted that over the last couple of months, but particularly from a patient perspective, having a very clear definition of this emergency interfacility transport is important. Ms. Kelmar stated, "What we've been finding and hearing from patients throughout the country is oftentimes they either get themselves to an emergency room or are brought to an emergency room that doesn't have the actual services that they need to treat their condition. The Committee wanted to recognize and acknowledge that especially in the era of greater consolidation and some communities moving within one health system like all their cardiac services to one hospital in the metro area or all their maternity work in another hospital. So, understand that sometimes you end up in your closest hospital that doesn't have the care that you need. A lot of patients were finding themselves needing that second ambulance, or maybe it's their first one if they brought themselves to the emergency room but needing an ambulance from one hospital to another. If you're in a hospital that doesn't have the care that you need, it's still an emergency; and you might as well be in your church parking lot or at home without the care that you need. So, this is an attempt to clearly define the emergency nature of a situation where you're already actually in a hospital but you're still not getting the care that you absolutely need."

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Yes
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Yes
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Recommendation 2D:
Ground ambulance emergency medical service means ground ambulance medical or transport services furnished to an individual for whom an immediate response was required to assess and/or treat a medical or behavioral condition that a prudent layperson reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance services. Such services include the ground transportation of the patient to a hospital or other medically appropriate destination as defined by Congress or the Secretaries. The determination as to whether an individual reasonably expected that the absence of immediate medical attention would result in serious jeopardy or harm shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.

Discussion:

Asbel Montes then opened the discussion on the Recommendation. Pete Lawrence stated, “This mirrors very closely what we put in place in California in the 1980s [sic]. The goal was that we got the patient to not think to themselves, 'Is insurance going to deny me?' So, we tried to make sure that this meets all the criteria.” Mr. Lawrence thanked the representative from Access California that provided input to the Committee.

Ms. Kelmar also thanked the representative from California for providing input to the Committee and noted that California has a great standard that takes into consideration a lot of different educational levels, cultural differences, and some of the nuances of what a prudent person standard is in many states. So, this opens it up and gives a little bit more benefit of the doubt to the consumer to make the right decision and not be denied coverage. Ms. Kelmar also noted that she supports this expansion based on the information provided by NEMSIS during the public meeting that was held in August. Ms. Kelmar stated, “What we saw there was only about 2% of 911 calls that were dispatched ended up being no-treatment/no-transport. So, folks generally call 911 when they need treatment. They seem to, for the most part, be making smart and good decisions about when they need emergency care. So, I don't think we have to narrow the definition to try to make people be smarter or be more hesitant to call care. We don't see that that's a problem right now. So, I think this is a great definition, and I appreciate the Committee working to get it.”

Carol Weiser discussed with the Committee a few technical points to the definition as to whether there must actually be a specific prudent layperson who has a belief, or whether instead the Committee is saying that a prudent layperson would reasonably believe.

Shawn Baird noted that this definition, along with the one that was discussed previously, are just essential to making any sort of substantive systematic change to help both consumers and keep the provider networks for access to care intact.

Asbel Montes noted that this term and the term previous that was just voted in the affirmative on the interfacility emergency transport in 2C will be referenced later in several recommendations. So, it's important to note when you see “ground ambulance emergency medical service”, it ties in with that interfacility definition that was voted on as well.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Yes
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Yes
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Recommendation 2E:
Ground ambulance provider or supplier is an entity that is authorized and licensed by the appropriate governmental entity to respond to a request for ground ambulance medical services. The Committee felt this was important to define. The reason why it's called 'ground ambulance provider or supplier' is to stay

consistent with other programs that depending upon if you're a hospital-based or not, you could be referred to as a 'provider' or 'supplier' as well as some other references throughout some of the recommendations and findings.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. The Committee has no comments regarding this recommendation.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Yes
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Yes
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Recommendation 2F:
Prompt payment is defined as means that a group health plan and health insurance issuer required payment under Recommendation 12 and/or 14 or a notice of denial of payment within 30 days of receiving a bill triggering the duty to make a minimum required payment or to issue a notice of denial of payment.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Asbel Montes noted this definition includes another term that will be defined in 2G, which is 'bill triggering the duty to make a minimum-required payment.'

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - No
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Yes
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes

Wingrove, Gary - Yes

Next PRI provided the opportunity for those that voted no to provide comments.

Adam Beck: “the 'No' vote is based on the belief that a required minimum payment is not the appropriate policy solution. It's not with an issue around prompt payment itself, which is generally required also within 30 days under most State laws. So the issue is not with the definition itself or the requirement for payment within 30 days. It's more tying it to the required minimum payment or addressing any separate recommendations.”

Recommendation 2G:
Bill triggering the duty to make a minimum required payment or issue a notice of denial of payment means a claim that includes, at a minimum, the following elements: coverage provider; insured's I.D. number; patient's name; patient's birth date; insured's name; patient's address; insured's policy group or FECA number; the date of current illness, injury, or pregnancy; the name of referring provider or other source; the ICD indicator; date of service; place of service; procedures, services, or supplies, including the CPT/HCPCS code and modifiers; the diagnosis pointer; charges; days or units; federal tax I.D. number; acceptance of assignment, either Yes or No, that's what's in parentheses; the total charge; the signature of physician or supplier; the service facility location information, including NPI; the billing provider information, and the including NPI.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. The Committee members discussed removing “at a minimum” from this definition. The Committee approved this modification.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Yes
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Yes
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Session 3: Disclosure/Coverages

Asbel Montes, GAPB Chairperson

Next Asbel Montes reviewed with the Committee the recommendations on consumer protections and disclosures.

Recommendation 3A:
Congress should require coverage of ground ambulance emergency medical services. A plan or issuer offering group or individual health insurance must provide or cover any benefits with respect to emergency ground ambulance services including emergency interfacility transports, then the plan or issuer must cover such

services.

a. Without the need for any prior authorization determination.
b. Whether the ground ambulance provider or supplier furnishing such services is participating provider or supplier with respect to such services,
c. Without imposing any requirements or limitations on coverage that is more restrictive than the requirements or limitations that apply to such services if they were received from a participating ground ambulance emergency medical services provider or supplier, and
d. Without regard to any other term or condition of such coverage

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Patricia Kelmar discussed the issue of surprise bills for people without insurance coverage for interfacility transports. Ms. Kelmar agreed with the concept of 3A, which pertains to emergency ground ambulance transportation, and 3B, which includes no transport in cases where the patient doesn't go. Ms. Kelmar believes that people need coverage for these services and that the current system of only paying for transportation is outdated. She also argues that no-transport treatments in the community should be covered, as medicine has evolved, and unnecessary expenses should be avoided. Ms. Kelmar noted that she doesn't' want to vote 'No' on either issue but believes this is the right public health decision.

Pete Lawrence agreed with Ms. Kelmar regarding the importance of health insurance covering EMS, as it is a system rather than just a means of transport. Mr. Lawrence noted this can impact patients financially when insurance companies do not pay for these services. Mr.
Lawrence suggested 3B as the solution, as there are multiple options available for this scenario.

Adam Beck discussed his view that medical necessity determinations can and should still play a role in determining the application of coverage for these particular emergency services, including the emergency interfacility transports.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - No
Kelmar, Patricia - Yes
Khawar, Ali – Absent
Lawrence, Peter - No
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Yes
Wijetunge, Gamunu - Yes
Wingrove, Gary - No

Next PRI provided the opportunity for those that voted no to provide comments.

Rhonda Holden: "Yes, for the same reasons that Pete mentioned, I just feel like it's critical that we have coverage for when we treat and don't transport because that's an incredible expense. When people call 911, we must respond. We don't have a choice. So, the comment made about medical necessity, being required for payment, just doesn't apply when someone calls 911."

Peter Lawrence: “I'm going to make it easy, what Rhonda said and what I've said previously. We need to cover non-transport services, or the patient gets impacted.”

Gary Wingrove: “I don't believe I feel really strongly that the cases of treatment and release and other things are important and shouldn't be ignored. That's why I'm 'No' on 3A, but I'll be 'Yes' on 3B.”

Rhonda Holden: “I just had one more comment about that, about the care that can be provided in the field, and we don't transport a patient. We could have someone who's actively coding and dies and ends up being transported by a coroner rather than by an ambulance service, and we have put an intense amount of care into trying to save someone's life. That's another reason that I feel so strongly that we need to vote 'Yes' on 3B and make that required coverage.”

Recommendation 3B:
Congress should require coverage of ground ambulance emergency medical services. If a group health plan or health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to emergency services then the plan or issuer must cover ground ambulance emergency medical services (including emergency interfacility transports and such services when an ambulance has responded, but no transport has occurred). In addition, the group health plan and issuers must cover such services;

a. Without the need for any prior authorization determination;
b. Whether the ground ambulance provider or supplier furnishing such services is a participating provider or supplier with respect to such services;
c. Without imposing any requirements or limitations on coverage that is more restrictive than the requirements or limitations that apply to such services if they were received from a participating emergency ground ambulance services provider or supplier;and
d. Without regard to any other term or condition of such coverage

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Ritu Sahni noted that in his opinion 3B is the better choice. Mr. Sanhi stated that this is a prime example of the incredible importance of medical oversight. When patients are not transported, there is an increased risk to both the patient and the health care system; and the methodology for reducing risk and ensuring proper patient outcomes is strong medical oversight.

Shawn Baird also noted the importance of recommendation 3B. Suzanne Prentiss stated if 3B was the only choice this would be her choice of recommendation. Ms. Prentiss noted that she regularly advocates for this in her state.

Patricia Kelmar also agreed that 3B is the better option. Ms. Kelmar noted that there is a need for a clear definition of no-transport services. She stated that ambulances should be paid for medically appropriate care in the field without transport, but also consider the overall cost of the healthcare system.

Regina Crawford discussed how she advocates for EMS every day across the country, and this is the current option 3B would just encase 3A.

Adam Beck discussed the terminology of this definition and addressed concern if the term 'must' and 'any benefits' are included in the definition this is a recommendation to basically cover anything that is provided by personnel without any limitation. Gary Wingrove noted that the limitation is really in the definition that we approved on emergency ground ambulance services. Carol Weiser stated that she agrees with Mr. Beck that the language is quite ambiguous as to exactly what is meant.

Vote:
Adler, Loren - Yes

Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali – Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Recommendation 4:
Congress should establish a statutory federal advisory committee to advise the Secretaries of Health and Human Services, the Department of Labor, and Department of Treasury on ground ambulance reimbursement policy to evaluate how expanding coverage and reimbursement of ground ambulance services beyond transports to hospitals, skilled nursing facilities, and critical access hospitals could improve patient outcomes, reduce overall health care costs, and support the continuum of care.

Among the topics the Committee recommends that such an advisory committee consider community paramedicine/mobile integrated health care, Advance Life Support first response, treatment in place, and alternative destination. The advisory committee could also provide guidance on how to address the rising costs of ancillary supplies, oxygen, high-cost drugs, and medical equipment in the context of pre-hospital emergency services. The intent of this recommendation was for a lot of information that was surrounding and may not necessarily have an ambulance response, but that emergency medical service providers do provide context around this as well as other things that may not currently be a covered benefit that needs further development on the ideas of coverage and then how the reimbursement actually looks and make it basically a profit committee that would provide these recommendations on a continuous basis to the Secretary of Health and Human Services, Department of Labor, and Department of Treasury.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Gam Wijetunga discussed with the Committee suggesting Secretary of Health and Human Services and to Congress establish a Statutory Advisory Committee. Rogelyn Mclean noted the Committee could recommend that the Secretary of Health and Human Services establish -- to the extent that he has authority -- that he establishes such a committee. Ms. Mclean stated the Committee could also suggest to Congress that a statutory FACA committee be set up within the final report.

Gary Wingrove and Shawn Baird discussed their thoughts on changes to this recommendation. Mr. Wingrove inquired if the real costs plus reimbursement will be a recommendation or finding. Asbel Montes confirmed this will be included in the findings.

Carol Weiser noted HHS committee's effectiveness depends on Congress's action on other recommendations, despite their support for flexibility in committee setup. Ms. Weiser acknowledged the Secretary of HHS's authority to set up committees but questioned their ability to accomplish much without these recommendations.

Vote:

Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Abstain
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Recommendation 5:
Ground Ambulance Emergency Medical Services should be incorporated in the definition of the emergency services under the Essential Health Benefit requirements.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Rogelyn McLean discussed with the Committee what is "Essential Health Benefit". The Affordable Care Act mandates coverage of essential health benefits, including ground ambulance emergency medical services. These services are already considered emergency services under the Act, but Congress did not define their definition. The Committee discussed the need for clarity on this matter, as different plans offer varying levels of coverage. Ms. McLean noted the Federal Government has not responded to this question directly, so the recommendation is to clarify that ground ambulance emergency medical services are essential health benefits.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Recommendation 6:
Congress should place a limitation on billing patients for ground ambulance emergency and non-emergency medical services before seeking insurance information.

1. A ground ambulance organization may not bill a patient until after it has been submitted to the patient's insurance company and a determination of payment has been made, unless the ground ambulance emergency or non-emergency medical services provider or supplier first make a reasonable, there's a technical, make a reasonable attempt to obtain the patient's insurance information but was unable to do so within 3 to 7 days

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Patricia Kelmar noted medical bills can be confusing for consumers due to the complexity of benefits and bills. To improve clarity, Ms. Kelmar suggested sharing insurance information between insurance companies and ambulance providers to ensure accurate billing. However, Ms. Kelmar noted the 3-to-7-day prompt payment timeframe may not solve the issue of patients receiving bills too soon when payment determinations have not yet been made.

Peter Lawrence clarified that the insurance company determines payment, not the patient's bill. The 30-day time frame is only applicable if insurance information is unavailable from the hospital. If this is not possible, a notice will be sent after a 3 to 7-day period. The speaker emphasizes that the insurance company must provide a ruling before sending a bill, as health benefits must be covered under every ACA-compliant plan.
Dr. Ayobami Ogunsola expressed reluctance about the use of the phrase "reasonable attempt" due to its weak and vague nature. Dr. Ogunsola suggested using a more specific term or removing the "reasonable attempt" altogether.

Edward Van Horne expressed concerns about the administrative burden of this limitation, especially when dealing with emergency situations. Mr. Van Horne stated a finite date and number could be more administratively burdensome and create a delay in the process. He noted if other recommendations are adopted, the sharing of information should be expeditious. Mr. Van Horne also suggested defining the "reasonable" number to ensure consumer protection.

Regina Crawford stated a reasonable collection time frame of 3 to 7 days, considering the existing process of billing companies and insurance companies. They suggest that additional recommendations could involve interchange of information depending on the facility and destination facility, especially around emergency situations. They also suggest technology solutions within billing departments to find patient information. However, a finite date and number could be administratively burdensome and create a delay in the process. The speaker believes that this recommendation works in tandem with other recommendations and requires information sharing in an expeditious manner. The number should be relatively or further defined to meet Dr. Ayobami's point.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Abstain
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes

Wingrove, Gary - Yes

Recommendation 7:
Congress should direct patients with concerns, disputes, and questions about ground ambulance emergency and non-emergency medical services billing to the No Surprises Help Desk.

The No Surprises Help Desk triages patient calls and connects them with the right resources back to their insurers, providers, or to local regulators or federal regulators at CMS or DOL.

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Patricia Kelmar discussed with the Committee the context of this recommendation. Ms. Kelmar noted The No Surprises Act aimed to provide a one-stop shop for consumers dealing with complex medical billing issues. However, due to state laws and different levels of enforcement, it was difficult for consumers to understand where to go and how to get their questions answered. The No Surprises Help Desk was created to help consumers find the right solution. It is recommended that people should be sent to the same place they are already trying to inform them about. Ms. Kelmar noted patients often cannot provide information about their insurance, so relying on other sources can be more administratively burdensome. The number should be relatively or further defined to ensure consumer protection.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Recommendation 8A:
Establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for ground ambulance emergency medical services.

Any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to ground ambulance emergency medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner if the services were provided by an in-network provider or supplier.

The patient cost-sharing requirement is 10% of the rate established under Recommendation 12, subject to out-of-pocket limits with a fixed dollar maximum.

Discussion
Asbel Montes then opened the discussion on the Recommendation. Patricia Kelmar discussed the importance of mirroring the No Surprises Act in medical billing, ensuring out-of-network payments count towards

deductibles and maximums. Ms. Kelmar stated that consumers should be directed to the same place they are already informed about medical billing. She noted that patients often cannot provide information about their insurance, so relying on other sources such as technology solutions is often necessary. Ms. Kelmar noted however, a finite number could be administratively burdensome and delay the process.

Loren Adler argued that the current cautionary protection for ground ambulances is inadequate, as 85% of transports are out-of-network. Mr. Adler suggested that limiting the number of in- network cost-sharing amounts to 10% or a fixed dollar number could help address this issue.
Mr. Adler stated he believes that this recommendation can work in tandem with other recommendations and requires sharing information in an expeditious manner.

Vote
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - No
Khawar, Ali – Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - No
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - No

Next PRI provided the opportunity for those that voted no to provide comments.

Patricia Kelmar - “I'm voting 'No' on this not that I don't believe that there should be some type of cap; but I think Option B is better. I've talked to patients who have bills in $8,000/$7,000/$10,000 ranges. Ten percent of that would be really hard to meet and would be a real deterrent for people to call an ambulance. The other thing I would say is I would really like folks to have a very clear idea in their head of how much this ambulance ride is going to cost them before they call 911. I think having 10% of a rate that may, depending on how the recommendations go later, could be variable by the community that you happen to have an accident in is just really not a great way to set a rate or have people understand what their coverage is. So I'm going to be voting for Option B.”

Dr. Ayobami Ogunsola: “Yes, my reason for voting 'No' is that 10% at a flat rate is -- I'm somewhat not comfortable with a flat rate. That is my major concern about that. So I don't want to subject patients to a flat billing or a flat cost-sharing rate of 10%. I just don't like the idea of paying a flat rate, and that is it. Thank you.”

Gary Wingrove: “Yeah, I mostly agree with Patricia. I think there are some areas where there's some recommendations in my head where there's one standout option, and the others aren't very good. I just think it's going to confuse people by saying, 'Here, pick one of these three choices,' when there's a standout option; and option B is that standout option. Otherwise, we're just saying we couldn't come to consensus on what it actually was.”

Recommendation 8B:

Establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for ground ambulance emergency medical services.

Any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to ground ambulance emergency medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner if the services were provided by an in-network provider or supplier.

The patient cost-sharing requirement may be the lessor of $100 (adjusted by the CPI-U annually) or 10% of the rate established under Recommendation 12, regardless of whether the health plan includes a deductible.

Discussion
Asbel Montes then opened the discussion on the Recommendation.

Ritu Sanhi noted that like recommendation 3, he voted "yes" on 8A because this option is better than no option at all. However, he thinks 8B is the best option.

Loren Adler discussed the importance of a finite number for patients accessing emergency services, specifically ground ambulances and interfacility services. Mr. Adler recommended modifying the language to state, "patient cost-sharing requirement may be no higher than the lesser of" to ensure the law's force. Mr. Adler supports the idea of a minimum payment standard or payment requirement with a limit in dollar terms or percentages of Medicare. Mr. Adler noted this level of protection is only viable for emergency medical services, as many localities already offer zero out cost sharing.

Vote
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - No
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Next PRI provided the opportunity for those that voted no to provide comments.

Adam Beck – "Just one of the other options is my preference here. No other comments." Recommendation 8C: Establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for ground ambulance emergency medical services.

Any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to ground ambulance emergency medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner if the services were provided by an in-network provider or supplier.

The patient cost-sharing requirement for ground ambulance emergency medical services may be no higher than

the amount that would apply if such services were provided by a participating ground ambulance provider or supplier.

Discussion
Asbel Montes then opened the discussion on the Recommendation.

Adam Beck stated he will be voting "Yes" on this option. Mr. Adler noted aligning this with the cost-sharing approach that applies to other services, or the No Surprises Act has worked and makes sense here. Mr. Adler stated that operationally, one of the things that's going to be challenging is since we're not recommending an approach where cost sharing is really based on a recognized amount or the qualifying payment amount and then what the in-network benefits would be based on that recognized amount or QPA.

Vote
Adler, Loren - No
Baird, Shawn - No
Beck, Adam - Yes
Godette-Crawford, Regina - No
Holden, Rhonda - No
Kelmar, Patricia - No
Khawar, Ali - Absent
Lawrence, Peter - No
McLean, Rogelyn - Abstain
Montes, Asbel - No
Ogunsola, Ayobami - No
Prentiss, Suzanne - No
Sahni, Ritu - No
Van Horne, Edward - No
Weiser, Carol - Abstain
Wijetunge, Gamunu - No
Wingrove, Gary - No

Next PRI provided the opportunity for those that voted no to provide comments.

Loren Adler: "Sure, I mean I think for the same reasons that Patricia and some others have stated, while I think this is better than nothing, I'm voting 'No' here because I want to sort of show my support for having more of a fixed metric, with the acknowledgement that I do understand that it is difficult to go away from something like this if it's simply left up to the sort of local governments to set rates like in recent state laws."

Shawn Baird: "Yes, some of my thoughts have already been captured on looking for greater certainty and what that amount would be for a consumer. But something that hasn't really been emphasized is the lack of data around actual in-network rates now because there are so few in-network providers in the ambulance world with insurers that I see this as being problematic in the sense that there's no real dataset to work off of that's meaningful when no negotiations took place in a broad scheme like other health providers to be in-network."

Regina Crawford: "I concur with the comments that I've made previously. You don't know what that bill's going to look like, and I think it just could be really astronomical. My concern is also there's no data to prove this. We don't have anything to compare it with."

Rhonda Holden – "Everything said above, but also going back to comments that we've heard over and over again, and even heard today from Angela in Oklahoma, that the insurance companies aren't always negotiating. It's sort of a take-it-or-leave-it. So, I would be fearful that this could be a really low payment amount that they might be receiving, or, I'm sorry, a really high payment amount that our consumers would be having to pay.

Patricia Kelmar: “Nothing additional to add.”

Peter Lawrence: “Nothing additional to add.”

Asbel Montes: “The only thing I would like to note is that there were several presenters, as well as subject matter experts, that have presented in the May meetings and subsequent subcommittee meetings around the percentage of ground ambulance providers who were out of the network, which would be really hard coming up with some type of participating ground ambulance emergency medical... I think it's important to know that there is data that's come out in all claims payer databases, as well as other data that's been out there and reported by the Health Care Cost Institute as well as FAIR Health that's painted a picture around the out-of-network ambulance services that would hit here. This, to me, becomes really problematic in that environment of coming up with an appropriate cost share. So, I believe recommendation or Option A or B is probably the best consumer protection is giving them that number, knowing what they could possibly or potentially be liable for.”

Dr. Ayobami Ogunsola: “Yes...is that Option C seems to me to be... So, for that factor, that's why I would vote 'No.' Because I have... Thank you.”

Suzanne Prentiss: “Thank you. Most of what I want to say has been covered; but for the record, I'm just going to hit a couple key points. If we're talking about consumer protections, which this section is and this option is, then A and B -- and preferably B although I voted for both of them, are geared for all consumers, not a set of consumers that are covered under participating providers. I also think it's worth noting it has been talked about throughout all the months that we've met -- and it came up today I think in public comment, that not all people don't, emergency medical services isn't like all health care providers that are covered under the No Surprises Act. The episodic nature and the emergent nature of the business puts us in a different place. So I think that that's worth noting as well as what drove me to vote 'No' for C and support A and B, preferably, B.”

Ritu Sanhi: “Nothing to add.”

Edward Van Horne: “Yes, thank you. Everything that's been said. Also to reiterate the point that when someone calls 911, they're calling because of a critical event that they're having. With how many ground ambulance providers are in a service area, you may not have ones that are in this type of supplier network. So, you can't put the patient to be concerned about do they call for help or not. It needs to be consistent. That's all I have.”

Gam Wijetunge: “Nothing to add, thank you.” Gary Wingrove: “Nothing to add.”

Session 4: Wrap-Up

Shaheen Halim, Ph.D., J.D., Designated Federal Officer Asbel Montes, GAPB Chairperson

Next Asbel Montes discussed with the next steps and provided the opportunity for final comments. Rhonda Holden suggested that the Committee vote on recommendations 3A and 3B and 8A and 8B again to provide a consensus for the report. All Committee members agreed with this suggestion. Asbel Montes noted the Committee will reconvene tomorrow with discussion and voting on Recommendation 9.

Shaheen Halim thanked all the presenters and members of the public for feedback during today’s meeting. The meeting was adjourned for the day by Ms. Shaheen Halim around 4:30 PM. The meeting will reconvene at 9:30 AM ET on Wednesday, November 1, 2023.

Day Two November 1, 2023

Welcome & Introduction/Recap of Day 1

The second day of the GAPB Advisory Committee (Committee) meeting began at 9:30 AM on November 1, 2023. Terra Sanderson, moderator with Provider Resources gave welcoming remarks and provided meeting logistics. Ms. Sanderson stated the meeting would be live cast and a recording would be available on the CMS GAPB website following the meeting.

Next, Asbel Montes provided the Committee with a recap of Day 1. Mr. Montes noted there will be no public comment in the oral component for Day 2, but additional public comment will be provided in a written form. Mr. Montes then reviewed with the Committee the voting process for recommendations. Mr. Montes then noted that no proxy is allowed for the Committee members during the voting process. After discussion each recommendation is final, and PRI will take the vote by calling each Committee member alphabetically. Committee members will vote, yes, no or abstain. Committee members that vote no will be given three minutes to discuss the reason for the vote. Mr. Montes then began the review of the recommendations.

Morning Sessions

Session 1: Cost/Payment

Asbel Montes, Committee Chairperson

Recommendation 9:
Congress requires the Secretary of HHS to amend the relevant conditions of participation to require health care providers to share patient insurance information with an emergency ground ambulance services provider or supplier that treated a mutual patient, upon request by the emergency ground ambulance services provider or supplier.

Discussion
Asbel Montes then opened the discussion on the Recommendation. Asbel Montes discussed with the team feedback received during the subcommittee meetings from ground ambulance providers on access to patient insurance information, Mr. Montes noted a presenter from the Office of Civil Rights discussed with the Committee HIPAA regulations and what is permissible to providers. Mr. Montes stated the Committee is seeking a amendment from the Secretary of Health and Human Services to make it a requirement that they provide this information to a ground ambulance provider or supplier in order to continue to protect the patient so they do not receive a bill.

Patricia Kelmar noted that this recommendation will help to ensure that in emergencies, patients insurance information is shared between the hospital and ambulance company for efficient billing. Ms. Kelmar stated it is crucial to clarify that hospitals should provide this information to ambulances, even if they are still in the hospital within the first few days after their 911 call.

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes

Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Recommendation 10:
Ground ambulance emergency medical services should provide a bill to consumers with minimum elements for a standardized bill.

I. All bills must include the following elements:
   a. Clarify whether or not the bill reflects a final determination by the patient's insurance.
   b. Provide information about how a patient can dispute the charges and the coverage determination.
   c. Provide information that they should not receive a balance bill and if they do, how they can report that illegal bill to be sure it does not appear as an amount owed or be sent to collections.

II. Communications from ground ambulance emergency medical services to patient before obtaining the patient's insurance information or completing a reasonable attempt to obtain said information must make clear that it is not a bill.
   a. Required language could be: "THIS IS NOT A BILL. We are attempting to determine your insurance information."

Discussion
Asbel Montes then opened the discussion on the Recommendation. Asbel Montes noted that this recommendation discusses some of the minimum elements that would need to be in a patient's bill. Mr. Montes noted that the Committee learned during discussions with billing offices and public comments that often not everything is included in a statement that a patient might be getting a bill relative to certain things. The recommendation is that a standardized bill be provided to consumers with the minimum elements in the bill. Mr. Montes noted that several states already have this process in place.

Patricia Kelmar discussed the recommendation and noted that patient billing is often confusing to consumers. This recommendation is to help ensure the consumers are aware of how to pay bills, including insurance determination, balance billing protections, surprise billing protections, and how to assert rights if a balance bill is received.

Vote
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes

Wingrove, Gary – Yes

Recommendation 11A:
Establish minimum guardrails for State and Local Regulated Rates for ground ambulance emergency medical services and non-emergency ground ambulance medical services to ensure reasonable regulated rates under Recommendations 12B and 14.

A state or local regulated rate for ground ambulance emergency and non-emergency ambulance medical services that are established outside of a state balance or surprise billing statute will meet the guardrail requirement under Recommendation 12B or Recommendation 14, if it:

I. Meets one or more of the following requirements:
   i. Takes into account emergency ground ambulance services provider or supplier's Operational Model and Cost
   ii. Takes into account emergency ground ambulance services provider or supplier's Payer Mix Revenue
   iii. Is adopted through a public process (e.g., city council meeting, public notice)
   iv. Includes a public process for the annual evaluation of ground ambulance emergency medical services rate if the process includes procedures that take into account public input, such as rulemaking. (E.g., tie an annual update to a cost evaluation by a specific local entity.)
   v. The establishment of a reimbursement rate for rulemaking through a state legislative/regulatory process or via local community public process.
   vi. Is adopted following a public hearing where rates are evaluated and discussed.
   vii. Is linked to another rate that is determined with public input at the State or local level.

AND

II. There is full transparency with the rate subject to public disclosure and reported to a state governing entity for accessible public viewing.

III. The tri-departments must maintain a publicly available database of state- and local -set rates that are binding for any minimum required payment, broken out by service and locality. States and localities must report the information required for such a database to the federal government.

Discussion
Asbel Montes then opened the discussion on the Recommendation. The Committee members addressed their support and reasons for oppositions for the Recommendation.

Vote
Adler, Loren - No
Baird, Shawn - Yes
Beck, Adam - No
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - No
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu -Abstain
Wingrove, Gary - Yes

Next PRI provided the opportunity for those that voted no to provide comments.

Loren Adler: "Thank you. I think I've spoken to my vote already with the acknowledgement that I do think the provisions in this are still useful as guardrails to the local process, but just in addition to option B. And then, you know, I do think to Shawn's point, I'll just sort of add something. I do think $1,000 balance bills are meaningful. I don't think that's nothing. You know, and that's a quarter of balance bills are roughly over $1,000. That is meaningful in terms of patient costs."

Adam Beck: "Yeah, I would associate myself largely with Loren's comments from earlier. I think my primary concern with option A is the lack of any upper limit guardrail and really giving full power to the same entity that is providing the service and making the charge to also be able to dictate a rate. I'll get when we get to option B, which I think of these two is preferable, given that there's some restraint on, you know, on excessive charges or really just inflationary rates. But I would both would have concerns if this is being viewed as a recommendation to apply state or locally mandated rates to a ERISA group health plans, which I think would be a bridge too far and something that would not be good public policy to recommend to Congress. The other thing I think with this sort of process is that it would be wise to allow for -- and I think this is referenced elsewhere in some of our mandate recommendations that payer provider negotiations and contracts can continue to exist. And so I think really allowing for a private market solution that may end up being more favorable towards the consumer and end up creating in network agreements that are beneficial to both parties, that those should be allowed to continue. And I'm concerned that these recommendations don't account for that solution, which really would, I think, be preferable to defaulting to any sort of whether it's federal, state, or local government rate setting. So that's some of my rationale for voting no on this."

Patricia Kelmar: "Just briefly, thank you, Loren, for a really well articulated argument of the concerns of the implication if we end up going with an out of network payment that requires the employers and plans to pay the locally set rate. The lack of cap in this option is what's most concerning to me. And I just want to underscore the extreme importance of getting roll up reporting to the states and then to the feds. I think that that will be the best way if this is the process that the Congress ends up choosing to monitor and keep track of rates. I've seen rates -- I appreciate that California has in place a cap, and that might be something that people want to consider as one of additional guardrails that the local ambulance rates can't do more than cover the costs. So that would be an important thing to consider maybe in future policy proposals. But just knowing in California, even right now, rates can vary by a thousand dollars from one neighborhood to the next, depending on the county which is governing your ambulance rates. So it's extreme differences and it could have a big impact on patient cost share and premiums eventually as well. So that's why I voted no. And I'll be voting yes on the next option."

Recommendation 11B:
Establish minimum guardrails for State and Local Regulated Rates for ground ambulance emergency medical services and non-emergency ground ambulance medical services to ensure reasonable regulated rates under Recommendations 12B and 14.

I. Local set rates cannot be higher than the Payment Reimbursement Options referenced in Recommendation 12A.

AND

II. There is full transparency with the rate subject to public disclosure and reported to a state governing entity for accessible public viewing.
III. The tri-departments must maintain a publicly available database of state- and locally set rates that are binding for any minimum required payment, broken out by service and locality. States and localities must report the information required for such a database to the federal government.

Discussion

The Committee members addressed their support and reasons for oppositions to the Recommendation.

Vote
Adler, Loren - Yes
Baird, Shawn - No
Beck, Adam - Yes
Godette-Crawford, Regina - No
Holden, Rhonda - No
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - No
McLean, Rogelyn - Abstain
Montes, Asbel - No
Ogunsola, Ayobami - No
Prentiss, Suzanne - No
Sahni, Ritu - No
Van Horne, Edward - No
Weiser, Carol - Abstain
Wijetunge, Gamunu -Abstain
Wingrove, Gary - No

Next PRI provided the opportunity for those that voted no to provide comments.

Shawn Baird: “Thank you. I certainly won't repeat all of the robust discussion that we just had, but I do think that my no vote really comes back to the principle that protecting transparency and allowing our consumers and patients the opportunity for the most direct access in the quality of care and rate setting happens at the local level, and that is where they can engage. And if there's a default federal rate that's set by Congress, that really basically strips some of that opportunity because that becomes the de facto rate, and there's far less direct access to participate in Congress than there is at City Hall.
And the other comment I would make is that I believe Ritu really summed up what we're trying to do here, which is make sure our patients get the best care possible, and that is why I voted no.”

Regina Crawford: “I'm not going to rehash what's already been discussed, but it all starts and begins at the local level. So I support. I do think Shawn and Ritu summed it up quite well. Enough said.”

Rhonda Holden: “Just as said by Shawn and others before me.”

Peter Lawrence: “Everything said prior, just reiterating local system, local control, local rates.”

Asbel Montes: “The only thing that I'm going to add there is I only agree with this recommendation in the absence of a local rate setting methodology. So, if there is not a local rate setting methodology, then it would be appropriate for something like this to happen. But once the locals set that or the states do something similar, then to me this becomes, and they follow the guardrails appropriately, then this should not be an impediment to that happening.”

Suzanne Prentiss: “Thank you. I've made my objections and my affirmations clear throughout the process. I want to thank Shawn for his comments just now on B, and also Ritu for always bringing us back to the patients that we serve and the medical, clinical part of this process that we need to preserve and help sustain as we're thinking about the work we do here. Thank you.”

Ritu Sanhi: “Thank you. I think I explained my vote. The one thing I do want to add, though, is I think this theme is going to percolate through the rest of the day. That being said, as I reflect on this, we've reached like 98% consensus. And when you really look at what comes out between these two options and what we

discussed before, it's almost on the margins. And so, I just don't want to lose -- it may have sounded a little contentious, or at least there was great discussion from a lot of people that I really respect. But I think at the end of the day, you're really talking about just some small differences of opinion in some small areas. That overwhelming consensus of this group was very positive and pretty similar."

Edward Van Horne: "Yeah, Ritu, you said it well again. This is all our focus about the patient and getting the patient out of the middle. I think the multiple recommendations we're working on I think has that general consensus. We recognize the nuance there is that EMS is local. Every time you call 911, regardless of where you are, an ambulance has to respond regardless of your ability to pay. And the local systems, the local rates, the local transparency builds that model so that it makes it work as appropriately as is needed to save those lives regardless. And that's what makes it so different than a hospital or a physician or a different type of healthcare that you can choose and who and where to go. You don't get that with 911. So I would say thank you."

Gary Wingrove: "Yeah, I would just add that there is no greater consumer protection than having an ambulance to respond. Just like we know there's variation in cost in California counties, I'd be interested to know if the wages vary greatly in every state. But we also know there are ambulance services closing and we don't have a minimum guardrail. And I'm less concerned about a public process that a community or a county might have than I am about the known ambulance closures that have happened and we haven't addressed those."

Recommendation 12A:
Prohibit balance billing and guarantee reasonable payment for ground ambulance emergency medical services.

I. Ground Ambulance Out-of-Network Rate is a National Set Rate by the Congress and Secretaries. The group health plan or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for ground ambulance emergency medical services provided to a participant, beneficiary, or enrollee.

   A. Payment Reimbursement Options
      1. For fully insured plans and other plans regulated by state law, the rate is the amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
      2. If there is no state balance billing law or the group or individual health insurance coverage is not regulated by state law, then the amount is
         a. If Medicare covers the service, a Congressionally set percentage of Medicare.
         b. If Medicare does not cover the service, either
            i. A fixed amount set by the Congress or
            ii. A percentage of a benchmark determined by the Congress.

   B. Timing of Payment
      1. Within 30 days of receipt of a bill as currently defined in the NSA.
      2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
      3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
      4. If it is determined that a plan or issuer has Not Adopted by Committee to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

   C. Maximum patient cost-sharing as indicated in Recommendation 8.

Discussion
Asbel Montes then opened the discussion on the Recommendation. The Committee members addressed their support and reasons for oppositions to the Recommendation.

Vote
Adler, Loren - Yes
Baird, Shawn - No
Beck, Adam - No
Godette-Crawford, Regina - No
Holden, Rhonda - No
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - No
McLean, Rogelyn - Abstain
Montes, Asbel - No
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - No
Sahni, Ritu - No
Van Horne, Edward - No
Weiser, Carol - Abstain
Wijetunge, Gamunu -Abstain
Wingrove, Gary – No

Next PRI provided the opportunity for those that voted no to provide comments.

Shawn Baird: “Thank you. My no vote was based on option A, not preserving the full tier of state balance billing down to state and local regulated rate down to negotiations with insurers and then finally as a last resort, a federal rate.

Adam Beck: “Yeah, my no vote, as I indicated earlier, I think would be cured if it weren't for a recommendation, I believe it's A2b that requires coverage and payment for non- Medicare covered services. So but for that item, I think this would be a reasonable recommendation.”

Regina Crawford: “Yes, my vote no is because I did not think -- option one did not allow the steps for the locals to negotiate those rates and I think that is imperative. Although we started negotiating rates, at this point, we still have a long way to go, especially with ground ambulance. So, I could not support that. I think option B is a better option. Thank you.”

Rhonda Holden: “The same, it's taking away the ability of the locals to negotiate rates and then also the mutually agreed upon reimbursement rates between an ambulance service and an insurance provider.”

Peter Lawrence: “12B provides much more appropriate rate setting processes from the state to the local, to the negotiations, to then the federal, and that's the reason why I voted no on 12A.”

Asbel Montes: “I'm a no vote, specifically for some of the reasons that everyone is giving here as well. This option didn't go far enough to make sure we preserved the local rights relative to the cost in different areas around those appropriate guardrails that we spent a lot of time discussing. And for that reason, I'm a no.”

Suzanne Prentiss: “Thank you. So, I'm a no vote for reasons that I have stated on our last recommendation and bringing them through here. I am working in all corners to protect state and local, well, the sovereignty at the state level and what's already recognized. So, although I appreciate all the comments that have been made, both for and against, I think that option B is the -- I'm going to be voting for B because it's preferable and

consistent with what I have voted on already. Thank you."

Ritu Sanhi: "Nothing to add. I agree with statements already made."

Edward Van Horne: "Yeah, thank you. I voted no, specifically as stated to preserve the ability to have the tiered response of tiered coverage from states to locals, to negotiations, and then a federal fallback if needed, which is 12B."

Gary Wingrove: "Nothing to add."

Recommendation 12B:

I. Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries. The group health plan or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for ground ambulance emergency medical services provided to a participant, beneficiary, or enrollee.

   A. Minimum Required Payment
      1. The amount specified in a State balance billing law (or in a state with an All- Payor Model agreement, the amount defined in that Agreement)
      2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
      3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the emergency ground ambulance services provider or supplier
      4. If none of the above exist, then the amount is:
         a. If Medicare covers the service, a Congressionally set percentage of Medicare.
         b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.

   B. Timing of Payment
      1. Within 30 days of receipt of a bill as currently defined in the NSA.
      2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
      3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
      4. If it is determined that a plan or issuer has Not Adopted by Committee to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

   C. Maximum patient cost-sharing as indicated in Recommendation 8.

   D. Minimum Guardrails for State and Local Regulated Rates for ground ambulance emergency medical services as indicated in Recommendation 11.

Discussion
Asbel Montes then opened the discussion on the Recommendation. The Committee members addressed their support and reasons for oppositions to the Recommendation.

Vote
Adler, Loren - No

Baird, Shawn - Yes
Beck, Adam - No
Godette-Crawford, Regina – Yes
Holden, Rhonda - Yes
Kelmar, Patricia - No
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - No
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu -Abstain
Wingrove, Gary – Yes

Next PRI provided the opportunity for those that voted no to provide comments.

Loren Adler: "I think I've said everything during the discussion portion."

Adam Beck: "Largely same principle as before, the coverage mandate for non-Medicare covered services, but then also this one does go a step further by mandating ERISA plans be governed by a state or local process, so that was also a deal breaker in this recommendation."

Patricia Kelmar: "Yeah, so I preferred option A, which is why I voted for that. And, you know, obviously in this option B, the important elements that I obviously, well, not obviously, that I do support are the timing payments, the guardrails, and the maximum cost share. So, I don't have any problems with that. It's just the payment mechanism. I just feel like it's going to be really confusing from the consumer perspective to understand which rate is applying, whether or not they're being overcharged, whether they're insurer or from the employer perspective who are paying these rates, you know, what's going on. So I think it's just much more confusing than option A and has the potential to have some issues with the local rate setting that I mentioned in the earlier conversation. That's why I voted no."

Dr. Ayobami Ogunsola: "Yes. My preference for option A is the fact that it provides a layer of checks, which I like, which I also think may be appropriate. And then option, my no-go to option B is because the methodology seems a little bit -- it should have been a little bit of complication here. So that is why I try to balance both. And my preference for option A is, I suggest, is more superior. And that's why I voted no for B. Thank you."

Following these presentations, the Committee adjourned for lunch.

Afternoon Sessions Session 1: Recommendations Review
Asbel Montes, Committee Chairperson

Next Asbel Montes began the afternoon sessions with continuing the review of Recommendations. Mr. Montes noted Recommendations 13 and 14 are predominately based on the non-emergency components. The Committee discussed each Recommendation and followed the discussion with a committee vote.

Recommendation 13A:
Establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for non- emergency ground ambulance medical services.

Any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to non- emergency ground ambulance medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner if the services were provided by an in-network non-emergency ground ambulance services provider or supplier.

The patient cost-sharing requirement is 10% of the rate established under Recommendation 14, subject to out-of-pocket limits with a fixed dollar maximum.

Discussion
Asbel Montes then opened the discussion on the Recommendation. Mr. Montes stated that Recommendation 13 is similiar Recommendation 8. Mr. Montes noted that when the Committee put the recommendations on how the prevention of surprise billing works, there's a reason why option A and option B for both, the non-emergency provision, and the emergency provision, is being voted on. While the committee agrees there needs to be some maximum cost of sharing that option of that amount for the participant or enrollee, there are different solutions to how to get to that.

Peter Lawrence suggested that based on the voting for Recommendation 8 that the Committee disregard Recommendation 13A and only vote on Recommendations 13B and 13C. Loren Adler noted that while there should be different protections between emergency and non-emergency, he agrees the vote should just be on 13B and 13C.

The Committee members then discussed examples of non-emergency ground ambulance medical services. The Committee agreed not to vote on Recommendation 13A.

Vote
No Vote

Recommendation 13B:
Establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for non- emergency ground ambulance medical services.

Any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to non- emergency ground ambulance medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner if the services were provided by an in-network non-emergency ground ambulance services provider or supplier.

The patient cost-sharing requirement may be the lessor of $100 (adjusted by the CPI-U annually) or 10% of the rate established under Recommendation 14, regardless of whether the health plan includes a deductible.

Discussion
Asbel Montes then opened the discussion on the Recommendation. Asbel Montes noted that 13B is very similar in the same to Recommendation 8B that was governing the provision within the preventing surprise billing and creating a reasonable for ground emergency medical services. Recommendation 13B is more relative to the non-emergency recommendation and is the same recommendation of the patient cost-sharing requirement.

Loren Adler discussed the importance of cost-sharing in non-emergency ground ambulance services, which are often vital and critical. Mr. Adler argued that out-of-network cost-sharing should not be higher than if the service had been in-network. They suggest that CMS should consider this in Part C plans, where cost-sharing shifts are successful. However, there is concern that without this, consumers may receive an inordinate bill for a 10-mile transfer, potentially costing them up to $500 or more out-of-pocket. They also suggest that there may not be an alternative service outside the medical necessity provision.

Vote
Adler, Loren - No
Baird, Shawn - Yes
Beck, Adam - No
Godette-Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Absent
Montes, Asbel - Yes
Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu -Absent
Wingrove, Gary - Yes

Next PRI provided the opportunity for those that voted no to provide comments.

Loren Adler: “Sure. I think I've explained why not. If we wanted to do something broader and lower cost-sharing across the whole healthcare system, all for that. I just think sort of picking and choosing individual services opens up a game where every -- there's a lot of important medical services, and it opens up a sort of game that's going to be difficult to -- well, maybe that's a good game if everything just has lower cost-sharing in my eyes, but that's sort of where I'm coming from here.”

Adam Beck: “Similar reasoning that this would create lower cost-sharing for out-of- network services than it would for in-network care.”

Recommendation 13C:
Establish a Maximum Cost-Sharing Amount for the participant, beneficiary, or enrollee for non- emergency ground ambulance medical services.

Any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to non- emergency ground ambulance medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner if the services were provided by an in-network non-emergency ground ambulance services provider or supplier.

The patient cost-sharing requirement for non-emergency ground ambulance medical services may be no higher than the amount that would apply if such services were provided by a participating non-emergency ground ambulance services provider or supplier.

Discussion
Asbel Montes then opened the discussion on the Recommendation. Adam Beck discussed he will vote “yes” on this option based on the assumption or the belief that this is reaching covered non-emergency ground ambulance medical services, which means that, A, they are a covered benefit as part of the patient's health insurance plan, which would also, B, allow them to be subject to any of the utilization management rules that would apply to any other covered service.. Mr. Beck also noted that this Recommendation works within Recommendation 14.

Loren Adler discussed one potential risk when lower cost-sharing is required for one type of non-emergency service is that the insurers may just deny more types of that service or try to deal with things that way rather

than, having 10 percent or whatever cost-sharing.

Vote
Adler, Loren - Yes
Baird, Shawn - No
Beck, Adam - Yes
Godette-Crawford, Regina - Yes
Holden, Rhonda - No
Kelmar, Patricia - No
Khawar, Ali - Absent
Lawrence, Peter - No
McLean, Rogelyn - Abstain
Montes, Asbel - No
Ogunsola, Ayobami – No
Prentiss, Suzanne - No
Sahni, Ritu - No
Van Horne, Edward - No
Weiser, Carol - Abstain
Wijetunge, Gamunu -Absent
Wingrove, Gary - No

Next PRI provided the opportunity for those that voted no to speak to their vote.

Shawn Baird: “Thank you. I think that the non-emergency -- I'm trying to sum up my comments briefly, and it gets really hard on this particular topic. I think the protection for the patient offered in Option B is appropriate, and I think as we revisit Item 8 on the emergency, we'll see that there was a consistent interest in keeping those protections strong and consistent. I heard a lot of the discussion around having various cost-sharing different between services on insurance, and my own insurance has different cost- sharing requirements for different service lines in it, and it's with a major insurer. So, I think that is actually fairly often done. The straight-across percentage, I struggle with it when we've had such an ineffective marketplace to determine what in-network and out- of-network really should be or is in an ambulance when so few ambulance providers are in-network. There just isn't enough to know what the cost- sharing requirement would be under Option C.”

Rhonda Holden: “I agree. I think Option B was just the superior option, and then Option C, I'm concerned that there just aren't enough in-network providers, and especially how that would impact in rural areas.”

Patricia Kelmar: “Yeah, just Option B seemed better, so that's why I voted.”

Peter Lawrence: “Option B seemed better.”

Asbel Montes: “At this time, I will just keep my comments to when we get to the recommendations on the prevention of balance billing, because it will all play into why this option is relevant.”

Dr. Ayobami Ogunsola: “Yes, it seems to me that Option B offers more protection than we can get in Option C. That's why I voted B as yes and no for C. Thank you.”

Suzanne Prentiss: “Quite simply, B is the better option, and I do think we need to be concerned about adequacy with, you know, having the number of participating providers available, especially, as Rhonda pointed out, for our more rural areas. This could become an issue. Thank you.”

Ritu Sanhi: “Nothing to add.”

Edward Van Horne: “Agree, Option B is better, and Option C does struggle with the solution on building out

appropriate networks in rural and suburban areas and getting participating providers."

Gary Wingrove: "Nothing to add."

Session 2: Recommendation Review

Recommendation 14A:
Prohibit balance billing and guarantee reasonable payment for covered non-emergency ground ambulance medical services.

I. Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries. The group health plan or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.

   A. Minimum Required Payment
      1. The amount specified in a State balance billing law (or in a state with an All- Payor Model agreement, the amount defined in that Agreement)
      2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
      3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the emergency ground ambulance services provider or supplier
      4. If none of the above exist, then the amount is:
         a. If Medicare covers the service, a Congressionally set percentage of Medicare.
         b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.

   B. Timing of Payment
      1. Within 30 days of receipt of a bill as currently defined in the NSA.
      2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
      3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
      4. If it is determined that a plan or issuer has Not Adopted by Committee to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

   C. Maximum patient cost-sharing as indicated in Recommendation 8.

   D. Minimum Guardrails for State and Local Regulated Rates for ground ambulance emergency medical services as indicated in Recommendation 11.

Discussion
Asbel Montes then opened the discussion on the Recommendation. The Committee members provided feedback on the recommendation and suggested adding an additional recommendation to vote on. The Committee added Recommendation 14C and voted on this later in the afternoon.

Recommendation 14B:
Prohibit balance billing and guarantee reasonable payment for covered non-emergency ground ambulance

medical services.

I. Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries. The group health plan or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.

   A. Minimum Required Payment
      1. The amount specified in a State balance billing law (or in a state with an All- Payor Model agreement, the amount defined in that Agreement)
      2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
      3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the emergency ground ambulance services provider or supplier
      4. If none of the above exist, then the amount is:
         a. If Medicare covers the service, a Congressionally set percentage of Medicare.
         b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.

   B. Timing of Payment
      1. Within 30 days of receipt of a bill as currently defined in the NSA.
      2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
      3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
      4. If it is determined that a plan or issuer has Not Adopted by Committee to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

   C. Maximum patient cost-sharing as indicated in Recommendation 8.

   D. Minimum Guardrails for State and Local Regulated Rates for ground ambulance emergency medical services as indicated in Recommendation 11.

   E. Notice and Consent for Certain Non-Emergency Ground Ambulance Medical Services The non-emergency ground ambulance services provider or supplier may not bill or hold liable the patient for more than the cost-sharing amounts consistent in Recommendation 13 unless it has provided notice with the information required by the current NSA within 72 hours prior to the date of the service and the patient has signed a written consent consistent with the information requirements in the current NSA.

Discussion

Asbel Montes then opened the discussion on the Recommendation. The Committee members provided feedback on the recommendation and suggested adding a additional recommendation to vote on. The Committee added Recommendation 14C and voted on this later in the afternoon.

Recommendation 15:

Emergency and non-emergency ground ambulance providers or suppliers and group health plans or health insurance issuers may access the Independent Dispute Resolution (IDR) process only when the Out-of-Network Rate (see Recommendations 12 and 14) is:

I. A set percentage of Medicare if Medicare covers the service or if Medicare does not cover the service, either
    a. A fixed amount set by the Congress or
    b. A percentage of a benchmark determined by the Congress and the process will be modified to be tailored to ground ambulance emergency medical services and non-emergency ground ambulance medical services.

The Committee recommends that the IDR process set forth in the NSA be adopted for ground ambulance emergency medical services and non-emergency ground ambulance medical services, with the following modifications:

A. Both parties would have the ability to request an IDR process, but only when the Out-of- Network Rate (see Recommendations 12 and 14) is a set percentage of Medicare or if Medicare covers the service or if Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.
B. The IDR entity should be required to consider the following ground ambulance emergency medical services and non-emergency ground ambulance medical services specific factors when determining the payment amount:
    1. The ground ambulance specific Out-of-Network Rate;
    2. The level of services being provided;
    3. The acuity of the individual receiving the services or the complexity of furnishing the services to the individual;
    4. The ambulance vehicle type, including the clinical capability of the level of the vehicle;
    5. Population density of the location where the patient was met;
    6. The time on task, including but not limited to wait-times and hospital wall-times;
    7. Distance from the destination, including but not limited to lack of access to providers within a reasonable distance (such as being in a medically underserved area); and
    8. State/local protocols and requirements.
C. The prohibition on the IDR entity considering other rates would be amended toremove Medicare rates from the list of prohibited factors.
D. The mileage and base rate elements of a single claim should be required to be batched (addressed) together. The process should also allow for batching of multiple claims that involve the same ground ambulance provider or supplier, insurer, level of service, and geographic area.
E. The cost of the IDR process should recognize the unique nature of ground ambulance service claims and their substantially smaller size when compared to claims of other providers. For the administration fee to be limited $50 updated annually (e.g., such as by the CPI-U). For the IDR entity charge, the amount could be to be a percentage of the value of the claim(s) in dispute.
F. The other IDR-related provisions of the NSA would apply without modification. The Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.
G. The other IDR-related provisions of the NSA would apply without modification.

Discussion

Asbel Montes then opened the discussion on the Recommendation. All Committee members provided feedback regarding this recommendation.

Vote

Adler, Loren - No
Baird, Shawn -Yes
Beck, Adam - No
Godette- Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - No
Khawar, Ali - Absent

Lawrence, Peter - No
McLean, Rogelyn - Abstain
Montes, Asbel - Yes
Ogunsola, Ayobami - No
Prentiss, Suzanne - Yes
Sahni, Ritu - No
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu -Absent
Wingrove, Gary - No

Next PRI provided the opportunity for those that voted no to provide comments.

Loren Adler: “I think I've said my piece on this.”

Adam Beck: “Yeah, I mean, the independent dispute resolution process was a mistake to write into the No Surprises Act, and it has proven in the years since to be an abject failure, both in terms of any policy outcomes as well as just the administrativefunctioning of an IDR process that has been egregiously overutilized primarily by the same private equity-backed emergency staffing firms that would likely end up being the actors that are most likely to pursue IDR under this approach. So, I think setting up any IDR systemis ill-advised. To recommend it when you have, in contrast to the No Surprises Act, you have an approach that we appear to be recommending where there is essentially a federal benchmark, a mandatory or required minimum payment that should eliminate the need for any subsequent independent dispute resolution. The reason, ostensibly, that Congress set up an IDR process followed by, you know, preceded by an open negotiation process under the No Surprises Act is because there is no mandatory initial payment, and there was a concern that initial payments would end up being insufficient or too low, and this gave an opportunity then for parties, primarily the providers and facilities and the air ambulance providers, to be able to seek what they believe to be a more reasonable out-of-network rate through IDR. Our earlier recommendations on required minimum payment flat out say that this is the out-of-network rate. So it is, to me, illogical to say out of, you know, one side of your mouth that this is the appropriate out- of-network rate, but we are going to, despite declaring that the appropriate out-of- network rate, allow for certain actors to be able to seek really a windfall on top of the already, you know, additional payments that they are getting as a result of the mandatory payments through this IDR process. I think there are flaws in the considerations that are laid out, and there's an open question about what exactly this penalty is that would be assessed for noncompliance. I think there are weaknesses in how this IDR process is set up, but the fact that it's even a part of the recommendation when it's so clearly failed with the No Surprises Act is, for me, a clear enough reason to vote no.

Patricia Kelmar: “Thank you. As I mentioned, I am concerned that there will be a huge amount of costs, administrative burden added to the system overall if we open up an IDR process. I'm confident that Congress will be sensitive to the needs of making sure that access continues in all the communities. We’ve seen states that have relied on a percentage of Medicare to be quite generous in that rate when states have passed surprise billing. I would expect Congress would act in a similar manner. Obviously, as consumer groups, we would be making sure that the minimum amounts are not the Medicare rate would be one that would support 24-hour, seven days a week, good ambulance emergency care. So, I just see this as an added cost, and that's why I voted no.”

Peter Lawrence: “As I've said before, we've got all these other rate structures and all these other processes in place to establish appropriate rates, and I think we've made great strides to get there. I understand everybody's concern expressed that we need one more backstop. I think the IDR process, if we came forward to Congress with the IDR, I think it gives Congress the ability to basically shoot low and then force everybody to go into the IDR process. And I don't think that that's the way we need to go. We need to have Congress set the rate. Am I being altruistic? Possibly so. But the bottom line is that the IDR process, in my opinion, creates a crutch and allows Congress to say, you guys don't like what we've done, go use IDR. So that's why I voted no on it. I

want Congress to take our recommendations, deal with them appropriately, and then establish a rate with everybody providing input, understanding that the GPCI is going to adjust for differences in geographic area and the rural, super rural adjustments will provide additional adjustment. I don't think the IDR process was appropriate for giving Congress an out."

Dr. Ayobami Ogunsola: "Yes, I voted no because I think it would be counterproductive and it's not cost effective. That's my judgment about it. Thank you."

Ritu Sanhi: "I voted no. This was very difficult though. This was not straightforward by any stretch. There were a couple of factors that led to my no vote. Number one, no matter who you talk to, probably the least effective and least popular portion of the No Surprises Act has been the IDR process. I mean, I guess there is a philosophy that if nobody likes it, then it must be doing something right. But I think that's been part of what has driven me to vote no. The other piece is, I don't necessarily share Patricia nor Peter's faith that Congress will set the right rate. What I do see as an additional backstop in this process is that a community or state could create its rate-setting process. Everything we've done until now has said that that would be the minimum payment. The combination of those two led to my no vote. "

Gary Wingrove: "Yeah. I am generally concerned about the cost with this one, and that's all the cost. It's hiring the firm that's going to go through it for you. That's not even spelled out. But anyway, I'm concerned about the cost, and I'm not sure that it adds value to any part of the equation."

Session 3: Recommendations Review

Asbel Montes, Committee Chairperson

Next, Asbel Montes continued the Recommendations Review. The Committee began with Recommendation 14. Mr. Montes noted that per Committee discussion Recommendation 14 now has three options to vote on. Recommendation 14A includes the minimum required payment and a walk through of the parameters. Recommendation 14B has the same thresholds as 14A with the notice and consent provision added. Recommendation 14C is the equivalent of Recommendation 12A except modified for non-emergency ground ambulance services.

<u>Recommendation 14A:</u>
Prohibit balance billing and guarantee reasonable payment for covered non-emergency ground ambulance medical services.

I. Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries. The group health plan or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.

    A. Minimum Required Payment
        1. The amount specified in a State balance billing law (or in a state with an All- Payor Model agreement, the amount defined in that Agreement)
        2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
        3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the emergency ground ambulance services provider or supplier
        4. If none of the above exist, then the amount is:
            a. If Medicare covers the service, a Congressionally set percentage of Medicare.
            b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.

B. Timing of Payment
   1. Within 30 days of receipt of a bill as currently defined in the NSA.
   2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
   3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
   4. If it is determined that a plan or issuer has Not Adopted by Committee to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

C. Maximum patient cost-sharing as indicated in Recommendation 8.

D. Minimum Guardrails for State and Local Regulated Rates for ground ambulance emergency medical services as indicated in Recommendation 11.

Discussion
Asbel Montes then opened the discussion on the Recommendation. . The Committee members provided feedback on the recommendation.

Vote
Adler, Loren - No
Baird, Shawn - No
Beck, Adam - No
Godette-Crawford, Regina - No
Holden, Rhonda - Yes
Kelmar, Patricia - No
Khawar, Ali - Absent
Lawrence, Peter - No
McLean, Rogelyn - Abstain
Montes, Asbel - No
Ogunsola, Ayobami - No
Prentiss, Suzanne - No
Sahni, Ritu - No
Van Horne, Edward - No
Weiser, Carol - Abstain
Wijetunge, Gamunu -Absent
Wingrove, Gary – No

Next PRI provided the opportunity for those that voted no to provide comments.

Loren Adler: “Sure, I mean, I think we've discussed this a little bit as well. For this one, I'd say this is a more weakly held no than the previous ones, given that there aren't that many non-emergency set rates to begin with and given that there are sort of market factors and some coverage decision processes that can still happen behind that, yeah, sort of after the fact stuff, so I don't think this is quite as determinative. As long as it is a pretty weakly held no, but basically the main reason is just the encroaching on ERISA issue here for my hesitation here.”

Shawn Baird: “Yeah, I would have been able to support this if it had what the next one we're voting on, option B, has as its sub-point E, which is the notice of consent provision allowing for patient choice.”

Adam Beck: “Yeah, just can't vote to support subjecting ERISA self-funded group health plans to the state

regulation."

Regina Crawford: "Sorry, I was muted. Same reason, I want to support the state authority to have some say in this, so option B is better for me."

Patricia Kelmar: "Nothing to add that I didn't already state in the earlier discussion around these different options, I think on recommendation 12, perhaps, and I think option C is the best."

Asbel Montes: "No comment at this time."

Dr. Ayobami Ogunsola: "Yes, there's no protective no, that's why I voted no."

Suzanne Prentiss: "I just think that there's a better option and reflecting on what some of my colleagues have said, so thank you."

Ritu Sanhi: "What she said."

Gary Wingrove: "What she and he said."

Peter Lawrence: "I'm back. Okay. I just prefer option B. Everything else has been covered by everybody else."

Recommendation 14B:

I. Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries. The group health plan or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.

   A. Minimum Required Payment
      1. The amount specified in a State balance billing law (or in a state with an All- Payor Model agreement, the amount defined in that Agreement)
      2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
      3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the emergency ground ambulance services provider or supplier
      4. If none of the above exist, then the amount is:
         a. If Medicare covers the service, a Congressionally set percentage of Medicare.
         b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.

   B. Timing of Payment
      1. Within 30 days of receipt of a bill as currently defined in the NSA.
      2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
      3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
      4. If it is determined that a plan or issuer has Not Adopted by Committee to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

C. Maximum patient cost-sharing as indicated in Recommendation 8.

D. Minimum Guardrails for State and Local Regulated Rates for ground ambulance emergency medical services as indicated in Recommendation 11.

E. Notice and Consent for Certain Non-Emergency Ground Ambulance Medical Services The non-emergency ground ambulance services provider or supplier may not bill or hold liable the patient for more than the cost-sharing amounts consistent in Recommendation 13 unless it has provided notice with the information required by the current NSA within 72 hours prior to the date of the service and the patient has signed a written consent consistent with the information requirements in the current NSA.

Discussion
Asbel Montes then opened the discussion on the Recommendation. . The Committee members provided feedback on the recommendation.

Vote
Adler, Loren - No Baird, Shawn - No Beck, Adam - No
Godette- Crawford, Regina - No Holden, Rhonda - No
Kelmar, Patricia - No Khawar, Ali - Absent Lawrence, Peter - No McLean, Rogelyn - Abstain Montes, Asbel - No Ogunsola, Ayobami - No Prentiss, Suzanne - No Sahni, Ritu - No
Van Horne, Edward - No Weiser, Carol - Abstain Wijetunge, Gamunu -Absent Wingrove, Gary - No

Next PRI provided the opportunity for those that voted no to provide comments.

Loren Adler: “Nothing further on this point.”

Shawn Baird: “Just that I think there is far too much complexity for us to be able to reach a recommendation on non-emergent at this point.”

Adam Beck: “I'd say, in particular, concerns about the notice and consent provision here.”

Regina Crawford: “It’s all been covered. Nothing further.”

Rhonda Holden: “Yeah, just the notice and consent I couldn't support.”

Patricia Kelmar: “Nothing to add”.

Peter Lawrence: “Nothing to add.”

Asbel Montes: “So I just want to go on the record. I'm generally supportive and want to make sure that, regarding the recommendation number 14, very, very supportive of making sure that we prohibit surprise billing and create some reasonable environment in the non-emergency when individuals are requesting it. I'm generally supportive of the notice and consent if it's done in enough time frame to allow that patient to have a choice of who they want to select, as not all non-emergency happens within less than 72 hours, or what have you. And this is also an elective procedure as well. My biggest issue that I have is, we're making assumptions around the required payment amount. And that required payment amount is a tiered approach if Congress adopts it. But in the event that it does not, and the market factors will correct in certain areas and markets across the country. But there are many markets where it will not. And so, with the failure of recommendation number 15 and the independent dispute resolution process in a very, very minimum capacity to be able to use that, in the event Congress opts to just this federal provision, and I am sure that option C will be voted on by a few as well in the affirmative, that doesn't look to the states to help with ERISA side of it. We are making assumptions that there is going to be a percentage to a Medicare rate that will ensure that the markets do not fail in certain areas across the nation. And right now, unfortunately, there is not enough data that allows for the

ground ambulance side of it outside of understanding costs to ensure there's market failure do not happen. So I really am probably more a no on most of these options relative to the absence of having some type of avenue while the patient is out of the middle that the provider and the insurer can agree on something if the market factor has not been an area that has been able to play out in those individual geographic areas. So I'm going to be on the record for that. Supportive of the prohibition, that definitely needs to happen, but how we're getting there is concerning."

Dr. Ayobami Ogunsola: "Yes, my take on this is that it is more restrictive instead of being protective, and can also be described as being arm twisting, or at best to be thought of a bit of conflict to the patient. And that's why I voted no. Thank you."

Suzanne Prentiss: "It's all been said."

Ritu Sanhi: "I just wanna echo some of Asbel's comments and hearken back to what I said earlier too, which is that I think we have broad consensus in the group that the patient should be left out of the middle. My concern was where we're going now and this process has been fascinating because I was planning to vote yes on this option until I heard a lot of this discussion. So I appreciate the discussion. My concern is that we are going to be left with no recommendation around non-emergency. And I do think that one of the fundamental things that we as a group agreed upon or seem to have consensus upon is that the patient should be left out of the middle in non-emergency also. And so I don't know if there's pallet or openness to discussing a more general recommendation that says something to the extent of what the overarching statement was for this section, which we would recommend prohibiting balance billing and guarantee a reasonable payment. However, given the complexities of non-emergent ground transport, we could not reach a consensus as to how to move forward with that. Something to that effect.
That would be my only addition. Thank you."

Edward Van Horne: "Yeah, everything has been said. I think in general, still trying to get the patient out of the middle, recognizing non-emergency is very different than the emergency and emergency interfacility urgent work. And I think the committee did a phenomenal job working through the pieces we needed for that. The non-E on not only disclosures, but network adequacy and ability to reimbursement levels for the quality of care that's needed still needs some more work. And that's why I voted no on that specific piece."

Gary Wingrove: "I also was planning to vote yes for this one, but in general, I absolutely support the notice provision. It's the consent that I'm having trouble with. And if it said something like in areas where a choice is an option, that may have made me do something different. But I think notice is important, but the consent isn't going to work for most of the country."

<u>Recommendation 14C:</u>

I. Ground Ambulance Out-of-Network Reimbursement is a National Set Rate by the Congress and Secretaries. The group health plan or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.

   A. Payment Reimbursement Options
      1. For fully insured plans and other plans regulated by state law, the rate is the amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
      2. If there is no state balance billing law or the group or individual health insurance coverage is not regulated by state law, then the amount is
         a. If Medicare covers the service, a Congressionally set percentage of Medicare.
         b. If Medicare does not cover the service, either
            i. A fixed amount set by the Congress or

ii. A percentage of a benchmark determined by the Congress.

B. Timing of Payment
   1. Within 30 days of receipt of a bill as currently defined in the NSA.
   2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
   3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
   4. If it is determined that a plan or issuer has Not Adopted by Committee to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage.) In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

C. Maximum patient cost-sharing as indicated in Recommendation 8.

Discussion
Asbel Montes then opened the discussion on the Recommendation. The Committee members provided feedback on the recommendation.

Vote
Adler, Loren - Yes
Baird, Shawn - No
Beck, Adam - No
Godette-Crawford, Regina - No
Holden, Rhonda - No
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - No
McLean, Rogelyn - Abstain
Montes, Asbel - No
Ogunsola, Ayobami - No
Prentiss, Suzanne - No
Sahni, Ritu - No
Van Horne, Edward - No
Weiser, Carol - Abstain
Wijetunge, Gamunu -Absent
Wingrove, Gary - No

Next PRI provided the opportunity for those that voted no to provide comments.

Shawn Baird: “My broad comment would be, again, that I think this whole non-emergent work is so complex and so different than the emergent. And I agree, on the one hand, you know, another committee member said, well, it seemed like we had sort of broad consensus to cover non-emergent, but as we dove into more and more discussion on the options, including option C, it has become apparent that that is a very significant, complicated matter to try to take on.”

Adam Beck: “Yeah, actually, kind of similar. I agree, you know, if it were just recommendation 14 without the options, that first screen, I could certainly vote yes. And I think of the three options, this is, from my standpoint, the preference, because it keeps ERISA preemption intact, but I think there are too many outstanding questions about how the other mechanisms would work, including, like, the cost-sharing, that it looks like we're referencing directly back to recommendation, I guess, 13. So just, I think too many unanswered questions in this to vote for the specifics.”

Regina Crawford: “I would totally agree with what Adam said, and Shawn. I just think this is too big to get our arms around, so I just think we have to continue to work toward finding something that will work.”

Rhonda Holden: “Yes, I think that we probably, if we try to tackle this in the future, if they come back and ask for a recommendation, we need to be well-versed in non-emergent transports and have some presentations from subject matter experts that can really help us look at the impact that it might have, all of those unintended consequences.

Peter Lawrence: “Couple items. Item one was the ability for local rates to be utilized was excluded, and that's critical in my opinion. The second is, you know, I agree with the earlier statements that we have a broad consensus within the group that we need to work on balance billing with non-emergent as well as emergent, but this group spent most of our time dealing with the emergency aspect, and we didn't spend a lot of time with the non-emergent aspect, and I think everybody just took the assumption that we would drag them together, which is not the case. We still, in my opinion, need to have some statements in the report that says that we need to be looking towards prohibiting balance billing on non-emergent transports, but there needs to be further discussion, and maybe it needs to be added into the recommendation we have earlier that identified that treatment in place and the cost of supplies and ALS first response needs to be established or discussed as part of a standing committee, and maybe we can add that into that that the Congress needs to look at it. Thanks.”

Asbel Montes: “So not to add much more to what everybody has said here as well, but I think when the committee came here through the charge and the introduction of Section 117 into the No Surprises Act, which established this advisory committee, was relative to the services that patients were receiving where they didn't have a choice. And whether they called 911 or the equivalent or from the consumer receiving a bill because they were transported from one hospital to another for the continuous and furtherance of that emergency condition as they viewed that emergency condition within the prudent layperson standard of services that were not available to transfer them somewhere for them to get that care. Now, I believe in a lot of our recommendations, we have addressed that. We've addressed it through the way the definitions are, and then we've gotten to this more complicated component around non-emergency. And I understand that we'd like to protect the insurer from everything, or the consumer, but I think that there needs to be a much more thought process through that that still allows for the markets to correct themselves. And in those areas where the markets may not be correcting themselves, is how do we make sure that access stays. And so, from that perspective, generally speaking, and I agree with Adam on this, recommendation number 14 and prohibit surprise billing and create a reasonable rate for the consumer for non-emergency services makes sense to me. It makes sense to most people that look at this. We get into the complexities of these options, and then we begin to determine that there's a lot more complexity to the non-emergency space that's outside of the purview of actually what we even begin to come in here with those lenses. So, for that reason, I'm really strongly suggesting a key finding. I like what Shawn has indicated as well. So maybe we need to think through this and ask for some type of more work to be done around this piece as well in those areas where maybe the market conditions are not doing what they should be doing properly.”

Suzanne Prentiss: “So, a lot of this has been covered. I think Asbel just summed it up nicely, and I don't feel that we can move forward. I think it's premature here in a very complex area that is such an important part of the work that the EMS profession is doing for the entire healthcare system. So, making this into a finding versus a recommendation so we can keep the spotlight on it and hopefully continue to work, I think is the best solution here, best possible outcome. Thank you.”

Edward Van Horne: “I agree with that, that we clearly as a committee have found that we need to solve and work with the non-E complexity and get the patient out of the middle. I think there's broad agreement on that. It's how we do that with the nuances of rural, suburban areas that are in-network. This space does have that done quite a bit still, right, where you've got providers in-networks and have that built, but how do you have the notice and consent? There's a lot to it. So, I like that idea on findings.
I do think this committee does need to come forward with something because we have been talking about it,

but we've been broadly working on the emergency solve and the emergency inter-facility, and that's been an important piece of the main charter. So thank you."

Gary Wingrove: "Nothing new to add."

Ritu Sanhi: "There's one other component I just want to add to this just to make it even more complex, but as a county regulator in my state, we have the authority to regulate all ambulance service, including non-emergent, and we have chosen not to regulate non-emergent pricing, et cetera. But in other situations, the payer mix and just the breakdown of your emergent business could be such that it's difficult to make money. It's difficult to basically cover your cost without some component of local non-emergent control also. And so I think that reinforces why there has to be at least the option for local oversight of non-emergent and rate setting."

Recommendations 3A and 3B Discussion
Mr. Montes discussed with the Committee, for the adoption of the members that voted yes on 3A that the recommendation is that 3B was the members preference The Committee agreed with this suggestion. Mr. Montes informed the Committee the original vote counts will still be part of the public record. However, for the report that is sent to Congress, Recommendation 3B would be the adopted recommendation based upon the vote count for 3B

Session 4: Wrap-Up/Next Steps

Shaheen Halim, CMS, Designated Federal Officer

Next Shaheen Halim discussed the next steps for the GAPB Advisory Committee. Ms. Halim noted the Committee has developed a comprehensive set of recommendations over the past six months, which will inform Congress and the Secretaries on what to do next. The Committee will develop the content for the report this winter, compiling notes and artifacts from meetings. The report is expected to be issued in early 2024 after being edited. The final report will be posted on the CMS.gov ***GAPB*** website., with presentations, transcripts, meeting summaries, and recordings available in phases. Ms. Halim thanked the Committee members and the public for their participation.

The third public meeting of the GAPB Advisory Committee was adjourned by Ms. Shaheen Halim around 4:00 PM.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

Shaheen Halim -S

Digitally signed by Shaheen Halim -S
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Shaheen Halim, Ph.D., J.D.
Designated Federal Official
Ground Ambulance and Patient Billing Advisory Committee
Centers for Medicare & Medicaid Services

Asbel Montes

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Asbel Montes
Committee Chairperson
Ground Ambulance and Patient Billing Advisory Committee

Appendix G – GAPB Topics for Public Comment

The following topics for public comment were discussed during the 2nd public meeting held on August 16, 2023 and subsequently posted with a public comment period that ended September the 5th.

The Committee seeks public comment on the following issues under consideration:

Please submit public comment by September 5th to the following email address: GAPBAdvisoryCommittee@cms.hhs.gov

1. Should balance bills for ground ambulance services be prohibited (as withservices currently under the purview of the No Surprises Act)?
2. Would it be appropriate to incorporate ground ambulance services into existing NSA protections?
3. Should any protections apply to non-emergency transports? If so, should those protections differ for emergency transports?
4. Should any protections apply to assessment, first responder, or other non-covered fees?
5. How can meaningful public and/or consumer disclosures be crafted?
6. Should there be cost-sharing limitations for EMS in Medicare Advantage?
7. Should there be a federal, universal EMS benefit?
8. Should EMT's and Paramedics be classified as providers?
9. Should state and local governments specify the out-of-network reimbursements?
10. Should a public utility model be deployed?
11. Should emergency ambulance services be considered "in-network" since the consumer has no choice when they call 9-1-1?
12. We are seeking information related to examples where consumers receive billsfrom ambulance providers for services not covered by an insurance carrier.
13. What communities or areas in the United States are without emergencyambulance service coverage?
14. Should NSA protections apply to volunteer ambulance service agencies?